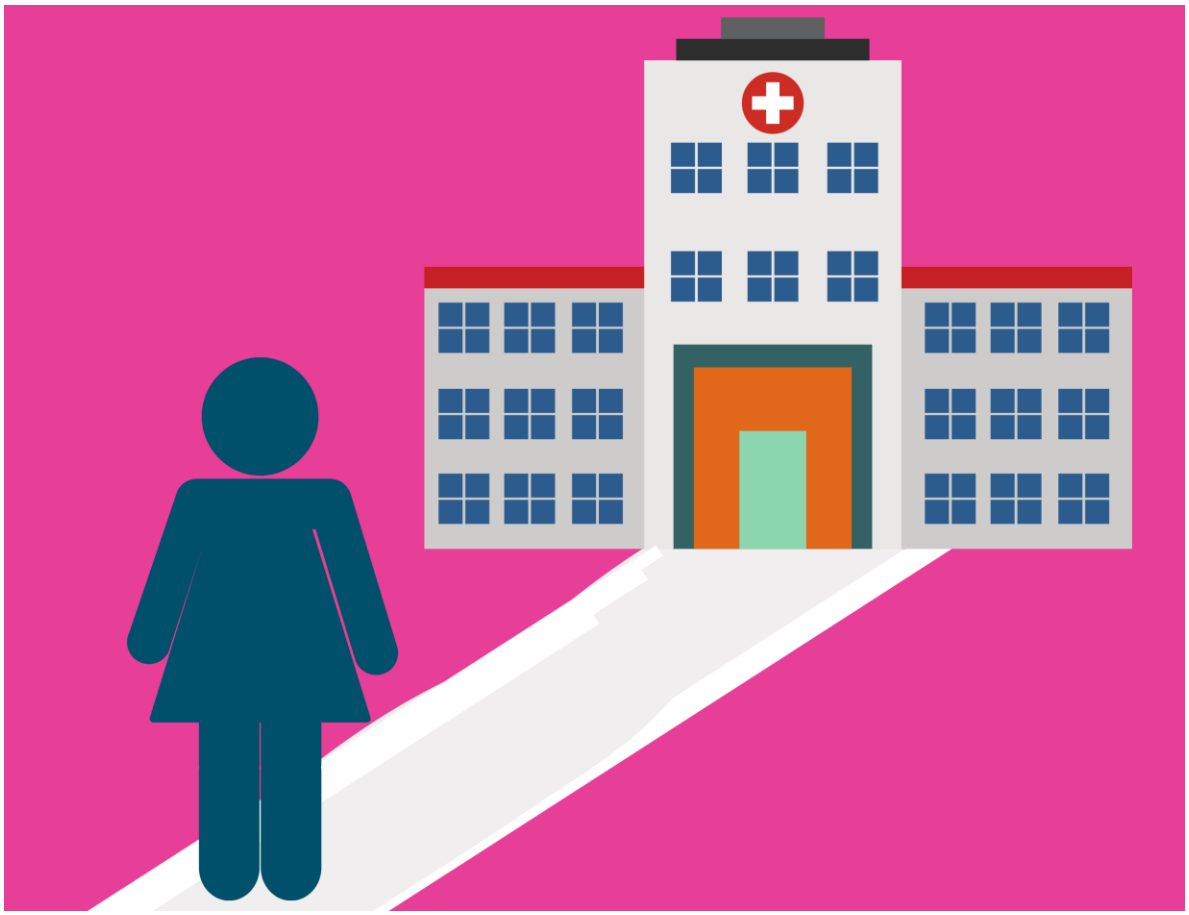
healthwatch Brent

Discharge from Hospital
(to appropriate care)
in Brent



December 2020

Table of Contents

EXECUTIVE SUMMARY

Why did we do this project?

Healthwatch Brent had received general feedback about discharge from hospital to appropriate care. The purpose of the project was to gather patients' views of their hospital discharge experience and referral to other services and their appropriateness.

We had planned to start the project following completion of implementation phase of the Health and Care Transformation Programme. This would allow Healthwatch Brent to gain some insight into whether the work done thus far has been effective from patients' perspectives.

However, the discharge process changed on Thursday 19 March 2020, in response to the COVID 19 pandemic. Every patient in general wards were to be reviewed, unless requiring ITU or HDU care, with the consideration of discharge to a less acute setting. Therefore, the focus of the report was amended to obtain the feedback from patients in Brent discharged from hospital and social care providers views during this time.

What we did and who we spoke to?

We obtained baseline data from London North West University Healthcare NHS Trust on the number of patients discharged and where to they were discharged to i.e. home, care homes, sheltered homes etc. The Freedom Of Information (FOI) data showed that over 6000 patients were discharged from the Brent, Harrow and Ealing boroughs, in March and April 2020. They were unable provide data for Brent residents only. They provided a list of the destinations that patients were discharged to.

