



Hospital Discharge Project

September 2021

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Background

This report will cover the Hospital Discharge Project carried out by Healthwatch Southampton (HWS). The report will be laid out in: Background, Method and Engagement, Results, Recommendations and Limitations.

This piece of partnership work by Healthwatch Southampton was granted funding via the Better Care Fund, small grant programme, to explore the local impact of the Government policy issued in March and August 2020 (Hospital Discharge Service: Policy and Operating Model) which altered the discharge pathways.

The Government issued national guidance on hospital discharge that all hospital trusts, community health services and social care providers in England have been required to adhere to from 20th March 2020. Under the new guidance, acute and community hospitals are required to discharge all patients as soon as it is clinically safe to do so.¹ The hospital discharge guidance was updated into a national policy, which confirmed that Discharge to Assess (D2A) would continue for the foreseeable future. This made it mandatory for local systems to embed new ways of working.

It is recognised that this happened at an unprecedented time when the Covid pandemic led to a national lockdown and many of the themes in this report will be reflective of the restrictions in place during that time, e.g. remote working practices, limited visitor access on hospital wards and in care homes. Local health and care systems were required to implement the D2A model in the space of a couple of weeks, developing new processes, teams and capacity to rapidly respond to the pandemic and the need to support hospital flow.

In addition staff were now working from home, not being able to visit wards and patients, similarly carers and families could not visit patients on the wards either.

This happened at a time when health and social care organisations have experienced challenges in recruiting and retaining staff such as nurses and social workers alongside the recognised challenges of retaining home care staff.

In August 2020, the Government published the Hospital Discharge Service: Policy and Operating Model.² This policy, while building on earlier guidance released at the start of the COVID pandemic, marks a significant departure from previous guidance, including delayed discharges. The policy embeds the Home First ethos and Discharge to Assess approach and includes provision of additional funding to support implementation of recovery support following hospital discharge.(until March 2022) The policy sits within broader ambitions to support people to live at home independently for longer.

From 1st September 2020, post discharge care is funded by the NHS for up to six weeks, and up to 4 weeks from 1st April 2021 - March 2022 and covers the cost of post-discharge recovery, rehabilitation and reablement care following discharge from hospital. During this time patients should receive an eligibility assessment for further longer-term needs and Packages of Care (PoC) to support them, alongside a financial assessment for funding for their care.

In Southampton a range of additional capacity was commissioned to support the new "Discharge to Assess" model, including additional home care and short term beds to provide a setting where patients can recover and their long term needs assessed. Short term beds were commissioned from care homes for those patients who were not independent enough to return home.

It was recognised that, in Southampton, the system was rich in quantitative pathways data, but that little was understood about the lived experience of patients, and their carers, in their discharge journeys at a time when they are particularly vulnerable.

1 Hospital discharge service guidance - GOV.UK (www.gov.uk)

2 Hospital discharge service Policy and Operating Model - GOV.UK

Worth noting too that at the time of this piece of work summer 2021 the months of June and July were particularly busy for the hospital in terms of record number of Emergency department attendances, more akin to the winter months, respiratory disease was particularly high.

The project aims were to coproduce a piece of work; incorporating views of carers and patients, and staff, in order to gain feedback on the system and the new ways of working. The intention was to make recommendations for the Southampton Discharge Hub, based on the experiences of patients and carers and look at how to collect ongoing feedback.

The coproduction team consisted of HWS, Carers in Southampton and The Alzheimer's Society. This team discussed the issues raised by patients and carers that were supported by these organisations and together formulated questions and areas to be covered by the survey.

Healthwatch England recently published a joint report (with the British Red Cross) in October 2020, which looked at how well the new hospital discharge policy, called 'Discharge to Assess' (D2A), is working for patients, carers and healthcare professionals in England.³ Their report found that although the speed with which people were discharged from hospital was important, to cope with demand at the peak of the pandemic, it could also lead to worse care and a lack of support for some patients leaving hospital if not implemented well.

The aim of this report is to highlight how the system can use patient and carer feedback to improve services and make the policy of D2A work locally. Recognising that it is a small scale snapshot of patients and carers experiences.

Engagement and Method

HWS used two ways to collect data for this work; survey and face to face interviews. This was to ensure that - voluntary sector colleagues, staff involved in discharge and the public could be reached in as many ways as possible. All engagement was carried out either through an online programme (TEAMS and ZOOM), phone calls, a survey online or a paper survey. Once the methods were chosen it enabled HWS to come up with a project plan.

Project Plan

Phase 1: Coproduction meetings with Carers in Southampton and Alzheimer's Society

Phase 2: Interviews with staff involved in the new system.

Phase 3: An online and paper survey directed at patients and their unpaid carers.

Phase 1

Phase one of the engagement process involved two meetings with two voluntary sector organisations representing carers and those living with dementia. These meetings drew out themes that HWS would find useful; these included, communication, planning for discharge, information, signposting and assessment.

The organisations, Carers in Southampton and The Alzheimer's Society, were able to provide valuable feedback on the experiences of unpaid carers and patients with factors that may need to be considered on discharge from hospital. Following consultation meetings, it was agreed that a paper survey was a good way to reach people who are digitally excluded; it was also felt that unpaid carers find it easier to engage with this at a time when it is convenient for them. These ideas helped HWS create phase two and three of their project plan. The organisations also helped with subsequent drafting and editing of a survey that would gain both patients' and unpaid carers' views of the discharge model.

