



Report on Discharge to Assess (D2A) at Staffordshire Hospitals

Healthwatch Staffordshire is the independent consumer voice for local people, championing quality health and social care and ensuring that the patient voice is heard by commissioners and providers of services across Staffordshire. We gather the views of the public and raise awareness of key concerns and issues that affect health and social care services as experienced by the patient / consumer. We focus on finding out what Staffordshire residents think is working well or not working well in health and social care and we work with other organisations to influence change. We recommend improvements and highlight examples of good practice.

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Background to the study

It is well known that the pressure on acute hospitals to find beds for patients who are acutely ill is a real and growing problem and is exacerbated when these acute beds are occupied by patients who are no longer acutely ill but for a variety of reasons cannot be discharged safely back to their home or to a place most appropriate to meet their needs. The majority of these patients are older and it is recognised that unnecessary delay in discharging older patients from hospital has been a systemic problem with a rising trend - the National Audit Office reported that between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days. For older people in particular, it is known that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. To combat this rising trend, health systems across the country were mandated to put in place a model of discharge to assess; the principle being that once a patient is medically optimised they should not remain in an acute hospital because they are waiting for an assessment. The Patient should be moved to a setting best suited to their needs where assessments are planned and undertaken there.

Put simply “**discharge to assess**” (D2A) is about funding and supporting people to leave hospital when safe and appropriate to do so and continuing their care and **assessment** out of hospital. They can then be **assessed** for their longer-term needs in the right place.”

<https://www.england.nhs.uk/blog/martin-vernon-3/>

NHS England outline three established pathways to discharge:

- Home based D2A: individual returns to their own home with care and support, as needed, and usually reablement
- Bed based D2A: patient transfers to a bed in community hospital/care home/nurse led step-down ward where assessments are planned. In some models, there is reablement
- Continuing healthcare pathway: spot purchase of nursing home bed, checklist and Decision Support Tool

Underpinning these is a set of principles outlined in their Quick Guide to Discharge to Assess. The simple rules/principles are evidence based - they can be used to assess existing services and should be the design principles that underpin a discharge to assess. These principles include:

Essential Criteria

- Supporting people to go home should be the default pathway, with alternative pathways for people who cannot go straight home.
- Free at the point of delivery, regardless of ongoing funding arrangements.
- To be safe if the person is going home, the assessment should be done promptly (within 2 hours), with rapid (on the day) access to care and support if it is required.
- Support services should be time limited - up to 6 weeks, in the best systems the average appears to be 2 weeks and can be longer than 6 weeks in exceptional cases.
- Non selective, a service that tries to always say ‘yes’ - to include support for end of life care.





User focus/patient centred care

- Put people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome.
- Take steps to understand both the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life.
- Ensure the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge.
- Ensure continuity of communication so all members of the team are working to the agreed care-plan, until discharge from the pathway.
- Where the patient may not have capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA), informed by the MCA Code of Practice and relevant case law.

Effective assessment

- Ensure that assessment is rapid, effective and able to mobilise the required services.
- Assess long-term care needs when the actual level of care required can be more accurately assessed.
- Take steps to ensure there is no duplication in assessments throughout the patient's journey from hospital to home.
- At the end of assessment and at transition to long-term support (if required) develop proactive/advance care plans where appropriate, with people and their carers, to help to mitigate the risk of crisis.
- Ensure that people do not have to make decisions about long term residential or nursing care while they are in crisis.

The impetus for undertaking this project is that Healthwatch Staffordshire received feedback from patients and relatives about their experience of hospital discharge through the Discharge to Assess (D2A) process. Whilst some of this was positive feedback, the majority of this was about people's poor experience of the process. Healthwatch therefore decided to undertake a study to look at experiences of D2A for patients being discharged from Staffordshire Hospitals. The aim of this study was to understand the D2A process from the perspective of the patient/family/carer and to find out the extent they are involved in the planning of their discharge. The study was undertaken with the above principles in mind to understand the degree in which the D2A services in Staffordshire are provided in line with these.



D2A Process



The two Acute Trusts involved in the study, University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), operate different D2A systems;

UHNM have a Track and Triage team who are made up of Social Workers and Therapists based on site and a Discharge Facilitator based on each ward who is responsible for completing the patient profile, keeping this updated and chasing things like housing issues, house cleans etc. to ensure that the patient could be discharged if safe to do so. They also had dedicated wards for patients deemed 'fit for discharge', where patients were transferred to from other wards. The patient profile is a pen picture of the patient which includes all personal details including Next of Kin, home circumstances, current care arrangements and current functioning ability on the ward. This is completed digitally and is a live document that is updated frequently and accessed by the Track and Triage team who arrange the care package required for the patient to leave hospital.

Queens Hospital Burton (UHDB) has a social work team based on site who arrange discharges for all those requiring assessment and ongoing placement. They will visit the ward to see the patient and determine, in conjunction with the ward staff, that a patient is 'safe' to discharge. We came across only one Discharge Facilitator who was employed on one ward. No other wards we visited had that role although this was being considered. Queens Hospital also has a fast track pharmacist on site to reduce delays for patients awaiting medication to take home. Queens did not have any 'discharge wards' but did use the discharge lounge to transfer patients waiting for transport or medication.

Methodology

This project was designed to use face to face semi-structured interviews. Interviews were chosen as they give an opportunity to explore with the participants their answers and gain a deeper understanding than is possible with questionnaires.

The target group were patients in hospitals in Staffordshire, including Royal Stoke; County Hospital in Stafford (UHNM); Queens Hospital, Burton upon Trent and the Community Hospitals; Samuel Johnson Hospital, Lichfield; Sir Robert Peel Hospital in Tamworth, University Hospitals of Derby and Burton (UHDB) and the Haywood Hospital in Stoke on Trent, Midlands Partnership NHS Foundation Trust (MPFT).

Many of the Patients we saw were patients deemed 'fit for discharge', but were either on wards waiting to go home, some were on a fit for discharge ward, some were on general wards and some were in the discharge lounge. These patients had been identified by hospital staff as being in the D2A process.