As part of our preparation for this work we spoke with care homes where Healthwatch Brent undertook Enter and View visits so gain an understanding of their experiences. CQC provided advice on which care providers to focus our efforts. We spoke to Care providers to find out their views on the hospital discharged process both pre-COVID and during the response phase of the pandemic.

We worked with Healthwatch England to develop the national Hospital Discharge survey that went live on 19 July 2020. The national survey was to gather and understand people's experiences of the changes to the discharge process during the COVID-19 pandemic to help identify what has worked well and where problems have occurred to ensure these are avoided in future.

Our partners and community contacts, circulated this survey to their clients and members We also spoke patients, identified by community groups, that were willing to share their insights on their experience of hospital discharge during this time. This report segmented the survey responses from Brent residents and patients and included the insights from care provides and patients in Brent.

What did people tell us?

75% of patients were not given information explaining the process of leaving the hospital.

75% of respondents did not receive a follow-up visit and assessment at home and one third of these patients these reported an unmet care need.

On discharge over a third (37%) of patients were not given information about who to contact if they needed further health advice or support after leaving hospital.

Although 62.5% of patients were tested for COVID-19, they often did not know the test result.

Although most patients were discharged during the day, there were still a small proportion (12.5%) of patients being discharged at night

There have been cases where the discharge of a patient from hospital to a care facility had not been communicated to families.

Generally, patients and families were very positive about the care received from healthcare staff in hospital, praising their efforts during such a difficult time. Care providers were also grateful for the support given by Brent council.

Why it is important and what we would recommend?

We are now in the period of anticipated winter pressures in the NHS, and COVID-19 cases are rising. Improvements need to be made to ensure people's needs are met effectively after they are discharged during both the next phases of the pandemic, and in the longer-term.

The following are areas where the health and care system in Brent must act quickly to appropriately implement existing policy:

For hospitals:

1. Provide everyone leaving hospital with a follow-up contact. Assign a single point of contact - Hospitals working with their partners to ensure patients are assigned a point of contact for further support, in line with national policy. Ensure families and carers also know who to contact, so they have a point of contact for the follow-up support of their loved ones or clients,
2. Ensure patients are tested and the results of the test known before they are discharged to a care home. Test results to be communicated with care homes prior to discharge, as set out in the Adult Social Care Winter Plan.

3. Ask about transport home, when discharging patients, checklists should be used to support conversations with patients, families and carers to ensure they have the immediate support they need to get home safely. No patient to be discharged at night unless transport can be arranged
4. Provide information about administering and managing medication to patients and carers to so that patients are supported appropriately after they are discharged. A suggestion is to link up with community pharmacists to help carry out post-discharge community assessments.
5. Post-discharge check-ins on every patient after discharge over the phone or in person.

For the Clinical Commissioning groups:

The British Red Cross has long been calling for the inclusion of a five-part independence checklist in the hospital discharge process to facilitate conversations between health professionals, patients, their families and carers about their physical, practical, social, psychological and financial needs[1]

Clinical commissioning groups should consider commissioning a patient or voluntary sector organisation to conduct these calls.

[1] https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/more-support-when-leaving-hospital/getting-hospital-discharge-right#Our%20recommendations

ACKNOWLEDGEMENTS

A special thanks to those patients who provided their responses to the survey and further details on their experiences, social care providers who responded to our enquires and the Healthwatch Brent volunteers. The Clinical Quality Commission colleagues for their advice and guidance and the FOI Team in London North West University Healthcare NHS Trust for providing some of the data on hospital patient discharge.

INTRODUCTION

Healthwatch Brent is part of a national network led by Healthwatch England, which was established through the Health and Social Care Act in 2012, to give service users of health and social care services a powerful voice both locally and nationally. We are the independent voice for people's views on Brent services, both good and bad. We listen to local people and feedback patient experience and liaise with local commissioners and decision makers, in order to improve services.

Healthwatch Brent has received general feedback about discharge from hospital to appropriate care. Recently, that discharge especially to social care has been rushed or not sufficiently organised to meet people's care needs.

The purpose of the project was to gather the views from patients of their hospital discharge experience and referral to other services and their appropriateness.

We had planned to start the project following completion of implementation phase of the Health and Care Transformation Programme to allow Healthwatch Brent to gain some insight into whether the work done thus far has been effective from patients' perspectives.

As COVID-19 is having a dramatic impact on care homes and home care which is likely to impact on both the implementation of the Transformation Programme but also the resident experience. Therefore, the focus of the report was amended to also obtain feedback from to social care providers in Brent on how the hospital discharge process works from their perspective.

