healthwatch Somerset

Supported transfer of care from hospitals:

Evaluating people's experiences to help shape improvements in care

April 2023

Contents

Note: Throughout this report there are embedded links to external websites. Full details of each one is listed under Appendix 4, page 25.

Any enquiries regarding this publication should be sent to us at info@healthwatchsomerset.co.uk

You can download this publication from healthwatchsomerset.co.uk

The Healthwatch Somerset service is run by Evolving Communities CIC, a community interest company limited by guarantee and registered in England and Wales with company number 08464602. We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch Brand) when undertaking work on our statutory activities as covered by the licence agreement

About us

Healthwatch Somerset is the county's health and social care champion.

We're here to listen to your experiences of using local health and care services and to hear about the issues that really matter to you. We are entirely independent and impartial, and anything you share with us is confidential. We can also help you find reliable and trustworthy information and advice to help you to get the care and support you need.

As an independent statutory body, we have the power to make sure that NHS leaders and other decision makers listen to your feedback and use it to improve standards of care. This report is an example of how your views are shared.

Healthwatch Somerset is part of a network of over 150 local Healthwatch across the country. We cover the unitary local authority area of Somerset Council.

Background

We are aware, from public feedback and our work with people and organisations working in health and care, that there is pressure on the delivery of both NHS and adult social care services. This has also been widely reported in the media

Some of these pressures can be seen through long waits for hospital beds. Reasons for these waits include an increase in demand for hospital care and difficulties in discharging people who no longer require hospital care due to a lack of care home beds and/or services to provide care at home and in the community.

Our aim

We wanted to explore the quality of the transfer of care process in Somerset and use the experiences of people who have been discharged from hospital to inform the organisations involved to support change and improve the process

Discharge to assess

Since the Care Act 2014, the requirement to carry out long-term health and care needs assessments before discharge resulted in some individuals experiencing delayed hospital discharge as they waited for their assessment to be carried out. This meant the appropriate transfer of care could not take place when a person was ready to leave a hospital.

Delayed discharges can result in poorer outcomes for individuals, such as loss of independence, or functional decline such as muscle deterioration in people who are older or have dementia; additional expense to the NHS as people occupy beds without a clinical need; and more complex or higher levels of care on discharge due to the loss of function described above.

Discharging people as soon as they are clinically ready is increasingly recognised as the most effective way to support better outcomes. It reduces time in a hospital bed and supports people to remain independent at home wherever possible. This model is known in England as 'discharge to assess'. Individuals recover in an environment that is familiar to them, while they receive care and reablement support in the community. Individuals are then assessed for their long-term health and care needs at a point of optimum recovery, allowing a more accurate evaluation of their needs

[Source: GOV.UK – Health and Care Bill: Discharge, March 2022]

Transfer of care pathways

There are four pathways through which people can be transferred from hospital to be cared for either in their own home or in a residential or community care setting.

Pathway 0 (Likely to be minimum of 50% of people discharged) A simple discharge home with no new or additional support required to get the person home..
Pathway 1 (Likely to be minimum of 45% of people discharged) People are able to return home with new, additional, or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow Home First principles, allowing people to recover, rehabilitate, or die in their own home.
Pathway 2 (Likely to be maximum of 4% of people discharged) Aimed at recovery, rehabilitation, assessment, care planning, or short-term intensive support in a 24-hour bed-based setting, before returning home.
Pathway 3 (For people who require bed-based 24-hour care) People discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting. Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

We know that the standard of the Discharge to Assess (D2A) process varies throughout the country. This is shown in reports such as:

- 590 people's stories of leaving hospital during COVID-19 [Healthwatch England, Oct 2020]
- Carers' experiences of hospital discharge [Carers UK, Sept 2021]
- Leaving hospital [Healthwatch Leeds, May 2022]

Musgrove Park Hospital

© Roger Cornfoot (geograph/2613054)

Considerations

In May 2022, Musgrove Park Hospital in Taunton opened a new discharge lounge to free up beds for new patients and to make it easier for patients who no longer need hospital care to return to their home. This change will affect people's experiences of the transfer to care process at that hospital going forward.

Somerset NHS Foundation Trust which manages our hospitals have also introduced Ready to Go Units. These dedicated units, which launched in December 2022, focus on rehabilitation to help patients to get the best care for them, according to their needs, and reduce the risk of deconditioning which is when someone's mental and physical health can decline from extended periods of bed rest, while they wait to leave hospital.

You can read more about the changes that have been introduced under the Stakeholder responses on page 13.

On 1 April 2023, Somerset Foundation Trust merged with Yeovil District Hospital to become Somerset NHS Foundation Trust. On the same day Somerset County Council became a Unitary Authority and the District Councils were disbanded. As a result, both of their websites have been updated.

What we did

Analysing public feedback

We analysed the public feedback we have recorded on our database since August 2021, and we reviewed the Somerset findings from the NHS Adult Inpatient Survey 2021, to identify common themes and issues.

Gathering people's stories

We wanted to focus on individual stories to better understand the quality of the transfer of care process, and to highlight what works well and what doesn't, and how this affects people's experience, health, and wellbeing.

We contacted several organisations providing services as part of the transfer of care process and asked for their support with the project by identifying specific case study opportunities. These organisations included the British Red Cross Somerset and the Community Council for Somerset (CCS) who are voluntary, charitable, faith and social enterprise (VCFSE) partners in Somerset Council's Home First scheme. We also used our social media channels and networks to invite people to get in touch to share their story.

We collected five case studies from people who had been discharged and transferred from Musgrove Park Hospital.

Talking to people in care homes

We have statutory powers to Enter and View publicly funded health and care premises to observe the quality of care and to speak to people about their experience of using the service.

During this project, in December 2022, we visited two care homes in Glastonbury and Taunton as part of our Enter and View work. Our authorised representatives asked people about their experience of being discharged from hospital. A summary of their responses can be found in Appendix 2 (page 18).

Key messages

We analysed all the feedback we gathered, alongside the NHS Adult Inpatient Survey 2021 findings for Somerset, and identified the following key messages.

