healthwatch

Working with

British Red Cross

590 people's stories of leaving hospital during COVID-19

October 2020

Contents

Foreword

As the NHS and social care sector battled the initial peak of the coronavirus, a major focus for the media, politicians, and healthcare managers was on the people entering hospital and how to prevent hospitals from being overwhelmed. This report is about the other end of the hospital journey. It focuses on the discharge process between March and August and shines a light on people's experiences of getting home from hospital.

Right at the beginning of the pandemic, new guidance was issued to help hospitals free up 15,000 beds to cope with the demand from COVID-19 cases. It sought to implement a nationwide roll-out of the 'Discharge to Assess' model, where people are helped to leave hospital faster by having their ongoing care needs assessed at home. Our research looks at what worked and what could be improved. Crucially, it also sets out several changes that need to be made now as we enter the busy winter period and the country tackles the growing pressures of a second wave.

A very different world

Leaving hospital during the pandemic has been a very different experience to pre-lockdown. So many things we previously took for granted have changed in some way, from shopping to seeing your GP or family and friends. This can make the transition extra stressful for patients, families and carers. NHS and care staff have also had to deal with the pressure of implementing new systems at speed, and frequently changing guidance, while navigating additional burdens in their day-to-day work, all on top of the challenges to their own health.

However, people have praised hardworking staff for providing high quality care in difficult circumstances and we heard much about good practice. The roll-out of a national approach was welcomed, particularly one that centred around reuniting patients with their loved ones sooner and considering the whole range of people's needs. Staff interviewed for this research also mentioned how it led to streamlined decision-making, improved handovers of care, and better communication between teams involved in discharge.

Exposing gaps

Unfortunately, we also found that the guidance was not implemented consistently. Sometimes basic checks, such as whether people needed transport to get home, were missed. In many cases people reported feeling unprepared to leave hospital and confused about who to contact for further information and advice. Many people who reported having unmet needs in the community never received a follow-up assessment after they left hospital. This led to issues with people not having the medication or equipment they needed to recover properly at home.

There was concern about some patients not being tested for COVID-19 while in hospital, and particularly about test results not being made available before discharge, making the task of safely managing ongoing care in the community more difficult, especially for care homes.

Simple solutions

As we anticipate the next phase of this outbreak, and as guidance is updated, we need to make sure lessons are learnt from the first wave. Healthwatch England and the British Red Cross have seen first-hand the cost of not getting this right – deterioration on leaving hospital, feeling unsafe and avoidable readmissions. From experience we also know that sometimes it's the simplest changes, like some of the recommendations set out in this report, that can make all the difference. They can take pressure off NHS and care staff, reassure family and carers, ensure a much better recovery for patients and promote safety for everyone.

Sir Robert Francis QC, Chair of Healthwatch England

Michael Adamson, Chief Executive of the British Red Cross

Introduction

Over the years Healthwatch and the British Red Cross have regularly heard from patients and healthcare staff that leaving hospital can be a difficult experience.

More than 400 people shared their experiences of hospital discharge with Healthwatch last year through direct feedback to local Healthwatch or through comments shared in response to our national 'Because We All Care' campaign. This encouraged us to take a closer look at people's experiences of leaving hospital during the coronavirus pandemic (COVID-19).

Previously, Healthwatch England's 'Safely Home'[1] report and the British Red Cross 'Home to the Unknown'[2] and 'In and out of hospital'[3] reports found that when the hospital discharge process is not followed properly, people can feel lonely, struggle to cope and feel uncertain about next steps.

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[1] Healthwatch England Safely Home report (2015): *https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings*

[2] British Red Cross, Home to the Unknown (2019): *https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/british-red-cross-home-to-the-unknown-full-report.pdf*

[3] British Red Cross, In and out of hospital (2018): *https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/in-and-out-of-hospital-report.pdf*

Because of the pandemic, the NHS urgently needed to free up capacity in hospitals to cope with a surge in demand from COVID-19 patients. To support this, a new hospital discharge process was introduced nationally, first set out in guidance in March 2020. It focused on getting people out of hospital quickly, to free up 15,000 beds and support the faster movement of patients in and out of hospital.[4]

People leaving hospital who may need out-of-hospital support to recover would now have their ongoing support needs assessed after they were discharged (usually in their own home), rather than in hospital.

The *discharge to assess* model places a new responsibility on acute hospital teams to work closely with community health and social care services to ensure people get the support they need after leaving hospital.

In August, the hospital discharge guidance was updated into a national policy, which confirmed that *discharge to assess* would continue for the foreseeable future and made it mandatory for local systems to embed the new ways of working developed in response to the March guidance.[5]

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[4] Hospital Discharge Government Guidance (March 2020): *https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements*

[5] Hospital Discharge Government Guidance (August 2020): *https://www.gov.uk/government/collections/hospital-discharge-service-guidance*

While this model was already being used in some areas before the pandemic, this approach is now being applied nationally for the first time.

By evaluating the impact of the new approach on patients and staff and assessing to what extent the national policy is being implemented on the ground, we look at the potential benefits of the *discharge to assess* model. We also show how key aspects of the approach can be improved, otherwise risking worse outcomes for people unless these issues are swiftly addressed.

Since a lynchpin of the *discharge to assess* model is close working between community healthcare, social care, voluntary care services and hospital discharge teams, people's experiences of discharge can also tell us how well health and social care services are working together.

The hospital discharge policy

On 19 March 2020, 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 20 March.[6]

Under the new guidance, acute and community hospitals are required to discharge all patients as soon as it is clinically safe to do so. Below we set out key aspects of the guidance issued in March, which was in place throughout

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[6] Hospital Discharge Government Guidance (March 2020): *https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements*

the period of our research. An update to the hospital discharge guidance issued in August maintained the same key principles.

Information on the new arrangements

The guidance states that information explaining the new hospital discharge process should be shared with all patients on admission to hospital.

Discharge

When a patient is ready to be discharged (following discussions with the patients, their family and any professionals involved in their care), patients should be escorted to the hospital discharge lounge within an hour.

Within two hours of arriving in the discharge lounge, discharge coordinators should arrange any voluntary sector support and immediate practical help for those who have no one else to do this, such as food shopping and turning the heating on.

The patient should then be discharged. These time targets have been relaxed in the August update, with the expectation that all patients are discharged on the same day that a decision to discharge is made.

Pathways

Patients should be discharged onto one of four pathways. It is estimated that 50% of patients are to be discharged home from hospital with no or minimal support, 45% of patients with support from community health and social care services (mostly in people's homes), and 5% of patients would be discharged to a care home (people on pathway two and three).

Follow-up visit and assessments after discharge
According to individual need, patients on pathway 0 should receive short-term assisted living support from voluntary care sector organisations. Patients on pathways 1 - 3 should be assessed for a recovery support package after leaving hospital. A lead professional or multidisciplinary team should visit patients at home on the day of or day after discharge to arrange for the support they need.

Discharge services should operate at a minimum seven days a week, from 8am to 8pm.

Choice of care home
For patients whose needs are too great to return to their own home, a suitable rehabilitation bed or care home should be arranged. During the COVID-19 pandemic, patients are not allowed to wait in hospital until their first choice of care home is available. This means that they may be placed in the first available care home, though care coordinators should follow up to ensure that people are able to move as soon as possible to their first choice.

Funding
From 20 March until the end of August, all post-discharge community support was fully funded by the NHS, to ensure the smoothest possible implementation of these

new arrangements and avoid confusion about funding responsibilities.

From 1 September, post-discharge care is only funded by the NHS for six weeks.

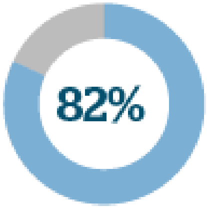
During this time, patients should receive an eligibility assessment for further funding for their care packages, alongside consideration of someone's longer-term care needs.

Testing

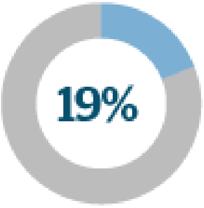
When the hospital discharge guidance was released on 19 March, there was no requirement to test people for COVID-19 before they were discharged, although the guidance suggest that where patients had been tested, COVID-19 test results were to be included in documentation that accompanied the person on discharge.

From 15 April, it has been a requirement to test anyone being discharged to a care home. From 18 September, test results must be shared with the care home before discharge, unless otherwise agreed.

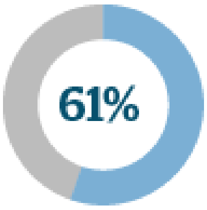
Key findings



didn't receive a follow up visit or assessment.



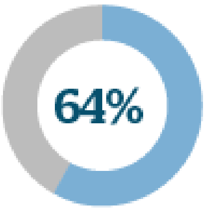
felt they were not ready to leave hospital.



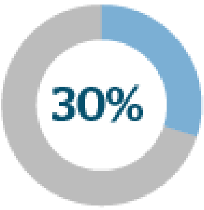
didn't receive information about the new discharge process during their hospital stay.

Almost 600

patients, carers and staff shared their views about hospital discharge during the pandemic.



of people discharged at night weren't asked if they needed transport support.



of people who were tested for COVID-19 didn't receive their test results before they left hospital.

We have heard from almost 600 patients, carers and staff about their experience of hospital discharge during the coronavirus pandemic.

Previous research has outlined the potential benefits of a *discharge to assess* model in getting people out of hospital more quickly, reducing delayed transfers of care and ensuring people have the right support to recover at home.[7] This matches what patients have told us makes a good discharge experience and staff we spoke to also reflected that the principles underpinning the *discharge to assess* model were beneficial.

Our research identified the following positive aspects of the new discharge process for staff and patients:

- **National approach:** National policy and dedicated funding for hospital discharge reduced bureaucracy by quickly setting up more efficient ways of working between health and social care services and standardising their handover processes.

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[7] Local Government Association, Why not home, why not today? Putting a stop to DTOC (2017): https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/efficiency-and-sustainability-adult and; NHS England, Quick Guide: Discharge to assess: https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf

- **Joined up working**: The new approach encouraged collaboration and better information-sharing between health and social care services.

- **Clear information about changes to the discharge process**: We found that patients who were provided with information explaining the new discharge process found it clear and easy to understand.