Phase 2

Phase two involved interviews with staff engaged in the discharge model. The opportunity to be involved in this piece of work was promoted by the operational lead for the discharge hub. The interviews addressed the experiences of staff in adapting to the new government regulations around discharge, including; challenges, successes, frustrations, the involvement of patients and carers. This was a semi-structured interview which had prompts for the interviewee through the interview (Appendix 1), so that staff were able to discuss and lead to topics as they wished, but also so the interview contained all the relevant data that needed to be collated.

Phase 3

Lastly, phase three of the project was an online and paper survey to gain valuable feedback from patients, service users, unpaid carers and their families about their experience of being discharged from hospital during June and July 2021. The survey aim was to gather patients' and unpaid carers' recent experience of being discharged from hospital. All surveys were anonymous, as respondents only gave their details if they wished to be contacted to discuss their response further.

Alongside the paper survey was an online option, email option or telephone interview. This ensured that all who wanted, could take part. The surveys, which were sent out in paper form, with a prepaid return envelope, were sent out to 200 patients. These were people who required care on discharge, either a reablement Packages of Care (PoC), or a more complex PoC or an interim placement in a residential/ nursing home. A respondent sheet was included which explained the survey, consent, and further support services available.

The survey asked forty-five questions in total including three questions relating to demographic characteristics. This survey involved both quantitative and qualitative data by using open and closed questions. The questions asked related to the information provided to patients whilst in hospital; and in particular concerning their discharge arrangements, such as where they would be discharged to, including information about follow-up care and the support they may have required. A full copy of the survey questions can be found in Appendix 2. Along with a participants information sheet in Appendix 3.

The questionnaire was sent out on 18th and 19th August and promoted on the HWS website until 4th October 2021.

Data collection via survey is usually known to have a low response rate. HWS received a 15.5% response rate which gave a good amount of data and allowed strong themes to be produced

The Likert scale questions caused potential confusion for some respondents. However to decrease this limitation and ensure the results were reliable, each survey response was subject to a thematic analysis. This allowed each respondents results to be valid to their opinion as each question was explored and examined in detail.

Confidentiality

Respondents' confidentiality and anonymity were paramount throughout this engagement work. Confidentiality was maintained by not using any respondents' names or names of anyone they mention in the report. Once people's opinions were collated a reference number was given. This meant that, when re-examining opinions, no information could be linked to a name or individual. With permission, semi-structured interviews were recorded and later transcribed. Once the information from the interviews, or survey had been transcribed, collated, and inputted electronically they were deleted/shredded to not allow any unwanted information to be shared.

Confidentiality was agreed to be broken in an interview only if the engagement worker had a strong belief that there was serious risk of harm or danger to either the respondent or another individual (e.g., physical, emotional, or sexual abuse, concerns for child protection, rape, self-harm, suicidal intent, or criminal activity) or if a serious crime had been committed.

A full analysis of the survey results is given on the next pages.

Results

Semi-structured Staff Interviews

This section of the report focuses on results of semi-structured interviews with staff involved in the discharge model. This is presented according to themes. Seven members of staff were interviewed. They expressed many views to Healthwatch Southampton about the discharge model. Therefore, the information shown in this report is comprised of subjects which have formed patterns through most of the data. The eight themes are discussed below in sections. The first five themes address the negatives and challenges the staff felt with this model. The last, three themes in this section show the positives the staff felt came out of this model.

Home Working

The government guidance during the Covid 19 pandemic and national lockdown included working from home; staff were therefore not on hospital wards as they normally would be. The new model was seen as a way that patients could access community support upon discharge. However, staff felt there was not enough investment in community care before this model was in place. The staff were organising care from their home; this meant they were either sending patients home from hospital with a care plan, or, if necessary, to a care home or Urgent Response Service. This left the staff feeling they were, *“one step removed from the actual front line”*. They found this difficult, as it meant they were not seeing patients face-to-face. The separation from the patient was seen as an obstacle to ensuring that the correct care was allocated after hospital discharge. This separation and being unaware of the patients’ views and wishes, meant the staff felt the work was very hard. All work strategies and methods previously used had to be adapted and changed. This meant a switch from information from the patients themselves to relying on other healthcare professionals’ suggestions, with the latter as the basis of the decision about the patients’ care. Overall, this way of working was felt by many to not work as well, and that, the, *“social work voice was still very much needed at the hospital even if the guidance doesn’t state this”*.

Communication

One theme that emerged from the national lockdown and staff not having access to patients on the hospital ward was communication. The staff felt that, due to the very limited contact with the patient, not enough information was being passed to them. Many staff spoke about how prior to this model, they would discuss the patients’ information with both the patients themselves and the healthcare professionals involved. This gave them a holistic view and enabled them to allocate the next best steps. However, according to staff, it took longer to get hold of people when needing to check facts. The staff interviewed felt that the hospital does not always provide the necessary information, which then means follow ups had to be carried out. Overall, this resulted in a long waiting period for patients. This is another issue arising from not being able to visit the ward and communicate with hospital staff face-to-face.

