healthwatch Worcestershire

People's experience of leaving Worcestershire hospitals during Covid-19

(March 2020 – April 2021)

Report
August 2021

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Acknowledgments

Thank you to everyone who took the time to speak with us during this project or who completed one of our Surveys. We are very grateful to you for sharing your experience with us.

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A special thank you to Kathleen Simcock, Interim Head of Service, Integrated Intermediate Care, who provided a single point of contact across the health and care system, for her help and support.

Note

A copy of the Survey will be available on our website.

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A. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

INTRODUCTION

During the Covid-19 pandemic there was a national imperative to free up capacity in acute hospitals in order to cope with demand for beds space created by the virus. In March 2020 the Government issued Hospital Discharge guidance[1], updated in August 2020 as the national policy and operating model[2]. This was the Guidance that was in place whilst we were undertaking this project, it was further updated in July 2021[3] and reference is made to this updated version of the Guidance where relevant. The Guidance sets out a process designed to support the faster movement of people out of hospital once they are medically fit for discharge. It sets out four Pathways[4] for people leaving hospital, with most patients being discharged home. Any assessment of people's short and long term needs should happen in the community using the "Discharge to Assess" model rather than in hospital. Although these changes were put in place to address Covid-19 the model is likely to remain in place.

We wanted to understand how hospital discharge in Worcestershire is working from a patient and carer's perspective, as well as broadening our understanding of the process through talking with some care providers and NHS and social care staff involved. Through 127 Survey responses and 15 qualitative interviews we gathered the views of 142 patients and carers who had experienced a discharge from a Worcestershire hospital between March 2020 and April 2021. We interviewed 5 care providers and 24 NHS and social care staff. The work was widely promoted through HWW networks as well as NHS, social care and VCS and community organisations. The majority of our Survey respondents are women (70%) and from a White British ethnic background (94%). The age range was evenly spread between those aged 24 – 64yrs (52%) and older age groups (47%). Most of our Survey respondents (67%), had been discharged from Worcestershire Royal Hospital with a further 27% from the Alexandra Hospital and 7% from Community Hospitals. Further details about what we did and who we heard from can be found in the Full Report.

KEY FINDINGS

Patients and carers acknowledged the huge impact of Covid-19 on health and care services. We heard positive comments about staff in these sectors, who were working hard to do their best for patients whist dealing with rapid change, additional work pressures and concerns about their own health.

Nevertheless, we have identified that there are issues and challenges experienced by patients and carers when people leave hospital, and we have focused on these, as this is where learning can be identified.

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[1] Covid-19 Hospital Discharge Service Requirements, March 2020, HM Government

[2] Hospital Discharge Service: Policy and Operating Model 21st August 2020, HM Government

[3] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government: www.gov.uk/government/collections/hospital-discharge-service-guidance

[4] In Worcestershire there are additional Pathways relating to people with highly complex needs or who require CHC fast track. See full Report

COMMUNICATION

Communication, or the absence of it, is often highlighted in our work as one of the areas that can have most impact on people's experience. We heard that two thirds of Survey respondents did not receive written information about the new discharge process during their hospital stay. Almost half (45%) of patients who responded to our Survey told us that their family, or someone else that they asked to be informed, were not told that they were leaving hospital. Just over half of unpaid carers told us that they were not sufficiently informed (53%) or involved (53%) in their relative's discharge, but they should have been. As hospital visiting is restricted due to Covid-19 it is even more important that families have clear lines of communication with patients and with hospital staff. There was support for communicating with patients through iPads and by telephone whilst visiting was restricted. However, family members reported difficulties being kept informed and updated whilst their relative was an inpatient, and at times lacked clarity about the plan for their discharge. Carers of patient's living with dementia or who were non – verbal reported feeling they lacked contact with their loved ones and unable to advocate on their behalf.

Communication with care providers is important as the Discharge to Assess model relies on support in the community to ensure that patients can be safely discharged. Gaps or inconsistencies in information relating to patient's health and the timing of their discharge from hospital can make it difficult for providers to effectively plan and prepare for their client or resident. There is scope for communication with patients, carers and care providers to be improved.

Recommendations

In line with recommendations made by Healthwatch England[5](HWE), while visiting restrictions continue, put in place special arrangements to improve communication and involvement with family and carers to enable them to participate in decisions made during and after the discharge process, particularly for patients with disabilities and additional needs, in line with the hospital duty to cooperate with family carers.

1. When people are admitted to hospital they are asked if they have a carer who should be involved in decision making about their care. If the patient does name a carer, attempts to contact them and involve them in discussions about hospital care and discharge should be made at every step, and in particular prior to a patients discharge from hospital.
2. Family and carers to be provided with a single point of contact who they can get in touch with for information about their relative while they are in hospital.
3. In line with the July 2021 Government Guidance patients, and where appropriate their family or carers, should receive regular updates and sharing of information about the next steps in their care and treatment.[6]

[5] These recommendations are made in Healthwatch England's (HWE) Report "590 people's stories of leaving hospital during Covid-19, October 2020, Healthwatch England working with British Red Cross" They are repeated and endorsed here as our findings show that they are relevant to Worcestershire

[6] Hospital Discharge and Community Support Operating Model, 5th July 2021, page 17

FEELING PREPARED TO LEAVE HOSPITAL

Some patients felt that their discharge from hospital was rushed; nearly one in three (29%) people felt they were not prepared to leave. Over half (56%) of people who told us they had a significantly worse experience of leaving hospital than they had previously felt that they were not prepared to leave hospital.

Some unpaid carers reported that they lacked sufficient information about the health status of their relative on discharge, or felt that their relative had been discharged too early. Care providers reported that they were sometimes given incomplete information about the patient on discharge, making it more difficult to plan for their care.

Recommendations

In line with the July 2021 Government Guidance:

4. Start conversations with patients, and their family or carer where appropriate, and plan earlier in the process so that patients are aware of when they may be discharged.
5. Ensure that individuals and their families are provided with the information supplied by NHS England, or a local equivalent, about leaving hospital and are fully informed of next steps.
6. Ensure that essential information is communicated and transferred to relevant health and care partners on discharge.

LEAVING HOSPITAL

Covid-19 testing

It is current policy to test everyone on admission to hospital for Covid-19, and to test all those being discharged into a care home, supported housing or other temporary accommodation. Home care providers told us that communication of a person's Covid-19 status has improved, but could be more consistent. Family carers told us of their anxiety about their loved one's returning home with a positive Covid test.

Recommendations

In order to provide help and reassurance to family carers and enable paid providers to better manage any potential risks

7. In line with recommendations made by HWE, and dependent on Covid infection rates in the community, consider whether all patients being discharged from hospital should be tested for Covid-19 before going home.
8. Covid-19 test results should be communicated to families and where relevant care providers, and included in documentation that accompanies the person on discharge.
9. Ensure that patients who are Covid-19 positive on discharge home are supported to self-isolate where this is needed by the patient or their family, for example, through referral to the Here2Help[7] scheme.

[7] Here2Help Coronavirus (COVID-19) | Worcestershire County Council

Discharges at weekends and at night

Patients and carers told us of some of the difficulties that they encountered when hospital discharge took place late on a Friday or at the weekend, when assessment and community support services may be more constrained, including difficulties in resolving issues with medication, lack of accessible clinical support or reduced access to community based care services. 11% (number (n)14) of Survey respondents were discharged at night (after 8 p.m.). Only 2 of the patients discharged at night told us they felt prepared to leave hospital.

Recommendations

10. Consider whether inpatient discharge after 8 p.m. is appropriate for any patient, and consider placing limits on weekend discharge which are determined by capacity in the system.

Reasons people waited to be discharged

37% of respondents waited over 4 hrs to leave hospital, and of these 8% waited over 8 hours. The two main reasons for waiting, across both Acute Hospitals, were for transport arrangements and medication. Waiting for transport can have "knock on impacts" such as patients being discharged into the night and can impact on care arrangements when patients arrive home later than expected.

Delays in prescribing and dispensing medication can impact on longer waiting times for discharge, suggesting that medication should be identified and ordered earlier. We also heard that clearer explanation and instructions of changes of medication, purpose, dosages, possible side effects and administration should be provided to patients, and where appropriate carers, on discharge. Care providers told us that information on changes to medication was not always conveyed to them prior to discharge, which could result in delays to this being administered.

Recommendations

11. Patients, and where appropriate their carers, should always be asked about transport requirements.
12. Review processes so that, at an earlier stage, patient's requirements for hospital transport can be identified.
13. Consider how the four hour window for hospital transport can be reduced, or transport capacity increased.
14. Patients, and where appropriate carers, should always be given information about the purpose of their medication and how to administer and manage it.
15. Consider how information about changes to medication can be communicated to care providers prior to a patients discharge to ensure continuity.

Discharge Lounge

From our feedback from patients and carers we feel that it is important that a patient's suitability for the discharge lounge is considered, as is currently the case in Worcestershire, and that there is a clear handover between the ward and the discharge lounge about a patient's particular needs and requirements.

Recommendations

16. Consider introducing a standardised format for information transfer between hospital wards and the discharge lounge.

Discharge Forms and Letters

We heard from patients, carers and care providers that the extent and accuracy of information provided in discharge forms and letters was variable, with patients sometimes being unclear about what to expect following their treatment or the future plan for their care. 44% of unpaid carers felt they did not have enough information to support their relative after discharge. Care providers explained how important discharge notes are to them, as they form the basis for their future care plans. GPs would welcome a timely, accurate, clear and precise short format "summary on a page" that identifies key information, including specific, unambiguous information about what action is required of the GP; information about the follow up plan, and the role of the hospital in that plan.

We are aware that the health and care system in Worcestershire intends to move to an electronic Shared Care record, which may overcome some of the difficulties with information about a patient's inpatient diagnosis and treatment, and the plan for their follow up on discharge.

Recommendations

17. Consider how the format for discharge notes will ensure that these provide an accurate, precise and consistent account of the patient's hospital stay and treatment, and are clear and specific about the follow up care and treatment to be provided by the hospital, GP and other health and care professionals.
18. This format should be developed through dialogue with patients and carers and with primary care and social care providers.

Named contact for follow up

53% of respondents to our Survey were not given information about who to contact if they needed further health advice or support after leaving hospital, despite the National Guidance stating this should happen.

Recommendations

19. In line with the July 2021 Government Guidance ensure patients receive information about who to contact if their condition changes, including direct contact points within the hospital and information signposting them to relevant voluntary sector or other community support.
20. Hospitals should also provide the patient's nominated family member /carer with this information where appropriate.

How this experience of hospital discharge compares to previous experiences
75% of respondent had previous experience of hospital discharge, when asked how this most recent experience compared 45% described it as worse, 33% felt it was about the same, whilst 19% described it as better. We identified that there are further opportunities for promoting feedback and dialogue with patients, carers and care providers.

Recommendations

21. Consider how opportunities to promote dialogue with and feedback from patients and carers and care providers can be maximised, including ensuring that patients are routinely informed of Patient Advice and Liaison Services and the complaints procedure.

REABLEMENT AND COMMUNITY SERVICES

Most respondents (63%) were not visited by health or care professionals when they left hospital as they did not need this. However a few patients (n16) reported that they needed support to settle in at home and were not provided with it, or that they had unmet care and support needs but had not received a follow up visit following their discharge (n12). Whilst these numbers are small it is important that patients who require support following their hospital stay are consistently identified and offered this.

Of respondents who did receive a visit to assess their care and support needs (n40), most (n29) were seen on the same day or the day after their discharge. The most common topics discussed were about aids and equipment, whether there were people to support them and whether they needed support for tasks such as washing, dressing and cooking.

31 Survey respondents were provided with services or support from a health or care agency. We had mixed reports about how well this support worked. 30% (n9) of respondents thought health and care teams worked very well together to support them, 40% (n12) thought teams worked moderately well together, whilst 30% (n9) thought teams had not worked at all well together.

We heard positive comments about the timeliness of the support provided and praise for the staff delivering it.

Concerns were expressed where support was needed, but not available, on discharge; plans for follow up care were not well communicated to patients and carers or where the support provided was felt to be limited. We also heard some concerns about the quality and consistency of the care services provided, but we do not know how widespread these concerns are.

We also heard some concerns about the availability of physiotherapy services once the reablement period had ended.

We heard mostly positive comments about the provision of equipment and OT services on discharge, but some concerns from providers about community OT provision once the reablement period had ended.

Recommendations

22. Ensure that patient's home circumstances are discussed with them on admission to hospital, or well in advance of discharge.
23. Ensure that all patients leaving hospital receive a holistic welfare check to determine the level of support, including non-clinical factors like their physical, practical, social, psychological and financial needs, as set out in the July 2021 Government Guidance.[8]
24. Consider whether there is sufficient capacity across the health and care system to support patients discharge.

SUPPORT FOR CARERS

Half of the unpaid carers who responded to our Survey felt their caring responsibilities were not considered when they should have been. Some carers did not see themselves as in need of support, but others described the additional stress placed upon them during the Covid-19 pandemic, which led to some carers feeling more isolated as they were unable to access face to face support.