The hospital discharge process has been changed from Thursday 19 March 2020 in response to the COVID-19 pandemic[2]. Every patient in general wards were to be reviewed, unless requiring ITU or High Dependecy Unit (HDU) care, with the consideration of discharge to a less acute setting.

As part of our preparation for this work we have engaged with care homes where Healthwatch Brent undertook Enter and View visits so have a baseline of understanding of their experiences of the hospital discharge process.

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/hmg-letter-hospital-discharge-guidance-v3.pdf

BACKGROUND

Brent Health and Wellbeing Board (HWBB) approved a refreshed set of priorities for Brent Health and Care Transformation Programme, building on the existing priorities agreed in October 2018. One priority of the programme included looking at patient centred older people's care, with one of the goals being to reduce delays in hospital discharge and improve patient experience. An update presented to the HWBB identified several ways in which discharge could be improved[3]. The implementation phase of this project was underway in October 2019 and will likely result in changes to discharge pathways.

To cope with a surge in demand from COVID-19 patients the NHS urgently needed to free up capacity in hospitals. To support this, a new hospital discharge process was introduced nationally, first set out in guidance in March 2020[4]. It focused on getting people out of hospital quickly, to free up 15,000 beds and support the faster movement of patients in and out of hospital.

This discharge to assess model is based on using four clear pathways for discharging patients as shown below was used:

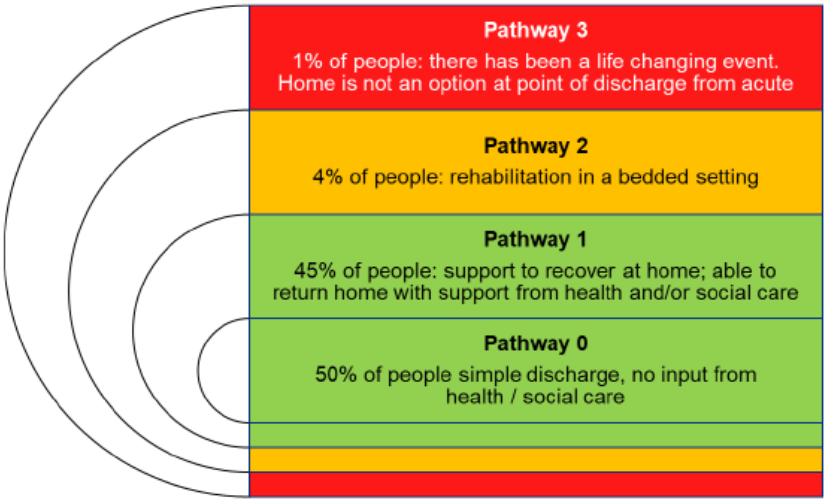


Figure 1: Discharge to Assess model

[3] Health and Care Transformation Programme Review, Health and Wellbeing Board 7 October 2019, Report from the Director of Integrated Care. https://democracy.brent.gov.uk/documents/s89544/Health%20Care%20Transformation%20Board%20-%20Update.pdf

[4] Hospital Discharge Government Guidance (March 2020): https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

The model worked on the premise that Acute hospitals were responsible for leading on the discharge of all patients on pathway 0, ensuring that the 50% of patients that can leave the hospital and only need minimal support do so on time.

Providers of community health services will lead on pathways 1-3 as they will lead in assessing and providing care for patients once they are home.

A single coordinator set up by community health providers in each acute centre will be accountable to a named Executive Board lead in their own organisation, for delivering the change.The co-ordination team to ensure all patients (irrespective of their address) are discharged on time and are provided with the follow up support as needed. The Discharge Service to operate at a minimum 8am-8pm, seven days a week. This approach to be applied to discharges from all NHS community and acute beds.

Although, whilst most people will be discharged to their homes, a very small number of patients will need and benefit from short or long term residential or nursing home care.

An update to the hospital discharge guidance issued in August maintained the same key principles.[5] It sets out how health and care systems can ensure that people are discharged safely from hospital to the most appropriate place. As well as continue to receive the care and support they need after they leave hospital.

[5] https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

METHODOLOGY

We decided that a survey would work well for this project, and user stories would also be beneficial to reinforce the findings with anecdotal evidence.

We contacted Healthwatch England (HWE) Intelligence Team to let them know that we are undertaking this project and contributed to developing the national survey questions. HWE ran national survey from 21 July - 26 August to collect the experiences of patients and carers who were discharged from hospital between March and August 2020. This was a survey to gather people's experiences (including patient's, carers, and relatives) of being discharged during the COVID-19 period.

Healthwatch Brent promoted the survey through our community partners, our newsletters, website, on social media as well as during engagement meeting with community groups in Brent. We analysed at the responses from Brent patients and residents in this report.