- **Choice over place of discharge**: Most of our respondents (60%) discussed where they were to be discharged to and were moved to their preferred location. Although it is to be noted that 28% did not have these conversations about their placement and preferred location.

- **Praise for hospital staff**: The public valued hospital staff for their caring attitudes, clear explanations and treatment during an extremely challenging period for both the public and healthcare professionals.

We also welcome that the updated policy released in August clarified and developed several aspects of the initial guidance and acted on feedback from the sector to relax the two-hour discharge timeframe.

However, this model relies on people's recovery needs being assessed and addressed in the community, which people have told us does not always happen.

- **Follow-up visits and assessments**: The *discharge to assess* model rests on the principle that people should have their recovery and longer-term support needs assessed in the community at a follow-up visit. However, we found that

82% of respondents did not receive these visits, and nearly one in five of these (18%) reported having unmet needs.

- **Follow-up contact**: More than one in three (35%) respondents did not receive contact details of a health professional they could get in touch with if they required further support or advice after leaving hospital, despite the national policy stating this should happen. As a result, people felt unsure about how to manage their condition at home.
- **Being prepared for discharge**: Some patients felt that their discharge from hospital was rushed; approximately one in five (19%) people felt they were not prepared to leave. Paid carers reported issues that affected their ability to prepare for their client's arrival after being discharged, with some patients being discharged too early and, sometimes, readmitted to hospital.
- **Communication**: Almost two thirds of the respondents (61%) did not receive information about the new discharge process. Owing to restrictions on hospital visits, there was also an increased need for families to have clear lines of communication with hospital staff and patients. However, family members encountered difficulties being kept up to date. Similarly, community service staff experienced issues communicating with hospitals about patient updates, time of discharge and COVID-19 test results.
- **Discharges at night (after 8pm)**: Nearly one in ten (8%) survey respondents were discharged at night with approximately two thirds (64%) of those not being asked if

they needed transport support. Patients experienced issues with communication about delays at night and social care staff reported little or no support for patients in the community.

- **Covid-19 testing**: 30% of those who were tested for COVID-19 while in hospital did not receive their test results before they left. Not receiving test results before discharge into the community was raised as a barrier to ensuring people were able to manage their care safely after discharge and avoid putting family and carers at risk. Staff highlighted that not receiving test results was particularly problematic for care homes, given the increased risk of widespread transmission among residents and staff.

The findings set out above have also led us to question the assumptions implicit in the policy about who should receive follow-up assessments and support.

The current policy uses a single national model to set the proportion of patients who should be discharged on each of the four discharge pathways. This could discourage local systems from independently assessing the support needs within their own population, which will vary significantly. Current guidance also caused confusion about the types of support that should be made available on each of the four pathways.

Finally, we would challenge whether pathway assumptions developed before the pandemic could or should be applied in a health emergency when people may not be able to access informal support networks that they would in normal circumstances. These assumptions were also grounded in a model that focuses on discharging older people from hospital. However, as the demographic profile of patients discharged from hospital during the pandemic is different, so might be their needs.

Ultimately, this has resulted in some people with support needs falling through the cracks of health and care services and receiving no follow-up care.

What we did

Using existing data sources, including local Healthwatch and British Red Cross reports, feedback shared with local Healthwatch and British Red Cross Independent Living services, insights from the Because We All Care campaign, and publications from external organisations, we conducted an in-depth scoping exercise to gather information about people's experiences of being discharged from hospital. The emerging themes were then used to develop the survey and interview guides for this project.

From 21 July - 26 August we ran a national survey to collect the experiences of patients and carers who were discharged from hospital between March and August 2020. We limited respondents to those discharged within this time so we could focus on what the process was like during the pandemic, coinciding with new guidance issued in March.

The survey was promoted through local Healthwatch and British Red Cross networks and by external stakeholders. The survey was developed using feedback from seven local Healthwatch and eight external organisations.[8]

Alongside this, eight local Healthwatch conducted semi-structured interviews with a range of staff who delivered discharge services throughout the pandemic, to get a professional perspective on how the new approach changed how they work. These local Healthwatch were chosen based on four main criteria including:

- A mixture of low, medium and high performing Acute Hospital Trust sites according to NHS England;
- Identifying areas with the greatest health vulnerabilities for COVID-19 according to the Institute of Fiscal Studies review and the British Red Cross Vulnerability Index.[9] Five of eight local Healthwatch were in the highest 20%;
- Whether the British Red Cross delivered discharge support services in those areas; and
- Ensuring geographical spread and an urban/rural mix.

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[8] Local Healthwatch: Nottingham and Nottinghamshire, Cornwall, Brent, Bucks, Wandsworth, County Durham and Harrow; and External organisations: EHRC, NHS England, Carers UK, Department of Health and Social Care, Care England, Patients Association, British Red Cross and NHS Providers.

[9] Institute of Fiscal Studies, The geography of the COVID-19 crisis in England report (2020): *https://www.ifs.org.uk/uploads/The-Geography-of-the-COVID19-crisis-in-England-final.pdf* and; British Red Cross COVID-19 Vulnerability Index: *https://britishredcrosssociety.github.io/covid-19-vulnerability/*

We also heard from 14 paid carers of people with learning disabilities who had been discharged from hospital through interviews conducted by a charity supporting people with learning disabilities.

Results

Who did we speak to?

We spoke to 529 people from 42 Sustainability and Transformation Partnership/Integrated Care System (STP/ICS) footprints in England, who shared their views on being discharged from hospital during the pandemic. 352 of these were patients and 177 identified as unpaid or paid carers.[10] Patients reported being admitted for a range of reasons including:

- Coronavirus
- Heart related issues, e.g. heart attacks
- Stroke
- Broken bones
- Pneumonia
- Appendicitis

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[10] For the purposes of the analysis, we have combined the survey responses from patients and carers as carers answered most questions on behalf of the patient, resulting in survey responses representing the patients' experience. Some questions were specific to a carers perspective and are analysed separately below.

- Childbirth

A comprehensive breakdown of demographics for survey participants can be found in the appendix.

We also conducted in-depth interviews with 47 representatives of services involved in the discharge process, including GPs, care home staff, hospital discharge coordinators, and patient transport providers. Additionally, 14 staff who specifically provide support to patients with learning disabilities were also interviewed.

Among respondents to our survey, there was an even distribution of patients being discharged between March and August, however, this seemed to peak in July, with 28% of respondents being discharged then. Although the launch of our survey may have contributed to this, we can see that the Hospital Episodes Statistics April - July 2020 data suggests there was also an increase in hospital admissions during July 2020 (23%) compared to previous months.[11]

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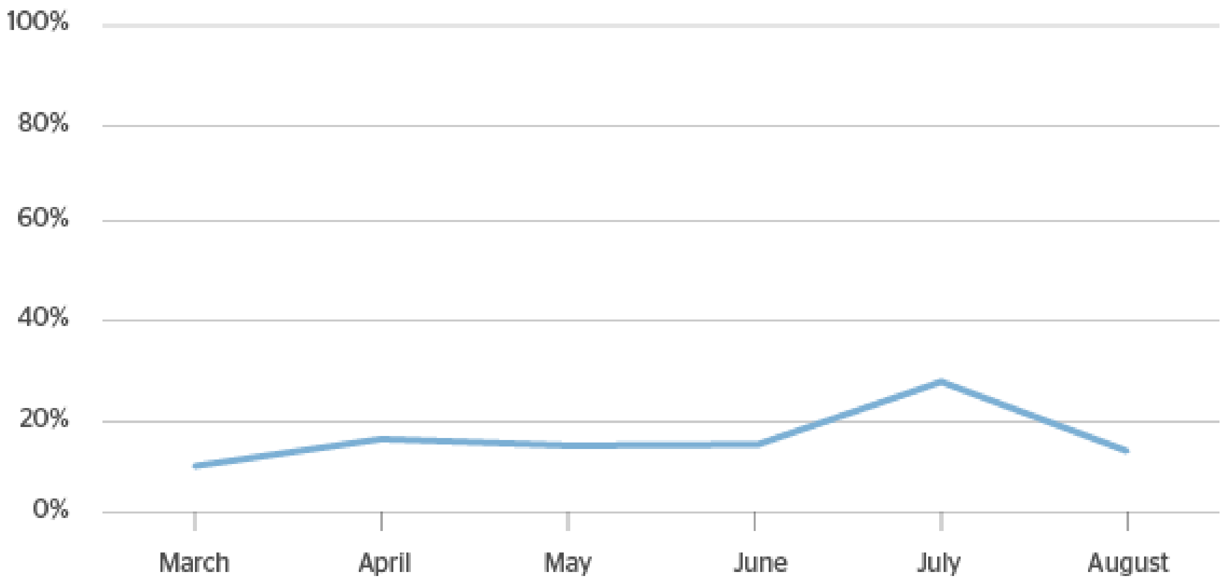
[11] NHS Digital, Hospital Episodes Statistics April - July 2020: *https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data/april-2020---july-2020*


Percentage of respondents leaving hospital per month

Most respondents were discharged during the week (Monday – Thursday), although 37% reported being discharged over the weekend (Friday – Sunday).

People discharged at night experienced difficulties when leaving hospital

While 90% of respondents were discharged during the day (before 8pm), nearly one in ten people (8%) were still discharged at night (after 8pm). Some of those discharged at night told us they experienced issues such as poor communication about delays and difficulties in accessing transport or out of hours community support.

Staff echoed this finding and reported that the expectation that people would be discharged as soon as they were ready meant weekend discharges and discharges at night were difficult to manage, as there was little to no clinical support (e.g. district nurses and GPs) available in the community during these times.

We heard that one patient experienced an eight-hour delay to their discharge and was unable to leave the hospital due to the exits being locked, further prolonging their time in hospital and adding to their distress and frustration.

> “Medication could have been sorted quicker, we need not have had such a long wait until 10pm, which was very late for both of us. And it didn't arrive; so had to leave without it.” – Female, 80+ years

The guidance instructed community health and social care services to operate a discharge service providing follow-up assessments and support at a minimum of 8am - 8pm, seven days a week. Staff reported that when services operated in this way, it made it easier and faster to arrange the right follow-up support for patients.

