healthwatch
Bristol

Charting the experiences of people being discharged from hospital on the Pathway 3 care route

May 2022

Contents

The NHS describes Discharge to Assess Pathway 3 as 'a focus on patients who have completed an acute episode of care in hospital but are unable to return to their previous place of residence and need on-going assessment of their long-term care needs.'

About Healthwatch Bristol

Healthwatch Bristol has a statutory duty and remit to provide a voice for people who use health and adult social care services. We give people an opportunity to have a say about their care or the care of their family, including those who are not usually heard.

We ensure that their views are taken to the people who make the decisions about services. Our expertise in engagement and coproduction during this project means we can provide detailed experiential evidence to statutory authorities and commissioners.

We share feedback with national stakeholders Healthwatch England, NHS England/Improvement and the Care Quality Commission (CQC) to ensure that your community's voice is heard. We make all findings public from our work with patients, families, carers, and citizens.

Healthwatch Bristol is a place where peoples experiences improve health and care. Healthwatch is committed to promoting equality and diversity and tackling social exclusion in all our activities. We aim to ensure equitable access to our initiatives and projects.

Aim

The project collates the qualitative experiences of individuals, families, carers, and staff involved with Pathway 3 discharges. It aims to use these to highlight good practice and recommend areas for improvement by examining where things have worked well or not worked well for recipients of the care. In addition, people told us about their care settings, pathway 1 & pathway 2 discharges, home care and transport and these appear as supportive evidence throughout the study.

Executive Summary

The project was identified as a priority by Healthwatch Bristol's Prioritisation Panel and chosen because it has a strategic alignment with local system development. There is national interest in improving the quality of discharges from hospital. The qualitative insights collated here, into the Pathway 3 discharge process, are from University Hospitals Bristol and Weston (UHBW), and North Bristol Trust (NBT), care home partners and adult social care provision in Bristol.

A survey asked for feedback from those leaving hospital via pathway 3 route into a care home for assessment. Information was provided by those on alternative discharge routes, and this is calculated within the data and reported where appropriate and relevant.

Healthwatch Bristol received 141 responses to the three survey designs and from these conducted 11 structured interviews and a further 15 open conversations. Healthwatch Bristol follows the 'Healthwatch England 'Code of Conduct for Public engagement, evaluation, audit, and governance.'

Headline statistics

- We collected a total of 141 survey responses, 11 structured interviews and 15 open conversations.
- 81 responses were from families, patients, or carers and 60 responses were from staff -some respondents gave feedback across more than one setting.
- Patient and family/carer responses by location was 50% University Hospital Bristol & Weston, 35% North Bristol Trust, 9% Adult Social Care, and 6% Care Home (all).
- Staff respondents came from across all levels of care. 62% University Hospital Bristol & Weston, 27% North Bristol Trust, 6% Adult Social Care and 5% Care Home (all).
- Over 40% of staff reported that they sometimes felt that pressure to reduce the length of stay impacted upon the quality of care they gave.
- 62% of patients who completed this question said that they were included in conversations regarding care.
- Over 70% of the hospital staff and 40% of care home staff stated that having worked closely with patients they felt their views were considered in planning future care.
- 53% of patients felt their care needs were regularly assessed in a hospital setting and 70% in care home locations.
- Of those that answered this question, 80% of patients and families at UHBW and 50% of patients and families at NBT said they knew which pathway they had been assigned to.
- Over 20% of families and carers voiced concerns regarding the consideration of their needs when creating care plans. 84% stated that no alternatives or options were discussed.
- 55% of patients and families did not know who to contact if they had concerns.

- 50% of staff felt that the needs of patients and their families were not accurately explained to them.
- 42% of staff felt that resources and equipment were not always appropriate for patient needs.
- 60% of families who said they knew who to contact, were related to patients at NBT.
- 71% of those families/carers who reported feeling more included in care discussions were referring to UHBW.
- Over 75% of those who responded to the question said that they felt delays in admission or discharge had led to a psychological negative effect.

Findings

- The transition from one care location to another was the biggest area of concern and includes stories of delays, poor information, and distress.
- Patients and families want to be involved in conversations about their care and to be informed as early as possible in the process about what the possibilities are.
- Care Plans are an integral part of the communication and planning process. 84% of those with one, told us no care options were discussed.
- Patients, families, and carers said that they were not always sure who to contact if they had concerns.
- People felt that members of the same team worked well together within the same setting but that this was not usually the case across different teams and separate locations.
- Over 40% of staff reported that they sometimes felt that pressure to reduce the length of stay impacted upon the quality of care they gave, and that resources and equipment were often inadequate for patient needs.
- Moving between wards during the hospital stay was highlighted as an issue for by both families and staff.
- The effect of Covid-19 on availability of social workers for these patients was mentioned as a concern.
- Staff made suggestions around improvements to the system, and we have included these in the report with our recommendations.

Recommendations

1. Provide clarity about the pathway the patient is on and explain what this means for them in terms of location and outcome. Staff should follow a checklist of patient and family understanding to minimise gaps in information around care and next steps in transition.
2. Evidence communication protocols for transition and enable and monitor the use of systems and data sharing throughout the pathway.
3. Involve Social Workers as part of the internal hospital process to enable alternative pathways to be evaluated fully prior to a Pathway 3 decision.
4. Evidence the provision of a range of accessible communication resources to include language and sensory impairment materials both in text and spoken information. Ensure the availability of interpreters. Ward round information is offered to families and carers at each visit.
5. Always provide patients and carers with a single point of contact to speak to.[1]
6. Evidence that changes and delays to discharge times are related and explained to patients and families/carers in a timely manner.
7. Evidence the provision of adequate resourcing to enable a consistent quality of care. Ensure that the Better Care Fund programme supports local delivery at a standard that is championed by service users.
8. A focus on admission prevention is taken, to take pressure off hospital resources and make the best use of beds.
9. Fully integrate Community Care and Care Home systems for effective support for service users.

