

DISCHARGE TO ASSESS PROJECT REPORT 2022

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About Healthwatch Cumbria

Healthwatch Cumbria (HWC) was established in April 2013 as part of the implementation of the Health and Care Act 2012.

Healthwatch England (HWE) acts as the national consumer champion for all local Healthwatch organisations, enabling and supporting HWC to bring important issues to the attention of decisions makers nationally.

A key role of HWC is to champion the views of people who use health and care services in Cumbria, seeking to ensure that their experiences inform the improvement of services. HWC are constantly listening, recording and reporting on the views of local people on a wide range of health and care issues, ensuring that people in the county are able to express their views and have a voice in improving their local health and care services.

By law, there must be a Healthwatch in every local authority, thus, Healthwatch are funded by and accountable to local authorities. Therefore, legislation states that every local Healthwatch must carry out the following statutory functions:

- Obtain the views of people about their needs and experiences of local health and social care services. Local Healthwatch make these views known to those involved in the commissioning and scrutiny of care services.
- Make reports and make recommendations about how those services could or should be improved.
- Promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services.
- Provide information and advice to the public about accessing health and social care services and the options available to them.
- Make the views and experiences of people known to Healthwatch England, helping us to carry out our role as national champion.
- Make recommendations to Healthwatch England to advise the CQC to carry out special reviews or investigations into areas of concern.



Executive summary

Discharge to Assess is where a patient is supported by a range of health and social care professionals and services, to return home safely, when it is safe and appropriate to do so – to ensure that they do not stay in hospital longer than necessary and are not re-admitted. They then can be assessed for long-term care and support needs, in the right place and at the right time for the individual.

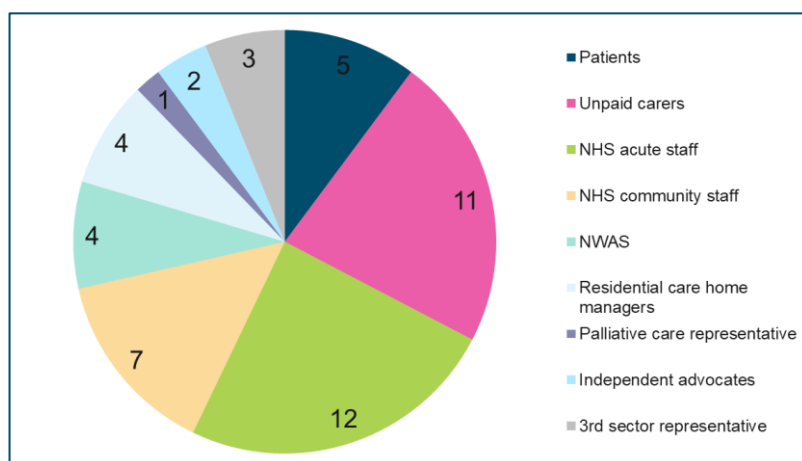
This discharge to assess project developed from a commissioned piece for NHS England & Improvement (NHS E&I), which gathered the insights of patients, unpaid carers, and NHS staff, with a specific emphasis on unpaid carers experiences of the discharge to assess process, into a HWC core project. The work was then expanded by widening the parameters to include conversations with residential care home managers, NHS transportation staff, independent advocates, as well as representatives from palliative care and 3rd sector organisations, on top of patient, unpaid carers, and NHS staff experiences.

Therefore, the amalgamated findings, from the wide range of experiences shared, provides an in-depth snapshot in time of the discharge process, with a particular insight on which aspects of the process needs improvement.

HWC chose to take a qualitative research approach to this project, by completing case studies with individuals (or having them complete open-ended survey questions, to closely resemble a structured interview). This developed a clear picture of the overall discharge process (at this point in time) and identified what could be done differently to make the discharge process flow smoother.

At times it was challenging to get people to engage with this project, however, in the end there was a total of forty-nine participants who took part in the project:

- 5 patients
- 11 unpaid carers
- 12 acute/hospital-based NHS staff
- 4 NWS staff members
- 7 community-based NHS staff
- 4 residential care home managers
- 1 palliative care representative
- 2 independent advocates
- 3 representatives from the 3rd sector



From the conversations with patients, it became evident that the two common factors in patients feeling that their experience of the discharge process was negative, was poor communication (meaning that they felt that they had not been kept informed), and not having the appropriate support in place at home at the point of their discharge. It was also highlighted from the patient experiences that were shared by advocates with HWC, that their role is essential in the discharge process when the patient is unable to advocate for themselves, to ensure the patients' needs are at the centre of the decision-making process.

From the discussions with unpaid carers, it showed that, similarly to the patient's discussions, that the two areas of the discharge process that need addressing are communication (between medical professionals and the patients and their unpaid carers) and having the appropriate support in place at the point of discharge. It was evident from the discussions that the quality of these two areas influenced how positively the unpaid carer felt that the discharge process had gone.

From the conversations with acute/hospital-based NHS staff several themes were highlighted, including concerns with the relationships between the acute and community teams, the issues with the lack of staff capacity, and the poor quality of communication that can occur. Communication was the most prominent theme that was discussed, including the need to improve communication between acute staff members themselves, with community staff members, as well as with patients and their unpaid carers. These concerns raised indicated that the acute staff were aware of the sources of some issues that some unpaid carers and patients face during the discharge process. Furthermore, it was evident from the responses that the staff are worried about the impact that a poorly executed discharge process can have on the patient and their relatives, and they feel that it is key to improve the delivery of this service.

From the discussions with NWS NHS Trust staff it was shared that a coordinated, clear and structured discharge plan with more than 24 hours' implementation notice, would increase the success of a patient transfer. With their key areas of concern around being able to achieve a successful discharge to assess, would be the quality of planning (including timings), communication, and staff/patient welfare.

From the conversations with community-based NHS staff there were several concerns raised, which ranged from receiving the incorrect information and the sometimes-poor quality of discharge planning, to the poor relationships between the community and acute teams. However, it was evident that having the correct information shared via good communication was the key to completing a good discharge process from the community-based staff perspective. They highlighted that this would allow the process to run smoother, especially for the patients and their unpaid carers as they could be kept updated with the correct information and they would have sufficient support available at the point of discharge.

From the discussions with residential care home managers, the main theme was around communication, and how this is currently a struggle for them. However, other topics mentioned by the care home managers in their discussions included issues with paperwork, the benefits of completing face to face assessments, the state that patients are in when they are discharged, medication issues and problems with GP access.

From the conversation with a palliative care representative, they emphasised that the discharge process is a very personal experience for each patient and person involved. But from the feedback that they have received from patients and unpaid carers, they shared that it seems the whole healthcare system needs to improve its communication. There seems to be a disconnect in the level of information about the discharge process and the ongoing care requirements that is given to patients and their loved ones, compared to the information that is shared with staff members (where there can also sometimes be issues).

From the discussions with independent advocates, it was shared that from their experience the discharge process can either be too rushed or it can be unnecessarily delayed. This can be due to professionals being reluctant to consider the views of the patient, once they have made a judgement on what they think is best for the patient based on their assessment. However, it was also raised during the discussions with advocates, that people should not wait whilst professionals are conducting assessments to determine what funding is agreed, and that people should be made clearly aware of their rights and options throughout the process.

From the conversations with representatives from the 3rd sector it was shared that from their perspective a good discharge is when the patient and their carer have been kept updated throughout the process, and that they are able to go home, with the right things in place, with a carer that is capable of supporting them, with all their expectations of the process met. Furthermore, it was raised by 3rd sector representatives that a good discharge starts at the admission, as this means that the communication channels will be stronger as they have been developed earlier in the process. As currently some carers have expressed to the 3rd sector organisations that communication between medical professionals and the patient's family, is not consistently at a high quality.

Therefore, to summarise, HWC engaged with nine different groups of people that are involved in the discharge process, who shared their views and opinions of the process from their experiences. From their feedback a reoccurring theme throughout was communication. It was evident that the main way to improve the discharge process was to improve the quality of communication, this included within the healthcare system as a whole (between different medical professional teams, such as hospital-based teams, community-based teams and patient transportation teams). As well as between medical professionals and their patients, unpaid carers, residential home staff and palliative care staff. Additionally, even the communication between 3rd sector organisations and the patients and their unpaid carers (to increase awareness of the support that is available) can be improved to improve the discharge process. Other aspects of the discharge process that were regularly raised as suggestions to improve, was the need to have the patients' needs as the main focus of the discharge process, having accurate information shared with the correct people prior to discharge (having the right people involved in the planning process) and having the necessary support in place at the point of discharge.

Rationale for the project

This project started off as a commissioned piece of work for NHS E&I. Following the completion of the commissioned work, Healthwatch Cumbria felt the project had room to expand and continue. This allowed for a more in-depth investigation into the discharge to assess process. Therefore, this report is the concluding part of the whole project.

Originally, the Experience of Care team at NHS E&I wanted to work with trusts across England, to develop the discharge to assess process, with the aim of the consequential guidance and pathways designed to provide more support to patients, and their unpaid carers. This was to be achieved by gaining insights from patients and unpaid carers (relatives, friends and neighbours) experiences, to evaluate the discharge process, highlighting areas of best practice and aspects that require improvement. However, during the project the focus was updated (by NHS E&I) to provide more focused attention to unpaid carers' experiences.

Collaboratively North Cumbria Integrated Care (NCIC) and HWC successfully bid to be involved in this piece of work, with HWC independently examining the discharge process ran by NCIC.

The HWC engagement work informed the development of the discharge process, by providing NHS E&I with an insight of how the discharge process has been for patients, their carers, and professionals, with a primary focus on unpaid carers' experiences. The findings gathered from the case studies, were written up in a report which was then sent to NHS E&I.

Then, HWC decided to expand the work into a core project, by widening the original parameters. To not only continue to collect case studies from patients, unpaid carers (relatives, friends and neighbours), and NHS staff but to also collect case studies from residential care home managers, NHS transportation staff, independent advocates, as well as representatives from palliative care and 3rd sector organisations. The reason to do this was to gain a more in-depth snapshot of the strengths and weaknesses of the discharge process, from a wider range of key perspectives, to inform detailed recommendations on how to best improve the service to benefit those involved in the process.

