healthwatch Oxfordshire

Your voice on health and care services

People's experiences of leaving hospital in Oxfordshire

Executive summary, recommendations and responses from providers and commissioners

November 2024

Executive Summary

"So the good care, it's not just about healthcare, it's about the quality of life and the relationship and everything – it's just priceless."
(Unpaid carer comment)

Over the past year, informed by national guidance, the Oxfordshire health and social care 'system' has been working to develop new pathways to care and support for people when they leave hospital. This has included a shift towards rehabilitation and care for people in their own homes or usual place of residence, as a way of supporting speedier recovery and independence. This in turn helps to relieve the pressure on acute hospital beds, by reducing hospital stays and associated negative impact on recovery. There is focus on providing 'joined-up care', with support services planning and working closely together around the patient.

Between May and September 2024, Healthwatch Oxfordshire reached out to hear from people in the county about their experiences of this care and support. We heard from people via a combination of online and paper surveys, face to face outreach, and interviews. We focused on patients returning home via two pathways – Pathway 0 (going home without additional social care) and Pathway 1 or Discharge to Assess (D2A) (going home with additional social care before being assessed for longer-term social care needs).

In all, we heard from a total of 293 people:

- **206 members of the public** about their experiences of leaving hospital and any follow-on care and support they received after their stay
- This included the views of **22 unpaid carers**
- We also heard from **87 health and social care professionals** from primary and secondary care and social care.

What people told us:

What's working well?

- Parts of the process are working well for some patients. People valued the support and care from health and care professionals. What was clear was that good, consistent communication, being involved in decision-making about their care, effective follow-up care and aftercare, and high-quality care all made their experience of care positive. Most people told us they were happy to be back in their own home.

- Health and care professionals are finding effective ways of working together around patients' needs. Central to this is the coordinated approach taken in the Transfer of Care Hub and in multidisciplinary teams, to help get more people home with the support they need.

What could be better?

- Some parts of the discharge process are not working well for everyone. There are challenges around consistent and clear communication, listening to people and involving their unpaid carers in decision making, delays in leaving hospital and getting care, and accessing follow-up care and aftercare from different services. There are also challenges around the quality and continuity of care provided.
- Some areas of joined-up communication across primary and secondary care can still be improved following discharge of a patient from hospital, including handing over care to GPs and district nursing teams.
- We heard that unpaid carers were not always included or did not feel listened to, and were not being offered support.
- Overall communication and information about the discharge support offer and expectations could be more accessible, both for patients and carers but also for the health and care professionals within the system.

Recommendations

We would like to make the following recommendations based on what we have heard. They focus on building on existing good practice to improve the experience of patients and unpaid carers as well as system working.

- Recommendations are for response for all system partners – including BOB ICB with Oxfordshire Place-Based Partnership, OUH, Oxford Health, Oxfordshire County Council and home care providers – as to how they will address them.
- For noting by Oxfordshire GP Network, Age UK Oxfordshire and Carers Oxfordshire.

1. **To improve the experience of continuity and quality of care for patients:**
   a) Note this report, including the experiences and voices of patients and carers, and reflect on potential to improve services in light of this insight.

b) The report has highlighted some gaps in joined-up care. Our recommendation is to use this report to identify gaps and inform the development of further service design and action plans to address them.
c) Identify scope for providing more person-centred care and support to both patients and unpaid carers at each step of the discharge process. For example, patients have told us about problems with timing of home care visits.
d) Build on the Health and Social Care Connections programme, to ensure that patients and unpaid carers continue to be involved in the co-design and future development of services.

2. Clear communication with patients and carers

This report indicates where improvements to communication with patients and carers could be made. We would like to recommend the following:

a) Improve communication about all aspects of the discharge pathway to ensure that patients and unpaid carers are fully informed about every step. For example, patients have told us that a leaflet and a single point of contact would be helpful.
b) Ensure that communication and information about discharge is accessible to all patients and unpaid carers, in line with the Accessible Information Standard.

3. Improve support for and identification of unpaid carers

Based on what we heard from unpaid carers, we make the following recommendations, noting OCC's Unpaid Carers Strategy:

a) Improve recognition and understanding of unpaid carers' role and capacity to provide care, including proactive identification of unpaid carers, for example flagging unpaid carers on medical records.
b) Improve holistic support to unpaid carers, including signposting to Carers Oxfordshire and other support.
c) We heard that unpaid carers were not always involved in decision-making about discharge. Ensure that, where appropriate, unpaid carers are involved in decisions about discharge.

4. To continue to develop joined-up working across the system

We saw that good progress has been made in services working together around discharge from hospital. The report identifies the following areas for continued improvement:

a) We heard that health and social care professionals are not always clear about discharge pathways, including the D2A offer and follow-on healthcare. We recommend exploring ways to improve communication with staff to ensure consistency of approach.

b) Work together to improve communication and understanding between services, e.g. interface between secondary care, GPs and district nursing teams when a patient is discharged, multi-disciplinary team handovers and discharge letters.
c) Explore potential to build in better support for patients through greater involvement of other relevant partners, for example home care providers and extra care housing providers.

The following responses from health and care providers and commissioners reflect how the support for people leaving hospital involves services working together.