We also spoke to Staff on wards at Royal Stoke and Queens Hospital.

We have also included some relevant experiences that have been reported to Healthwatch during the course of its everyday engagement work.





Results

102 interviews were carried out with patients from a number of wards.

We spoke to mainly elderly patients across the hospitals. The participants had a range of reasons for being in hospital with a split between those who had been admitted on a planned basis and those who had been admitted on an unplanned or emergency basis. Only four participants said that their most recent admission had been a direct readmission following a previous discharge.

From the information supplied we found that

- 33 people said that they were admitted as an emergency
- 18 people specifically mentioned that they were admitted as a result of a fall
- 4 people said that they had been re-admitted after a recent discharge
- 2 people said that had been sent to the community hospital directly by their GP
- 1 person said that they were waiting to be transferred to a Community Hospital

“On the previous discharge from Queens I was not consulted – I was sent to a nursing home – I was not happy in the home and had an infection so have now been sent back here (Queens)”

“I fell down stairs at Easter, nothing broken. Went to Stoke by ambulance, then I was sent to County (hospital) - don't know how long. Went home - nurse visited and immediately sent me back to County saying I should never have come out - had bed sores”

“I had been in (hospital) for five months, left a few weeks ago, but was brought back as care package not right – couldn't get night visit and deemed not safe”

“I don't know what is happening – I was in hospital for assessment and then had to be re-admitted to acute hospital”

A number of people said they had been transferred to where we met them from another hospital and out of the information that was given

- 8 people had been transferred to Samuel Johnson Community Hospital from Queens Hospital in Burton
- 3 people had been transferred to Sir Robert Peel Hospital from Queens Hospital in Burton
- 4 people had been transferred to Sir Robert Peel Hospital from Good Hope Hospital
- 3 people said that they had been transferred to Haywood Community Hospital from Royal Stoke
- 1 person said that they had been moved to County Hospital, Stafford from Good Hope Hospital.





Overall, most of the participants had not been involved with the D2A process. There were, however, very few suggestions for improvements to the discharge process. Most did not identify any barriers or delays to their discharge. There were some areas that can be identified as being worth consideration for improvement but on the whole most of those that took part in the interviews were satisfied with their experience of the hospital discharge process.

We asked people if they had been involved in the discharge process and arrangements:

- 26 People said that they had been involved in the discharge process
- 14 people said that the discharge process was being dealt with by a relative
- 4 people were uncertain of whether they had been involved
- 31 people said that they had not been involved with the process
- 5 people said that they had just been told today that they were being discharged today

Patient involvement of the discharge process

Of those patients who said they had been involved, it varied in what they considered to be involvement and for some it was simply being told what was happening to them rather than being an active participant in the decision-making process.

Whilst for most of those participants the lack of involvement was not a particular issue with how they felt about the discharge process, for some of them the perceived lack of communication was an area for improvement.

For some of the participants a lack of communication meant that they were unaware of the decisions that had been made about their discharge. This included knowing when they were going to be discharged as well as where they were going to be discharged to.

“I have been involved all the way – my family are being consulted too at present”

“They have started talking to me about aids that are available for when I go home – I have been walking up practice stairs to show I can manage”

“I have done the rehab for stairs – nothing else mentioned yet”

“Yes, I have been told some things” “Some lady came round to discuss discharge”

“Nothing has been mentioned yet – I’ve no idea how much longer I will be here”

“Yes, my wife has been involved – I am not sure how discharge process has worked – I think my wife maybe arranged it”

“I have not been involved at all, neither has my sister– I am keen to have some care assistance when I go home”

“I am involved, with family helping to make decisions. I previously had a care package at home – now just waiting for the right care package”

“I have not been involved at all – I think my son may have done everything. I don’t know if I am going home or into a care home”





“Not involved or have not been told anything” (x4)

“I have been very involved - I went to visit a care home where I will be moving to, but I have to go back to my own flat first”

“Myself and my wife have been spoken to about discharge daily – I will be going back home – we don’t know any details about a care plan or package but think the District Nurse will visit”

“I have not been involved at all – there is no information that I am aware of”

“Yes, I have been involved – I know all about it, the bed needs moving downstairs”

“Not exactly been told I can be discharged, or when, just inferred”

“Not really been involved – I’ve been in 12 days, today is the first time it has been mentioned”

“The Doctor said yesterday that I could go home tomorrow with a care package – I don’t know if this has been arranged”

“I have been here three weeks and there has been no discussion”

“I didn’t know I was going home until today”

Lack of information and short notice of being moved or discharged

Patient experience – From pillar to post

Healthwatch received a call from a lady who explained that her mother had, nine weeks earlier, suffered a severe stroke and was admitted to Royal Stoke. She told us that two weeks later, on arriving to visit her mother, her mother was not on the ward and at this stage staff advised that the patient had been transferred to rehabilitation at County Hospital, Stafford. The lady then told us how her mother had been at County for seven weeks when the family was suddenly informed of an imminent transfer to Samuel Johnson Hospital in Lichfield. On making further enquiries, the lady was advised that her mother would then be assessed on the care package she would require.

The daughter was concerned that after several weeks on the rehabilitation ward at County that it had been obvious that her mother would be unable to return home and that that a care home place would be required.

The caller also advised that her father was very upset about the proposed further move to Lichfield as he would find it very difficult to visit his wife.

Healthwatch were concerned that no assessment had been made during the latter part of the stay at County Hospital. It seemed that as there are now Discharge to Assess beds at Samuel Johnson that there had been no attempt to start things moving whilst the patient was at County Hospital.

Healthwatch liaised with the hospital to look into the matter with a view to making things less stressful for the patient and her family. Following the intervention of hospital staff the decision was made to complete the assessment at County Hospital rather than have another transfer for this patient.





Some participants talked about suddenly being told they were being moved or discharged, with people being moved or discharged on the same day that it was first mentioned to them.

