healthwatch Oxfordshire

Your voice on health and care services

People's experiences of leaving hospital in Oxfordshire

"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, health and social care services in Oxfordshire have been working together to develop a new approach to supporting people when they leave hospital. This has included a shift towards supporting people to get home sooner and recover in their own home. As part of this, services have developed ways of providing 'joined-up care', by 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).

Who did we hear from?

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**

87 health and social care professionals from primary and secondary care and social care

What did we hear was 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 did we hear 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.

No one discussed it with me, even though I had told them several times I would be alone at home and was very worried about this

My mother is elderly and a little confused. I asked several times to be involved and informed, instead (I was told) she was the only person involved

I was in hospital for seven days. I asked daily for an interpreter but there was no interpreter available... I was discharged with medication but I had no instructions

Next steps and action

We have shared the report with key health and social care decision-makers in Oxfordshire.

What we would like to see:

- **Quality and continuity of care**. Identify gaps in care quality and continuity, and develop action plans to address them and make sure care is person-centred. This would include making sure that patients and unpaid carers are involved in the co-design and development of services.
- **Communication**. Better, clearer communication with patients and unpaid carers about discharge pathways, including making sure that information is accessible to all.
- **Unpaid carers**. Improve the support for unpaid carers and make sure that unpaid carers are recognised and, where appropriate, included in decisions about discharge.
- **Joined-up working**. Improve communication about discharge pathways to ensure health and care professionals have a consistent approach, and improve understanding between services.

What has already happened:

✓ A new information leaflet about discharge is being finalised - we have used what people told us to give feedback on this and encourage providers to seek feedback from patients and unpaid carers too.

✓ Health providers are testing out a process for proactively following up with people who have recently been discharged from hospital, with a view to rolling this out across the county.

✓ Providers are delivering workshops and webinars for health and care professionals from different services to improve understanding of discharge and promote joined-up working.

Thank you to all those who shared their experiences.