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[1] Healthwatch England National Guidance https://www.healthwatch.co.uk/response/2022-03-31/our-advice-government-nhs-objectives-2022-23

Introduction

People are admitted to hospital for a variety of reasons. Policy dictates that assessment regarding discharge from acute care is initiated as early as possible during the stay. NHS England define the discharge process as occurring when people who are clinically well and no longer require an acute hospital bed but may still need care services and support, are discharged home or to another care provider. Assessment for longer-term care and support is then undertaken. For those with more complex needs this will entail a hand over process from a hospital to care home setting and a holistic assessment to be made for permanent ongoing care (either returning home with a dedicated support package or remaining/transferring to a suitable long term residential placement). This is known as Discharge to Assess (D2A) Pathway 3.

D2A Pathway 3 requires integrative working across a multitude of teams, organisations, family, friends, carers assessing multifarious needs and establishing and adapting care giving for an individual with complex needs. The aim is to prevent unnecessary long stays in the acute setting by avoiding secondary complications and thus enabling improved flow and allowing assessments to be made within a time and setting more appropriate to long term care. Offering person-centred and holistic support are central to this work. This complicated endeavour was made more difficult during 2020-2022 by the Covid-19 pandemic.

Bristol City Council, local NHS trusts and care providers worked with Healthwatch Bristol to establish a means of gathering patient, staff and family lived experience data and to highlight good practice, positive outcomes, and work toward improving the delivery of services. We began this research after a nationally applied reduction in the D2A assessment window from 42 to 28 days. Local providers told us the longer window ensured good outcomes for patients, and 'an increased likelihood of avoiding long term residential care, allowing people to return with support to their own homes.'

There is enormous pressure upon the hospitals to vacate beds while people wait in these beds for a follow-on place. Both UHBW and NBT are currently working to improve their discharge procedures and address issues that are both related to the pandemic and usual procedures. We have liaised with them both prior to and after the research phase of the project

Pathway 3 accounts for 1% of the Bristol Hospital discharge figures[2] but demands considerable staff resources and processes that support good patient care. Sirona Health & Care, the community care provider, collates figures [3] which show their workload from patient discharge. Between Oct 2020 to Sept 2021 there were 872 weekly Pathway 3 referrals to Sirona.

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[2] Joint Strategic Needs as Health & Wellbeing profile 2020/21 Bristol City Council

[3] Sirona Health and Care Dashboard Oct 2021

The project aims to collate patient, family and carer lived experience, to enrich the understanding of, and appreciation of narratives that go behind the statistical data.

Methodology

- Following initial conversations with care providers project planning and Equality Impact Assessment were begun and research was carried out between October 2021 and March 2022.
- Co-production on the project interviews meant questions were co-designed with staff, providers, carers, and patients – partner groups are identified in the appendix.
- The anonymous surveys were co-created by staff, patients, carers, and families.
- A trial survey was piloted with care providers and VCSE groups prior to amendment and distribution.
- Three surveys captured the views of Patients, Care Staff, and Families/Carers.
- Both online communications, and hard copies of surveys were provided and distributed.
- Some surveys were completed by telephone surveys and others received by post.
- Survey responses totalled 141 across the three groups.
- 26 in-depth semi-structured interviews built on survey answers to focus on themes. Participants were asked to express their personal views.
- Early findings were shared, and interviews were revisited with a small section of the participant group to check information.
- Risk assessments, safeguarding and aftercare were advised upon by partner groups and embedded within the study.

Demographics

Healthwatch collect participant demographics to ensure our findings are representative. We work hard to enable diverse communities to be an active part of our studies and routinely report the demographic monitoring data as part of our transparency mandate and our commitment to helping tackle health inequalities. The full list of demographic information requested can be seen in Appendices 1, 2 & 3.

The demographic information has allowed us to analyse differences in experience of care between groups we aimed to involve in the project.

Not all respondents chose to answer all questions and the findings are collated from the following:

- 54% of patients who completed the survey answered at least some of the demographic questions, 7% chose to leave contact details
- 57% of families /carers who completed the survey answered at least some of the demographic questions,40% left contact details
- 35% of staff who completed the survey answered at least some of the demographic questions, 8% left contact details

Categories with zero results are not included.

Gender

Patients	Family/carers	Staff
62% Female	78% Female	88% Female
38% Male	22% Male	12% Male

Identifying as a different sex than at birth

Patients	Family/carers	Staff
0%	2%	1%

Sexual orientation

	Patients	Family/carers	Staff
Heterosexual	100%	94%	91%
Gay	0%	3%	6%
Bisexual	0%	3%	0%
Pansexual	0%	0%	2%

Ethnicity

	Patients	Family/carers	Staff
White British	86%	80%	77%
Asian	4%	3%	5%
Asian Chinese	10%	11%	0%
Black	0%	4%	8%
Black Mixed	0%	2%	0%

Identifying as a carer/ care giver

Patients	Family/carers	Staff
33%	85%	14%

Identifying as having a disability or long-term health condition

Patients	Family/carers	Staff
72%	15%	19%

Marital or partnership status

	Patients	Family/carers	Staff
Married	44	75	41
Single	28	8	37
Partner/cohabiting	0	6	21
Divorced	0	8	11
Widowed	28	3	0

No participants reported being pregnant, breastfeeding or having given birth in the proceeding 26 weeks.