“Keep moving beds”

“The first I knew about discharge was when care home came in to make admission assessment”

“I was previously sent from Queens to Samuel Johnson, but they sent me straight back to Queens”

“I was in Queens for six weeks and then moved to Samuel Johnson – the discharge from Queens to Samuel Johnson was not discussed at all – I was suddenly told I was being moved – the family were not too pleased with the sudden move with no notice”

“I’m going home today – the nurse has just said about discharge”

Patient experience - where is my aunt now?

Healthwatch received a call from a gentleman concerned about this aunt, aged 99, who has been admitted to Royal Stoke after a series of falls. He told us that his aunt was “black and blue” and had a cracked pelvis. He explained that he was next of kin but lived nearly 200 miles away and has been visiting as often as possible, otherwise keeping in touch by telephone.

He was concerned that he has not been kept informed about what is happening to his aunt, that any information has been difficult to obtain.

Then he found out that his aunt had been moved the previous day from Royal Stoke to the Haywood Hospital and no-one had thought to let him know. His enquiries confirmed that his aunt has been moved to the Haywood for assessment.

The nephew says that although his aunt has carers, following these falls and the injuries, he cannot imagine that she will be able to go home and be cared for there. He is wondering why the assessment was not made or at least started during the 9 nights that his aunt spent in Royal Stoke, where he would think it would be obvious from early on that his aunt would need an assessment for future care needs.

His main concern is lack of communication - his aunt suddenly being moved. He feels that his aunt has been moved from “pillar to post” and although he understands that the acute hospital needs the bed he feels that the way everything has been handled is poor.





Family support and involvement

Firstly, for some of the participants, their family were the key players in making decisions about their discharge, liaising with the hospital and with social care. A number of participants who said that they were not involved in making decisions about their discharge said that their family members were acting on their behalf.

“I let my nephew sort things”

“No-one has spoken to me, but spoken to my daughter”

“I’m not involved, but (information) may have been given to my son”

“Lady from care home has visited and daughter has visited care home”

“No, left it to my two sons - my son say he is happy with the way everything is going”

“The social worker had a conference with my son – I feel it is too soon and I wouldn’t cope – I get lonely at my flat – they say I will have help to get up and go to bed, but I am worried about whether that is enough”

“I live at home – have carers twice a day, but daughter is trying to organise a live-in carer – I don’t want to go to a care home”

“My daughter has been arranging things. I live at home on my own and had carer come in twice a week. Patient has no say, just been told about rehab”

“My sister is involved in arrangements – she passes on the information” (x5)

“Family are trying to sort out care home”

Secondly, for those that were returning to their own homes, the support of family in being able to manage at home was a theme. The support of family members was mentioned in relation to having confidence when they were back at home.

“I’m going home – everything is ready at home – my daughter is my main carer”

“I am going to a relatives home – I am desperate to leave – I have all my things packed”

“My grandson going to stay with me as well as my daughter visiting daily, plus a care package”

“I will be going home - waiting for house to be fixed up with aids. I live alone, but my daughter is just round corner the corner”

“I live at home on my own, but my son and his wife live over the road and I will have care twice a day”





However, the involvement of family members was not always what the participants wanted.

Although most participants who had their family involved in the decision-making process were happy with the intervention, there was one case where the participant felt that their relatives' intervention was unnecessarily prolonging their stay in hospital. Although the participant said that they wanted to go home, they felt that this was only possible if their relative agreed to it.

"My son won't agree to the care package"

"I could have gone home today, but problems with my son, he is stopping me coming out"

For some participants living with family was seen positively in relation to having confidence in being able to cope when they were discharged. However, for one participant living with family members was not a positive experience and was not what they wanted on their discharge. That participant felt that they were not being listened to and their preferences not being considered and that their living arrangements were unsuitable.

"I don't want to go home - live with my brother and sister-in-law.

I'm not happy, on my own all day – relatives out all day and I cannot to the loo on my own.

I've not really been spoken directly to about discharge. The nurse has just told me. The doctors don't seem to listen."

Where people were being discharged to

When we asked where people were being discharged to they told us

- 64 people said they were going home or hoping to go home
- 9 people were unsure of where they would be going
- 3 people said they were going to respite care before going home
- 4 people said they were going to a nursing or residential home
- 3 people said they were going to Sheltered Accommodation or Extra Care Housing
- 1 person said they were going home initially, but then moving to a care village
- 1 person said they were going to live with relatives
- 2 people said they were going to Community Hospitals for rehab and further assessment
- 1 person said that they were homeless and did not know where they would go – they have been told that they need ground floor accommodation.





A large proportion of people mentioned that they were very happy about going home and were very much looking forward to getting home. Many people mentioned that they would have carers and support to enable them to live at home and the majority of people were pleased to have this support arranged.

Some people were unsure whether they would be going home or into residential care.

“Home – can’t wait to get home”

“I’m going home – quite happy to wait a bit but want to get back home”

“I am hoping to go home with some equipment at home and a care package arranged”

“I’m going home when strong enough to cope. A care package is being arranged. I am looking forward to being home, I’m being positive and working hard (on rehab)”

“I am not sure where I am going yet and I am not sure that I can manage at home on my own”

“I am going home tomorrow, but will need temporary assistance with dressing and undressing”

“I’m going home with a domiciliary care package – I’m very happy with that”

“I’m going home, very happy with that but unsure if I’ll manage”

“I have no idea where I am going – just going along with the flow”

Care packages

Participants had been identified by hospital staff as being assessed for their ongoing care needs in order to complete discharge.

There were some participants who had been in receipt of care packages before admission, which needed review and others who now needed a care package that they had not needed before.