- There is a lack of communication and information from hospital staff to patients and their family or carers about the transfer of care process and the support available to them.
- There are also gaps in communication from hospital staff regarding diagnosis and treatment.
- Patients, families, and carers are often notified of their discharge from hospital on the same day, sometimes with only a few hours for them and their family or friends to prepare.
- Transporting patients home can be problematic due to a lack of community transport or support moving patients to and from personal transport.
- Some patients felt they had been discharged from hospital too early.
- Some patients did not feel listened to by hospital staff.
- There is confusion surrounding the need for, and provision of, essential clinical items such as dressings, and also community equipment required during recovery.
- There is a lack of continuity of care between the health and social care services.

What we found

Public feedback

General feedback we received from the public about D2A, since August 2021, indicates:

- There is a lack of communication from both hospitals and social services.
- Discharge can happen very quickly/abruptly without adequate notification to family/carers which in at least one case left the person discharged from A&E waiting outside the hospital for an hour to be picked up by their family/carer.
- The current model causes concern to patients and family/carers especially in cases of dementia.
- Special assessments required by occupational therapists or mental health nurses are not always carried out in a timely manner.

Talking to people in care homes

All the people we spoke to in care homes understood why they were resident in the care home. The majority knew when they would be returning home and why there may be delays; for example, awaiting adaptations in their home or sourcing a care package. Their families and carers had been kept well informed. Overwhelmingly people told us they wanted to get back to their own home.

NHS Adult Inpatient Survey

The most recent available results of the NHS Adult Inpatient Survey 2021 indicate that our Trust is on par with similar Trusts in their support for patients leaving hospital in Somerset, but there are improvements to be made. (This annual survey looks at the experiences of adults that have been an inpatient at an NHS hospital, and topics are calculated by comparing the Trust's results to the average of all Trusts.)

Personal stories

All five of the stories we gathered were about transfers of care from Musgrove Park Hospital (MPH) in Taunton. We recognise that they are not representative of everybody's experience, but they do highlight some of the key issues that were identified through this project.

Two of the five did not qualify as D2A but they did contain experiences about different transfers of care. Three of the people we spoke to went through the D2A process, one of these people was readmitted to hospital so went through the process twice.

One participant told us about an experience of pathway two discharge, the other experiences we recorded were about pathway zero discharges. Only one of these cases did not experience a delay to their transfer of care.

Three of the D2A cases were over the age of 75, one was aged between 65–75 years, one was aged between 50–64 years.

Health services

None of the participants were given a Hospital Discharge leaflet (see example shown right).


HM Government

NHS

You are leaving hospital: returning home

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to return home to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

Everyone we spoke to said they thought there were some things the health services could have done differently.

Social care services

Both participants discharged on a pathway zero would have benefitted from some community equipment. One participant was told they would have to provide it themselves, one received some through the District Nurse Team.

Case studies (all names have been changed)

Barbara's story

Discharged on pathway 0* from Montacute Ward

[*Pathway 0 is a simple discharge to go home with no new or additional support required]

Barbara underwent surgery at MPH. After the operation she experienced a violent reaction to one of the medications that she received intravenously. Barbara had tried to explain the problem but there were some communication issues which Barbara felt were due to language differences. Barbara felt so ill she refused all medication after this because when she tried to explain the problem to the nurses, they treated her as if she was being difficult.

Barbara is a carer for her husband and was promised a pre-discharge meeting; unfortunately this didn't happen. The hospital did not offer any provision of support for her recovery at home. She was not given any information about how she may access support for her recovery or her caring role for her husband.

Barbara was only notified of her discharge a couple of hours before it took place. She lives over an hour's drive away from MPH and relied on a family member to collect her.

> **I feel as though I was discharged early because they needed my bed. I told the hospital about my problems, but it feels as though they didn't want to listen because it meant they would have to do something about it.**

At the time of her discharge the open wound from Barbara's surgery was infected and still required special dressings; she also required bowel incontinence products due to the nature of her surgery. Barbara was not provided with extra dressings when she left MPH and had to insist they give her enough bowel incontinence products for the long journey home. Her husband went to several chemists to try to obtain more dressings but was informed that they do not stock them.

Barbara's husband contacted her GP about where to get more dressings and the GP was able to refer Barbara to the district nurse. The district nurse was concerned that Barbara had been sent home from MPH with an open and infected wound. Consequently, the nurse initially visited Barbara everyday to change dressings.

> **The district nurses were angels.**

Barbara was not offered any social care support when she was discharged from MPH but did find out about the CCS Village Agents and CCS Somerset Carers through other support she received through caring for her husband. Barbara also tried to book some physiotherapy to assist her recovery, but unfortunately there was such a long waiting list she was unable to access this service.

Richard's story

His wife was discharged on pathway 2* from Montacute Ward

[*Pathway 2 is aimed at recovery, rehabilitation, assessment, care planning, or short-term intensive support in a 24-hour bed-based setting, before returning home]

Mary, Richard's wife, had dementia and was initially admitted to the Intensive Care Unit as she was very ill; she was then moved to the Montacute Ward. It was decided it would be best for Mary to finish her rehabilitation in a residential care setting when she was deemed well enough to be discharged. There was a delay to Mary's discharge as they had to wait for a space to become available at a suitable residential home which could meet Mary's needs.

Richard was given three days' notice before Mary was transferred to Lavender Court Care home, Taunton. On the day of the transfer, Mary was taken from the Montacute Ward to the new MPH discharge lounge. Richard and Mary waited there for most of the day before being taken by community ambulance to Lavender Court. Hospital staff did not communicate any information about Mary's condition with Richard before she was discharged but they did notify Lavender Court that Mary should be fed soft foods.

After over a month rehabilitating in Lavender Court, Mary started to vomit and could not eat anything, so she was taken to MPH and admitted to the Acute Medical Unit overnight. Mary was then returned to Lavender Court by ambulance, but Richard was not informed of this and only found out when he travelled to MPH to visit her. Richard did not receive any information about what treatment, if any, Mary received while in MPH and there were no discharge notes on her return to the care home.

Mary remained at Lavender Court for several more months and was receiving physiotherapy and starting to walk; the staff there were talking about the possibility of her returning home with Richard. Unfortunately, Mary then started vomiting again and returned to MPH where sadly she unexpectedly passed away soon after.

Sarah's story

Two separate pathway 0 discharges from MPH

Discharge one: Acute Medical Unit

Sarah was admitted to MPH Acute Medical Unit for a couple of days due to a crisis with a previously diagnosed chronic long-term condition (Addison's disease). Sarah's discharge was delayed due to her concerns about the cancellation of her regular medications that manage her long-term condition.