Age

	Patients	Family/carers	Staff
21-25	0%	0%	2%
25-40	2%	0%	42%
40-50	11%	20%	34%
50-64	20%	38%	20%
65-79	29%	42%	0%
80+	26%	8%	0%

Religion

	Patients	Family/carers	Staff
None	58%	69%	68%
Christian	42%	25%	25%
Muslim	0%	4%	7%

Conclusions from participants talking about their experiences

Talking about the discharge route

We asked patients, families, and carers to identify the pathway route that cared for them. The project concentrated on hearing from those who identified pathway 3 but recorded all information about care and discharge where this was relevant to service provision.

Most of the feedback concerned hospital stays. Most of the patients had been discharged via D2A Pathway 3 (56% said Yes, 21% were unsure and 23% said No) Responses from family/carers declared pathway 3 in 43% of cases.

20% of respondents were unsure which pathway they had been assigned to. Interviews uncovered gaps or unclear discussions. One participant stated, “I was told that it was a pathway 3 plan and advised to go home and Google it.”

The staff members we spoke to came from a variety of care settings and fed back that they often felt it was difficult to keep patients and families fully informed regarding D2A procedures during the initial stages of care.

Identifying the location of care

Patient and family/carer responses by location was 50% University Hospital Bristol & Weston, 35% North Bristol Trust, 9% Adult Social Care, and 6% Care Home (all).

14 % of respondents commented on more than one service provider.

Staff respondents came from across all levels of care. 62% University Hospital Bristol & Weston, 27% North Bristol Trust, 6% Adult Social Care and 5% Care Home (all).

Of those that answered this question, 80% of patients and families at UHBW and 50% of patients and families at NBT said they knew which pathway they had been assigned to.

Talking about admission

Interviewees were asked about their experiences of admission in relation to receiving discharge information. Most spoke of good ward care they received and information that their stay would be based on medical need. Staff reassured them they “would get me home as soon as possible”. One 84-year-old respondent felt especially well informed on his first day and was able to ask questions regarding adapting his home circumstances, and how he would eventually manage transport for his onward care.

Families reported less positively. They commented on a lack of information or availability of senior staff to discuss the diagnosis or care. One participant said she was not informed of her mother's admission. One could not find her father in the ward on his first day and staff members were unable to locate him.

One interviewee stated that “The admission process did not include conversations around care or the pathway by which mum would return home. In fact, no discharge conversation was had, except when I asked. I had concerns that mum might be returned home without adequate support.”

Two participants commented on their anxiety about Covid-19. Both said staff responses about timely, appropriate discharge helped to calm their concerns.

Questions about inclusion

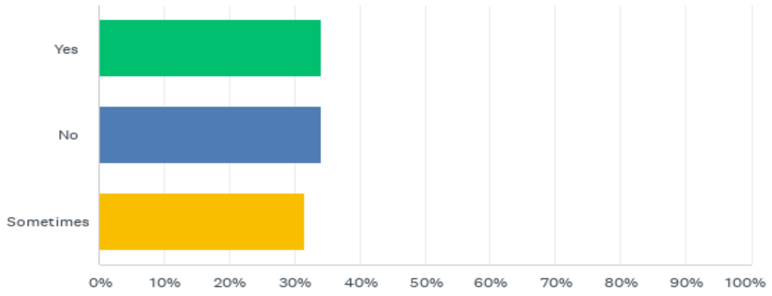
The surveys for patients and for families/carers gathered data around being included during updates and care discussions, this question was suggested by the hospital trusts.

62% of patients who completed this question said “Yes” they were included in these conversations. (Graph on page 12)

Family and carers (below) that stated “Yes” or “sometimes” indicate a similar experience.

Supplementary comments from patients were positive and included “It could not have been better“ and “I was always asked what I thought”

Q6 Did you feel included in the discussion when the patient was updated or informed by staff?



Families who have English as a second language gave a mixed response. One stated that “There were communication problems with staff all the time due to language barriers and no offer of an interpreter.” Another said “We were not good in English so staff were very patient in explaining the situation of my mother with us”.

Those with English as a first language also commented.

Concerning his elderly mother one interviewee stated, “The care was good but there were no conversations, phone calls or contact to the family to discuss or inform us, there were no care team meetings or conversations about changes or expectations.”

Respondent Y stated “Staff talked solely to my husband (the patient) and obviously he wanted to come home but that was not what I felt should happen.”

One respondent shared that “Clear options around discharge and next moves were discussed with me and I was given options, but mum was not included in this.”

Others said the opposite was true. “The hospitals don't talk to each other. Sometimes medical staff talk to the patients who are ill already and may not take much in, and no-one talks to the carers. Unless you ask, information isn't offered.” They said they needed help knowing what questions to ask and how to evaluate the information.

A family member said "I was called and asked how I felt about the next move and if it was okay with me. I agreed, as I was told the home was just up the road so we could visit...It was 5 miles away!"

Some respondents who had left the hospital commented on wanting to be included in discussions at the care home too. One speaking of his brother said "I gave them my name number and an email address as their first contact to keep me up to date with his assessment. As of today, I have never received any update of on the care assessment, even after I emailed the manager. There is a concerning lack of cooperation and information from them."

Other care home residents were more positive "I am very impressed; I have a chat everyday about my care and what's happening."

When the patient is moving on to assessment, they wanted to be part of the conversation. One respondent stated that she received "Good care plus texts to update me from the care provider."

