British Red Cross

Listening to what matters

Placing people's needs at the centre of hospital discharge practice and policy in Wales

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Acknowledgements

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Foreword

The British Red Cross in Wales has a proud history of working in partnership with the NHS and social care staff to prioritise patients' pastoral needs. We have been helping to support people home from hospital for over 20 years and since 2018 our staff and volunteers have been working directly with emergency departments across Wales. We are committed to working with NHS staff to improve the experiences of patients at what can often be an extremely anxious time in their lives. Through this work, we not only see first-hand the incredible level of care provided by NHS and social care staff, but also the importance of getting hospital discharge right. The Covid-19 pandemic has further highlighted what we already knew about the value of leaving hospital at the right time and with suitable support in place.

In response to the challenges posed by Covid-19, the Welsh Government issued new discharge guidance in April 2020 to help free up hospital beds to cope with the demand of Covid-19 cases. The guidance sought to implement the nationwide roll-out of the Discharge to Recover then Assess (D2RA) model, which aims to allow patients to be discharged more quickly and to have their ongoing needs assessed at home.

The research and findings set out in this report explore patients' general experiences of discharge since May 2020 and seek to understand what has worked well under the new arrangements, but also what needs to be improved.

Changing environment

Our research found that, while many people we spoke to were keen to go home, leaving hospital during the pandemic can feel daunting, with many feeling apprehensive about going home at an uncertain time. In addition, NHS and social care staff have also had to deal with the pressure of implementing systems at pace while navigating their day-to-day work. Despite these challenges, patients we spoke to praised the hard work of staff who have provided high quality care in difficult circumstances, and highlighted examples of good practice.

Gaps in practice

Unfortunately, our research has found that the guidance is not being consistently implemented, with issues around communication throughout the discharge process and follow up contacts when leaving hospital. We have also found that practical needs were not always met, and discharge assessments were not always being carried out where patients felt they had support needs.

These issues are further compounded by wider concerns around the ability of the health and social care system to deliver the new discharge model in light of current pressures.

Significant solutions

As the principles of 'home first' and the D2RA model remain in place, it is important to reflect on and address lessons learned since the new guidance has come into force. From our experience, we know that well-planned, person-centred discharge, including listening to people's holistic needs, can make all the difference. While a lack of resources underpins some of the issues in this report, we have also identified some simple steps to improve the discharge process which can happen relatively quickly. This involves ensuring hospital discharge teams implement the current guidance in place and that the Department for Health and Social Services amends the guidance to address gaps in policy. Through listening to what matters to patients, we have developed recommendations which we hope will improve the discharge process in Wales for patients, carers and professionals alike.

**Kate Griffiths, Director for
Wales at the British Red Cross**

Executive summary

This research explores how well the hospital discharge process is currently working for patients and their carers in Wales, providing insight into people's experiences of hospital discharge and the perspectives of those working across this area. We focused on people's experiences of discharge between May 2020, just after the *Covid-19 Hospital Discharge Service Requirements* came into effect, and October 2021. The following was investigated:

- patients' and carers' experiences of hospital discharge in Wales over the period in question
- the extent to which people's needs are met when leaving hospital
- the extent to which the hospital discharge process is person-centred.

The research consisted of 16 in-depth interviews with patients and voluntary and community sector (VCS) professionals, focus groups with 15 statutory health and social care staff, and an online survey of 100 patients and carers of patients who had been discharged from hospital since May 2020.

Key findings

Overall perceptions of discharge

While discharge practices work well for many patients, feedback from patients with more complex needs was less positive

Half of the patients and carers who responded to our survey were satisfied with how their discharge was managed, while around two-fifths were dissatisfied.[i]

Patients and health and social care professionals alike expressed concern around the extent to which discharge processes are meeting the requirements of those with complex needs; in particular, concerns were raised around communication, assessments and preparedness for discharge.

Professionals are positive about the D2RA model, but say that more resource is needed to ensure it is effective

All of the professionals involved in this research thought that the D2RA model was a good approach. There was cross-sector agreement that patient outcomes tend to be better when people are able to recover at home, as long as there is capacity to provide a follow-up assessment and support at home once discharged.

However, most professionals involved in the research felt that the model is not working as it was designed to due to significant pressures and challenges across the sector, such as staffing in health and social care, availability of social care services in the community, and the sustainability of funding for services in the community.

Those responsible for implementing the guidance could benefit from more information and training

In light of the above, professionals we spoke to highlighted that the D2RA model has been implemented to varying degrees across different parts of Wales. In some cases, this was felt to be due to a lack of knowledge of the model, indicating a need for more information and training.

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[i] 37 of 74 survey respondents were 'very' or 'fairly' satisfied with how the discharge was managed while 28 of 74 were 'very' or 'fairly' dissatisfied.

Communication around discharge processes

Many patients are not receiving information leaflets about the discharge process, or follow-up contact information

Many of the patients and carers who took part in our research had not received an information leaflet on admission or discharge and not all received contact information in the event that they needed further health advice or support after leaving hospital, despite this being set out in the guidance. Of those who were given a contact, most were able to successfully contact someone when they needed to.

Better communication and information sharing across different parts of the system would improve overall discharge processes

Despite some examples of successful joined-up working between teams, there was widespread agreement among patients and professionals that communication is lacking between relevant care teams. Our findings indicate that community-based staff are not always involved enough in discharge arrangements for patients put onto a D2RA pathway, which can lead to delays in post-discharge support being put in place. A lack of guidance on communication between acute and community hospitals was seen to exacerbate the challenge of information sharing.

‘What matters’ conversations are not taking place consistently, despite patients feeling that they could be helpful

Our research suggests that, despite ‘what matters’ conversations being a longstanding principle in health and social care, these conversations are not consistently taking place, meaning that the wishes of patients and their families are not routinely being considered in relation to discharge. Our findings emphasis the importance of these conversations for all patients, whether assigned to a D2RA pathway or not.

Carers’ needs and support

More work is needed to ensure carers feel fully informed and know where they can access support

The carers who took part in our survey tended to feel less informed about, and involved in, the discharge process than patients themselves, and many felt that their needs were not being considered as part of the discharge process. In addition, while support is available for carers both through VCS organisations and via carers’ assessments, carers were mostly unaware of the support on offer.

Practicalities of discharge

Time taken to discharge often exceeds the three-hour target

Our research indicates that the three-hour target stipulated in the guidance is not consistently being met, with patients commonly reporting waits of four or five hours to be discharged. For the most part, this caused uncertainty and inconvenience to those friends and family who were waiting to collect them, rather than having more serious consequences for patients.

While patients tended to highlight issues within the hospital as causing delays, health and social care professionals emphasised external factors such as the availability of transport and social care.

There is a lack of clarity and consistency around the offer of support with transport home

A large proportion of patients said that they were not asked about their transport needs when discharged from hospital, and some who needed support with transport did not receive it. Current discharge guidance states that patients who don’t have anyone to assist with transport home should receive support from care co-ordinators in organising this, though it is unclear whether this applies only to people on D2RA Pathways or to all patients.

Meeting patients' needs

Some people are still falling through the gaps with unmet needs

On the whole, the discharge model was found to meet most patients' needs. However, around one in six survey respondents reported unmet needs.[ii] Our research indicates that, while some people were assessed both pre- and post-discharge, others were not assessed at all.

Pre-discharge assessments: Professionals told us that assessments as part of board rounds[iii] prior to discharge tend to focus on a patient's medical needs rather than their social and cognitive needs. Health and social care professionals from both the statutory sector and the VCS felt that a holistic approach should be prioritised. The British Red Cross's five-part independence checklist is a good example of such an approach.

Post-discharge assessments: Some survey respondents (including two who were on D2RA Pathways) felt that they needed an assessment after leaving hospital but didn't receive one, resulting in support needs not being met. It is important to note that many of our respondents were identified as 'simple discharge' and were thus not identified as requiring an assessment after leaving hospital.

[ii] 12 of 71 survey respondents reported that they had support needs which were not identified at point of discharge or during an assessment.

[iii] 'Board round' refers to the process of a multidisciplinary team reviewing key information about a patient (such as diagnosis, date of admission and expected date of discharge) at a computer screen or written board, rather than at the patient's bedside (ward round).

Recommendations

The British Red Cross is calling for improvements to guidance on discharge to better meet people's needs when they leave hospital. This report identifies 20 recommendations which focus on ensuring that current guidance is being implemented, making improvements to current guidance, and taking actions to address wider constraints on the discharge system. In light of our findings, we have identified the five recommendations below as needing the most urgent attention:

1. **Provide all patients with a leaflet about discharge when entering and leaving hospital**, as stated in the current discharge guidance. This should be implemented by the hospital discharge teams.

2. **Improve communication with and involvement of family and carers**. Ward staff should consistently involve families (including those with lasting power of attorney or a nominated family member for patients living with dementia) and carers in decisions made during the discharge process.

3. **Provide hospitals with the guidance and tools needed to better determine the most appropriate discharge pathway for patients**. The Department for Health and Social Services should amend the national policy, or issue complementary guidance, to include a set of minimum standards for all patients being discharged, including those patients on simple discharge, and advice for hospital staff around how to determine the appropriate discharge pathway for patients, building on recent guidance.[1]

4. **Update current discharge guidance so that holistic checklists are used to support conversations with patients, families and carers to ensure they have the support they need at home**. The British Red Cross five-part independence checklist should be carried out by multidisciplinary teams (MDTs), encompassing practical, social, psychosocial, physical and financial needs, and prioritising what matters to the patient.[2]

5. **Invest in community-based support to address the gaps in provision, including at the weekend**. The Welsh Government should invest in community-based support to better meet the increased workload and improve joined-up working between hospitals, community healthcare, the VCS, social care services and transport services.

Glossary of acronyms

Acronym	Full Name
A&E	Accident & Emergency
D2RA	Discharge to Recover then Assess
GP	General practitioner
MDT	Multidisciplinary team
OT	Occupational therapist
UHB	University health board
VCS	Voluntary and community sector

Introduction

Background

Over the years, the British Red Cross has regularly heard from patients and healthcare staff that leaving hospital can be a difficult experience for patients and carers. Our UK-wide research *Home to the unknown*[3] found that support to help people in their transition home from hospital was inconsistent, with many patients falling through the gaps with unmet needs. Similarly, our research in England *In and out of hospital*[4] and *590 people's stories of leaving hospital during Covid-19*[5] found that hospital discharge processes are often not followed properly, with many people feeling unprepared to leave hospital and struggling to cope once home.

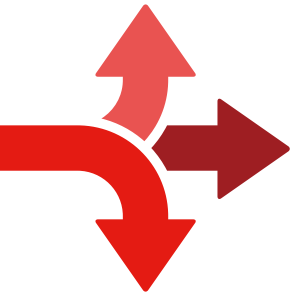
Other organisations have published research looking at discharge in Wales specifically and have highlighted issues around patient involvement, poor communication and lack of effective planning.[6]

While previous research can provide useful context on hospital discharge across the UK, most research in Wales was carried out prior to the pandemic. This research report seeks to understand people's experiences of discharge in Wales since April 2020 and explores the impact of changes in policy and practice within Wales since this time.

Hospital discharge guidance

A Healthier Wales[7], published in 2018, is the Welsh Government's long-term plan for health and social care in Wales. It sets out the vision of a seamless 'whole-system approach to health and social care', which is focused on health and wellbeing, and on preventing physical and mental illness. A key principle of the plan is to deliver services as close to home as possible.

In 2020, the NHS in Wales urgently needed to free up capacity in hospitals to cope with the surge in demand from Covid-19 patients. To support this, the Welsh Government issued the *Covid-19 Hospital Discharge Service Requirements*[8], which 'health, social care, third and independent sector partners in Wales' were required to adhere to from 6 April 2020 (this is referred to throughout as 'the guidance'). The guidance requires that acute and community hospitals must discharge all patients as soon as they are clinically safe to do so and that patients who are identified as needing out-of-hospital support to recover are to have their ongoing needs assessed after they are discharged (usually to their own home); this is referred to as the Discharge to Recover then Assess (D2RA) model.



D2RA Pathways

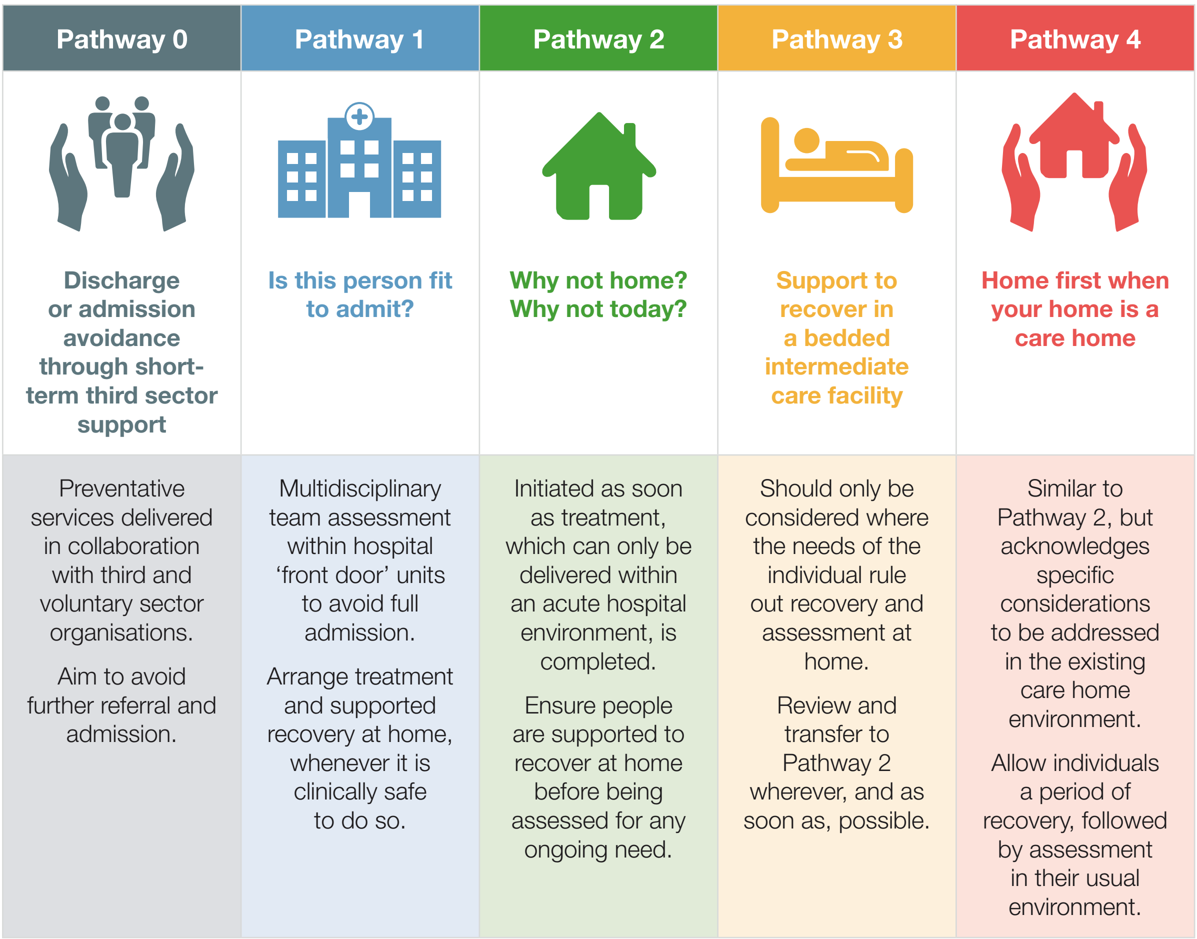
For patients requiring ongoing support, the default will be immediate entry on to a D2RA pathway. Within D2RA there are five pathways, as shown in Figure 1 opposite, which we refer to throughout this report:

- **Pathway 0**: After having received a treatment, upon assessment to discharge, short-term support from the voluntary and community sector (VCS)[iv] is identified as needed.
- **Pathway 1**: Patients are assessed at the front door of the hospital, without being admitted, and identified as requiring treatment and support to recover at home.
- **Pathway 2**: Those who may need more or increased support at home after treatment is completed will be put onto the 'home first' pathway. This is the default pathway for those who may need support at home once in-patient treatment is completed.
- **Pathway 3**: For patients whose needs are too great to return to their own home, transfer will be arranged to a suitable 'step down' bedded facility, which could be a community hospital, care home[v] or other emergency surge capacity. The nominated care co-ordinators will follow up to ensure patients are able to transfer to their own home, or move to their long-term care home, as soon as possible.
- **Pathway 4**: The patient is discharged to recover then be assessed in their existing care home. This is much like Pathway 2.

