

**Healthwatch Brighton and Hove
Hospital Discharge Wellbeing Project (HOPs)
April - September 2020**

Published: September 2020

The Hospital Discharge Wellbeing Project (HOPS) project started early in April 2020 as part of the response to COVID 19; the service is offered to anyone discharged from hospital - not just those with the virus- or virus-related conditions. The project is jointly funded by Brighton and Hove City Council and NHS Brighton and Hove Clinical Commissioning Group (CCG) - initially for six months, with an extension until end December 2020 - with oversight from these organisations and Brighton and Sussex University Hospitals NHS Trust.

Local Healthwatch is the official watchdog and voice for patients and the public, for health and social care, we work closely with other Healthwatch in Sussex, the Brighton and Hove Community Hub and local voluntary and community organisations, particularly with Community Works, Possibility People and the Carers Centre supporting this project.

People are phoned by Healthwatch trained volunteers within a few days of discharge from hospital, usually in the first week. We are not a care provider organisation; our role is to signpost and assist people to find the help they need. This is also not an engagement project- i.e. we are not primarily asking people directly about their experience of discharge, although we do ask if there are any outstanding issues associated with their hospital discharge, or issues that have arisen since coming home from hospital, previously unanticipated, with which they may need assistance. People referred to HOPs have been discharged from hospital on Care Pathways 0 and 1 = Needing no further assistance (0) or Needing some assistance which can be provided at home, in their normal place of residence.¹ Referral from care pathways 2 and 3 would not be appropriate as people in these pathways leave hospital to transfer to care homes or nursing homes, temporarily or permanently.

Contents

Background	4
The guidance recommended:	4
Performance summary	5
1. Issues to note	7
1.1 Need for the service	7
1.2 Reassurance for the City Council and NHS	8
1.3 Public and Patient confidence in the service	9
1.4 Successful contacts	9
1.5 Referral flow	10
1.6 Are people made aware of this Healthwatch service?	11
1.7 People referred onto additional community support	12
1.8 HOPs and unpaid Carers	12
2. Discussion and case studies	
2.1 The impact of HOPS - Hospital Discharge Wellbeing signposting	12
2.2 Improved experience of hospital discharge and integrated care	13
3. Sustainability	15
4. Hospital re-admission rates for HOPs	16
5. Mental Health needs	16
6. Comments from HOPs partners	17
7. HOPs volunteers	19
8. HOPs Case Studies	20

Background

The HOPs project was developed as part of the Healthwatch, Brighton and Hove City Council and NHS response to COVID-19 but is available to people discharged from hospital whatever their condition, COVID related or not. The concern from Healthwatch was to help people by signposting them to local services that might be harder to find during the COVID period.

On the 19th March 2020, The Department of Health and Social Care, published its guidelines for the NHS and local authorities for hospital discharge in the context of the COVID-19 pandemic:

<https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients>

On the 8th of April, just a few days after that guidance, the Healthwatch Brighton and Hove HOPs project made its first phone calls to local people after discharge from the Royal Sussex County Hospital.

The guidance recommended:

- ✓ Discharge requires teamwork across many people and organisations and the funding and eligibility blockages that currently exist cannot remain in place during the COVID-19 emergency period
- ✓ Patients will still receive high quality care from acute and community hospitals but will not be able to stay in a bed as soon as this is no longer necessary. For 95% of patients leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home.
- ✓ Councils and adult social care should coordinate work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery
- ✓ The voluntary and community sector should mobilise quickly and focus on safety and positive experiences for patients on the discharge process, enabling patients to feel supported at home. They can also help reticent patients feel much more comfortable about being discharged
- ✓ Provide ongoing community-based support to support emotional wellbeing, such as wellbeing daily phone calls and companionship

- ✓ Engage with NHS providers (particularly discharge teams) to provide solutions to operational discharge challenges, freeing-up clinical staff for other activities - focusing on the patients on pathway 0
- ✓ Coordinate support between voluntary organisations and existing volunteers within NHS providers.

The HOPs project was conceived within the spirit of that DHSC guidance and for many is starting to be not just a part of the COVID response but something that should be 'business as usual'. A continuing light touch support and signposting service to check on and assist people after hospital discharge.

Performance summary

April 7th - September 14th

- 1,424 people have been referred to the project
- 1,152 attempted contacts to the 14/09/2020
- 704 successful contacts
- 208 attempted unsuccessful calls – were referral information indicated there might be issues, follow phone text messages were sent offering a proactive follow up
- 151 are still active – allocated to volunteers and being called in the next 7 days
- 114 are on a waiting list – will be allocated in the next 3-7 days

1,152 people covered by this report; an additional 151 people are currently being managed within the project, 114 are on a waiting list ⁱ

HOPs supported 709 people referred April to September 2020. The proportion of people referred that we were unable to contact is as emerging issue.

People we have called several times but who have not responded to calls or messages represents 18% of all referrals. That has increased over the life of the project roughly in proportion to the rising number of referrals. Of the people we were unable to contact 35 were passed onto their GP surgery for follow up care that could be provided or arranged by primary or community health care services.

