**Herefordshire and Worcestershire**
**Integrated Care System**

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Jane Stanley
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Dear Jane

**RE: Healthwatch Worcestershire Report – People's Experience of Leaving Worcestershire Hospitals During Covid-19 – response to recommendations**

Thank you for sharing with me your report into people's experience of leaving hospitals during the Covid-19 pandemic. It is clear that a significant amount of work has gone into preparing this report and I welcome the recommendations that you have set out.

As requested, I am pleased to enclose a system-wide response to these recommendations in the form of an action plan. The actions described within our response have been agreed by NHS partners and Worcestershire County Council, noting that many of the recommendations are applicable across our local system.

During the pandemic the health and social care system has had to make significant changes to the way it operates. We have had to take into consideration the risks of exposure to Covid-19 infection within a clinical environment whilst also ensuring that we have sufficient space available to safely look after patients who test positive for Covid-19. We continue to aim to meet national discharge requirements wherever possible, which place emphasis on a person's home being the most Covid-19 secure environment.

Many of the recommendations made in the report are incorporated in the on-going improvement work overseen by the system's Home First Committee and we would expect to see the benefits of this work being realised over the coming months. Progress with this action plan will be closely monitored through our Discharge Requirements Group which includes representation from all system partners.

I hope this response demonstrates our ongoing commitment to working together to address the issues that you have identified. If you have any questions or concerns about these actions, please don't hesitate to get in touch.

Yours sincerely

**Simon Trickett**
Chief Executive
Herefordshire and Worcestershire ICS

CC

Matthew Hopkins, Chief Executive, Worcestershire Acute Hospitals NHS Trust
Sarah Dugan, Chief Executive, Herefordshire & Worcestershire Health & Care NHS Trust
Paula Furnival, Director of People, Worcestershire County Council
Kathleen Simcock, Interim Head of Service, Integrated Intermediate Care

**System Action Plan**

| Area | Recommendation | Lead | Comments | Actions | Timescale |
|---|---|---|---|---|---|
| Communication | 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. | Senior nursing staff in both Trusts and the Onward Care Team for operational leadership and delivery. System leaders to maintain oversight and delivery of strategic changes taking place as part of the HomeFirst Programme. | Recommendation to be reinforced through work on HomeFirst, Dr Ian Sturgess' recommendations and 'Perfect 10 Days'. Acute Trust Discharge Policy requires review, revision and updating. The Hospital Discharge and Community Support Policy and Operating Model (July 2021) should be used to inform the update. Consideration will be given to the value of having a System-wide Discharge Policy. (It should be noted that contact with carers requires consent to be given by the patient.) Range of tools to aid effective communication to be considered in more detail and deployed as appropriate. | Recommendation to be made to the System's Discharge Requirements Group (DRG) for review and update of Discharge Policy. Lead to be identified. | 30.12.21 |
| Communication | 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 | Senior nursing staff in both Trusts. | Consideration to be given to introduction of 'Discharge Checklist' to support entire process. | To be addressed as detailed above. | 30.12.21 |

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| Communication | 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 | Ward MDTs and Onward Care Team. | Recommendation to be included in policy refresh. New OCT model with Cluster Wards will improve this. | As in 1 & 2 above | 30.12.21 |
| Feeling Prepared to Leave Hospital | 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 | Ward MDTs and Onward Care Team. | In the new OCT model, the social care team will be involved in patients discharge planning earlier in their journey, so individuals and their families have information earlier to be ready to leave hospital. | During the pandemic new methods of communication, namely laptops and tablets were introduced to be able to connect patients and staff with relatives and carers in the context of the physical restrictions and distancing that were required. This required periods of familiarisation and practice. New forms of technology will continue to be embraced. | 30.12.21 |

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| Feeling Prepared to Leave Hospital | 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. | Senior nursing staff in both Trusts and Onward Care Team | Discharge information and nationally recommended leaflets require to be more comprehensively used. This could be supported by introduction of a Discharge checklist. | As in 1&2 above. Written discharge information will be reviewed as part of policy review. | 30.1.22 |
| Feeling Prepared to Leave Hospital | Ensure that essential information is communicated and transferred to relevant health and care partners on discharge. | Ward MDTs and Onward Care Team | Introduction of new 'Safe to Transfer' electronic form will assist with this. Pilot due to commence shortly. | As outlined under Comments | Pilot to commence late October 2021. |
| Leaving Hospital | In line with recommendations made by HWE, and dependent on Covid-19 infection rates in the community, consider whether all patients being discharged from hospital should be tested for Covid-19 before going home. | Trust Medical Directors | Testing arrangements are kept under continuous review and will remain compliant with national requirements. | None identified currently. Compliance with national guidance will be maintained. | On-going |

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| Leaving Hospital | Covid-19 test results should be communicated to families and where relevant care providers and included in documentation that accompanies the person on discharge. | Ward MDT. | Included as part of Electronic Discharge Summary (EDS) and discharge documentation. | As outlined under Comments | On-going |
| Leaving Hospital | 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 scheme. | Onward Care Team | Those who are Covid-19 positive and moving to a Care / Nursing Home and cannot independently self-isolate are provided with extra 1:1 support. Those going home are supported via PW1. Hotel accommodation is also provided to those who are self-caring. | Access to Here2Help to be re-communicated to ward MDTs for simple discharges. | 30.11.21 |
| Leaving Hospital | Consider whether inpatient discharge after 8p.m. is appropriate for any patient, and consider placing limits on weekend discharge which are determined by capacity in the system | | Home First Improvement plan includes earlier in the day discharges. | Where discharges occur unavoidably late, ensure they are appropriately supported. | On-going |