Another commented on care at home and told us "The next day we got a call from the community nursing team. They came two days later to make an assessment. He was wonderful and gave a dedicated 30 minutes of information and support to me and family members and explained things."

We managed to speak to a home care worker regarding inclusion, who said wherever possible relatives were involved in care conversations, even if they do not share a household with the patient.

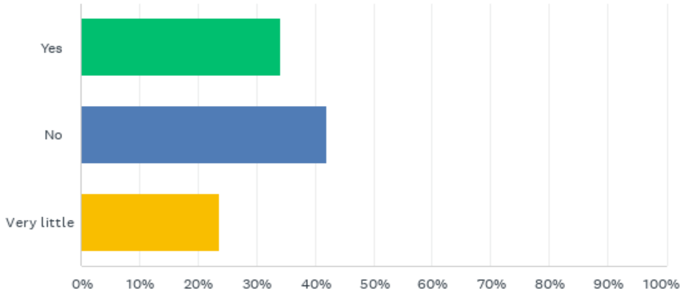
Talking about Care Plans

The survey asked for comment on their care plans and regular assessments. We asked those who gave contact details, supplementary questions.

Over 70% of the hospital staff responses stated that having worked closely with patients they felt their views were considered in planning future care. 40% of care home staff said this was the case. 53% of patients felt their care needs were regularly assessed in a hospital setting and 70% in care home locations.

Over 20% of families and carers voiced concerns regarding the consideration of their needs when creating care plans. 84% stated that no alternatives or options were discussed.

Q5 Were all your concerns and needs considered in the care plan?



Low responses to this question prompted us to ask interview respondents about receiving a care plan or equivalent, either written or verbally. Only one reported having seen a plan or being part of this process.

Respondent H reported “As far as I could see there was no plan. I would like to have been offered a proper room, and have staff together, not separately (the nurses, Occupational Therapist, and consultant) to talk about what would happen. The reasons for lack of plan were not given”.

One interviewee stated that “The last email I sent the manager was asking for a copy of his care plan, but I never received a reply.”

Talking about her mother, Respondent A said “I received no written care plan, but a care package was discussed although the paperwork sent home with her had four possible diagnoses.”

Patient’s son reported that “no one ever spoke to us about a care plan or a discharge plan“.

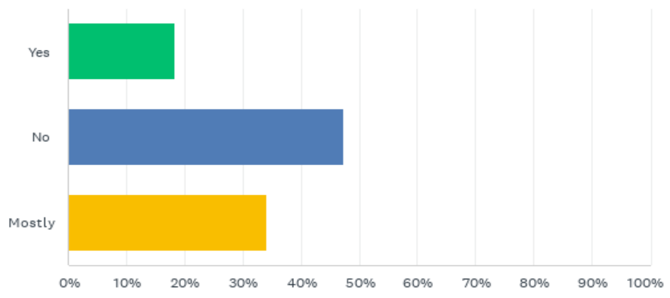
Patient’s husband reported that “no written or verbal care plan was created and after four weeks the assessment was still very vague. The resulting care package was unsuitable, and my wife was in such pain with her skin that she could not bear to be touched (which) the medication required.”

Patients' wife reports that although discharge was spoken of frequently, she was not given a written or verbal care plan or made aware this was available.

A staff member commented that “we need more time to assess people after they become medically fit, to establish the best pathway to meet their needs prior to having to make a discharge destination decision and plan”.

18 participants (patients/family/carers) in our surveys had received a plan. We asked if it was progressing according to their expectations?

Q10 Is the care plan happening as you expected?



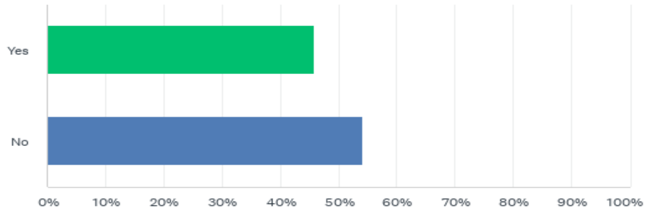
A nurse told us “There are big expectations from patients and families about what the service can deliver, but realistically our health and social care is extremely depleted in funds…and we face a lot of criticism for not arranging (packages) soon enough, when it is simply not our fault, but a strained and limited service with long, long waiting lists.”

We asked participants irrespective of a care plan, if they felt confident in the knowledge of what would happen to them. 85% stated they did not.

Talking about points of contact

We asked people if they knew who to talk to if there were problems or wanted to ask questions. 55% of patients and families did not know who to contact if they had concerns.

Q9 Did you know who to contact if you had concerns ?

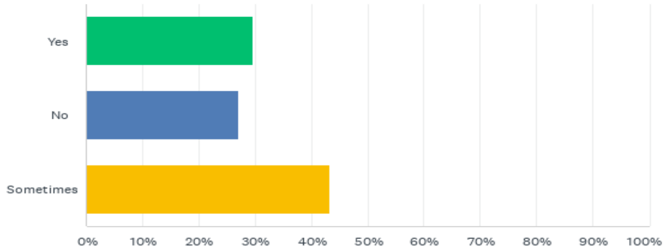


A staff member added that “If patients are going to pathway 3, they should be given a clear understanding of what this entails and a case manager that is accountable.”

Workforce integration across settings

We were interested to hear how staff collaboration impacted on understanding of the patient's need. Our survey asked if staff worked well together. Over 70% of families and carers who responded said "Yes "or at least for some of the time.