Therefore, this is the concluding report that amalgamates all the findings from the experiences shared via the case studies and contains a series of recommendations based on the feedback provided.

Methodology

HWC chose to take a qualitative research approach to this project, to gather a variety of in-depth insights. By completing the case studies with individuals, who view the discharge to assess process from a wide range of different perspectives, HWC gained an in-depth snapshot of the discharge process and identified what could be done differently to make the process flow smoother.

The table below, shows a figure breakdown of who HWC spoke to about their thoughts and opinions of the discharge process:

Who?	Number of case studies	Further detail
Patients	5	3 of which were provided by the advocates
Unpaid carers	11	10 relatives 1 neighbour
NHS staff members	23	12 acute/hospital-based staff 4 NWS staff members 7 community-based staff
Residential care home managers	4	
Palliative carer representative	1	
Independent advocates	2	
3rd sector representatives	3	
TOTAL	49	

At times it was challenging to get people to engage with this project, however, due to the HWC engagement officers' lateral and innovative thinking, they managed to obtain a total of forty-nine participants.

The original aim of this project (which came from the commission by, the Experience of Care team at NHS E&I) was to discover and develop best practice guidance and pathways around the support of patients, and their unpaid carers when being discharged from hospital. The initial HWC engagement work aimed to inform this development, by providing a full insight of how the discharge process

really has been experienced by patients, their unpaid carers, and medical professionals.

Due to the pressures faced by NHS staff involved in the discharge process, it was agreed to capture their views via an online survey (with an option for them to have a follow-up discussion with HWC if they wanted to). The survey questions were co-designed by HWC and the NCIC Transfer of Care Hub Manager, who also shared the survey link to the relevant staff members. It was also shared by the NCIC and Adult Social Care communication teams. To reflect a structured interview format, and encourage the respondents to share their thoughts, the survey was comprised primarily of open questions. There was a total of nineteen responses, which came from both acute/hospital-based and community-based NHS staff members.

HWC collaborated with the Chief Officer of Eden Carers, to design questions to ask patients and unpaid carers to explore their experiences of the discharge process. Also, with the help of Eden Carers and West Cumbria Carers, HWC created an invitation letter, which explained the project and invited people to take part.

Then HWC began engagement with the purpose of obtaining participants for case studies, in a variety of ways:

- The HWC website dedicated a page to the project, and consistently promoted the project via social media.
- One hundred hard copies of the invitation letter were distributed by Eden Carers and a further one hundred hard copies by West Cumbria Carers (who also emailed the invitation letter to another three hundred unpaid carers).
- An online sign-up form was created, where people could leave their contact details if they wanted to be involved. The link was shared via HWC through the newsletter, website and social media. NCIC and Cumbria CVS also shared this link in their newsletters.
- HWC visited the Cumberland Infirmary and distributed eighty hard copies of the invitation letters.

On the 24th of March, HWC was informed by representatives from NHS E&I, that the project's main focus was to be changed to be on unpaid carers experiences. Thus, HWC updated the invitation letters, sign-up form, HWC website page and the case study questions to reflect this. Plus, HWC contacted any unpaid carers that had already done a case study with us, to ask them some additional questions.

HWC then continued to actively seek participants by:

- Designing and promoting an online survey for unpaid carers (which consisted of the revised case study questions, with open text boxes)
- Visiting West Cumberland Hospital and distributing fifty hard copies of the invitation letters.
- Arranging for Human Support Group (Whitehaven) to distribute invitation letters.

Engagement for the commissioned project ended on the 22nd of April 2022, and a report was compiled of the experiences, thoughts and opinions shared by twenty-seven people (unpaid carers, patients and staff) on the discharge process.

However, HWC decided to continue to do this project, with the aim of collecting more views from a wider range of perspectives to gain a clearer view of the entire discharge process to be able to give more useful and beneficial recommendations.

The unpaid carers and NHS staff survey remained open, with the idea that HWC would receive more responses. Also, the HWC website page dedicated to this project remained live, and our newsletter circulated the project information again encouraging people to get in touch and share their experiences.

HWC re-visited West Cumberland Hospital (25th April 2022) for the day (HWC set up a drop-in station in their coffee shop), and the Cumberland Hospital (27th April 2022) for the afternoon (HWC set up a drop-in station in the atrium) to engage with the members of the public and ask them about their recent experiences of discharge to assess.

HWC then considered the discharge process in its entirety and identified the groups that are involved in the process that had not been engaged with. From this, HWC reached out to:

- Northwest Ambulance Service (NWS) to capture the views of those involved in transporting the patient during the discharge process. HWC arranged a video call with some senior staff members to explain the project and discuss the questions. They agreed to circulate the questions to their team for feedback, and then forwarded us their own and their staff responses.
- HWC phoned up residential care home managers to ask if they would be interested in sharing their views and experiences, of when a resident gets discharged. With those that expressed an interest, HWC set up either teams meetings or phone calls dependent upon their preference. Unfortunately, some individuals who agreed to take part had to cancel due to the unpredictable natures of the care managers jobs, however four case studies went ahead.
- HWC emailed a palliative care representative to share their opinion, to see if they would be interested in sharing their views on when a patient is moved into palliative care once discharged from hospital. A video call was arranged and an unstructured case study with the representative was carried out.
- HWC emailed the independent advocates at People First Independent Advocacy, to gain the views of advocates who are familiar with the discharge process. The email included two questions asking about their experience of the discharge process for them to respond to. They also shared with HWC three case studies of individuals they supported who had recently gone through the discharge process (GDPR was followed).
- HWC contacted a range of 3rd sector organisations (including, Cumbria CVS, West Cumbria Carers, and Eden Carers) to gain the insight of the charity organisations who support people who are going through the discharge process and their carers. One-to-one conversations were had with the 3rd sector representatives, where they discussed their thoughts of the discharge process.

In two instances this discussion was followed up with the representative typing up their views and thoughts, and in the other, an additional individual attended the conversation to take notes throughout.

This further engagement allowed HWC to capture another twenty-two people's views on the discharge process. For this project to conclude with a total of forty-nine case studies.

Additionally, to further expand on the knowledge developed on the discharge to assess process, on the 20th of May 2022, a HWC representative attended a 'discharge to assess training session' facilitated by NHS England, hosted by People First Independent Advocacy. The session was aimed at providing independent advocates with updated information about the hospital discharge process, as well as to provide a space for the NHS to share their learnings (what has been identified as been working well and the challenges). There was also an opportunity for questions and a wider discussion of the process between the attendees.

The engagement for the entire project ended on the 25th of May 2022.



Figure 1: Our HWC Engagement Officer (Lisa) doing engagement at Cumberland Infirmary for the D2A project

Findings

Patients

There have been five patient case studies completed for this project. Two of which were carried out by a HWC engagement officer, and the other three were provided to HWC by independent advocates from People First Independent Advocacy.

Of the two case studies conducted by HWC, both participants were female, one was over 65 years of age, and the other was aged between 56-65. The patients had both been discharged from hospital recently and unfortunately both had a negative experience of the process.

The two common factors in the patients experience of the discharge process, was poor communication (meaning that they felt that they had not been kept informed), and not having the appropriate support in place at home at the point of their discharge.

PATIENT QUOTE

"They could have had the equipment in place, they should have listened to my concerns, they should have listened to my additional needs."

One of the patients shared that they were "not involved at all" in the discharge process. She shared that she did not feel listened to, as she would be asked questions but then felt that staff would not listen to her answers, often feeling like all the medical professionals could see was her broken leg and neglected to consider her Multiple Sclerosis. The patient shared that because of the condition she was in she was not very mobile, and her concerns were about being able to get to the bathroom and being able to wash. The medical professionals suggested solutions were to give her adult nappies to use during the night and for her to wash in the kitchen sink. This annoyed the patient as she felt that her concerns were not being considered seriously, and she was not being listened to about what she felt her capabilities were as washing in the kitchen sink would still be difficult. While the other patient explained that they had received mixed messages about when they would be discharged, with the physiotherapist saying it would be the next day, but then the doctor didn't tell her till days later. This poor communication seemed an issue for both patients as they felt uninformed and not listened to throughout the discharge process.

The other issue for both patients was the lack of the appropriate support in place at their homes at the point of discharge. One of the patients shared that they were promised a return machine which would help them get out of bed and into a chair, but this was not in place at the point of their discharge, which resulted in them being stuck in bed for two weeks. The same patient also mentioned that they were meant to receive four visits a day from a carer, but they never came. However, the physiotherapists did eventually come to her home, but this was three

weeks after the patient had been discharged. The other patient explained that they had fallen over previously and received care at home to help, however, on this occasion they received no help despite the fall being worse. The patient was informed that the staff were very busy and wouldn't be able to help but was told she would get a phone call to check up on her, which never happened. Both patients seemed to be frustrated by the lack of support and indicated that they had to rely on their relatives to support them instead. One of the patients shared that her husband did everything for her, and he would have benefited from a professional carer's support. Both patients stated that they did not have someone come to do a further assessment after they had got home, neither to assess them nor to see how their unpaid carers were coping with the situation.

From the conversations with the patients, the following were suggested as ways to make the discharge process better:

- Improve communication by involving patients in their own discharge planning process and keep them updated on developments.
- Medical professionals should listen to the patients concerns and listen to their additional needs, as collaboration between the two parties could mean a more successful discharge.
- Have the equipment that the hospital said patients need and would receive in place at the point of discharge.
- Having some carer support available to give the patients unpaid carers some relief.

People First Independent Advocacy also shared with HWC three patient case studies they had which involved the discharge process. All the case studies evidence the importance an independent advocate can have on the discharge process when the patient's needs are not at the centre.

A patient was readmitted to hospital following their original discharge, and the patient had experienced distress from being discharged to a different care home (outside the local area), than the one they were in before the original hospitalisation. The new care home that the patient was discharged to did not have sufficient knowledge of the patients medical or social history, and thus when the discharge caused the patient huge distress, the new care home was unable to effectively engage with them. The advocate was brought in to help and liaise with the patient's original care home. The patient is now back in their original care home receiving the appropriate support and care from those that know them well. This evidences that different patients require different levels of support throughout the discharge process, and that someone's discharge process is wider than their most recent hospitalisation (meaning that a patient's prior medical and social history should be considered when planning someone's discharge). Furthermore, after the initial discharge, once the advocate was informed of the situation, they contacted both the NHS trust and the local authority and raised a safeguarding alert to establish what had happened and who supported this decision-making process. However, the local authority were not aware that the patient had been in hospital and were not involved. As a result, this prompted conversations between the advocate and the NHS. This further supports the need for the right people with full knowledge of the patients social and medical history to be involved in the discharge planning.