People are not getting information about new procedures on admission

As stated in the March guidance, every hospital patient should be given information when they are admitted about the changes to the discharge process due to COVID-19. Of those who were provided with this information, 91% found it easy to understand. However, most survey respondents (61%) did not receive any information on how the process had changed.

There was little variation in the provision of information throughout the 42 STP/ICS areas, suggesting that people were consistently not receiving this information, regardless of their location.

A third were not provided with a contact for follow-up support

The new guidance requires patients to be provided with a single point of contact if they need further health advice once they have been discharged.[12] We found that 35% of respondents were not provided with this information.

Staff in the community also reported that they were not always provided with this information. When they were aware of a designated contact, they reported that organising discharge and follow-up care was straightforward. However, not allocating patients to a single point of contact impacted not only the patient themselves, but also the health and care professional supporting them.

People also told us that they received insufficient information about the follow-up support they would receive after they left hospital, as well as not being provided with enough information or support about how to manage their health condition after being discharged.

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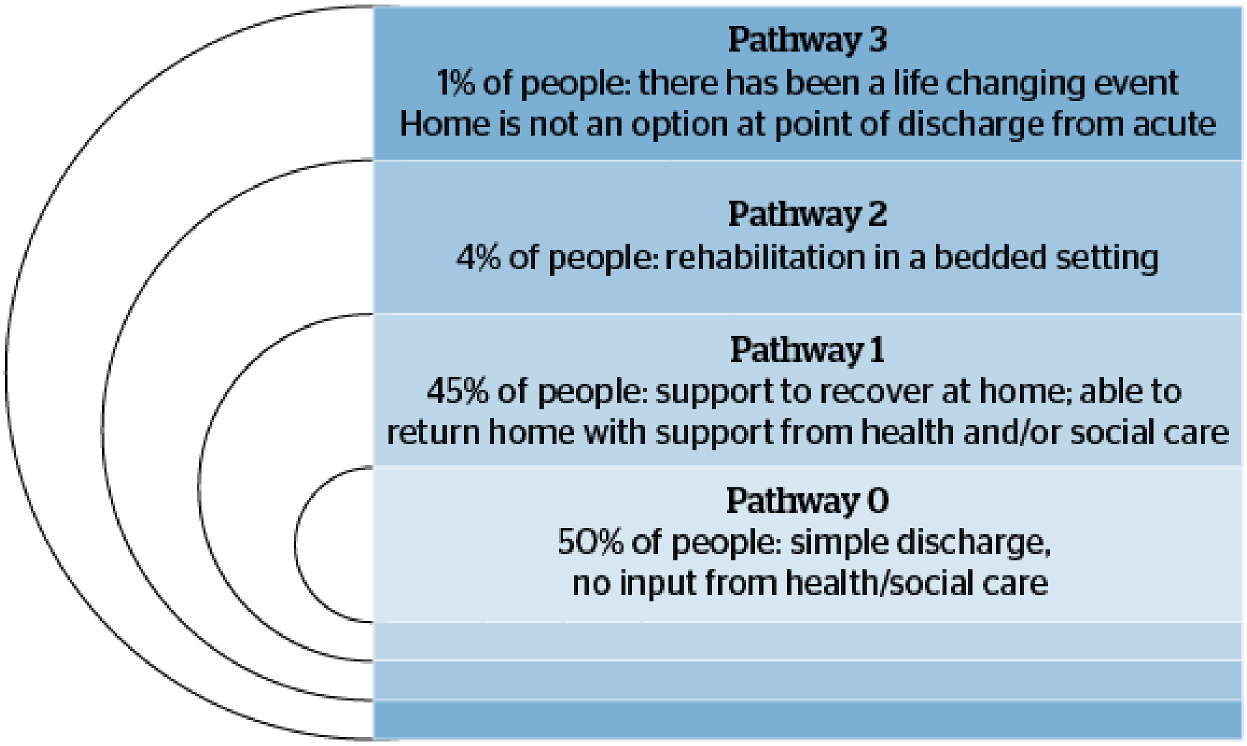
[12] Hospital Discharge Government Guidance, pg.6 (August 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912199/Hospital_Discharge_Policy_1.pdf

> “I just felt very vulnerable once home... Unfortunately, I struggled with giving myself the injections every night, and also the stockings, my husband really struggled putting them on for me. I also realised that my husband was struggling to do a lot of the basic things around the house, which I felt obliged to help where I could, again feeling a little abandoned. I suppose the COVID-19 situation has made it more difficult, as family members are unable to help, as we were having to self-isolate for two weeks. I feel a daily visit would have been more comforting, and possibly some help in the home for maybe the first two weeks.” - Female, 65-79 years

Staff interviews revealed that often, care homes or other community services received either no or contradictory information from hospitals, including on medication management or COVID-19 test results. This led to services being unsure about how best to care for and support their clients in the community.

> “We had a lady who went into hospital... she was a widow... so she had no next of kin... When we were ringing up the hospital, they wouldn’t tell us anything...we needed to know a lot more information... Hospice got involved and they got a colleague to go...to the ward to say that the [name of home] was her next of kin, you need to tell them what’s wrong and how she is, they need to know because they are the ones who will be looking after her, so they really need to know how her health is, what her ability is like...can she stand up...can she walk” – Sefton, Care Home Manager

Assumptions about discharge pathways are causing confusion



Pathway 3
1% of people: there has been a life changing event
Home is not an option at point of discharge from acute

Pathway 2
4% of people: rehabilitation in a bedded setting

Pathway 1
45% of people: support to recover at home; able to return home with support from health and/or social care

Pathway 0
50% of people: simple discharge, no input from health/social care

The March hospital discharge guidance set out four pathways for managing how patients moved from hospital to the community, based largely on research conducted by Professor John Bolton.[13]

This pathway model sets an expectation that:

- Around 50% of patients should be discharged home from hospital with no or minimal support.

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[13] John Bolton, Reducing delays in hospital transfers of care for older people (2018): *https://ipc.brookes.ac.uk/publications/Reducing-delays-in-hospital-transfers-of-care-for-older-people.html*

- 45% of patients should be discharged with support from community health and social care services, mostly in their homes.

- 5% of patients should be discharged to a care home (as set out in the diagram above).[14]

It is not clear to us that using a single set of percentages as a national assumption for the proportion of patients on each pathway is useful, particularly during a pandemic. Professor Bolton's report emphasises the importance of local systems monitoring and understanding the level of need within their own population and setting local assumptions on that basis in order to commission the right services. We are concerned that the use of a single number as a national assumption might result in local systems using this as an informal "target" rather than developing their own assumptions. This appears counter-productive to ensuring that post-discharge support services are responsive to local needs.

We are also concerned that there is confusion about the types of support that should be available to patients on each pathway, and who is responsible for linking them into these services. This is resulting in some people with support needs receiving no follow-up care.

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[14] Hospital Discharge Government Guidance, pg.27 (March 2020): *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911541/COVID-19_hospital_discharge_service_requirements_2.pdf*

In the guidance, Pathway 0 was presented as “simple discharge, no input from health and social care”, with support limited to patient transport home and ‘settle in’ support for 48 hours after discharge, like shopping or turning heating on. However, this is not the intended meaning of Professor Bolton’s pathway model, which distinguishes between post-discharge assessment and support that focuses on recovery, versus longer-term care.[15]

His model acknowledges that not everybody will require long-term care and emphasises the importance of short-to-medium-term recovery support for older people. This is grounded in a multidisciplinary approach and might include voluntary support, as well as follow-up by therapists, GPs, district nurses and other community health and social care services.

The key distinction between Pathway 0 and Pathway 1 is that those on Pathway 1 require some formal health or social care support to help them manage their recovery prior to them receiving an assessment for their longer-term needs. Those on Pathway 0 may need a follow-up visit from a therapist or a GP and may be in addition supported by a volunteer or a neighbour or a family member. These people are unlikely to require further help and therefore won’t need a formal assessment unless they request one later.

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[15] Bolton’s model also focuses on post-discharge support for older people.

However, the guidance released in March does not mention intermediate care for those on Pathway 0, seemingly leading some staff to assume this means ‘no follow-up support’.

The updated hospital discharge guidance clarifies this somewhat, stating that Pathway 0 “may include a limited number of arranged follow-up appointments (for example, the removal of stitches in a clinical setting or at home)” and that “voluntary sector services can also be used to support discharge and prevent further admissions to hospital”.

However, there is no guidance on how decisions should be made about someone’s hospital discharge pathway and thus their required follow-up care. This may lead to differences in the support people can access after they leave hospital.

88% of people who told us they had care needs after being discharged that have not yet been met, also did not receive a post-discharge visit and assessment. It therefore seems likely that many people who were deemed not to require a follow-up visit were also not receiving a reablement support plan, which would have helped them get back on their feet.

Both Healthwatch and the British Red Cross have long reported on the challenges involved in the hospital discharge process and follow-up support, which can then lead to emergency readmissions.[16] Given the *discharge to assess*

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[16] British Red Cross, In-and-out of hospital (2018): *https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/more-support-when-leaving-hospital* and; Healthwatch England, Emergency Readmissions Report (2018):

model relies on assessments and follow-up support being provided in the community, it is critical that this gap of provision is addressed.

Very few patients were visited and assessed for ongoing health and care needs after discharge

A lead professional must visit patients who need support to recover at home to assess their follow-up needs, on the day or day after they have been discharged from hospital. However, there appears to be a contradiction within the guidance about who is entitled to these follow-up visits.

In places it implies that everyone who is discharged to their own home should receive an assessment for post-discharge support: “For 95% of patients leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home.”[17] Yet elsewhere, it is implied that only patients on Pathway 1 would receive a home visit and assessment for follow-up care.[18]

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https://www.healthwatch.co.uk/report/2018-11-14/emergency-readmissions-whats-changed-one-year

[17] Hospital Discharge Government Guidance, pg.7 (March 2020): *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911541/COVID-19_hospital_discharge_service_requirements_2.pdf*

[18] Hospital Discharge Government Guidance, pg.4 (March 2020): *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911541/COVID-19_hospital_discharge_service_requirements_2.pdf*

It is also unclear whether people who had a long-term care package prior to hospital admission would receive a visit and assessment after they leave hospital. The policy only refers to this group in relation to their funding arrangements.[19]

In discussions with stakeholders surrounding this research, we have encountered varying interpretations of whether this should include everyone who has been discharged to their own home (Pathways 0 and 1) or only those deemed to require longer-term recovery support (only Pathway 1). It is also not clear who is responsible for the decision to discharge people on a certain pathway and how this decision is made, an issue which could have profound implications if it is assumed that only those on Pathway 1 would receive an assessment for follow-up support.