178 people (25%) were proactively referred on by Healthwatch for some form of community support, 515 (75%) people were supported during the phone conversation, signposted to advice or information, or needed no further assistance.ⁱⁱ

204 (29%) people - had questions or issues post discharge of these 119 had issues or questions that related directly to their hospital discharge.ⁱⁱⁱ

59% Female 40% male 1% preferred not to say/unspecified.

45% - had long-term health or disability issues lasting more than 12 months.

18.5% - identified by NHS by letter or text as extremely vulnerable

180 (25%) - are unpaid carers, of those 32 people wanted to get additional support from the carer's hub.

83% people told us they had not received a leaflet explaining they would be receiving a call from Healthwatch before being discharged from Hospital - if not are you still happy to proceed with this Healthwatch call = Yes 98.3% No 1.7% for the 11 people who answered 'No' the call was ended.

13 people needed food or supplies.

41 people needed help paying for food.

17 people with safeguarding concerns.

42 people needed extra communication support due to sensory disability or dementia.

82 people had identified and current mental health problems, with 22 people there were current and active safeguarding concerns.

Over the period April to September there were 4 instances where the discharge did not seem to have been managed well and issues were escalated for investigation, these were all resolved quickly and satisfactorily. There have been two minor data breaches of data regulations neither of which involved data being shared beyond trusted agencies, both have been reported and resolved using established procedures.

42 people were identified at the time of referral as having a need for additional communications support e.g. related to a sensory or learning disability or a need for interpreting/translation services. Where these needs have been identified, at the time of referral or when contacted by HOPs volunteers individual support has been arranged. We are in discussion with the Sussex Interpreting Service (SIS) to provide routine access to their services or divert referrals requiring this service directly to them.

9 people have been identified as having a hearing disability and we are arranging to have access to a BSL (British Sign Language) service to assist people with that need in the future.

We are currently exploring ways of improving the service to people needing additional communication support. A sense check with hospital clinicians is that the number of people needing additional support in this way are small but it is possible that some of the people we have been unable to reach with the project have additional communication needs. The key issue is accurate information provided at the time of referral to trigger the right sort of help.

1. Issues to note

1.1 Need for the service

There seems to be a clear need for the service with 25% of people referred on for some sort of community support and 29% having issues post discharge, and 17% having issues or questions related directly to their hospital discharge. There is some evidence that hospital discharges and subsequent community support are not always managed well, see: <https://www.healthwatchbrightonandhove.co.uk/wp-content/uploads/2019/04/Hospital-Discharge-Final-Report-8Feb2019-with-cover.pdf>

Pre COVID 19 we were helping the local acute Hospital Trust and City Council with an action plan to improve pre and post discharge care planning. This project was a natural progression from that work.

“..... I do not know how we ever managed without this, without doubt Healthwatch have prevented hospital readmissions.”

A senior nurse has told us

This is a brilliant example of collaboration between BSUH, Brighton and Hove City Council, and Healthwatch Brighton and Hove, which provides enhanced follow up and support for Brighton and Hove residents after their hospital discharge. It's been a great way to find out how people are doing, what their experience has been like and crucially if there's anything which could have been done to make things better.

I have seen benefits such as more rapid resolutions of issues after discharge that individuals are having, and the bringing together of a wide range of professionals who may not have met otherwise to focus on making improvements, such as a recent cross-sector meeting about our patients with mental health needs. I am also delighted that local residents receive such holistic care, with the follow up providing an additional opportunity to signpost and refer people on to invaluable voluntary and community sector services - ranging from befriending, other forms of social prescribing, carer support and help with essentials such as food.

Dr Philip Rankin who has worked with the BSUH Discharge Hub the past few months said

1.2 Reassurance for the City Council and NHS

It should probably not come as a surprise that people needed some extra help after hospital discharge. Not everything can be predicted by hospitals and we are living in exceptional times. It is reassuring however that of the 1,152 people covered by this report only four discharges were escalated because the discharge did not seem to have been managed well. Those issues/ problems were readily identified, the families contacted by senior nurses and the issues resolved, with lessons learnt promptly [and the CQC advised].

A useful early lesson from this project may be that we need to plan for the unpredictable nature of hospital discharge, and not regard it as a failure if all needs are not anticipated. In this group of vulnerable people, 45% had long term health conditions and 29% had unpaid carer responsibilities, 18.5% had been identified by the NHS as extremely vulnerable, that amounts to a high-risk community. Those risks, however, are largely predictable and seem to be manageable within existing NHS and City Council resources. These resources have been re-deployed and boosted during the COVID response period however there is no indication that anyone needs special or additional support beyond what already exists at present.

This Wellbeing check project is in its infancy, links between the project and primary care and NHS Community services are not automatic, some of the systems we employ are lacking resilience and are vulnerable to predictable and avoidable pressures, e.g. staff and volunteer holidays or shortages. Links between the project, Adult Social Care and the Brighton and Hove Community Hub are good, with social care being able to identify people who are already known to social workers and who already receive social care services.