The second case study showed the importance of patients being placed on the correct pathway. In this case, the patient was unable to go back to independent living after being hospitalised so was discharged to a care home instead. The care home manager contacted the independent advocate, and expressed concern for the patient, as they had been moved to the care home with no items of clothing, toiletries, or any personal items. The advocate established that the patient had not been referred to Adult Social Care and there was no plan in place to access a needs assessment. In response, the advocate raised a safeguarding concern, challenged health and social care services to provide an appropriate framework to support the patient, and started the welfare application to the Court of Protection to support the care home to gain access to the patients clothing and finances. This shows that the discharge process has to be planned and discussed with the right people, as if the care home or an independent advocate was involved in the discussion earlier the patient may have been discharged via the correct pathway for them.

The final case study shared that a patient was not told by their friend or medical professionals about the decision to end their tenancy and move them to a care home permanently after being discharged there for assessment. The medical professionals had just taken the patient's friend's word that they had lasting power of attorney for finances. The housing officer involved raised concerns and refused to terminate the patient's tenancy without their knowledge and referred for an independent advocate to help the patient. The independent advocate faced hostility for stepping in and delaying the discharge, however, the advocate explained that lasting power of attorney only comes into effect when someone is deemed to be unable to make decisions based around their care, support and finances, and the Mental Capacity Act states that a person must be assumed to have capacity unless proved otherwise through a medical capacity assessment. Thus, assessments had to be done to determine if the patient had capacity before any decisions were made about terminating their tenancy. The advocate's intervention meant that the situation was resolved, the patient was safe, and their rights were protected. This case study evidences that patients should be informed of their options and rights, that the patient's needs, and wishes should be at the centre of the process, and that the speed of discharge should not be deemed as being more important than it being done correctly.

Thus, from the patient case studies provided by independent advocates, it is indicated that the following factors need to be done to make the discharge process better:

- Acknowledge and take into consideration the patient's prior medical and social history when planning the patient's discharge.
- Involve the right people in the discharge planning process (the patient, the care home, and where it seems applicable an independent advocate).
- Patients should be well informed of their rights and options during the discharge process, this could either be done by providing documentation which explains these things to patients or by having an advocate explain these to them.

Unpaid carers

There were eleven unpaid carer case studies completed in this project. Ten were of relative's experiences (seven in-depth conversations, and three open question survey responses), and one was a neighbour's experience, of supporting a patient after they had been discharged.

All the relatives that spoke to HWC about their experience of caring for a loved one after they had been discharged from hospital were female, and half of them were over 55 years of age.

One of the relatives shared that their experiences of the discharge process had been inconsistent, as their loved one had been hospitalised twice, and the previous experience had been good, but the most recent was not. This highlights that improving the consistency of the quality of the discharge process is vital.

Seven relative participants felt that the discharge experience from their perspective had been negative. From all these relatives' experiences, there were two themes that emerged as reasons that significantly contributed to creating a negative discharge experience for a patient's unpaid carer; the first was feeling like they were not being kept informed on the patient's discharge process, and the second was the patients not having the appropriate support in place at home/care home at the point of discharge.

UNPAID CARER QUOTE:

"They could have been honest with him [the patient] from the start and told the truth. Communication was terrible. They could have had the things in place they said they would."

All seven of the relatives who had a negative experience shared that they felt that they had not been kept informed in the patient's discharge process, and poor communication was an issue. Three of the relatives stated that they were actively ringing up the hospital, to get information about their relative. One of these relatives, went on to further explain that they felt as if they were becoming a "nuisance" and felt that the medical staff were "trying to bypass" them. Occasionally, this lack of clear direct communication, caused further issues as it meant that sometimes the relative felt under prepared for the patient's discharge. For example, one relative carer explained that she was told when she rang up that her husband was to be discharged the next day, which gave her little time to get his other medical prescriptions (from the chemist) sorted before his discharge. She also shared that the time of her husband's discharge was inappropriate because he was diabetic and needed structured mealtimes, which were disturbed by the timing of his discharge. Another relative shared that they were only given a day's notice about the patient being discharged, and that they were told it would be in the morning, but it ended up being the early evening instead. Thus, overall, the unpaid carers indicated that if they had been consulted more throughout the process it would have been smoother. As one relative expressed that the poor communication caused a lot of confusion and anxiety for their grandmother, who was the patient, but the relative also shared that the poor communication was very frustrating for themselves and the rest of their family. The feeling of frustration

as a result of poor communication was indicated and shared by other participants as well.

Another issue that all seven of the relatives that had a negative experience had in common was that the patient that they were helping, did not have the appropriate support in place at their place of residence at the point of discharge. This lack of support caused issues for the relative, as it meant that the patients often had to rely on them (or other unpaid carers) more heavily for help. For example, one relative found the experience hard as they had to juggle supporting the patient, who after being discharged still “needed support to wash, dress and use the toilet” and working their full-time job. Another relative explained that in their experience the equipment needed to support the patient was not ready at the point of discharge, it took three weeks for a ramp to be installed and the shower chair arrived late (which then had to be sent back). Another relative, shared that while the patient was given a teatime call by carers, the carers would turn up at any time from 14:45 to well past teatime which was not helpful as sometimes they would arrive when the patient did not want to have dinner and the relative could not get the patient into a regular routine. Therefore, not having the appropriate support in place for the patient at the point of discharge is a concern for relatives as ultimately until this support is provided the additional support that the patient requires often comes from the unpaid carers themselves. One relative stated that they felt that the lack of support in place resulted in the discharge being potentially very dangerous for their grandmother as once she was discharged, she struggled to manage independently, however, with more resources and equipment she may have found it much easier. Relatives also raised issues about the quality of the assessments that the patients received after they were discharged, and this was an issue as the assessments could influence the amount of additional support the patient received. One relative shared that the assessment consisted of “asking the patient to get off the chair, walk to the bathroom, sit on the toilet, walk to the bedroom and sit on the bed”. Indicating, that the carers situation (rights, ability and willingness to support) was not taken into consideration during the patient's assessment. Therefore, as the relative revealed, from this assessment the patient was deemed to be “fine”. However, the relative did not think this was a fair assessment as the patient had dementia and some days, he was fine and others he was not, and they felt that the assessment did not reflect this. Another relative explained that the patient was assessed on the day they were discharged, but no one came back after this assessment was completed, and there was no clear message if they would get a follow up. The patient had already fallen over previously, so already had a lot of equipment in place, but after the second fall the patient was less mobile, both the relative and patient felt that they needed more support after the second discharge but actually received less.

On the other hand, two relatives felt that their experience of having a relative discharged was positive. Both of these individuals felt that they had been kept informed throughout the patient's discharge process and shared that the patient had the appropriate support in place at the point of their discharge. Interestingly, one of the relatives, explained that they worked on the ward that the patient had been admitted to, and they thought that because of this situation they may have been kept more informed as they were often given updates by other staff members when they were working. This relative said that they thought that this contributed to the positive experience that they had. Therefore, this further

supports that communication and having the appropriate support at the point of discharge are significant in evaluating the quality of the discharge process from the unpaid carer's viewpoint.

UNPAID CARER QUOTE

"I was working in the ward with her – if it was someone who didn't work on ward it would make it more difficult. I mean I never went asking about anything, they told me about her as I was in work. I may not have been told things if I didn't work there."

Finally, one relative shared that the discharge experience from their perspective had been "ok", indicating that it was neither positive nor negative as the quality of service that they received was mixed. The relative had felt that they had been kept informed throughout the discharge process. However, they did reveal that the patient was the one that had kept them well informed, who had been getting told accurate information from the ward nurse, including on when the discharge would occur. But the experience was mixed, as the equipment (including, fitted bars on the bath/shower, and a walking frame) that the occupational therapist told the patient they would be provided with, never arrived. The relative shared that after eight weeks they phoned the occupational therapist and cancelled the equipment as by this point the patient felt that they no longer needed it. Thus, the relative shared that the discharge process was "ok" as the equipment never arrived, but they were kept informed of what was happening and when the patient would be discharged and therefore felt that themselves and other relatives could prepare and organise support for the patient.

From the case studies completed with relatives, the following suggestions were raised as ways to make the discharge process better:

- Improve communication between the medical staff and the relative (both written and verbally).
- To confirm the discharge date and times with both the patient and their relatives.
- Patients to be reassured throughout the process about what is happening and involving them in the forward planning of their own discharge.
- To have a named person to keep the unpaid carers updated throughout the process – someone that they could reach out to and contact when needed.
- To ensure the equipment and resources that are discussed are put in place.
- To receive an assessment, equipment and packages prior to discharge.
- Patients to be signposted to useful and relevant services/resources.
- Patients to be offered extra help and assistance financially.
- Option of offering practical support, to patients and unpaid carers, such as helping with shopping.
- To have the offer to have people ringing to provide support and check on the patient and their relatives.

- Have someone from the discharge team to check on the patient over a few days.
- To have a leaflet about discharge to assess (including what the process is and a couple of contact numbers) provided, with a blank back page where the discharge team could write in details of when the patient was assessed, details of their care plan, when staff would be revisiting the patient.

The individual who helped their neighbour after they had been discharged, was a 36–45-year-old man. He supported the patient and the patient's wife once he had been discharged, by doing "odd jobs" such as shopping and preparing the room so that it was fit for the patient's needs. He said his neighbours were elderly and needed this extra support which he was willing to provide. The neighbour said that he was kept informed and updated by the patient's wife who told him about the discharge, though he was under the impression the patient's wife was not told about the discharge straight away. The neighbour explained that after a while someone came to assess the patient, which was when it was determined that the patient would have carers come in twice a day to help. The neighbour expressed that in his opinion he would determine the discharge process to be poor, as the assessment was not done immediately or done when the patient was at their most vulnerable, so the neighbours had to wait a long time to receive the support they needed, and thus needed to rely on him and others to help them instead.