She was told she was being discharged the same day it occurred and was only given about half a day's notice. Sarah was offered transport, but this would involve a substantial wait. She was keen to return home, so she decided to walk to the train station.

During her walk to the railway station Sarah passed out. She does not remember the fall. Fortunately a nurse was also walking to the station and witnessed what happened. Sarah landed on her face and suffered cuts and severe bruising; she also broke her arm in three places and was readmitted to MPH.

Sarah felt that she was discharged too early from hospital. MPH admitted that her blood pressure was not properly monitored prior to her discharge.

Discharge two: Blake Ward

Sarah was readmitted to MPH to investigate the cause of her temporary loss of consciousness on her way to the railway station. She spent six weeks in hospital and was given a heart monitor which she has to wear for two years.

While in hospital a CCS Village Agent was working with Sarah to arrange a grant for her to have her faulty boiler replaced. Sadly, after a few weeks nothing had been accomplished. Sarah had tried to contact the village agent but was unable to speak to them as they were on holiday.

When MPH decided she should be discharged from the Blake Ward Sarah did not feel well enough to go home and would have been unable to get inside her house as the village agent had her front door key. On this occasion the staff at MPH listened to her and accepted that she should be monitored a little longer before going home.

> **I felt the discharge facilitator was brutal and wanted me to go into a care home.**

When it was agreed that Sarah was being discharged she was given 48 hours' notice; the doctor told her that she would need a care package at home. The Blake Ward arranged for patient transport volunteer to take her home and gave her a small food package to take with her. Sarah felt that the ward staff went 'above and beyond' on the day of her discharge.

An Occupational Therapist (OT) came to assess Sarah prior to her discharge; the OT only spoke to her to tell her what she could do. The OT removed the care package as they believed that Sarah did not need it and could look after herself. The OT didn't listen to Sarah when she tried to explain what she couldn't do and instead wanted to hear this from a nurse. There was a nurse standing close by who had listened to the conversation; the nurse confirmed everything Sarah has said was correct. Sarah didn't feel listened to by the OT.

Occupational Therapists work with people of all ages and can look at all aspects of daily life in your home, school, or workplace. They look at activities you find difficult and see if there's another way you can do them.

[Source: NHS – Occupational therapy]

Sarah found that when she was at home, performing daily tasks with one hand was difficult and she would have benefitted from a care package even if it was just for a week. As her boiler was not working, she had to carry a kettle of hot water upstairs to wash, and there was no heating in the house. Although Sarah had been given some exercises to do, she believed that physiotherapy would have also been valuable.

When Sarah returned to MPH for a follow up check she received conflicting instructions – the Orthopaedic Consultant told her to wear the brace on her arm all of the time however, the Orthopaedic Nurse had previously told her to remove it.

David's story

British Red Cross and the vital support provided by voluntary and community services

David had been in hospital with a left leg femur fracture and was being discharged from Yeovil District Hospital to his home address.

In preparation for his discharge, a bed had been set up downstairs so that David could use it once home and the Discharge Team were now looking for transport assistance and community support. During the referral process, it was mentioned that David may need support in identifying a Micro-Provider for a cleaner.

The British Red Cross support worker collected David from Yeovil District Hospital within two hours of the referral. While in the discharge lounge the support worker completed a Service Risk Assessment to ensure that David met the service criteria and was safe to be transported and supported by the service.

The support worker took time to introduce themselves to put David at ease as he was feeling anxious about returning home. He felt that the final part of his discharge journey was being rushed as he had only been told he was going home that morning. The support Worker used a wheelchair to assist David to the service vehicle and transported him home. During the journey home, the support worker discussed with David his situation to check if all areas of assistance had been identified at the point of referral, as often extra areas are identified that were not picked up in the hospital. At the home, the support worker helped to settle David and discussed a shopping list which was later completed, unpacked, and put away.

While in David's house, the support worker also undertook a Home and Property Assessment, with consent, and it was identified there were no fire alarms or a community pendant alarm in place. The Micro-Provider identified during the referral support was required to help with cleaning for two hours on a Monday, but while undertaking the assessment at home it was clear David wasn't restricted to a Monday and required future assistance with shopping. Financial support was also discussed, and the Attendance Allowance form was requested via the Department for Work and Pensions on behalf of David to potentially assist with future finances.

A support plan was made using this information identified, and a safe and well follow-up call was agreed for the next working day.

During the follow up call, David confirmed he would like to proceed with looking for a Micro-Provider, receive future shopping support and have a Piper Alarm and a key safe fitted. Once all was completed, the support worker ensured all was in place and David was aware that the British Red Cross would be ending their support.

> **The British Red Cross has been brilliant, nothing but thanks and I can't fault your service at all.**

Recommendations

1. Efforts should be made to address the breakdowns in communication between all staff involved in a patients care and discharge, this includes:
   - Communications between all healthcare professionals in the acute setting involved in a patient's assessment, treatment, and decisions to transfer care.
   - Communications between healthcare and social care professionals including those who sit outside of the traditional social care services such as the Community Council for Somerset.
2. Communications from health and social care professionals to patients and their family/carers requires improvement. This includes:
   - Timely updates and explanations about treatments, prognosis, and transfers of care for patients and their family/carers.
   - Improved communication skills, such as active listening and empathy, when addressing patients and their family/carers.
   - The provision of some printed material around the transfer process and support that patients and family/carers can refer back to. It is important that support information includes telephone numbers so that people who are not connected to/confident with digital services can still access support.
3. Consideration should be given to the suitable transportation of patients due to be discharged. It is clear that some people still require additional support for such a journey even when they are seen to be 'medically fit' to be transferred. It should also be clear who will be responsible for the cost of this transport.
4. The needs assessment process requires improved continuity and the consideration of a wider concern about the suitability of a patient's situation before transferring them home.

Next steps

Since this report was drafted, we are aware that the NHS Foundation Trust and Adult Social Care have been working hard to improve patient experience of being discharged from hospital and to increase capacity within the adult social care sector. This work has included introducing Ready to Go Units, working with the VCFSE sector to provide support to patients and re-launching the Proud to Care campaign which promotes the benefits of working in the care sector.

Our findings will be presented to various organisations who have significant interest in transfers of care, and the report will be published on our website. The data and report from this engagement will also be shared with Healthwatch England.

We will also be following up this report in our workplan next year, when we focus on care in the community/intermediate care.