The project also links well with the Mental Health Rapid Response (MHRR) service provided by Sussex Partnership Foundation Trust [SPFT], that team have helped prepare a referral and support route for Hops volunteers who contact with people who present with self-harm and suicidal ideation. However, these remain among the most personally challenging sort of call our volunteers make, and we have had volunteers pull out of the project after having manage calls of this nature. An emerging issue is the number of people being referred to the project with self-harm, attempted suicide, suicidal ideation, and serious mental health problems. As a 'snapshot' early in September 20 we checked 100 people on our waiting list and for 20 people self-harm, attempted suicide or risky behaviour was the main reason they had visited hospital and a further 15 - 20 people had that and mental health issues in their referred information. The project is linking with the MHRR service and hospital based psychiatric liaison service to explore these issues.

1.3 Public and Patient confidence in the service

Client accepting the call = 98.4%

Call was helpful = 97%; extremely or very helpful = 66%

Permission to check back in a few months = 75%

1.4 Successful contacts

Healthwatch were unable to directly support 448 of the 1152 people referred from April to September 20.

It is important to note that we attempted to reach most of these people and often discovered from their family that they were not living at home:

Tried to ring several times but no response to calls or messages	= 208
Re-admitted or still in hospital	= 52
Discharged to or now live at another setting, care/nursing home	= 42
Not residents of Brighton and Hove	= 39
Wrong information given	= 36
Missing contact information	= 19
Other reason for failing to make contact	= 69
Staying with family and friends	= 2

There are five distinct groups of people, who we have been unable to reach:

- People where we tried several times, but they did not pick up the phone or respond to messages = 208
- People in a hospital or other care setting or with their family = 96
- People living outside the City = 39
- People we might have contacted with better referral information = 55
- Other reasons = 69, in the main these are duplicated records

The 96 people now living in a variety of care settings we will assume are having their care needs met, similarly for those people living outside Brighton and Hove (we have referral processes for people who may benefit from a similar scheme operating in East Sussex).

The 55 people we might have contacted with better referral information points to us needing to improve the referral path to HOPs.

We are further investigating the clinical and personal profile of the 208 people we called several times but were unable to reach. This represents 18% of all those referred and our plans for developing the project into the future require us to better understand that group of people. For example, if a large percentage have additional communication needs, or serious and persistent mental health issues, or perhaps these are just people who have chosen not to call us back because they do not need the HOPs services.

1.5 Referral flow

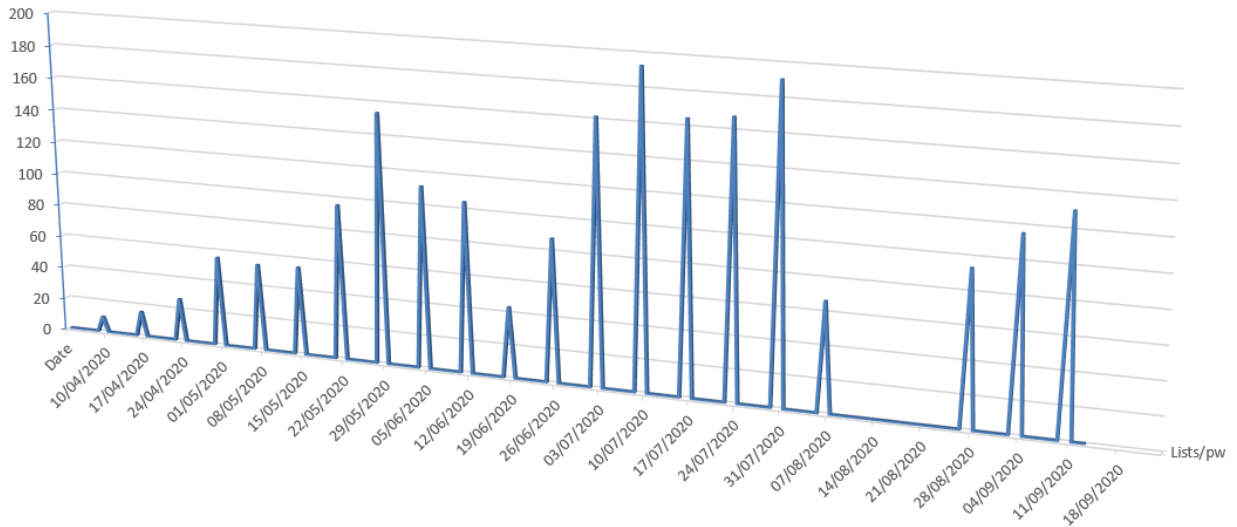
The project is focused on people discharged from hospital on pathways 0 and 1 - typically able to be supported in their own home.

Referral numbers started relatively low, and we had a two-week trial period in early April 20. Referrals rose to 50-100 people per week in July and are now running at 160+ per week and mid-September [at the time of preparing this report] we are experiencing another surge in referrals. There was dip in referrals in August associated with admin; staff at BSUH being on leave, perhaps demonstrating the vulnerability of the project, as not currently being imbedded into NHS systems as 'business as usual'. Excluding April 20, as a trial period, referrals from May to mid-September have run at 100 per week on average with notable surges.