UNPAID CARER QUOTE

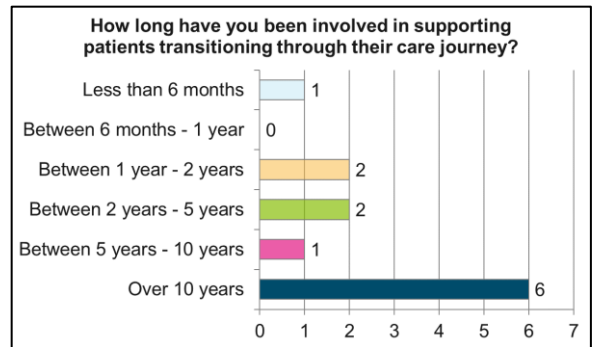
"He's doing a lot better now, so I'm not needed to help out as much, but I think the process was a bit poor, really. Things weren't in place straight away and my neighbours are really vulnerable."

Thus, from this neighbour case study, it is indicated that the following things need to be done to make the discharge process better:

- Assessments to be done immediately (quicker) so equipment, resources and support can be promptly put in place for carers and patients.
- Improve communication between medical professionals and relatives, which would give relatives ample time to prepare for the discharge.

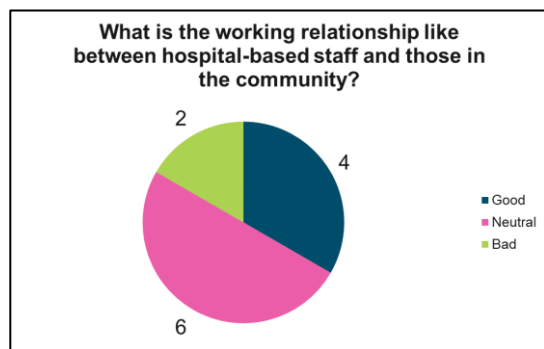
Acute/hospital-based staff

12 acute/in-hospital staff members who are involved in the discharge process (including ward therapists), shared their thoughts, views and experiences, highlighting what they think needs to be addressed to improve the process. 50% of the acute staff that responded have been involved in supporting patients transitioning through their care journey for over ten years.



From the survey/case study responses, there were several themes that staff highlighted. The concerns of the staff, including relationships between the acute and community teams, staff capacity, and communication, indicate that they are aware of the sources of some issues that some unpaid carers and patients face. It was evident from the responses that the staff are worried about the impact that a poorly executed discharge process can have on the patient and their relatives, and they feel that it is key to improve the delivery of this service.

From the acute staff responses, currently, there seems to be an acknowledgement of a lack of understanding of the pressures and needs faced by different teams involved in the discharge process. As one acute staff member explained, community staff do not always understand the pressures that are placed on acute staff to meet demand. While community staff feel as their acute colleagues do not understand the high levels of risk and activity they have to deal with, without significant support. The staff member emphasised that this causes friction and relationship problems between the teams. Another staff member suggested that



neither the community nor the acute staff have full knowledge of the pressures that their partners experience, and therefore time spent in each other's environment would be beneficial. This acknowledgement from the acute staff shows that while they feel that the community staff do not understand their pressures, they admit that this occurs both ways, and they need to better understand the pressures their community colleagues are under.

Another concern raised by acute staff, was that there are capacity issues, and these are having a direct impact on the effectiveness of the discharge process. As one staff member summarised, there are significant pressures on the healthcare system as a whole but most compounded by under resourcing due to vacancies and inability to recruit. This has a knock-on effect as the lack of staff capacity in the acute setting means, that they are very reliant on having robust community services in place to support, but this is not available in all areas. This means that there is a risk of patients being discharged with the assumption that they will get care and support, that does not materialise. However, another acute staff member acknowledged that sometimes a lack of community support in delivering a timely discharge, which can result in patients becoming deconditioned and unwell, is due to staff capacity issues in the community as well. Due to this, currently the acute team are occasionally required to support patient discharge to assess visits to their homes. But, as another acute staff member said, if the acute

team are to continue to support the discharge process in this way, then this needs to be recognised as this will require some additional investment into the team as the acute work is still waiting for them when they return to the ward.

The most prominent theme that was discussed across the acute staff survey responses was communication. This included improving communication, externally between the acute staff and the community staff, internally between different acute staff, as well as communication between acute staff and their patients/families.

It was raised that to improve the discharge process, acute and community services need to communicate in a timely and detailed way prior to discharge, including having an accurate and detailed handover/referral. This could mean all attending a joint discharge planning meeting.

Acute staff members believed that a joint and collaborative approach to working is the best, where there is a mutual understanding and respect for each other's roles, as this often results in information being handed over in a clear way. Some acute staff members suggested that this could mean a wider variety of staff members attending a joint discharge planning meeting, with one staff member emphasising that they felt that holding discharge planning meetings at ward level work well. An acute staff member suggested that discharge runs smoother when a ward therapist also attends the discharge to hand over the information in person, whilst another further explained that it works better when a ward therapist meets with both the patients, their carers and the community team to discuss the patient's needs, (especially when the patients are more complex). All this suggests that if the communication between the acute and community staff could be improved, it would ensure that the discharge process runs smoother.

Acute staff members also raised the necessity to improve internal communication between different acute staff, to make the process better. One response suggested that the discharge to assess process needs to be fully explained at all levels, including to ward staff, to improve understanding and to be aware of what different staff members require from each other, and when. Another discussed that acute staff general communication needs to get better, explaining that nurses must be informed of new systems of work and any changes in communication methods, sharing that they felt that if managers are getting informed, they have not been effectively cascading the information to ward level. One acute staff member suggested that it would be beneficial in communication, to offer more support and training to nursing, pharmacy and medical teams in terms of the discharge process, as currently the lack of communication means that there are often delays in medication and discharge letters, which result in unnecessary delays to the process and impacts the general flow throughout the hospital.

It was acknowledged by several acute staff members in their survey responses that, it is key for patients and their relatives to feel supported and kept informed throughout the process, thus emphasising that clear communication is necessary. There were concerns about the level of information and understanding that both patients and their relatives have in regard to the different discharge streams, as well as a lack of understanding about the roles and functions that different services have. It was also discussed that patients and their relatives need to be fully informed in a timely manner of what is proposed and why, to make them feel involved, informed and supported in the discharge process. This point being raised

by acute staff members indicates that they there are aware of the issues and frustration that some unpaid carers and patients have towards communication, and evidences that this is an aspect of the process they want to improve.

Additional points made by acute staff members which are worth mentioning are that a good discharge consists of the discharge checklists being completed, as this ensures that all possible safety measures have been taken to provide a safe discharge. Also, it was raised by an acute staff member that it would be beneficial if discharge to assess patients would stop being moved to a different ward the day or night before they are due to be discharged as this can cause unnecessary stress for the patients, and for the staff who have to ensure that with the patient the correct belongings, paperwork and equipment is moved too.

Therefore, from the acute/in-hospital staff members survey responses/case studies, the following suggestions were raised as ways to make the discharge process better:

- Acute and community staff to spend time working and experiencing each other's environment, to improve understanding of the pressures the other team face.
- Review the workforce staffing gaps and have a recruitment drive, to confront staff capacity issues.
- Use staff effectively, such as, by using different staffing levels and bands to support work where possible. For example, if an occupational therapist is required to support a patients discharge by completing an assessment at a patient's residency, once the assessment is done the occupational therapist should be freed to return to the wards to get back to in-patient duties quicker by having a band 4 assistant practitioner to stay and complete all necessary documentation, arrange future calls and support.
- Have joint discharge planning meetings held at ward level which include a wide variety of relevant staff.
- Ensure that all levels understand the discharge to assess process (and what is required to happen and when at each level, a full understanding of the whole picture allows individuals to understand how what they do and do not do can have a knock-on effect to the entire process).
- Develop a digital record, referral and communication system that is fit for purpose.
- Provide regular support and training to the nursing, pharmacy and medical teams in relation to the discharge process.
- Ensure medication and discharge letters are ready on time.
- Acute staff members to keep patients and their relatives informed throughout the discharge process.
- Have discharge checklists completed for every discharge.
- Stop the unnecessary movement of patients to a different ward the day or night before they are due to be discharged.

NWAS staff

There were four case studies completed by NWAS staff members (Northwest Ambulance Service) for this project. The main topics of the discharge process they discussed was, planning, timings, communication and welfare.

NWAS shared that a coordinated, clear and structured discharge plan with more than 24 hours' implementation notice, increases the success of a patient transfer, with one NWAS staff member explaining that when a discharge is well planned it makes the process easier for all concerned and patient care is not nearly as often adversely affected by delays. Meaning that poor discharge planning can cause delays, which was emphasised by the conversations with NWAS staff members. One staff member detailed that the transport aspect of a patient's discharge can cause delays in the process. It was highlighted that transport delays occur most often when either same day bookings are made, bookings are made late in the day or if there are multiple bookings made for a similar time. This is because these bookings are challenging for NWAS to accommodate. But a staff member expanded on this and shared that these types of bookings can have a substantial knock-on effect, as there can be big issues if the patient requires a home assessment, and due to delays or late bookings this cannot always be done on the same day. Consequently, this could lead to bed blocking, as well as have an impact on patient welfare if they thought or hoped to go home. Therefore, NWAS believes that good discharge planning is essential to improving the flow and success rate of the discharge process, as it would reduce the number of delays.

The timing of the discharge is essential to get right according to the NWAS staff members, as a well-coordinated discharge plan with more than 24 hours implementation notice, increases the success of the transfer. A NWAS staff member explained that a short notice transfer creates operational pressure for both the ambulance and the hospital ward. The rush to get patients discharged quickly, sets unachievable expectations, which combined with the increased pressure it causes, can mean that the discharge is not smooth for the patient, as there is a higher risk that something is forgotten or not done correctly. NWAS would like to have ample time to plan for a patient's transportation, especially with the geographical challenges of Cumbria and the impact this can have on patients. A NWAS staff member also spoke about when the assessments are done in the process, currently the risk assessments are only requested once the patient is ready to go home, but they stated that it would be helpful for the discharge plan to allow time for the risk assessment to be completed earlier, so that NWAS staff are aware of the needs of the patient when they are planning their transportation (in relation to aspects such as, size of vehicle, location of destination, length of travel time).