[iv] Note that the guidance refers to the VCS as the third sector.

[v] Note that this may not necessarily be the patient's preferred care home. If this is the case, NHS and Local Authority partners will track and monitor this.

FIGURE 1: Welsh Government information on the D2RA pathways[9]



Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4
Discharge or admission avoidance through short-term third sector support	**Is this person fit to admit?**	**Why not home? Why not today?**	**Support to recover in a bedded intermediate care facility**	**Home first when your home is a care home**
Preventative services delivered in collaboration with third and voluntary sector organisations. Aim to avoid further referral and admission.	Multidisciplinary team assessment within hospital ‘front door’ units to avoid full admission. Arrange treatment and supported recovery at home, whenever it is clinically safe to do so.	Initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Ensure people are supported to recover at home before being assessed for any ongoing need.	Should only be considered where the needs of the individual rule out recovery and assessment at home. Review and transfer to Pathway 2 wherever, and as soon as, possible.	Similar to Pathway 2, but acknowledges specific considerations to be addressed in the existing care home environment. Allow individuals a period of recovery, followed by assessment in their usual environment.

The majority of patients will be able to be discharged without any additional support beyond what was in place prior to their admission – we refer to these cases as ‘simple discharge’ or those who have not been assigned onto a D2RA pathway. The guidance does not set out any assumptions around the proportion of patients who are to be discharged onto each pathway, other than to state that the majority will be discharged without any further support. NHS Wales's 2008 *Passing the Baton* document estimates that 80 per cent of all discharges are simple in nature.[10] However, this report pre-dated current guidance and so it is difficult to be clear about the proportion of patients now placed onto a D2RA pathway.

The timeline of the D2RA model indicates that the model existed prior to the pandemic, with Pathways 1-4 created at the Home First national conference back in 2018.[11] Further, other research in Wales suggests that the D2RA model was used in discharge practice in Wales prior to 2020, though it was not consistently implemented across health boards.[12] The introduction of the guidance saw the D2RA model, including Pathway 0, become part of national policy for the first time.

An update to the hospital discharge guidance in December 2020 maintained that the principles of home first and D2RA pathways would remain in place after the pandemic.[13] In July 2021, the Minister for Health and Social Services introduced six goals for urgent and emergency care. Goal six focuses on a home from hospital when ready approach, with proactive support to reduce the risk of readmission.[14] Further, the Minister announced that funding had been made available for Regional Partnership Boards for the year 2021/22 to ensure consistent delivery of the D2RA pathways.[15]

Funding – D2RA Patients

The sample information leaflets provided in the guidance state that if a patient requires care and support when they get home, this will be arranged and any care provided will be free of charge for a period of time to support recovery.[16] According to the Covid-19 Hospital Discharge Service Requirements Frequently Asked Questions[17], care and support would not be chargeable to the individual for a period of up to six weeks. After this time an individual may be required to contribute to the cost of their care.

British Red Cross working with the NHS on discharge

The British Red Cross helps around 84,000 people a year to live independently at home in the UK. We have a long history of working with the NHS in Wales to deliver home from hospital services. In 2021 we delivered eight such services across Wales and accepted 2,737 new referrals for support.[vi] Through this work, we have seen the positive impact support at home can have, both on individuals and the healthcare system.

We have also been supporting in various emergency departments in Wales since December 2018 where we work closely with NHS staff to prioritise patient pastoral needs. As part of this service, we provide support at home through a short intervention offering assistance ranging from befriending services and domestic support, to supporting referrals to Care & Repair for home adaptations and to social services for care needs assessments.

Research objectives

By gathering evidence about the experiences of patients who have been discharged from hospital since the guidance came into force and the perspectives of those working in health and social care, this research aims to explore how well the hospital discharge process is currently working for patients and their carers in Wales, and to equip the NHS in Wales to support patients leaving hospital in the future.

The research focuses on people's experiences of hospital discharge in Wales between May 2020, just after the guidance was published, and October 2021. It is important to get hospital discharge right for everyone, which is why we investigated the experiences of simple discharge patients as well as those on D2RA pathways.

THE RESEARCH EXPLORES:

1. Patients' and carers' experiences of hospital discharge in Wales over the period in question.
2. The extent to which people's needs are met when leaving hospital.
3. The extent to which the hospital discharge process is person-centred.
4. The extent to which people's experiences of hospital discharge meet the objectives set out in the D2RA model.
5. What those working in this area consider are the strengths and weaknesses of discharge practices and models.
6. What changes are needed, in policy and practice, to ensure that people have the support they need when they leave hospital.

[vi] In 2021 the British Red Cross accepted 2,737 new referrals for support, with seven cases pending over to 2022.

Methods and recruitment

The research consisted of an online survey of patients and carers of patients who had been discharged from hospital since the start of May 2020; a series of in-depth interviews with patients, carers and VCS professionals; and focus groups with statutory health and social care professionals. All fieldwork took place in September and October 2021.

Online survey

10-minute
survey with patients and carers

100
responses in total
(64 complete, 36 partial)

16 in-depth interviews

(30-60 minutes each)

10
patients

1
carer

5
VCS professionals

2 focus groups

(90 minutes each)

FOCUS GROUP A:

8 hospital-based statutory health and social care professionals

FOCUS GROUP B:

7 community-based statutory health and social care professionals

Online survey

Patients and carers were recruited to take part in the online survey via a number of the British Red Cross’s VCS partners in Wales, who put out invitations to their network of practitioners and contact lists and promoted the survey via social media. Anyone who was aged 18 years or over, living in Wales and had been discharged from an acute hospital setting between May 2020 and October 2021 (or anyone who had cared for someone who met this criteria) was eligible to take part in the survey.

In total there were 100 responses, though not all respondents answered every question. There were 64 complete responses, with drop offs at various points throughout the survey. This means that the response size varies by question. Exact base sizes are made explicit throughout the report.

Due to the sample size and self-selective nature of the survey, the extent to which the findings are representative of the wider population of Wales is not known. Certain groups may be more likely to have participated than others, for example, those who were particularly dissatisfied with their discharge experience (or particularly pleased), those who are computer literate, and Welsh or English language speakers. Despite this, the data collected does provide valuable insight into the patient and carer experience, and the extent to which the issues raised in the qualitative research findings reflect more widespread issues.

Interviews and focus groups

Patient interview participants were recruited following their participation in the online survey, which asked whether they were willing to be contacted again for the purpose of this research.

VCS professionals from the health and social care sector were recruited through British Red Cross networks as well as using these contacts to recruit further participants. Statutory health and social care professionals were recruited for the focus groups with support from VCS organisations, statutory organisations and medical colleges.[vii]

Due to the Covid-19 pandemic, all interviews and focus groups took place remotely, via telephone or video conferencing.

For more information about who took part in this research and how they were recruited, please see Appendix 2 – Methodology.

[vii] Age Cymru, British Red Cross, Board of Community Health Councils, Care & Repair Cymru, Carers Wales, Hospice UK, the Welsh NHS Confederation, Royal College of General Practitioners Wales, Royal College of Physicians Wales, Social Care Wales and the Welsh Government.

Research findings

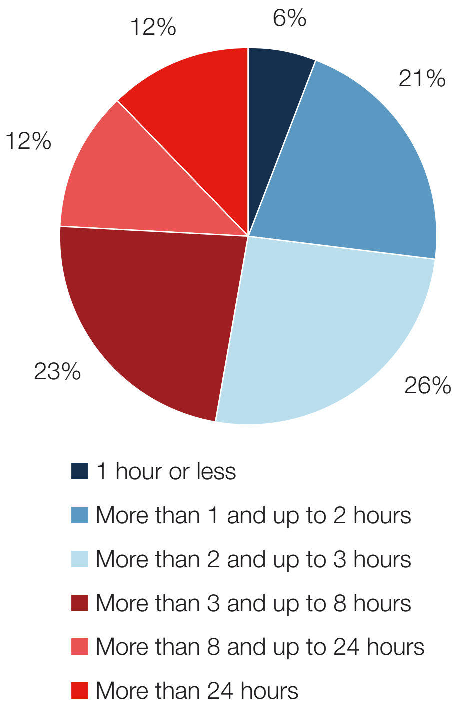
1. Discharge procedures and practicalities

Discharge timing

Discharge delays

All patients interviewed had experienced some level of delay in discharge, with delays tending to be around four to five hours long. Our survey results suggest that these were not isolated incidents. As Figure 2 shows, almost half of survey respondents (47 per cent / 36 of 77) also reported waiting more than three hours to be discharged after being told they were well enough to go home, with around a quarter (23 per cent / 18 of 77) waiting more than eight hours. Around one in ten (12 per cent / nine of 77) waited more than 24 hours.

FIGURE 2: How long did you/your friend, relative or client wait between being told you/they were well enough to leave hospital and being discharged?



BASE: All respondents (77)

Although frustrating, none of the interview participants reported significant health consequences as a result of delayed discharge. While patients mostly reported the delays causing an inconvenience for friends and family who were ‘on standby’ to collect them from the hospital, some reported waiting outside for hours.

> **“Originally, my wife and daughter were going to pick me up, or just my wife, but because it dragged on for so long… it was too late for my daughter to be back asleep by 7.30pm. So there was no way for me to arrange for pickup. The only thing I think would’ve been useful was if someone had advice on public transport for getting home.”**
>
> **Patient, South West Wales**

Delays within the hospital

The most common reason for delayed discharge reported by patients during interviews was waiting for medication to be prepared and delivered by the hospital pharmacy. Many considered this wait to be unnecessarily long. It was a cause of great frustration, particularly for those who felt ready to go home.

> **“The thing I wanted to do was get home… [pharmacy issues] delayed it, it didn’t make me anxious but it was just frustrating, I really wanted to be home, sat in the chair with something to eat and just relax back into my own surroundings.”**
>
> **Patient, South East Wales**

> **“The only downside was pharmacy, and getting the medication released in time for me to go home… I think I spent four or five hours waiting for the pharmacy to deliver my medication to go home with.”**
>
> **Patient, South East Wales**

During the interviews, several patients reported that a consultant had visited them and agreed to their discharge but had then been side-tracked or called away, meaning that the relevant paperwork had not been completed. This resulted in delays to discharge, sometimes several hours long.

> **"The nurses were really good and they kept saying 'yeah we're still waiting for the doctor to come back, he's just passing around.' Then I got seen at 7.30pm in the evening or something like that."**
>
> **Patient, South West Wales**

This patient was eventually sent home late in the evening without a report on some testing which had been lost. They said that they left the hospital at an inconvenient time, feeling uncertain, 'deflated' and disappointed with the communication.

Echoing the findings of the patient interviews, the main reasons our survey participants gave for waiting more than three hours to be discharged was that they were waiting for medication (18 of 36 respondents). One survey respondent said that they had to leave before their prescription was ready and return for it in the morning, as the result of major delays. Other reasons provided by survey respondents included waiting to see a doctor (14 of 36 respondents), waiting for transport (six of 36 respondents) and waiting for confirmation of place of discharge (six of 36 respondents).

Wider system pressures

While patients tended to highlight issues within the hospital as causing delays, professionals placed greater emphasis on factors outside the hospital – the key issues being availability of transport and domiciliary care.

Health and social care professionals expressed concern about wider system pressures causing discharge delays and undermining the aims of the current discharge model. For example, the shortage of ambulances to take patients home – an issue compounded in rural areas – means that many planned discharges are pushed to the end of the day or to the following day, outside of the busiest periods for the ambulance service.

> **"We're struggling with hospital discharge because we're unable to get the ambulances, especially if they need a stretcher. We struggle in our rural areas."**
>
> **Community-based statutory health and social care professional**

Our findings suggest that adequate transport provision is fundamental to the effective operation of discharge services.

The most common issue mentioned by health and social care professionals from both the statutory sector and the VCS was the 'social care crisis'. They explained how patients are often kept waiting for significant periods of time to be discharged from hospital due to delays putting domiciliary care packages in place. This was widely seen to be the result of insufficient resource in the social care sector to meet demand.

> **"The problem is in [domiciliary] care. How we can attract more people into [domiciliary] care I don't know. We need to make it more of an attractive career. With us working toward home first, the whole market of what we can provide at home needs to be looked at."**
>
> **Hospital-based statutory health and social care professional**

The above findings highlight the importance of addressing wider system constraints in order to speed up the discharge process. Comprehensive and timely provision of social care, in particular, is central to the operation of the D2RA model.

Time of discharge

None of the patients we interviewed reported being discharged in the morning. A few were discharged early in the afternoon, but late afternoon discharges were most common, even when participants had been told of the intent to discharge them in the morning or the previous evening. Two interview participants had been discharged in the evening. Similarly, only a small minority of survey respondents (seven per cent / seven of 99) were discharged between 8pm and 8am, with the vast majority (93 per cent / 92 of 99) being discharged during the day.

The guidance does not state what time patients should be discharged. However, we found that being discharged later in the day or evening can cause stress for patients and their families, even if assigned to a simple discharge pathway, as arrangements can be more challenging and transport options may be limited. Generally, the patients we interviewed said they would prefer earlier discharges to allow them more time to get home and feel settled.

VCS professionals also felt that late evening discharges can be problematic for those in need of domiciliary care as care visits may not be scheduled until the following morning. This is a particular concern for people with memory loss or dementia, especially if they are given prescribed medication.