“They said two weeks, but it’s now only seven days – I was told on Monday that it’s been brought forward as the package is in place”

“I was kept fully informed at Stoke, prior to this move to the Community Hospital. I am now being assessed. I can’t go home – I could not cope – I want to go to a care home but have not yet had discussion about where – they are waiting for funding. Don’t know how long I will be here”

“Doctor said this morning that it’s OK to go home, but need to sort out care package first – I previously had carers four times a day, but the care company has given the slots away”

“I have not been involved – been told this morning that I am going home and will have two carers visit twice a day”

“I will be going home and have agreed a package of four visits a day for help getting up, meals and going to bed. Some aids are being installed at home and I am being given some choices”





We asked people how they felt about the way their discharge was organised

- 10 people stated that they were happy, quite happy, fine or OK with the arrangements
- 7 people stated they were very unhappy, not happy or that their experience was not good

“Ok, although the communication could have been better”

“Not good, could do better, seems inconsistent, some communication, but little explanation”

“Very unhappy at the length of time – I just want to go home. I feel that there have been mix-ups. I was told that I was out of area for one package, so couldn’t go”

“There has been a lack of communication from Queens, not just to the patient, but to the family”

“Will have to see how things are after six weeks before deciding whether further care package is needed. It’s good that everything has been sorted”

“A bit cross, I feel I should have been discharged already”

“Very happy with the way everything has been handled”

When we asked about any barriers there were in being involved in the discharge process...

- 15 people said that there were no barriers to being involved in the discharge process
- 9 people said that there were barriers with 2 citing housing issues, 2 waiting for a care home place, 5 waiting for a care plan or care package to be put in place, 5 mentioning poor communication and 2 waiting for non-emergency ambulance transport

“All communications have been with my daughter”

“Staff communication, but now happy with arrangements”

“Not really – just formality and red tape” “I have not been kept informed or listened to”

“Nothing so far, but not yet asked what the system is for finding a care home”

“The brokerage system (for care home placement) – my daughter is adamant that I’m staying in hospital until somewhere suitable is found – she’s spoken to loads of places – nowhere has a place”

“No problems, no barriers in planning, everyone is good, the whole family has been involved in plans”

“Slow Occupational Therapist service, with delays – not really been listened to”

“Patient ambulance transport only – anyone’s guess when they will turn up”

“Not kept informed – just waiting and waiting”

“I need an increased care package”



Delays to discharge



Some participants were delayed because they were waiting for a care package to be put in place.

One participant told us how they had been assessed but they unsure the care that was agreed would be sufficient.

When asked if there were any delays to their discharge....

- 9 people indicated that there were no delays
- 13 people indicated that there were delays, with 5 of those citing waiting for a care package
- 5 people said that they were unsure if there had been any delays
- 2 people said the process was too quick – the both indicated that they did not feel well enough to be discharged.

“Awaiting care package / care plan / getting the right care plan” (x7)

“I think I’m still being assessed but am not sure”

“Waiting for plan to be put in order – it’s going to be doubled”

“Someone is going to my house to assess facilities” “Awaiting assessment”

“I don’t know as I haven’t been consulted” “No particular delays just a bit slow”

“I won’t know until after my assessment this afternoon” “I’m just waiting to go to the discharge lounge”

“I was initially expecting to be in two days, now delayed waiting for a care plan to be done”

“I feel there have been unnecessary delays in going home – I am not sure why I have been kept in so long”

“I’m going to a Community Hospital as I am led to expect physio. There’s no choice, it’s a question of waiting for a bed”

“The Social Worker at the hospital is very good. He has found a suitable one (care home placement) but brokerage not phoning back or answering emails”

“My son says he is happy with the way everything is going, but mentioned an issue of council social care not picking this up for six weeks”

“Therapy have to approve new flat – it was turned down as they said it was not suitable for a wheelchair”

“I’m waiting for care package – the social worker came three weeks ago, but I have not heard or seen anything since”

“I’m just waiting for a bed at the Community Hospital – one has just been allocated”

“I have no date for discharge – waiting for a bed guard of some description – it should be delivered tomorrow”

“The ward sister says I’m waiting for an assessment bed” “ just waiting for social care team”

“It seems a long time and then it happens in a rush”





We asked people how confident they felt of managing upon being discharged to home or elsewhere

- 49 people said they were confident, very confident or reasonably confident with several saying they would be OK with the care package
- 8 people were not sure or worried about how they would manage at home
- 5 people said they would not or could not manage at home

Most participants were confident that they would manage at home with the care packages that were put in place.

“Yes, I have a good support network”

“I’m very happy, I’m steady with a walker”

“Confident if I can get help with my 92 year old husband”

“I will also have the District Nurse visiting – they are talking once a day”

“Ok, providing they look at helping with supports to get in and out of the shower and loo”

“Very – if it’s chosen care home – I do not want to go back home – the house is now up for sale”

“OK with care package – I think social services have been good”

“My house has a stairlift and a wetroom – I can’t wait to get home”

“Very confident – I want to go on a cruise to Barbados”

Of the people who responded to the question about how confident they felt of managing at home or elsewhere upon discharge, approximately one in four were not sure or worried about managing or said they would not or could not manage.

“I’m worried as I’m still weak”

“I’m not sure – in doubt about getting out of bed”

“I can’t go home, I could not cope – it would be fine if it is a care home”

“I am not sure I will manage at home, particularly with self-administration of insulin, but I feel I’m too young for a care home”

“I’m not sure – hope my confidence will improve in the following days”

“I’m not ready to be discharged yet – I need to stay here longer”



Moving to residential care



There were a small number of participants who were going to be moving on to residential or nursing homes.

Generally, those that were moving into residential care were happy with the decision to be doing so, although one participant made it clear that it was only on the proviso that it was a specific care home.

One participant had been unaware that it was planned that she moves to a care home instead of going to her own home.

“I’m going to a Nursing Home – I don’t really know if there is a choice – I think there is, but it’s complicated”

“I’ve been in Sir Robert Peel for two weeks – they’ve been talking about a nursing home since being admitted to Queens in Burton”

“It was only mentioned yesterday about going into a home for a week – don’t know where that will be”

“Have lived at home on my own – they are sorting out the discharge with my daughter. A care home visited me last Friday (in order) to put in a bid – not sure who arranged for them to come in”

“I am going to a care home – was offered a place that was totally unsuitable, poor CQC rating, totally inappropriate. Another unsuitable one was for people with mental disability. I accepted another one, but when they phoned to confirm they were told that the bed was no longer available.