Recommendations

In line with the NHSE July 2021 Guidance

25. Ensure that before discharge, conversations are held with family members about their availability and capacity to care, these conversations should inform unpaid carers who need help of their entitlement to a carer's assessment.
26. Ensure that where this is a new caring duty, or there are increased care needs, a carers assessment, where required, is undertaken before caring responsibilities begin.[9]
27. Ensure that any children and young people who may have caring responsibilities at the point of discharge are identified and referred to young carers services or offered a needs assessment where appropriate.

DID PATIENTS GET THE SUPPORT THEY NEEDED TO RECOVER

We asked the respondents to our Survey whether they, or their relative, got enough support from NHS and care services to help them to recover and to manage their condition. 24% thought that this was definitely the case, 38% thought this to some extent, whilst 29% thought that more support would have helped them and 9% did not need any support.

[8] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government, Page 8: www.gov.uk/government/collections/hospital-discharge-service-guidance

[9] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government page 8: "A carers assessment can be completed after discharge, but should be undertaken before caring responsibilities begin" www.gov.uk/government/collections/hospital-discharge-service-guidance

WHAT NHS AND SOCIAL CARE STAFF TOLD US ABOUT HOSPITAL DISCHARGE

On the whole both NHS and social care staff we spoke with were positive about interagency working across health and social care.

We heard support for the Discharge to Assess model which was seen as having potential to improve flow and capacity within the Acute hospital, reduce delayed transfers of care, assist patient recovery at home, and provide responsive, integrated care at home for patients who required support.

Some NHS staff we spoke to felt that discharge planning in Acute settings should start earlier in the patient's stay, rather than at the point where a patient was identified as medically fit for discharge, and that making decisions about patient's fitness for discharge and discharging patients earlier in the day would improve flow across the system, as well as providing a better experience for patients.

We had mixed feedback from NHS and care staff about capacity in Reablement services and Neighbourhood Teams for patients on Pathway One, which could be a potential block to patients being discharged. Capacity could be affected by geography (more difficult in the south of the County and in rural areas), timing (less capacity in the evenings and at weekends), staffing, availability of domiciliary care, and volume of demand.

Social care staff highlighted that the use of Discharge to Assess beds could potentially lead to multiple moves for vulnerable patients. Social care staff understood and were supportive of the need to increase capacity in hospitals, but advocated for a need's led, more flexible approach rather than always following a "Pathways" approach.

It was clear that staff were motivated to improve the process, and wanted to get it right for patients and carers.

Recommendations

28. Consider how planning for hospital discharge in acute hospital settings can be started earlier in the process, in order to enable patients to be discharged earlier in the day.
29. Allow for flexibility within the Pathways approach when this is required to meet the individual needs of patients.

1. ABOUT HEALTHWATCH WORCESTERSHIRE

Healthwatch Worcestershire (HWW) provides an independent voice for people who use publicly funded health and social care services. Our role is to ensure that people's views are listened to and fed back to service providers and commissioners in order to improve services.

2. WHY ARE WE LOOKING AT HOSPITAL DISCHARGE?

During the Covid-19 pandemic there was a national imperative to free up capacity in acute hospitals in order to cope with demand for bed space created by the virus.

In March 2020 the Government issued Hospital Discharge Guidance. This set out a process designed to get people out of hospital quickly, to free up bed space and support the faster movement of patients in and out of hospital.[10] Local systems are required to embed the new ways of working set out in the Guidance. A key element is the Pathways approach, where patients are discharged under one of four pathways dependent upon their care and support needs. Following discharge their ongoing care needs are assessed in the community (Discharge to Assess).

Building on work undertaken by Healthwatch England[11] we wanted to understand how hospital discharge is working from a patient and carers perspective in Worcestershire, as well as broadening our understanding of the process through talking with some care providers and the key NHS and social care staff involved.

Worcestershire Hospitals

The Worcestershire Acute Hospitals NHS Trust is responsible for running the Worcestershire Royal Hospital (WRH) in Worcester and the Alexandra Hospital (the Alex) in Redditch, the County's two main inpatient Acute Hospitals. The Trust also runs the Kidderminster Hospital and Treatment Centre, which offers clinical facilities and patient accommodation for a wide range of day case, short stay and inpatient procedures, and the Burlingham Ward, an Endoscopy Unit at the Evesham Community Hospital.

In addition the County has seven community hospitals/rehabilitation wards across Worcestershire that provide a range of inpatient and outpatient services. These are located in Worcester, Pershore, Evesham, Bromsgrove, Malvern and Tenbury. These hospitals are run by the Herefordshire & Worcestershire Health and Care NHS Trust (H&WH&CT). The H&WH&CT also runs the Wyre Forest Ward at the Kidderminster Hospital and Treatment Centre.

[10] Hospital Discharge Service Requirements, March 2020, HM Government

[11] 590 people's stories of leaving hospital during Covid-19, October 2020, Healthwatch England working with British Red Cross

The National Hospital Discharge Guidance

Hospital Discharge Service Guidance was first published by the Government in March 2020[12], then updated in August 2020[13] as the "Hospital Discharge Service: Policy and Operating Model". This was the Guidance that was in place whilst we were carrying out our project. This was further updated in July 2021 as the Hospital Discharge and Community Support Policy & Operating Model [14]. This follows the principles of the previous guidance but with some updated elements, and is referenced in this Report where relevant. Although these changes were put in place to address Covid-19 the model is likely to remain in place for the foreseeable future.

The approach set out in the Guidance is that all hospitals must discharge all patients as soon as it is clinically safe to do so, with the expectation that all patients are discharged on the same day that a decision is made to discharge.

There is a new responsibility on acute hospital teams to work closely with community health and social care services to ensure people get the support they need after leaving hospital.

In the national model patients should be discharged from acute hospitals onto one of 4 pathways. The Pathways in place during the time that this project (August 2020) was undertaken are summarised below[15]

Pathway 0 - minimum of 50% of people, no formal input from health or social care needed once home

Pathway 1 - 45% of patients with support to recover at home, able to return home with support from health or social care

Pathway 2 – 4% of people – rehabilitation or short term care in a 24-hour bed setting

Pathways 3 – 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long term care is likely to be required.

Discharge services should operate at a minimum seven days a week, from 8am to 8pm.

Further explanation about how these Pathways work in Worcestershire is set out below.

Pathway 0 – Simple Discharge

Patients on Pathway 0 do not require any new support from health or care services. They may return home, to an existing care home, or restart or increase

[12] Covid-19 Hospital Discharge Service Requirements, March 2020, HM Government

[13] Hospital Discharge Service: Policy and Operating Model 21st August 2020, HM Government and NHS

[14] Hospital Discharge and Community Support: Policy and Operating Model 5th July 2021, HM Government and NHS Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

[15] The descriptions here are based on the August 2020 Guidance, which was in place during this project. This has since been replaced by the July 2021 Guidance which updates the descriptions of the Pathways

an existing package of homecare. They may also have a limited number of follow up visits, for example to remove stitches or for wound dressings.[16]

Discharge arrangements for patients on Pathway 0 will usually be made by ward staff, but these responsibilities may be shared with staff in the discharge lounge at the Alexandra Hospital.

Ward staff are responsible for booking hospital transport for patients who require this across all the Pathways and for organising patients take home medication and written discharge summaries and letters.

Onward Care Team

An Onward Care Team, led by the H&W Health & Care Trust, has been established to work with patients who are medically fit to leave the Acute Hospital, but who are likely to require onward health or care support services after discharge. They are responsible for assessing these patients and co-ordinating arrangements for their discharge under Pathways 1 – 5.

Pathway One – support at home from health or social care

All patients across Worcestershire who require a period of health or care support at home to recover, reable or rehabilitate are referred to the Reablement Service[17], managed by Worcestershire County Council, for an assessment of their needs. The guidance states that the assessment visit should take place on the same day or the day after patients are discharged from hospital. The service works alongside NHS Neighbourhood Teams, which include District Nurses and other health professionals, who will work with patients with primarily health needs. There is some flexibility between the services about who provides the assessment and support, depending on capacity. Following the assessment patients may receive nursing or therapy support, be supplied with equipment, or a time limited Reablement plan will be developed with the person. If it is clear within the first 72 hours that the person will require longer term care and support at home this will be sourced through the Council's Brokerage Team.

Under the July 2021 Government Guidance this Pathway should include people whose homecare package is restarting after lapsing during their hospital stay.

Pathway Two – rehabilitation or short term care in 24hr bedded setting

In Worcestershire most people on this pathway are discharged to a Community Hospital for further recovery or rehabilitation, but the Pathway also includes patients who are discharged to more specialist rehabilitation settings (e.g. stroke, neurological) or to hospice or community hospital based palliative care.

[16] The July 2021 Guidance states that they may also receive holistic wrap- around support, personalised to their needs immediately after discharge, such as low intensity or informal settling services or support from voluntary and community organisations

[17] The Reablement service includes a range of staffing roles including assessors, Occupational and Physiotherapists, two nursing staff, Promoting Independence assistants, and a limited night service.

From Pathway Two patients may be discharged home; referred to the Reablement Service or Neighbourhood Teams (Pathway One) or to Pathway Three below.

Pathway Three – bed based 24 hr care

Patients may be referred from Community (and occasionally Acute) Hospitals to a Discharge to Assess bed in a care or nursing home or other specialist setting if further assessment of their long term support is required. In this case the Hospital Social Worker or an allied professional will continue that assessment with the person once they have left hospital and are in a care setting.

During the Covid-19 pandemic patients are not allowed to wait in hospital until their first choice of care home is available. So patients may be placed in the first available home, although care coordinators should follow up to ensure that people are able to move to their first choice as soon as possible.

Worcestershire - Pathway Four & Five

In Worcestershire there are additional Pathways.
Pathway Four is for highly complex patients where other pathways are not meeting their needs. Pathway Five is for patients who are at end of life, and access "fast track" Continuing Healthcare (CHC). They may be discharged with a home based package of care or to a nursing or care home.

The August 2020 Government guidance established that the NHS will be responsible for meeting the cost of care for a period up to a maximum of 6 weeks post hospital discharge, so care is free to the individual during this period. People discharged between 1st July and 30th September 2021 will have up to four weeks of funded care.

During this time assessments, including financial assessments, for any longer term Continuing Healthcare or social care needs are expected to take place.

3. WHAT WE DID

As a result of the current restrictions, due to Covid-19, we were unable to undertake face to face engagement.

From 21st January to 27th April 2021 we ran online Surveys to collect the experiences of patients and unpaid and paid carers of people who were discharged from hospital between March 2020 and April 2021. Paper copies of the Surveys were available on request, along with a reply paid envelope. The Surveys were based on one developed by Healthwatch England in July 2020 after an extensive scoping exercise to identify key themes.

The Surveys were widely promoted across the County through Healthwatch Worcestershire Networks and Bulletins, local community networks and organisations including Age UK Herefordshire & Worcestershire, Worcestershire Association of Carers, Council of Association of Local (Parish) Council ebulletin, and St Richards Hospice. We contacted local faith and Black and Ethnic Minority organisations and spoke with them about the project. Information about the Surveys was sent to NHS organisations, GP practices and District Councils. 1,500

leaflets promoting the Surveys were supplied to the Worcestershire Acute Hospitals Trust to be included in take home medication and 200 paper copies of the Surveys with reply paid enveloped attached were supplied to Worcestershire County Council for inclusion in the Reablement Service information packs. The Surveys were also widely promoted through HWW Twitter and Facebook accounts.

We conducted semi-structured, in-depth qualitative telephone or video interviews with patients and carers who responded to a letter about the project sent out on our behalf by the NHS to 283 eligible patients who had been discharged from an Acute Hospital on Pathway One, Two or directly to a Care Home during November 2020.

We contacted care and nursing homes directly, and through the Worcestershire Care Homes Managers network, to inform them of the Survey and of the opportunity to speak with us about their experience of hospital discharge. Worcestershire County Council provided the same information to all Domiciliary Care providers on our behalf.

In addition, in an exception to our usual practice, we conducted semi structured interviews with NHS and social care managers/staff who are involved in hospital discharge. These interviews provided useful context for our work, and we have reported some themes that emerged from these discussions in this Report.

4. WHO WE HEARD FROM

142 people shared their views on being discharged from a Worcestershire hospital during the Covid-19 pandemic

Quantitative Survey

127 people responded to our Surveys, 78 patients and 49 unpaid or paid carers.

Whilst the total Survey responses were higher (106 patients and 58 carers) we filtered the responses so that all the responses in this report relate to people's experience of being discharged from Worcestershire hospitals only.

For the purposes of the analysis, we have combined the survey responses from patients and carers, as carers answered most questions on behalf of the patient, resulting in survey responses representing the patients' experience. Some questions were specific to carers and are reported separately[18]. In our narrative we have referred to a carer's relative when referencing carers answers about patients, but appreciate that carers may have a different relationship to the patient such as friend, neighbour or client.

The majority of our Survey respondents are women (70%) and 30% are men.