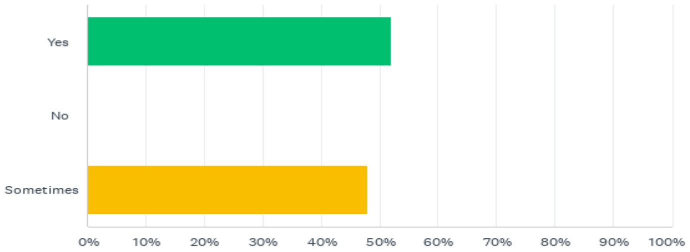
Q8 Did members of staff work well together to meet your needs?



90% of the patient respondents who received the care, said "Yes".

This was mirrored by the respect expressed of staff had across the teams, with no one reporting that they felt unvalued by colleagues.

Q7 Do you feel valued by your multi-disciplinary team colleagues?



However, during interviews, we heard that there were communication concerns.

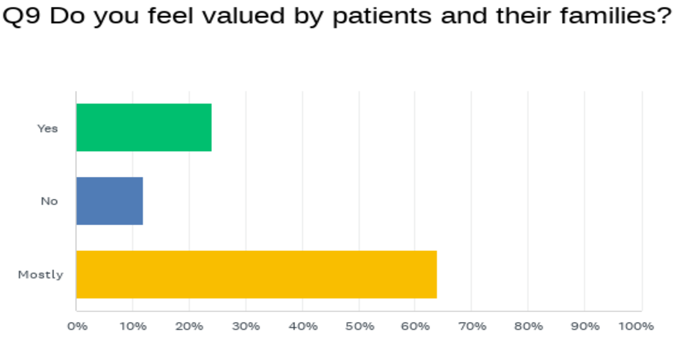
Respondent C. told us "The assessor informed me that mum would be discharged but when I rang the ward nursing staff, they were unaware of this and rang me back later to confirm it.

Respondent R. stated that "The_adult social care worker cannot be reached. It took them nine days to answer an email, they don't call you back, the call centre for social help is understaffed. You hardly ever see same person in a setting."

An interviewee told us of communication and collaboration break down at times. They said "She was suddenly sent home although the Occupational Therapist had said she was not fit to go. She was discharged the next day."

Respondent R. said that collaboration across services lacked cohesion stating "Once mum was in the home, I received several calls from care agencies who believed she was still in hospital and were wanting to plan for when she returned home."

Almost all respondents experienced positive attitudes and kindness from staff. Only 10% of staff reported not feeling valued by patients, families or carers.



Positive comments concerning staff were the norm for every service provider from hospital trusts, assessment locations and eventual settled residency care.

One interviewee stated "I was attended by two particularly good staff. I received excellent care; I cannot fault them. The staff take their time and are absolutely first class".

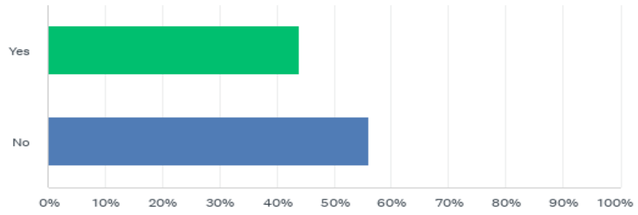
Patient L felt much the same. "The staff were brilliant with both me and my husband, we could talk through everything. It's a very friendly atmosphere"

Respondents from a D2A pathway 3 care home said "I can't describe how happy I am, the staff here are wonderful". "I can't complain about anything, I ring the bell and they come." "They're always so cheerful and helpful." "I have been pleased with the whole process and its marvellous here".

Staff talking about care

Staff themselves reported facing difficult issues. Just over half the staff who responded said they did not feel they had enough time with patients to deliver the care as required.

Q8 Do you feel you have enough time with patients to deliver the care required?



50% felt that the needs of patients and their families were not accurately explained to them.

"More time should be spent with them providing care that is 'not rushed.' Taking more time to sit and listen to patients, encouraging them to express concerns and spend time actively communicating with other people."

40% felt that pressure existed to reduce the length of stay and that this sometimes compromised the quality of care for patients.

"There is a drive to create flow through the hospital. This means creating discharge plans early and not giving patients appropriate time to engage in rehabilitation."

"There are huge pressures to quickly formulate discharge plans, lots of pressure and expectation to do this as soon as patient is medically fit for discharge, which can often be unfair on the patient as they haven't had the time to improve".

"We consider positive risk taking but we are acutely aware that there is a shortage of hospital beds and community resources. Sometimes we are signposting to other services when ideally, we would refer for a therapy assessment in their own home but due to (expected) delays, we need to decide whether a patient could go on to a D2A pathway 3 bed instead."

"It is challenging to balance the ethos of bespoke care planning for individuals when the options to discharge are limited and there is added pressure of maintaining hospital flow so that the front door is not overspilling. So yes, pressures do exist to get patients out and that is not a bad thing, however there are efficiencies to be gained on the pathway out."

"I have never been involved in a case where discharge planning is not heavily dictated by bed pressures and lack of service provision."

One respondent said "The length of stay is unreasonably long, and we have patients who have stayed for over three months when medically fit for discharge."

42% felt that resources and equipment were not always appropriate for patient needs.

“The waiting times for resources and equipment are unreasonably long.”

Communication was cited as an issue. “There is very poor information sharing with the acute trust around the equipment or rehabilitation available in Pathway 3 beds.”

“We have had a system-wide issue for several years relating to the provision of a chair for patients with additional seating requirements going into a nursing home. The Bristol City Council policy of providing equipment to nursing homes isn't workable nor enforced. This adds delays to discharge and needs to be addressed.”

“Very often the pathway 3 is not suitable for the patient but is simply all that is available. There has been a rise in care providers declining to take patients, making their stay in hospital considerably longer that it should be.”