NWAS STAFF QUOTE

"Communication and timing is everything when considering discharge."

Furthermore, communication was a key issue raised by the NWAS staff members, particularly to do with the mobility of a patient. One staff member shared that the lack of communication around patients' mobility increases the possibility of a failed transfer, as if a patient has access issues this causes problems for NWAS's

ability to provide support, especially when patients need to attend further appointments. NAWAS staff members felt that more information needs to be willingly provided at the point of transport booking, as if they are given the time, they can adapt to the needs of the patient as much as they can, to make the transfer as smooth as possible. But another NAWAS member of staff shared that they felt that patients should be allowed to get stronger after they are deemed to be medically fit within hospital before they are discharged, as they felt this would lead to an increase in successful discharges because the patient would be fitter before they undertook the journey.

Another aspect around the discharge process that was discussed by NAWAS was the impact it can have on the welfare, of both patients and staff members. A NAWAS staff member stated that failings in or delays to the discharge process could have a significant impact on patient welfare especially if they thought or hoped that they would be going home. Another staff member shared that whilst in hospital, patients lose independence, thus clear communication and constant support is needed to help them through the situation. Another NAWAS staff member highlighted that poor discharge planning and the pressure on the NAWAS service, can make staff members frustrated but these elements can also affect the quality of patient care. The staff member stated even though patient care is a major concern, they also have concerns about the affect this can have on the staff, and it may increase complaints from the public.

NAWAS STAFF QUOTE

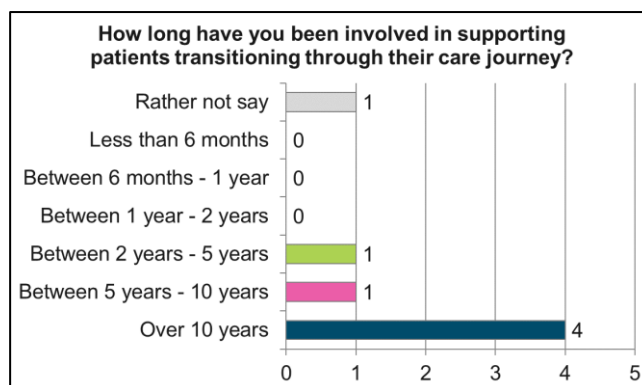
"I think patient care is the major concern, but I also have concerns about the affect this can have on the staff."

Thus, from the NAWAS staff members case study conversations, the following suggestions were indicated as ways to make the discharge process better:

- Discharge planning started as soon as possible.
- A structured plan which details how a patient will be made transfer ready, especially around pre-booking both medicine and transport with at least 36 hour led time.
- Use the new ways of communication (virtual) to have a more inclusive working approach to planning discharge.
- Assessments (including risk assessments) to be completed before the patient is ready to be discharged, so that the necessary equipment is already in place when a patient arrives home.
- More information shared with NAWAS at the point of transport booking.
- Allow more time once a patient is medically fit to get stronger before they are discharged.

Community-based staff

7 community-based staff members who are involved in the discharge process (including community nurses), shared their thoughts, views, and experiences, highlighting what they think needs to be addressed to improve the process. 57% of the staff that responded have been involved in supporting patients transitioning through their care journey for over ten years.



From the community-based staff survey/case study responses, there were several themes that staff highlighted. There were a variety of concerns raised by the community staff, which ranged from receiving the incorrect information and the sometimes poor quality of discharge planning, to the relationships between the community and acute teams. But this showed that they want to improve the discharge process, as they are aware of the impact that a poorly executed discharge process can have on the patient and their relatives.

Several community staff shared that they felt that there is a substantial need to involve community staff in the discharge planning process. It was mentioned that community staff are currently rarely invited to any discharge planning meetings. But with their expertise in rehabilitation, community experience, and the knowledge of the practical implications of what is expected from the community staff versus what the patient requires, community staff feel that their input to the discussions are vital and are currently being missed. One staff member shared that they felt that neglecting community staff in the discharge planning process means that the impact and risk involved in a poor or incomplete discharge plan is not understood. Two community staff members emphasised that it should not just be management that need including in the discharge planning discussion, but also the staff who do the day-to-day work and are actively involved (as they are the ones having to deliver the support that is agreed upon).

COMMUNITY BASED STAFF QUOTE

"Invite community staff to discharge planning meetings and listen to what they have to say as they often know the set up at home."

It was raised in the community staff responses that there was a feeling that there was a lack of inpatient assessment, with the suggestion that there is a misunderstanding of the discharge to assess process. It was emphasised that there should be an inpatient assessment completed prior to discharge, which is followed up by the patient's long-term needs being assessed in the home environment. This will make the discharge process better for patients if it was done this way, as then the hospitals can assess the patients and ensure that they are provided with the necessary equipment for a safe discharge, which can then be further assessed within the community. This means that all provision would not be left to community staff to arrange, who rarely have access to all the necessary equipment at the

time of discharge. Thus, this evidences that the community staff are aware with the issues that some unpaid carers and patients face with not having the appropriate support in place at the point of discharge, and they think this needs to be dealt with to improve the discharge process.

Also, it was emphasised that accurate and detailed information should be gathered prior to discharge. One community staff member explained that best practice of the discharge process is when information is gathered prior to discharge to establish what is available or already in place for a patient at the point of discharge to ensure a safe discharge to the patient's home. The information gathered includes identifying what equipment is needed, if any additional care is required, what medication is needed, an evaluation of the environment that the patient is returning to and a decision to if this is safe, and a pre-check to see if the community teams have capacity to ensure that patients can continue to be supported. The community staff stated that, often this information has not been gathered prior to the patients discharged, and/or is not sufficiently shared in the handover, which means that in these situations patients are sent home without accurate information passed on, the essential medication or the necessary equipment. From the responses this was evidentially a huge concern for community staff, as one highlighted that if the information is not passed on, is incorrect or is not made available it can affect the patient's quality of care. Therefore, community staff feel that it is essential to gather the key information prior to discharge, as it means that those patients with complex social and medical situations can be identified early, and thus any potential barriers can be solved prior to patients going home.

Issues around timings of the discharge process were raised by community staff. They highlighted that timings need to be suitable for all involved. The process shouldn't be rushed, and ample time needs to be given for full assessments and to get the relevant equipment/resources in place. A community staff member said that the discharge process is fast paced, but without the correct base-work (good assessments, correct referrals and accurate communication), then the discharge is riskier, more stressful and time is wasted in attempting to fix the cracks and chasing up information. One community staff member gave the example of the shifting role of the community therapist, as since it has become more about firefighting and helping to fix issues in the discharge process, they are not able to use their time to effectively treat patients through rehabilitation. Thus, patients are not receiving the best care they could be if the process was done efficiently, and staff were given the sufficient time to do their roles. Another community staff member emphasised that there has to be enough time allowed for a full assessment of needs to take place, as another explained that both the acute and community teams are trying to achieve the same goal (successful patient discharge) and the teams need to be understanding and supportive of each other in trying to do this, including giving each other enough time to complete the necessary work and assessments to a high standard.

COMMUNITY BASED STAFF QUOTE

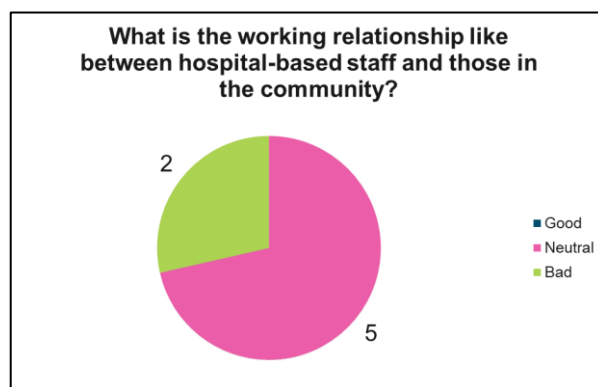
"The process is fast paced and without the correct scaffolding in place to make it slick and timely, the discharge is riskier, and more stressful for community services, the family and the patient."

Another concern raised by community staff, was that there are capacity issues, and these are having a direct impact on the effectiveness of the discharge process. One community staff member shared that they felt that there is a misconception about the number of community staff available to help with the discharge to assess. They said that in reality there are not stand-alone teams or individuals solely focused on discharge to assess but instead staff are in fact providing rapid response and covering many different aspects, in an attempt to prevent admissions and to provide community rehabilitation services to patients. Thus, there was a feeling shared that more community staff are required to keep up with the demand on the services, and a community staff member suggested that making roles specifically dedicated to discharge to assess could be beneficial. As well as community services needing more staff, there was a feeling shared amongst some community staff that the acute teams also need more staff to help them with their capacity.

Several community staff members shared that there was a need to improve communication between the acute and community services. One community staff member highlighted that the lack of communication between the teams can cause huge issues, such as in some instances when the communication has been so poor that the community teams have not been aware a patient has been sent home until they already have. As a

result, in these situations the community staff are put under significant pressure, because the patient requires urgent assessment, which impacts on the wider team and other patients as diary management is disrupted, which then places even more stress on the community staff. Better communication would mean that the necessary information at the point of referral is shared, that there is appropriate planning between the staff involved so that everyone is aware of the transfer and their role within the process, and timings are agreed. One community staff member stated that improved levels of communication would minimise frustrations. But another shared that they understood that acute staff are under immense time pressures which affects how they can communicate with community staff, and consequently there are often multiple staff members trying to coordinate the same discharges which causes misinformation and duplication of tasks. Thus, there was a suggestion that there is a 'link person' that can maintain an awareness of planned transfers and be the centre point of communication between the acute and community teams, to try and improve the communication between the two areas.

Thus, there seems to be a lack of understanding of the specific pressures and needs faced by the different teams involved in the discharge process (acute and community teams). One community staff member shared that they felt that both the acute and community teams are over worked and under a lot of pressure, and both teams need to have an appreciation of each other roles and be aware of the other's limitations. Another community staff member stated that they did not always feel that the two teams understand the working pressures of each other's environment and believes that cross-organisational working (such as staff swaps for a day, or buddy up schemes between community and acute staff), with more



emphasis on rotations, shadowing and secondment opportunities could help ease this issue. The idea behind this being that giving staff the opportunity to spend time in each setting, would develop an appreciation of the issues that the other teams may be facing, and from these more supportive relationships could be built.