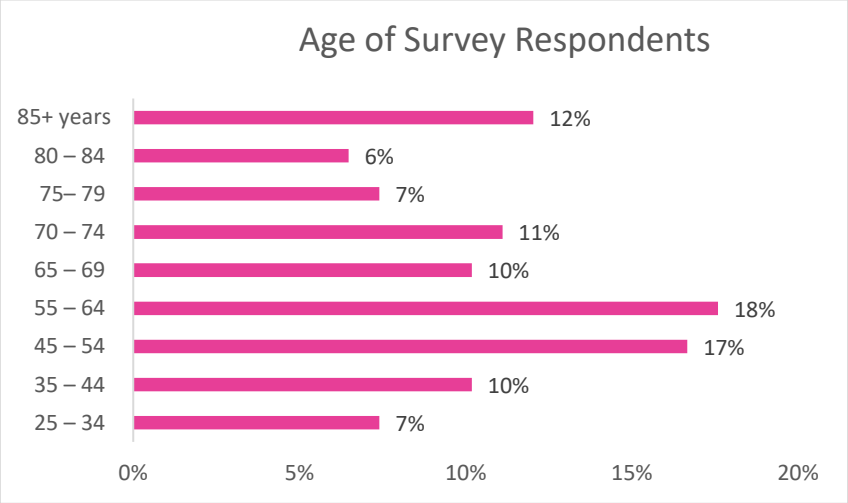
We asked people how they described their ethnic background. 94% described themselves as from a White British background, 2% as from a White Other ethnic

[18] This was the methodology used by Healthwatch England in their Report

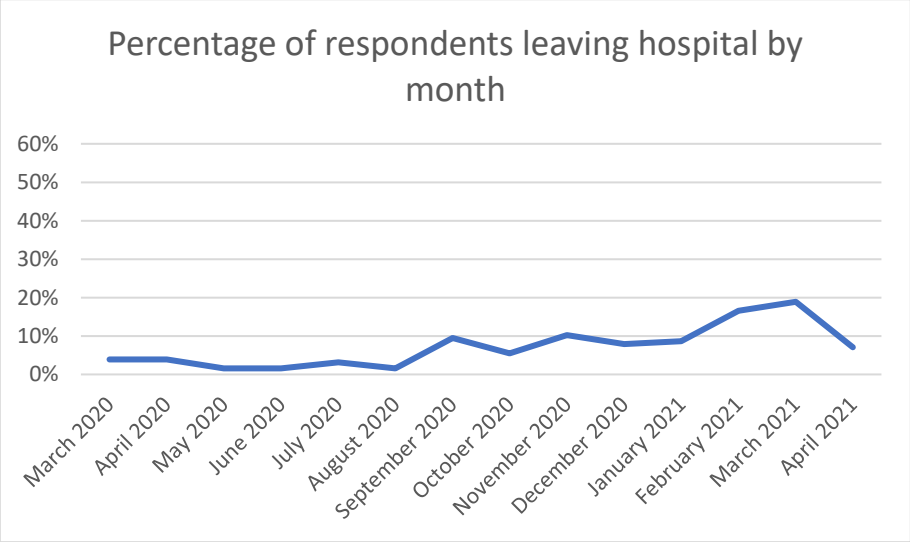
background, 1% as Chinese, 1% as Mixed - Black Caribbean and White, and 1% as White Irish. 1% preferred not to say.

A majority of respondents (66%) identified as having a long term condition and 34% of respondents identified as having a disability. Of these 26% had a physical disability, 3% had a visual impairment, 3% experienced mental health issues and 2% had a learning disability.

The age range of our respondents was evenly spread between those under 64 of working age (52%) and older age groups (47%). We did not have any responses from people aged under 24yrs.



51% of respondents were discharged from hospital in 2021, with 36% of these being discharged in February and March. These are the months during which the Survey was being actively promoted. 49% were discharged between March – December 2020.



Most of our respondents (67%), had been discharged from Worcestershire Royal Hospital with a further 27% from the Alexandra Hospital and 7% from Community Hospitals.

Most respondents to this Survey (86%) were discharged from hospital to their own homes, some (8%) went home and had family and friends come and stay with them, and 2% went to a care home.

Not all questions were answered by all respondents. When non-response is present, percentages are reported based on the numbers answering the question. Where numbers are small for clarity we have used numbers (n) rather than percentages.

Qualitative interviews

We conducted 15 semi-structured, in-depth qualitative telephone or video interviews with patients (7) and unpaid carers (8). These interviews were with patients, or their relatives, who were discharged from hospital in November 2020, and were a self-selecting sample who responded to our letter, so we cannot know if their responses are representative of patient and carer views in general.

However, each individual's experience is valuable and valid, and common themes did emerge from these interviews which are reported in the findings below.

We spoke with four women and three male patients; the age spread is between 42 – 90 yrs. Most interviewees (5) were White British, 1 was Indian and 1 Irish. 6 of the 7 respondents defined themselves as having a disability or long term condition. Five patients were discharged from Worcestershire Royal Hospital (WRH) and 2 had experienced discharge from the Alexandra Hospital (the Alex) and also a community and private hospital.

Most of the carers we spoke with (7) were women, the age spread is between 41 – 84 years. All were White British. 1 defined themselves as having a disability or long term condition. Four had a relative who was discharged from the Worcestershire Royal Hospital and four from the Alex. One carer had also experienced a discharge from a community hospital.

Care providers

We conducted 5 semi-structured, qualitative telephone or video interviews with care homes (2) and home care agencies (3)

NHS and Social Care Staff

We also conducted interviews with 24 representatives of NHS and social care services involved in the hospital discharge process including from the Onward Care Team, Reablement Service, Neighbourhood Teams, Acute Hospital, Community Hospital, Social Workers and Housing services. We also spoke with a Local Medical Committee representative to understand the GP perspective.

KEY FINDINGS

We acknowledge that the Covid-19 pandemic has necessitated rapid changes to health and care services, including to the hospital discharge process. NHS and Social Care staff have had to deal with the pressures of quickly implementing new ways of working, increased workloads, in addition to concerns about their own health. People we spoke with and respondents to our Survey acknowledged the impact of Covid-19 on health and care services and we heard positive comments about staff in these sectors, who were working hard to do their best for patients.

Nevertheless, in this Report, we have identified that there are issues and challenges experienced by patients and carers when people leave hospital, and we have focused on these, as this is where learning can be identified.

5. COMMUNICATION

Communication, or the absence of it, is often highlighted in our work as one of the areas that can have most impact on people's experience. Good communication between staff, patients and their families is even more important during the Covid-19 pandemic due to restrictions on hospital visiting.

From our Survey respondents we heard of positive examples of good communication between the hospital, patients and carers.

"Excellent staff who kept me informed at every stage. I had superb treatment" Survey respondent, Patient

Nevertheless, some key issues relating to communication emerged.

Unpaid carers communication with the hospital whilst their relative was an inpatient

Carers reported mixed experience of communication with hospitals about their relative's health.

We heard from some carers about how they were supported to communicate with their relative using iPads or phones, which was reassuring to both patients and carers. However, not all of the carers we spoke with were aware of the availability of iPads on the wards for communication.

We also heard of difficulties communicating with the hospital to receive updates on their relative's health, these included getting through to the ward or to the right person, the quality of the information about their relative's condition or treatment including receiving inconsistent information from different people and the attitude of the staff – some of whom were described as helpful or lovely, whilst others were described as rude or abrupt.

"I used to phone up every day. But of course, I do realise they were busy, but all I got was, he's comfortable, he's had a sip of water, or he's had a sip of drink. He's not eating, he is eating, not a lot, he's not talking and that's the only information I ever had … I was never really told any, any details. … and we got different, different answers all the time. Nothing straightforward." Carer Interview

"The lack of communication was a big problem. I was also called once to be given the wrong information and twice he was mistaken for someone else. His wishes were not taken into consideration, and I was not informed" Survey respondent, Carer

Carers of patients living with dementia or who were non-verbal reported feeling they lacked contact with their loved ones and unable to advocate on their behalf, which increased their concerns and anxieties. Not all of the carers we spoke with were aware that visits could be made in exceptional circumstances, however one carer had emailed the hospital and requested a visit to their non-verbal relative, but did not receive a response.

"We couldn't sit with X, Mum in particular, for 20 years has always been with X at hospital or we've spoken up for X. Always been able to anticipate X's needs, anticipate issues with medications. And even though I sent an email in .. and said, you know, on your website, it says in extreme circumstances, somebody can have a family member with them…I just never got response to my email.. that's very rude isn't it ... because it was extreme." Carer interview

Patient information leaflets about hospital discharge

NHS England (NHSE) has produced leaflets for patients describing the arrangements for hospital discharge under the discharge to assess model. NHSE expects that the leaflets will be shared with and explained to everyone on admission to hospital and on discharge.

However, most survey respondents (67%) did not receive this information.

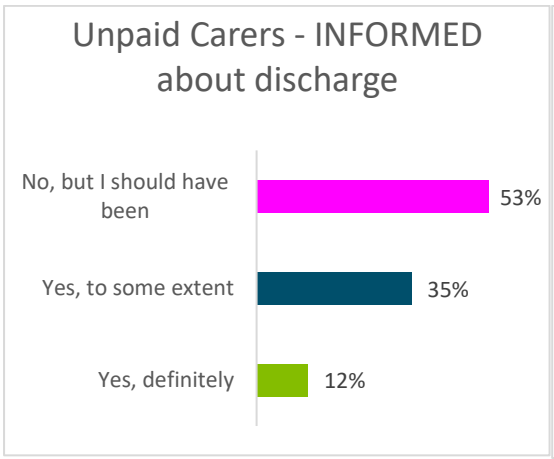
Of those that did receive this information most found it easy to understand.

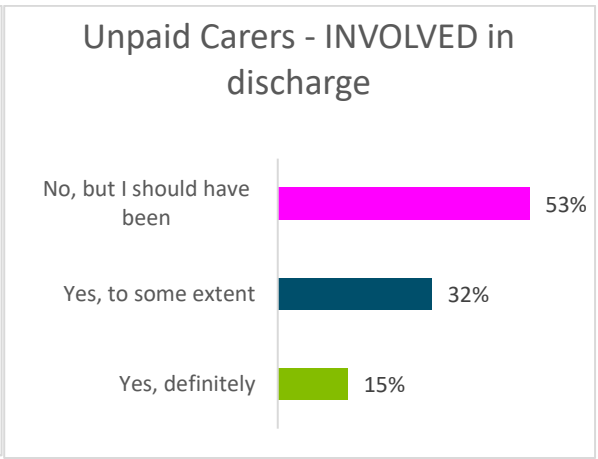
Our findings suggest that people were not consistently receiving written information on what they might expect.

Communication with unpaid carers about discharge

45% of patients who responded to our Survey told us that their family, or someone else that they asked to be informed, were not told that they were leaving hospital.

Just over half of unpaid carers told us that they were not sufficiently informed (53%) or involved (53%) in their relative's discharge, but they should have been. Others felt informed (33%) or involved (32%) to some extent.





Carers we interviewed reported that they were sometimes given conflicting or confusing information about when a relative's hospital discharge would take place. They described a lack of communication from the hospital about the discharge plan.

"Contact throughout the whole time was very sporadic, so I kept having to call them and there was a lot of confusion really about what was going to happen and what was going on. So I only really found out on the day that they decided they were going to discharge X. But they didn't call me at all I kept having to ring them to check" Carer interview

"It went on, day after day, they kept changing their mind…One day I made 38 phone calls to the hospital…and its only cause I counted them on my mobile phone. You lose track in the end. No one will speak to you, you know, phone back later. Can't speak to the physio, phone back in a bit. Trying to sort out X discharge, trying to sort out rehab, we were just getting nowhere, and I mean I was ill as well." Carer interview

This suggests that communication with unpaid carers about hospital discharge could be improved.

Communication with care homes and care agencies

Interviews with care providers revealed that they also had mixed experiences of communication with hospitals.

They reported that, at times, they received little, or sometimes contradictory, information from hospitals about a resident or client's health, their treatment or the plan for their discharge. Sometimes this may be due to data protection issues, but providers we spoke to felt there was room for improvement in communication, particularly with Acute hospital settings.