“We often experience significant pressure to medicate a patient due to challenging behaviour because staffing shortages mean that a 1:1 is not available”

Talking about care

Although staff were not criticised the standard of care was described sometimes as disappointing.

One respondent spoke about her husband's care. “When he soiled himself, I was given a pair of gloves and some wet wipes. No personal care was provided, and he was unshaven and dirty and would have remained so had I not dealt with this. Staff shortage was obvious and those who were present were very busy. He was not given toilet visits and was wetting himself through the pads and this has made his continence issues much worse. I was given no guidance around continence care at the hospital”.

Some family members also spoke of their concerns about personal care. “During his stay I feel his health deteriorated as he was left for long periods of time in wet and soiled clothes and bedding.”

Another said “We had a bad experience with the hospital. Doctor told us that (mother) couldn’t have food, but the nurses or the staff failed to take down the ‘nil by mouth’ notice (when it was no longer applied), resulting in my mother not receiving any food, and this had caused us a lot of distress.”

Speaking about his wife's care, respondent R said “The junior doctors and the registrar seemed unable to agree. I never saw the same staff twice. Some were abrupt, some made dosage mistakes and were dismissive”.

One respondent answered, “I think the nurses and doctors were very professional and were very caring to me.”

And another added “I have been to the same hospital eight times now and the staff and care cannot be faulted.”

Respondent S was positive regarding the care of her mother “I felt hospital care was mostly wonderful, the care itself was clean and safe and a nursing assistant understood mums food issues and bought her biscuits and magazines from the shop and took a lot of time with her.”

Respondent J told us about his father's quality of care once he had been moved to the assessment care home “He was in bed with the sides up. As he thrashed about, they padded the sides, but he was covered in bruises. He couldn’t reach his water jug. The place looks marvellous, but the care is atrocious. He had continuous water infections and cried out in pain when urinating. His fingernails were dirty, and he had no haircut or shave. “

Hospital nurses commented on levels of care too. “It’s currently terrible. People are waiting too long for beds and are given no feedback following assessment. There is poor communication between ward staff and patients. Personally, I would not recommend this to my relatives”

Another nurse commented "The current system is not person-centred, there is little evidence it improves patient outcomes, and it seems to be forcing some of most vulnerable patient groups into unsafe or uncertain situations.”

Talking about ward moves

Our survey had open text to hear about any other issues patients, families/carers, and staff had relevant to the D2a Pathway 3 process. Ward moves were repeatedly mentioned, and we recorded these and enquired about them in interviews.

The daughter of an elderly patient noted “My mother was on four different wards during her stay. Each time I was not informed, and my mother became increasingly confused”.

A patients wife recorded a difficult experience. “Have you any idea what it is like to arrive on the ward to visit and find the bed empty? The thoughts that go through you head! No-one was available to tell me what had happened. Eventually they said he had been moved to another ward. I was frantic"

Respondent M's wife was also moved. "She was one three different wards during this stay. No information seemed to be handed between one ward and another."

Staff also commented on moving. "We should strive for less ward moves, and better staffing levels to meet patient's needs".

Discharge and transition

Discharge experiences were shared with us by both D2A Pathway 3 respondents and by those who were unsure of the pathway specifics. One person told us "My mum was discharged at 8:00pm, only twenty mins after I was told she would be there for another two days."

Respondent N told us of his distress during his mother's discharge. "She is 96 and often confused. The ambulance staff were told to take her to the home. She was unconscious in the wheelchair when she left the hospital and they queried it but were told to do their jobs. The care home manager quite rightly sent her back to the hospital. Two days later they sent her again. (Mother) was emotional and upset by the incident as were the whole family."

Speaking about her elderly mother who has Dementia, respondent S. told us "Her assessment was watching her make a cup of coffee and watching her walk. She was considered fit enough to be discharged. I was surprised that the assessor seemed unaware of anything beyond the physical condition. Mum was assessed only this one time."

Another survey participant said "Originally the hospital said that my mum should stay in the hospital for a few days more - but subsequently she was discharged. I felt that her condition was not very stable, and she should stay in the hospital for a few more days before being moved on to the assessment place."

One person said "There was no obvious plan of action for getting care in place to enable mum's discharge. She had been on the discharge ward for about 2 weeks and was getting distressed."

A Pathway 3 survey respondent commented "With a pushy discharge officer dealing with us we felt unsure and not confident about the whole affair. When someone aged 89 is admitted with pneumonia, we expected more consideration from them".

Lack of clarity was mentioned by a partner "I was told it would happen sometime, then on the day I was given five hours' notice. I had to go back to the hospital to collect medication which was a shambles as I was sent to two separate locations to collect it. The care home manager said he was told the move would happen the following day and was only alerted on the day, that the move would go ahead. Apparently, it happened as he was in a trolley leaving the ward."

Waiting was also an issue. "The nurses and I thought the doctor would come to check on me before discharge, but I waited for five hours, and the doctor still hadn't come. In the end, the nurse collected my medication and told me that I can leave."

Some transitions from hospital to another setting didn't happen as expected. "When he arrived, he was wrapped up with his incontinence stuff and then just put in a bed and left".

Talking about aftercare

A lack of communication concerning care following the hospital stay, featured in most of the survey responses.

"I was utterly confused as to what was actually going to happen"

"It was all very rushed, and the care support wasn't set up, but we had to go anyway"

Some respondents were happy "Overall, I am pleased with the discharge arrangement for my son, and I believe this care home provides him with the appropriate care he needs, and I can see a slight improvement in his condition."