London North West University Healthcare NHS Trust FOI team provided information on the number of patients discharged and where to they were discharged to i.e. home, care homes, sheltered homes etc. There were over 6000 patients discharged during March and April 2020, in the boroughs of Brent, Harrow and Ealing. See Appendix I. They were unable to provide information on patient address, age, and ethnicity as it may constitute a disclosure of personal identifiable data.

We spoke to care providers to find out their views on the hospital discharged process both pre-COVID and during the response phase of the pandemic. The questions we ask are outline in Appendix II. There are over 935[6] care providers in Brent, so to focus our efforts on we sought advice from the CQC colleagues and the list obtained from London North West University Healthcare NHS Trust, see Appendix III for the care providers we contacted.

[6] https://www.cqc.org.uk/search/services/care-homes?location=Brent%2C%20UK&sort=default&distance=15&mode=html&f%5B0%5D=im_field_care_homes%3A3618

FINDINGS

The Healthwatch England report *590 people's stories of leaving hospital during COVID-19* was published on 27 October 2020[7]. Although the number of respondents that took part in the survey from Brent was small (8 respondents) we analysed the feedback from patients in Brent, both in terms of the survey and direct patient and community feedback we received and how it compares to the findings in the HWE reports.

Data on Hospital Discharge

The FOI Team in London North West University Healthcare NHS Trust provided the the data on hospital patient discharge for the month after the hospital discharge changed. The table in Appendix I, shows the total number of patients was 6636. 85% of patients were discharged to their usual place of residence 49% of the patients discharged were men and 51% were women. The list of homes that patients were discharged to is given in Appendix II. The FOI team were unable to provide data on borough of residence, age or ethnicity of the patients discharged as it may constitute a disclosure of personal identifiable data.

Survey data and patient and social care providers insight

The analysis of the responses to the survey and patient insights on the process in Brent are presented below. The majority (87.5%) of the Brent respondents to the survey were female. The age profile and ethnicity given by the respondent is shown in Appendix IV.

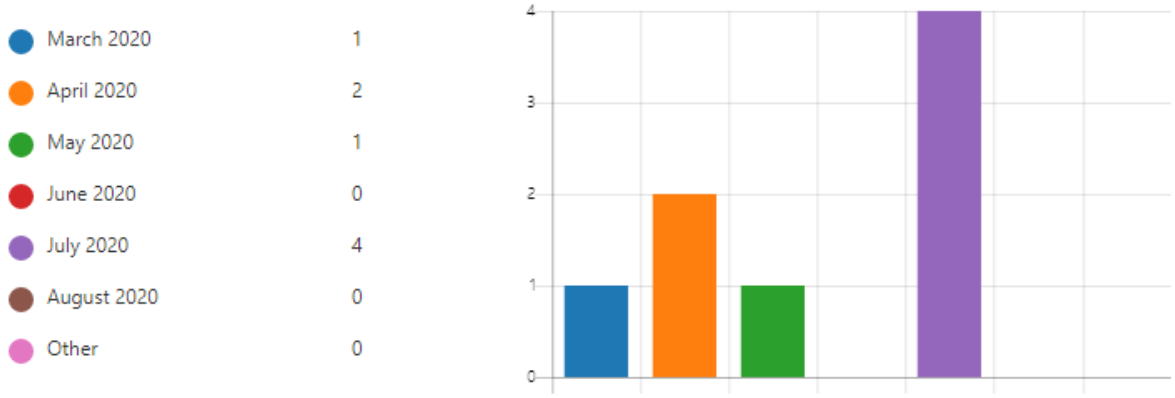
The list of providers we contacted can be found at Appendix II. Some care providers were reluctant to engage with us and uneasy about discussing the admission process into their facility from hospital.

The discharge process- When were patients discharged?

Patients were asked which month they were discharged from hospital. The survey of Brent responses showed that number of patients discharged from hospital peaked in July, see graph below

[7] https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20201026%20Peoples%20experiences%20of%20leaving%20hospital%20during%20COVID-19_0.pdf

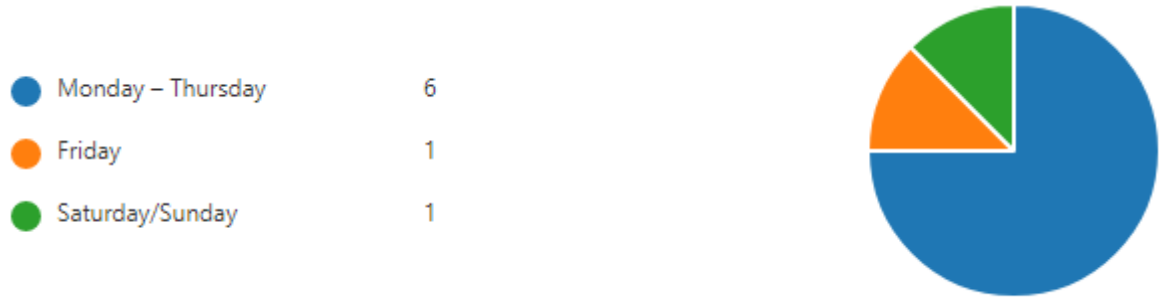
Figure 2- Number of patients discharged each month



What day were you discharged?