> **“We’ve had people with dementia dropped off at home at 9.30pm at night with a bag full of medication; there’s a high risk of overdose, no food in the cupboards, they don’t know if it’s the right house… at best, its disorganised without any kind of standardised practise; at worst it’s a genuine safeguarding risk.”**
>
> **VCS professional**

This highlights the importance of communicating with patients and families and ensuring that those who require immediate further support, i.e. those assigned to a D2RA pathway, are not discharged at night when no further support is in place.

Discharge timing – Is the guidance being met?

What the guidance says

The three-hour target – all patients

All patients must be transferred to an allocated discharge area or lounge **within one hour** of the decision to discharge; and **within two hours** of arriving at the discharge lounge discharge co-ordinators will organise transport home, any VCS support, and immediate practical measures, such as shopping and heating arrangements, where needed for those who do not have anyone to do this for them.[18]

Time of discharge – all patients

The guidance does not give any detail on the time of day a person should be discharged. However, it does state that community healthcare services should operate 8am-8pm seven days a week.[19]

What we found

Both our qualitative and quantitative findings indicate that the three-hour target is not consistently being met. While patients tended to highlight issues within the hospital as causing delays, professionals emphasised external factors such as the availability of transport and social care.

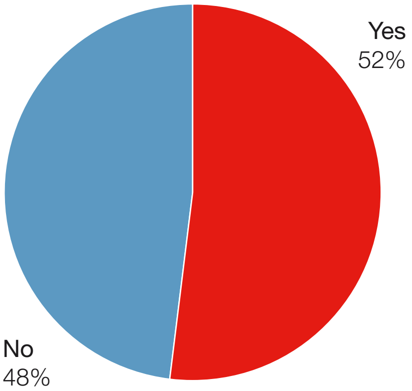
Our findings suggest that if patients requiring follow-up support on a D2RA pathway are discharged after 8pm, follow-up support may not be available until the next morning.

Transport

Seven of the ten patients we interviewed were not explicitly asked about their transport needs by hospital staff when their discharge was being planned. In particular, some younger patients felt that assumptions were made that their transport needs were covered, when this was not always the case. Although patients may have access to transport on certain days or at certain times, delays in discharge can cause planned transport to fall through.

In our survey, only 52 per cent of respondents (42 of 81) reported that they, or the person they cared for, were asked if they needed support with transport to the place they were discharged to (see Figure 3 below).

FIGURE 3: Before you/your friend, relative or client left hospital, were you/they asked if support was needed in getting transport to the place you/they were discharged to?



BASE: All Respondents (81)

Positively, of the 42 respondents who were asked whether they needed support with transport, all who said that they did (17 people), were provided with it. However, 39 (of 81) respondents were not asked whether they needed support; of these, around a fifth (eight people) said that support was needed. This means that around one in ten of our survey respondents (eight of 81 respondents overall) had an unmet transport need. This reinforces our qualitative findings.

Some of the patients we interviewed spoke of having to rely on public transport to get home from hospital, which was often 'patchy' and only available at certain times of day. In some cases, this caused further discharge delays.

> **"… I don't really have any family or anybody in the area that could've come to collect me. I did have to get the bus home and a couple of days later when I was feeling well enough, I had to collect my car from the hospital car park. But I certainly wasn't offered any transport or any support getting home, which would've been helpful."**
>
> **Patient, South East Wales**

VCS professionals raised concerns that, while buses and taxis are suitable forms of transport for some patients, they can be problematic for those with complex needs.[viii]

As seen above, statutory health and social care professionals expressed frustration about delays with ambulance transport. This can lead to significant delays to discharges which can put the patient at risk of their condition deteriorating, and potentially lead to avoidable readmission.

> **"I had a patient who we managed to avoid hospital admission [for]; they were scheduled to go to a care home but waited over eight hours for ambulance transportation to go four miles from their home to the care home. We simply haven't got the resources."**
>
> **Community-based statutory health and social care professional**

[viii] For the purpose of this report, 'complex needs' is defined as a patient who has multiple health conditions and/or disabilities, meaning they are under the care of more than one consultant or specialist, have experienced several hospital admissions over recent years and/or have moved between several acute and community hospital settings in their treatment. It can also mean someone who has impaired cognitive ability.

Frustrations around transport were echoed by VCS professionals. They mentioned that the unreliability of patient transport means that patients can arrive at home without much warning, often at inconvenient or inappropriate times of day. Some spoke of patients arriving home 'distressed' because of the confusion around transport and associated delays. This can impact negatively on family members – the carer interviewed as part of this research said that this had been their experience.

The findings above highlight the importance of asking patients (and/or carers) about their transport needs and of helping to arrange transport where needed. It is important that discharge plans take account of potential transport delays and that transport plans, and information on any delays, is communicated to patients and their families.

Transport – Is the guidance being met?

What the guidance says

Arranging transport home – lack of clarity around who this applies to

The guidance states that where a patient does not have anyone to assist with practical measures, such as transport home, this will be organised by the discharge co-ordinators.[20]

While discharge co-ordinators are responsible for arranging transport home where required, the Welsh Ambulance Service NHS Trust (WAST), Non-Emergency Patient Transport Services (NEPTS) and the VCS will be expected to provide support to enable the transfer of patients as part of the discharge process.[21]

The guidance does not specify whether this is an option for all patients or just those patients assigned to a D2RA pathway who don't have anyone to assist with practical measures such as transport home. This should be clarified.

Arranging transport home – D2RA patients on Pathway 0

For patients on Pathway 0, hospital discharge teams will arrange dedicated staff to support and manage those patients. The guidance makes clear that this includes co-ordinating transport with providers.[22]

What we found

Both our qualitative and quantitative research found that a large proportion of patients were not asked about their transport needs, and that some who needed support with transport did not receive it.

Preparedness for discharge

Feeling ready

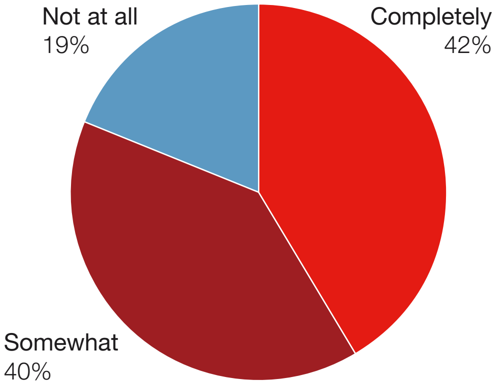
Among our qualitative research participants, we found a distinction between being medically ready and emotionally prepared for discharge. Most patients interviewed said that they had felt 'ready' for discharge in the sense that they were keen to recover in their home environment rather than in hospital. However, even when this was the case, many still felt apprehensive about the process. Some remained in hospital longer as a result.

> **"If I'm truthful, I don't know whether I did [feel prepared] or not. I was so looking forward to going because obviously the treatment had been successful … and obviously (I felt) very conscious that if I know they need the beds it would make me feel very guilty if I was in hospital and I didn't need to be."**
>
> **Patient, South East Wales**

The majority of the patients we spoke to were given peace of mind by knowing that checks had been made to ensure they had somebody at home to support them. However, in some cases, people lacked this assurance from hospital staff, and some interviewees with more complex needs felt unprepared for discharge due to inadequate communication and assessment by hospital staff.

Our survey results suggest that it is not uncommon for people to feel unprepared for discharge. As Figure 4 shows, around one fifth (19 per cent / 15 of 81) said they, or the person they cared for, felt 'not at all' prepared, two fifths (40 per cent / 32 of 81) felt 'somewhat' prepared and around a further two fifths (42 per cent / 34 of 81) felt 'completely' prepared.

FIGURE 4: To what extent did you/your friend, relative or client feel prepared to leave hospital?



BASE: All Respondents (81)

Practical arrangements

Some VCS professionals felt that decisions about whether to discharge are not always based on a proper assessment of the individual's situation (the assessment process is explored in more detail later in the report). Where patients are not prepared for discharge into the community, VCS services are often called upon to provide support in potentially unsafe situations where individuals can be at risk of serious harm.

> **"From a professional perspective it's grim. It's really heavy work and I have concerns about my staff, about second-hand trauma about some of the cases they're working with because of the severity of the problems."**
>
> **VCS professional**

Both VCS and community-based statutory health and social care professionals said that decisions to discharge can be based on assumptions – for example, that a patient's home is safe and suitable. One VCS professional felt that some patients will 'downplay' their potential needs at home, in order to get discharged earlier. It was felt that this reliance on professional and patient judgement, as opposed to holistic assessment, can lead to inappropriate discharges.

> **"Bearing in mind that most patients in hospital want to get home, they will say anything to get home, so the reality of a bedside assessment of how people live in the home is actually... quite different than he was probably telling the staff in the hospital... there are issues there that really need to be sorted out."**
>
> **VCS professional**

Some VCS professionals shared examples of patients' homes not being fully checked[ix] before they were dropped off. One VCS professional said that patients, whose needs may have changed since being admitted to hospital, are often discharged to unsuitable home environments. Homes can become unfamiliar and potentially hazardous spaces for those who have had extended periods in hospital, particularly those with cognitive impairments and/or mobility issues.

[ix] The guidance states: "If support is needed on the day of discharge, co-ordinated home assessments between health and social care will ideally take place on the day of discharge to make sure support is in place. The co-ordinator will make the arrangements to ensure that services and equipment are in place to meet the individual's immediate care needs and review and assess ongoing care if this is required."

Equipment

Statutory health and social care professionals told us that equipment shortages often made it hard to prepare people for discharge. This could range from complex equipment requiring home adaptations, such as a stairlift, to simple aids such as commodes or grab-rails. This concern was echoed by VCS professionals who reported some patients being discharged without the correct equipment in place. These challenges were seen as contrary to the guidance – which applies to those patients on a D2RA pathway – and as potentially negatively impacting people's dignity.[x]

> **"We've had several cases where people needed the profiling beds and the correct adaptations in the home and they weren't there at the point of discharge, but discharge was completed anyway… The outcome of not having a well-managed discharge process is people losing dignity and that's the best-case scenario, it can get much, much worse."**
>
> **VCS professional**

There are, however, examples of good practice in facilitating equipment fittings. One VCS professional told us about a team within their organisation that is embedded in a hospital setting and attends ward rounds with hospital staff. This means they can support occupational therapists (OTs) to identify any equipment that is needed early on and can order it immediately.

> **"There was one round [a VCS professional based in hospital] was on and [the nurse] was saying the only reason [the patient] is not getting discharged is because she needs a stairlift… [the VCS professional] went on the iPad and said, 'The stairlift will be done today'. Just like that. So, if you're not at the bedside, you're not part of the discussion you don't get that quicker response. That's why co-location, for me, being accepted as part of a team is so important."**
>
> **VCS professional**

Pressures within acute and community settings

General pressures within acute settings can mean that patients are not given adequate opportunities to get out of bed and improve mobility prior to discharge, impacting negatively on feelings of preparedness.

> **"The physiotherapist was supposed to come in and get her up and get her stronger, but it didn't happen."**
>
> **Carer, South West Wales**

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[x] The guidance states: "Nominated lead co-ordinators for each local Joint Equipment Store will need to ensure that there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs at home. This includes ensuring access to equipment quickly and facilitated seven days a week."

Levels of support in the community can also affect patients' feelings of preparedness. Community-based statutory health and social care staff expressed concern about increased numbers of patients being inappropriately discharged (i.e. without support from a family member or carer to bridge the gap before more formal care is introduced), causing significant strain on community resources and on patients' families. They said that this was having a knock-on effect on their colleagues, who were already having to deal with an increased workload due to higher levels of acuity across the board. Some reported regularly having to call GPs to assess patients as soon as they were discharged or, in some cases, ambulances to return patients to hospital. It was felt that more effective communication and assessment could have prevented this.

> **"A patient was seen by [Admissions, Discharges and Transfers] in A&E and was sent straight home. We went out on a crisis call, saw her, and the GP sent her back... and so she was being yoyo-ed into A&E."**
>
> **Community-based statutory health and social care professional**

This demonstrates the importance of addressing wider system concerns, and indicates a need to focus resources on community-based support and on reforming social care, which would also help to support universal implementation of the D2RA model.

Preparedness for discharge – Is the guidance being met?

What the guidance says

The guidance does not reference anything around preparedness for discharge specifically, however the following sections of the guidance are relevant to this issue:

Suitability for discharge – all patients

The guidance notes that any patient meeting the clinical criteria, i.e. whose acute treatment is completed, will be deemed suitable for discharge.[23] Further prompts include asking whether this person's care can now be provided in another setting, whether this person needs to be on a D2RA pathway, the value for this person remaining in hospital, and 'actions for today' (i.e. what needs to happen next).[24]

Practical needs – lack of clarity around who this applies to

In addition, the guidance states that discharge co-ordinators will organise practical measures such as shopping and turning the heating on for those who have no one to do this for them[25] which may make patients feel more prepared for discharge. It is likely that this is for all patients who will have nobody to do this for them, however, the guidance does not clearly specify which patient groups this provision applies to. Clarification would be beneficial.

Equipment – D2RA patients

The guidance states that nominated lead co-ordinators for each local Joint Equipment Store will need to ensure that there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs (those placed onto a D2RA pathway) at home.[26]

What we found

Most patients who participated in this research felt at least somewhat prepared for discharge. However, a significant minority felt unprepared.

Professionals emphasised that issues such as unsuitable home environments, a lack of community-based support, and delays in equipment provision can result in patients feeling and/or being unprepared to go home. Both VCS and community-based statutory health and social care professionals said that assumptions are sometimes made about the safety and suitability of a patient's home.

2. Communication and information

There was widespread agreement among the patients and professionals involved in the research that good communication is key to successful discharge. However, most expressed concern that this is lacking throughout the health and social care sector.

> **"There's no connection between community settings, community response teams, community resource teams, district nurses, the wards. None of it links in, there's no flow; each service cuts dead and then the next one kicks in… the information remains isolated, there's no structure around it."**
>
> **VCS professional**

The patients we interviewed with less acute health needs tended to feel that the communication they received about the discharge process was effective and to report a positive experience overall. However, this was not the case for those with more complex medical and social needs and a history of moving between different wards and hospitals. Some participants shared examples of situations whereby important medical information was not shared between hospitals.

> **"The record keeping and referring between hospitals is awful. When we got to [the second hospital], if my husband hadn't photocopied a letter we got from discharge, they wouldn't have had it… the communication, with having computers and everything, just doesn't work properly."**
>
> **Patient, Mid Wales**

> **"The notes didn't come across from [the first hospital] straight away, there was definitely mixed messages sent from [them] to [the second hospital] and it was a case of she was supposed to have other x-rays and things like that and that definitely wasn't fed through."**
>
> **Carer, South West Wales**

The above experiences highlight issues with information sharing between hospitals, suggesting a need for lead staff members supporting information sharing in each health board to review existing data sharing arrangements.