That bed was offered on Friday but was gone by the Monday.

Brokerage is completely out of order – just trying to get the cheapest”

“It was a shock on Friday when a care home came in (to make an assessment for admission) – it was the first I knew of it. Before, at home, I had carers coming in. I am not sure whether I would like to go home or not or who makes the decision – maybe it’s too expensive to have carers at home.

I felt under pressure over the weekend to make a decision. I’m not sure who arranged for the care home to come in.”





Housing

Two participants told us that they had issues with their housing during the course of their interviews. Although, the number of participants is in not large in the context of how many people took part in the project, it is felt that the issues that these participants faced are worthy of inclusion in the report.

“I am currently homeless - do not know where I will be going, need to be ground floor – at the moment nowhere to go. I have been in hospital since February – I feel lost at the moment, not knowing – I worry about what is going to happen. Housing is the main barrier and delay to me being discharged from hospital”

“I’ve been here two months with no mention of discharge. I live in a third floor flat, but now need a ground floor, so waiting for housing. Housing has telephoned a couple of times, but no-one from housing is seeing me -I have no idea of what is happening – I’m going along with the flow. Therapy have to approve a new flat – it needs to be suitable for a wheelchair. It’s completely disorganised, but it’s not the fault of the hospital. Housing need to be more responsive”

When asked people about who had spoken to them about their discharge we were told:

- 16 people said it had been discussed with the Consultant or a Doctor
- 10 people said it they had been spoken to by nurses
- 3 people said they had been spoken to by a social worker
- 2 people said they had been spoken to by the Physiotherapist or Occupational Therapist
- 1 person said that they had been spoken to by the Head Nurse, Consultant and Therapist
- 1 person said that they had been spoken to by the Matron, Junior Doctor and Physiotherapist
- 1 person said that that they had been spoken to by the staff and her sister
- 1 person said that they had been spoken to by the Physiotherapist and the Doctor
- 9 people said that they had been spoken to by a member of their family
- 9 people said that no-one had spoken to them, or not yet
- 1 person said that no-one had spoken to them, but housing had phoned a couple of times.
- 1 person said no one, but the Occupational Therapist has just been to speak to me.
- 10 people said they had been spoken to but they were unsure who had spoken to them
- 2 people said that no-one had spoken to them, but their family were trying to sort out a care home
- 1 person said they were spoken to by a lady from a care home (making an assessment)
- 1 person said that they had been spoken to by a Doctor and Occupational Therapist at Queens before being moved, but no one had spoken to them since the move
- 14 people said that no-one had spoken to them about their discharge
- 7 people said that had just been spoken to about discharge that morning by a Doctor or Nurse.

A number of participants who said that nobody had spoken to them about their discharge or could not recall anyone speaking to them. Those that said they had spoken to staff from the hospital largely spoke in terms of being informed of their fitness to be discharged.

However, very few said that they had spoken to a social worker, although with some having new care packages or looking at entering care homes it might be expected that they had at some point had contact with a social workers or social care assessor. It is not clear if participants had really not spoken to anybody from social care, or whether they were interpreting the questions as simply being about their medical discharge from hospital.





What patients thought could be improved

When we asked people what, if anything could be improved to make discharge a better experience only 16 people made comments, mostly around communication

“Everything – communications”

“Not enough communication. More communication”

“Just keep us informed. Be more honest with it. Talking to patient and family”

“Knowing what is happening, time limits are poor, it should be quicker to organise things”

“Communication, explanation and speedier OT service”

“Thinking about care home in first place”

Some people made positive comments about the discharge experience

“It seems to work”

“It’s all good, just relax, give it time and good things will happen”

“Happy with everything”

Is everybody getting the assessment they need?

Healthwatch receive feedback about people’s experiences and recently we noted an increase of people contacting us about discharge – mainly the issues causing concern when people either do not seem to have had any assessment prior to discharge or where they have been told that no support is needed when the patient or family consider that some support is needed. It is likely that these type of incidents are outside of the Discharge to Assess process – it can occur because the patient has been sent to the wrong place or the right place, but at the wrong time.

We heard of an issue where a patient has been discharged from an acute hospital to a community hospital for rehabilitation. However, the patient was not medically fit for rehab as he still had medical needs. These did not require an acute bed and these needs could have been met elsewhere, such as a nursing home or community hospital ward until the patient was medically fit for the rehabilitation ward. The result being that as soon as the patient arrived at the rehabilitation ward, they were trying to discharge the patient home (without an assessment).





Patient experience - Too late for an assessment

Healthwatch were contacted by a lady who told us of her experience of discharge in relation to her mother. Her 92 year old mother had recently been discharged from Samuel Johnson Hospital. The daughter told us that the social worker had stated that her mother did not need any care or support, either at home or a residential care home – the daughter said she found it difficult to understand why her mother was not offered at least six weeks support in line with discharge to assess. The daughter told us how her mother was quite frail and needed a walking frame to have any mobility. The mother had been living with her daughter, but the family had found that they could no longer meet her care needs. The daughter said that when she explained this to the social worker that the response was “you are making her homeless then”. The daughter reported that the social worker then gave the daughter a list of accommodation. The daughter told us that “Nothing was available in the short time frame”. She said that, feeling desperate and under pressure, she looked for a care home. She found a place in a care home and her mother was discharged to the care home with the family paying the fees. The daughter went on to say that her mother kept having falls within the care home and this had resulted in her mother being taken to Queens Hospital and then her mother being transferred back to Samuel Johnson again. The daughter explained how her mother was then discharged back to the care home on a Monday – her mother died on the Friday. The daughter said that they found out that her mother had been given an appointment for a chest x-ray for six weeks later because of pneumonia. The daughter finished the telling of her experience by saying that two weeks after the death of her mother that she received a phone call about “an assessment for her mother”.