We found that 82% of respondents did not receive a visit and assessment from a health and care professional, with nearly one in five (18%) of those who did not receive a visit reporting unmet needs after leaving hospital. 45% of people with a disability and 20% of people with a long-term condition told us they had support needs that were not being met following their discharge.

We heard that 25% of those who reported having outstanding support needs lived alone and that 74% of those still needing support were between 50-80+ years old,

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[19] Hospital Discharge Government Guidance, pg.25 (August 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912199/Hospital_Discharge_Policy_1.pdf

suggesting that there is a real gap in the provision of post-discharge community health and social care services for those who are likely to need additional help.

People with outstanding needs reported that they were unsure of how to manage their condition following discharge, including how to administer medication, and who to contact for further advice and support. We also heard about issues relating to the provision of mobility aids and other equipment in the home, and a lack of consideration of people's home situation after they left hospital, e.g. living alone or mobility constraints.

There was little variation between regions in relation to whether patients had a visit, suggesting that this is an issue being experienced nationwide. It should be noted, however, that our samples across the different STP/ICS regions were not large enough to make regional comparisons.

Healthwatch Brighton and Hove wellbeing project

In Brighton and Hove, the voluntary and community sector provides care for many people after they leave hospital. With the arrival of the pandemic, Healthwatch quickly realised that patients being discharged would potentially be left without support, as community organisations suspended or changed the services they offered.

To help mitigate this, Healthwatch Brighton and Hove set up a wellbeing check service, through which trained volunteers contacted people to ask whether they had any concerns about their condition, or whether they needed community support during their recovery, such as help with food shopping or additional home care assistance.

Between April and September, they received over 1,400 referrals to the service. 25% of those contacted were referred on for extra community support, and 29% had at least one post-discharge issue identified, though not all of these could have been resolved by the hospital discharge process.

All referrals came from the hospital via the discharge hub team and Healthwatch Brighton and Hove’s focus was on people who are typically able to live in their own home, but who might need some extra care or help. When hospital administration staff were unsure if someone should be referred for a wellbeing check, a clinician was on hand to make a final judgement.

As a result, Healthwatch established working relationships with a variety of community support services enabling them to directly refer people to these organisations when needed. The project also worked with the Mental Health Rapid Response service provided by Sussex Partnership Foundation Trust to further support people who required a mental health intervention.

97% of those contacted said that the follow-up call was helpful, and three-quarters of people gave Healthwatch permission to check back again in three months’ time.

This project would not have been possible without Brighton and Hove Council agreeing to divert funding they provided for a similar Healthwatch initiative to the wellbeing check service, which was also then matched by the NHS. While it was positive that the council was able to respond quickly, this means that the project is not fully embedded within NHS systems and does not have guaranteed funding.

Local commissioner said: “As joint commissioners, Brighton and Hove Clinical Commissioning Group and Brighton and Hove City Council have been pleased to work with Healthwatch and Brighton and Sussex University Hospitals Trust on the development of this work, and recognise the support that has been provided to many local patients through the wellbeing checks. At a time when the hospital has been under pressure, and the public have been impacted by COVID-19, the development of this service has also supported hospital staff, improved patient experience and has highlighted clear areas for change. The collaborative approach has brought many benefits.”

The Brighton and Hove Wellbeing Project provides an example of a successful project linking together local authority, NHS and voluntary services to make sure people’s support needs were met after discharge from hospital. Similar services, if formally commissioned across the country, could help prevent hospital readmissions and ensure that the *discharge to assess* approach leads to better outcomes for patients.

Feedback on the wellbeing checks: “The Healthwatch Wellbeing service put me in touch with people who could help me at home. I feel better supported and more able to

> live independently. The worry and anxiety initially felt by my family when I was discharged from hospital has been significantly reduced."

Quality of the assessment

Overall, 64 people were visited by a health professional and had a discharge assessment. We asked them to identify what was discussed during their visit. The most common topics included discussions about general wellbeing (58%) and whether others were able to support them (47%). We found that 91% of those who answered this question only reported discussing 1-4 of the following topics.

During the discharge assessment, which, if any, of the following were you asked about? (multiple choice)

Answer	%
How were you feeling and if you had any general concerns	58%
Whether there were people to support you and keep you company	47%
Whether any changes were needed to make your home safe and comfortable (e.g. working heating)	36%
Whether you might need support for tasks (e.g. washing, getting dressed, cooking)	34%
Whether you needed support taking any medication	19%
Other	19%

Don't know	8%
Whether a short-term wheelchair loan would be helpful for you	6%
If you were concerned about finances	5%

Most people who needed transport home but didn't receive it, weren't asked how they were getting home

Healthwatch and the British Red Cross have often previously heard about difficulties in patients getting transport to help them leave hospital.[20]

Although the policy states that transport home should be arranged for those who need it ahead of discharge, there were mixed responses about whether this happened. 47% of people reported that they were asked if they needed support in getting transport, compared with 44% reporting that they were not asked. Patients often needed transport support to leave hospital, but it seemed that not everyone who needed it received it (34%; refer to the figure below).

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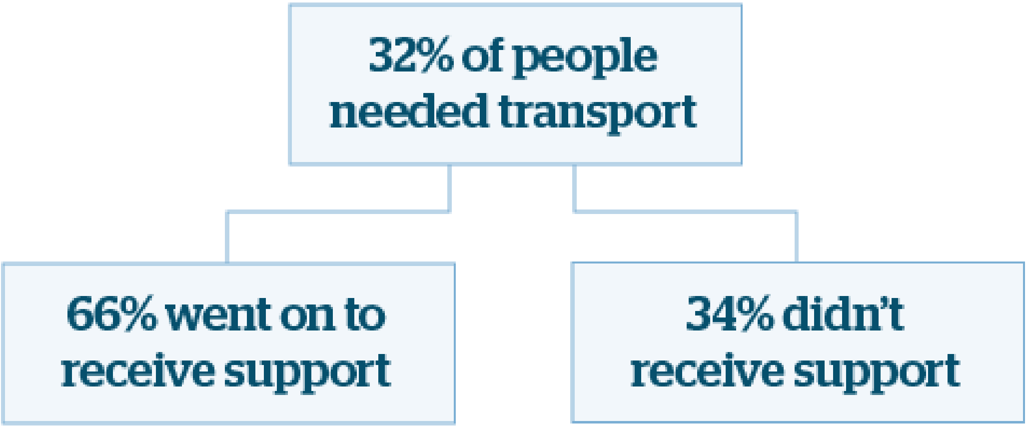
[20] Healthwatch England, Safely Home report (2015): *https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings*; Healthwatch England, There and Back report (2019): *https://www.healthwatch.co.uk/report/2019-10-02/there-and-back-what-people-tell-us-about-their-experiences-travelling-and-nhs* and; British Red Cross, Home to the Unknown (2019): *https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/british-red-cross-home-to-the-unknown-full-report.pdf*

How many people received transport support?



The main barrier to receiving transport support was a lack of communication with the patient about whether they needed help with making transport arrangements. Out of the people who told us they needed transport support and were asked about this, 96% then went on to receive transport. On the other hand, 91% of people who needed transport but did not receive it, were not asked if they required help with transport in the first place.

The impact of poor communication was exacerbated when people were discharged at night or required additional support to leave hospital. Of those who were discharged at night, 64% were not asked if they needed transport support home, compared with 43% of those discharged during the day. One refugee or asylum seeker reported having to get a taxi home, despite financial concerns over how they were to afford it.

These findings highlight the importance of hospital staff asking if patients require transport support in the first instance.

Staff interviews revealed that experiences of coordinating patient transport varied from region to region. We heard that in some areas there were no reported issues in obtaining and delivering transport. In fact, there was more transport availability as competing services no longer required vehicles (e.g. school transport).

Nevertheless, staff also reported poor experiences of coordinating transport for patients. Infection control and social distancing measures meant that some vehicles could not be used. Also, the regular cleaning of vehicles affected waiting times for transport and availability of the service. Some staff reported patients experiencing long delays for transport and a lack of communication about when transport was to be expected. This is an issue that Healthwatch has reported prior to the pandemic.[21]

Mixed experiences of communication between patients, hospital staff, family, and carers

Communication is regularly reported across Healthwatch and British Red Cross research as one of the areas that can have the greatest impact on people’s experience. Good communication between staff, patients and their families is

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[21] Healthwatch England, Safely Home report (2015): *https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings*

even more important during the pandemic due to visitation restrictions and a lack of patient choice.

Guidance issued on 8 April instructed hospitals to suspend visits to inpatient services. Although this national policy *has now been relaxed,* and visitation restrictions are now down to local decisions, many hospitals continue to have no or very limited visitation opportunities.

Families and carers were not always kept informed

Hospitals have a duty to cooperate with families and carers.[22] They need to ensure that the carer is present or informed when the patient is assessed for follow-up support and that a timely carer's assessment is completed in line with section 10 of the Care Act 2014.[23] While the hospital discharge policy references the need to inform carers when discharging patients from hospital, it falls short of taking into account carers' own needs and circumstances, which can lead to poor care for patients and challenging circumstances for carers at home.

Families reported mixed experiences of communication with hospitals about their relative's health. Some families felt they were supported to communicate with their relative and 46%

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[22] Luke Clements, Carers and their rights (2018): *http://www.lukeclements.co.uk/wp-content/uploads/2018/05/7th-ed-draft-Carers-Guide-11.pdf*

[23] Luke Clements, Carers and their rights (2018): *http://www.lukeclements.co.uk/wp-content/uploads/2018/05/7th-ed-draft-Carers-Guide-11.pdf*

of unpaid carers reported being involved in decision making about their loved one's discharge and follow-up care.

However, many relatives still experienced difficulties contacting the hospital wards to receive updates on their relative's health and felt not involved in their loved one's discharge (47%). We often hear about issues relating to communicating with family members, but in the context of COVID-19 good communication with the next of kin is especially important, as Robin explains.