Furthermore, communication between the discharge teams, families and unpaid carers was also challenging. The staff described how, previously, when they were on the ward together with visitors, the opportunity arose to discuss the patient’s needs with another individual (family member or carer). However, when the teams contacted the families and unpaid carers, they might not have seen the patient either during their hospital stay, due to Covid 19 lockdown restrictions on hospital visitors to hospitals, or during their isolation period. This could mean several weeks. For example, one respondent reported having asked a family member a question and being given a response that referred to how the patient was before they went into hospital, as they had not seen any decline or progression since. Overall, this shows that information is not as helpful as it could have been when family and unpaid carers had the opportunity to see the patient daily on the hospital ward. Whereas before, the conversations with the family members and unpaid carers were face-to-face, they are now over the phone. Staff described the issues they face when not being able to get hold of the family or unpaid carers. Staff faced the same situation when contacting other health and social care professionals e.g., a social worker. Everyone was busy and adapting

to changes. This presented obstacles for discharge staff in discharging patients to the correct place.

Another communication issue; was that when patients were being discharged, family members and carers were not always informed. This caused conflict and/or distress which the discharge teams would then have to sort out. One interviewee stated how the hospital was so busy with discharging people (so that they were safe and less likely to contract Covid) that it meant community discharge teams were taking over patients that they had little contact with. Consequently, information was sometimes missed and led to situations such as the one mentioned above. Messages which previously had been passed from the team to the hospital staff were also forgotten.

Job Roles

Due to Covid 19 lockdown restrictions and discharge staff working from home, nurses were taking on part of the social care role they had not done before. Many of those interviewed were of the opinion that the healthcare professionals now taking on some of the social care work previously done on the ward did not fully understand their new role. With this lack of understanding about job roles, the interviewees felt that the *“patient really got lost”*. They stated that it was hard from their perspective to see staff struggling on both sides. The lack of communication between the patient and the discharge teams was felt by many to go against the values of Social Care. The holistic social care model was felt to have been replaced with the medical model. The respondents thought this situation would result in social care interventions being missed. Many patients were stated to need a care home; however, the discharge teams believed the decline in health could have been prevented if patients had been offered support earlier, e.g., independent living with reablement and/or rehabilitation.

Pressure

One aspect that was clear throughout this engagement work was the pressure staff were under. The changes staff had to manage were described as hard. One word was used predominantly throughout all the staff interviews; this word was ‘difficult’. There was pressure on the hospital staff to discharge patients quickly so there would be enough beds in case of an increased level of need for Covid patients, but also so that patients would be at less risk of contracting the virus. However, a faster patient turnover meant a higher workload for discharge staff. For example, a discharge team staff member stated that, pre-Covid, they had, on average, 42/43 people on their list per day, and now were dealing with up to 80/90. This workload meant that the work had become increasingly stressful and demanding. The pressure came from making sure that everyone was discharged from the hospital, but also that they had the correct care plan in place. One respondent described this as, *“really tough to create”*. Due to the increased pressure and *“burn out”* reported by some interviewees, the interviews addressed whether the discharge teams had managed to retain staff. All the interviewees described staff retention as good. However, many said that their workforce needed to be larger and that the sector was understaffed. More staff would relieve pressure on the rest of the team. The system acknowledges at the time additional investment in staffing was made for social work and nursing staff, however the challenges remained around recruiting enough good quality staff during unprecedented times.

Funding for patients was said to have been *“good”* with this new model. The discharge team staff stated that the funding was there to be used. Previously this was an issue. However, this was no longer the case and helped relieve the pressure slightly.

Impact

The staff interviews show a clear theme regarding the impact of both the national Covid 19 lockdown and the challenges of working from home and a new discharge model. The staff reported there being, *“lots of cases where it was very, very, hard for us”*. Individuals were discharged when *“medically stable”* and the therapy, social care assessments and provision were to be completed at home. It appeared to many that it was left to community care provision to make individuals safe. This was seen as an issue, as pre-Covid domiciliary care had been struggling. According to one interviewee, *“domiciliary care at the moment is on its knees”*. Another said that they believed that because of the rush to get patients out

of the hospital, *“we have very poorly people coming out of hospital. People very poorly and frail being discharged”*. Before Coronavirus, their rehabilitation was provided within the hospital. Therefore, the patient was guaranteed to have had appropriate therapy before being discharged. However, under the new model, individuals were discharged home to their family or a short term bed in a care home, or with community based therapy, the staff interviewed felt that many patients who were discharged to a care home short term bed were not necessarily in the most appropriate place. They voiced the view that, when therapy and rehabilitation are left out there is a *“missed window”*. Also, where patients are discharged into care homes without rehabilitation, they settle in and miss the opportunity to get back on their feet independently with a wraparound care package. This led to slightly increased care home figures. There is now a review of the patient after four weeks, which used to be six. However, staff are reporting that there is not enough time to do the reviews. *“They can only do what they can”*. Once again, this is seen by staff to decrease the chance of independence. Overall, the respondents would rather the patients stayed in hospital a little longer and were offered suitable care. The current situation was believed to increase patient decline in mobility and cognitive performance. The system needs to ensure sufficient rehabilitation and reablement capacity in the community to ensure patients and carers have choices.

Covid testing and Covid Vaccinations

Interviewees were asked whether Covid testing had taken place in the hospital before discharge of patients. There was a mixed response to this question. Some stated that the hospital was very *“strict”* about testing patients before discharge. They regarded this as positive and that it was something *“the NHS was really good at”*. However, others were unsure. One respondent stated that they were not aware of any occasions when a test was not carried out before leaving the hospital. Others reported that when testing was new there was not always commissioning and governance behind it. This meant tests were sometimes missed because it had been thought that they had already been done. This resulted in confusion. However, as the pandemic went on, testing before discharge became routine. Furthermore, care homes were said to also do their own testing within 48 hours of discharge. Patients then still had to isolate for 14 days in their care home even if negative.