"They were very helpful and had arranged a translator for us to explain the aftercare arrangement and the procedure before my son was discharged."

"Having the community team visit on a Sunday, at my mother-in law at home on the day of discharge was so helpful. It got things moving to provide the support she needed."

Talking about what works well and what could be better

As part of the study, we wanted to give respondents the opportunity to comment on improvements and successes, below is a selection of their comments.

Patients

“There are communication problems with the staff in the hospital due to the language barriers, as I cannot understand English. It would help if a translator could be provided during my stay in the hospital after the operation, as this was only provided before the operation.”

“I think the procedure for being discharged was a bit too long as I had to wait for a long time for the staff to prepare the medication to take home.”

“The staff liaised directly with the care home and arranged stress-free transfer on the day.”

“As I cannot speak English very well and have problems in communicating with the staff, nurses and the doctors at the hospital, so if there is an interpreter who is based at the hospital, it will be a great help to myself.”

Families/carers

“At the care home facility there was no contact, no guidance, no continuity, no thought for his elderly wife”

“We were given a home assessment and recommended grab rails but although these were not fitted or provided, he was allowed home”.

“Mum was taken in on Dec 24th, she spent four days in a solo room and no one medical spoke to me before Jan 7th.

Staff

We received suggestions from hospital staff regarding models of best practice

> “There should be more positive risk taking from our community partners.' by doing assessments in people's homes rather than making this part of the assessment in the home.”

“We should stop looking at short term answers that really don’t work. We need better working relationship between hospital and community.”

“Shared access to patient records.”

“There needs to be sufficient staffing levels to meet patient care needs. Patients need to engage in stimulating activities and access to television, there should Increasing visitors allowed”

“Better patient information documentation.”

“A mental Health label for a patient (irrespective of what that is) can act as a deterrent with care homes citing that they do not have 'the training' to deal with that.”

“There needs to be a clearer understanding of community services available so when discussing with patients, a more accurate picture can be provided.”

“Patients should have more visibility and direct contact with social workers in an acute hospital setting"

“Quicker turnaround from referral to start date for D2A and fewer exclusion criteria for D2A.”

“'The service involves a slow and untrusting referral process, a long wait for start date and then minimalistic delivery. A more patient focussed, timely, trusting, integrated and flexible service would be much more positive.'

“It would be helpful to reinstate a representative multidisciplinary team into hospital settings. At present there is not representation for medical, nursing, and social care needs available to act as a bridge between community and inpatient services. This system lets patients and their families down when it comes to discharge planning. It reduces the quality of care we can provide for our patients, and it creates communication issues that potentially increases risk.”

“Improve communication between healthcare professionals and families.”

“A better understanding of placements available and ongoing support from therapies in terms of assessments and interventions to support families and carers who have concerns about needs not being met”.

“I would like to see more clear guidance for care/nursing homes to work from around accepting patients with more complex needs. Specifically, the appropriateness of persistently not accepting complex cases”.

“Often a patient is assessed based on whether they are willing to go to a Pathway 3, but we do not know where that is going to be or whether the patient wants to go to the chosen place. It can be argued that the patient doesn't have all the relevant information to weigh up the decision. Their choice is removed.”

This theme was echoed across many comments.

“The lack of continuity and the lack of social workers in the hospital has been detrimental to the discharge process”

Variance between locations and demographic groups

Most patients reporting positive experiences across the full range of questions were white British males aged 50 or over.

Care homes received more positive feedback concerning communication and care but less regarding medical information and family/carer support.

60% of those who said they knew who to contact, were patients at NBT.

71% of those families/carers who reported feeling more included in care discussions were referring to UHBW.

Staff from NBT expressed greater concern regarding ward moves.

Late evening or night-time discharges accounted for 20% of the discharge concerns voiced by carers and families.

Over 75% of those who responded to the question said that they felt delays in admission or discharge had led to a psychological negative effect.

Recommendations

1. Provide clarity about the pathway the patient is on and explain what this means for them in terms of location and outcome. Staff should follow a checklist of patient and family understanding to minimise gaps in information around care and next steps in transition.
2. Evidence communication protocols for transition and enable and monitor the use of systems and data sharing throughout the pathway.
3. Involve Social Workers as part of the internal hospital process to enable alternative pathways to be evaluated fully prior to a Pathway 3 decision.
4. Evidence the provision of a range of accessible communication resources to include language and sensory impairment materials both in text and spoken information. Ensure the availability of interpreters. Ward round information is offered to families and carers at each visit.
5. Always provide patients and carers with a single point of contact to speak to.[4]
6. Evidence that changes and delays to discharge times are related and explained to patients and families/carers in a timely manner.
7. Evidence the provision of adequate resourcing to enable a consistent quality of care. Ensure that The Better Care Fund programme supports local delivery at a standard that is championed by service users.
8. A focus is put on admission prevention to take pressure off hospital resources and make the best use of beds. Community care and Care Home systems that integrate to provide effective support for service users.
9. Fully integrate Community Care and Care Home systems for effective support for service users.

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[4] Healthwatch England National Guidance https://www.healthwatch.co.uk/response/2022-03-31/our-advice-government-nhs-objectives-2022-23

Stakeholder responses to the draft report

Maria Kane, Chief Executive, North Bristol Trust

“The Discharge to Assess Pathway 3 was implemented in March 2020 at the beginning of the Covid-19 Pandemic, the timing of this negatively impacted the implementation plan as social distancing in the hospital required our Social Service colleagues to move off site. This was in tandem with infection prevention controls with discharge to nursing homes, Covid testing and periodic closures of homes because of staff absence and/or infection control which provided challenges to timely transfer to the Pathway 3 for many patients.