Robin's story

"Back in May I got a phone call from mum saying that dad had been taken to by hospital by ambulance with severe chest pains, and the hospital was keeping him overnight. At this point we were both trying to keep calm and tell each other it was all going to be okay. But inside, I was extremely stressed. My dad is in his 70s, has COPD - which makes it hard to breathe - and should have been shielding at home, so I was worried he might easily catch coronavirus in hospital.

"As we weren't allowed to visit, mum had to keep ringing the hospital to find out what was happening. Eventually a doctor told us that dad had experienced a heart attack, they would be doing a procedure to clear his arteries, and he should be home in a few days.

"Unfortunately, the procedure got pushed back and no one told us. That meant dad was in hospital for longer than planned. It was difficult being kept in limbo, but more than that it had a significant knock-on-effect on mum. Dad takes care of mum at home, doing little things like helping her take a bath, or going shopping, and it was hard to know whether to get some temporary care support in place.

“The hospital kept changing their mind about whether dad could come home. Mum just kept calling trying to even get a small bit of information to find out what was happening - it was incredibly stressful. I remember she called me in tears as she felt so hopeless about the situation.

“As it was a bank holiday, the doctor looking after my dad was off duty. He had said it was okay for dad to be discharged, but frustratingly didn’t leave any instructions. What this meant was the new doctor who took over dad’s care said he couldn’t make the call as there were no notes.

“A nurse who had been taking care of dad all week told him to just self-discharge as the doctor couldn’t agree on what to do. But that worried us too, as we weren’t sure it was the right thing to do. Eventually dad just self-discharged and took a taxi home, but I don’t think he was even tested for COVID-19.

“There wasn’t much information about aftercare from the hospital - dad was told to take paracetamol and talk to his GP. We didn’t really know how to take care him, or what signs to look out for in care there was a problem. Eventually a week later a nursed did a home visit and luckily everything was okay.

“I completely understand that doctors and nurses were rushed off their feed. But it’s hard as a family member to not know what’s happening, it’s so easy to think of the worst. I think a bit of communication would have helped us prepare mentally for the situation, especially about how to care for dad at home. I also think hospital staff need to communicate better amongst themselves, as it wasn't right for dad to get inconsistent information from different doctors, and I'm still not sure whether a nurse should have really advised dad to self-discharge"

53% of unpaid carers felt that their caring responsibilities were not considered when they should have been - this included not being kept informed, being unclear about the patient's transport arrangements, and a lack of information about how to support their loved one after discharge. 54% of paid and unpaid carers felt they did not receive enough information to support their friend, relative or client after discharge.

"Communication with family could have been better. Sometimes it was difficult to find out what was happening to our relative. We were not told when to phone or who to ask for... We could not visit due to Covid, so it was a difficult time and we wanted to support our Mum and be prepared for her homecoming." – Female, 65-79 years

Hospitals and care homes reported difficulties communicating with families, particularly around managing relatives' expectations, communicating about the 'unknown' and the restricted visitor policies.

Paid carers also had mixed experiences of communication with hospitals.[24] Some were kept informed of patient progress and were made aware of discharges. There were some positive experiences in which carers and hospital staff worked together to provide support despite restricted visitation. This included organising 1:1 observation rotas for patients who needed additional support.

We also heard about the use of technology (e.g. phone, WhatsApp, Microsoft Teams) which encouraged communication between services. Regular meetings were conducted with a range of staff from different services to facilitate better joined up working. Most staff reflected that, in general, the new discharge policy has encouraged services to become more joined up in their approach to delivering care and follow-up support. However, often, positive communication was a result of existing and well-established working relationships, highlighting the extent to which implementation of the new approach is down to local initiative, with lots of regional variation.

> "It's had a really positive effect...and we need to keep it going. Networking has been really helpful. Working in silos doesn't work for patients...We have been longing to do this for a long time...things have been stilted for a couple of years, so we want to break those barriers down and improve that. This is

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[24] We heard from 14 paid carers of people with learning disabilities.

the start of a new way forward."
– Warwickshire, Community Discharge Team

Some paid carers though reported difficulties communicating with hospital staff, as the next of kin were often contacted instead. This is particularly important as the *discharge to assess* model relies upon support in the community to ensure the safe discharge of patients. There were various gaps in information-sharing relating to patient health status and time of discharge, making it hard for community staff to prepare effectively for a patient's arrival. Additionally, staff were often provided with inconsistent or missing discharge summaries and test results. When hospitals were questioned about this, social care staff experienced hostility from hospitals when challenges arose in obtaining and sharing COVID-19 test results.

"Pressure to accept clients because they needed the beds. Told they had had COVID tests but when asked for proof of these and completed paperwork they complained that I was being difficult and refused admission." - Cornwall Home care provider

Disabled people and their carers experienced difficulties communicating with hospital staff

These communication challenges were particularly difficult for patients with disabilities and their family members and carers. Some patients with disabilities, including those who were blind, deaf or had learning disabilities, told us that they experienced difficulties communicating with hospital staff, making it hard to understand the issues relating to their discharge. Family members reported feeling disconnected from and unable to advocate on behalf of their loved ones which, in turn, increased their worries and anxieties during these times of uncertainty.

Most patients were discharged to their preferred location, but staff felt uncomfortable about lack of patient choice

During the pandemic, patients did not have the right to choose where they were discharged to, in order to avoid any unnecessary delays to discharge. Nevertheless, 60% of respondents were discharged to their first-choice location after a conversation about their preferences, with 83% of these going to their own home. Fifty people told us they were discharged to a nursing or care home, with 42% of these being discharged to their preferred care home.

However, over a quarter of our overall respondents (28%) reported that they did not discuss where they were to be discharged to, leaving some people confused and anxious about the next steps.

> “They were just discharged without discussion or involvement into a care home miles away from where we/they live, surrounded by strangers.” - Female, 50-64 years

For family members, it was distressing being unable to visit their relative, especially if their placement was out-of-area. However, for some care home residents, staff found ways for them to communicate with their families by using technology.

Hospital staff reported that the removal of patient choice over where they were to be discharged to made them feel uncomfortable, due to their inability to accommodate patient and family preference and some patients being distressed at being placed in unfamiliar settings.

Care home staff often encountered families refusing to accept their relative's discharge placement as they found it difficult to explain that people no longer had a choice about where they went to after leaving hospital.

Most patients were not discharged within two hours

The guidance in March required all patients to be discharged within two hours of being told they were medically fit to leave hospital. However, we found that 61% of people waited over two hours after being told they were to be discharged. The proportion of people reporting delays was consistent between March and August. Patients also told us that there was often a lack of communication regarding why their discharge was delayed.

The main causes of delays included waiting:

- for medication
- for transport arrangements
- for discharge letters
- to be seen by a doctor

The delays to discharge and associated causes are issues that Healthwatch and the British Red Cross have consistently heard about prior to the pandemic.[25]

It is worth noting that in the updated hospital discharge policy released in August, the requirement to discharge people within two hours has been relaxed. The expectation is now that people will leave hospital on the same day that they are ready for discharge. For those cases not requiring any follow-up, this should be within three hours.

This change is welcome as we also heard from our staff interviews that the two-hour requirement was unreasonable and often a barrier to ensuring people had the right support before going home.

One in five patients felt unprepared to leave hospital

Some patients felt that their discharge from hospital was rushed; approximately one in five people (19%) felt they were not prepared to leave hospital. For those who were discharged at night, 27% felt they were not prepared. People who told us they had a significantly worse experience of leaving hospital than they had previously, generally felt that it was too soon for them to be discharged.

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[25] Healthwatch England, Safely Home report (2015): https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings

> "However, they still discharged me. I could barely walk...I knew I wasn't well enough to go home but I didn't feel like I could question the doctors." – Female, 18-24 years

These findings were echoed by paid carers who reported several issues that affected their ability to appropriately prepare for their client's arrival after being discharged from hospital. Paid carers reported that some clients had been discharged too early and, consequently, readmitted to hospital due to their health needs. Emergency readmissions is an issue that both Healthwatch England and the British Red Cross have reported on prior to the pandemic.[26]

British Red Cross assisted discharge services adapt to the coronavirus pandemic

British Red Cross works in over 25 emergency departments and 100 hospitals across the UK. In 46 of those hospitals, our teams are offering COVID-19 specific support or extended winter pressure services to cover the COVID-19 period, helping to get people home from hospital and settled in at home.

Between March and September, the British Red Cross has transported over 23,000 people home from hospital, and

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[26] Healthwatch England, Emergency Readmissions Report (2018): https://www.healthwatch.co.uk/report/2018-11-14/emergency-readmissions-whats-changed-one-year and; British Red Cross, In and out of hospital (2018): https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/in-and-out-of-hospital-report.pdf

provided 63,000 mobility aids, including to NHS and local authority teams to help get people out of hospital and keep them mobile at home or in supported care. We also provided equipment to some NHS ‘step down’ centres where some patients recuperated from COVID-19.

The Assisted Discharge Service based in Leighton Hospital, Crewe, is one of the busiest teams. The service runs 9am – 8pm daily and by the end of September had supported over 1,600 people. During COVID-19, the service adapted to changing demand.

Service manager Alison Deighton explains: “At the start of the outbreak we were very busy, when beds were being cleared as part of the national effort to ensure hospitals had surge capacity. Then there was a natural dip in demand, so we moved over to help with outpatients, transporting people who were anxious about how to safely attend their appointments. We also took some patients, due to have elective surgery, to the ‘drive thru’ COVID-19 test. These patients did not have access to a car or a relative to transport them”

Having the Red Cross team already embedded within the hospital, additional staff redeployed from other services and other help such as mobility aid loans, helped with the flexibility of the service as they adapted to support NHS staff and patients. The knowledge of the team also made that extra difference in helping patients navigate life in recovery outside of hospital.

"We'd use the time on the journey home to explain lockdown life to patients who'd entered hospital before COVID-19. Masks, shielding, social distancing – people were coming out into a different-looking world, so we helped people adjust. Our staff had local knowledge to advise patients which greengrocers were delivering as alternatives to supermarket deliveries or queues. We used follow-up phone calls to carry out additional welfare checks and, for more vulnerable people, our support at home or crisis response teams could drop off food or medicines at doorsteps."