Majority (87.5%) of the patients were discharged during the week, with most (75%) patients were discharged between Monday to Thursday. However, patients were a small proportion being discharged at the weekend. See graph below.

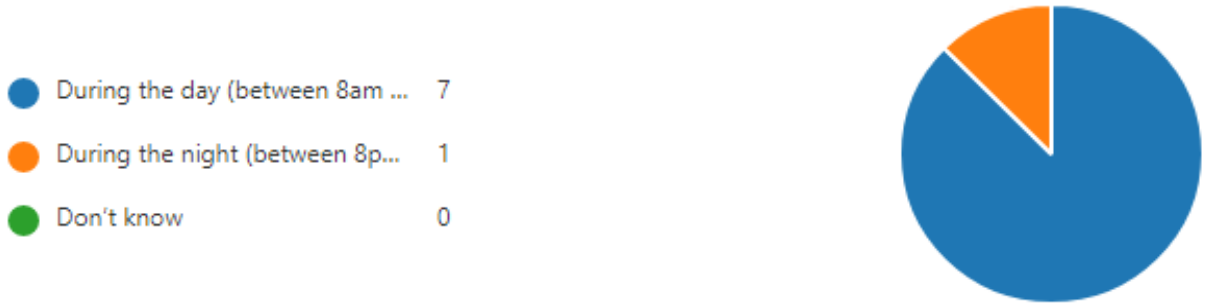
Figure 3- Number of patients discharged for days of the week



What time of day?

When asked about what time of day they were discharged from hospital, the majority (87.5%) of patients confirmed that they had been discharged between 8am and 8 pm. However, there were still patients being discharged at night, after 8pm.

Figure 4- Number of patients discharged at each time period of the day



The waiting time to be discharged.

Patients were asked "How long did you wait between being told you were well enough to leave hospital and actually leaving the hospital?" Most (63%) of the patients discharged waited between 2 and 24 hours, while 26% of patients waited for 1 or 2 hours. Although one patient (12%) waited over 24hours to be discharged.

Figure 5- Number of patients waiting time until discharged

Patients told us that the discharge process was often longer as they had to wait for the discharge letter and medication to be confirmed

"Waiting for the discharge letter was what held me up when I wanted to go home"

"The staff caring for me were great, but the discharge process was ragged"

Case study

A patient with an ongoing medical condition had to be admitted to the hospital. During their stay in hospital ward, they had taken the medication that had been prescribed to them by their GP at the usual time of day. The hospital staff had been unaware that the patient had this medication was with them. This oversight on admission caused a delay in discharge, as the patient then needed to be kept in hospital for another day for observation.

Social care providers view

We had asked social care providers about when they received patients discharged from hospital. Often the difficulties that arose when admitting patient at night as this often-disturbed other residents and there was usually less staff available to process new residents. There are some concerns expressed about the seamlessness of discharge for patient from one service to another as often the hospital-

"The hospital forgets to send the paperwork especially from wards in NPH."

"A body map is not done prior to discharge (from hospital) so the home does this when admitting a patient and when transferring patient to hospital as there have been occasion when patient has bed sore not accounted for in the hospital."

"We were satisfied with the plans, given the situation. CCG were dealing with all discharges and assessments were done over the phone, which was not ideal as some details were missed. These were then picked up when the patients arrived at the care home."

"Normal procedure would involve the assessment taking place at the hospital, with a suitable slot being booked in advance."

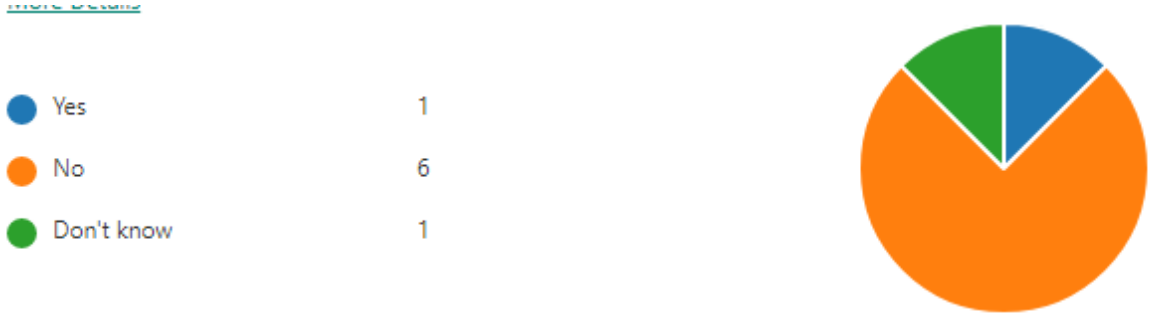
Communication with patients

The Discharge guidance states that information explaining the new hospital discharge process should be shared with all patients on admission to hospital.