"So if a resident goes into hospital it's really difficult for us to get a handle on what that treatment is and what their plan is. Invariably we are the last one to know. We will get a phone call to say, oh we're sending them back today. They don't arrive. And then we chase - so are they coming back today? "Oh no no we've changed, it'll be tomorrow now because we didn't book the ambulance in time." But we've then geared up staffing numbers for somebody to be coming back." Care Home

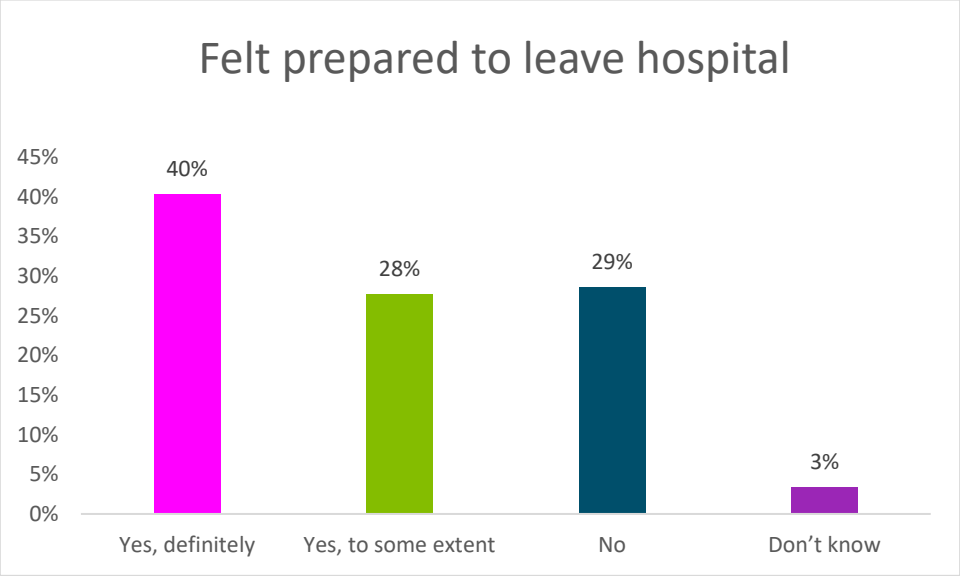
Care providers we spoke with felt that their detailed knowledge of a person, and how they usually were when well, was underused by hospitals. When this communication does happen, it is greatly appreciated.

Care agencies told us that a particular difficulty for them was being asked to re-instate packages of care with insufficient notice.

"Hospital discharges can be quite disjointed affairs really to be honest with you, and we often don't have enough information. And there isn't a lot of clarity on exactly when someone will get home. And sometimes we don't know until they're in the vehicle, the ambulance, or indeed until they get home. And so, it definitely could be tremendously improved…where there's a really strong level of local dialogue, it works well. But where there isn't, it can sometimes be very disjointed." Home Care Agency

6. FEELING PREPARED TO LEAVE HOSPITAL

Whilst 40% of respondents to our Survey told us they definitely felt prepared to leave hospital some felt their discharge was rushed; nearly one in three people (29%) felt they were not prepared to leave hospital.



Notice of discharge to patients

Most Survey respondents (72%) were told that they were being discharged on the day they left hospital, whilst 23% were told the day before.

Some of the patients we spoke with were clear that they were ready to leave hospital and keen to get home.

Others however reported feeling rushed, or that the priority was to free up hospital bed space. Some patients told us of being discharged shortly following procedures or operations, or before they felt that their hospital based rehabilitation had been concluded.

'I felt unprepared probably because I've read all the information about having pacemaker implants and it says like you should rest….as soon as I got back [to the ward] I had a cup of tea and thought I can rest now and it was no you have got to leave, you've got to go … well it just felt awful' Patient interview

"Hospital stay for three days, discharge within one hour of MRI and diagnosis of stroke. No follow up" Survey respondent, Patient

'I didn't feel it was my time to leave, because when I was in hospital I had physiotherapy. I really wanted to stay in longer because I was still on that physiotherapy…. so I didn't feel ready to go and I didn't think I was ready to go but I accepted it because I had no choice' Patient Interview

Feeling unprepared to leave hospital can impact on patient experience. Over half (56%) of people who told us they had a significantly worse experience of leaving hospital than they had previously felt that they were not prepared to leave.

In the view of unpaid carers we spoke with their relative was not always ready to be discharged from hospital

Seven of the eight carers that we spoke with told us their relative's physical condition had deteriorated during their hospital stay, and some told us that, in their view, their relative was not ready for discharge.

"He was constantly falling all over the place, he wasn't right, and to tell me that he was fit to come home. I don't believe it. I don't believe it for one minute" Carer interview

"As far as I was concerned … this was a man who could hardly walk ... I'm led to believe now, somebody told me, that this is what they call an unsafe discharge ... it just shouldn't have happened." Carer interview

In the case of three of the carers, their relative was re-admitted to hospital as an emergency within 30 days of discharge for the same condition. This is an indicator that is used nationally to look at how local Clinical Commissioning Groups are performing.

In some cases carers concerns had been exacerbated by a lack of communication / "handover" from the hospital about the health status of their relative or the ongoing plan for their care. This reinforces the need for good communication between carers and the hospital about the patient's health status at the time of discharge.

"In view of the lack of visiting we were not really prepared for how frail he was and the challenge of getting him home" Survey respondent, Carer

Care Homes and Care agencies were sometimes given incomplete information

Care homes and care agencies reported that they were sometimes given incomplete information about the health status of the person on discharge.

Examples given were being told that patients were able to mobilise or weight bear when this was not the case, or pressure sores were described as bruising or red marks rather than a sore. Two failed discharges were also described to us by a care home. Care providers were understanding of the pressures on Acute hospital settings, but appreciated being given full and accurate information.

"Because sometimes they'll get back here. And it's like, oh, hang on a minute. They told us they were mobilising. And actually, they're not. So that, you know, we appreciate that they need the beds in the Trust, we accept that. But you know, be honest with us and just say, because … if you know then you can prepare" Care Home

7. LEAVING HOSPITAL

Testing for Covid-19

Most patients (78%) had been tested for Covid-19 whilst they were in hospital, however 12% told us that they had not been tested and 10% did not know.

Although 60% of those who were tested received their results in hospital, 29% did not receive their results before being discharged, 11% did not know.

We understand that in Community Hospitals the current regime is that patients are tested for Covid-19 on admission as a hospital inpatient, then again at day 3, day 5 and day 12.

We are not clear of the regime at the Acute Hospital, or whether all patients are routinely tested for Covid-19 prior to discharge.

Carers that we spoke with told us their concerns about their relative being discharged from hospital when they were Covid positive, or where their Covid status was unclear.

One carer had been unable to get clear information about whether or not their relative, who had tested positive for Covid-19 whilst in hospital, was still positive on discharge, as, at the time, the hospital had refused to do another test.

"I think if they'd have either communicated differently, better, or just done a Covid test on her to get her a negative result, it would have reduced the anxiety of sending her home to me dealing with this on my own as I have done for 15 years. It was very, very traumatic. This is killing people all over the country, all over the world. X nearly died of it and they sent her home Covid positive to me, without any consideration for my mental health, my physical health, my already difficult to manage physical condition. You know, I didn't agree with how they did that I didn't agree with that." Carer Interview

We site this example in order to highlight the anxiety that this can cause to carers and family members.

Residents who are being discharged to a care home must have a PCR Covid-19 test within 48hrs prior to discharge. Care homes must be informed of a resident's Covid-19 status before they are discharged from hospital, so that the most appropriate setting for that resident whilst they are Covid-19 positive can be identified.[19]

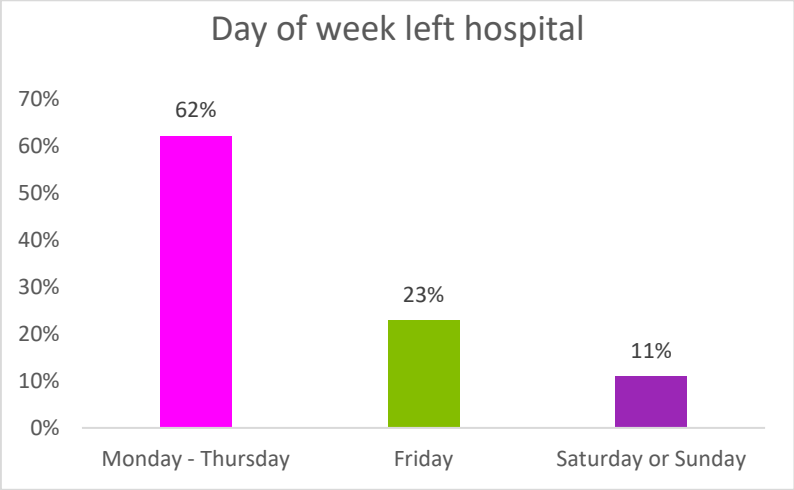
Care agencies that we spoke with described a mixed picture. Whilst knowledge of a person's Covid-19 status was felt to have improved since the start of the pandemic, we were told that care agencies do not always receive information about whether tests have taken place, or documentation of the results, resulting in further contact with the hospital to obtain this information.

[19] Discharge into Care Homes: Designated Settings, 17th May 2021, HM Government. Discharge into care homes: designated settings - GOV.UK (www.gov.uk)

Reablement and Neighbourhood teams use full PPE at all times, whether or not they know if a person is Covid-19 positive, in order to keep people and staff safe and reduce transmission.

Day and time of discharge

While the majority of our respondents (62%) left hospital on a Monday – Thursday, 23% were discharged on a Friday and 11% at the weekend.



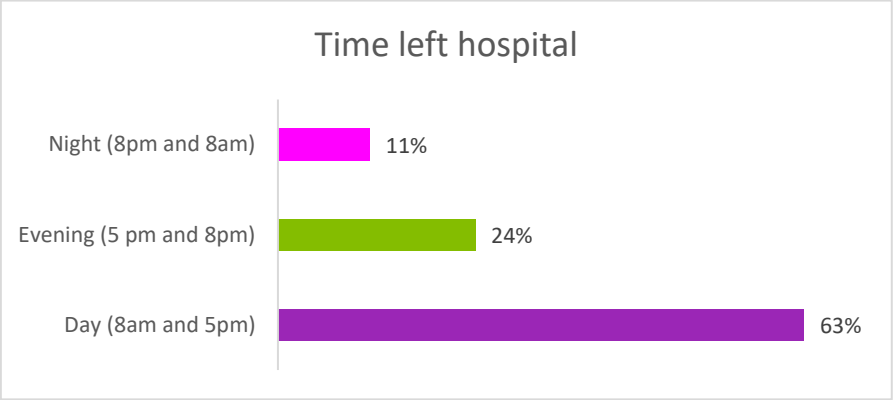
Patients and carers told us that discharge late on a Friday or at the weekend could be problematic. We heard of issues with accessing community support services, resolving issues with medication and being unable to get in touch with the appropriate person at the hospital to raise concerns about the persons health status.

One of the carers we spoke with described how they had been informed their relative was ready for discharge on a Sunday at 2 p.m., the actual discharge took place at 7.45 p.m. The carer was told that there was no community support available at that time. Although the Neighbourhood Team called the following morning in the interim their relatives had experienced considerable distress.

"They literally sent him home with no care package in place whatsoever, which I thought was disgusting. I thought that was totally not acceptable and although yes he was medically fit, surely, in my mind, the idea would have been. It's late. We'll have to keep him another night and then Monday we start again and the carers come round and they work out what they're going to do with him. And my Mum actually hurting herself … bear in mind, she's 79 as well. So I just thought it was appalling that they had done that" Carer interview

Timing of discharge

Most respondents to our Survey (63%) were discharged during the day (8.00 a.m. – 5 p.m.), 24% were discharged in the evening (5 p.m. – 8 p.m.) and 11% during night (8 p.m. – 8. a.m.).



Of those patients discharged at night 36% (n5) were from the Worcestershire Royal Hospital and 64% (n9) were from the Alexandra Hospital. 5 had waited longer than eight hours to be discharged. The main reason given for the wait was waiting for transport (n5). Only 2 of the patients discharged at night told us they felt prepared to leave hospital.

"The delay in discharge was very distressing as initially I expected him home early afternoon and then he eventually returned at half past midnight when it was cold and difficult with his lack of mobility to get him into the house and then settled for the rest of the night." Survey respondent, Carer

Care Homes we spoke with told us they set a "cut off" time (6 p.m. or 8 p.m.) after which they won't accept residents. They do this to allow day staff time to complete the necessary paperwork, settle the person back into the home and deal with any problems which may arise. They also expressed the view that they do not think it is fair for elderly patients to be discharged later at night, and that this can be disruptive for other residents. Although this is usually respected they had examples of residents returning home later than the cut off, which impacted on the individual and other residents in the home. They felt that hospitals needed better understanding of the home's perspective on the timing of hospital discharge.