It was acknowledged by community staff that patients and their relatives should feel supported and kept informed throughout the process, with safety being a priority. One community staff member spoke about communication between the community staff and patients and their unpaid carers need to be strong, so that there can be an effective transfer of information and suitable discharge plans actioned. The community staff member indicated this can be done better by meeting with patients and unpaid carers earlier in the process, whilst another shared that the working relationship between the community staff and the patient and their unpaid carers, should be close and focused on education and support. It was raised by community staff that the discharge to assess process is not always well explained or communicated to the patient and their family which causes distress to them especially when it fails. This causes further issues for the community team as if the patient is not aware of the process, then they often refuse to return to hospital, putting further pressure on community teams to support. One community member shared that because of their role in the discharge process the community staff often bear the brunt of the patient and their family's frustrations, when services cannot be delivered to support a discharge, which can result in verbal abuse and the concern is that this may escalate further one day. Thus, it is important for the patients to be well communicated with, as they need to be fully aware of the entire process and need to have realistic expectations of the support that the community team can provide them.

The final point made by acute staff members which is worth mentioning is that if the patient has a long journey from the hospital to their place of residence it can mean that the patient is too fatigued on arrival to complete any assessment to be safely left at home. This is an issue with the impact of the geography of Cumbria and thus, the length of travel time needs to be taken into consideration when planning the transportation of discharged patients. To ensure patients have the best chance of having an accurate assessment.

Therefore, from the community-based staff members survey responses/case studies, the following suggestions were raised as ways to make the discharge process better:

- Involve community staff in the discharge planning process.
- Have high quality inpatient assessments carried out for every patient prior to discharge and use these initial results to inform the discharge plan, to ensure a high-quality checklist can be created and used.
- Information should be gathered prior to discharge to establish all the factors that are either available or already in place (including equipment, care, and resource needs), and this needs to be communicated clearly to the community teams.
- Ample time needs to be given for full assessments and to get the relevant equipment and resources in place.

- Increase the number of community staff to increase capacity to keep up with the demand on the services.
- Have an individual or team within the community specifically dedicated to discharge to assess.
- Invest more in resources which are dedicated to providing rehabilitation for people at home and in the community, to reduce the number of admissions and readmissions to hospital.
- To improve communication, have a 'link person' that can maintain an awareness of planned transfers and be the centre point of communication between the acute and community teams.
- Have the acute and community staff members undertake cross-organisational working (such as staff swaps for a day, or buddy up schemes between community and acute staff), with more emphasis on rotations, shadowing and secondment opportunities, to raise awareness of the pressures the other teams face.
- Communicate clearly with patients so that they are fully aware of the entire discharge to assess process and set realistic expectations of the support that the community team can provide them, this could be through providing an explanatory leaflet.
- In the discharge planning, the length of travel time to transport a patient home needs to be taken into consideration.



Figure 2: Our HWC Engagement Officers (Kate and Lisa) out doing engagement

Residential homes

There were four case studies completed with care home managers for this project. They spoke to HWC about their experience of the discharge process from their point of view, and what changes they think would need made to improve the process for care home managers/staff and for the patients (who are also their residents). The main theme that came from these conversations was about communication, and how this is a struggle.

One care home manager indicated that the discharge process works better when there is good information being shared from both sides. They shared that when one of their residents is admitted into hospital, they provide the hospital with an admission pack, which includes a patient passport, and a selection of information about the resident that is relevant to the resident (including all the information regarding their medication).

RESIDENTIAL CARE HOME MANAGER QUOTE:

"I think details work really well. Lots of new information about the new resident and their current needs."

But it was evident from the conversations with the care home managers that when it is a new resident being discharged to the care home, there is often not enough information shared from the hospital to the care home about the patient. It is essential for the care home to know information about the resident and their current needs. As one care home manager explained, if the patient has dementia, delirium or behavioural problems, they need to know what to expect and there needs to be a plan in place before discharge. If the care homes are aware they will be able to put in place proper proceedings to accommodate the needs of the patient. Another care home manager shared that if they have a good understanding of needs then the care home can support the patient better. But on top of that they can prepare the room for the new resident so it is ready for them, they can start to build a rapport with the patient's family and can contact them about getting clothing for the patient and personal photos.

RESIDENTIAL CARE HOME MANAGER QUOTE:

"If we don't get accurate information we can't always care for their needs."

Additionally, one care home manager stated that getting information is a struggle because there is no proper communication between the wards and the care home because if they phone the wards the wards will not tell them how the patient/resident is doing, this is because despite potentially knowing the patient for many years they are not the next of kin. However, another care home manager shared that if the hospital does not call the care home with updates once the resident is in hospital, then the care home themselves phone up the hospital to get updated on the progress of the resident. This care home manager went on to say that the phone calls that they deemed to be most necessary around the discharge process were; from the wards to give information and details about the discharge, from the hospital pharmacy to check that the

medication being prescribed is correct, and from the physiotherapists and occupational therapists to check that the care home has the right equipment at the home ready for discharge (and if the care home doesn't then the hospital should order it). They said that when they receive these calls then they feel as the discharge will go well, as it shows that the hospital is doing their due diligence and they are double checking things. But another care home manager expressed that even if they do get information from the hospital or if they ring up to double check what is needed before a resident is to come home, they can receive conflicting information.

RESIDENTIAL CARE HOME MANAGER QUOTE:

"We had COVID in our building and lost twenty-four residents to it. We were the first care home to get COVID in this area. We just don't get the right communication and we were blamed for COVID in care homes even though we tried our best."

Furthermore, care home managers expressed that poor communication resulting in them getting conflicting or inaccurate information caused them great difficulties. One suggested to try and mitigate this there should have a named nurse that they could contact, as having someone specific to contact and speak too about the patient could mean there was less chance of them receiving inconsistent information. Another care home manager stated that when it is not clear what time a resident is returning home it can cause issues, as care homes need to ensure that they have the correct staff to resident ratio, and they need to have senior staff working so that they can check the patient's medication. Therefore, having patients return to the care home not at an agreed time or in the late evening is not suitable for them.

However, other topics mentioned by the care home managers in their conversations included issues with paperwork, the benefits of completing face to face assessments, the state that patients are in when they are discharged, medication issues and problems with GP access.

The care managers shared issues around paperwork issues. It was made apparent that it was not uncommon for there to be paperwork missing, which means the care home has to chase it up and get it sorted. Two care home managers mentioned that the transfer of care/discharge forms are not normally good and only have basic information. It was also raised that the language on the discharge forms is not good, as there are too many acronyms. The care home manager who raised this point shared that they had mentioned this to the hospital before and was told that their care home staff should know the acronyms, but as the care home manager pointed out not all their staff are medically trained nor are they all nurses, so they are not required to know the acronyms.

Care home managers mentioned that prior to the Coronavirus pandemic their staff used to be able to go into hospital to see the patient (face to face) themselves and carry out their own assessment alongside the hospital's. This used to make things more accurate and prevented patients coming to the care home that wasn't suitable for them (for example, if they required more expert nursing care than the care home could provide them with). However, these face to face assessments by the care homes are not being completed at the moment.

Alternatively, the communication from the point of referral, need more details. If the care home knows the patient's needs, then they can work out if they can accommodate these or if the patient needs to go to another care home. When discussing patients receiving further assessments from the hospital through the discharge to assess process, two care home managers shared that their residents did not have anyone who came out to assess their needs once they had been discharged. One said, "it's like they're abandoned and then it's our responsibility."

There were concerns raised about the state that patients have been discharged from hospital in. It was indicated that patients have been discharged without proper clothing. With one care home manager describing a situation when one patient was discharged with a nightie, dressing gown and a pair of socks, so the care home provided her with some clothes from another resident who had unfortunately passed away. The same care home manager admitted that the care home often have to buy patients toiletries as well. Another manager described that, in the past patients have returned home with cannulas still in their arms/hands and without medication. Discharging a patient in these conditions is not fair and is potentially unsafe, and it should not happen.

Medication was raised as a concern by multiple care home managers. While one admitted that the process of getting medication has got better, it was made clear that this is an issue that care homes have faced often, and some continue to do so. One care home manager explained that quite a few patients are now coming out of hospital with a month's supply, they stated that this is really good as if the patient have been transferred to the care home this may be from a different town and will need registering with a GP before they can receive any further medication. Thus, if the patient came out with 2 days medication, they wouldn't be able to get a GP in that time, as in the best-case scenarios it can still take up to a week to re-register with a new GP. However, other care home managers expressed frustration at the constant issues that they have with getting medication for newly discharged patients, as sometimes patients are discharged without enough or sometimes without any medication.

Building on from this discussion, a care home manager expressed that they have issues with accessing GP care. They highlighted that in the Carlisle area they have been largely unable to find a GP that is taking any new patients on. But they did admit that this does not seem to be such an issue in Whitehaven. This is a problem for the care home as they need to get their residents registered so that they can receive health care and additional medication.

Therefore, from the conversations with the care home managers, the following were either indicated or suggested as a way to make the discharge process better:

- Hospitals to follow through with their phone calls so that the care homes can be updated and be prepared with everything in place at the point of discharge.
- Have a named nurse or person in the hospital that the care home can contact, with queries and for information.
- More information and honesty from the hospital about the patients' needs and situation, including having all paperwork in order and patient details/needs shared with the care homes.

- Remove the acronyms from the transfer of care/discharge forms, and for them to have more information.
- Allow for care homes to go in to have face to face meetings with the patients and carry out their own assessments like pre-COVID.
- Communication from the point of referral, more details needed to stop wasting time. If the care home knows the patient's needs, then they can work out if they can accommodate these or if the patient needs to go to another care home.
- Patients to receive follow up assessment from the hospital once discharged.
- Patients to be discharged with proper clothing.
- Patients to be discharged with enough medication, suggested 28 days is normally a good amount.



Figure 3: Our HWC Engagement Officer (Lisa) out doing engagement

Palliative care organisation

For this project HWC spoke to a palliative care representative, who gave their views on the discharge process.

The representative emphasised that the experience of each patient, their relatives and friends, is individual, and each will view the experience differently as what one person may consider to be good another may not.