This brought the interview onto the subject of Covid vaccinations. One key finding was that many of the staff felt more relaxed with the roll out of the vaccine. The majority felt that the; *“world was a lot safer”*. The impact on the clinical healthcare side was believed to be huge. It was suggested that it would, and has, slowly reduced the emergency aspect of the pandemic, and made care homes more confident. It also eased the worry for staff now they had at least limited access to the ward. They are more concerned about being *“pinged”* by the NHS app regarding being in contact with someone. However, it did not affect the discharge process significantly.

Partnership Working

A positive aspect of the new model was partnership working. Every respondent stated that this had improved over the Coronavirus and lockdown period. New connections were made, and they were described as *“strong”*. Phrases such as: *“relationship-wise we’re much stronger”*, *“relationship-wise it means it’s unblocked things”*, *“everybody kind of came together”* and *“learning to work together better than they did before”* were used. This shows how staff members relied on each other as the uncertainty of the future brought them closer together. This positivity can be a resource which all staff feel can be used effectively in the future. It also impacted the discharge process in a positive way. One interviewee stated that it, *“helped speed up discharge and work better”*. It is encouraging to hear such views of a health and social care process.

Appreciation

Another clear and positive aspect was the appreciation the team had for each other and all the staff in the discharge process. It was reported that the staff had all worked extremely hard in a difficult situation. It was also clear that staff had looked after each other. One interviewee stated how, *“utterly resilient people can be when they need to be”*. Many said that it brought everyone together and enabled staff to be more aligned with each other. The hard work and dedication to the line of work showed how much the

staff really cared about what they do. Morale was indicated to be a; “complete high in the early stages”. However, “burnout” was also a factor now. Yet, with understanding from managers, the staff had been looked after and time off had been taken when possible. This state of appreciation and care for staff is perhaps one of the reasons that staff retention has been good.

The interviews with the staff gave a good insight into the unprecedented time of the Covid 19 pandemic, lockdowns and restrictions on working and how this impacted alongside a new discharge model. Overall, staff expressed a strong preference for the previous ways of working and felt that the new model missed key aspects which facilitated patients’ care after discharge, e.g. face to face contact with patients, carers and hospital staff, sufficient community capacity, patient choice, and a person centred approach to care

Survey Results - Patients and Unpaid Carers

The paper surveys, returned by freepost, represented a 15.5 return (31/200). One respondent chose to share their experiences via the telephone. The results are shown in themes. The data consist of both quantitative and qualitative results.

The results for the Discharge Surveys concerning unpaid carers and patients who had been discharged from hospital between June and July 2021 are shown below. Of the 31 respondents, 17 individuals were unpaid carers, and 14 individuals were patients. Eight of the patients who took the survey had a carer, or relative help with completing the survey. It is important to note that not every respondent answered every question on the survey.

1. Are you?

[More Details](#)

- The carer who provides servic... 17
- The patient 14

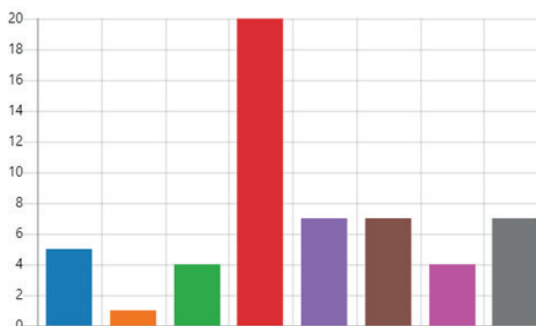


One question concerned the patients’ conditions. This helped Healthwatch Southampton get a picture of various conditions in the hospital throughout the discharge process. The results are shown below. Note: total number of responses is greater than 31 as some respondents ticked more than one condition.

3. Do you or the person you care for have any of the following conditions?

[More Details](#)

- Physical Disability 5
- Learning Disability 1
- Mental Health Conditions 4
- Mobility Issues 20
- Dementia 7
- Sensory Impairment (vision or... 7
- Stroke 4
- Other 7



Negative Experiences: Main Themes

Of the thirty-one respondents, 6 reported a neutral experience of the discharge process, 12 reported an overall positive experience and 13 a negative experience. It was notable that, where respondents had a poor experience, scores and comments were extremely negative. These revolved around one major issue; i.e., that of poor communication. This can be divided into two main themes: Lack of Communication and Inconsistency.

Lack of Communication

Carers, in particular, reported negative experiences of the discharge process. Typically as a result of lack of information from hospital and discharge staff and a lack of consultation by staff. One carer described her mother being discharged to a care home without her (the carer) being informed, despite having told staff that this is not what the patient or family wanted. Another responded that, *“I had to arrange care. No-one told me the patient was coming home”*. Another, of his wife, *“I was unable to find out where she was”*.

One respondent spoke of her distress at significant delays in her husband’s discharge to die at home. She was initially told that this was due to lack of transport but, after making *“numerous”* calls over a 2-week period was told that there was a lack of available care. She arranged care herself. She said, regarding communication from the hospital, *“I felt forgotten all the way through”* and *“Be honest with people from the start. Communicate, ask about their situation, listen to what they say”*. This was echoed by others, e.g., *“I was never consulted,”* and, *“Don’t leave family/carers in the dark about what’s happening. Communicate better. Listen to the family and their concerns.”*

It was acknowledged that visiting restrictions, due to Covid and lockdowns, had contributed to problems with communication, as there was little face-to-face contact which would have otherwise, happened naturally on the wards.