Forward projection of likely demand, in consultation with BSUH indicates a 'new normal', likely future routine level of demand at 190-230 referrals a week. Our initial expectation that people would be contacted with a week of discharge has been compromised and with have taken corrective action to secure a low waiting time and reliable service:

- Proactively texting people who have been on the waiting list for 3 weeks
- Ensuring that people who actively request a call receive that service promptly
- Recruiting new volunteers
- Amending the advice leaflet to establish realistic expectations of the service

HD Wellbeing Service
List Frequency - Weeks



1.6 Are people made aware of this Healthwatch service?

83% of people told us they had not been informed by the hospital we would be calling them. This should be a routine part of the discharge process.

That is difficult for volunteers one of whom was told, by a relative of the person being called:

“.....I have no idea who you are we were not told you would be calling us and I am telling you nothing.....*phone slammed down....*”.

The issue of people, or their families, not being given advice leaflets or discharge booklets was also a theme in the Healthwatch ‘Let’s get you home’ report mentioned previously.

We might be wise not to rush to judgement, hospital staff often say that the correct advice and/or documents were provided. People may have been too ill or anxious to remember, a leaflet might have been casually discarded, however it is an unresolved issue that needs further investigation and 83% seems to be too large a proportion for there not be some lesson to be learnt.

1.7 People referred onto additional community support

178 people were referred on for specific additional community support

Referred to	Healthwatch	Self-referral	Total
BHCC Community Hub online	6	15	21
Possibility People, Link Back scheme for over 55yrs	27	14	41
Aging Well service [over 50yrs]	9	17	26
Together Co – befriending	4	8	12
Carers Hub	5	30	35
GP Surgery	6	13	19
NHS/BHCC Community Assessment Scheme	2	1	3
Mental health support	3	13	16

A further 50 people were signposted or referred for other, unspecified, community support.

1.8 HOPs and unpaid Carers

Unpaid carers may be family and friends or volunteers e.g. from the Brighton Carers Hub, <https://carershub.co.uk/>

- 180 from the 709 people we directly supported (25%) were themselves unpaid carers
- 35 of those people wanted support from the Brighton Carers Hub and were signposted or referred directly by HOPs volunteers

We would like to explore further the multiple impact on families when an unpaid carer is taken into hospital and the issues and pressure associated with their subsequent discharge. The profile of many people called by HOPs is that of being socially and medically vulnerable: 25% unpaid carers, 45% with long term health or disability issues and 18.5% identified by the NHS as particularly vulnerable to COVID. We have not yet been able to investigate the impact on the person for whom they normally act as an unpaid carer when temporarily that assistance is not available.

2. Discussion and case studies

2.1 The impact of HOPS - Hospital Discharge Wellbeing signposting

HOPS is not the only service in Brighton and Hove that supports hospital discharge, the Red Cross have a take home and settle service and Possibility People have a post discharge social prescribing service, there are other specialist post discharge support services serving smaller communities of common interest.

The unique role that HOPS provides is threefold:

- A check on discharge arrangements and new or unexpected community needs

- Routine and proactive, light touch, contact to check if people need any extra help
- A signposting service for people who may be vulnerable and have needs unrelated to hospital discharge

This role is entirely consistent with the objectives of local Healthwatch, one of which is to help signpost people through the complex systems of health and social care.

It is too early in the project, and it has not yet been possible, to fully evaluate impact on metrics such as re-admission rate, the capacity to do that lies with the NHS and is not in the gift of Healthwatch.

We, however, show impact in several ways:

- ✓ 17% of people we contacted has issues directly related to their hospital discharge, most discharges seem to have been managed as planned therefore it is likely that most of these will be unexpected, unanticipated issues that arose once they got home. This should not be a surprise to health and care providers or commissioners but before HOPS the mechanism for dealing with those issues was to rely on people to seek help spontaneously themselves. But we know that the people most likely to have additional issues are vulnerable, 45% have long term health and care problems and 25% are unpaid carers.
- ✓ 25% of people were referred or signposted for additional community support
- ✓ HOPs has provided a high degree of assurance that most hospital discharges are managed well in the best interests of patients and their families, we have been able to signpost people to the services that fit with their individual care needs, preferences and expectations

This had brought the right kind of help, more directly to people, in a timelier way, than would have happened without the HOPS initiative.

2.2 Improved experience of hospital discharge and integrated care

People welcome the HOPS calls over 98%, only 11 people did not accept the wellbeing check that we offer. 75% were happy to be recontacted for a follow up call. That is not currently part of the project but is a potential add in for the future.

97% of people found the call was helpful and 66% rated that as extremely or, very helpful.

A quick call to check on wellbeing has the potential improve the hospital discharge and community follow up experience. Personalising the process and being more proactive and responsive to emerging or unexpected care needs, that is a desirable outcome.

3. Sustainability

The project was started quickly and with commendable flexibility exercised by the City Council and NHS in allowing existing Healthwatch resources to be re-directed and providing additional funding. The initial 6-month funding period is close to amend and a further 3 months funding has been provided to allow sustainability planning.