The July 2021 national policy states:

"The need for a timely discharge … should not result in discharges that are unsafe, such as happening overnight, or lead to people not being fully informed as to the next stages of their care."[20]

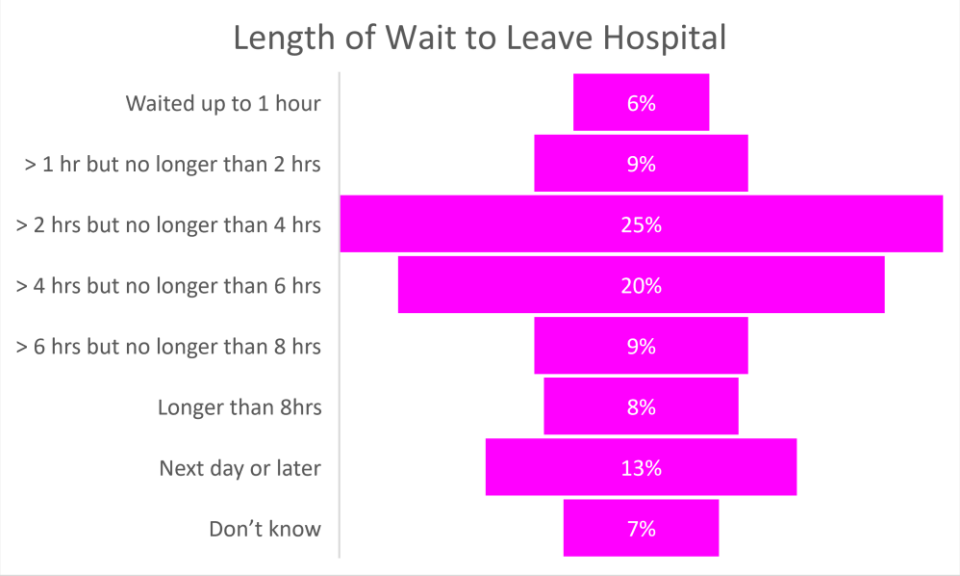
Furthermore, the Staff Action Cards, which summarise the responsibilities of health and care staff in the hospital discharge process, states in its key messages that discharge should take place "preferably before 5pm."[21]

Waiting for discharge

We asked respondents to our Survey how long they waited once they were told that they were well enough to leave hospital. 15% waited less than 2 hours, 25% waited between 2 – 4 hours, 37% waited over 4 hrs to leave hospital, and of these

[20] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government, Page 4: www.gov.uk/government/collections/hospital-discharge-service-guidance
[21] Hospital discharge service: action cards - GOV.UK (www.gov.uk)

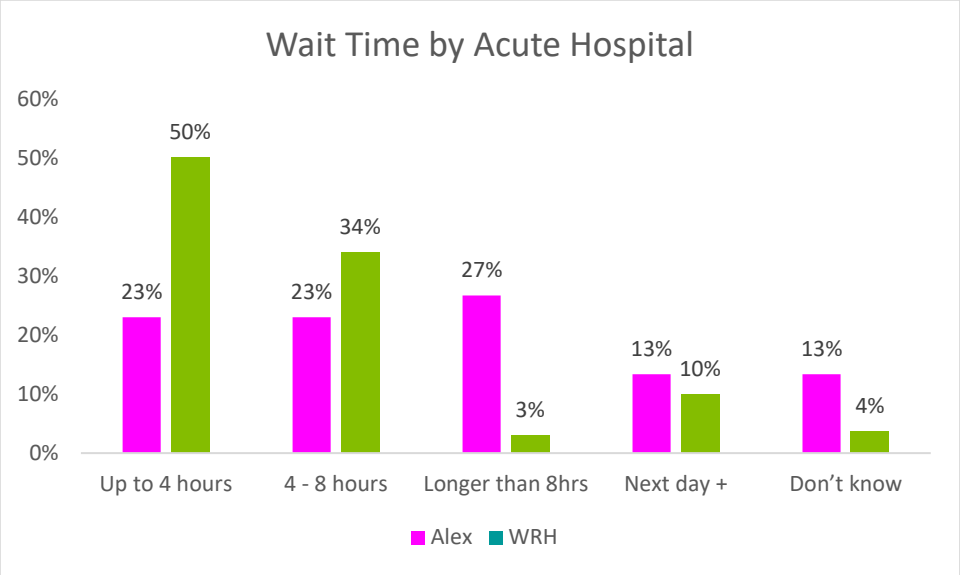
8% waited over 8 hours. 13% were discharged the next day or later. 7% of respondents did not know how long they waited.



The chart below shows wait time by Acute Hospital. 50% of respondents who were discharged from the Alexandra Hospital waited over 4 hours, and of these 27% waited longer than 8 hours.

37% of respondents discharged from the Worcestershire Royal Hospital waited over 4 hours, with 3% of these waiting longer than 8 hours.

It should be noted that we had fewer respondents from the Alexandra Hospital.



Reasons people waited

We asked people who had waited over 2 hours to leave hospital the reason they waited. These are ranked below in order of frequency; people could select more than one reason for their wait.

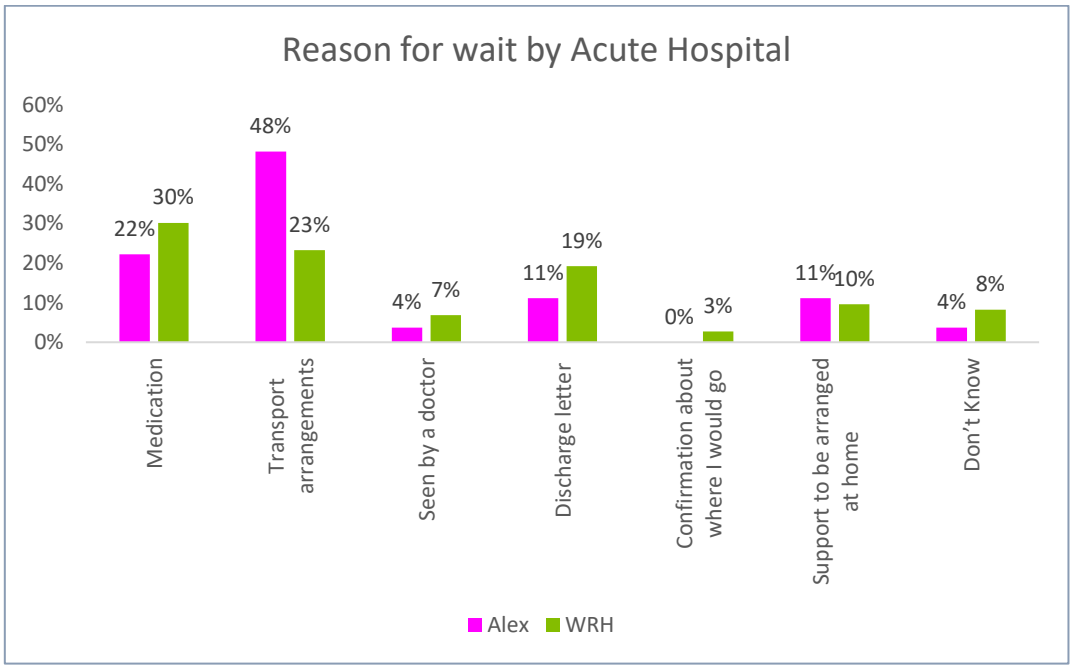
The main reason's respondents gave us for waiting more than 2 hours:

- Transport arrangements
- Medication
- Discharge letter from doctor
- For immediate support to be arranged at home
- Don't know why they were waiting
- To be seen by a doctor
- Confirmation of where they would be discharged to

Other reasons given were lack of communication with family about discharge and waiting for family to arrive to care for the patient.

The following chart shows the reasons for waiting at the Alexandra and Worcestershire Royal Hospital.

It shows that waiting for transport and medication were the two top ranked reasons why people waited over two hours at both the Alex and WRH.



We heard through our patient and carer interviews of some delays to discharge for patients whilst they were waiting for their care plans to be put in place. Some of the other reasons for delays are further discussed below.

Transport

Transport was an issue that we heard a lot about during our discussion with patients, carers and staff.

46% of Survey respondents were asked if they needed support with transport. Of these 50% needed and were provided with support. Only 4% of people who were asked if they needed transport were not provided with it, even though they needed it.

40% of respondents were not asked if they needed support with transport. Of these most (83%) did not need any support, however 17% of people who were not asked if

they needed transport support told us that they did need this. It is important that hospital staff always ask patients if they require support with transport, both to determine who needs this and prevent unnecessary use of hospital transport.

"I wanted to be fetched by my husband but was told that I must use hospital transport as it had been arranged without asking me." Survey respondent, Patient

Staff interviews identified that there is a four hour window for patient transport, which can obviously build in delays for patients. Social distancing and regular cleaning of vehicles can also affect the availability of the service and the length of waiting times.

Waiting for transport was the reason given for their wait by 50% of the patients who waited over 8 hours to leave hospital. One patient told us they had a 12 hour wait for transport. We heard that on occasion the transport that was booked was unsuitable for the patient's needs, and that patients sometimes found the transport cold and uncomfortable.

We also heard how delays to transport could cause knock on impacts to care arrangements.

"Mum was told in the morning she could go home that day and the existing (paid) carers were reactivated – carers were told to come in for their normal teatime visit. However Mum did not arrive home until 18.45, well after they had to leave. The time it took for transport to be provided was much too long." Survey respondent, Carer

Ambulance and transport staff also received praise from our respondents and were variously described as cheerful, friendly, kind and obliging.

"I was satisfied with the transport. I was taken to it in a wheelchair by a friendly driver. He stayed with me until my family arrived at my home" Survey respondent, Patient

Medication

Waits for medication were identified as the second most common reason for patient waits over 2 hours. This extract from our interview with a carer illustrates the issue:

"I was told late morning, that x would be discharged in the afternoon, and they were just waiting for meds to be prescribed. So I turned up at the car park at one o'clock in the afternoon, and eventually took x home at six o'clock… So I waited five hours in the car park. I popped up to reception twice to see if there was any progress and was just told that we're still waiting for the meds. I was given no indication of how long it would take to dispense the meds…. It was exceedingly frustrating. Surely they must know, you know, how long it takes to prescribe and dispense the meds from a hospital. For it to take five hours rather than one hour or however long I might have expected it, seems pretty extraordinary really." Carer interview

Comments from patients and carers who responded to our Survey also highlighted these delays, and suggested that medication required on discharge could be

identified and ordered sooner. We heard that delays in medication can also adversely impact on booked patient transport.

We also identified a number of other issues relating to medication, including not being provided on discharge with an explanation about why changes to medication had been made, what specific medicines were for, or receiving instructions about how to administer them.

"I was discharged with injections to use and I was not shown how to use them. I felt I was being rushed to go home" Survey respondent, Patient

"I wasn't told what the medications were, there were four of them, what the effects of those medication were, or what the potential side effects were." Carer interview.

"Medication – much of it new – was sent home in boxes, just in a carrier bag. My relative has used a dosette box previously and would not have coped with it on his own. His own medication, sent into hospital with him was returned in a bag marked with personal details of another patient" Survey respondent, Carer

We also heard from a few carers that they were not aware that their relative had been catheterised whilst in hospital, and had not been provided with information about catheter care or with appropriate supplies.

Care agencies described to us the difficulties they experienced with a lack of forewarning about changes to medication or new medications being prescribed. They explained that all medications have to be entered onto their own systems before paid carers can administer them. They need clear information about dosages and the administration of creams. Delays in receiving this information can, in the worst case, result in a gap in taking the medication for the client.

"It's inconsistent, again, sometimes they'll let us know if they've got medication change and then sometimes they won't. And it's not until the client gets home, with their bag of …. new medication, and then we then have to put all of that on the system before the caregiver can even administer it… It's another job that could have been done before the client even got back, to make that transition for the client from hospital to home a lot smoother. And it can make the transition a little bit bumpy sometimes." Home Care Agency

Care Homes we spoke with also described to us some examples of issues they had experienced with medication when a resident had been discharged from hospital.

In addition to the above we have already raised with the Worcestershire Acute Hospitals Trust some specific issues relating to medication that were communicated to us through our patient and carer interviews which raised wider quality or patient safety issues.

Discharge Lounge

National guidance says that every patient who is medically fit for discharge should leave the ward and go to a dedicated discharge area. The purpose of this is to create a flow of patients and to empty beds on the wards.

There are designated discharge lounges at the Alexandra and Worcestershire Royal Hospitals. The lounges operate differently, there is variation in opening times, facilities and the extent to which staff in the discharge lounge take responsibility for aspects of the discharge process usually carried out by the ward (e.g. preparing discharge summaries, booking transport or ordering medication).

However, staff, patients and carers told us that in Worcestershire not all patients go through the discharge lounge prior to leaving hospital. Some may wait in the ward or in a waiting area located nearby. We heard that there are various reasons for this including: patient need/circumstances – due to their medical needs and condition not all patients are suitable/able to wait in the discharge lounge; the lounge is not sited/equipped to deal safely with all patients; there may be insufficient capacity in the lounge; discharge maybe outside the lounge operating times. We were told that it is a Ward decision which patients are transferred to the Discharge Lounge.

'The patients that we are working with a lot of them have very complex, physical and mental health needs and actually it's not in their best interest to move them multiple times' NHS staff

Whilst some patients reported positive experiences, particularly in relation to staff in the discharge lounge and the availability of meals in the lounges, we did hear about long waits. One carer described a 7 hour wait in the lounge whilst a care package was being organised and questioned whether the discharge lounge was the right setting for their relative, who required continuity of care and a quiet environment. A patient described feeling scared, as they felt left alone and were concerned about receiving their insulin injections and having access to appropriate food.