Stakeholder responses

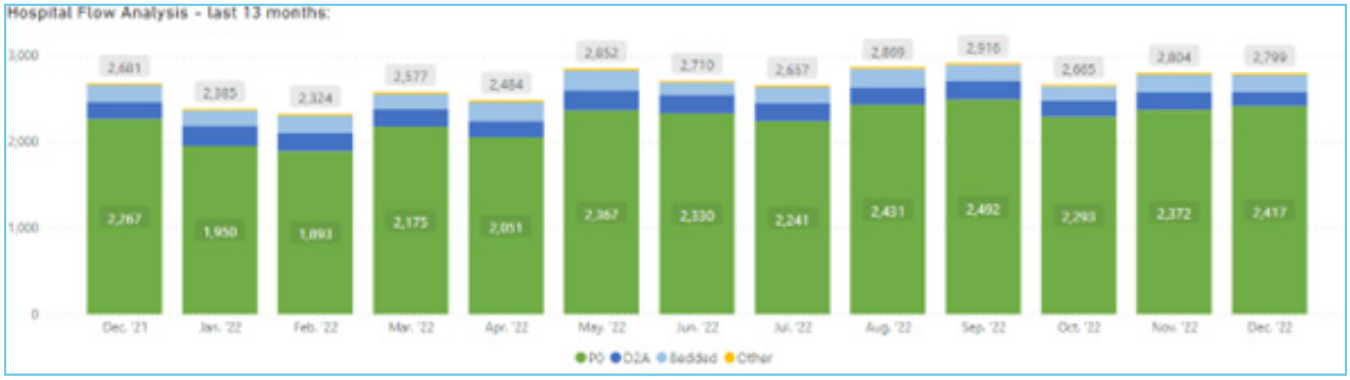
Phil Brice, Director of Corporate Services, Somerset NHS Foundation Trust

Experiences of discharge arrangements in acute and community settings

Discharge activity

By way of context for the five stories highlighted in the Healthwatch report, the data below shows the volumes of discharges per pathway in Somerset from December 2021 to January 2022, covering the period of the Healthwatch report.

Discharges per pathway (over 65years)



Public Feedback (Discharge to Assess)

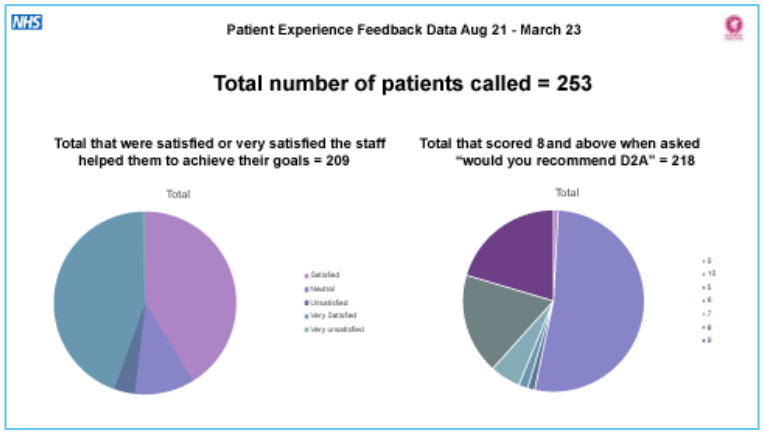
Discharge to Assess supports in excess of 150 people to leave hospital every month. Obtaining feedback from service users is a high priority and helps to shape the ever-evolving service. People using the service are therefore offered a telephone call review after the service has ended to provide verbal feedback on their experiences. The telephone call feedback process enables the service to 'do more' of what works well, as well as learn from negative experiences. Between August 2021 to March 2023, 253 feedback calls have taken place.

There are two themes from the findings in the Healthwatch report that are consistent with the feedback from the 253 telephone calls. These are:

- 'lack of information from hospital staff about discharge' and
- 'not involved in discharge planning'.

The other themes listed in the Healthwatch report have not been raised within the 253 feedback calls. A mental health nurse has been recruited to the Discharge to Assess team, so specialist assessments are accessible to services users.

The feedback calls have yielded largely positive feedback. The range of experience from those calls is shown in the graphs below.



2021 NHS Inpatient Survey

Other sources of patient feedback include the national surveys that are undertaken and published by the Care Quality Commission. The 2021 surveys for the two acute hospitals in Somerset highlighted the following areas for improvement:

Yeovil District Hospital & Musgrove Park Hospital

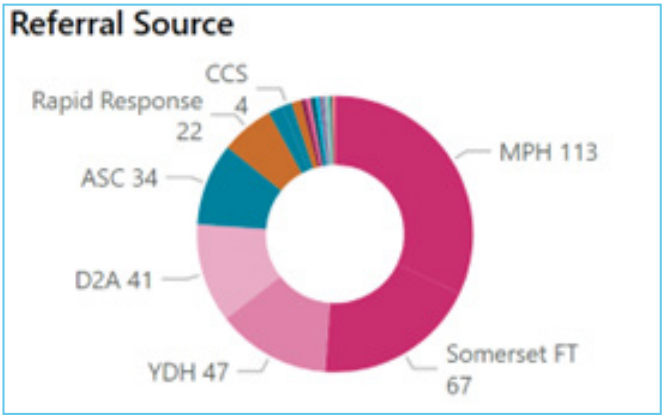
1. People not being given enough health & social care support on discharge

Alongside the pathway 1, pathway 2 and pathway 3 discharges a high number of people are supported to leave hospital in Somerset with the support of VCSE services. VCSE services support people in a different way to statutory services. These services have a unique way of connecting with people at a local level. To strengthen the voice, maximise the awareness and create ease of access to these services, Somerset has created a joined up 'single point of contact' referral route into VCSE services. This approach has been recognised by other systems across the UK who wish to adopt a similar approach.

Over the last six months, Somerset has invested additional funds in VCSE services. This has resulted in VCSE presence on the Yeovil Hospital and Musgrove Park Hospital sites. VCSE colleagues also attend board rounds to promote early discharge planning conversations with patients. Somerset was also successful in securing two winter grants to expand the Red Cross 'take home and settle in' service in 2022/23. The additional investment in VCSE services in Somerset has resulted in more people than ever being supported each month by VCSE services.

