Support Following Discharge from Hospital or Rehabilitation Bed - Your Views

Healthwatch Birmingham welcomes the opportunity to respond to Birmingham City Council's Support Following Discharge from Hospital or Rehabilitation Bed - Your Views. Our key role is to make sure that patients, the public, service users, and carers (PPSuC) are at the heart of service improvement in health and social care. In line with our role, we have focused our comments on:

- Patient and Public Involvement and engagement
- What we have heard from Birmingham residents

Healthwatch Birmingham notes that the opportunity to share views has been available since July. We are pleased that this has given patients and the public time to consider their views to respond. We also note that an email address has been available for the public to contact if needed but feel a postal address and telephone number could have been made available for members of the public without digital access to share their views.

We welcome that the views of PPSuC have been sought at this stage of the work and are interested to see what other engagement activities will be held on this topic as the work progresses, particularly for those who speak community languages or communities of experience who are not digitally engaged.

We also note that the questionnaire did not ask for demographic details of respondents. Unfortunately, this makes it hard to identify any barriers that specific communities may be facing, either in their response to the questionnaire, or by the fact that members of that community may not have shared their views at all.

Experiences

People have told us about their experiences around discharge, either for themselves or relatives. We have mostly heard about discharge from hospital settings. This has been when sharing their views of services received or contacting us for help when faced with a difficult situation. Whilst not all these experiences relate directly services provided by the council, they show the overall experience people are having around discharge and highlight the gaps in the support available to them at that time. All experiences are from the last two years.

Communication

Healthwatch Birmingham has heard from many people who have experienced problems with communication between services at the point of discharge. This has ranged from unclear discharge instructions, not being informed where relatives are discharged to, or being unaware about services they can access.

> *"Following this, she was informed that her father would be discharged to his care home. Once there, she was told that a member of staff had had to call paramedics. The paramedics called her directly on her mobile and asked*

about her father's diabetes and how much insulin he was on. His discharge documentation from the hospital made no mention of his diabetes."

"No discharge letter so we don't know what the tablets are they have given (does he need to continuously need to take these? his doctor does not know either)."

"Caller's brother […] had a terrible discharge with no discharge letter or medication. […] Breach of confidentiality as his father was called by the hospital - but this was information which shouldn't have been shared with him due to past safeguarding concerns. He should not have been given any information on his whereabouts or the situation."

"I was sent home later the same day and given a letter with telephone numbers to ring if I needed any help or advice following catheterisation and pending contact from the Urology Department. Everything went completely silent for several weeks! No calls from the District Nursing Team as promised by A & E and no contact from the Urology Department. The telephone numbers on the letter handed to me on discharge were useless. I could never get anyone to answer and eventually sat on the telephone for SEVERAL HOURS ringing round NHS departments trying to find someone, somewhere who could give me the advice I needed. I eventually tracked down a member of the [hospital] Urology nursing team who was brilliant. I was in need of catheter supplies which my GP was unable to prescribe and she was able to supply them. I had resorted to buying what I needed on Amazon"

"The caller's mother suffers from vascular dementia. She had a fall while at home and was admitted […] hospital. From hospital she has been discharged to an unknown location. Social services are also involved, however neither the hospital or social services will tell him where his mother is. His older brother is the carer from the mother, he visited her in hospital but again he has no idea where she has been transferred to. The older brother has complained to social services because of the lack of information provided."

"Service at hospital brilliant. But lack of communication from discharge services. No contact with family. Poor coordination from the service."

Involvement

People have told us about feeling uninvolved with discharge arrangements for their relatives. This has ranged from disagreements between family members of a correct course of action, to having their relatives ongoing medical care changed without their knowledge.

"Last year when trying to get help for my mother with heart failure and worsening dementia, had no response at all from adult social services when

contacting them, and when she was in hospital we waited Weeks for a social worker to contact us about her going into care, then Mom would be medically unfit by time something sorted ended up getting COVID in hospital and died without any family around . I don't feel it is right for people to wait weeks for a response it would speed hospital discharge and help struggling families."

"Caller's wife had a stroke in December and was discharged to a care home whilst they assess her future care. He feels his wife would be better at home with support, but his stepdaughter (wife's daughter) doesn't want her to go home to him as they do not get on."

"Unable to visit my husband who has made distressing phone calls to me. Not enough liaison i.e. calling when change of plan concerning discharge."

"[His sister] is currently resident in an NHS Rehabilitation centre. [They] are attempting to discharge her to an unsafe and unsuitable environment, and I would like to discuss this situation with Healthwatch Birmingham. They do not feel discharge home appropriate for somebody with mobility issues. They are hoping for an interim solution until a more suitable location is decided. They are concerned that she has been pressured into signing discharge form, and she is a vulnerable adult with mental health issues."