Patient experience - End of life and no assessment

Healthwatch received a call from a lady whose husband had recently died. He had advanced cancer and had been going to a hospice one day a week to give his wife some respite as it was becoming increasingly difficult for her to provide the right care for her husband as he became frailer and she herself had health problems. The caller told us how her husband was taken to Queens Hospital following a fall and was at Queens for ten days before being transferred to Samuel Johnson Hospital. When it came to discharge, the caller told us that she was told that they would discharge her husband to home – the wife said that she explained that she could no longer manage, that her husband by this stage could not walk amongst many other difficulties. The caller says that the staff at Samuel Johnson insisted that her husband could walk, although the staff at the hospice had previously commented on how “he could no longer walk”. The wife reported that she was simply told “then you need to find a care home”. There did not appear to have been any assessment about the type of care that her husband needed but with advanced cancer and attendance at the hospice it may have been expected that an end of life assessment be made prior to discharge – the wife told us that she was not aware of any type of assessment. The wife looked for a care home near to where they lived as this is what her husband wished. She went to see a care home which she liked and thought may be suitable. The wife said that she had felt “under a lot of pressure” as Samuel Johnson said they were going to discharge. Her husband was discharged to the care home and after approximately one week had a further admission to Queens Hospital with an overnight stay. The medical staff had said that there was “nothing more we can do for him” and he was discharged back to the care home. He died after ten days in the nursing home. The wife told us that people, including staff from the hospice, suggested that his should have been classed as end of life care and she should not have had to pay the nursing home fees.

The concern in this case is the discharge process and whether a proper assessment was made and the right care provided in the most suitable place.





What staff told us about the D2A process

During our fieldwork we spoke to staff on all of the wards we visited. Staff at Queens hospital seemed to have a clearer understanding of how the system works. The social work team visits the patient on the ward and makes the arrangements for discharge with only minimal input from ward staff.

We spoke to several staff at Royal Stoke hospital who had a different view. When asked if they felt that the D2A process had led to an improved experience for patients, the majority of Discharge Facilitators and ward Sisters/Managers thought that it hadn't, and in fact was worse.

Royal Stoke Staff Comments

"Ward staff have no control at all over discharge anymore, we just get told that a patient is going. This could be at an hours notice giving no time to properly prepare them"

"We are continually being asked for more and more information and it is all done on computer so they (Track and Triage Team) don't even see the patient"

"Track and Triage will only come to see a patient by exception. This is called 'Eyes On'. Sometimes by the time a package of care is available for patients, they have deteriorated and have to stay on the ward"

"Discharge Facilitators have to keep the patient profile updated as well as chase up things like housing issues, house cleans and equipment. This takes up a lot of our time"

"Track and Triage make decisions on patient's that they don't even know and have never met"

"It is the DF or ward staff that patient families contact and have a go at about lack of communication / information about discharge"

"It is just a paper exercise, the patient does not seem to be viewed as a person in all of this"

We were told of delays in care packages being available. One lady was waiting for a package but that her family had taken her out on a Sunday from the ward to attend a family event and then returned her back to the ward. We were also told that sometimes it felt as if the Track and Triage team kept sending the profile back to the ward as a delaying tactic because there was no care package available. There was a strong view that the Track and Triage team were a fairly invisible team that sat at a computer all day making decisions about patients care needs with very little communication with the staff who knew the patient and their capabilities. This was something nursing staff seemed to struggle with. There was very little positive feedback about D2A from staff at Royal Stoke who felt that they had little to do with it other than the Discharge Facilitators whose specific role it was. Although they were universal in saying how demanding and at time pressured the role was they were also happy with the role and found it quite rewarding.

Asked if the D2A process had reduced delays in discharge as expected, again the perception of staff was that it hadn't.

"Patients transferred to the 'ready for discharge' wards often can wait for weeks for the right care package to go home, a community hospital bed or other things like housing issues, house cleans etc."

"One lady has been in here 6 weeks waiting for a house clean, she is desperate to go home and is deteriorating in mood"

To achieve a balance to this view we met with the Track and Triage Manager and some of the team who were present. They were able to articulate very clearly and passionately what the purpose of D2A was "to facilitate a 'safe' discharge to an appropriate place for further rehabilitation or assessment of longer term needs". The manager was surprised by some of the comments made and assured us that ward staff were and are regularly briefed about D2A and are communicated with by the team on a regular basis. From our discussions with staff from both areas there are communication issues that need to be addressed.





What happened next – follow up interviews

People taking part in the original interviews were asked if they were happy to be contacted again to see what their experience was following discharge. 29 people were interviewed by telephone after a suitable interval.

What people told us:

- 12 people said that their overall experience of discharge had been good and they were happy about it
- 3 people said that their experience of discharge was poor
- 12 people said they were still having carers in at home on a regular basis
- 5 people said that they had carers for a period of time but they no longer had carers
- 1 person said that they still have carer visit, but it is now reduced to once a day
- 1 person said that they went home without the planned carers in place as they could not be sourced
- 1 person said they were told not to drive until after having physio, but no-one ever got in touch with them to arrange physio
- 5 people said they were happy with the care package
- 4 people said that they were still having physio at home
- 1 person said OT had visited them at home to arrange modifications to their home
- 4 people said that they were still having physio / OT appointments at the community hospital
- 1 person said they had had physio following discharge but that had now finished
- 2 people said that their GP had been supportive and visited them at home
- 7 people were having regular visits from the District Nurse Team
- 3 people said that they can now cope well without carers
- 2 people said that they can manage without carers, but they still have some difficulties
- 2 people said that they were continuing to improve at home
- 2 people said that they had issues / problems with the carers
- 1 person was re-admitted within a week of being discharged – they reported that they were discharged without any assessment
- 2 people were readmitted within weeks
- 1 person had recently had two falls and the District Nurse had mentioned that they may need to go back to hospital
- 3 people were now in a care home, all originally for short-term placement, but that had now become permanent for one person
- 1 of the people discharged to a care home had moved care home as the original placement was unsuitable
- 1 person in care home said that they had not received the planned weekly district nurse visits to change dressings





"I have continued to improve at home – I do not need to use the walker or commode that was provided any longer. Home support finished after three weeks"