Both community and hospital-based health and social care professionals considered communication to be a significant challenge; both internal (i.e. among health care staff) and patient-facing communication was raised as an issue. Statutory health and social care professionals mentioned several factors impacting communication, including a lack of clarity on who has responsibility for communicating the needs of patients, a high turnover of staff and staffing shortages. These issues mean that communicating with other professionals, families and the patients themselves can drop down the list of priorities.

We found a clear need to clarify responsibility for liaising with patients, whether they are assigned to a D2RA pathway or not. However, our findings suggest that there is also a need to address underlying staffing issues that hinder clear and consistent communication.

Both therapy staff (such as physiotherapists and OTs) and VCS professionals felt strongly that discharge planning should begin when a patient is admitted and that a communication strategy should be built around this. This would enable all professionals involved in the patient's care to understand the patient's health, mobility and pre-existing social needs prior to admission in order to identify potential needs at discharge. It was felt that this does not routinely happen.

> **"Patients aren't told what's happening. Our job is to gauge what the patient's mobility was like before, sometimes we're unable to do this as they arrive at the hospital."**
>
> **Hospital-based statutory health and social care professional**

VCS professionals explained how early communication about an upcoming discharge from professionals involved in the person's care can enable them to put support in place as soon as the patient leaves the hospital. This would help alleviate some of the delays to more formalised care.

> **"You can shave off days by having the right conversations much earlier."**
>
> **VCS professional**

Involving staff from across sectors in ward rounds including the VCS (particularly for patients on Pathway 0) was felt to be important.

Statutory health and social care professionals said that failing to talk to families early in the process only led to a need for more phone calls further down the line to relay information from different agencies around discharge. Health and social care professionals from both statutory and VCS sectors wanted to see improved communication, more person-centred discharge processes and MDT approaches, to improve delivery of the discharge model.

Communication between professionals – Is the guidance being met?

What the guidance says

Communication between professionals – all patients

The guidance refers to supporting and working with other teams including MDTs. Social care colleagues or appropriate representatives from the integrated discharge team should be involved in the twice daily ward reviews.[27] However, it does not mention the VCS.

Communication between professionals – D2RA patients

The guidance states that hospital discharge teams will provide advice and support to ward teams on the D2RA Pathways and act as the key problem-solving contact between hospital and community teams.[28]

Co-ordination between NHS providers, NHS volunteers and the VCS is also mentioned in relation to patients placed on Pathway 0.[29]

However, the guidance does not refer to communication requirements between acute and community hospitals for Pathway 3.

What we found

The patients and VCS professionals we spoke to felt that community-based staff were not involved enough in discharge arrangements for patients put onto a D2RA pathway. Involving a range of sectors on ward rounds was felt to be important.

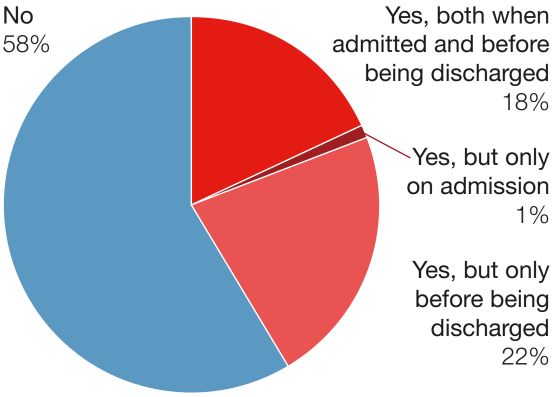
A lack of guidance on communication between acute and community hospitals was seen to exacerbate the challenge of information sharing. The guidance document could be an effective tool with which to clarify this.

Information leaflets

Information leaflets have been designed to be shared on admission and prior to discharge. The guidance states that all patients, their families and carers, and any formal supported housing workers should be involved in discussions around discharge, using these leaflets. However, most of the patients that we interviewed said that they had not received a leaflet giving information on the discharge process, either on admission or during their stay. Several had received leaflets on other aspects of their care, such as looking after wounds or rehabilitation exercises, which were generally considered useful.

The survey also found that most patients (58 per cent / 39 of 67) had not received an information leaflet (see Figure 8 below). The remaining 42 per cent (28 of 67) said that they or the person they care for had received one, with the leaflet on admission being the most likely not to have been provided. Around one in five (18 per cent / 12 of 67) received a leaflet both on admission and on discharge. Of the 28 people who did receive a leaflet, all but one respondent found the information easy to understand.

FIGURE 5: Did you/your friend, relative or client receive these leaflets?



BASE: All respondents (67)

Around half of the patients interviewed were unconcerned about not receiving a leaflet, either because they were able to gain the information they needed by speaking to ward staff, or because they did not feel any additional information was needed. Others mentioned that they were so ill during their hospital stay, they wouldn't have been able to take in any written material and felt it was inappropriate to offer it at that time. However, some said that it may have been something they could have reflected on at a later stage or would be a good way to offer contact details for the ward. The guidance provides an example of the leaflet for those leaving hospital, and this shows that contact details should be provided.

A minority, particularly those with more complex care needs, felt that they would have really benefitted from a leaflet.

> **"I think it's just something written down, what to do in the case of an emergency, given to whatever family member is looking after you, you know if XYZ call this number. Just something to look out for, be sign[post]ed [to] kind of thing… I suppose just some information on how you could continue your care at home would be useful."**
>
> **Patient, South East Wales**

Health and social care professionals from statutory and VCS sectors alike highlighted the importance of giving written information in line with the guidance, and for that information to be accessible and in an easy-read format.

These findings suggest that guidance around providing information leaflets is not currently being implemented consistently. Given we identified no constraints to distributing leaflets, this should be immediately addressed.

However, we also identified a need for supplementary information for some key groups. Some VCS professionals felt that those with lasting powers of attorney or a nominated family member should be given information setting out the potential discharge pathways and what is planned for the patient. This is not something that routinely happens.

> **"Nobody is given that information at all, nobody is told 'this is your way out, here's a flow chart and we'll take you through the steps'. Just something easy… a leaflet that says when it's time for you to go home, this is how we'll manage it."**
>
> **VCS professional**

Information leaflets – Is the guidance being met?

What the guidance says

Information leaflet – all patients

The guidance states that a leaflet on hospital discharge must be shared and explained to all patients on admission to hospital.

In addition, once a decision to discharge is made, all patients and their family or carers, and any formal supported housing worker are to be informed and receive a leaflet stating why they are being discharged and what they may expect afterwards.[30]

Information leaflets – D2RA patients

The leaflet which should be given to all patients when they are being discharged also states that if care is required for a period of time following discharge, this will be free of charge. This applies only to patients placed on D2RA pathways.[31]

What we found

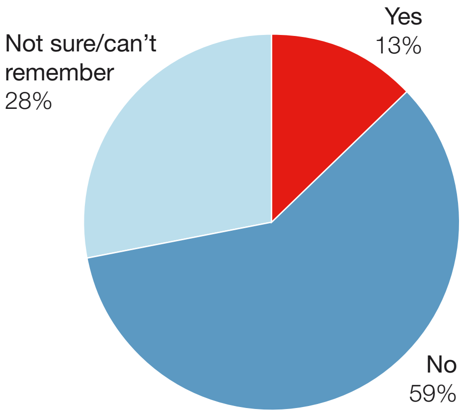
Our findings highlight that not all patients received a leaflet on admission and on discharge, indicating that the guidance is not consistently being met.

Preferred language

Although our survey was available in Welsh, language was not a key consideration in the discharge experience of most of the patients involved in the qualitative interviews, as their main language was English. One interviewee was Welsh-speaking and said that their language needs were fully met at their local hospital, where a high percentage of staff were able to communicate with them in Welsh.

As seen in Figure 6 (right), around three fifths of survey respondents (59 per cent / 47 of 79) said that they, or the person they care for, were not offered the choice of communicating in Welsh, with only 13 per cent (ten of 79) saying they were. Another 28 per cent (22 of 79) said they weren't sure or couldn't remember (carers were more likely to say they weren't sure).

FIGURE 6: Were you/Was your friend, relative or client given the choice of receiving information and/or communicating in Welsh?



BASE: All Respondents (79)

It is not clear from the survey results why some patients were not offered the choice of communicating in Welsh, however, all patients should be offered this choice in line with the 'Active Offer' (see guidance box below). Despite this, when asked if they were able to communicate in their preferred language, the vast majority of survey participants (96 per cent / 77 of 80) said they were, meaning most patients' language needs were met.

VCS professionals highlighted the importance of being able to accommodate a patient's choice of language and stressed that this is particularly important for those living with dementia. There was concern among VCS professionals that language is not routinely factored into processes, which can be detrimental to the patient. This is not just an issue for Welsh speakers, but affects others whose first language is not English.

> **"We had a case where a gentleman whose first language was Arabic was losing his English due to his dementia. That discharge process went through a best interest meeting... and even through Court of Protection involving hospital social work and discharge process and at no point was Arabic used in the communication with him. In the cases where we have [a language need], I see no evidence of it [being met]."**
>
> **VCS professional**

VCS professionals also highlighted the importance of effective non-verbal communication as part of the discharge process. One VCS professional felt that techniques used in the community to aid communication are not routinely being used by hospital staff, as they are seen as too much of a burden to adopt, generally as they require more time and specific resources.

> **"They may have English but they may not actually have the means to convey their words. We've had our staff trained in talking mats, the tactile communication tool and we're allowed to be brought into the discharge process and be able to facilitate that so that people who are less verbal or non-verbal can communicate. There's just no appetite [among] the healthcare professionals and discharge staff to go to that level because they think it seems burdensome."**
>
> **VCS professional**

The above findings demonstrate the importance of introducing communication in a person's language of choice, including non-verbal communication, with the help of VCS professionals, particularly for those patients living with dementia.

Preferred language – Is the guidance being met?

What the guidance says

Language is not referenced in the *Covid-19 Hospital Discharge Service Requirements*. Guidance around an ‘Active Offer’[32] (providing a service in Welsh without having to ask) and provision of interpreters for British Sign Language[33] and other languages[34] is referenced in documents outside of the hospital discharge guidance document.[xi]

What we found

Our research found that the Active Offer was not being consistently made. Furthermore, our evidence suggests that communicating in a person’s language of choice would be particularly beneficial for those patients living with dementia. However, this doesn’t always happen in practice.

Contact information

Half of the patients interviewed were provided with a contact number for the ward they were discharged from, or a key person in the hospital who could support them if needed.

> **“I was told who to call no problems. They actually phoned me from the department the next day just to check that I was recovering and everything was alright, which I thought was really nice.”**
>
> **Patient, East Wales**

A further three patients did not mention or recall if they’d received a contact number and two had not received one (but were not concerned as they had not required support after discharge).

Of the five that did receive a contact number, one reported they had had to ask for the number (and didn’t believe it would have been offered otherwise) and another had been given a generic contact number for the hospital. One patient explained how they had had difficulty contacting their stroke nurse to discuss concerns post-discharge:

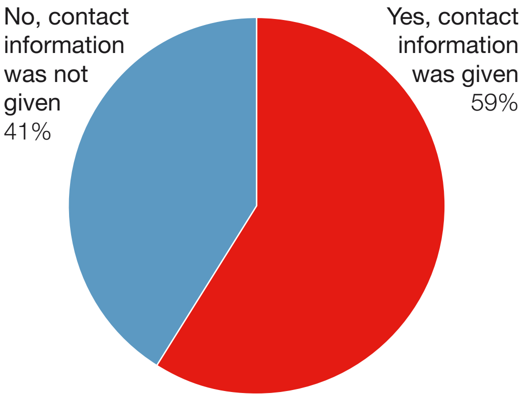
> **“When I tried ringing the hospital to speak to her about things that have happened since my discharge, it’s almost impossible to get through to her. I’ve left messages, but I guess because she’s the only one [stroke nurse] she is really busy. I think, if I had any feedback to give it would be to have a contact number that you can give people to get hold of the stroke nurse, or even just an e-mail.”**
>
> **Patient, West Wales**

Among our survey participants, around two fifths (41 per cent / 33 of 80) reported that they, or the person they were caring for, were not given information about who to contact if they needed further health advice or support after leaving hospital (see Figure 7 below). This broadly reflects the findings from our interviews.

Positively, of those who were given contact information and tried to get in touch (24 of 47), almost all successfully managed to do so (22 of 24); only two tried without success.

[xi] Note that in developing services, health boards must have regard to certain principles which build on the ways of working from the Wellbeing of Future Generations (Wales) Act 2015 and this includes having adequate interpretation services for all aspects of healthcare.

FIGURE 7: Were you/Was your friend, relative or client given information about who to contact if you/they needed further health advice or support after leaving hospital?



BASE: All Respondents (80)

These findings indicate a need to consistently provide all patients with a leaflet which includes locally agreed contact details, as recommended in the discharge guidance. Doing so will ensure that the process of making contact is straightforward and that the onus is not on the patient to ask for details.

Contact information – Is the guidance being met?

What the guidance says

All patients

Information leaflets for patients being discharged to their usual place of residence and for patients moving to further non-acute bedded care should contain locally agreed details for patients to call about any concerns or about their care.[35]

D2RA patients

In addition, for those patients on a D2RA pathway, guidance notes that the local community teams will lead on co-ordinating arrangements for patients, including the allocation of the care co-ordinator as the key point of contact for patients and their families and carers.[36]

What we found

Our findings suggest that the guidance is not being met consistently, as not all patients received contact information.

3. Personal choice and ‘what matters’ conversations

‘What matters’ conversations

A ‘what matters’ conversation is a targeted conversation focusing on what matters most to the individual, based on their personal preferences and wishes.[37] ‘What matters’ conversations help to identify how the individual wants to live their life, what might be preventing this, and what support might be required to overcome those barriers. They are often used as part of an assessment process.[38]

The concept of ‘what matters’ conversations is affirmed in the Social Services and Wellbeing (Wales) Act 2014 (SSWBA).

‘What matters’ conversations

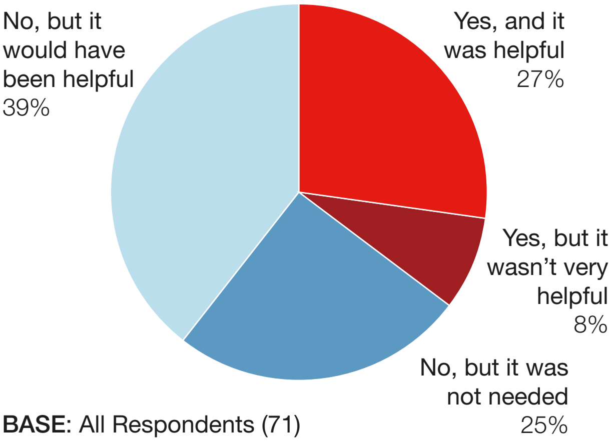
Feedback on ’what matters’ conversations during the discharge process was mixed among those participating in the qualitative research. As with previous findings, the complexity of the case and severity of a person’s condition was a factor. For some with less complex needs, there was a feeling that what mattered to them was considered and they were broadly happy with how this impacted the discharge process as a result.