When you were in hospital, were you given information explaining that the process of leaving hospital has changed due to coronavirus (COVID-19)?

Most (75%) patients were not given this information, see graph below

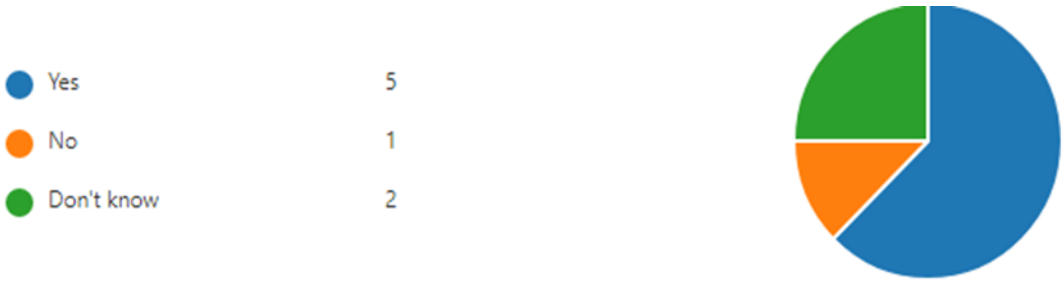
Figure 6- Number of patients who received information explaining the discharge process changes



Coronavirus testing in hospital

Patients were asked "During the time you spent in hospital, were you tested for coronavirus (COVID-19)?" The graph below shows that some patients did not know if they had been tested, while 62.5 % of patients said they had been tested.

Figure 7- Number of patients who knew if tested for COVID 19 in hospital



Patients that had been tested raised the concern that the results from the COVID test in hospital had not been made known to them.

Social care providers view

Some care providers were reluctant to engage with us and uneasy about discussing the admission process into their facility from hospital. The Care providers that were willing to speak to us told us that during the

"Hospital pushy and insisted patient discharged back into our care."

"The council would normally be responsible for managing any process around discharges from hospital."

As the pandemic progressed there was gratitude from the care providers for the support from the council.

"We asked for a COVID test, all were negative. The home was well prepared with PPE, supplied by Brent council."

"(We) Always asked them to be tested for COVID before they come into home."

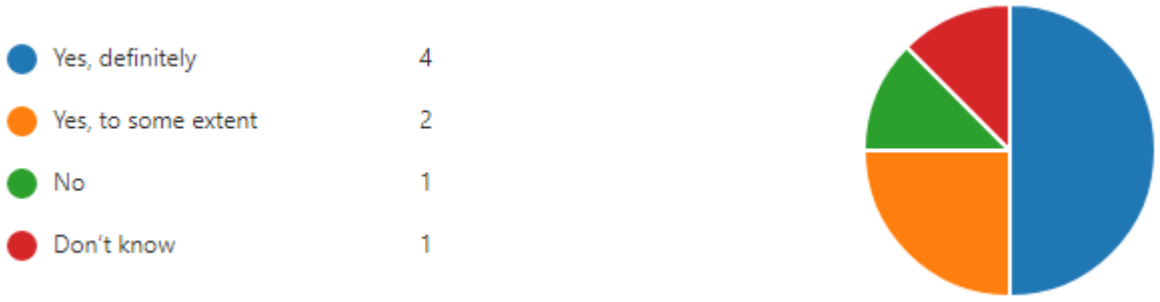
"Brent Council were very supportive during this tough time. They even contacted the GP who then checked in with the care home."

"We had never had the same level of communication or support prior to COVID. Would like this sharing of information to continue in the future?"