Now, as the health, social care system and populations of Bristol, North Somerset and South Gloucester (BNSSG) move into the new world of living with Covid -19, it is right that we take stock of how this discharge pathway from the acute hospital is working for patients who cannot immediately return to their home. We welcome the recommendations to focus the improvement work for this pathway.

North Bristol NHS Trust has already commenced implementing the recommendations. The Trust’s Patient Experience Team are engaging the Patient & Carer Partnership Group and Carers Strategy Group in reviewing and helping to update the information provided to patients and their families about this pathway, to ensure clarity of the pathway with clear points of contact for questions and that ongoing support is available.

We will work with Community health and Local Authority partners to implement improvements consistently across BNSSG and invite the Healthwatch Team to revisit and review the Pathway 3 experience again later this year to evidence these improvements.”

Sarah Dodds, Deputy Chief Nurse, University Hospitals Bristol and Weston NHS Foundation Trust

“We are pleased that we have been able to advise, contribute and work collaboratively with you to complete this beneficial report, which will be supportive of the work plans that are developing across the BNSSG system. Hearing from our patients and service users is incredibly beneficial to ensure we provide care and services that meet their needs.

At UHBW we have commenced a new workstream entitled “Every Minute Matters”, a programme with identified streams of work, central to our plans for improving our discharge processes.

The aim of the workstream will initially be to relaunch the SAFER Patient Flow Bundle, which will include implementation of the Clinical Utilisation Review Programme (CUR), criteria led discharge (CLD), enhancing the robustness of board rounds and effective use of Estimated Date of Discharge (EDD). The SAFER Patient Flow Bundle is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity); evidence shows that when the tool is followed consistently, length of stay reduces, and patient flow, safety and experience improves. We will plan clear communication to manage discharge effectively including monitoring with a performance dashboard and utilising an education plan for developing staff awareness and education.

Understanding what matters to patients and carers is central in our endeavour to improve the quality of care people receive from us. The evidence presented in this report helps us maintain a focus on improving communications about a patients’ discharge or transfer of care and, the importance of there being a clear process for people to receive support and information after they have left our care.

We look forward to working together and co-designing initiatives to improve our patients’ experience of hospital discharge to their place of residence.”

Shane Devlin, Chief Executive Officer, BNSSG Integrated Care System

Thank you for sharing this report with us. While we are heartened to see so many positive comments about care received from staff across all settings, we fully recognise the difficulties and poor experience some people have faced when being discharged from hospital on the P3 pathway. We will use this important feedback from people, their families and carers, to inform work already underway to improve the experiences people have being discharged from hospital; and consequently, improve population health and wellbeing.

Our whole health and care system is under considerable pressure currently. We know this can lead to frustration, delays and distress for patients and families. We also know that once someone's need for acute medical care is complete, the best place for them to be in terms of recovery is back at home or in an alternative setting – whether that's a rehabilitation bed, their care home, or somewhere else with the support they need. As such, improving the flow through our hospitals so that people are able to recover their independence at home or another setting is a top priority for our health and care partnership.

We will be investing £17m in the 'Discharge to Assess' model in Bristol, North Somerset and South Gloucestershire this year. This will bring the whole system – including council partners and our community provider - together to better co-ordinate people's discharge. The programme will improve people's hospital journey, reduce length of stay, and ensure that everyone can move on from hospital once they are medically well enough to do so.

This work will also address some of the specific concerns set out in your report, including:

- recruiting and retaining therapists and other key staff;
- considering a patient's discharge from the moment they are admitted into hospital: having early conversations with individuals, their carers and families;
- improving transitions, and communication around transition, as people move from one location to another.

We are committed to make real improvements and we encourage patient feedback to ensure we are getting it right. We look forward to continuing to work with Healthwatch and others to embed the voice of people and communities at the heart of all we do.

Stephen Beet, Director of Adult Social Care, Bristol City Council

Adult Social Care in Bristol have worked closely with Healthwatch Bristol to help them plan and undertake this research. The last two years have been extremely challenging for the health and social care system, with pressures on all services. The Local Authority has worked closely with NHS partners to ensure that people in Hospital receive the right support to leave Hospital and return home wherever possible. The findings of this research are extremely valuable and we are extremely grateful to Healthwatch Bristol and to all those who have taken part. In particular we are grateful to the people who have used these services for sharing their experiences, as this is essential towards helping us improve and ensure people receive the best possible care. We will work with partners to ensure that we implement the recommendations and address the issues it has highlighted.

A new “Home First programme” is reviewing Hospital discharge and D2A arrangements with the principle that home is best and a move away from bed-based care wherever possible. I think the recommendations in this report align well with this (programme) and will help influence this work.

Acknowledgments

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North Bristol Trust

University Hospital Bristol & Weston

Brunel Care

Sirona Health & Care

Carers Support Centre

Chinese Community Wellbeing Society

Bristol Dementia Action Alliance

Cedar Care Homes

Oakhill Mansions

Bristol Ageing Better

Age UK

Bristol Black Carers

The Pocklington Trust

Lineage

The Anchor Society

SW Seniors Network

WE Care & Repair

The Marmalade Trust

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Appendices

Appendix 1, 2 and 3 - surveys

Appendix 4 – Equality Impact Assessment

Appendix 5 – Theory of Change

To view or download the appendices for this report, please visit
www.healthwatchbristol.co.uk/charting-experiences-people-being-discharged-hospital-pathway-3-care-route

If you require this information in an alternative format, please email helen@healthwatchbnssg.co.uk.

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