When patients did not survive, Red Cross staff took belongings home to the families, including important keepsakes like a lock of hair.

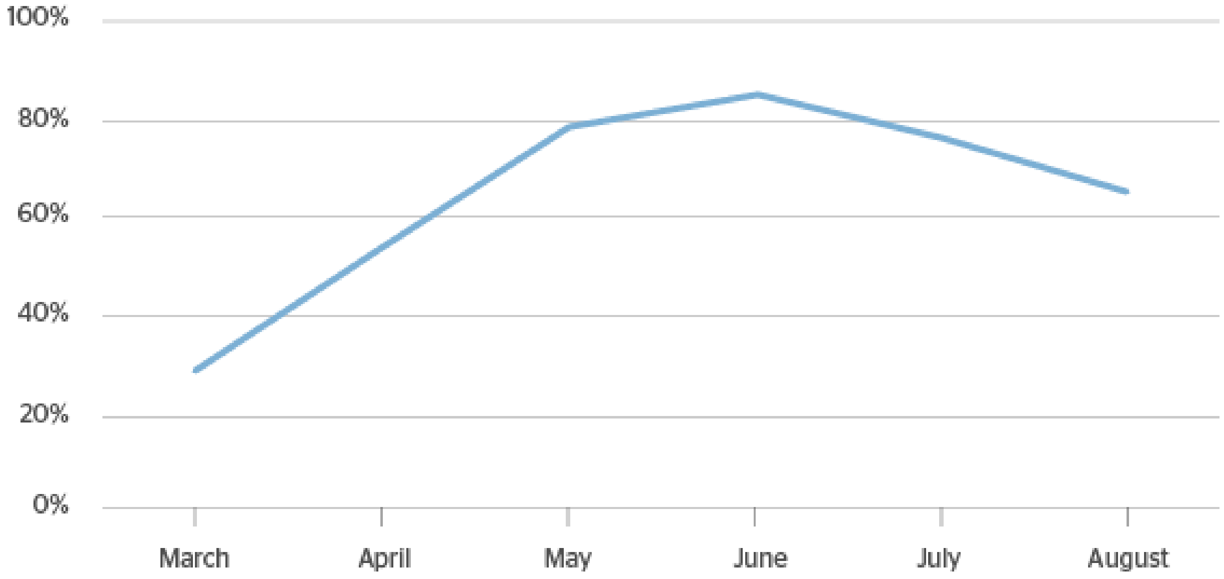
"With winter coming, I imagine we'll be seeing a surge in flu and COVID-19. Some hospitals are already clearing wards to get ready. The Trust knows how we work, that we're flexible, so we're ready to adapt as needed. We can up-skill Red Cross staff from similar services fast to expand our capacity."

COVID-19 testing

Although most patients (67%) were tested for COVID-19 during the time they spent in hospital, 24% of patients were not tested. In March, the majority of patients (59%) reported not being tested for COVID-19, but at this time it was not policy to systematically test people being discharged from hospital.

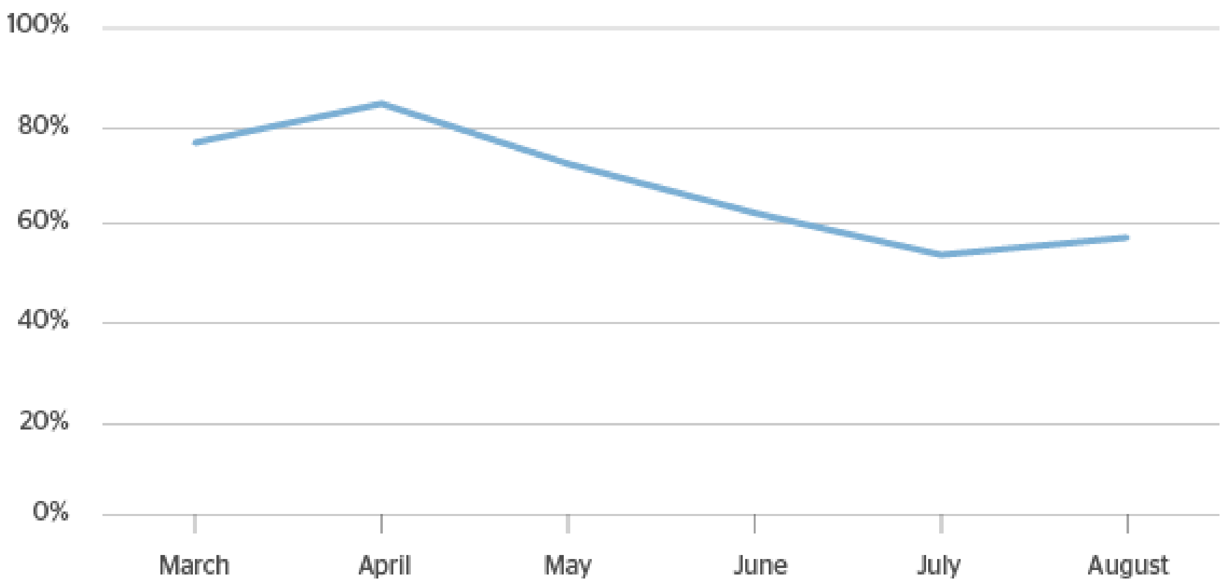
In the following three months more patients consistently reported being tested for the virus, but the proportion of respondents being tested declined in July and August. Despite the policy stating that all patients discharged to a care home should be tested for COVID-19, we found that 26% of our survey respondents who were discharged to a care home were not tested. Although we heard from a small sample of people discharged to a care home, there is still a significant proportion of people who were required to be tested but did not receive one.

Percentage of patients being tested for Coronavirus (COVID-19)



Although 64% of those who were tested received their results in hospital, 30% did not receive their results before being discharged. This means 44% of respondents left hospital without any COVID-19 test results being shared with them. Since April, the general trend suggests that the sharing of test results has gradually decreased. In July, a particularly high proportion of respondents (41%) did not receive their test results before they left hospital.

Percentage of patients receiving their results



Paid carers reported experiencing resistance from hospitals when asking for coronavirus test results for the patient they were supporting. This included a lack of documentation of test results and sometimes no information about whether tests had taken place. This often resulted in care homes refusing to accept admissions of patients without tests or results being shared, due to potential infection control repercussions and keeping staff safe. These refusals were often met with challenges from hospitals.

> “The discharge was very quick, staff initially queried unsafe discharge. This was due to [a] lack of safe equipment for support needs (no occupational therapy involvement) and the consultant initially refusing to undertake a repeat COVID

> test. Once challenged with relation to government guidelines, the consultant accepted to do this and also arranged OT involvement for the equipment." – Care staff for people with learning disabilities

Hospital staff regretted the lack of testing when patients were being placed into care homes, despite following the early discharge guidance. There were delays in accessing tests for hospital patients, care home residents and staff members. Additionally, there were delays in obtaining test results which subsequently delayed patient discharge. These delays were worsened when care homes refused patients who had not received their test results from the hospital.

> "Send people to care homes without swab results...always been unfair and straight away the care homes, quite rightly, kicked off about it, so we very quickly implemented a 'when you tell us you've got a bed, we'll do a swab'. But...if you're not told about the bed until 4p.m. on a Thursday, you can't swab them until 4p.m. Thursday and therefore the bed's waiting empty for another 24 hours while you wait for the result, because swabs take a long time to come back as well."
> – Cornwall, Hospital Trust

Guidance issued since March, including the adult social care action plan (April) and the adult social care winter plan (September) emphasise that it is essential to test anyone being discharged to a care home, and that results should be available and communicated with care homes before discharge.

However, it is still not policy to test everyone who is discharged from hospital to another location (usually their own home), although some hospitals are doing this. Improvements in testing capacity should have as an ambition immediate access to a COVID-19 test for anyone who wants one, with everyone being offered a test at the point of discharge.

Medication

Health and care staff highlighted several issues in relation to patient medication. For example, patients were often discharged without medication or not given enough medication. Alongside this, there was little, or no, information given to patients and their carers about administering medication. Due to social distancing rules, some GPs were not conducting home visits which made it difficult for some people to obtain follow-up prescriptions. In addition, when patients experienced delays to their discharge because they were waiting for their medication, this affected the preparation of the services they were being discharged to.

Little consideration of home situation and a lack of equipment

The guidance indicated that commissioners for NHS and social care equipment were to ensure that local equipment services had enough supply and that patients leaving hospital could quickly access any equipment they needed, seven-days-a-week.[27]

The experiences people shared with us, however, show one of the key needs that people had after leaving hospital, and which was often not met, was in relation to equipment and mobility aids. Only 6% of people who had an assessment discussed equipment and mobility aids. This highlights a critical gap in the assessment of people's needs after they leave hospital. Paid carers echoed this observation and suggested that there was a lack of support and consideration for people's home situations and living conditions, including their need for equipment and mobility aids.

> "Very little consideration is given as to the environment that the patient is returning to and the support that is available." – Care staff for people with learning disabilities

Staff in the community reported that the rapid pace of discharge led to pressures and difficulties in training staff to use specialised equipment safely. In addition, equipment was not always provided in a timely manner, if at all, and care providers also reported difficulties ordering equipment for discharged patients as this was a new way of working for many services.

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[27] Hospital Discharge Government Guidance, p.18 (March 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911541/COVID-19_hospital_discharge_service_requirements_2.pdf

> “The Council changed their policy about equipment loans, so...we’ve had no equipment provision supplied, except on a loan for a maximum of 6 weeks...but residential homes have never had to price such things, they’ve never had to go out to tender, to look at quotes and all of a sudden they’ve got this massive expense of having to replace all the hoists.”
> – Cornwall, Care provider

The August hospital discharge policy, which proposed community health services be responsible for the provision of equipment entailed less detail about the supply of equipment than the March guidance. This is concerning given that access to equipment emerged as a key unmet need of respondents in our research and needs urgent attention for the winter period, where needs for equipment and mobility aids are expected to increase.