Inconsistency

A common source of frustration for patients and carers was the number of different professionals they had contact with during the discharge process. Prior to discharge, the carers spoke of calling the hospital and having to repeat their story to different staff each time. *“It was an endless battle to talk to someone who knew what was going on”* and, *“I had to make numerous calls to talk to anyone about the patient’s needs.”* Post discharge, they described confusion caused by receiving calls from different professionals; *“it causes confusion for the family.”*

Respondents expressed the view that it would have been most helpful to have one named person to deal with.

The situation was complicated by having to communicate across departments or teams, e.g., being given differing information by medical or social care staff. *“All departments seem to work with different systems, none of which talk to each other,”* and, *“too many fingers in the pie.”*

Further Findings

34. Did you feel that you / the person you care for was well enough for discharge?

[More Details](#)

● Yes	19
● No	9



68% of people did feel the person they care for was well enough for discharge. 32% of people did not feel the person they care for was well enough for discharge.

12. Were you or the patient signposted to any organisations for support?

[More Details](#)

[Insights](#)

- Yes 15
- No 13



53.6% felt they were signposted for support. 46.4% felt they were not signposted to any organisation for support.

20. Were any referrals that needed to be made completed before discharge?

[More Details](#)

- No referrals were needed 8
- Yes referrals were needed and... 14
- Referrals were needed but ha... 9



25% of respondents felt no referrals were needed to be completed before discharge, 45% of respondents felt yes referrals were needed and were made, 29% of respondents felt a referral was needed but had not been made.

26. At discharge were you or the person you care for given contact details of a social care or health professional you/they could get in touch with?

[More Details](#)

[Insights](#)

- Yes 12
- No 13
- N/A 5



40% of respondents felt that at discharge they were given contact details of social care and health, 43% of respondents felt that no they were not given contact details, and 17% felt that this did not apply to them or the person they care for.

35. Have there been any other assessments for care needs? (select as many as apply)

[More Details](#)

- A care needs assessment in a ... 8
- An assessment of longer term ... 12
- There have not been any asse... 9



27% of respondents had a care needs assessment in a day or two of discharge, 41% of respondents had an assessment of longer term needs within 6 weeks of discharge and 31% have not had any assessments since leaving hospital.

19. Upon discharge did anyone check that you / the person you care for had the following (Please click all that apply to you)

[More Details](#)

- Appropriate paperwork eg a c... 17
- All the medication needed 22
- Enough information about me... 14
- Any new equipment needed 9
- Personal property eg front do... 13



38% of respondents were unhappy with their experience of care during discharge. Individuals who had experienced the discharge process without the necessary procedures in place felt their discharge experience to be negative. There were examples from respondents of personal belongings going missing including glasses, paperwork and property.

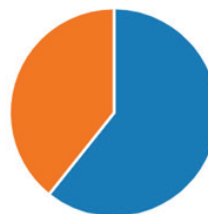
Impact

Negative experiences mentioned above meant that 41% of the people involved in the survey felt let down. One respondent described themselves as “devastated”. The discharge process had impacted on respondents’ lives. For example, not knowing where their relative or patient had been discharged to, discharge of patients not transmitted to the family member/carer until the last minute (“discharge was out of the blue”) and not having time to get anything in place for discharge (11 out of 28 reported this in Question 16). This all increased the stress and worry for the individuals who had to adapt their lives to the patient’s return. In some cases, the respondent was a carer for more than one individual, e.g., parents. One respondent said that the disruption of the discharge occurring, without prior knowledge, upset the other individual they cared for. Another voiced this by saying; “stressed after dealing with the aftermath of this”. This was enforced by the questions with Likert scales, as some respondents wished there had been a zero-option due to the upset caused.

16. Did you have enough time to make the arrangements you needed to before you the person you care for was discharged?

[More Details](#)

- Yes 17
- No 11

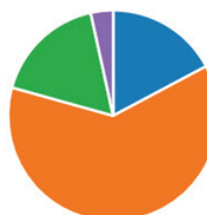


The timing for discharge is important to patients and their carers and families. In this survey where individuals had been discharged in the evening or at the weekend (6 respondents 19%) felt that this caused family members and carers pressure and anxiety.

18. Were you / the person you care for discharged

[More Details](#)

- In the Morning 5
- In the Afternoon 18
- In the Evening 5
- Overnight 0
- On the Weekend 1



In some cases, the patient was discharged to be able to die at home. Where the discharge experience was poor the process upset respondents; *“it added to my grief immensely”*. When individuals complained and voiced how unhappy the process had made them, they felt they were not shown consideration or listened to. One respondent stated that, *“there appears to be little will to say sorry, we got it wrong and we will change”*. This made the respondent feel powerless.

Lastly, some respondents believed that their negative experience of discharge was because of the Covid restrictions. There were many comments about visiting restrictions and the patient being in hospital alone. The lack of contact between the patient and the family member/unpaid carer made them feel they were not consulted. One respondent stated, *“Without the restrictions things would have been easier for all”*.