Their relative described the situation:

"I think the only thing that let it down for X was they were on their own, they obviously, they can't get up unaided to go to the toilet. X is a diabetic, didn't really have anything to eat, ... they've got X ready from early in the morning and then they were just waiting for the ambulance. I think it's a shame because it's almost like they forget about them when they go into the discharge lounge because the nurses give her insulin to her in the morning. They need to make sure that .. she's got something that she can actually eat because the teeth aren't brilliant. And because of her swallow, you know, nothing was … prepped or left for her so she could eat it safely. And you know, she's just being left in the lounge" Patient and Carer joint interview

We were told of an initiative at the Worcestershire Royal Hospital to introduce an electronic referral form, which would be completed by the ward and ensure that key information was available to staff in the discharge lounge.

Discharge letters and forms

We heard from patients, carers and care providers that the extent and accuracy of information provided in discharge forms and letters was variable.

We were also told that there could be variance in the format of discharge notes between the Acute and Community Hospitals, with the Acute using a form and the Community Hospitals a letter.

Information provided to patients

Patients told us that there were sometimes errors or omissions on their discharge letters, or that arrangements for follow up had not been provided or were not clear.

"Doctor did not fully explain my discharge papers and I was not told of the side effects of the operation fully upon leaving hospital, so caused me some distress at home as I didn't know what was expected and what was a problem" Survey respondent, Patient

"No one knew whether I had stitches or staples and if I needed to get stitches removed, dressings I was provided with were either too small or too big for some of my wounds. I had no wound care advice. No one told me what I was allowed to do after my major surgery I looked it up on the internet and spoke to friends after I got home" Survey respondent, Patient

Information to unpaid and paid carers

44% of unpaid carers who responded to our Survey felt they did not have enough information to support their relative after discharge

Some carers we spoke with reported inconsistent or incorrect information on their relative's discharge notes. Others described being unclear about how to look after the person they care for. This lack of information was exacerbated further due to restrictions on visiting and a lack of face to face information about discharge.

"Nobody told me what I gotta do, or when, I didn't know nothing … Just no information. Bearing in mind this damn Covid, you can't go and see, you can't find anyone, you couldn't talk to anybody, you know, so you just have to take what they said." Carer interview

"I could have done with some advice on how to care for my wife as a stroke victim with severe dementia who did not understand what had happened or was happening" Survey respondent, Carer

Care Homes described varying amounts of detail on discharge forms and letters, particularly in relation to how the person had been in hospital (eating and drinking). These notes are important as they inform care plans within the home.

"Discharge notes are very important for us. And sometimes, a person could come out of hospital with, with nothing, you know, we don't know what treatment they've had, any change of medication, any challenges, follow ups, we just don't know anything sometimes. And then other times the discharge note is very, very good. It just needs to be more robust. That's a vital important thing, I think, when somebody has been discharged to have that information" Care Home

Care Agencies described that they rarely had sight of discharge summaries. Lack of information is exacerbated as currently they are unable to visit hospitals to carry out re-assessments of their existing clients. We were told that there should be better information sharing when the patient has given their consent to this.

"One of the problems is that there isn't sufficient information sharing … the data is there, but there's not a lot of exchange between systems …Why can't we actually have some of the relevant care notes or discharge notes?" Home Care Agency

GP perspective

We heard how important hospital discharge notes are to GPs, as they are the basis for the GP's plan of follow up care.

Whilst some Acute Hospital departments are good at contacting GPs about particularly vulnerable, or at risk, patients and ensuring that discharge notes are quickly received by the surgery, this is not consistent across all Departments.

Discharge notes that GPs receive can be lengthy, and it is not always clear what, specifically, the GP is being asked to do. The Discharge notes may also be completed by a member of a consultant's team who have not necessarily themselves seen the patient, so there is a danger that information becomes "lost in translation" or that the plan is not always clearly understood by the person completing the notes.

GPs would welcome a timely, accurate, clear and precise short format "summary on a page" that identifies: diagnosis and treatment whilst in hospital; any medication changes – including information about monitoring, any potential risks and when medications might need to be reviewed; specific, unambiguous and clear information about what action is required of the GP; information about the follow up plan, and the role of the hospital in that plan.

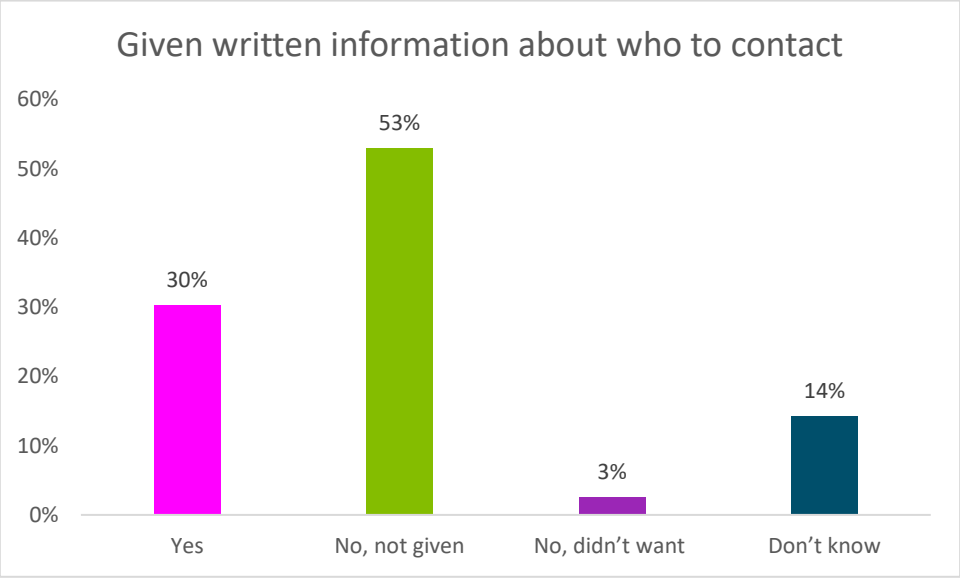
This should be completed by someone with knowledge of the patient and the plan for their care, and who has an awareness, developed through training, of the needs of the professional in receipt of it. Further information could sit behind this, providing more depth and understanding in a specific case.

Electronic Shared Care Record

Healthwatch Worcestershire are aware that the health and care system in Worcestershire intends to move to an electronic Shared Care record, which may overcome some of the difficulties with information about a patient's inpatient diagnosis and treatment, and the plan for their follow up on discharge.

Named contact for follow up

We found that 53% of respondents to our Survey were not given written information about who to contact if they needed further health advice or support after leaving hospital.



A number of patients reported being unclear what would happen after they left hospital, or what the plan was for their follow up care.

"I did talk to one of the staff.. because I was quite upset because I didn't know what was happening to me, and I didn't know how I was going to manage things .. and she said I will get the nurses to come and have a word with you, but they never did." Patient interview

"Once discharged you seem to get forgotten and need more information as to what happens next" Survey respondent, Patient

Without this information patients can be left unsure about who to contact or how to manage their condition at home.

This could also lead to greater demand on GP services, and frustration for patients, as they may contact their doctor to try to find out information about their hospital stay, discharge letter or plan for their future care.

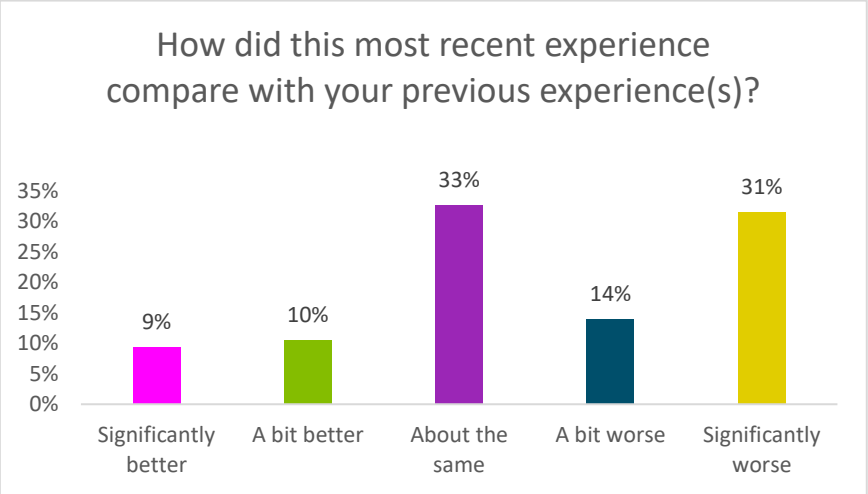
The July 2021 Government Guidance states patients should receive information about who they can contact if their condition changes once they have been discharged

"Patients can be provided with a range of information ranging from direct contact points within the clinical team who supported the person in an acute or community hospital, through to signposting to relevant voluntary or housing sector partners for help in day-to-day tasks"[22]

How did this experience of hospital discharge compare with previous experience?

75% of respondent had previous experience of hospital discharge, when asked how this most recent experience had compared with their previous experiences 45% described it as worse, 33% felt it was about the same, whilst 19% described it as better and 2% did not know.

[22]Hospital Discharge and Community Support: Policy and Operating Model, July 2021, page 8



Some of the patients and carers we spoke with were unaware of Patient Advice and Liaison Services (PALS) or the hospitals complaints procedure. Some had used the complaints process, but not all were satisfied with the response they received.

It was also clear from our conversations that patients and carers did not necessarily want to make a formal complaint, but they did want to be listened to. It is important, that when issues are raised, these are responded to in a timely way and the specific issues raised are adequately addressed.

"I did register my concerns with PALS, and they asked me to make contact with Ward X and try and speak to the ward manager, I tried numerous times but again, they didn't call me back. So I just left it. I just thought .. I've just got so much else, you know, going on" Carer interview

Care providers we spoke to described a lack of forums to provide feedback and engage in constructive dialogue with health and social care providers. Some were aware of processes for providing feedback, but were unsure what happened to the information that they provided.

8. REABLEMENT AND COMMUNITY SERVICES

Patients who require support to recover or ongoing care in the community following their discharge are on Pathway 1 of the hospital discharge process. This means that a lead professional from either the Reablement or Neighbourhood Team must visit patients who need support to recover at home to assess their follow-up needs on the day or the day after they have been discharged from hospital.[23]

Discussion of care and support needs in hospital

The August 2020 Guidance, which was in operation at the time of this project, states that information about the home circumstances for people should be collected at the point of admission, including the identification of immediate needs of the individual at home following discharge.

[23]Hospital Discharge Service: Policy and Operating Model, August 2020, page 15

Whilst most respondents (61%) were asked by hospital staff about their circumstances at home, 22% of Survey respondents told us that their home circumstances had not been discussed with them and 17% did not know.

Similarly, whilst hospital staff had discussed with most respondents to our Survey where they were going to be discharged to (67%), for some (23%) this was not the case.

The July 2021 Guidance makes it clear that staff must always involve the person in the planning of the care needed on discharge from hospital, and involve family, carers and other professionals involved in their care, where appropriate.[24]

Furthermore, it states that:
"All persons leaving hospital should receive a holistic welfare check to determine their level of support, including non-clinical factors like their physical, practical, social, psychological and financial needs"[25]

Support to settle in at home

35% of Survey respondents (n39) were provided with support to settle in when they returned home (e.g. heating turned on, check they had essential food/equipment). A further 14% (n16) told us that they needed this support, but they were not provided with it.

Patients who received a discharge assessment after leaving hospital

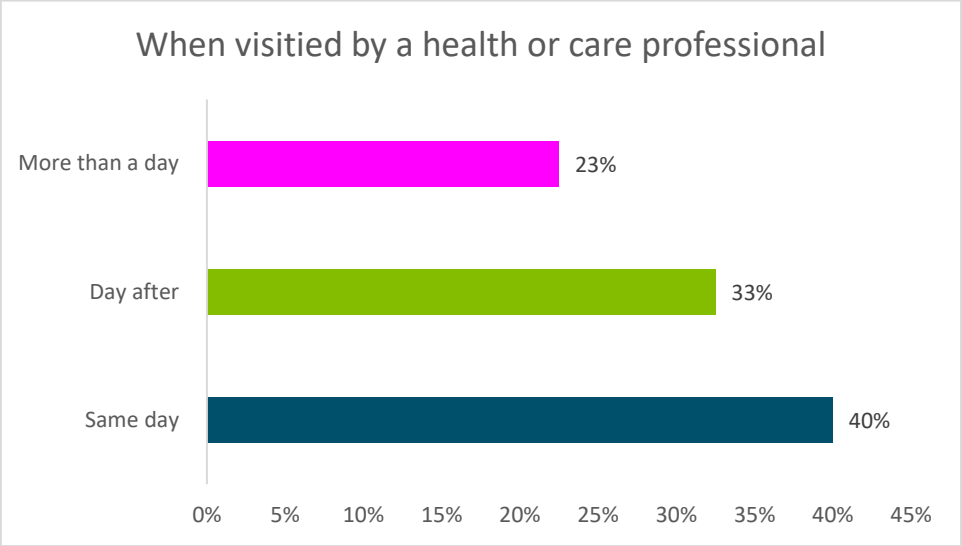
Most Survey respondents (63%) did not need, and were not visited by a health or care professional to assess their support needs when they left hospital. However 16% (12) of people who did not receive a visit reported that they had care and support needs that were not being met at the moment.