On leaving hospital:

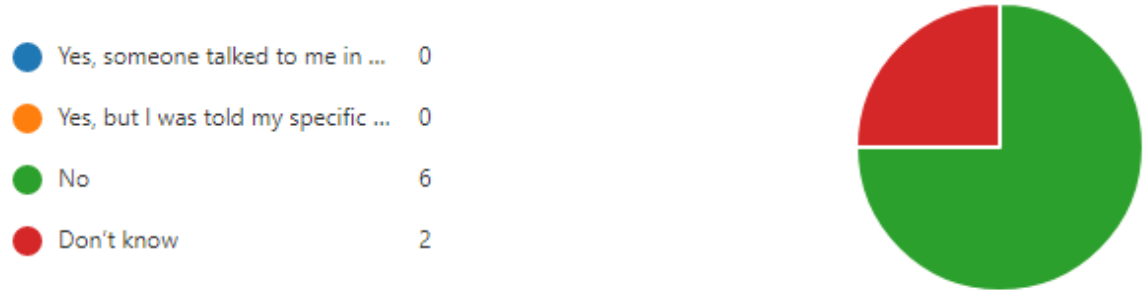
Did you feel prepared to leave hospital?

Patients were asked if they felt prepared to leave hospital. Most 75% of patients were ready to leave hospital and a 12.5% of the patients did not feel ready to leave the care of the hospital.



. Figure 8- Number of Patients who felt prepared to leave hospital

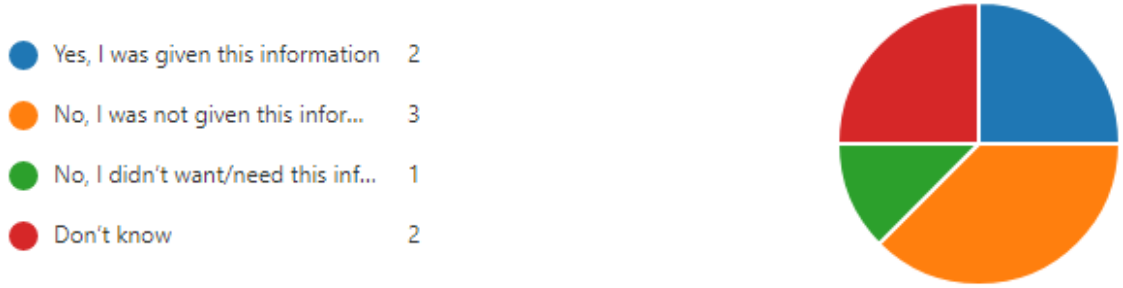
Before you were discharged, were you told you would receive support from health and/or social care services after you left hospital (for example, home visits from a care worker)?



. Figure 9- Number of Patients told about support when leaving hospital

75% of patients had not been told about receiving support from health or social care services. Only 25% of patients were given information about who to contact if they needed further health advice or support after leaving hospital see the graph below

Were you given information about who to contact if you needed further health advice or support after leaving hospital?



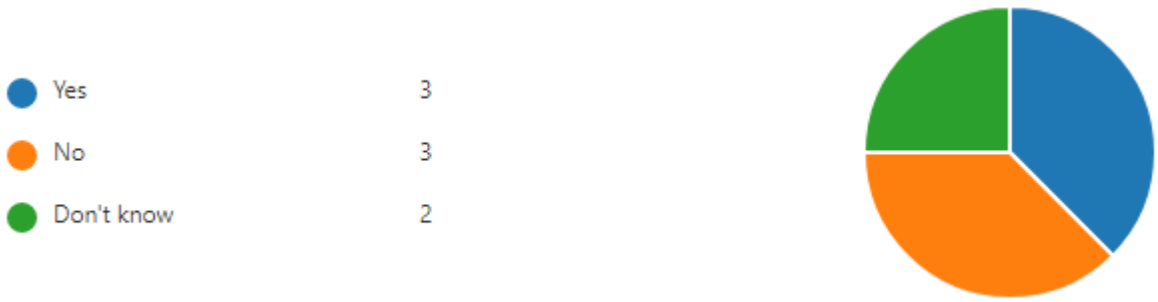
. Figure 10- Number of Patients told who to contact if they needed help after leaving hospital

Some patients (25%) were given information on who to contact if they need support or further advice after leaving hospital. Although 37.5 % of patient dis not

receive any information while 12% did not want any information. The rest of the patient did not know if they had been given this information

How did you leave hospital?

Patients were asked “Before you left hospital, were you asked if you needed support in getting transport to the place you were discharged to?”



