healthwatch Worcestershire

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

(March 2020 – April 2021)

Summary Report
August 2021

Acknowledgments

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Note

A copy of the Full Report and the Patient Survey is 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.

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[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.