It should be noted that these numbers are small, it is noted here as it is important that patients who require support following their stay in hospital are consistently identified and offered this.

34% of respondents (40) did receive a visit to assess their support needs.

Of these respondents 40% (n16) received a visit the same day they left hospital, 33% (n13) the day after and 23% (n9) more than a day after they left hospital. 2 respondents did not know.

[24] Hospital Discharge and Community Support Operating Model, 5th July 2021, page 17
[25] Hospital Discharge and Community Support Operating Model, 5th July 2021, page 8



What the assessment covered

We asked these respondents what topics they were asked about during this discharge assessment. They could tick all that applied. The most common topics were about aids and equipment, whether there were people to support them and keep them company and whether they needed support for tasks such as washing, dressing and cooking.

Topics asked about in the discharge assessment (multiple choice)	
Answer	%
Whether any equipment or aids would be helpful for you	16
Whether there were people to support you and keep you company	13
Whether you might need support for tasks (e.g. washing, getting dressed, cooking)	13
Whether any changes were needed to make your home safe and comfortable (e.g. working heating, bed moved downstairs)	11
How you were feeling and if you had any general concerns	11
Whether you needed support taking any medication	11
Whether you were able to manage household tasks (e.g. shopping, cooking and cleaning)	11
Whether any adaptations were needed to your home (e.g. ramp to your door, changes to bathroom facilities)	9
If you were concerned about finances	1

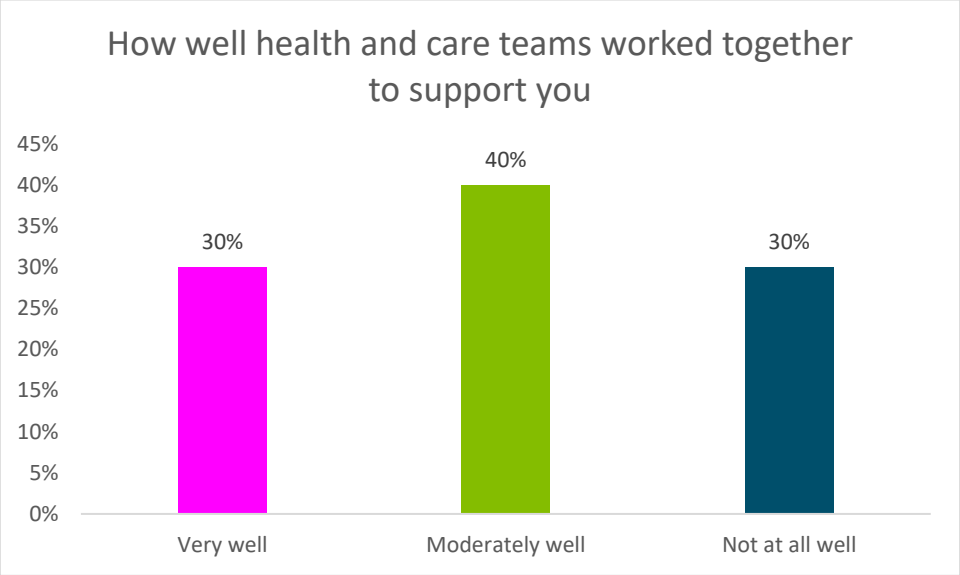
Some patients and carers we spoke with described a comprehensive assessment process whilst others felt that the focus was less holistic.

"I don't think we went into that much detail actually, she was just finding out what happened to me in hospital and filling in her forms, you know, to record what I was saying" Patient interview

Following the assessment 78% (n31) people were provided with services / support from a health or care agency.

How well health and care teams provided support

We asked respondents how well they thought health and care teams work/had worked together to support them.



This shows that 30% (n9) of respondents thought health and care teams worked very well together to support them, 40% (n12) thought teams worked moderately well together, whilst 30% (n9) thought teams had not worked at all well together to support them.

People told us **how the process worked well**.

"The service which arrived at my Dad's home on the day of his discharge were excellent. The person arrived on time and spent time on talking with me and my Dad about his needs and what support could be provided. She put this in place and it was great. Additional aids e.g. Zimmer frame etc. were provided in a timely fashion. The wrap around care services provided to support Dad in the early days after discharge were also excellent" Survey respondent, Carer

"The Reablement service were parked outside as my husband got out of the ambulance. Questions asked, that night the team came in and all was well" Survey respondent, Carer

We heard praise for Nurses in the community and for paid carers for the support that they provided to patients and carers after they were discharged from hospital.

"The District Nurse came round the day I got home ..They came round twice a week at first.. they come round once every fortnight now .. and that's very satisfactory now" Patient interview

We also heard of **difficulties encountered** where support was not available.

"Discharged home to husband with dementia, no equipment at home on discharge. No OT visit until the care agency became involved, after a call from the family" Survey respondent, Carer

"Despite being told by the hospital OT that a referral would be made for home support this did not happen, and we had to make contact to initiate any home assessment and support" Survey respondent, Carer

We noted, through our interviews with patients and carers, that they were often unaware on discharge that they would be receiving an assessment visit, or that there was a plan for care for themselves or their relative in place.

"They haven't said what was going to happen. They haven't said what care was coming in. And in fact, the next day ..there was a knock on the door. And Mum went to answer the door. And this lady's there then she said, I've come to see X, and Mums like who are you? She says I'm from the care company. And we know nothing about it." Carer interview

One patient, who has a disability, told us that the support that they received had been limited and had not enabled them to regain their independence, resulting in frustration:

"I feel I have had nothing. OK, so they have come and got me up, made sure I got to bed safely .. but basically I feel I have not had any support to get better. The support I have had from the Reablement team I can go to bed and get up and get on my chair safely. That's it. They don't want to know." Patient interview

Some patients and carers described the difficulties they had experienced accessing adequate physiotherapy support, some had seen a physiotherapist and then been sent leaflets with exercises for them to do at home, which they struggled with. Others had experienced a change of care provider after their discharge. Whilst most were satisfied with the provider we did hear that they missed the continuity of care.

"Very nice, you know, very professional … it's just the fact that I didn't know them, bearing in mind that I had somebody for 18 months before. You get to know people don't you?" Carer interview

We also heard from a few patients about issues relating to the level of skills and experience of paid carers provided through the reablement service, the timing of care calls being erratic and patients experiencing multiple carers.

"We had 21 different carers over 3 weeks at varying times (between 8.15 – 11.30 a.m.) and aids/equipment and risk level assessed but inaccurately by initial assessor first day at home. The concept of the Reablement team is excellent but short staffed and poor communication within their team" Survey respondent, Patient

We do not know how widespread these issues are.

Occupational Therapy and Equipment

Patients and carers we spoke with had generally had a positive experience with the provision of equipment and aids on discharge from hospital. We heard about hospital beds being delivered to home prior to patient discharge, patients being discharged with the equipment they needed or that this had been delivered quickly to patients and carers.

We did, however, have a few comments about delays to seeing an Occupational Therapist in hospital and about equipment being delivered.

Care homes described how, on occasions, residents had been discharged from hospital without the required equipment.

Care Agencies described the impact that a couple of days delay in the provision of appropriate equipment could have on an older person's recovery and of occasions when the lack of appropriate equipment had led to re-admission, as the person was unsafe at home without this.

We heard that getting OT support in the community, rather than as part of the reablement service, could be difficult.

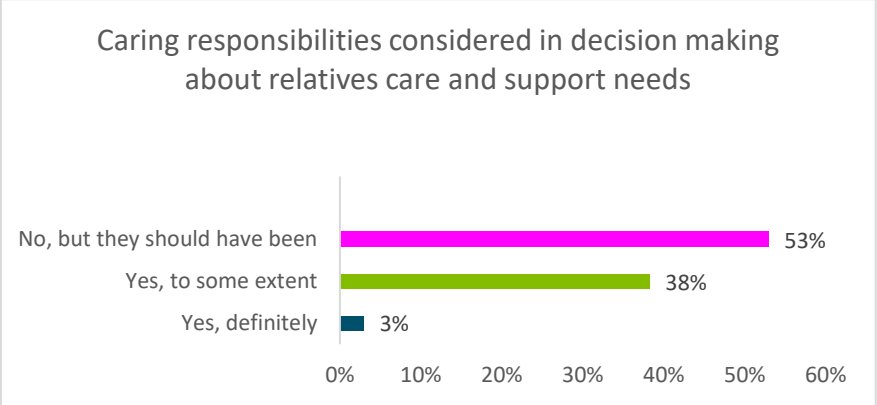
"For the OT system to be effective it needs fast availability of both people (OT's) and equipment, both have to be working together... I think the problem with the OT teams is … with them not getting to the right place at the right, you know, in good time. And that then impacts equipment doesn't it" Home Care provider

We include this here for further consideration by the health and care system.

9. SUPPORT FOR CARERS

We asked unpaid carers if they felt that their own caring responsibilities were considered in the decision making about their relative's care and support after they left hospital.

Half (53%) of the unpaid carers who responded to our Survey felt their caring responsibilities were not considered when they should have been. A further 38% felt their responsibilities were considered to some extent, 3% through this was definitely the case. 6% did not know.



Carers we spoke with, and those who responded to our Survey, told us that they did not always feel that their needs were considered.

"Whilst I understand the need to discharge patients ASAP, I think it needs to be remembered that family members who are also carers can't just drop everything at short notice and may need to put in or change existing support arrangements before their relative can come home." Survey respondent, Carer

"I was not involved in his discharge arrangements, I was told he was coming home! An occupational therapist had spoken to me in the morning, and after she explained how poor his mobility was now, we agreed that he was not fit for home and should have some rehab. A nurse later phoned me from the Discharge Lounge to say that he was coming home & I then found out quite by chance that he had been catheterised. She told me that it would be better if he came home by hospital transport, rather than me collecting him. When he arrived home I was shocked by his appearance, he looked unwell and he was brought into the house in a wheelchair (normally he would walk). So many health professionals and equipment came into our house, we were exhausted by it all. 19 days later he was readmitted to hospital with further problems and died after contracting COVID19 while there." Survey respondent, Carer

Some of the carers we spoke with did not see themselves as a carers, or as or as the person in need of support.

"I mean, if I'm honest, I haven't felt the need to have as much support. I just wanted to see my Mum have the right support for her. So I haven't really given much thought to myself." Carer interview

Other carers however described the pressures they experienced looking after their relatives twenty four hours a day. This pressure has been exacerbated by Covid-19, which led some carers to feel more isolated as they were unable to access face to face support.

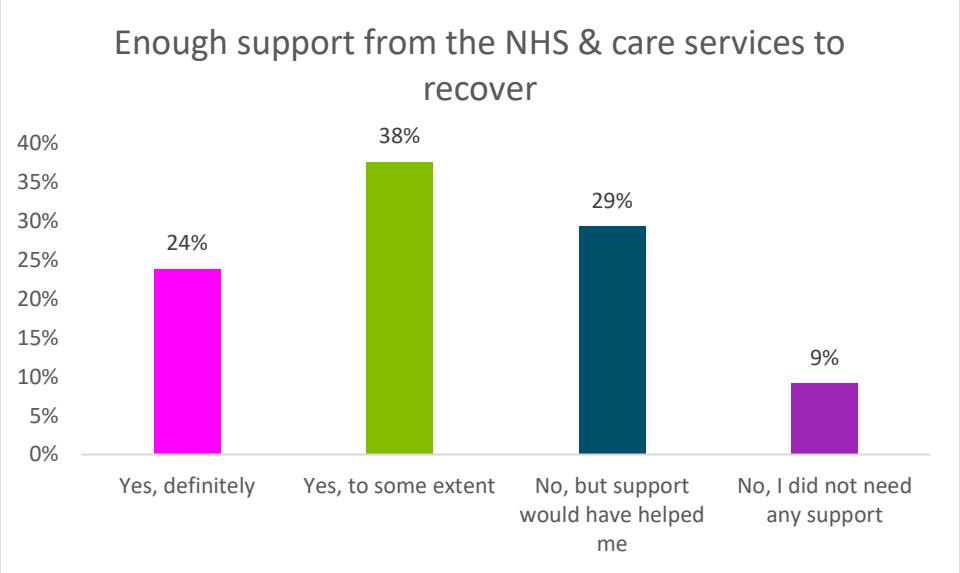
"Covid sort of added to your pressures as a carer, because if I have any time out I just got in the car and I just drive round. Just to get out of the house. Just to have a little break. If we haven't got this Covid I would ask for more time. But what's the point… you know you you're stuck here in the house and there is nothing you can do about it. You've just got to get on with it .. it is tough at the moment. I try not to let it get me down." Carer interview

The July 2021 Government Guidance makes it clear that before discharge, conversations are to be held with family members about their availability and capacity to care. These conversations should inform unpaid carers who need help of their entitlement to a carer's assessment. Where this is a new caring duty, or there are increased care needs, a carers assessment should be undertaken before caring responsibilities begin, although this may be after the patient has been discharged from hospital. It also states that any children and young people who may have caring responsibilities at the point of discharge are identified and referred to young carers services where appropriate[26]

[26] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government page 8

10.OVERALL, DID PATIENTS GET ENOUGH SUPPORT FROM NHS AND CARE SERVICES TO RECOVER

We asked the respondents to our Survey whether they, or their relative, got enough support from NHS and care services to help them to recover and to manage their condition.