The key issues for sustainability planning are likely be:

- Is this a time limited project relevant only during COVID response and COVID Restoration and Recovery or might it be a useful long-term addition to local service provision?
- Has the project provided evidence of benefit to individuals and the health and care system to sufficient to justify further investment?
- The project cannot be provided long term within existing resources and will require a small on-going investment from commissioners like that already provided by BHCC and B&H CCG. As an addendum to this report Healthwatch will provide future financial projection estimates for commissioners
- The project has led to a similar service being developed by the NHS and Healthwatch East Sussex, while Western Sussex Hospitals NHS Foundation Trust carry out a parallel function in house. Sustainability discussions might include an exploration of place-based vs Sussex wide options
- The project has already included some elements of ‘added value’ e.g. phone follow up of people who declines or reduced their homecare packages during COVID lockdown. Additional added value opportunities should be explored as part of sustainability discussions e.g. potential contribution to NHS COVID Phase III planning, Mental Health services COVID Restore and Recovery planning and potential service redesign, linking HOPs data with BHCC data on people who are COVID Shielded - to allow priority to be given for follow up, potential for something similar for people with mental health issues particularly suicide attempts, self-harm, suicidal ideation
- Commissioners will need to consider a procurement process if this project develops from being experimental and time limited to ‘business as usual’
- The project is currently funded to the end of December 2020 by the NHS with a commitment by BHCC to the end of the 2020/21 financial year, therefore sustainability discussions should be concluded, ideally, by the end of November 2020 to allow Healthwatch to construct an exit plan should that be necessary

4. Hospital re-admission rates for HOPs

Healthwatch are not able to provide comparative data on hospital readmission rates for HOPs against a control sample or past trends. That is probably difficult and potentially unreliable given the way hospital admission and discharges have been, necessarily, managed in differing ways during the COVID period. However, we have data on hospital readmissions for a sample of people receiving HOPs calls. Dr Phillip Rankin, BSUH, reviewed 110 out of 1424 people who had been supported by HOPs sampled from a spread April-August 2020. He considered 7-day re-attendance rate, 7-day readmission rate and 30-day re-admission rate.

	Re-attendance 7 days	Re-admission 7 days	Re-admission 30 days
No	101	103	85
Yes	9 [8%]	7[6%]	25 [23%]

Of the 25 reattend/readmitted within 30 days, 3 have died, 2 were related to recurrent mental health needs.

5. Mental Health needs

At present we can only provide a snapshot of people presenting to HOPs with serious mental health issues, the signposting for many will be into established relationships with Mental Health services, statutory sector, and VCS. We should acknowledge the excellent support and co-operation the project has had from the NHS Mental health Rapid Response Team (MHRRT) in Brighton Hove, the NHS Mental Health Psychiatric Liaison Service (MHPLS) based at the RSCH and the Community Roots team at Southdown Housing [who have also provided Suicide Awareness training for HOPs volunteers and Healthwatch staff].

Recently reviewing hospital discharge arrangements for people with mental health needs, with the MHRRT and MHPLS, hospital social work team and discharge hub staff, provided some invaluable insight and lessons to be learnt:

- A strong sense of common purpose and willingness to support the HOPs project and improve services for people with mental health issues
- Some frustration and resignation, including experienced front line professional with decades of dedicated service, with flawed and fragmented system for tracking and keeping in contact with vulnerable people. A system that responds well and promptly when people are in urgent need, but which does not provide built-in routine check and light touch proactive contact. HOPs provided one such opportunity, but we are deeply aware that we are unable to contact over 30% of the people referred#
- The disconnected nature of current support systems includes no automatic tracking and linking hospital discharge with City Council social care, primary care or voluntary and community services. The journey of someone vulnerable with emotional and mental health issues can be in and out of hospital for a variety of reasons. Some not

associated with their mental health but nonetheless physical health issues that impact their emotional wellbeing. With no trigger built into the system to offer proactive support unless their fall into a personal or health crisis. This in the context of overwhelming evidence of the impact on people in the City of health inequalities associated with social determinants – poverty, poor housing, loneliness, and social isolation

- Systems and staff supporting front line services that are under constant and heavy demand with little or no capacity to respond to emerging and rapidly changing needs for data analysis and information transfer. This applies not just to mental health but to the wider demands of improving pathway 0 and 1 hospital discharges
- A need to further improve support for volunteers, on the HOPs project, but also the wider community and voluntary sector, who often feel they carry a responsibility and duty of care to people with whom they are intended only to have brief and very time limited contact.

A review of 1,567 referrals to HOPs April-September 2020 included 247 people with mentions in the notes of suicide, suicidal ideation, overdose, self-harm, self-neglect, mental health, depression, low mood, anxiety. Which accounts for 15.8% of those referred. We are currently exploring with NHS Mental Health Services how we might best provide support and signposting for these people, given that the proportion of people referred with these kind of issues is unlikely to drop significantly, particularly in the context of current activity and demand in mental health services and reported surges in demand from the VCS.