However, the representative shared that the whole healthcare system needs to improve its communication. As there seems to be a disconnect in the level of information about the discharge process and the ongoing care requirements that is given to patients and their loved ones, compared to the information that is shared with staff members.

The representative shared that patient's relatives have shared that getting clear information has become increasingly challenging and difficult. The representative acknowledged that the Coronavirus pandemic has added an additional level of difficulty to this as visitation was halted. Thus, suggested that to combat this issue patients, their relatives and unpaid carers would benefit from being given a named person to contact for queries. This would provide the individuals with the feeling of having greater accessibility to information, as they would be given the option to directly speak with someone rather than being signposted to websites and expected to understand the information provided.

The palliative care representative shared that the relationship between the hospice at home service and the hospitals are good and the links are robust. They did mention that sometimes it can be difficult to speak to ward staff or to get through to the ward by phone which is a similar experience to that of patients and relatives.

Therefore, from this case study conversation with a representative from palliative care, the following was suggested as a way to make the discharge process better:

- Have a named person assigned to a patient, who the patient or their unpaid carers can contact for queries.

Advocates

To gain the insights of advocates views of the discharge process, HWC spoke with two independent advocates from People First Independent Advocacy.

One advocate shared that the discharge process can vary from either feeling rushed or feeling as if there are unnecessary delays. They believe that occasionally the reason for this is because sometimes professionals involved in the discharge process are unable to fully consider the views of the patient, due to the pressures they face within their role. However, consequently, sometimes professionals can develop a fixed view of what they think should be the outcome of the discharge plan, based on what they think is best for the patient, based on their assessment of the patient's health and support needs, without taking into account wider factors.

The other advocate discussed that the Care Act legislation has not changed regardless of the new hospital policy of discharge to assess. They expressed that people should not stay in hospital for months with no input from the local authority when they have new eligible needs. The advocate believes that instead, it should be looked at in hospital, and not when the patient is sent to a discharge to assess bed as once a patient is in a discharge to assess bed it can be weeks before assessments are carried out, which can exacerbate an individual's condition. The example that the advocate gave to demonstrate their thinking was that a person who suffers from dementia should not be moved to a discharge to assess bed whilst they wait for a needs assessment, or a CHC (Continuing Healthcare) assessment, or if their wish is to go home as people should not wait whilst professionals are conducting assessments to determine what funding is agreed. The advocate emphasised that they are worried about the discharge situation, as they have seen people be moved to placements against their wish, with no decision specific capacity assessment completed, and they felt that due to capacity and wider pressures, the hospital is unable to fully understand the legislation.

Thus, the advocates shared the following suggestions as ways to make the discharge process better:

- Resolve funding issues by having a clear agreement in place that does not delay a person accessing the care and support they need.
- Reablement needs to be more openly available and offered to those who may need it, as it is a very helpful service.
- Provide people with regular phone calls, which can inform people of their rights under the Care Act/Mental Capacity Act, and the role of statutory agencies.
- Have practical support offered to people who may need it once discharged, such as help to do their shopping or signposting them to other services that could be useful for them.
- Improve the rehabilitation service for patients.
- Accessible information available for the person so they are fully able to understand what is happening to them and why.
- Clear lines of communication between community and hospital setting for joined up care and support.

3rd sector representatives

There were three representatives from three different 3rd sector organisations who spoke to HWC about their thoughts about the discharge process, especially around the impact the process has on unpaid carers and their experiences.

The first representative was from Cumbria CVS, who spoke about their knowledge of carers experiences of the discharge process. The representative said that some carers have expressed that they felt the communication was not as good as it should have been between the medical professionals and the family. The representative said that while the unpaid carers have often acknowledged that the medical staff are under immense pressure, especially during covid, the carers have felt that they were not as involved in the discharge process as they would have liked or would have found beneficial. It was raised that sometimes unpaid carers feel pressured to agree to a discharge despite the extra stress that caring for a patient after discharge can bring. But the representative also mentioned that some unpaid carers have reported having a good experience and have been delighted with the support that the patients have received following discharge.

The second representative was from Eden Carers, who shared that a good discharge is where a patient and their unpaid carers have been kept updated throughout the process (including the date and time of when the discharge is to take place) and that their expectations have been met. The representative expressed that they know some discharges go well, where both the patients and unpaid carers expectations have been met, but usually the unpaid carers that the organisation support contact them when something has gone wrong. Thus, they have heard about patients being discharged with the incorrect or no medication, missing or no teeth, hearing aids and/or glasses missing, patients being discharged in a hospital gown when they entered hospital in their own clothes, or patients being sent in taxis back to empty homes. The representative feels that there is a disconnect between NHS England (its strategy reports and guidance) and the shop floor (those actioning the information and following the guidance). They said that the guidance does not seem to be followed, and this might be to do with understaffing, leading to lack of staff time to spend reading the guidance, or investment not going in the right places. Thus, the representative would like the NHS to be more proactive, as it consults with organisations and the public to produce reports, initiatives and design restructures, but they need to action and respond to what they hear and get told.

*3rd SECTOR REPRESENTATIVE QUOTE:
"Good discharge starts at admission!"*

The third representative was from West Cumbria Carers, who stated that a good discharge starts at the admission. The representative explained that a good discharge is the patient being able to go home, with the right things in place, and with a carer that is capable of supporting them. Therefore, the main benefit of discharge starting at admission, would be that the communication channels would be stronger as they would have been developed earlier in the process. This means that patients need to be asked at the point of admission if they have someone who is able to help at home, and if so, who? Then the communication between

the hospital and carer can start at the beginning of the process. Improving the communication would make a significant difference, as the carer will feel informed, but the patient will also feel supported throughout the process. Furthermore, the representative highlighted that getting the carers involved earlier in the process would be beneficial, as a patient's social history is as important as their medical history when it comes to discharge. Carers can be a pivotal piece of the discharge process, which can save a lot of work as they know an awful lot about the patient and are more likely to be honest about the patients' abilities (patients can sometimes say anything to get themselves back home as soon as possible). Thus, starting the discharge at admission, could help to develop a better process overall. The representative also mentioned that while the 3rd sector carer organisation is allowed in with the discharge team, they are not yet back in on the wards. Usually on the wards the organisation volunteer would talk with carers about their situation and signpost them, inform them about the support the charity can provide, and occasionally do carers assessments. The representative wants to get the knowledge of what support the 3rd sector can provide to the patients and carers on the wards in some capacity. They suggested that this could be done by allowing organisation volunteers back on the wards, or by having a specific role for carer support within the discharge process, such as a carers coordinator as medical professionals are there to look after the patients who are poorly, and no one wants to waste this resource. Thus, a carer coordinator, would be in a prime position to raise awareness of the 3rd sector carer organisations and work with the organisation to support the carers.

Therefore, from the conversations with the representatives of three of the 3rd sector organisations, the following were either indicated or suggested as a way to make the discharge process better:

- Hospitals to actively seek and act on the feedback they receive from patients and their unpaid carers experience of how the discharge went, to receive regular information on what is working and what is not.
- Ask patient's at the point of admission if they have someone who is able to help at home, and if so, who? Then start building a rapport with the named person from the beginning.
- Allow 3rd sector organisation volunteers back on the wards, so that they are able to talk with carers about their situation and signpost them, inform them about the support the charity can provide.
- Develop a specific role for carer support within the discharge process, such as a carers coordinator. Part of their duties would be to raise awareness of the 3rd sector carer organisations and work with the organisation to support the carers.

Conclusion

This project developed from a commissioned piece for NHS E&I, which focused on the insights of patients, unpaid carers and NHS staff, with a specific emphasis on unpaid carers experiences of the discharge to assess process, into a HWC core project. The work was expanded by widening the parameters to include conversations with residential care home managers, NHS transportation staff, advocates, as well as representatives from palliative care and 3rd sector organisations.

This report amalgamates all the findings from the experiences shared via the forty-nine case study participants. Which provides a clear and in-depth snapshot of how the discharge process is perceived by a wide range of key perspectives, with a particular insight on which aspects of the process need improved.

There were many interesting points and thoughts raised by participants, but from their feedback a reoccurring theme throughout was communication. It was evident that the main way to improve the discharge process was to improve the quality of communication. This included within the healthcare system as a whole (both within their teams, and between different medical professional teams, such as hospital-based teams, community-based teams and patient transportation teams) as well as between medical professionals and their patients, unpaid carers, residential home staff and palliative care staff. Additionally, even the communication between 3rd sector organisations and the patients and their unpaid carers (to increase awareness of the support that is available) can be improved to improve the discharge process.

Other aspects of the discharge process that were regularly mentioned in the different discussions, was the need to have the patients' needs as the main focus of the discharge process, needing to have accurate information shared with the correct people prior to discharge (having the right people involved in the planning process) and requiring that the patient has the necessary support in place at the point of discharge. It was highlighted that improving and ensuring these elements of the process would increase the quality of the discharge process.

Acknowledgements

Furthermore, HWC would like to thank all the people who supported with and participated in this project.

- Cumberland Infirmary staff (particularly, the discharge navigators and discharge team, and facilities department)
- West Cumberland Hospital staff (particularly, the discharge navigators and discharge team, and facilities department)
- Paul Carruthers – NCIC Transfer of Care Manager
- Emma Cooper – registered Manager of Cumbria Human Support Group
- Dani Leslie – CEO Carer's Support Eden

- Angela Longrigg - CEO West Cumbria Carers
- Cumbria CVS
- NWS – Patient Transport Service
- People First Independent Advocacy - advocacy department

As well as a huge thank you to all the patients, and unpaid carers who did a case study with HWC, all NHS staff that completed a survey, and the registered managers of residential care homes and the representative from the palliative care organisation that were involved.



Figure 4: Our HWC Engagement Officer (Lisa) doing engagement at West Cumberland Hospital for the D2A project

Key Recommendations

During the conversations HWC had with each group involved in the discharge process, there were many suggestions and recommendations made by individuals about how to improve the process. All these suggestions have been included within the main body of this report. But this section contains the 16 recommendations that have been identified as the key recommendations. They have been divided into five categories: planning, communication, support (resources, equipment and assessments), staffing and, feedback and understanding.

Planning

1. Have joint discharge planning meetings held at ward level, which involve all the necessary and right people in the process.
2. Start the discharge planning as soon as possible.
3. Acknowledge and take into consideration a patient's prior medical and social history when planning a patient's discharge.