Mental capacity assessments

Owing to the restricted access to hospitals during the pandemic, mental capacity assessments of patients were not carried out by social workers in hospitals. This led to difficulties obtaining mental capacity assessments and contacting social workers in the community. Instead, some hospital staff had to conduct these assessments, when they reported lacking confidence in doing them or were not adequately trained to deliver them. This has been challenging for staff and caused delays for patients’ discharge.

> “I’m still getting complaints this week from consultants saying, ‘I’m not doing an MCA [Mental Capacity

> Assessment]' and 'I'm not doing a best interests discussion, I need a social worker'. Well, no, they need to do it themselves, and the social worker should happen in the community." – Cornwall, NHS Trust

Impact of coronavirus on discharge from mental health hospitals

Mental health services faced significant challenges as a result of the pandemic. The national hospital discharge guidance issued to all NHS trusts on 19 March did not specifically cover mental health hospitals, but neither did it exclude them. Mental health guidance on managing capacity and demand followed later in the month on 25 March. This said mental health hospitals should review all patients to support safe discharge where feasible, so that inpatient capacity could be maximised for the COVID-19 response.

Analysis conducted by the mental health charity Mind shows that an additional 2,441 people were discharged from mental health hospitals in March compared with February - a 26% increase.[28] According to NHS England guidance, each person being discharged should receive an individual assessment of needs and risks with the involvement of family and carers, but based on surveys conducted during the pandemic and individual testimony, the mental health charity Mind has

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[28] Mind, The impact of coronavirus on discharge from mental health hospital (2020): https://www.mind.org.uk/media-a/6293/the-impact-of-coronavirus-on-mental-health-hospital-discharge-briefing.pdf

raised concerns that these may not have been carried out in all cases.

Some patients felt they were discharged too quickly and others, like Kate, felt that they didn't have enough support in the community.

Kate's story

At the end of a six-week stay in a mental health hospital in Derbyshire, Kate was discharged shortly before the national lockdown began. After leaving hospital, she was visited by a community psychiatric nurse (CPN), who told her that ordinarily she would receive further weekly visits, but because staff were being redeployed due to COVID-19 pressures, the support she would be entitled to wasn't available. After this, she received no further contact or support.

Kate started to feel more anxious and depressed. Eventually she called a national mental health helpline, who told her that as she had recently been discharged, her local mental health clinic should be looking after her. Upon calling the clinic, she got a voice message encouraging to contact the national helpline.

Kate persisted and was eventually able to make contact with the clinic, request another visit from a CPN, and get access to a series of weekly counselling appointments. But she says these weren't enough to help her feel better. She had been on a waiting list for talking therapy for over a year, but after her stay in hospital, she found out that she had been taken off the waiting list when she was admitted, on the assumption that the support she needed would be provided in other ways.

She signed up to the waiting list again, but after having to move to a new house and re-register with a new practice, she is now at the bottom of the list again.

Mind shared concerns that pressure to discharge patients during the coronavirus pandemic has exacerbated existing issues with patients being discharged before being ready to leave hospital or discharged without a care plan. Community mental health services were already under strain prior to the pandemic and were put under even greater pressure by the increased number of rapid discharges. This, alongside the shift to digital services, is likely to mean that people had even fewer options available for support in the community.

The lack of clarity regarding the intended application of national hospital discharge guidance to mental health trusts has made it difficult to monitor or benchmark discharges during the pandemic. Although it has now been clarified that the national discharge guidance is not meant to apply to mental health hospitals, clearly they have still faced pressures to discharge people more quickly whilst also being excluded from the additional funding and support for community health services designed to bolster post-discharge support for acute hospital inpatients.

Ahead of the winter pressure period, we need to see clearer guidance around the role of mental health hospitals in the pandemic response, stricter standards to support safe discharge practice, and additional funding for community mental health services, especially if they are expected to support an increased number of people recently discharged from hospital.

New arrangements took a toll on staff wellbeing

The new discharge guidance meant staff from a range of services had to adapt to new ways of working. We heard that the pandemic and the changes to working practices caused health professionals to feel overwhelmed and anxious. Staff reported that these feelings were a result of dealing with new and distressing responsibilities (e.g. end of life care), difficulties still being compassionate with patients while using Personal Protective Equipment (PPE), coping with the additional capacity pressures and demands, and coming to terms with the unknown, particularly relating to contracting COVID-19 and returning to work.

We heard that positive experiences such as being a member of a supportive and close-knit team, experiencing recognition from the NHS trust or executive teams, exercising resilience by working together and mentally preparing for potential difficulties could mitigate poor wellbeing.

Patients were grateful for NHS staff

We often hear that people value the staff that deliver their care. During the pandemic this has been a particularly prominent theme. Patients and their carers praised staff attitudes and frequently shared that staff were kind and caring in their interactions. Patients and carers valued when staff clearly explained the progress of their health throughout their stay in hospital and appreciated information on the discharge process. They were also particularly grateful for the treatment they received while in hospital.

> “The Doctor and Team advising me as to what would happen after I was discharged. The overall care I was given was very good. The doctors and nurses dealt with me in a professional and caring manner. The paramedics who took me to the hospital were kind and caring. Everyone I met at each stage explained carefully what exactly was going to happen.” – Male, 50-64 years

A lack of preparedness and capacity within the system meant difficult trade-offs

Care home staff reported that they sometimes did not have enough time to provide the right equipment for their residents due to the speed of discharge. Carers found that hospitals were unable to consider the time it takes to train staff to operate equipment safely and to install the equipment in time for their resident’s arrival. While we recognise that the pandemic created a clear impetus for hospitals to act quickly to free up capacity, this feedback points to a lack of resilience and preparedness in the system to deal with unexpected pressures.

Staff members highlighted that there were opportunities and challenges that arose as a result of changes to staffing levels. For instance, in the circumstances where staff needed to shield or were feeling unwell, this led to increased pressure on their teams and reduced overall capacity.

In some cases, services redeployed shielding staff to undertake alternative tasks. Staff shared that one positive of redeployment was improvement in the expertise and capability of staff who gained new skills:

> “Having that available workforce...drove transformation but also it meant that we had some richness of skills and strengths...so the referrals were getting dealt with by people who weren’t the most junior...which...added to the richness of trying to keep people safe.” – Cornwall, Voluntary organisation

However, redeployment also resulted in difficulties developing rapport when new staff were involved in delivering care to patients:

> “A lot of the wards were using nurses that weren't particularly aware of the person's needs, so they might not be allocated that ward. They were just working on there that day because of the pressures that they were under, I suppose.” – Nottingham, Care Home Manager

NHS England’s Commitment to Carers Team found that a hospice staff member, whose responsibilities included bereavement support for carers and end of life care, was redeployed into a COVID-19 testing facility. As a result, this left a large gap in support for carers.

As we go into winter and COVID-19 cases are on the rise again, services need to be given the right resources to prepare for another period of increased pressure.

Conclusions and recommendations

Our research indicates the *discharge to assess* model could be beneficial for patients and staff if properly resourced and implemented. It could enable people to get out of hospital more quickly while still having the right support to recover, as well as facilitate closer and more collaborative working between health and social care services.

The model relies on people's whole needs being assessed and addressed in the community, but this is often not happening in practice. The high proportion of people who did not receive information about the changed process or an assessment from a health professional reveals that the approach set out in the policy remains in many places an ambition, rather than a reality.

If a national *discharge to assess* model is to benefit patients, it is essential to tackle these challenges by immediately implementing the existing policy and by providing additional resource and support to overcome current barriers to implementation. In the medium term this model also needs embedding within broader health and social care reforms. Without this, the new approach risks normalising poor quality of care as patients are rushed out of hospital without the right follow-up support for recovery, increasing the potential of hospital readmissions and poor post-discharge health outcomes.

Below we have highlighted where improvements need to be made to ensure people’s needs are met effectively after they are discharged during both the next phases of the pandemic, and in the longer-term.

Immediate action

As we enter a period of anticipated winter pressures in the NHS, and COVID-19 cases are once more on the rise, we've identified the following areas where the health system must act swiftly to ensure existing policy is appropriately implemented.

Provide everyone leaving hospital with a follow-up contact

Always assign a single point of contact: Hospitals should work with their partners to ensure patients are assigned a point of contact for further support, in line with national policy. Given current infection control measures and changes in the provision of community support, this contact could enable people to better navigate health and care services. People who receive a comprehensive assessment for follow-up care after they leave hospital should also receive a contact as their situation might change.

Ensure families and carers also know who to contact: Hospitals should also give families and carers this information so they have a point of contact for the follow-up support of their loved ones or clients, and national policy should be updated requiring hospitals to do this.

Improve testing

Support people to self-isolate safely while awaiting test results: The NHS should endeavour to provide results of COVID-19 tests conducted on admission to all patients before discharge. Where patients have not been tested on discharge, or where they are ready for discharge before test results are available, an assessment of their living situation should be made in conjunction with the multidisciplinary team (for those on Pathways 1) or in consultation with their family or informal support network (for those on Pathway 0). Where it is deemed safe for patients to self-isolate at home while awaiting test results, the hospital should ensure they are supported with tasks such as food shopping or picking up medication through NHS volunteers or local voluntary and community sector support.

Ensure everyone gets tested before they are discharged to a care home: Local and national system leaders must act swiftly to ensure testing on admission from and discharge to care homes is fully implemented, especially as COVID-19 cases are now on the rise. Test results must be communicated with care homes prior to discharge, as set out in the Adult Social Care Winter Plan.

Increase testing capacity: It is current policy to test everyone on admission to hospital, and to test all those being discharged to a care home. However, we recommend that this is extended, as testing capacity is increased, to enable any patient being discharged from hospital to get a priority test before going home. This will provide reassurance and help family carers and paid home care services better manage any potential risks.

Routinely offer and arrange patient transport

Always ask about transport home, as part of a wider conversation about people's non-clinical needs: When discharging patients, checklists should be used to support conversations with patients, families and carers to ensure they have the immediate support they need to get home safely.

Ensure no one is discharged at night unless transport can be arranged: Patients discharged at night were more likely to need but not receive transport home. If it is not possible to guarantee transport, patients should remain in hospital until it can be arranged.