"Had been doing OK until she had a fall on Saturday and another this morning. She's not feeling well enough to talk – I am unsure if she might go back into hospital" (District Nurse answered phone)

My mother was discharged to a residential home, she went there directly from hospital. Has been there 5 weeks as a temporary resident, but not well enough to come out, and no family lives close by. Still seeing Physio and OT. Left Samuel Johnson without a discharge letter, so the home had no idea of medications required. I am having to do all the running around – very disappointed with the system – there has been a complete lack of communication. My mother was supposed to have her dressings changed weekly, but no District Nurse has visited at all – we did have assistance with this from OT when they were visiting another patient, but the dressings have only been attended to twice in five weeks" (Daughter of patient)

"I left hospital in early June – I kept saying I would need carers and that I would pay for them. Nothing seemed to happen. OT came on morning of discharge saying they had tried 11 agencies but couldn't find anyone. I was sent home. I have never had any carers – my neighbours arranged to have hot meals delivered. I was told not to drive until after physio, but no-one has ever been in touch regarding physio. I have now gone to a private physio and it has done wonders. I feel that there is no communication either in hospital or after discharge"

"I am not happy with the system – I was in County Hospital (Stafford) and they decided that no assessment prior to discharge was necessary. I ended up in Royal Stoke after a week, requiring surgery"

"Discharge was poor, care package is fine – Physio is great"

"My mother was discharged from County (Stafford) without medication at the end of May. She was home for three weeks and then taken back in (to hospital). My mother was very poorly although by the second week of July they told me that she was medically fit to go home. I then has a call the following morning to say 'get here quickly' – I managed to get there by 9 a.m., but my mother had passed away. I am very unhappy with the entire process" (Daughter of patient)

"My mother had good care at the hospital but was discharged to a care home which was for people with dementia and my mother does not have dementia although the staff at the home were great. My mother has now been moved to another home which is closer to home but is having some problems adjusting. She would like to go back to her own home, but it may not be safe to do so – she has now had 28 falls. No official final decision has been made on that"

"I came out four weeks ago, happy just to be home. I had Carers for 4 weeks but now finished –I feel I can cope without carers or support"

I left hospital a couple of weeks after the interview, and was happy with care plan put in place for me. They did however ignore the fact that I am the carer for my 92 year old husband, so my daughter had to organise a completely new care plan that catered for both of us. We are happy with the state of things now"

"I am going back to Haywood for OT. I have been out a few weeks and still got carers coming in 4 times per day. I am happy with everything, but unsure how things will be when the carers finish other than my daughter helping"





“My mother-in-law is now in a care home. She went in for re-hab and ended up staying following discussions with social worker and district nurse. We felt very involved in the whole process as a family and happy with outcome” (Daughter-in-Law of patient)

“I had carers for 4 weeks but no-one now. The District nurse came in to dress my foot. I am very slow but can manage, and the carers thought I could manage on my own. I had physio trying to assist with getting my legs working, but they have now finished, so my main form of contact with people is by phone”

“I have been back at home for several weeks now and have a 4 times per day care plan. I get occasional visits from District Nurses. I feel happy with everything. I had requested to always have a female carer at night – very occasionally 2 male carers have turned up to wash me, but my partner always helps out”

“We have been delighted with all Carers who have visited my mother. Had Home First, but now it’s AMG. They visit twice per day, and I live over the road - I make meals, but Mum is now getting more independent. She went back into hospital with a very high temperature – Home First recommended getting paramedics out, and they took her in. She had mild pneumonia and was developing ulcers. Very pleased again with everyone at Royal Stoke and the whole process” (Son of patient)

“Carers originally came in 4 times per day, but that was cut down to 1 visit per day last week. I feel fine now and the District Nurse is pleased with my progress. I try to do everything myself and I am generally pleased with everything”

“The carers finished a couple of weeks ago. I feel I’m managing well on my own and I am happy with everything”.

“I have carers visit 4 times per day. Had previous carers in for 6 weeks, all very good. Very happy with everything, still having ongoing treatment for my leg”

“I’ve been at home for 4 weeks. I have carers visit 4 times per day and have got physio visiting twice a week and my GP has done a home visit. I am going to start going to gym at Haywood every Friday. I am happy with everything”

“I have carers visit 4 times a day and also have physio. I am getting OT for changes to the house, currently staying at daughters whilst the changes are done. I am having trouble getting carers to shower me, do hot water bottles and other things. One carer in particular won’t help”

“I’m happy with everything - Carers come in 4 times a day”

“My wife has been out of hospital for 2 months now and has Carers visit twice per day. Everything was arranged for us and we are quite happy with things. We’ve had support from social services plus the occasional visit from a District nurse and our local GP is very good”

“My son did all the work, arranging Carers and District nurses. I have now been completely discharged from hospital. The Carers visit 3 times per day, still ongoing and the District nurse comes. The carers do my medications daily. I am really quite happy with everything”

“I have Carers visit 4 times a day - very pleased with them. I also have visits from the District Nurses when necessary. OT came in yesterday – setting up ramps for both front and back doors for wheelchair. My family visit regularly and I am happy with everything”





A patients journey - All's well that ends well

Proposed discharge causing concern

Healthwatch received a request for advice towards the end of April 2019. The caller contacted us regarding her Grandad who was at Sir Robert Peel Hospital as she has been told that they are discharging him to "home". The history was that Grandad had a bad fall and had been admitted to Good Hope Hospital – he had broken two limbs. Staff at Good Hope were ready to discharge from the acute hospital setting after a couple of weeks, and the granddaughter reported that some staff were saying that he needed to be transferred to a non-weight bearing bed (potentially in a care/nursing home) until he was able to go to Sir Robert Peel for rehabilitation. He was however discharged to Sir Robert Peel rehabilitation unit. The granddaughter told us that after a day or two at Robert Peel, the staff there said they "can't keep him" (as he was not ready for rehabilitation) and they would "discharge him home". The patients granddaughter was very concerned as he was non-weight bearing, bed-bound and was worried about him being discharged home, even if carers were to attend up to 4 times a day as had been suggested.