We acknowledge the poor experience that is reflected in the personal stories included in the Healthwatch report and it is disappointing to read the examples where people were either not supported, or declined support with VCSE services who can offer support with things like transport, practical support once home, home clearances and improvements, advocacy and companionship. The figures below show that over 300 people are consistently supported by our Somerset VCSE services each month. Musgrove Park Hospital, Yeovil Hospital and our community hospitals are the largest referrers. This illustrates the value the VCSE investment in Somerset is having on discharge planning/transfers of care.

Voluntary, Charitable and Social Enterprise referrals over a 4 week period in January 2023



2. People being given contacts for post hospital support/advise

This is an important theme within the Healthwatch report. It corresponds to the feedback we hear from people using our health and care services. We took an active decision not to continue using the national leaflet referenced in the Healthwatch report, hence why no one will have received this leaflet. Instead, we created pathway specific leaflets, personalised to the type of services we have built in Somerset. These leaflets are available electronically or in paper format (see Appendix 3). However, we know from the D2A telephone call feedback sessions, and the recent pathway 2 Healthwatch report that patients/service users are not consistently issued with Somerset pathway leaflets.

Somerset has an integrated 'Discharge Improvement Group' that meets monthly. This group has set an ambition for pathway leaflets to be issued consistently to support discharge planning. A 'discharge checklist' has been created and recently signed off as an official Trust document to ensure that literature is consistently issued. 'Information packs' are in development phase. These packs will provide patients with resources and advice available for after hospital care/after hospital complications.

Personal stories

Taking into account the experiences described in the Healthwatch report and our own feedback, the initiatives below describe some of the ways in which acute and community services are striving to improve discharge planning experiences for the people of Somerset:

1. **Discharge Facilitator role.** We recently increased this workforce by 25% at Musgrove Park Hospital and have introduced this role to selected pathway 2 units. The capacity of the weekend discharge facilitator role at Musgrove Park Hospital has been doubled. These roles act as the communication link between families/care givers and the hospital ward teams. Their role aims to improve communication and improve the effectiveness of transfers of care (discharge).
2. **Transport.** We recognise that transport home from hospital can be a challenge. To improve this part of discharge planning, access to a late transport crew is available for times of increased demand. Following a successful bid, both Yeovil Hospital and Musgrove Park Hospital were successful in obtaining extra funding for Red Cross transport-home services during autumn/winter 2022/23; helping an additional 22 people per month to return home with transport support, and after hospital care if required. The new discharge lounge at MPH has dedicated parking bays outside the lounge to make the collection of patients easier for families/care givers. People are now requesting for their relative to be sent to the discharge lounge because of the ease of collection!
3. **Discharge Lounge.** In additional to the transport/collection benefits, the discharge lounge provides an opportunity for patients to leave the ward earlier on day of discharge. The discharge lounge has a dedicated team of staff and volunteers who are there to double check actions for discharge have been completed, additional explanation around changes to medication and after hospital care instructions. The infrastructure within the discharge lounge provides a peaceful environment and the flexibility for people to either sit out in a chair or rest in bed ahead of the journey home.
4. **Ready to Go Units.** Strategic plans are underway in Somerset to reduce the delays in transfers of care, particularly for those needing Pathway 1 & 2 services. Whilst those plans are underway, delays are unwanted, but inevitable. To mitigate the risks associated with staying hospital longer than needed, Ready to Go units have been created. With the support of reablement-trained staff and volunteers such as Age Uk, patients are being kept active whilst remaining in hospital. In many examples, care needs have been reduced following a stay on the Ready to Go units.

Edwin Jose, Home Manager at Brunel Care, Glastonbury Care Home

Thank you for the feedback and sharing these responses. We will discuss this with the intermediate care services in our governance calls to action any learning from this.

Mel Smith-Wild, Service Manager, British Red Cross, Somerset

Here at the British Red Cross, we work inside a Single Point of Contact System (SPOC). Our team provide a transport and settling in service and community wrap around support.

In a recent article, NHS Chief Amanda Prichard stated that the current pressures facing the NHS are tougher than during the pandemic. Across the board we are seeing the cost-of-living crisis impact the way we work, while our staff and volunteers in our services deal with a population who have increasingly complex needs.

The VCFSE sector continue to have a vital role to play in supporting discharges, and in creating resilience across the health and care system. Thank you for sharing the findings of this report, we will continue to support the system and drive improvement forward for patient discharge experience.

Mel has shared a case study obtained by the British Red Cross for the purposes of this report to illustrate the value that working with the VCFSE sector can bring to the system, see page 11.

Thank you

We would like to thank Barbara, Richard, Sarah and David for sharing their stories with us and acknowledge their significant contributions to this report. Thanks also to everyone who shared their feedback with us, including those who spoke to us in the care homes we visited. Thank you to our volunteers, and British Red Cross Somerset, for their assistance in identifying suitable case studies.

We would also like to acknowledge the hard work and dedication of health and social care professionals who are currently working under difficult conditions.

Appendices

Appendix 1. Questions used in the case study

Details of the health services you are telling us about

- What is the name of the hospital you/your cared for were admitted to?
- Which ward were you/your cared for discharged from?

Your story about leaving hospital

- Was there a delay to your/your cared for discharge? Yes/No
- If so, please tell us why:
- Were you/your cared for given a HM Government Hospital Discharge leaflet such as the one at the end of this form? Yes/No
- Please tell us about what happened on the day of your discharge from hospital. (For example - how much notice did you have? Were your family/carers/independent living support kept well informed? How did you get home?)
- Do you think there is anything about your discharge from hospital that could have been done differently? Yes/No
- Please expand on your answer:
- Is there anything else you would like to tell us about your discharge from the hospital?

Details of the social care support you are telling us about

- Did you require community equipment to help you during your recovery? Yes/No
- If yes, what was the name of the organisation that provided this?
- Is there anything you would like to tell us about the service/equipment you received from this organisation?
- Did you receive social care support from on organisation? (This could be from adult social services, and/or a voluntary or charitable organisation such as the British Red Cross or Community Council for Somerset Village Agent).Yes/No
- If yes, please tell us which organisation(s) helped you:
- Did the organisation(s) offer you support to further help you with recovery? (For example - provision of a formal care package, information about supporting community groups, or special equipment). Yes/No
- Please tell us more about this:
- Did you receive NHS rehabilitation or Social Services support at home? Yes/No
- Please tell us more about this:
- Do you think there is anything about your care and support at home that could have been done differently? Yes/No
- Please expand on your answer:
- Is there anything else you would like to tell us about the support you received at home?