Positive Experiences: Appreciation

Although negative aspects of the discharge process for individuals are mentioned above, there were also positive aspects. However, when the thematic analysis was conducted, the surveys which showed a positive discharge process had very few comments. This was in contrast to the negative discharge survey responses. The 39% of respondents who had a positive experience of discharge left comments showing their appreciation of the staff. Even respondents who had had negative experiences expressed their thanks to teams that had been supportive along the way. Some comments below show how some respondents feel about the discharge service:

“6-week care service was excellent. Really helped patient to recover at a critical time”.

“The Discharge team were helpful”.

“Staff were good”.

“Rapid Response team was excellent”.

“Dementia nurse is superb; you need more people like her”.

“South Hants Hospital was good at communication”.

“Care good. Ward looked after the patient well”.

“Domiciliary Care was great”.

It was positive to see how some teams or services made such an impact that the respondents wanted to draw attention to them. Reinforcing that services, NHS and Social care do a good job helping people recover and maintain independence, as well as contributing value to individuals' lives.

Conclusion

The discharge to assess process has been shown to have the potential to benefit patients where it has been well resourced and implemented. It can speed up discharge from hospital while providing care and support to patients and their carers. It has also enabled more collaborative working between social care and health staff.

However, for Discharge to Assess to be successful, it also requires timely assessment of needs, provision of appropriate packages of care in the community and access to rehabilitation and reablement (and the funding and workforce to support this), as well as good communication with patients and carers and across teams. Our survey responses show that without this there is a strong risk that patients and carers will experience stress and for patients there is an increased risk of poor recovery, hospital readmissions and admissions to care homes.

Recommendations

Improved Communication is key to;

Engage with patients, carers, and families

- Ensure that patients are asked if they have a carer or other person they wish to be involved in decision-making.
- Make information about Advocacy Services available for those who might need additional support.
- Keep people informed about discharge and plans for follow-up care.
- Assign a single point of contact to enable clear communication and ease of access for support and signposting.
- The discharge model is shown in this report to work best with face-to-face contact between the staff member, patient, and patient's family/unpaid carers. When restrictions have eased within the hospital, it is recommended that the discharge staff enter the wards to conduct their work. This allows staff, patients, and families/unpaid carers to feel more involved and comfortable within the process.

Provide better support for carers

- Ensure that carers are aware of support services and of their rights, e.g., to a carer's assessment.
- Ask carers if they are able and willing to provide the necessary support to the patient before they are discharged.
- Seek patient and carer feedback on a regular basis. Bear in mind that some people may be digitally excluded.

Provide adequate resources

- Identify reasons for gaps in timely provision of assessments in the community.
- Ensure sufficient rehabilitation and reablement resource in the community to proactively support people during their recovery and assessment period either in their own homes or in a short term bed setting
- This may require increase in staffing in order to expand capacity.
- Consider making use of voluntary and community resources to support people leaving hospital.

Build on what has gone well

- Co-operation, support and collaborative working between social care and health staff.
- Retain the best of effective new processes.

Limitations

- The engagement process for staff interviews was via online video calls. This meant that buffering and poor internet connections could have affected some speech by distorting it. Yet, to decrease this limitation the interviews were recorded and transcribed (with the respondents' consent). This allowed HWS to be able to re-listen and focus on information to make sure that what was understood was correct.
- Small sample size of respondents in both staff, patient and carer feedback recognising that it is a small scale snapshot of patients and carers experiences.
- HWS received some incomplete forms on the postal survey with regard to personal characteristics. This needs to be considered for further engagement projects in order to inform the pilot studies. Other issues, such as gender, disability, sexuality and specific issues, e.g. fertility, may also need to be considered for future projects in offering support to people. Therefore, further investigation of existing patient and public feedback and engagement on these issues may be necessary.

References

1. Hospital discharge service guidance - GOV.UK (www.gov.uk)
2. Hospital discharge service Policy and Operating Model - GOV.UK
3. 590 stories of leaving hospital during COVID19. Healthwatch and British Red Cross. October 2020

Appendix 1

HOSPITAL DISCHARGE PROJECT QUESTIONS FOR STAFF

Preamble:

- Thanks for agreeing to participate
- Survey background
- Interested in what it's been like for staff as well as patients and carers
- Responses anonymized, not attributed
- Permission to record? Will be deleted
- What's the role of staff member/their team?

Their experience of adapting to the changes - especially as government guidelines changed rapidly in response to the pandemic

- What has gone well? The positives
- What not so well? The negatives?
- Particular challenges? Frustrations?

Impact on staff - positive/negative

- E.g: well-being, burn-out, morale
- Has it drawn teams closer together?
- Support received?

Views re involvement of patients and unpaid carers in the discharge process

- Have the changes made this better or worse?

Views re testing and discharge - did testing happen?

- Views on vaccination roll-out - has it made discharge safer, easier?

With hindsight: if you had a blank sheet of paper, what would look different?

- Change anything - and why?

Wrap up:

- Anything not covered, anything else you want to say?
- Acknowledge their work and difficult time they've had to deal with
- Thanks for time and taking part
- Welcome to contact me

Appendix 2

Healthwatch Southampton- Hospital Discharge Survey

This survey is for people who have been in hospital at least overnight and have been discharged during the period June - July 2021 (The Patient) and for people who care for them (The Carer). During the pandemic procedures for hospital discharge have changed to ensure people are only in hospital if they have a clinical need to be there.

Healthwatch Southampton wants to understand whether hospital discharge processes are working well for patients and carers, or if there are problems that need to be addressed to ensure people get the treatment they need and are discharged safely.

