Safely home: our special inquiry and beyond

Neil Tester
Director of Policy and Communications
Healthwatch England
The Healthwatch network

- 152 local Healthwatch
- 900 staff
- 6,000 volunteers
- 300,000 face-to-face interactions
- Insight from 500,000 people
- Amplifying **seldom heard** voices across health and social care
- Partners for **improvement** based on people’s needs
Why and how did we focus on discharge?

• Early priority identified by local Healthwatch.

• The financial cost of this problem had been recognised but not enough was known about the human cost.

• With the help of 101 local Healthwatch, we heard the stories of more than 3,200 people.

• We focused on older people, people with mental health conditions and those with experience of homelessness - if the system could learn to work for them, it would work for all.
Key findings

People’s experiences:

• People were experiencing unsafe, delayed or untimely discharge due to a lack of co-ordination between health, social care and community services.
• There was a lack of information and support available for people after discharge, often leading to readmission.
• Many people felt discriminated against or stigmatised during their care, often feeling 'rushed out the door'.
• People did not feel involved in decisions about their ongoing care after discharge.
• Individuals' full range of needs were often not considered when being discharged - including their housing situation, carer responsibilities etc.
Key findings

The power of personal stories
Key findings

What people said they want:

• To be treated with dignity, compassion and respect.
• For their needs and circumstances to be considered as a whole - not just their presenting symptoms.
• To be involved in decisions about their treatment and discharge.
• To move smoothly from hospital to onward support available in the community.
• To be properly informed about where to go for help after discharge.
Why have solutions been so elusive?

- Sometimes it’s just really complicated: there is no shortage of guidance and good practice identifying solutions - at the time of publication from a survey of 120 Trusts we found that they were using guidance from 57 different documents.

- Uneven usage creates huge variation in outcomes and makes evaluation more tricky.

- But sometimes it’s fairly simple: almost all of those Trusts had a discharge checklist - but fewer than half checked to see whether people had a safe home to go to or the basic support they needed when they left.
So what happened next?

- Pre-publication, we and the Department of Health brought together key national stakeholders
- Subsequent cross-government discharge programme which has sponsored some of the initiatives you’ll hear about today
- Helpful additional guidance from NICE and SCIE
- Local Healthwatch continue to follow up with commissioners and providers to help drive improvement
So what happened next?

• We worked with NHS England to support the development of guidance for staff - including a quick guide on helping patients understand their choices when being discharged to a care home.

• This encourages staff to have discussions with patients at the point of admission so that patients and families can be part of planning.

• https://www.england.nhs.uk/2016/04/neil-tester/
So what happened next?

• Parliamentary and Health Service Ombudsman’s report highlighted the continued importance of safe, effective, respectful discharge.

• Drawing from the PHSO report, the Parliamentary Administration and Constitutional Affairs Select Committee also set out its expectations of the Department of Health and NHS England.

• Our submission to the PACAC inquiry updated policymakers on the intelligence from local Healthwatch follow-up activities.
Green shoots and how to grow them

- Healthwatch Essex research
- Healthwatch Gloucestershire repeat exercise
- Focus on people not just “flow” - unsafe or unsupported discharge and unplanned readmission helps no-one
- 2017-19 CQUINs: “proactive and safe discharge”
- A cultural revolution: Red2Green-style approaches - putting people’s needs first is efficient
A question for you...

What can **you** and your team do about each of those experiences people described to us?

[www.healthwatch.co.uk/safely-home](http://www.healthwatch.co.uk/safely-home)

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@HealthwatchE

[neil.tester@healthwatch.co.uk](mailto:neil.tester@healthwatch.co.uk)

@NTtweeting