Appendix 2. Pathway 2 beds - care home residents

Summary of findings from our Enter & View visits at two care homes in Glastonbury and Taunton

Aim

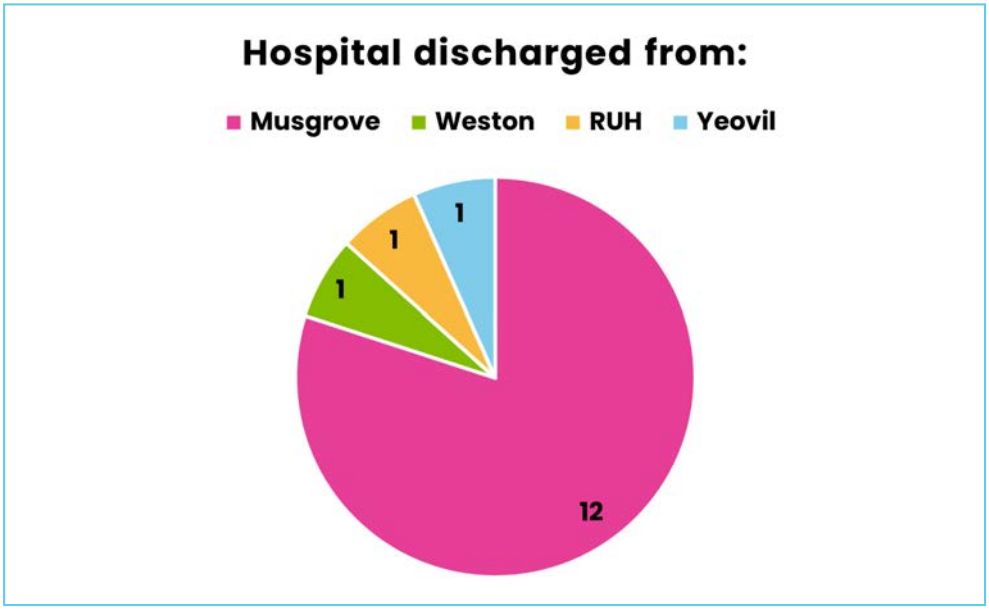
To gather feedback from users of the service who were moving through pathway 2 having been discharged from hospital. To seek their understanding of the pathway purpose and the effectiveness of reablement on their overall health and wellbeing. To explore how they are enabled to gain the confidence and skills to be able to return to and manage at home.

Type of research

Evaluation and engagement through interviews held with residents and where possible family members/carers of the resident. Visits were carried out by Enter and View trained volunteers overseen by a Healthwatch staff member. Residents were informed about the independence of Healthwatch and how they remain anonymous in any reports that are produced. Healthwatch calling cards were left with residents so they or their families could get in touch with us.

Findings – hospital discharge process

All the people we spoke to had been discharged from hospital into the care home. They had spent from between two and six weeks in hospital. One gentleman told us: "I've been in and out of hospital since June because of several falls and an operation."



Some people experienced delays in being discharged from hospital; due to waiting for transport (two people) and waiting for a care home place at Glastonbury instead of Yeovil (one person).

On the whole people and their families had been kept informed about the discharge process and when they would be discharged.

"Yes I was told on the Friday and moved on Monday."

"Yes – I knew what was happening and didn't have a long wait."

"Yes, but my son was not. I was told a couple of days before discharge."

"I was told the date, with no warning and was out the same day."

We asked people how they felt at the point of leaving hospital and whether they felt prepared

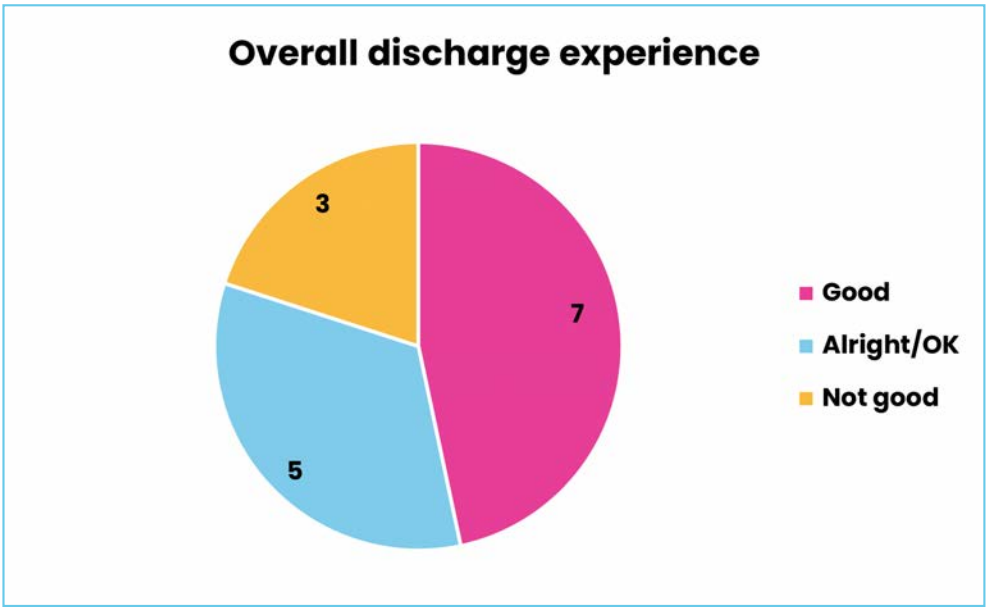
"Surprised. I didn't know what was happening."

"I had my doubts about being ready to leave but I've got more confidence now I'm here."

"I was ok once I'd satisfied myself about the facilities at the home."

"I felt I needed more physio before I left the hospital."
"I did not feel prepared – it was all a rush."

We asked people to describe the overall discharge experience



Findings – care home experience

All the people we spoke to understood why they were resident in the care home. The majority knew when they would be returning home and why there may be delays; for example awaiting adaptations in their home or sourcing a care package. Their families and carers had been kept well informed.

We asked people to describe their experience of being in the care home and how this was different to hospital

"Very different to hospital. I get on well with the staff, who are excellent, supportive and easy to talk to. I am able to get out and about and make my own tea and snacks."
"Yes it is outstanding here, I'm very well looked after."
"Fine – it is much better than hospital."
"It's lovely in here. The physio looked after me and I've settled into my own regime of what I do."
"I enjoy it here, it's different from both my own home and the hospital."
"It feels different to being in hospital."