6. Comments from HOPs partners

“The process of discharge can sometimes be quite rushed, so people often don’t leave hospital with all the information they need. This follow up call provides a safety net. Often we are working with people with very complex needs who need extra support to understand what services might have been set up for them or what support they might be able to access in the community”

“I had a case the other day when a couple who were in rehab discharged themselves and left their rehab unit without their discharge summary or any information. When Healthwatch called the family, their adult children were able to liaise with the discharge hub and ensure that the support was put in place that was required to support their parent’s recovery. The mother required follow up appointments and x rays as she had broken her neck and leg; the advantage of having the call from Healthwatch follow up was that the couples frustrations and concerns could be addressed by someone who knew their case and could advise how the daughters could chase the appropriate follow up. ”

“I think the service provides reassurance to families when their loved ones leave hospital; it gives them confidence when we tell them what should happen post discharge and how to chase it if it does not happen”

Marilyn Hall - Matron Integrated Discharge Team (IDT), BSUH

“When an individual or their family has any questions linked to the discharge, the Healthwatch Wellbeing Service has been able to work with the Discharge Hub to connect patients to the professionals who cared for them in the hospital in a timely way; providing reassurance and the appropriate advice, and on occasions linking to their G.P.

Under Covid-19 people are vulnerable, we have an ageing population and many people live alone. Often people decline support when they are in hospital and it is only when they get home, they realise how different it is without 24-7 care. I think there is real value in an independent person calling these people when they return home, to explore if the person needs any additional support. This service provides a safety net and ensures people don't slip through gaps in the system

The Healthwatch Wellbeing service recently contacted the discharge hub, as they had spoken to the son of a man who had recently been discharged home following a fall. He has been told an OT will come to the house but had no further information. The discharge hub were able to talk to the rapid response service and ensure the family the OT was visiting that day at 1pm to undertake an assessment and provide details about the twice a day package of care that had been set up”

Veena Lalsing: Discharge Hub Co-ordinator, Brighton and Sussex University Hospitals Trust (BSUH)

“I think the service is a really good idea, as it captures people that sometimes slip through the net and who may not be followed up in the community. Sometimes when we talk to relatives or friends on the wards they have unrealistic expectations of the support they can offer their loved one when the person leave's hospital. The family can struggle to meet the person's needs and there is no easy access to support or advice once you are home”

“We are seeing a lot of people coming into hospital because of self-harm or they may have taken an overdose. These people have mental health needs, which the hospital is not set up to deal with and there seems to be very limited support in the community. Sometimes all these people need is a phone call, a friendly voice when they get home, reassurance that someone care's and is checking up on them; it can make a big difference to these people”

“I think communication between Healthwatch, and the hospital has been really good. If there have been any issues, they have been dealt with them quickly. In the 22 years I have worked for the NHS, I haven't seen an equivalent service, with the same offer”

Marina Richardson- BSUH - Discharge Hub Administrator

7. HOPs volunteers

- Initially HOPs were delivered by a team of 5 longstanding volunteers, previously they provided follow visits and calls to people in Brighton and Hove receiving Home Care services. A sample of Home Care users would be contacted by our volunteers every month to test the quality and reliability of the services they received and make suggestions for improving the service user experience. This project was suspended during the COVID lockdown and replaced by HOPs
- The team of 5 volunteers has been expanded to 18 caller volunteers and one admin' volunteer. New volunteers were recruited temporarily from other local Healthwatch in Sussex, then on a longer term basis from the volunteer teams at the Royal Sussex County Hospital (RSCH) and Brighton and Sussex University Hospitals Trust (BSUH), the local NHS acute hospital trust and Sussex Community Foundation Trust who provide community health services in Brighton and Hove. We have now approached the local mental health trust to include some of their volunteers and people with lived experience of mental health services. Southdown Housing kindly provided training free of charge on suicide awareness. With more free training provided on Safeguarding and data management and GDPR by Brighton and Hove City Council
- Since April 2020 Healthwatch has had 27 volunteers working on the project with a turnover of 8 volunteers
- A former student volunteer at Healthwatch has been taken onto our staff team fulltime to support the HOPs project
- New volunteers have been recruited from:
 - Existing Healthwatch volunteers and our Board of Directors = 7 volunteers
 - Established Healthwatch volunteer recruitment processes = 3 volunteers
 - BSUH NHS Trust volunteers now working with Healthwatch = 6 volunteers
 - Sussex Community Foundation Trust (SCFT) volunteers now working with Healthwatch = 3 volunteers

HOPs has been a truly collaborative exercise in sharing volunteers with the NHS and in volunteers co designing and coproducing the service with NHS, City Council and Healthwatch paid staff.

The Healthwatch HOPs volunteers have provided 2816 hours of volunteering from April to September 2020, equivalent to 80 weeks of a nurse's time and worth £36,500 financial value.

Our volunteers said:

“HOPs provide a wonderful safety net for people that need it”

“Working on this project with Healthwatch has been rewarding, interesting and makes me feel I make a really difference to people's lives”

“I started as a volunteer with Healthwatch when I was student and now work with them full time, mostly on the HOPs project. It has been a challenge but a great opportunity, only two people from my graduation year have proper jobs - this has given me a real start in my working life.”