Increase transport providers' capacity and resources: The national hospital discharge policy emphasises the importance of operating discharge services, including community care, at a minimum 8am-8pm seven days a week. Transport providers should be supported to operate in the same way. They should also be equipped with the skills, time and resources to support people into their homes, rather than simply dropping them off at their address. Assisting patients into their home provides a vital opportunity to check their home environment is safe.

Improve the administration of medication

Always provide information about medication: Information about administering and managing medication should always be provided to patients and carers to ensure that patients are supported appropriately after they are discharged.

Link up with community pharmacists: Local health systems should include pharmacists in the multidisciplinary teams carrying out post-discharge community assessments, if they are not already.

Utilise local volunteers and the voluntary and community sector: People who have recently been discharged from hospital should be offered support from an NHS volunteer or other community sector organisations who can help them to access and pick up medication. More broadly, hospitals should be enabled to make full use of NHS volunteers to support getting people home and helping them manage household tasks after discharge.

Short-term system change

We've also identified the following areas where there is confusion around existing policy, barriers to implementation or gaps in policy, which need to be addressed to avoid worse health outcomes as a result of the *discharge to assess* model.

Increase follow-up visits and assessments of people's health and care needs

Rapidly explore the low number of follow-up visits: The Department for Health and Social Care and NHS England should further explore why nearly one in five people who shared their experience with us had unmet needs and more than four in five people did not receive a follow-up visit to assess ongoing support needs.[29] This work should seek to understand regional variation, barriers and solutions.

Address identified barriers: Local and national efforts must be made to address the factors contributing to the low number of follow up visits. This might involve updating the pathways policy so that it is clearer, promoting it, improving pre-discharge checks so that people are supported through the appropriate pathways, or ensuring there is capacity in the community to carry out the follow-up visits.

Monitor at a local level: Local health and care systems should monitor the extent to which follow-up visits and assessments are taking place after someone leaves hospital and notify the relevant service to conduct a visit and assessment if they haven't taken place.

Monitor at a national level: The Care Quality Commission should monitor whether the delivery of follow-up assessments is improving by including questions in its

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[29] The national guidance estimates that approximately 50% of patients leaving hospital do not require a follow-up visit (see our analysis of this insight on page X). If we take this figure into account, this research suggests that three in five patients who were likely to have required a follow-up visit and assessment were not getting one.

inpatient survey about whether patients received a follow-up visit, and whether all their post-discharge support needs were met.

Review and clarify discharge pathways

Clarify and promote the hospital discharge policy to frontline staff: Amend the national policy to avoid different interpretations of pathways. It should clarify that Pathway 0 does not mean “no further follow-up”. While the current policy includes an intention to provide transport support and living assistance for 48 hours for this group, it should also reiterate the potential need for a recovery plan with clear links into therapy, nursing, GP and/or voluntary care services.

Provide hospitals with the guidance and tools to better determine the most appropriate pathway for patients before winter: The national policy should be amended, or complementary guidance issued, to include advice for hospital staff on how to better determine which pathway patients should be on. A holistic evaluation of patient needs should be carried out when determining the level of follow-up support and appropriate pathway for the patient, including considering non-clinical factors, like their physical, practical, social, psychological and financial needs.

Reconsider the inclusion of national assumptions about proportions of patients in each pathway: It is not appropriate to have a single number as a national assumption for proportions of people who are on Pathway 0. Local systems should instead use their understanding of local need to set pathway assumptions. First and foremost, hospital staff and their partners should determine pathways by assessing each patient's individual needs.

Roll out post-discharge check-ins

Check in on every patient after discharge over the phone or in person: Everyone leaving hospital should receive a wellbeing check-in after discharge. These check-ins should cover people's holistic needs, linking them into support services where appropriate.

The British Red Cross has long been calling for the inclusion of a five-part independence checklist in the hospital discharge process to facilitate conversations between health professionals, patients, their families and carers about their physical, practical, social, psychological and financial needs.[30]

These checks are even more important during the pandemic while people are self-isolating and waiting for their COVID-19 test results after leaving hospital, shielding, or managing additional anxiety related to COVID-19. Clinical commissioning groups should consider commissioning a patient or voluntary sector organisation to conduct these calls.

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[30] British Red Cross, Five-part independence checklist: *https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/more-support-when-leaving-hospital/getting-hospital-discharge-right#Our%20recommendations*

Improve access to equipment to support people’s recovery

Address barriers to accessing equipment: Local health systems should address the barriers preventing quick access to equipment that community health and care staff raised with us. These included unclear or restrictive local policies, as well as a lack of training.

Commission local equipment services: Local commissioners should ensure equipment services are sufficiently supplied throughout the winter period, when increased needs for equipment and assistive technology are expected.

Provide information about equipment services: Hospitals should routinely offer information about accessing mobility aids and other equipment at the point of discharge with clear contacts.

Involve carers and family despite visitation restrictions

Put in place special arrangements to improve communication and involvement with family and carers: While visitation restrictions continue, special arrangements need to be put in place to ensure families and carers can participate in decisions made during and after the discharge process, particularly for patients with disabilities or additional needs, in line with the hospital duty to cooperate with family carers.

This should include:

- Family and carers being provided with a single point of contact who they can get in touch with for information about their loved one while they are in hospital.
- Guidance ensuring people admitted to hospital are asked if they have a carer who should be involved in decision-making about their care. If the patient does name a carer, attempts to contact and involve them in discussions about hospital care and discharge should be made at every step of the process.
- Carers themselves receiving a wellbeing check, being told how to access additional community services to support them after their friend or relative's discharge and making them aware of their right to a carer’s assessment from their local authority.
- Hospital discharge teams checking what support carers can provide and whether they have a contingency plan should their circumstances change. If they are not able to provide their usual level of support to the patient, this needs to be considered.

Continue to improve technology

Ensure technology facilitates integration of services: Local commissioners should review existing IT contracts and data-sharing arrangements to ensure appropriate systems are in place throughout the *discharge to assess* process.

Medium-term policy change

The following are system-wide considerations around resource and commissioning which must be acted on in order to ensure the *discharge to assess* approach is beneficial for patients in the longer term.

Increase investment in community services: A clear benefit of the new approach includes improvements to joined-up working between hospitals, community healthcare, the voluntary and community sector and social care services, fostering a more patient-centred approach to discharge and reablement. However, the model will only be successful if these services are sufficiently resourced in the community.

Ensure services in the community can also operate seven days a week: Increase investment in community services so that they are able to support the community discharge service seven days a week.

Consider and mitigate the consequences of redeployment: Do not assume that new community discharge services can be set up by redeploying existing staff. Assess local needs and put in place the resource to support appropriate staffing, ensuring that staff redeployment doesn't result in negative repercussions for other groups of patients.

Address the workforce shortage: At a national level, the NHS People Plan for 2020/21 should be built on to create a fully costed and funded health and care workforce strategy based on a robust assessment of population needs. This strategy should identify skill shortages and gaps, outlining measures to address these. We also need legislation to clearly assign roles, responsibilities and accountability for workforce planning and supply. This will shift the system towards longer-term decision making for the workforce.

Invest in and recognise the voluntary and community sector's potential: The voluntary sector should be embedded into hospital discharge processes and commissioned to support people leaving hospital. The voluntary sector can help to relieve pressure on the health and social care sector, improve patient flow and achieve better outcomes for people. They can also help to tackle fatigue within the health and social care sector and be deployed flexibly along the hospital discharge process.

Commission discharge support services: The NHS and social care must work together to commission post-discharge support services that focus on recovery and recuperation. As recommended in Professor Bolton's research, which has been used as a basis for assumptions within the national discharge policy, these should be bespoke services rather than redeployment of existing services.[31] These services should be available to all on pathways 0-3, separate from longer-term care and support services.

Reform social care and community healthcare: In the longer term, the *discharge to assess model* can only be successful if social care and community services are sufficiently resourced and available locally. A long-term

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[31] John Bolton, Reducing delays in hospital transfers of care for older people (2018): https://ipc.brookes.ac.uk/publications/Reducing-delays-in-hospital-transfers-of-care-for-older-people.html

settlement for social care service provision should be taken forward to support universal implementation of the *discharge to assess* model.

Thank you

Healthwatch England and the British Red Cross would like to thank all the individuals and organisations who contributed towards this research.

- All of the patients, family members, carers and staff members who shared their experiences of the hospital discharge process. By telling us your stories, you are helping us improve the process for everyone in the future.
- The 111 local Healthwatch who helped us promote the survey to their communities, as well as research they've carried out on this in their area.
- The 8 Local Healthwatch who conducted interviews with service providers, contributing to the rich insight from a staff perspective:
    - Healthwatch Bolton
    - Healthwatch Cornwall
    - Healthwatch East Riding of Yorkshire
    - Healthwatch Norfolk
    - Healthwatch Nottingham and Nottinghamshire
    - Healthwatch Sefton
    - Healthwatch Wandsworth
    - Healthwatch Warwickshire

- All 26 of the organisations/individuals who assisted in developing and promoting the survey as well as shared their insight with us:
    - Age UK
    - Alzheimer's Society
    - Association of Directors of Adult Social Care
    - British Heart Foundation
    - British Lung Foundation
    - Care England
    - Care and Support Alliance
    - Carers UK
    - Diabetes UK
    - Equality and Human Rights Commission
    - Local Government Association
    - Mencap
    - Mind
    - Ministry of Housing, Communities & Local Government
    - National Health Service England
    - National Voices
    - NHS Providers
    - Nuffield Trust
    - Patients Association
    - Parkinson's UK
    - Professor John Bolton
    - Rethink Mental Illness
    - Richmond Group of Charities
    - Royal College of Nursing

- The Department of Health and Social Care
- The King's Fund

Appendix 1: Demographics

The majority of our survey respondents were women (77%), straight (87%) and from white ethnic backgrounds (93%).

A majority (53%) of respondents identified as having a long-term condition and 31% of respondents identified as having a disability.

The age range of our respondents was evenly spread between the working age and older age groups (we did not receive any responses from people aged 13 - 17). The general age demographic of people who responded to our hospital discharge survey is consistent with the age distribution of people who are admitted to NHS hospitals in England, according to the Hospital Admitted Patient Care Activity 2019/20 data.

Women and people from a white ethnic background are overrepresented in our survey when compared with the Hospital Admitted Patient Care Activity 2019/20 data.

Age of survey respondents