"(H)e was discharged into a care home. He has been moved to a new GP surgery. She was told that her husband's medication for his challenging behaviour had been increased. She doesn't know what medication he is on."

"The caller's wife was discharged from hospital to a care home. She had dementia and the care home have registered her with a local GP without informing the husband. 'My wife has dementia with a lasting power of attorney activated. My wife is not legally able to give permission for them to register her with a new GP practice.' 'There was no mention in the discharge process, of continence or the fact that she had been trained to wear a pad at night.'"

"Callers mom was discharged from hospital, end of life, to live with daughter. She has turned a corner and was allocated a social worker through ACAP to assess her and to possibly arrange a nursing home as family unable to continue caring at home. Social Worker not contacted them for over 4 weeks and family can't get hold of anyone to find out what's happening. Doctor has been making regular visits and he can't get through to Social Worker either."

"[…] hospital discharge team assured relative that their mother would not be discharged and subject to re-enablement care, user was given a temporary

placement in care home and discharged from the hospital without proper care regardless of assurances. very difficult to contact and being ignored by the team at the Hospital."

Mental Health

Healthwatch Birmingham has been contacted by people in Birmingham with concerns about a lack of support, information and timely follow up for people with mental health conditions.

"The caller's grandfather is currently in hospital. He has paranoid schizophrenia and his living conditions at home are bad. He thinks electricity is dangerous so does not have a fridge, and only has one set of clothes, etc. She said his house is very dirty. He was sectioned a couple of years ago, but has been discharged from his CMT. The family are concerned about him being discharged from hospital back home. They want him to be discharged into a care home."

"My mother was admitted due to poor mental health and alcohol intoxication. My mother heard the nurse say that they her department was not for people like her (being intoxicated) and to go home and drink her normal amount of alcohol. I spoke with the discharge nurse and asked her what amount would that be as she is not an alcoholic and was binge drinking due to her mental health she didn't have a satisfactory answer and dismissed me and just asked to pick her up and she was being discharged now. So my mum took her advice reduced her alcohol intake and contacted mental health services which the discharge nurse and I both knew would be stretched and would not be able to help immediately. It took them three weeks before they could come and see my mom. She died from alcoholic ketoacidosis 12 days after being discharged and several days before any mental health recovery team made contact. No info was given about AKA"

Safety

We heard from one member of the public who highlighted a particular concern for the safety of her relative and communication between services during discharge.

My mother was discharged mid-afternoon on [date]. I was called on the morning by [hospital] and it was discussed and agreed that she would require use of a stretcher in order to get her home safely by ambulance. However the ambulance drivers/paramedics who brought her home placed her in her bespoke chair omitting to place the all day sling underneath her which is the only and correct way she is transferred from chair to bed with the use of a suitable hoist. The hoist is a sizeable piece of mobility equipment in a living room of modest size. It is in full view of any person visiting my mother who herself copes with one room living. In addition the black all day sling was also clearly in view on her single bed alongside the bespoke chair. However her

carers were unable to transfer her to bed for personal care on their teatime call, 3rd of the day, due to the omission of the sling which resulted in her carers having to call 999 for paramedic assistance. They are not under Health & Safety rules allowed to attempt to move my mother without the correct apparatus to follow procedure. The first call made between 3-4pm to the emergency services was clearly not logged as when her carers returned for their last call, 4th of the day, the situation was unchanged and it was apparent that she would potentially be in her chair all night. A further call by her carers was made between 7-8pm to the emergency services wherein it transpired there was no evidence of the earlier call! Her carers were informed that the emergency services was under high demand and the wait would be 3/4 hours minimum. I subsequently took a call from the emergency services and discussed that whilst sympathetic to their workload, it was extremely concerning for family to accept that my mother could be left in her chair for hours, potentially from late afternoon through until morning. We all feared to think how much discomfort she would be in when finally moved. In the meantime, her carers received a call from the emergency services stating that they would try and send someone in the area to attend to this situation swiftly. Our hopes were then raised but dashed by a subsequent call advising that high demand was still continuing and the wait would still be 3/4 hours minimum. She was finally attended to around 11pm after being left in her chair from 3.30-4pm until 11pm. Thankfully she does not appear to have suffered any adverse consequences from this unacceptable situation. The fact remains that had the ambulance drivers/paramedics who brought her home paid attention to her discharge information and my mother's obvious severe frailty this situation could have been avoided completely, the associated stress and the guilt of having to request a return visit by the ambulance emergency service who I'm sure are under overwhelming pressure, need not have happened!

Healthwatch Birmingham welcome the focus on support following discharge and making sure these meet the needs of all those who live in Birmingham. We look forward to seeing more details as the work progresses.

Yours Sincerely,

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