“Volunteers are able to have an independent conversation with the person, which can help the person feel reassured when they leave hospital. Through our contact we assess what has been going on for that person and advise on what support they might be able to access. We provide a link back to the hospital or GP where necessary. We recently had Suicide Prevention Training, which was a valuable session for all of us, as sometimes the conversations we have are challenging”

8.HOPs Case Studies

Case Study 1

Mary came out of hospital without the wheelchair they went in with (misaid on admission). They were now being asked to buy another wheelchair and they were distressed as this was a large expense and the chair had been lost through no fault of their own. Our volunteer was able to assist with the procurement of a new wheelchair without the requirement to pay again.

Case Study 3

Sarah left hospital unsure about her medication, the instructions for use, and whether she had been put on 'new pills'. Our volunteer spoke to the hospital, re-confirmed the exact requirement and instructions for use and was able to talk this through with the Sarah.

Case Study 4

Paul left hospital without their partner being informed. They arrived home with medical patches to be applied to the body and an understanding of how they should be applied. However, when the partner read the instructions that came with the patches this suggested the information the person had been given in hospital was incorrect. Our volunteer was able to contact the person's local pharmacy and clarify instructions with their partner. By doing so, the anxiety felt by Paul and his partner was ameliorated.

Case Study 5

Sharon appeared at first independent, but through talking with our volunteer several needs were identified. These included help with shopping (Sharon did not have enough food and no delivery plans) befriending, potential memory loss and some financial difficulties. Our volunteer referred the person to a local voluntary organisation who carried out a significant assessment of the person and collaborated extensively with a long-distance family member. As a result of this referral, several support services were put in place. These included:

- Age UK (financial review and benefit support),
- The City Council Early Response Service arranged emergency shopping and one-off laundry service, (after which the family member arranged regular food delivery).
- Contact with the GP regarding memory issues and referral to Responsive Services - short term support provided by the City Council and NHS Community Health services
- Brighton and Hove City Council Access Point (for an Adult Social Care assessment)

Together Co a local voluntary organisation providing befriending and similar services, for a regular volunteer shopper for smaller items.

Case Study 6

Jessica was discharged with a positive COVID result and potentially inadequate care package in place. Our volunteer spoke to the family member who was concerned that Jessica was not adhering to social distancing. Also, that there were signs of deteriorating mental health and that the care package in place was not adequate to cover this. In addition, the family member supporting at home has their own long-term health condition, and other carer responsibilities within the family. While managing well to balance the various needs, the situation with Jessica, was causing the family member to be at breaking point. Our volunteer was there to listen to the family member, reassure them during this stressful time and put in place initial contacts of support including referral to a local voluntary organisation, Possibility People.

Contact with Possibility People has since resulted in the following:

- signposting to PALS,
- liaison with the Specialist Older Adults Mental Health Service
- referral to Alzheimer's carer support team
- information provided to the family member about the Carers Hub, how to access Disabled Facilities Grants funding and local peer support services.

Case Study 6

Arthur had a history of attempted suicide and was assigned with mental health support but had not seen their contact for a couple of weeks. When our volunteer spoke to the person, they were desperate for someone to speak to and agreed for our volunteer to contact the Rapid Response Team (RRT) on their behalf. Our volunteer was able to put Arthur in touch with the RRT and they arranged urgent additional support.

Case Study 7

Paul was discharged from hospital but unsure about the result of a COVID test. Our volunteer made the call to the hospital discharge hub, to track the results down, and was able to assure the person that the test had been negative.