24% thought that this was definitely the case, 38% thought this to some extent, whilst 29% thought that more support would have helped them and 9% did not need any support.

Praise for NHS and Care Staff

We heard from our interviews and from Survey respondents that people were appreciative of NHS and care staff. They recognised that Covid-19 had increased the pressures on staff, and were appreciative of the treatment they received in hospital and of support in the community.

"All the staff have been very professional and help in making my discharge .. as smooth as possible. They even gave me a warm send off and I am very touched by the dedication and passion of the medical and nursing staff" Survey respondent, Patient

"All staff were exceptional …. They could not have been more helpful" Survey respondent, Carer

"The reablement service arrived within 3 hours of being discharged and were very helpful" Survey Respondent, Patient

11.WHAT NHS AND SOCIAL CARE STAFF TOLD US ABOUT HOSPITAL DISCHARGE

In order to get a rounded picture of hospital discharge, and as an exception to our usual practice, we spoke with 24 NHS and social care staff to understand their perspective.

On the whole both NHS and social care staff we spoke with were positive about improved communication and interagency working across health and social care.

We heard support for the Discharge to Assess model which was seen as having potential to improve flow and capacity within the Acute hospital, reduce delayed transfers of care, assist patient recovery at home, and provide responsive, integrated care at home for patients who required support.

For patients who may require long term or bedded care it provided an opportunity for social workers or care coordinators to get to know people better, as they continue working with an individual outside of the hospital setting.

It was clear that staff were motivated to improve the process, and wanted to get it right for patients.

We have drawn out a few key themes from our conversations with staff, as they impact directly on patient experience.

Planning and timing of patient discharge

The intention of the national Guidance is that each individual will be reviewed daily to identify people medically fit for discharge to leave that day, but planning for discharge should happen as early as possible.

Some NHS staff we spoke felt that discharge planning in Acute settings should start earlier in the patients stay, rather than at the point where a patient was identified as medically fit for discharge. This would enable more pre-planning of discharge arrangements such as medications and booking hospital transport, as well as planning onward care support.

Community Hospital staff told us that discharge planning started on the day of admission, and described how they were able to “get ahead” of the discharge process by anticipating medication and transport needs. This more planned approach from community hospitals was backed up by care providers who described better communication and more timely discharges of people from these settings, whilst recognising the additional pressures on Acute Hospitals and their staff.

Staff across health and social care agreed that making decisions about patient’s fitness for discharge and discharging patients earlier in the day would improve flow across the system, as well as providing a better experience for patients.

Later discharges from hospital affects capacity across the system. It creates a concertina effect, reducing the number of same day assessments that the Reablement Service and Neighbourhood Teams can complete, puts pressure on night services and creates delay and uncertainty for patients, carers and care providers.

Capacity in the system to support hospital discharge

To provide some context in relation to discharge information from both WRH and the Alex, we requested data to include the total number of discharges during the period 01/11/20 - 30/11/20, the reasons that patients did not leave on their Medically Fit for Discharge date (MFFD) and the numbers who were discharged the next day.

Over the month of November, a total of 466 patients were discharged, with 320 discharged from WRH and 146 from the Alex. 34 of these patients were not known to the Onward Care Team.

Of the remaining 432 patients 77 (18%) were discharged on the same day that they were identified as MFFD.

From this snapshot of hospital discharge data, it is apparent that there were multiple reasons that 355 patients did not leave on their MFFD date, these are shown in the table below.

Reason did not leave on MFFD date	Number
Change in patients' fitness for discharge (i.e. no longer fit) or waiting for internal review (e.g. medical, OT, Physiotherapy)	90
Pathway 0, simple discharge no services (not discharged by Ward)	23
Pathway 0 capacity of existing care agency to restart care	30
Capacity in Pathway 1	84
Capacity in Pathway 2	78
Capacity in Pathway 3	3
Capacity in Pathway 5	15
No discharge destination (housing related)	13
Safeguarding	8
Equipment needed to enable safe discharge	7
Patient/family choice – declined plan	4

129 (37%) of the 355 patients MFFD were discharged on the following day.

226 (48%) out of 432 were discharged within 24 hours of MFFD date.

We appreciate that this is simply a snapshot in time, and the position may have changed since this information was provided to us.

During the project we had mixed feedback from NHS and care staff about capacity in Reablement services and Neighbourhood Teams for patients on Pathway One. This could be affected by geography (more difficult in in the south of the County and in rural areas), timing (less capacity in the evenings and at weekends), staffing, availability of domiciliary care, and volume of demand. Some NHS staff told us that at times there is insufficient capacity in Reablement services.

Flexibility within the Pathways approach

Social care staff highlighted that the use of Discharge to Assess beds could potentially lead to multiple moves for vulnerable patients. A patient could move from an Acute Hospital to a Community Hospital/Rehabilitation setting, to a temporary Discharge to Assess bed in a nursing or care home pending assessment of their long-term needs and then potentially move to a different, permanent residential setting. At the time of writing people would be required to self-isolate in each residential setting.

This was the experience of a carer of a person living with dementia who was in a Discharge to Assess bed.

"Yeah, we've got a social worker that's working with us now. And we're at a stage where we're trying to keep my Mum where she is now long term, because it's clear that going back to [her own home] is not an option for her really. Just because she's so frail. But I think I'm so disappointed because I think what she's been through, although for some people it would be stressful, if you haven't got dementia, it would be stressful. But I think it's .. had a real detrimental effect on my Mum's health. You know, I feel like she was just pillar to post and it's clearly had a detrimental effect on her ongoing wellbeing, and that's probably part of the reason why she can't go back to where she lives." Carer interview

Social care staff described, and welcomed, greater flexibility being available to them when they knew that patients would have long term care needs to be able to place a person directly into their long term setting or to reinstate care at home directly with a previous provider where this was the best option for the patient.

Social care staff understood and were supportive of the need to increase capacity in hospitals, but balanced this with support for a need's led, more flexible approach rather than always following a "Pathways" approach, when this was not the best option for the person.

Discharging people who are Homeless

We were told that there is one Homeless Discharge Pathway Liaison Officer for the two Acute Hospitals and the seven Community Hospitals who is employed by Worcester City Council but funded by the NHS and Social Care. The postholder has a direct link with the Onward Care Team and acts as the link between the patient and ward into the District Council Local Housing Authorities and multiple housing associations across the County. When they are not available there is a jigsaw referral portal which the social workers support and the wards refer in to. The postholder takes the referrals for patients who are either already homeless or become homeless in hospital. We were not able to speak with anyone who is / was homeless and discharged from hospital.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Forms

The ReSPECT process creates personalised recommendations for a person's clinical care in emergency situations, where they may be unable to make decisions or communicate their wishes. The plan is written on a ReSPECT form completed following a conversation with the patient, and where appropriate a carer, with a health professional. We have raised an issue with the WAHT about the completion of ReSPECT forms in the Acute setting. We will be monitoring this through our involvement in ReSPECT and End of Life workstreams.

12.RECOMMENDATIONS

During this project we heard the experiences of patients and carers who were discharged from hospital between March 2020 and April 2021.

The Covid-19 pandemic has created significant challenge for patients and their carers, and for health and social care professionals. We heard that patients and carers valued health and care staff and recognised the huge impact that Covid-19

has had on the way that health and social care services are delivered and managed. It was clear from staff we spoke with that they were motivated to improve the hospital discharge process and wanted to get it right for patients.

Nevertheless, in this report, we have identified that there are issues and challenges experienced by patients and carers when people leave hospital, and we have focused on these, as this is where learning can be identified.

We recognise there are significant implications for the health and wellbeing of patients and their carers of not getting hospital discharge right first time – potential deterioration on leaving hospital, feeling unsafe, avoidable re-admissions – and these impact on the individual, their families, carers, friends, and on the wider health and care system.

The Recommendations below flow from our findings.

RECOMMENDATIONS

COMMUNICATION

In line with recommendations by Healthwatch England (HWE)[27], while visiting restrictions continue put in place special arrangements to improve communication and involvement with family and carers to enable them to participate in decisions made during and after the discharge process, particularly for patients with disabilities and additional needs, in line with the hospital duty to cooperate with family carers.

1. When people are admitted to hospital they are asked if they have a carer who should be involved in decision making about their care. If the patient does name a carer, attempts to contact them and involve them in discussions about hospital care and discharge should be made at every step, and in particular prior to a patients discharge from hospital.
2. Family and carers to be provided with a single point of contact who they can get in touch with for information about their relative while they are in hospital
3. In line with the July 2021 Government Guidance people, and where appropriate their family or carers, should receive regular updates and sharing of information about the next steps in their care and treatment[28]

FEELING PREPARED TO LEAVE HOSPITAL

In line with the July 2021 Government Guidance:

4. Start conversations with patients, and their family or carer where appropriate, and plan earlier in the process so that patients are aware of when they may be discharged.
5. Ensure that individuals and their families are provided with the information supplied by NHS England, or a local equivalent, about leaving hospital and are fully informed of next steps.

[27] This recommendation was made in the HWE Report on hospital discharge. It is endorsed here as our findings show that it is relevant to the situation in Worcestershire

[28] Hospital Discharge and Community Support Operating Model, 5th July 2021, page 17

6. Ensure that essential information is communicated and transferred to relevant health and care partners on discharge.

LEAVING HOSPITAL

7. In line with recommendations made by HWE, and dependent on Covid infection rates in the community, consider whether all patients being discharged from hospital should be tested for Covid-19 before going home.
8. Covid-19 test results should be communicated to families and where relevant care providers, and included in documentation that accompanies the person on discharge.
9. Ensure that patients who are Covid-19 positive on discharge home are supported to self-isolate where this is needed by the patient or their family, for example, through referral to the Here2Help[29] scheme.
10. Consider whether inpatient discharge after 8 p.m. is appropriate for any patient, and consider placing limits on weekend discharge which are determined by capacity in the system.
11. Patients, and where appropriate their carers, should always be asked about transport requirements.
12. Review processes so that, at an earlier stage, patient's requirements for hospital transport can be identified.
13. Consider how the four hour window for hospital transport can be reduced, or transport capacity increased.
14. Patients, and where appropriate carers, should always be given information about the purpose of their medication and how to administer and manage it.
15. Consider how information about changes to medication can be communicated to care providers prior to a patients discharge to ensure continuity.
16. Consider introducing a standardised format for information transfer between hospital wards and the discharge lounge.
17. Consider how the format for discharge notes will ensure that these provide an accurate, precise and consistent account of the patient's hospital stay and treatment, and are clear and specific about the follow up care and treatment to be provided by the hospital, GP and other health and care professionals.
18. This format should be developed through dialogue with patients and carers and with primary care and social care providers.
19. In line with the July 2021 Government Guidance ensure patients receive information about who to contact if their condition changes, including direct contact points within the hospital and information signposting them to relevant voluntary sector or other community support.
20. Hospitals should also provide the patient's nominated family member /carer with this information where appropriate.
21. Consider how opportunities to promote dialogue with and feedback from patients and carers and care providers can be maximised, including ensuring that patients are routinely informed of Patient Advice and Liaison Services and the complaints procedure.

[29] Here2Help Coronavirus (COVID-19) | Worcestershire County Council

REABLEMENT AND COMMUNITY SUPPORT SERVICES

22. Ensure that patient's home circumstances are discussed with them on admission to hospital, or well in advance of discharge.
23. Ensure that all patients leaving hospital receive a holistic welfare check to determine the level of support, including non-clinical factors like their physical, practical, social, psychological and financial needs, as set out in the July 2021 Government Guidance[30].
24. Consider whether there is sufficient capacity across the health and care system to support patients discharge.

SUPPORT FOR CARERS

In line with the NHSE July 2021 Guidance

25. Ensure that before discharge, conversations are held with family members about their availability and capacity to care, these conversations should inform unpaid carers who need help of their entitlement to a carer's assessment.
26. Ensure that where this is a new caring duty, or there are increased care needs, a carers assessment, where required, is undertaken before caring responsibilities begin.[31]
27. Ensure that any children and young people who may have caring responsibilities at the point of discharge are identified and referred to young carers services or offered a needs assessment where appropriate.

WHAT NHS AND SOCIAL CARE STAFF TOLD US ABOUT HOSPITAL DISCHARGE

28. Consider how planning for hospital discharge in acute hospital settings can be started earlier in the process, in order to enable patients to be discharged earlier in the day.
29. Allow for flexibility within the Pathways approach when this is required to meet the individual needs of patients.

[30] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government page 8:
[31] Hospital Discharge and Community Support Operating Model, 5th July 2021, HM Government page 8: "A carers assessment can be completed after discharge, but should be undertaken before caring responsibilities begin" www.gov.uk/government/collections/hospital-discharge-service-guidance