The family had arranged a meeting with the Discharge Nurse, so Healthwatch discussed with family about writing some notes in advance of the meeting, questioning whether any sort of proper assessment had been made as it seemed to the family that Grandad needed continuing medical care (it being less than three weeks since he had had his fall). Healthwatch also advised to ask about other options i.e. nursing home for a period until he was ready for rehabilitation and to ask about what physiotherapy if any was being done currently to keep his functionality as well as is possible with his injuries because of the high risk of de-conditioning.

The Family reported back that the Discharge Nurse had reconsidered and the discharge had been postponed.

Grandad is interviewed by Healthwatch during our Discharge to Assess interview sessions

On reviewing the interviews that we have made during our research into the Discharge to Assess process, we found that in the early part of June 2019 we had met and talked with the same gentleman whose concerned granddaughter had called us in April.

Grandad explained to our interviewer that he had been in Good Hope, then Robert Peel, then had gone back to Good Hope and finally back to Robert Peel where he had been for several weeks. He was able to tell us how he was hoping to go home soon and was doing physio work at the moment to prepare for going home to his bungalow (which he loves). He told us that someone had mentioned the possibility of going home the following week, although he wasn't sure who had spoken to him about going home. He said that he lived at home with his wife, who already had a care package in place and that "I will have to be added on". He told us that he was very happy with the way things were going, the progress he was making and how he was looking forward to going home.

Healthwatch catch up by phone with the follow up on patient experience of Discharge

Seven weeks later this gentleman was telephoned as part of the work to follow people through their journey.

We were delighted to hear from that the gentleman that "the carers finished a couple of weeks ago". He told us that he felt that he was managing well on his own and is happy with everything.

Healthwatch were very pleased to hear that this patient had, after the initial hiccups because of being sent to the wrong place at the wrong time, that everything had worked out well. He had received the medical treatment he needed, the appropriate rehabilitation and that the discharge process with initial support at home had been successful in getting him home to his family and once again independent.





Conclusions

Feedback from patients being discharged from the hospitals in Staffordshire was mixed. Although not all participants were necessarily involved in the planning of their discharge they did not appear to be unduly concerned about this as some of them had family support to take care of arrangements. However, for some participants, the lack of communication with them was an area for improvement and there were many participants who seemed unsure of what was happening with their discharge in terms of when they might expect it and where they were going to go. For many participants who said they had been involved with plans for discharge, this amounted to being the recipient of information rather than actively involved in decision making.

There are issues, both for patients and their families, of patients being transferred between hospitals, mainly to an assessment bed or rehabilitation bed, where it has seemed to happen “suddenly”. Whereas it is understood that sometimes notice is short as beds become available, again there appears to be a lack of communication or explanation that this is likely to happen.

The support of family was important both in terms of decision making during the discharge process and also in being able to manage when they returned home. However, having family making decisions or providing support was not always what the patient wanted and therefore, the discharge process needs to make provision for this.

Most people were happy with the arrangements that had been made but there was some feedback that waiting for care packages was delaying their discharge from hospital.

Likewise, there were a small number of participants who were being discharged to residential or nursing homes. On the whole participants were happy with the decision to move to a care home, however, there were comments about the difficulties of finding a suitable care home and the processes that were involved.

Housing issues were raised by two of the participants with the suitability of accommodation being an issue. A lack of suitable accommodation meant that discharge was delayed for these particular participants.

Participants told how the staff that they spoke to about their discharge were largely nursing or medical staff, although many also said that they had not spoken to anyone about their discharge. With the number of participants who were going to care homes or having a care package on their return home, it might be expected that they would have spoken to some social care staff, however, it is not clear if they had or not.

There is concern that not all patients with ongoing health or care needs are receiving appropriate assessments. Trusts should provide information and training for staff around discharge to ensure consideration is made as to whether the patient may have care needs and that an appropriate assessment is arranged.

It was evident that in Royal Stoke hospital in particular, there were issues between ward staff and the Track and Triage team around visibility, communication and involvement in the D2A process that needs to be addressed. Although we were told that a lot of communication and briefing has been carried out with ward staff, this has somehow not resulted in a clear understanding of what D2A is or the benefits for patients and this does seem to be having an impact in terms of ‘ownership’ and ‘buy in’ to D2A.





Recommendations

Information for patients

Ensure that patients are kept informed about the progress of their discharge and when they might expect to be discharged, what arrangements need to be made before they are discharged and who is responsible for making those arrangements.

Staff should try to give as much notice as possible when patients are being transferred between hospitals keeping patients and relatives informed. It is appreciated that sometimes people are moved at short notice because an appropriate bed has become available, but patients and their families should be made aware that they are likely to be moved, the reasons for this explained and the likely time frame for the transfer.

Aide-memoire – Consider whether it may be possible to introduce an aide-memoire for patients who may struggle to remember the information they have been given about transfers, assessments, discharge and care needs.

Care packages

Care Packages need to be arranged in a timely way with patients and families kept informed of the likely timescales for discharge so that patients do not become de-conditioned or deteriorate mentally whilst waiting.

Care Homes

A move to a care home as part of the D2A process needs to be explicitly explained as to the purpose and expected length of stay so that Patient's understand its role in the D2A process and not get confused believing that they are going into a long stay placement without a proper assessment.

Housing

Early engagement with housing providers is essential where patients current housing situations are not suitable for discharge. Ensure that patients in these situations are supported and kept informed on the progress that is being made to resolve their housing issues.

Family support

Recognise the role of families in discharge planning, however, not at the expense of direct communication and involvement of the patient. Although for most patients the role of family is a welcome one, ensure that there is provision in place to recognise where there is tension within the family and have support in place for patients in this situation.

Staff information and training

Consider how communication between staff on wards and the discharge team and with patients and families can improve so that ultimately patients and families are more engaged in the process.

Trusts should provide information and training for staff around discharge to ensure consideration is made as to whether the patient may have care needs and that an appropriate assessment is arranged.





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