Case Study 8

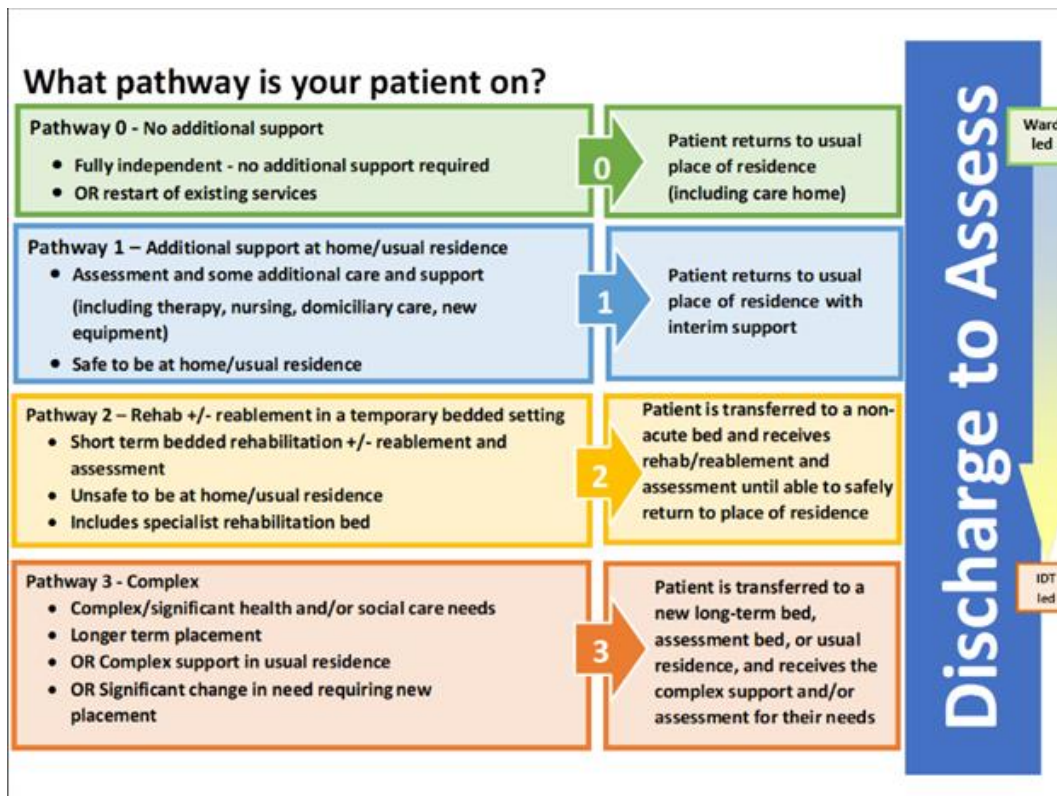
Lisa had been discharged from hospital but when our volunteer phoned she spoke to Lisa's landlady and discovered Lisa was 'missing' and had been for four weeks. The landlady was about to lock up the accommodation, and store Lisa's belongings and wanted advice about reporting her as a missing person to Sussex Police. After numerous phone calls our Healthwatch volunteer discovered there had been two hospital discharges over a four week period but Lisa had never actually arrived home to her lodgings. We found her in a Care Home 30 miles away, safe and sound and we were able to ensure her belongings and accommodation were secured for when she was able to return home.

Case Study 9

Lisa had been discharged from hospital but when our volunteer phoned she spoke to Lisa's landlady and discovered Lisa was 'missing' and had been for four weeks. The landlady was about to lock up the accommodation, and store Lisa's belongings and wanted advice about reporting her as a missing person to Sussex Police. After numerous phone calls our Healthwatch volunteer discovered there had been two hospital discharges over a four week period but Lisa had never actually arrived home to her lodgings. We found her in a Care Home 30 miles away, safe and sound and we were able to ensure her belongings and accommodation were secured for when she was able to return home.

David Liley, Chief Officer, Healthwatch Brighton and Hove
 17/9/20
david@healthwatchbrightonandhove.co.uk
 07931755343

ⁱ Hospital discharge pathways are shown below, with referrals to HOPs are for people on care pathways 0 and 1



ⁱ Referrals with failed contact:

Failed contacts total = 448 from 1152[38.9%]

From the 448 failed contacts:

- Tried several times, but no response to calls or messages (46.1%)
- Re-admitted or still in hospital (11.8%)
- Been discharged to or are living at another service or care/nursing home (9.3%)
- Do not live in B&H (8.6%)
- Wrong information given (8%)
- Missing contact information (4.2%)
- Staying with family/friends (0.4%)

Action: Request to BSUH for future reports on readmission rates for people passing through the HW HD Wellbeing project to indicate impact on readmission rates. BSUH admin to join the project oversight group and have routine contact with the Healthwatch Team. BSUH

admin' to carefully sift those people not living in B&H addresses. Note Healthwatch East Sussex similar project has now started and has received approx' 700 referrals.

ii People referred for extra Community Support = 178

Referred to	Healthwatch	Self-referral	Total
BHCC Community Hub online	6	15	21
Possibility People, Link Back scheme for over 55yrs	27	14	41
Aging Well service [over 50yrs]	9	17	26
Together Co – befriending	4	8	12
Carers Hub	5	30	35
GP Surgery	6	13	19
NHS/BHCC Community Assessment Scheme	2	1	3
Mental health support	3	13	16

A further 50 people were signposted or referred for other, unspecified, community support.

iii Post discharge 204 (29%) people has issues or questions post discharge of these 119 had specified issues directly related to their hospital discharge:

From the 204 (29%) people with identified post discharge issues, 119 had issues specifically related to their hospital discharge, 85 people had issues or questions unrelated to the discharge. We need a 'deeper dive' to understand the issues and processes identified post discharge.

- Care Package = 31
- Physical issue = 32
- Medication and Pharmacy = 24
- Equipment = 14
- Service or appointment = 18

Sub total = 119

Other = 85 this category includes many issues unrelated to hospital discharge so is not particularly helpful as a source of intelligence

56 people from the 704 people successfully contacted were referred to the hospital discharge hub

How to contact Healthwatch

Healthwatch Brighton and Hove:
Healthwatch Brighton and Hove
Community Base
113 Queens Road,
Brighton
BN1 3XG



Share your experiences of health and social care services with us:

office@healthwatchbrightonandhove.co.uk

- 01273 234040
- @healthwatchbrightonandhove
- @HealthwatchBH
- healthwatchbh

Website: www.healthwatchbrightonandhove.co.uk