> **“I felt that I had a lot of time to ask as many questions as I wanted, and I came away feeling reassured that I’d had their full attention for the time I needed.”**
>
> **Patient, South West Wales**

Feedback from patients with more complex needs was less positive; they, along with the VCS professionals who we spoke to, felt that ‘what matters’ to patients is often overlooked during the discharge process, with priority given to addressing medical needs. Around half of the patients who participated in an interview said that they were not offered a specific conversation around what mattered to them regarding the discharge process. For some, this was not an issue because they felt that their needs were met through other conversations with ward staff. Others felt that such a conversation would have been beneficial, as it would have enabled them to access other services, such as mental health support, upon discharge.

Similarly, around a third of survey respondents (35 per cent / 25 of 71) reported that they, or the person they care for, had a conversation with someone at the hospital about what matters to them with regard to their discharge (see Figure 8 below); of these, most (19 of 25) felt that the conversation was helpful. Around two fifths (39 per cent / 28 of 71) said they did not have such a conversation, but that it would have been helpful.

FIGURE 8: Did you/your friend, relative or client have a conversation with anyone at the hospital about what matters to you/them?



BASE: All Respondents (71)

These findings suggest that the person-centred model of discharge, and the separate guidance FAQs document which references ‘what matters’ conversations, would be well received by all patients, not only those to whom the D2RA model applies.

Wider system pressures

Therapy staff[xii] in hospitals and in the community said that ensuring care is ‘person-centred’ is a key principle of their practice and is factored into all decision making in relation to discharge. However, they felt that this approach is not always taken by other professionals involved in looking after their patients.

[xii] Occupational therapists and physiotherapists.

Other statutory health and social care professionals agreed with this. Some felt that while they tried to work in a person-centred way, pressures within the system, particularly within the context of the pandemic, made it difficult for them and their colleagues to do so.

> **"From a nursing perspective, most wards are working on 50 per cent of a substantive work force. Not to make excuses, but these are things we can't shy away from…"**
>
> **Hospital-based statutory health and social care professional**

They told us that staffing issues were a significant challenge in taking patients' wishes into account. The extra resources required to communicate with families who are unable to visit the hospital due to Covid-19 regulations means that their views are also not routinely factored in.

'What matters' to families

It can be difficult to balance what patients want and what their families can support them with. Health and social care professionals from both statutory and VCS sectors reported that, often, patients want to leave hospital but families do not feel able to support them at home. Shortages in care packages can result in health and social care professionals being unable to balance the wishes of both the patient and their family, which can lead to readmission.

> **"Families are looking at us as a lifeline to tell the patients they can't go home. It's really hard for them to accept patient capacity and we have to allow them to make unwise decisions."**
>
> **Hospital-based statutory health and social care professional**

The above evidence highlights the challenges associated with considering people's wishes as a part of getting social care right for those leaving hospital. It is vital to take patients' views into consideration, but the views of those who are expected to provide care are equally important. Failing to take both into consideration can lead to gaps in support.

Despite 'what matters' conversations being a well-known principle within health and social care, community-based statutory health and social care professionals, and most VCS professionals, did not feel that the wishes of patients or their families were routinely considered in relation to their discharge and that processes are based first and foremost on the needs of the hospitals. This was largely considered to be due to the aforementioned pressures on the system, rather than a reflection of the hospital staff's competencies or a lack of willingness to take these needs into account.

> **"It's driven by the discharge being achieved at all costs, but then we have cases where discharge is delayed for so long because no one is speaking; it swings wildly between the two… There's no element of person-centred work, it's just based around the medicalised model."**
>
> **VCS professional**

> **"Focus is not always on the patient; it's focused on the process and resource management, and clinical decisions, rather than the patient."**
>
> **VCS professional**

These findings highlight a need not only to discuss and prioritise what matters to patients and their families, but also to recognise and address the wider system pressures that can prevent these wishes from being acted upon.

'What matters' conversations – Is the guidance being met?

What the guidance says

D2RA patients

While the guidance does not specifically require 'what matters' conversations to take place prior to discharge, the frequently asked questions (FAQs) document states the suspension of choice during the pandemic "does not mean that the NHS in Wales will stop talking about 'what matters to me.'"[39]

The guidance and FAQs are unclear on whether 'what matters' conversations apply to simple discharge patients. Nevertheless, the notion of what matters is a principle across the NHS[40] and should be informing discharge both within and outside of the guidance.

What we found

Our research suggests that despite 'what matters' conversations being a longstanding principle in health and social care, people are not consistently being asked what matters to them and there are barriers to ensuring that what matters to people guides discharge.

Our research demonstrates that these conversations are important for all patients, whether assigned to a D2RA pathway or not.

4. Assessments and meeting people’s needs

Pre-discharge assessments

Although the aim of D2RA is to move the assessment process to after discharge from hospital, the model still relies on there being a rapid assessment of broad suitability for this pathway and to determine the best pathway to follow. Where these assessments are not carried out properly it can lead to problems post-discharge for patients and staff. Health and social care professionals spoke about the difficulties carrying out pre-discharge assessments, particularly when there is a high turnover of staff on wards.

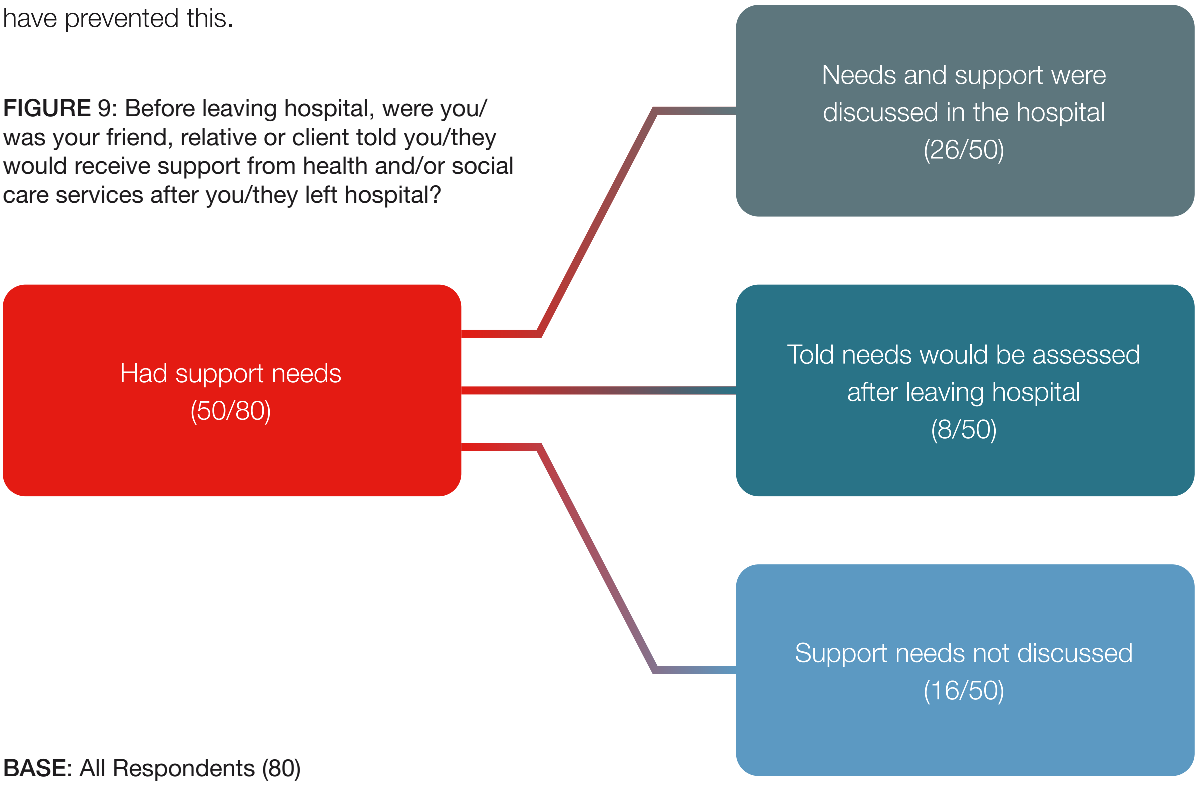
> **“We’re using a nursing assessment to make decisions, without notes from therapists. So, we’re making decisions from a nurse’s perspective who barely knows the patient.”**
>
> **Hospital-based statutory health and social care professional**

Two of the ten patients we interviewed, as well as the patient looked after by the carer we interviewed, had been readmitted to hospital after their initial discharge. In all of these cases they felt that adequate assessments upon discharge could have prevented this.

> **“Even though she wanted to come out, she didn’t feel strong enough to come out. Well, she fell that following morning so there was definitely something that wasn’t right. So, I think if she’d had her needs reassessed maybe that would’ve prevented her falling.”**
>
> **Carer, South West Wales**

These findings are reflected in our survey results, which found that around a third of respondents who identified as having support needs (32 per cent / 16 of 50) did not have their needs discussed at all prior to discharge. Around half (26 of 50) did have their support needs discussed at this stage and eight were told their needs would be assessed after leaving hospital (see Figure 9 below).

FIGURE 9: Before leaving hospital, were you/was your friend, relative or client told you/they would receive support from health and/or social care services after you/they left hospital?



BASE: All Respondents (80)

A holistic approach

VCS professionals told us about missed opportunities for more holistic assessment, in which a patient’s social and cognitive needs were recognised alongside their medical needs. It was felt that holistic assessment would support more successful discharge and recovery. Statutory health and social care staff agreed that this should be a priority but felt assessments were currently based on medical needs above all else, due to a combination of pressures within the system and longstanding cultures within hospitals.

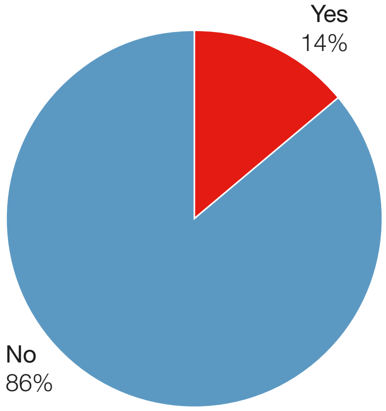
> **“There’s a sweet spot for medical discharge and if we haven’t got all the things in there then that [opportunity] is gone and it could be gone for a long time; it could be gone for weeks and months. You’ve got to get everything in place for that, it’s a jigsaw.”**
>
> **VCS professional**

> **“If you’re making a cake you have to have all of the ingredients in place or it’s not going to turn out right… all the ingredients are in place from the identification, the collaboration, it’s holistic, people-centred and all the agencies come together and it’s seamless.”**
>
> **VCS professional**

A holistic welfare check, covering practical, physical, social, psychological as well as medical needs could support effective discharge planning. The British Red Cross has called for the inclusion of a five-part independence checklist in the hospital discharge process to facilitate conversations between health professionals, patients, their families and carers, about their practical, social, psychosocial, physical and financial needs.[41]

Only around one in seven (14 per cent / nine of 64) survey respondents said they were asked about their non-clinical needs at any point, with 86 per cent (55 respondents) saying they were not asked (see Figure 10 below), demonstrating that the focus of assessments is very much on the clinical, rather than the holistic, state of the patient.

FIGURE 10: Did anyone at any point ask you/your friend, relative or client about any non-clinical needs you/they might have, for example help with practical, physical, social, psychological, or financial independence (this is called a holistic welfare check)?



BASE: All Respondents (64)

Pre-discharge assessments – Is the guidance being met?

What the guidance says

Early identification of possible care and support needs – all patients

The guidance states that to ensure early identification of any possible care and support needs, including housing issues, and to allow MDTs to undertake arrangements in good time, social care colleagues or appropriate representatives from the integrated discharge team should be involved in the twice daily ward reviews.[42]

This should be the case for all patients, as this will help to identify if a patient requires ongoing support which would result in a patient being assigned to a pathway (and receiving an assessment after discharge).

The guidance states that any patient who meets clinical criteria for discharge (i.e. acute treatment is completed) is deemed suitable for discharge[43], and does not reference non-clinical needs when completing board rounds.[44]

What we found

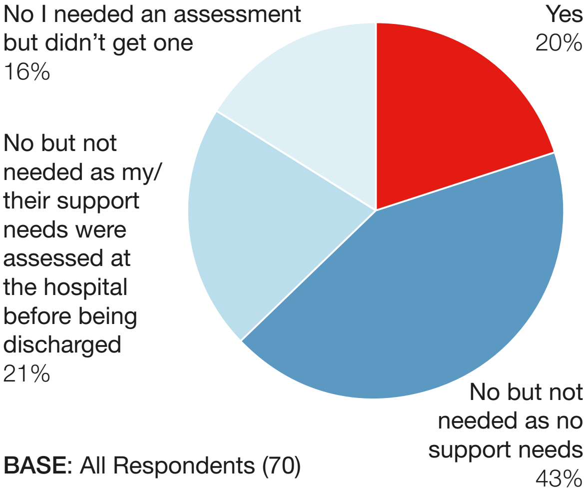
The evidence suggests that appropriate assessments of support prior to leaving hospital are not happening consistently, putting people at risk of falling through the gaps.

Post-discharge support and assessments

All but one of the patients we interviewed were simple discharge patients, so would not have been eligible for assessment post-discharge and most agreed that assessment was not needed. The patient we interviewed on Pathway 2 received an assessment by a physiotherapist working in the community. The carer we interviewed felt that the person they cared for (who was on Pathway 3) could have benefited from a post-discharge assessment, but did not receive one.

We asked survey respondents whether they were visited by a healthcare professional to assess their support needs after leaving hospital. One fifth (20 per cent / 14 of 70) reported that they, or the person they care for, had been (see Figure 11 below). However, 16 per cent (11 of 70) felt that they did need an assessment but didn’t get one. This included two D2RA patients (one on Pathway 0 and one on Pathway 4). The remainder felt that the decision to be assessed or not be assessed was appropriate.

FIGURE 11: After leaving the hospital, were you/was your friend, relative or client visited by a healthcare professional to assess your/their support needs?



BASE: All Respondents (70)

Community-based assessments

Statutory health and social care professionals gave examples of previously hospital-based discharge teams who now work in multidisciplinary discharge teams in communities (this is not standard practice everywhere at present). Although this was largely considered a positive move by the statutory health and social care professionals we spoke to, some highlighted practical complications around assessing patients in the community, which often has to be done virtually due to Covid-19.

> **"Three of us were discharge co-ordinators based in the acute [team] and we co-ordinated all the discharge planning. Then the model changed, and we were placed in the community for the Home First Bureau. We're trying to deliver virtually what we were doing on site but we're missing the assessment factor. We're having to take other people's assessment. We're doing the pulling rather than pushing out."**
>
> **Community-based statutory health and social care professional**

Some statutory health and social care professionals felt that hospitals are dependent on 'key gatekeepers' for in-home assessments to occur at the right time, meaning there is a 'scatter gun' approach across Wales as to when and if they happen. This can be a particular issue in large hospitals where patients and staff are moved around more often.

Community-based statutory health and social care professionals said that there remained confusion around the role of assessments under the current discharge model, with examples of the same assessments being carried out both in hospital and in the community. One statutory health and social care professional reported that, in one area, patients would not be discharged into community services without a full assessment in hospital – in contravention of the current discharge model.