This survey will take 15-20 minutes to complete. We really appreciate your time.

If you would prefer to talk through your responses please call Healthwatch 02380 216 018 or email Healthwatch healthwatch@southamptonvs.org.uk

A carer is someone of any age who provides unpaid support to family or friends who could not cope without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. The carer does not have to live with the person they are caring for.

About you

1. Are you?

The carer who provides services freely (NB Carers Allowance is not payment)

The patient

2. If you are the Carer, please state if you are answering as yourself or on behalf of the Patient.

3. Do you or the person you care for have any of the following conditions?

Dementia

Mental Health Conditions

Learning Disability

Other

Sensory Impairment (vision or hearing)

Stroke

Physical Disability

Mobility Issues

4. If other please say

This section is about your/their time in the hospital.

5. When you / they were in hospital how well did the hospital communicate with you? On a scale of 1-10. (1 communication was very poor I was unable to get the information I needed to 10 the hospital communicated very well and I had all the information I needed when I needed it).

1 2 3 4 5 6 7 8 9 10

6. Did poor communication cause any problems or impact on you or the patient's care?

7. While in hospital were there any discussions about future plans and wishes for care?

Yes

No

8. Was a new Respect form completed? (Respect = Recommended Summary Plan for Emergency Care and Treatment. A personalized recommendation for your clinical care in emergency situations where you cannot make decisions or express your wishes)

Yes

No

9. Would you like to add more detail?

Care planning before discharge.

10. In the hospital, when discharge and care needs were being planned, did you feel you were consulted or involved in those decisions? On a scale of 1-10. (1 I felt excluded and kept in the dark to 10 I felt fully involved and consulted)

1 2 3 4 5 6 7 8 9 10

11. Please explain your number choice.

12. Were you or the patient signposted to any organisations for support?

Yes

No

13. Which organisation were you signposted for support to?

14. If you/the person you care for, left hospital with a new personal care NHS reablement /aftercare provision, did you feel well informed about what this meant and what would happen before the end of the 6 weeks? On a scale of 1 to 10. (1 being yes I felt fully informed to 10 being no I felt confused and not knowing what would happen next)

1 2 3 4 5 6 7 8 9 10

15. Were you given the information you needed about the discharge itself timing and transport? On a scale of 1-10 (1 being yes I was fully informed and knew exactly what was happening to 10 being no I was not informed and had no idea what was happening).

1 2 3 4 5 6 7 8 9 10

16. Did you have enough time to make the arrangements you needed to before you the person you care for was discharged?

Yes

No

17. If No please tell us what happened?

About the discharge.

18. Were you / the person you care for discharged

In the Morning

In the Afternoon

In the Evening

Overnight

On the Weekend

19. Upon discharge did anyone check that you / the person you care for had the following (Please click all that apply to you)

Appropriate paperwork eg a copy of the discharge letter

All the medication needed

Enough information about medication to ensure it was taken safely

Any new equipment needed

Personal property eg front door key, spectacles

20. Were any referrals that needed to be made completed before discharge?

No referrals were needed

Yes referrals were needed and made

Referrals were needed but had not been made

21. Please tell us more

22. If unpaid care was provided before admission, was the carer asked if they were able/willing to continue to provide this care, or an enhanced level of care, if needed, after discharge?

Yes

No

23. Please tell us more.

24. Did you need transport arranged?

Yes

No

N/A

25. Please tell us more

26. At discharge were you or the person you care for given contact details of a social care or health professional you/they could get in touch with?

Yes

No

N/A

27. Were you or they referred to any organisation for support?

Yes

No

28. What organisation were you or they referred to for support?

29. When you or the person you cared for left hospital where were they discharged to?

To live independently with a spouse or partner

To live with family or friends

A care home

Other

30. Please tell us more.

31. Was this the same as before you/ they went into hospital?

Yes

No

32. Was this expected to be permanent or temporary residence?

Expected to be permanent

It was temporary for rehabilitation or recovery

Other

33. Please tell us more.

Reassessment and future care needs.

34. Did you feel that you / the person you care for was well enough for discharge?

Yes

No

35. Have there been any other assessments for care needs? (select as many as apply)

A care needs assessment in a day or two of discharge.

An assessment of longer term care needs within 6 weeks.

There have not been any assessments since leaving hospital

36. Were there any other assessments in any of the areas stated below?

Continuing healthcare

Financial assessment

Occupational health assessment

Other

37. Were the assessments

Whilst in hospital

Since leaving hospital

One is needed but not happened yet/planned

Do not need one

38. If there were any assessments please tell us about these. What worked well? Could anything have been made better?

39. Has the quality of the whole discharge process had any effect on the health and wellbeing of you or person you care for? If it went well did that have a good impact? If it could have gone better has this caused problems?

40. Overall, how well do you feel the whole process has been managed - the discharge planning in hospital, the discharge itself, and the support after discharge? (1 being very poor to 10 being amazing)

1 2 3 4 5 6 7 8 9 10

41. Would you like to tell us anything else that could help improve the service?

42. If you would like to talk to someone at Healthwatch Southampton about your responses please leave either an email address or a telephone number and your first name and someone will get back to you.

Name

Telephone

Email

Equality and Diversity Questions.

The following questions are optional. This information will be kept confidential. The reason for collection is to ensure that we are engaging and being inclusive with who is accessing/can access our service. This will also help us to see if we are doing an efficient job while engaging and informing you. Thankyou for your time.