What matters most to people

Overwhelmingly people told us they wanted to get back to their own home.
"Returning to my flat and independence".
"Get my health back and go home."
"Being safe, I want peace of mind."

One resident told us they were waiting for care at home to be organised.
"It's important to get the attention I need at home; I'm waiting to get care at home organised."

Two residents told us they were awaiting adaptations to their homes before being able to return.
"The stairs at home in my flat are too narrow for me to fit through with my cast on."
"I can't go home until my home is put right for me to be safe there"

Summary of visit to Glastonbury Care Home – 6 December 2022

Four volunteers and one staff member visited the home. The visit was planned and arranged via the home manager.

About the home

- There is a holistic approach to care, which is evident in the actions and conversations of the staff. It is evident that care is person centred.
- There were plenty of staff around including the manager and deputy. We observed good interaction with the residents.
- Residents have their own ensuite room. They are encouraged to walk about and get outside if appropriate.
- There is a resident therapy dog on the unit.
- Activities take place in the lounge organised by 'homemakers'. On the day of our visit residents were making Christmas decorations and helping to decorate the tree.
- A brass band was visiting the home – they first played music outside, which could be seen from residents' windows, before entering the home.

Who we spoke to

- We were able to speak with eight residents. Some have cognitive impairment so we were unable to carry out the interview questions with them.
- We did not speak to any family members or relatives while we were there.
- We spoke to the manager and staff, including a social worker and lead therapist, who gave us a good overview of the home and their ethos.

Summary of visit to Oake Meadows Care Home, Taunton, 14 December 2022

Two volunteers and two staff members visited the home. The visit was planned and arranged via the home manager.

About the home

- The approach to care is person centred with a view to enabling residents to return to their homes.
- Staff are supportive and we observed good interaction with the residents.
- It appears to be a happy, caring environment.
- Residents have their own ensuite room. They are encouraged to walk about and use the lounge and dining room, if appropriate.
- There is open visiting for family members

Who we spoke to

- We were able to speak with eight residents, all of whom were in their rooms.
- We spoke to one family member – the son of a resident.
- We spoke to the home manager, unit manager and staff on the unit.

Appendix 3. NHS information

Leaflet: Discharge and Assess

Helping you get better at home:
Discharge to Assess
For residents of Somerset

NHS

SOMERSET County Council

Why home is best for getting better

Hospital is the best place to be if you are very ill or need surgery, but studies suggest the best place to recover is at home. Staying in hospital too long can result in poorer health and longer recovery times, so as soon as you are well enough, we will discharge you to the best possible place to support your recovery – in most cases, this will be your home.

Helping you get better at home

Discharge to Assess (which you may hear referred to as **D2A**) has been created to help people get home more quickly, offering a range of services including assessment (measuring your health and ability to perform everyday tasks) and rehabilitation (helping you get back to your normal life). This means you can get better in the comfort of your own home with the support of our team of professional therapists and reablement staff.

What to expect

Before leaving hospital, your needs and discharge arrangements will be discussed with you, and your family if you would like them to be involved. Then our **Discharge to Assess** service will work with you in your own home to support your recovery and set important personal goals which will help you regain your independence.

This will involve a key worker, who could be an occupational therapist, physiotherapist, adult social care worker or a rehabilitation assistant (depending on your needs) who will work with you to **set your goals**, as well as experienced reablement staff who will help you to **meet these goals** when they visit. They will also find out if you need any practical support, such as help with your shopping, and can help you get in touch with a team of volunteers.

What you can do

- Speak to staff about how **D2A** works and how it can support you
- Think about your goals for your recovery at home
- Include friends and relatives in the conversation – can they offer support to you once you are at home?
- Participate in the recommended therapy
- Let us know when you no longer need support

Are there costs involved?

This service is free of charge. If you need further support, you may be asked to contribute financially – this would be discussed at your review.

Who can I talk to and find out more?

You can talk to ward staff to find out more about **D2A** and what options are available to you – in fact, we will start talking to you about your arrangements for discharge as soon as possible.

Jane's story:

Below is one patient's experience of how **D2A** has helped her with getting home and finding the confidence needed to live independently again.

Jane (name changed) lives in a bungalow in Somerset with her husband and son, and came into hospital after a fall. Although she already had problems with mobility, she was keen to go home as soon as possible, and was given the opportunity to get better at home with the Discharge to Assess service.

Her fall meant she would need some extra care and support to manage everyday tasks at home, so the Discharge to Assess team worked with Jane and her family to decide what things Jane could do on her own, and what things she would need extra help with. Jane's family agreed they could assist her with getting in and out of bed, and getting meals and drinks. Health and social care professionals arranged to help Jane with some of the things she found difficult on her own, such as going to the toilet, washing and getting dressed, and moving around the house. They gave Jane some exercises to help her regain her mobility, and the equipment helped her get around more comfortably while she got better. Each day she was able to practice carrying out tasks with the support of the Reablement team.

Jane recovered much faster than expected, and within just a few days, her mobility returned and she was able to wash and dress herself and go to the toilet on her own. Just five days after coming home from hospital, Jane was successfully discharged from the service, and no longer needed any help from health and social care staff.

Why you recover faster at home

When you are really sick or injured, hospital is where you need to be, but for recovery there are many reasons why home is best.

Rest

Quality sleep is essential for recovery but getting a good night's sleep in hospital can be difficult, with busy wards, people talking, lights and noises from equipment. Not getting enough sleep can slow down your recovery, so getting back home to your own bed as soon as possible is important.

Fitness, strength, and mobility

Staying in bed for long periods can result in loss of mobility, fitness, and muscle strength; those aged over 80 can lose 10% of their muscle mass after just 10 days in a hospital bed, so it's important to keep moving as much as you can. Home is also a good place to work on your mobility – for example, practising climbing your own stairs or getting in and out of your own bed makes more sense than practising at hospital, where the sizes and floor surfaces are different to yours.

Improved mental and emotional wellbeing

Being in a familiar environment with friends, family and loved ones is good for your mental and emotional wellbeing and feeling more settled and relaxed can help speed your recovery.

Less risk of infection

Being unwell can affect your immune system, giving you reduced resistance to bacterial or fungal infections. Being at home reduces the risk of infection, as you will have fewer people around you than when in a busy hospital environment.