> **"We get a ping-pong back and forth [regarding the correct assessments]."**
>
> **Community-based statutory health and social care professional**

This shows the importance of frontline staff being fully informed about the detail and purpose of the D2RA model, and confident of how to implement it.

Our findings from both the interviews and the survey also highlight that some people are receiving an assessment both pre- and post-discharge, while others are falling through the gaps and not being assessed at all.

Post-discharge assessments – Is the guidance being met?

What the guidance says

Immediate support needs – D2RA patients

For those on D2RA Pathways 0 to 4, arrangements will be made to meet individuals' immediate needs on discharge. Hospital discharge teams will arrange dedicated staff to support and manage patients on Pathway 0, including VCS groups to help ensure patients are supported in the first 48 hours after discharge and provide settle-in support where needed. For Pathways 1-4, the care co-ordinator will arrange and organise this.

Assessments – D2RA patients

Community healthcare teams take overall responsibility for ensuring effective delivery of the D2RA pathways.

Patients on D2RA Pathway 2, whose immediate needs are not met on discharge, should receive a home visit from a lead professional or MDT on the day of discharge, or the day after, to determine what support is needed in the home environment and rapidly arrange for that to be put in place.[45] Community healthcare teams will also use MDTs to assess and arrange packages of support for Pathways 1 and 2 on the day they are home from hospital. For those whose needs are too great to return to their own home transfer will be arranged to a step-down bedded facility (Pathway 3).[46]

The webinar on the *Covid-19 Hospital Discharge Service Requirements*[47] makes it clear that arrangements to meet immediate needs apply to those returning to their usual place of residence. However, the guidance could be made clearer on this.

In addition, those on D2RA Pathways 1 to 4 must be tracked and followed up for long-term needs by community health services.[48]

What we found

We found evidence of patients who felt that they needed a post-discharge assessment not receiving one, this included some who were on D2RA pathways.

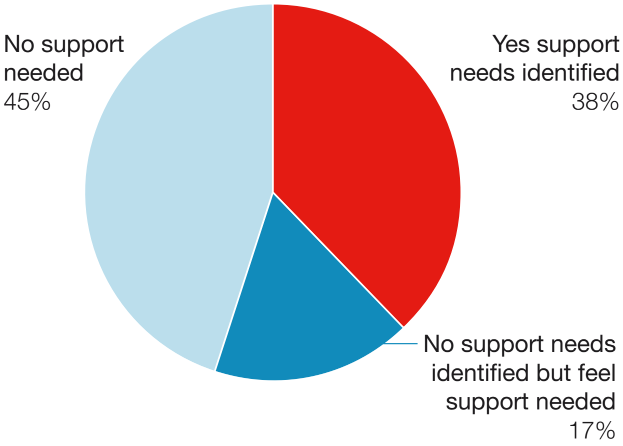
The feeling among professionals was that there are inconsistencies in providing assessments, which should be clarified in the guidance for practitioners working on the ground.

Unmet support needs

The majority of people who took part in our interviews and survey did not report any unmet needs. Overall, for those patients we interviewed who had less acute needs and a good support system at home, needs were largely being met by the current discharge model. However, a few of the patients we interviewed had sought support once discharged, including recontacting the ward they were discharged from, or asking their consultant, their GP or a VCS organisation. This suggests that some patients who were not put onto a D2RA pathway felt they needed more support than that provided.

In our survey, around two fifths (38 per cent / 27 of 71) reported that support needs, for themselves or the person they care for, were identified either at the point of discharge or following an assessment after leaving hospital (see Figure 12 below).

FIGURE 12: Were any support needs identified, either at the point of discharge, or following an assessment?



BASE: All Respondents (71)

In the main, this support was provided by a GP (nine respondents), domiciliary care providers (six respondents), hospital staff (six respondents) or health and social care staff (five respondents). A further two fifths (45 per cent/32 of 71 respondents) felt that no support was needed.

This leaves around one in six of our survey participants (17 per cent/12 of 71) feeling that they had support needs that were not identified at point of discharge or during an assessment.

Through our interviews, we also found that where a patient was identified as not needing any further support but was particularly frail and/or had a complex medical history, their needs were less likely to be being fully met by the current system. Those we spoke to who fell into this category tended to feel they needed further support.

Both community-based statutory health and social care staff and VCS professionals also expressed concern that there has been a significant increase in the severity and complexity of the needs of those on their caseloads, as well as an increase in inappropriate discharges, leading to increased pressures in other parts of the system or readmissions.

It is important to note, however, that there was wide-ranging support for the D2RA model and the challenges were seen as products of pressures across the sector and a persistent lack of resources, which mean that the model cannot be implemented to its full potential, rather than due to problems with the model in itself.

Notably, there was agreement among all health and social care professionals involved in this research – both statutory and VCS – that the needs of patients living with dementia are not being effectively met by current discharge processes.

> **"It's a case that we see in people who are in a very vulnerable position, they're being put more at risk as a result of the discharge practice, whether it's their dementia advancing because they're in hospital too long in an unfamiliar surrounding or they're discharged too quickly with no package of care in place."**
>
> **VCS professional**

> **"Dementia patients I think are much more difficult to leave hospital. With dementia, there's no intensive support at home. We're limited in intensive support."**
>
> **Hospital-based statutory health and social care professional**

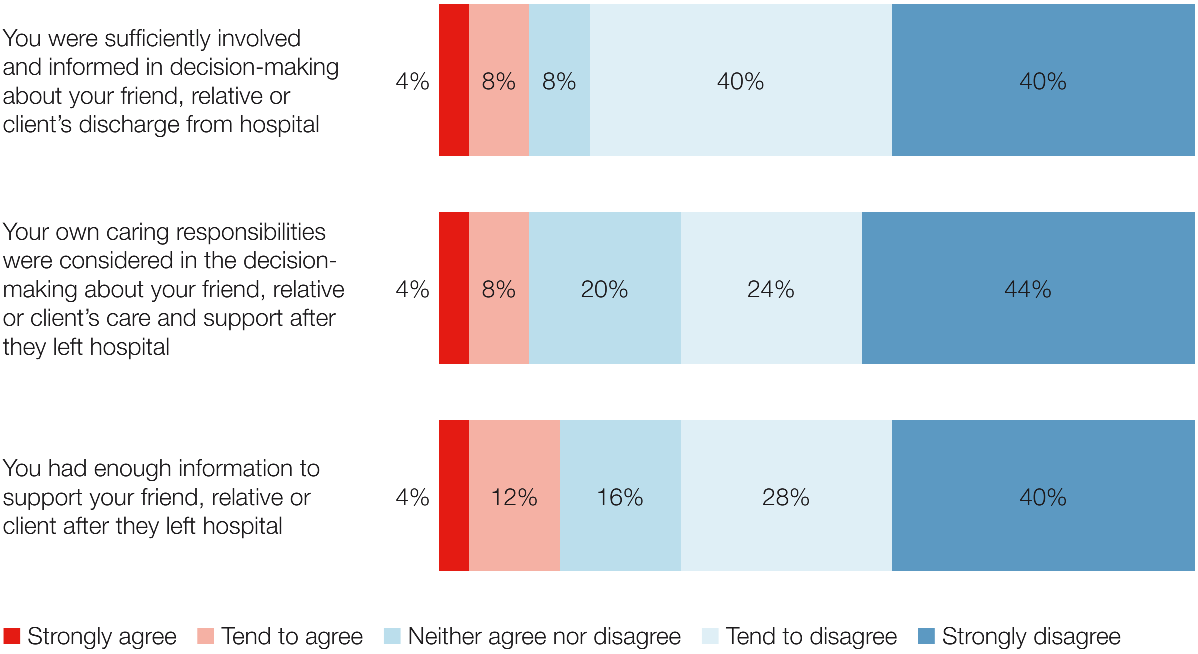
These findings suggest that we need to scale up community services to address an increase in need and complexity and to meet the needs of people with dementia and other additional needs. The most frequent reason given by survey participants for having unmet support needs was that no one asked about support needs, or support needs weren't identified (ten of 19 respondents); that they did not know where to find support (six of 19 respondents); or that support from family or friends was not available or adequate (four of 19 respondents). The most common areas of unmet need were health needs, such as symptom management or wound dressing (eight of 19 respondents); people to keep them company or someone to talk to (seven of 19 respondents); and help with tasks such as washing, getting dressed or cooking (five of 19 respondents).

Carer needs and support

Involvement

Despite the guidance clearly stating that families and carers must be fully involved in the next steps after discharge, our findings suggest that most carers do not feel well informed or considered during the discharge process. While we had only a small sample of 25 carers in our survey, we found that the majority did not feel sufficiently informed and involved in decision-making (80 per cent / 20 of 25 respondents said this); nor that their own caring responsibilities were considered in decision making (68 per cent / 17 of 25 respondents); nor that they had enough information to support their friend, relative or client (68 per cent / 17 of 25 respondents) (see Figure 13, below).

FIGURE 13: As a carer, to what extent do you agree or disagree that…



BASE: All Respondents who are carers (25)

The carers who responded to our survey reported more negative experiences than patients with regards to contact information, leaflets and 'what matters' conversations:

- Patients were more likely than those caring for them to say they received information leaflets: around half (24 of 45) of patients said they received leaflets compared to around a fifth (4 of 22) of carers.
- Patients were significantly more likely than carers to say they had been given information about who to contact – around seven in ten (36 of 50) patients said they were given contact information compared to around a third (11 of 30) of carers, suggesting that carers are often less informed.
- Regarding 'what matters' conversations, patients were significantly more likely than carers to say that they had had one, and it was helpful – around a third of patients (18 of 49) said this compared to one of 22 carers. Carers by contrast were more likely than patients to say 'no, but it would have been helpful' – around two thirds (15 of 22) of carers said this, compared to around a quarter (13 of 49) of patients.

In our qualitative interviews, one VCS professional and one carer expressed frustration at 'sporadic' communication from hospitals when loved ones were being treated and in preparation for discharge. This can make planning for discharge difficult and people are left feeling 'in limbo' about the patient's care. In the individual's experience, it also caused anxiety as it was difficult to understand what their loved one's overall health and recovery would be like.

> **"There wasn't very much communication, and she was very weak coming out... There wasn't really a handover or anything for the nurses up there from what I remember... she was very distressed that night."**
>
> **Carer, South West Wales**

Support

Support for carers may be available through VCS organisations, which provide information factsheets on carers' rights, helplines and support groups. In addition, some carers may have support needs that are identified through a carer's assessment undertaken by social services. Some examples of the support a carer may receive include respite, help with housework, or a laptop.[49]

One VCS professional felt that part of the issue with this process is a lack of support and information which allows people to identify themselves as a carer or someone who intends to give care. People looking after family members often do not think of themselves as 'carers', thinking of that as a more formal role, and this can prevent them from taking steps to access support. This can have a knock-on effect on the physical and mental health of the carer and diminish their capacity to cope.

> **"Carers' knowledge of their rights is very, very low. A lot of carers, on average, take possibly three or more years to identify themselves... . That's why the onus is so important on healthcare staff to identify those carers and signpost them to the sources of information, advice and support they need."**
>
> **VCS professional**

Professionals felt it was important for patients and their carers to be aware of their rights and have access to advocacy services (which, we were told, are provided for free by many VCS organisations but are not routinely promoted).

> **“A lot of it comes down to communication; telling people that they have rights and what those rights are… The carer quite often, especially if they’ve been looking after someone for a long time, will know what that person wants; they’ll know what their likes and dislikes are and will know how that person wants to be treated. So, often the carer can advocate but quite often they’re not given that opportunity.”**
>
> **VCS professional**

Carers of patients placed on a D2RA pathway

VCS professionals felt that the D2RA pathway model is too reliant on finding opportunities for families to provide care, usually in the short-term, to bridge the gap between discharge and a longer-term care package becoming available. Families can be under pressure to provide care and while some are prepared to do so, some feel it is effectively forced upon them. VCS professionals we interviewed felt that they, as well as community-based statutory health and social care staff, are having to classify discharges as ‘unsafe’ as a result, resulting in readmission for some patients.

> **“People phone us up and they say, ‘Mam is being discharged and there is no package in place’, and they just expect you to do it. At which point then effectively it’s classed as an unsafe discharge.”**
>
> **VCS professional**

Ensuring there is proper support for carers, and adequate social care support for those whose family members cannot or do not want to provide care, will be vital if the discharge process is to be effective.

Carer needs and support – Is the guidance being met?

What the guidance says

All patients

The guidance makes clear that most patients will be discharged without any further support other than that provided for by their ‘usual mechanisms’ – for many this includes the support of family and other carers.

In addition, the guidance notes that families must be fully informed of the decision to discharge and next steps[50] [51], whether their loved one is put onto a D2RA pathway or not.

In terms of support and training, the guidance states that community palliative care teams should have arrangements in place to provide advice, training and support to family and carers to assist with end-of-life care at home.[52] There is no further reference to support and training for carers in the guidance.

D2RA patients

A key contact for families and carers of patients on a D2RA pathway will be the care co-ordinator.[53]

What we found

Our evidence suggests that the requirement to involve family and carers is not being consistently met and D2RA guidance is potentially putting additional pressure on family and other carers.

Expanding guidance to ensure hospital teams work with social care staff and VCS organisations to identify carers and provide them with clear resources for support could be one way to help address the gaps in communication with and support for carers.

5. D2RA model

The notion of D2RA was widely supported by all professionals involved in the research. There was cross-sector agreement that patient outcomes tend to be better when people are able to recover at home, and that deterioration can be prevented when a person avoids a prolonged hospital stay, as long as there is capacity to provide a follow-up assessment at home once discharged.

> **"Patients are recovering better at home, as long as you have that response to go out to them. If you can have that right response, it can work."**
>
> **Hospital-based statutory health and social care professional**

As seen earlier in this report, experiences shared by patients and health and social care professionals suggest that, where patients have less complex needs, for the most part, they are being discharged when they are ready. However, the statutory health and social care professionals we interviewed felt that there is work to do in refining referral pathways and procedures to ensure this is the case for all.

Most professionals involved in the research felt that the model is not working as it is designed to and that there are significant pressures and challenges across the sector impacting every part of the process. There was also a feeling that the D2RA pathways are 'in development' and that implementation of the model is inconsistent across Wales:

> **"There's just no consistency of approach within local health boards, there's no consistency of approach with managing discharge. Then that expands across Wales, there's no consistency from area to area about how the experience and process is going to be managed."**
>
> **VCS professional**

Many professionals we interviewed felt that they were still learning how to effectively discharge patients in line with the guidance. They spoke of attempting to strike a balance between reducing the number of in-hospital assessments for patients to enable rapid discharge, and ensuring that discharges are safe. Some felt that the definition of being prepared for discharge has shifted; it was felt to be less clear-cut than previously, and dependent as much on the support and mitigations that are in place to allow patients to be discharged, as on a patient's condition. It was felt that this shift will take time to embed and that education for ward and community staff will be required, to enable them to make judgements in line with the guidance.