43.How would you describe your gender?

Woman

Non-binary

Man

Prefer not to say

Transgender

44.How old are you?

Under 18

18-24

25-44

45-64

65-84

85+

45.How would you describe your Ethnic Origin?

Asian

Bangladeshi

Chinese

Indian

Pakistani

Asian other

Black

Black African

Black Caribbean

Mixed White/Asian

Mixed White/Black African

Mixed White/Black Caribbean

White British

White Irish

White Gypsy/Traveller

White Other

Other

All Done. Thank You!

Thank you for taking the time to complete this survey and share your experience with us. What you tell us will be fed back to the organisations responsible for hospital discharge and care assessments.

If you need any kind of support, advice, or information , please contact us at:

healthwatch@southamptonvs.org.uk (mailto:healthwatch@southamptonvs.org.uk) or see the contact details for other support services at the end of our information sheet attached with this survey.

Appendix 3

INFORMATION SHEET

A Public Engagement Exercise into the experience of Discharge from Hospital during the Coronavirus Pandemic in Southampton

Healthwatch Southampton would like to invite you to take part in a public engagement project. Before you decide, you need to understand why this engagement is being carried out and what it would involve for you. Please take the time to read the following information carefully. Ask questions if anything you read is not clear or if you would like more information. Thank you.

Introduction

Healthwatch Southampton understands the pandemic has been a difficult time for patients and their carers and we would like to better understand your experience of the discharge from hospital: what's worked; what were the problems; what could be done differently.

By doing this work, we can influence local decision makers and help to make sure that lessons are learnt where things have not gone well. Our final report will make recommendations for improvements, based on what you've told us.

Who is Healthwatch and what do we do?

We are the independent national champion for people who use health and social care services. We're here to find out what matters to people and help make sure your views are heard to shape the support you need.

How Healthwatch works:

There is a local Healthwatch in every area of England. Healthwatch aims to find out what people think about health and social care services, and what could be improved. Healthwatch shares the public's views with those with the power to make change happen. Healthwatch also help people find the information they need about services in their area, as well as support and refer individuals who wish to make a complaint about a health service.

Nationally and locally, we have the power to make sure that those in charge of health and social care services hear people's voices. As well as seeking the public's views ourselves, we also encourage health and social care services to involve the public in decisions that will affect them.

The engagement process:

We are working in partnership with: Southampton City Council; Southampton City CCG; University Hospitals Southampton Trust; Solent NHS Trust. We are also consulting with Alzheimer's Society and Carers in Southampton. However, all patient and carer engagement will be undertaken by Healthwatch Southampton as an independent organisation.

Potential participants' details have been provided by the UHST Discharge Hub, for discharges taking place during some months of this year. We will initially invite you to complete a survey enclosed, or online, at www.healthwatchsouthampton.co.uk depending on your preference. You can also email us with comments at healthwatch@southamptonvs.org.uk or ring us on 02380 216 018 and follow-up telephone interviews will be offered.

Do you have to take part?

Participation is completely voluntary, and you have the right to refuse participation, refuse any question and withdraw at any time without any consequences.

Possible risks involved with taking part:

There are no known potential risks to this engagement work. Although, some conversations may cause an individual to feel emotional or distressed due to the sensitive nature. If this does occur please do not hesitate to contact any of the contacts listed below.

Will taking part be confidential?

Your confidentiality and anonymity will be viewed as paramount throughout this engagement work. Confidentiality will be kept by not using any participants name or anyone's name they have mentioned. Once people's opinions have been collated, as mentioned above, a reference number will be given. This will mean that when re-looking over opinions no information can be linked to a name or individual.

Confidentiality will only be broken if the engagement worker has a strong belief that there is a serious risk of harm or danger to either the participant or another individual or if a serious crime has been committed.

Once the information from the notes or participant information consent forms has been used, it will be deleted/shredded.

The project will be fully compliant with data protection regulation and GDPR.

Results of this engagement project:

The results from the public engagement will be documented in the form of a report. The results of this project will be publicly published once all experiences have been collated and the partnership organisations have had a copy of the report. This will allow you to be able to see your impact on the project as well as the recommendations that are presented.

Contact:

Healthwatch Southampton:

Website: www.healthwatchsouthampton.co.uk

Telephone: 02380 216 018

Email: healthwatch@southamptonvs.org.uk

Support Contacts:

Options Counselling

023 80630219

Email: enquiries@optionscounselling.co.uk

www.optionscounselling.co.uk

Care for Family

<https://www.careforthefamily.org.uk/>

029 2081 0800

Offers Bereavement support

Carers In Southampton

023 8058 2387

Email: enquiries@carersinsouthampton.co.uk

<https://www.carersinsouthampton.co.uk/contact-us>

Carers UK

0808 808 7777

Advice and Support Line

Age UK

0800 678 1602

Advice Line

Alzheimer's Society

0333 150 3456

Dementia Connect Support Line

Equalities Monitoring Information

25 of 31 people who took part in the survey provided information on equalities and diversity information.

Under 18 : 0

18-24: 0

25-44: 0

45-64: 5

65-84: 13

85+: 7

Healthwatch Southampton

Southampton Voluntary
Services

Kingsland Square

Southampton

SO14 1NW

Telephone: 02380 216 018

Email: [healthwatch@
southamptonvs.org.uk](mailto:healthwatch@southamptonvs.org.uk)