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| Leaving Hospital | Patients, and where appropriate their carers, should always be asked about transport requirements | Ward staff | This is integral to improving communications regarding discharge. | Transport issues to be kept under review. | On-going |
| Leaving Hospital | Review processes so that, at an earlier stage, patient's requirements for hospital transport can be identified. | | This is integral to improving communications about discharge. | Transport issues to be kept under review. Findings will inform commissioning arrangements in the future. | On-going |
| Leaving Hospital | Consider how the four-hour window for hospital transport can be reduced, or transport capacity increased. | Commissioners | To be considered as part of regular contract review arrangements. | Plan to trial shorter window during a 'Perfect 10 days' exercise. This will be incorporated if successful. It should be noted that four hours is the national standard. | On-going |
| Leaving Hospital | Patients, and where appropriate carers, should always be given information about the purpose of their medication and how to administer and manage it. | Pharmacy and ward staff | Recommendation to be covered in overall improvement work on communication with patients. | | 30.12.21 |

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| Leaving Hospital | Consider how information about changes to medication can be communicated to care providers prior to a patient's discharge to ensure continuity. | Pharmacy and ward staff | Recommendation to be covered in overall improvement work on communication with patients. | | 30.12.21 |
| Leaving Hospital | Consider introducing a standardised format for information transfer between hospital wards and the discharge lounge. | Director of Capacity and Flow | Currently under review and improvement. | | 30.11.21 |
| Leaving Hospital | 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. This format should be developed through dialogue with patients and carers and with primary care and social care providers. | | Review of discharge communication and documentation will be undertaken as part of the improvement work underway and review of policy documentation. This will include consideration of communication documentation filed in patients notes. | | 30.1.22. |

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| Leaving Hospital | 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. | | Tailored discharge information and leaflets as per policy guidance. | | 30.1.22 |
| Leaving Hospital | Hospitals should also provide the patient's nominated family member / carer with this information where appropriate. | | See above | | 30.1.22 |

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| Leaving Hospital | 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. | System Discharge Requirements Implementation Group | Prior to the Covid-19 pandemic, Health and Social Care staff routinely gave out the Compliments, Comments and Complaints leaflet with a letter explaining that feedback is used to develop and improve services. This practice will be recommenced. Information on PALs will continue to be made available. | A System-wide 'Problematic Discharge Process' is also in place which is used to improve service delivery. | 30.12..21 |
| Reablement and Community Services | Ensure that patient's home circumstances are discussed with them on admission to hospital, or well in advance of discharge. | Ward MDT and Onward Care Team | Will be addressed by improvement work on discharge planning. | | 30.12.21 |

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| Reablement and Community Services | 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 | | Currently moving towards implementing revised Government guidance, based on the 'Discharge to Assess' model. | | 30.12.21 |
| Reablement and Community Services | Consider whether there is sufficient capacity across the health and care system to support patients discharge. | Commissioners | The Home First programme is fully dedicated to this ambition and is progressing well, including moving to trial an integrated intermediate care approach from 13.9.21 and planning for a Perfect 10 days in November. Pathway 1 has had additional investment in capacity. Likewise Pathway 3 has a refreshed specification and corresponding investment. | | 13.9.21 and on-going review thereafter |

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| Support for Carers | 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. | Onward Care Team | Social care staff discuss with family members details of the care they provide and clarify the availability of this support. Carers assessments are explained to all known carers. A review of how this is offered, recorded and audited is underway to ensure this is being offered consistently. | | 30.12.21 |
| Support for Carers | 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. | OCT and Pathway 1 | As above. | Carers Awareness work is underway as part of Carers Strategy review. Action Plan includes the requirement for further participation of staff in e-learning. Carers Strategy to reflect the need for improved arrangements for sign-posting, a default to opt-in to ensure informed choices about support and engagement are made. | 30.11.21 |

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| Support for Carers | 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. | WCF | WCF Early Help currently working with commissioned services and Acute Trust Safeguarding Lead for Children to raise awareness and identify CYP with caring responsibilities to make referral for needs assessment. | | 30.12.21 |
| What NHS and Social Care Staff Told Us About Hospital Discharge | 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. | Senior nursing staff in both Trusts and Onward Care Team | Policy revisions, communications and engagement exercises either underway or planned. Performance metric for early in the day discharge measured and managed as part of performance review process. | Performance metric for early in the day discharge measured and managed as part of performance review process. | 30.11.21 |
| What NHS and Social Care Staff Told Us About Hospital Discharge | Allow for flexibility within the Pathways approach when this is required to meet the individual needs of patients. | Ward staff, Onward Care Team and Discharge Pathway teams | Patient's support needs are considered when referral is made and discussion with pathway providers takes place when needed to ensure individual needs are most appropriately met. | Functional needs of patients to be recorded by ward staff on 'Safe to Transfer' electronic form to inform the most appropriate, person-centred discharge arrangements. | 8.11.21 |