But... if you can't go home

If you need more complex care, we will look at other ways to support you. This could include getting better somewhere else – such as in another bed in the community, where professional staff will support your recovery and rehabilitation.

SOMERSET County Council

NHS

Flyer: Patient reablement

What you can do

- Think about your goals for your recovery and discuss them with staff
- Include friends and relatives in the conversation
- Participate in the recommended therapy and help with your support plan

What is the aim of this service?

This service has been created to support you to get home as soon as you are well enough to be discharged from hospital.

... if you can't go home

Most of the time, people can return home, but if you need more complex care, health and social care staff will work with you to identify other ways to support you.

Does this service cost anything?

Only the reablement part of the service is free. Once the team have agreed that you have reached your expected potential and will no longer benefit from reablement you may be required to pay for your care and support needs following a financial assessment.

Who is this service for?

It doesn't matter how old you are, as long as you are registered with a Somerset GP, you can access this service. This service is for anyone who needs:

- Extra assessment (measuring your health and ability to perform everyday tasks)
- Rehabilitation (support to help you get back to your normal life) with an aim of getting back home)

Who can I talk to and find out more?

You can talk to ward staff to find out more about Reablement Units and what options are available to you – in fact, we will start talking to you about your arrangements for discharge as soon as possible.

NHS

Helping you recover

SOMERSET County Council

Improving Lives

Why might I need to go to a Reablement Unit?

A Hospital is the best place to be if you are very ill or need surgery, but studies suggest the best place to recover is at home. Staying in hospital too long can result in poorer health and longer recovery times, so as soon as you are well enough, we will discharge you to the best possible place to support your recovery – in most cases, this will be directly back to your home.

What is a Reablement Unit?

A Reablement Unit is where people go if they can't be supported directly home from hospital. It's somewhere that health and social care staff can assess your needs in more depth to find out what kind of care and support needs you have, either long or short term. We have a number of Reablement Units in Somerset, where health and care staff can spend more time with you to find out what your short and long-term goals for recovery are. They will work with you on a plan which will aim to help you get well enough to return to your own home or to a suitable place that can best meet your needs.

Why am I not being assessed in hospital?

Acute hospital wards are for emergency short-term treatment (if you are very unwell or need emergency treatment), but they are not suitable for assessment, which takes longer. It is important that hospital beds are free for people who need them.

Rest

Quality sleep is essential for recovery but getting a good night's sleep in an hospital ward can be difficult, with busy wards, people talking, lights and noises from equipment. Not getting enough sleep can slow down your recovery, so if you need further assessment, we will move you to a Reablement unit where you will be more comfortable.

Less risk of infection:

Being unwell can affect your immune system, giving you reduced resistance to bacterial or fungal infections. Going to a Reablement Unit reduces the risk of infection, as you will have fewer people around you than when in a busy acute hospital environment.

What to expect

- Before leaving hospital, your needs and discharge arrangements will be discussed with you to help us plan your discharge from hospital, and also your family if you would like them to be involved.
- Staff at the hospital will work with you and the people who support you to help decide when you're well enough to leave the acute ward - if you need more assessment and recovery time to help you manage, we will talk to you about going to a Reablement Unit if you are not able to go straight home from hospital.
- The ward will talk to you about any belongings that you may need to take with you. They will help you make arrangements and answer any questions that you may have.
- When you arrive at the Reablement Unit, health and social care staff will be able to find out what help you need long term or short-term, with the aim of helping you return home. They will work with you to support your recovery and set important personal goals which will help you regain your independence.
- During the Covid pandemic we will need you to isolate for a period of time but we will continue to support your Reablement plan with the help of our professional team.
- If there is a delay in moving on from the reablement unit, irrespective of whether you are now contributing to the cost of care and support needs following a period of reablement, you may be required to transfer to a different location whilst you wait for your long term care to be available.

Poster: Single point of contact

Need to make a referral?

CCS people · place · enterprise

Working with British Red Cross

NHS

Somerset's Community SPOC can help.

Phone: 01749 836700
Visit: bit.ly/ComSPOC

An Intermediate Care Service – working alongside Acute Hospitals, Rapid Response, D2A and Bedded Care

Somerset's **Community Single Point of Contact (SPOC)** is a referral pathway coordinated by **British Red Cross** and the **Community Agent service.** The service links people with a range of support options provided by voluntary and community sector organisations. The service supports transport, shopping, care navigation, home checks and practical solutions to help people manage to live safe and well at home.

Phone to find out more.

Do you need to refer someone?

Just phone **01749 836700** or visit **bit.ly/ComSPOC**

Phone lines are monitored Monday to Friday, between 9am and 4pm. For a same day response or for urgent requests or transport referrals that need a two hour response, please phone before 4pm. Online referrals can be submitted 24 hours a day, seven days a week.

Please note that referrals received after 4pm may not be picked up until the next working day.

To find out more

Watch the video: https://bit.ly/3ceBd85

01749 836700

www.bit.ly/ComSPOC

Improving Lives

SOMERSET County Council

Appendix 4. Reference: embedded links

Page 4	GOV.UK – Health and Care Bill: Discharge, March 2022	https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-discharge
	four pathways	https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#annex-c-pathways-for-the-discharge-to-assess-model
	590 people's stories of leaving hospital during COVID-19	https://www.healthwatch.co.uk/report/2020-10-27/590-peoples-stories-leaving-hospital-during-covid-19
	Carers' experiences of hospital discharge	https://www.carersuk.org/media/gmrk1hec/carers-experiences-of-hospital-discharge-report-2021.pdf
	Leaving hospital	https://healthwatchleeds.co.uk/reports-recommendations/2022/leaving-hospital/
Page 5	Home First scheme	https://somersetcommunityconnect.org.uk/wp-content/uploads/2021/04/Home-First-Guide.pdf
Page 7	NHS Adult Inpatient Survey 2021	https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey
	Hospital Discharge leaflet	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1071925/leaving-hospital-returning-home-leaflet.pdf
Page 10	NHS – Occupational therapy	https://www.nhs.uk/conditions/occupational-therapy/

healthwatch Somerset

Healthwatch Somerset
Woodlands House
Woodlands Business Park
Bristol Road, Bridgwater
TA6 4FJ

healthwatchsomerset.co.uk

0800 999 1286

1nfo@healthwatchsomerset.co.uk