There was also a consensus that there is not enough knowledge of D2RA and its various pathways across the health and social care sector. We heard from individuals working both in hospitals and in the community, who felt that they did not know enough and needed further training. Some felt that primary care physicians are not aware of the model, despite their potentially pivotal role in the process.

> **"There is absolutely no understanding about Discharging to [Recover then] Assess in GP-land."**
>
> **Community-based statutory health and social care professional**

Wider system pressures

Statutory health and social care staff were very concerned that delays in accessing domiciliary care, primarily due to staff shortages, would impact their ability to effectively discharge patients to recover at home. They felt that a lack of resources made it impossible to fulfil the aims of the D2RA model.

> **"The responsibility that [social care workers] have is enormous and I can understand why lots of people are leaving the sector at this time and why we can't recruit… without them we can't get people out of hospital."**
>
> **Community-based statutory health and social care professional**

According to the statutory health and social care professionals we spoke to, the short-term funding models on which intermediate care teams depend, including the Welsh Government Transformation Fund and Integrated Care Fund, make retaining staff difficult. Staff felt that for this kind of model to take pressure off secondary care and follow a D2RA model effectively, long-term, proportionate resourcing is required.

All the professionals who took part in this research reported an increase in the severity and complexity of the needs of those on their caseloads since changes to the discharge guidance were made in April 2020. However, this was not necessarily considered to be the result of the discharge model itself. Community-based statutory health and social care and VCS professionals were also concerned about caseloads increasing in size since March 2020. They felt that they have been using significant resources responding to discharged patients 'in crisis', while patients already on their caseloads, with less complex but still important needs, are pushed further down their list of priorities. It is difficult to know whether this is driven purely by the new model or by the wider effects of the pandemic, which brought about the change in guidance.

Professional participants spoke about pressures on ward staff to discharge seven days a week and subsequent pressures on community staff to respond to this demand, even though a true seven-day service to mirror that of the hospitals does not exist in the community.[xiii] Community teams felt the pressure and expectation on them was too great. This was echoed by VCS professionals who said they were having to respond to increased demand in the community, with no additional resource.

> **"We try to bridge our gaps but there's only so much you can do and a lot of the time the phones don't get answered. We can't get the resources we need to do what we want to do."**
>
> **VCS professional**

There were, however, examples of the VCS working effectively to support statutory health and social care professionals under the D2RA model. Furthermore, a minority of statutory health and social care professionals said that they believed there was enough capacity in the system to support the model.

> **"We've got a great relationship with both community and health-based occupational therapy. We've also got, in all our agencies, trusted assessor status."**
>
> **VCS professional**

> **"There is capacity in the system, it's just all about… getting the right response to the right person at the right time."**
>
> **Community-based statutory health and social care professional**

However, most professionals we spoke to felt that a number of things needed to change around communication, assessment protocols, knowledge of the framework and integrated working.

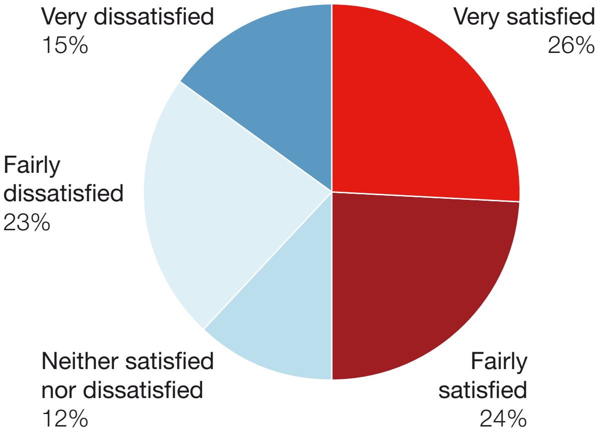
[xiii] This includes some statutory care teams that do not operate overnight or on weekends and assessments and reablement care not being offered on weekends.

6. Overall experience of discharge and key improvements needed

Overall satisfaction

Considering the whole discharge process from the time patients were well enough to leave hospital until shortly after they were discharged, Figure 14 shows that half of survey respondents (50 per cent / 37 of 74) were 'very' or 'fairly' satisfied with how the discharge was managed. However, almost two fifths (38 per cent / 28 of 74) were 'very' or 'fairly' dissatisfied with the way it was managed.

FIGURE 14: How satisfied or dissatisfied are you with the way your/your friend, relative or client's discharge was managed?



BASE: All Respondents (74)

There were some significant differences in that patients were more likely than carers to say they were satisfied overall – around three fifths of patients (30 of 46) were satisfied overall compared to around a quarter (seven of 28) of carers, mirroring earlier findings that carers' experiences were less positive in general than patients'.

When reflecting on the discharge process as a whole, around a quarter of respondents (26 per cent / 19 of 74) felt that their needs were 'fully' met, while the same number (26 per cent / 19 of 74) felt they were 'mostly' met. However, around a third (35 per cent / 26 of 74) felt that their needs were only met 'to some extent' and around one in seven (14 per cent / ten of 74) felt that their needs were 'not at all' met (see Figure 15).

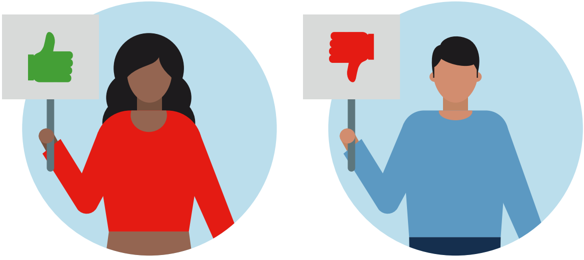
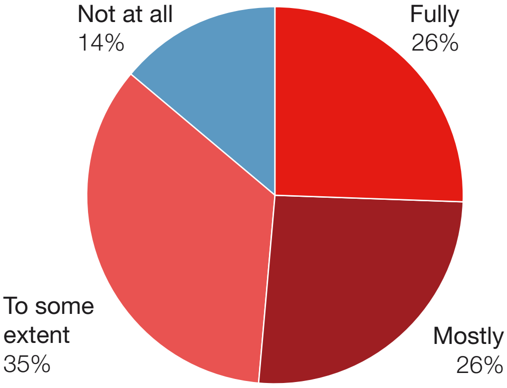


FIGURE 15: To what extent do you feel that your/your friend, relative or client's needs were met?



BASE: All Respondents (74)

When asked to give more detail about 'what went well' a recurring theme raised by survey respondents was the care and support people received from friendly, helpful staff throughout their stay. The expertise and professionalism of doctors and surgeons, in particular, was recognised, including the time taken to clearly explain situations to patients and their families; many patients and families felt involved and consulted during the discharge process. The transport teams within the hospitals and those that took patients home were also recognised by many as something to be praised, along with the aftercare support and advice that people received from VCS organisations. Many respondents also said that they were attended to, treated and discharged in a timely and organised manner.

In terms of 'what could have gone better', lack of communication was the most frequent complaint, with many survey respondents referring to this in some way. Other frequently reported issues were delays to discharge, a lack of adequate information about post-discharge follow-up appointments, and not being offered follow-up appointments when needed – all issues which have been explored earlier in this report.

Improving current practices

In order to make improvements to current discharge procedures, most statutory health and social care professionals felt that improving communications between acute and community MDTs was a key issue. However, staffing shortages were seen as a barrier to achieving this.

In addition, it was felt that health and social care staff across the board need more access to training on the current discharge model to ensure that they understand the approach, the pathways and the staffing structures supporting it in their area. It was felt that the D2RA model is currently open to interpretation, and that structures need to be in place to rectify this.

> **"Clear understanding of a proportionate D2RA [is needed] – everyone seems to have their own interpretation and some are proving difficult to challenge."**
>
> **Community-based statutory health and social care professional**

Many statutory health and social care professionals felt that patients needed more information about what their discharge journey will look like, including offering 'easy read' information. We also heard it was important to communicate the rationale for new discharge processes – helping people to understand the evidence that people recover better at home than in acute settings. There was also felt to be room for improvement in the way hospital staff communicate with patients around discharge.

> **"Hospitals need to stop saying 'we'll get you some carers before you leave hospital', instead they need to say 'we'll discharge you with support from intermediate care and they will be able to assess your needs at home.'"**
>
> **Community-based statutory health and social care professional**

Short-term cycles of funding for community support were seen as causing issues for successful discharge. Some community-based statutory health and social care professionals told us that community services have often come to an end by the time ward staff become aware of their existence.

In addition, some statutory health and social care professionals felt that there should be more community-based and intermediate care services available seven days a week, as well as more preventative projects in the community.

> **"Every person that we have to respond to because they've not come out with a restart of care… or because the family can't cope, is another person we can't then prevent being admitted in the first place."**
>
> **Community-based statutory health and social care professional**

VCS professionals felt strongly that continuity of care was a key issue, with a need for different professionals working with a patient to share information so that important issues are not missed. They also argued that assessments should take on a holistic approach considering medical and social needs and including signposting to a wide range of organisations. It was also felt that there should be consistent access to support, advice and advocacy services for both patients and their carers.

> **"You'd expect there to be a holistic assessment of the needs of the person and their carers. I would expect everyone would have the same experience or access to the same services no matter where they are in Wales or no matter the provider."**
>
> **VCS professional**

It was felt that planning for discharge as early as possible – involving community staff and VCS organisations in the process – would mean that 'key windows of opportunity' are less likely to be missed and that delays and inappropriate discharges could be avoided.

Conclusions and recommendations

Our findings indicate that, while there are instances of good practice, the hospital discharge process is not consistently meeting the needs of patients and carers in Wales. Through exploring the experiences of patients, carers, and those working in the health and social care sector in Wales, we have identified some issues with discharge in general and with the D2RA model specifically.

While discharge practices seem to work well for many patients, issues with arrangements on the day of discharge, including delays once a decision to discharge has been made, were frequently reported. We found gaps in communication with, and the involvement of, patients and carers, indicating that guidance is not always followed. We also found evidence of problems with communication and collaboration among professionals.

Worryingly, we found that patients did not always feel that their needs were met once they returned home. We found evidence of inadequate pre-discharge assessments, and in particular a failure to consider non-clinical needs. The findings suggest that longstanding good practice around focusing on 'what matters to me' is not consistently being followed in relation to discharge planning. We also found some evidence of gaps in assessment after discharge.

Our findings suggest that the D2RA model is viewed positively among professionals. There was cross-sector agreement that, as well as straining systems, prolonged stays in hospital can be damaging to people's physical and mental health. However, the model's potential is not yet being realised in practice given current pressures at every level of the health and social care system. Compounded by the pandemic, there are resourcing and staffing issues in acute settings, within community teams and among public and private social care providers. These issues lead to breakdowns in communication, equipment shortages, lack of knowledge of discharge processes or, in some cases, poor and inappropriate experiences of hospital discharge and unsustainable workloads across statutory and VCS health and care services.

If the current discharge guidance, including the D2RA model, is to work effectively we need both to address gaps in current implementation, and to improve areas of the guidance. Communication with patients must improve, including providing information more consistently. We need to ensure that patients are asked about what matters to them, and that carers are consistently involved in discussions around discharge, particularly where people have additional needs. We also need action to address wider system pressures that hold back effective discharge processes.

Implementing the current guidance

We recommend the following actions to improve implementation and delivery of existing guidance. These recommendations are aimed at acute hospital staff and multidisciplinary teams who carry out hospital discharge planning and delivery. We propose that the Healthcare Inspectorate Wales should oversee and monitor this.

1. Provide all patients with a leaflet about the discharge process when entering and leaving hospital

Ward staff should provide all patients with a leaflet giving information about discharge when entering and leaving hospital. This is detailed in the guidance and should be consistently implemented.

2. Provide everyone leaving hospital with a single point of contact

Hospitals should work with their partners to ensure that patients are assigned a point of contact for further support should they need it following discharge. This should include:

- Ensuring that locally agreed details are inserted into the patient discharge choice leaflets for all patients being discharged to their usual place of residence and for patients moving on to further non-acute bedded care, as stated in the guidance.
- Providing the care co-ordinator's contact details for patients allocated to a D2RA pathway, as stated in the guidance.

3. Involve carers and family members in decisions around the discharge process

Ward staff should consistently involve families, including those with lasting power of attorney or a nominated family member for patients living with dementia, and carers in decisions made during the discharge process. Where visits are restricted, special arrangements need to be made to enable this.

Hospital teams should work with relevant organisations to help identify all those relied upon to provide care as part of a discharge plan and ensure they are linked to sources of support for carers.

4. Reduce delays in medication being prepared and delivered by hospital pharmacies

Hospital pharmacists should ensure that people have timely access to prescriptions needed to enable discharge.

Improving the current guidance

We make the following recommendations to improve current guidance and address gaps in policy and implementation that hinder effective discharge. Recommendations related to changing the guidance are for the Department for Health and Social Services. The remaining recommendations on improving practice are for ward staff or wider system colleagues and this has been explicitly stated within the recommendation.

Clarifying existing policy and practice

5. Review and clarify discharge service requirements

Hospitals should be provided with the guidance and tools needed to better determine the most appropriate pathway for patients. The national policy should be amended, or complementary guidance issued, to include:

- A set of minimum standards for all patients being discharged, including those patients on simple discharge.
- Advice for hospital staff around how to determine the appropriate discharge pathway for patients, building on recent complementary guidance such as *Home First: The Discharge to Recover then Assess Model*[54] published in January 2022.

6. Routinely ask about patient transport needs

The guidance should be clarified to ensure discharge co-ordinators ask all patients about transport home as part of a wider conversation about their practical needs.

The British Red Cross five-part independence checklist[55] should be used to support conversations with all patients, families and carers to ensure they have the immediate support they need to get home safely. Transport should be arranged for those that need it.

The guidance should be updated to ensure that discharge teams do not discharge at night (8pm to 8am) unless transport needs have been considered.

7. Continue to improve technology

Lead staff members that support information sharing in each health board should ensure that data sharing protocols and information technology (IT) services support the flow of information between acute and community hospitals and key providers involved in discharge.

Improving current policy and practice

8. Improve communication between sectors working on hospital discharge

Acute hospital teams should support greater use of MDT approaches and other techniques to improve communication among professionals working in hospitals and the community across sectors, including the VCS, to support people being discharged.

9. Improve communication with carers about caring responsibilities

To ensure carers' support is not relied upon without their consent, the guidance should be updated so that hospital discharge teams check what support family and carers can provide and whether plans are in place should circumstances change.

10. Roll out a holistic welfare checklist

The guidance should be updated to include holistic checklists to support conversations about discharge with all patients, families and carers.

The British Red Cross five-part independence checklist should be used by MDTs to support conversations which focus on what matters to the patient and should include a person's practical, social, psychosocial, physical and financial needs.[56]

11. Ensure that patients placed on a D2RA pathway have appropriate access to assessment following discharge

Action should be taken to address barriers to conducting regular assessments in the community. This may involve updating the pathways policy so that it is clear where an assessment is required, promoting complementary guidance such as *Home First: The Discharge to Recover then Assess Model*[57], and ensuring there is capacity in the community to carry out assessments.