Communication

4. Patient and their carers to be reassured throughout the process about what is happening and kept informed by medical professionals. With a named contact person assigned to the patient who can answer any queries.
5. To have a leaflet about discharge to assess (including what the process is, what the patients' rights are, and a couple of contact numbers) provided, with a blank back page where the discharge team could write in details of when the patient was assessed, details of their care plan, when staff would be revisiting the patient.
6. To improve communication, have a 'link person' that can maintain an awareness of planned transfers and be the centre point of communication between acute and community teams.
7. Hospitals keep care homes updated, so that they can be prepared with everything in place at the point of discharge.

Support: Resources, equipment and assessments

8. Have the relevant equipment and resources that has been discussed with the patient in place at the point of discharge.

9. Patients to be discharged with enough medication, suggested 28 days is preferred practice.
10. Patients to receive a follow up assessment from medical professionals quickly once discharged, to assess a patient's long-term needs, so additional equipment, resources and support can be put in place.
11. Signpost patients and unpaid carers to useful and relevant services/resources.
12. To have the offer to have people ringing to provide support and check on the patient and their relatives, after the patient has been discharged from hospital.

Staffing

13. Have the acute and community staff members undertake cross-organisational working (such as staff swaps for a day, or buddy up schemes between community and acute staff), with more emphasis on rotations, shadowing and secondment opportunities, to raise awareness of the pressures the other teams face.
14. Review the workforce staffing gaps and have a recruitment drive, to confront staff capacity issues.

Feedback and understanding

15. Ensure that all levels understand the discharge to assess process (specifically what is required to happen and when at each level).
16. Hospitals to actively seek and act on feedback received from patients and their unpaid carers on their discharge experience (including what is or is not working).

Glossary of terms and abbreviations

ABBREVIATION	DESCRIPTION
CHC	Continuing Healthcare
CQC	Care Quality Commission
D2A	Discharge to Assess
DoLS	Deprivation of Liberty Safeguards
HWC	Healthwatch Cumbria
HWE	Healthwatch England
IMCA	Independent Mental Capacity Advocate
NCIC	North Cumbria Integrated Care
NHS E&I	NHS England & Improvement
NWAS	North West Ambulance Service

Appendices

The appendices A to F, are lists of questions asked to case study groups about the discharge to assess process, to gather their personal thoughts and experiences. However, not every question in the list would have been asked to every participant as the conversations were semi-structured which provided the option to expand on comments made. Furthermore, discussions with palliative care and 3rd sector organisation representatives were open, meaning that while focused on discharge to assess, there were no set questions.

Appendix A

Discharge to Assess Questions for patients

- Q1. Please tell us about your experience of leaving hospital? (Focussing on the few days beforehand.)
- Q2. Did a member of staff talk to you about what support/extra care you would need when you left hospital? Who did that? What did they say? If not, why not?
- Q3. Were you involved in the discharge plans?
- Q4. Were you kept informed? How were you kept informed?
- Q5. How long before you were discharged were you told that it would be taking place?
- Q6. Was the discharge made at an appropriate/suitable time for you?
- Q7. How did you get home? How was this journey?
- Q8. Did you leave hospital with all your own belongings? (For example, dentures, mobile phone, glasses, wallet. medication)
- Q9. Was the appropriate support in place at home/care home at the point of discharge? (From what patient said we should be able to work out which service was involved.)
- Q10. Were you asked if you had additional support needs prior to the point of discharge?
- Q11. Was ongoing support from your GP surgery discussed?
- Q12. Were all your support needs met? (What support did you receive?)
- Q13. Were you told what support you should've got?
- Q14. Overall was it a positive experience?
- Q15. What could have been done by the hospital or adult social care to make it a better experience for you?

Q16. Once discharged, did someone come to further assess you at home to see how you and your unpaid carer were coping, and any additional support/adjustments that may be needed? If yes who was this? How did it help?

Q17. What extra care/support would have been beneficial for you or your unpaid carer?

Appendix B

Discharge to Assess Questions for unpaid carers

Q1. In what ways have you been involved in the discharge process of the patient?

Q2. Did a member of staff talk to you about what support/extra care the patient would need when they left hospital? Who did that? What did they say? If not, why not?

Q3. Were you involved in the discharge planning for the patient?

Q4. Were you kept informed of the patient's discharge process? (If so, who kept you informed?)

Q5. How long before the patient was discharged were you told that it would be taking place?

Q6. Was the discharge made at an appropriate/suitable time for you?

Q7. Did the person you care for leave hospital with all their own belongings? (For example, dentures, mobile phone, glasses, wallet, medication)

Q8. Was the appropriate support in place at home/care home at the point of discharge? [From what patient said we should be able to work out which service was involved.]

Q9. Once discharged, did someone come to further assess the patient at home to see how they were coping, and any additional support/adjustments that may be needed? If yes, who was this? How did this help?

Q10. Overall was it a positive experience?

Q11. Overall, what did you think of the discharge process?

Q12. What could have been done by the hospital or adult social care to make this experience better for the patient?

Q13. What extra care/support would have been beneficial to support you?

Q14. What could have been done by the hospital or adult social care to make this experience better for you?

Appendix C

Discharge to Assess Questions for NHS acute and community staff

Q1. What is your job title?

Q2. As a social care professional, in what way have you been involved in patients' transfer of care?

Q3. Can you give an example of witnessed good practice in relation to patients transferring from one health/social care service to another?

Q4. What patient transfer of care processes work well?

Q5. Can you give one or two examples of witnessed bad practice in relation to patients transferring from one health/social care service to another?

Q6. What are your biggest concerns around the transfer of patient care?

Q7. Which of those is your single biggest concern?

Q8. What is the working relationship like between hospital-based staff and those in the community?

Q9. What suggestions do you have to make the transfer of patient care better in general?

Q10. Is there anything that would make the transfer of care process better specifically for you and your colleagues?

Appendix D

Discharge to Assess Questions for NWAS staff

Q1. What is your job title?

Q2. As a health care professional, in what way have you been involved in patients' transfer of care?

Q3. What patient transfer of care processes work well?

Q4. Can you give one or two examples of transfer of care that hasn't gone well?

Q5. What are your biggest concerns around the transfer of patient care?

Q6. Which of those is your single biggest concern?

Q7. What suggestions do you have to make the transfer of patient care better in general?

Q8. Is there anything that would make the transfer of care process better specifically for you and your colleagues?

Appendix E

Discharge to Assess Questions for residential care home managers

Q1. What is your job title?

Q2. As a social care professional, in what way have you been involved in patients' transfer of care?

Q3. Can you give an example of witnessed good practice in relation to patients transferring from one health/social care service to another?

Q4. What patient transfer of care processes work well?

Q5. Can you give one or two examples of witnessed bad practice in relation to patients transferring from one health/social care service to another?

Q6. What are your biggest concerns around the transfer of patient care?

Q7. Which of those is your single biggest concern?

Q8. What is the working relationship like between hospital-based staff and those in the community?

Q9. What suggestions do you have to make the transfer of patient care better in general?

Q10. Is there anything that would make the transfer of care process better specifically for you and your colleagues?

Appendix F

Discharge to Assess Questions for independent advocates

Q1. In your experience as an advocate, overall, what do you think of the discharge process at the Cumberland Infirmary and/or West Cumberland Hospital?

Q2. What extra care/support do you think patients and their unpaid carers would most benefit from?

Appendix G

NHS Quick Guide to Discharge to Assess

<https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf>

An online guide which provides practical tips and case studies to support health and social care systems.

Appendix H

NCIC Discharge to Assess Information Leaflet

A guide to discharge to assess aimed at patients and carers.

#noplacelikehome

DISCHARGE TO ASSESS RECOVER AT HOME



WHAT IS DISCHARGE TO ASSESS (D2A)?

Discharge to Assess is made up of a range of health and social care professionals and services, supporting people to return home following an admission to hospital.

The aim is to support patients and prevent them staying in hospital any longer than they need to, and to ensure they are supported to return home safely.

The service is free, although any ongoing support could have financial implications following assessments.

WHAT WE DO:

This service provides planned, short term assistance to you in order to maximise your independence following a period of illness, injury, disability or loss of confidence.

Teams within your community will review your abilities when you get home, we will look at what support you have available from family and friends and will arrange any additional short term support to enable you to be as independent as possible. If you need any equipment to help you in your day to day life, we will support you to access this.

If required, with your consent, you may need to be referred to staff from other teams who will be able to discuss with you any options for ensuring you are able to maintain as much independence for as long as possible .

We have links with many other community and voluntary services and are happy to provide information for you to access, as and when, you would like to

WHAT TO EXPECT FROM THE SERVICE:

Throughout the process your views and opinions will be central to the decisions that we will make together.

The community team will meet you at your home to assess your mobility, and how you are able to manage within your home environment. We will discuss what your family, friends and wider community are able to support you with, and then discuss options for any additional support which may be required. If you need any additional support this will be arranged by the most suitable available service.

If we feel together that you will not be able to be fully supported at home, then this will be discussed with you. The team will recommend a temporary alternative placement for you, where you will receive ongoing rehabilitation to enable you to return home later.

If no temporary alternative placements are available at the time required, you may need to return to the hospital ward you were discharged from until an additional, alternative placement is available for you, you will continue to receive rehabilitation during this time.

Your abilities will be regularly reviewed from whichever setting you reside.

WHAT DO YOU NEED TO KNOW?

On the day of your discharge we request that you are wearing comfortable clothing and footwear that you can walk in safely to support your return home.

Where possible we ask that your family, friend or next of kin collect you from the hospital. Where this is not possible, transport will be arranged to take you home and we will meet you when you have returned home.

If it is not possible for you to arrange for your home to be ready for you to return to i.e. shopping in, heating on then please discuss this with a member of the ward staff so we can be made aware.

It is essential that either you or a family member have a key or are aware of your key safe number for your property to allow access when you return home.

The hospital ward will co-ordinate your discharge to ensure you have all of your medication, discharge information and that all relevant referrals have been completed.

Should you require any further assistance following your discharge you can contact the

Integrated Care Community team

01228 853333

Other formats Available

Adapted from University Hospitals of Morecambe Bay NHS Foundation Trust



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