12. Monitor readmissions to identify patterns of unmet needs

Readmissions for those placed on simple discharge and those on a D2RA pathway should be monitored by the Department for Health and Social Services. This work should also seek to understand variation among health boards, barriers and solutions.

13. Meet the needs of patients living with dementia

The Department for Health and Social Services should work with organisations who support people affected by dementia and people living with dementia to ensure that discharge processes meet the needs of those patients living with dementia. This should include introducing communication in language of choice including non-verbal communication, with the help of health and social care professionals working in the VCS.

This should also include taking on board recommendations from the Cross-Party Group on Dementia's upcoming report *Hospital Care in Wales*[58]:

- Hospitals to trial set discharge time slots for people living with dementia to enable care homes, carers and family members to support, understand and contribute to the discharge process.
- Discharge teams to ensure that care plans, medicines and transport are in place prior to discharge and that any documents are included in a 'discharge folder' to travel with the patient.

14. Improve access to equipment to enable hospital discharge, prevent admission and support people's recovery

Hospitals should work with co-ordinators for their local Joint Equipment Store to routinely offer information about accessing equipment at the point of discharge.

Addressing the wider constraints on the hospital discharge process

We make the following recommendations to address the wider system failings which prevent effective discharge. These recommendations are for the Welsh Government.

15. Address staffing concerns

Welsh Government should utilise 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' to address gaps in the workforce and should include how non-traditional roles can assist with this.[xiv]

16. Move away from short term funding

A shift in practice to longer term resources should be committed to in order to sustainably fund integrated care programmes and preventative projects within community services.

17. Invest in community-based support, particularly to enable the provision of support on weekends.

18. Increase transport providers' capacity and resources to operate at a minimum 8am-8pm seven days a week.

19. Invest in and recognise the voluntary and community sector to enable it to play a wider role in supporting discharge.

20. Reform social care and develop a long-term settlement for social care funding.

[xiv] Non-traditional health roles refer to those who are not registered as health and social care staff.

Appendices

Appendix 1 – List of figures

Appendix 2 – Methodology

Interviews and focus groups

The qualitative elements of this study comprised 16 semi-structured, in-depth interviews (ten with individuals who had been discharged from hospital since May 2020, one with a carer and five with VCS professionals) and two focus groups with statutory health and social care professionals (one group working in acute settings[xv] and one working in community settings). Fifteen individuals were involved across the two focus groups – eight in the hospital-based group and seven in the community-based group. All fieldwork took place in September and October 2021.

In line with Covid-19 restrictions guidance at the time, all interviews and focus groups took place remotely, via telephone or video link (Microsoft Teams).

Patient and carer interviews lasted around 30 minutes, VCS professionals between 45 minutes and an hour, and the focus groups around 1.5 hours. Participants were assured of complete confidentiality and that they were free to be as open and as honest as they wished insofar as they would not be named in this report. In order to ensure anonymity, names of individuals and organisations and identifying comments have been removed from the verbatim comments.

Patients and carers

Patient participants were selected at random from the subset of survey respondents who agreed to a follow-up interview. The carer was recruited from survey participants who had agreed to participate in future research, the person they care for was not one of the patients interviewed.

The table below provides a breakdown of the hospital and the corresponding health board which the interviewees were discharged from – the total includes the patient whose experience we interviewed the carer about. Reflecting the makeup of the survey respondents, there is a higher proportion of participants from East Wales, particularly Aneurin Bevan University Health Board and The Grange University Hospital. Two participants were also discharged into the care of community teams in Powys from hospitals near the border in England. Five male and five female participants were involved in the interviews, the carer was female.

One of the patients we interviewed was on D2RA Pathway 2, all others were simple discharge patients. The individual looked after by the carer engaged in the research was discharged through D2RA Pathway 3. (See Background section for an overview of the D2RA pathways).

FIGURE 16: Profile of qualitative respondents (patients) by hospital and health board

Hospital	Health board	Total
University Hospital of Wales	Cardiff and Vale University Health Board (UHB)	1
Nevill Hall	Aneurin Bevan UHB	1
The Grange University Hospital	Aneurin Bevan UHB	3
Ysbyty Gwynedd	Betsi Cadwaladr UHB	1
Withybush	Hywel Dda UHB	1
Prince Philip	Hywel Dda UHB	1
Glangwili	Hywel Dda UHB	1
Hereford	Outside Wales	1
Royal Shrewsbury	Outside Wales	1
	Total	**11**

[xv] An acute setting is defined in this report as a hospital where patients receive treatment for a severe injury, period of illness, urgent medical condition or to recover from surgery. It does not include community hospitals or 'step-down' facilities.

Voluntary and community sector professionals

The VCS professionals involved in the interviews worked for a range of different organisations supporting patients and/or carers in Wales including Age Cymru, British Red Cross, Care & Repair Cymru, Carers Wales and Hospice UK. One participant had a local delivery role supporting patients discharged from hospital, another managed a service supporting patients in the community, and the remaining three held policy-based roles with a Wales-wide overview.

Statutory health and social care professionals

Statutory health and social care professionals who participated came from a range of health boards, including Swansea Bay, Betsi Cadwaladr, Powys, Hywel Dda and Aneurin Bevan. Hospital-based roles included deputy heads of nursing, patient flow co-ordinators, discharge facilitators, and senior managers. Community-based roles included general practitioners (GPs), social workers, occupational therapists and physiotherapists.

The survey

The survey ran from 10 September to 18 October 2021.

It was designed to be broadly in line with previous British Red Cross research carried out in England[59], while also covering issues specific to hospital discharge in Wales. It identifies the situations around which each discharge took place, and how closely procedures were followed during each step of the discharge process, from the point at which the patient was well enough to leave hospital to the extent of any follow-up assessments and care once the patient had been discharged.

In the main, the survey asks about the experience of the patient (from the patient or carer's point of view), however there was also an additional section for carers at the end of the survey, asking specifically how they found the discharge experience as a carer.

Sharing the survey

The partner organisations who worked with us directly on this research are Age Cymru, Board of Community Health Councils, Care & Repair Cymru, Carers Wales and Hospice UK. We also contacted associations and councils for voluntary organisations and services across Wales, many of whom agreed to share and promote the survey within their networks.

The survey link was also shared (and re-shared) multiple times throughout the fieldwork period on social media (e.g. Twitter and Facebook) by the British Red Cross, ORS and several of our partner VCS organisations.

Survey response

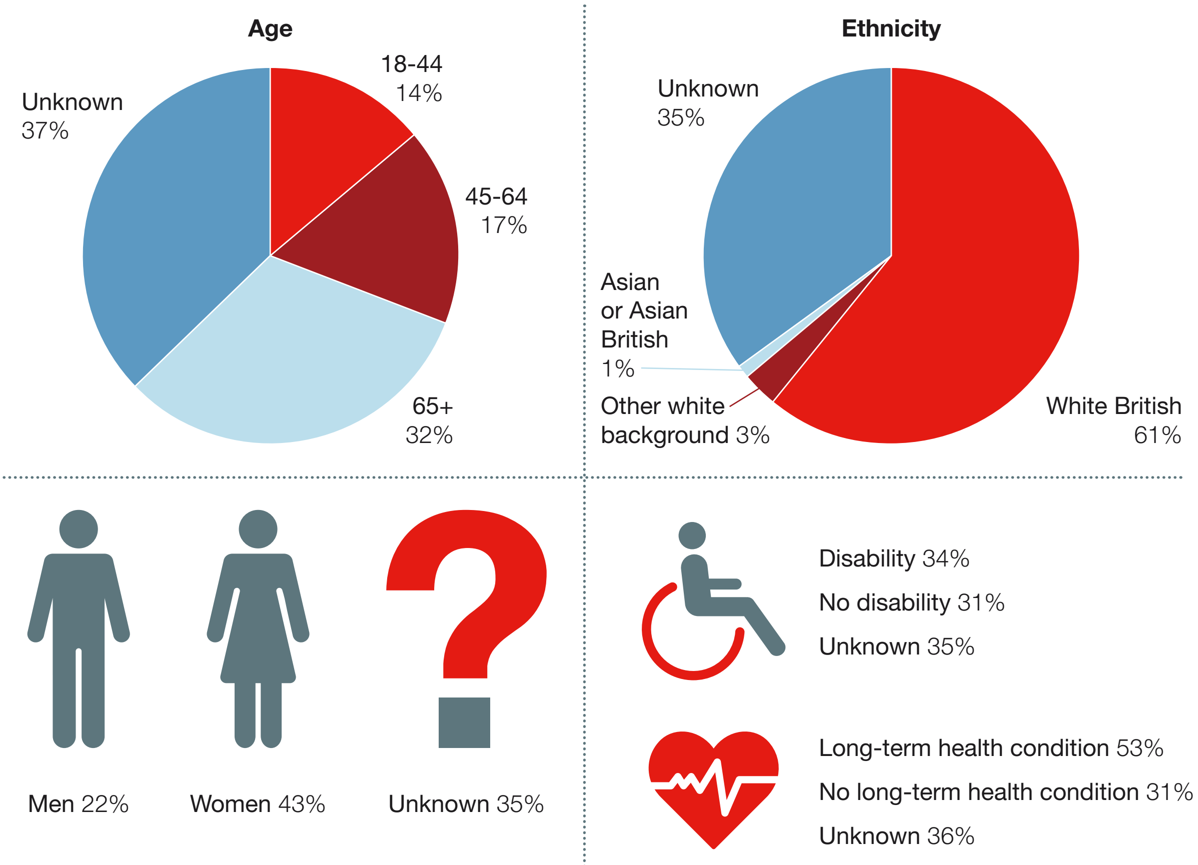
As stated in the introduction, there were 100 responses, though not all respondents answered every question. There were 64 complete responses, with drop offs at various points throughout the survey. We have analysed responses for anyone who answered up to at least Q5 in the results (100 respondents), however it should be remembered that the results to each question will be based on a different number of responses (the base number is noted on each chart). Owing to the low sample size, the results are, in general, discussed in terms of the number of respondents rather than in percentage terms.

Who took part?

65 per cent of respondents to the survey were patients and 35 per cent were carers looking after someone who had been discharged from hospital (the majority of these, around nine in ten, were unpaid).

Figure 17, opposite, shows the breakdown of some of the socio-demographic characteristics of the survey respondents (self-defined by the respondents). While we promoted the survey widely via VCS partners and on social media, our reach was limited and participation was self-selecting, meaning that the resulting sample is not representative of the overall Welsh population. It is important to note that there was a large percentage of respondents with a disability (34 per cent) and/or long-term health condition (53 per cent) and a small percentage of non-white respondents (1 per cent). This may bias some of the results, and as such it represents a limitation of the research.

FIGURE 17: Socio-demographic characteristics of survey respondents



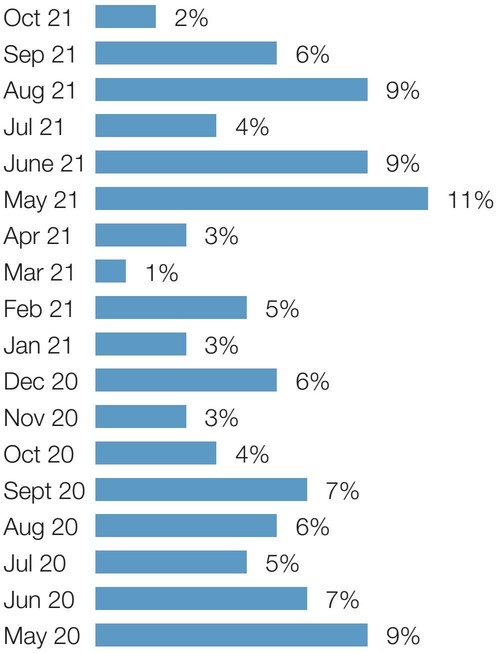
BASE: 100

Respondents included patients living across all but one of the 22 local authorities within Wales (Vale of Glamorgan); however, it should be noted that there was a higher proportion of responses from south and mid Wales than from north Wales.

Respondents were discharged from 23 different hospitals across Wales, while four were discharged from a hospital in England. The hospitals with the highest number of responses were Royal Gwent hospital, Newport (14); The Grange University Hospital, Cwmbran (13); Prince Charles Hospital, Merthyr Tydfil (9), University Hospital of Wales, Cardiff (8); Ysbyty Gwynedd, Bangor (7); Nevill Hall Hospital, Abergavenny (6); Morriston Hospital, Swansea (5).

As Figure 18 shows, the month patients were discharged in is also spread across the 18-month period from May 2020 to October 2021.

FIGURE 18: In which month did you/your friend, relative or client leave hospital?



BASE: All respondents (100)

The vast majority of survey respondents (90 per cent / 91 of 99) were admitted for treatment in hospital, while eight per cent (eight of 99 respondents) had an initial assessment 'at the front door' and the decision was made by a health professional that they should be assessed and/or treated and supported at home (D2RA Pathway 1), rather than receiving treatment in hospital. Figure 19 below shows the number of survey respondents on each discharge pathway.

FIGURE 19: Discharge pathways of survey respondents

Discharge pathway	No. respondents
Simple discharge	66
D2RA Pathway 0	2
D2RA Pathway 1	8
D2RA Pathway 2	5
D2RA Pathway 3	5
D2RA Pathway 4	3
Not known	11
Total	**100**

Survey eligibility and interpretation of the data

Anyone aged 18 years+ and living in Wales who has been discharged from an acute hospital setting since the start of May 2020 (or someone who cares for/looks after someone who meets this criteria) was eligible to take part in the survey.

A 'carer', for the purpose of this survey, is anyone who looks after somebody else, whether in a professional capacity or a family member or friend, regardless of whether they are paid or unpaid.

For the purpose of this survey, 'hospital discharge' means 'leaving hospital after a visit there' regardless of whether the patient was admitted or not. This includes patients who attended a hospital and were assessed as being clinically safe to receive treatment and support at home. Being admitted could be as an inpatient, an outpatient or a day patient.

An 'acute hospital setting' means a hospital where the patient has received short-term treatment of a serious illness or injury and does not include maternity services. However, in some situations, the patient may have been treated in an acute hospital for a serious illness or injury and then transferred to a community hospital (D2RA Pathway 3). In these cases, we have asked patients or their carers to reflect on the discharge experience from the community hospital (the most recent they were in). Similarly, if the patient has been in an acute hospital more than once since May 2020, they were asked to reflect on their most recent experience. Further, while the patient must be living in Wales, it doesn't matter if the hospital they visited was in England.

Where differences between patients and carers have been highlighted as significant there is a 95 per cent probability that the difference is significant and not due to chance. Differences that are not said to be 'significant' or 'statistically significant' are indicative only.

Please note that where percentages do not sum to 100, this is either due to rounding, the exclusion of 'don't know' categories, or multiple answers. In some cases figures of two per cent or below have been excluded from graphs.

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