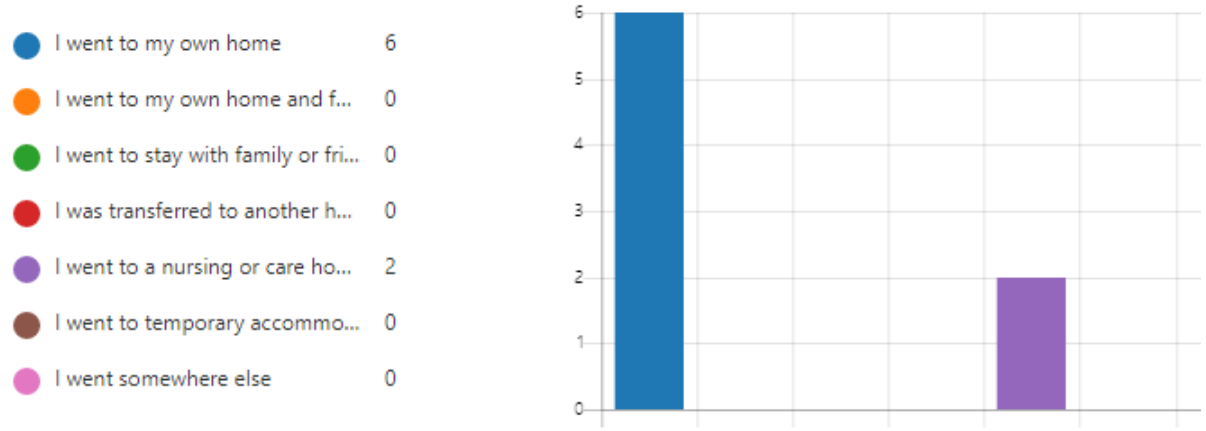
. Figure 11- Number of Patients asked about transport when leaving hospital

The graph above shows that (38%) of patients were asked if they needed transport and 38% of patients were not asked about transport to the place of discharge.

Although 75% of patients were discharged to their own home. While 25% of patients were discharged to a nursing or care home, see graph below. Those discharged to their own homes were taken their by an unpaid carer or relative. Hospital transport was arranged for the patients that went to a care or nursing home.

Where did you go after leaving hospital?

. Figure 12- Number of Patients discharged to each location



The patients discharged to the care or nursing homes were not discharged to their first choice of care home

Social care providers view

We asked social care providers whether the patient/ their family know about the patients plans for discharge from hospital into their facility. Most care providers that responded felt that their clients were not informed generally.

"One patient's next of kin phoned to say they were not aware of the discharge to care home."

"No, they did not seem to be fully aware."

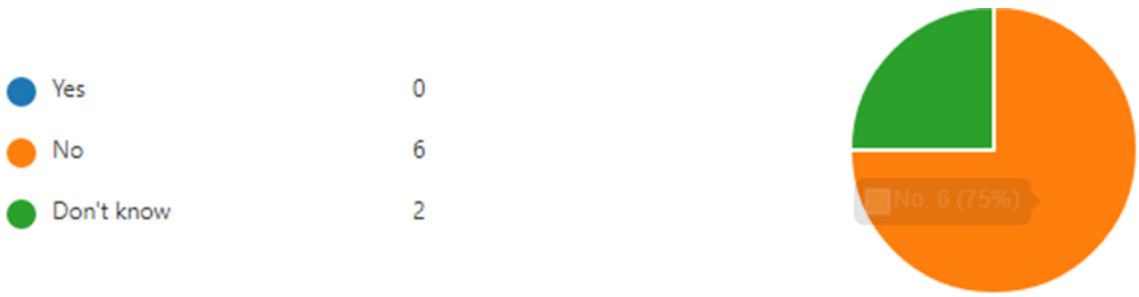
"Many residents do not have capacity to understand the events. COVID assessment forms."

After leaving hospital

The guidance on care after a hospital stay[8], states help and support should be arranged before you go home (are discharged). Patients were asked if a discharge assessment was done after they left hospital. A discharge assessment will determine whether you need more care after you leave hospital.

Were you visited by a health professional to assess your support needs (this is called a discharge assessment)?

[8] https://www.nhs.uk/conditions/social-care-and-support-guide/care-after-a-hospital-stay/arranging-care-before-you-leave-hospital/



. Figure 13- Number of Patients who had a discharge assessment on leaving hospital

This graph shows that there were some patients that did not know if a discharge assessment was done. However, the majority (75%) of patients did not have a discharge assessment.

Patients were asked if they have any support needs for which they do not have any help, see graph below:

Do you have any support needs for which you don't have any help with at the moment?

. Figure 14- Number of Patients needing support after leaving hospital

38% of patients did not have any support needs, while 38% of patients felt that they did have support needs and were not getting the help they needed.

Did you understand information you were told/given?

. Figure 15- Number of Patients who understood information given to them

Although most (62.5%) patients did understand the information they were told or given. A quarter of them only understood some of the information and 37.5 patients did not understand it.

> "A patient suffering from mental health condition was discharged at 3 am for A&E and was found wondering the streets by the police."

Case study

A resident that had a stable mental health condition due to a good support network began to experience auditory hallucinations during lockdown. The patient threw themselves out of the window and was admitted to hospital

The patient was discharged from hospital after recovering from the physical trauma of the incident. After discharged no one called the patient, no home visits took place for a couple of weeks

The patient felt very abandoned and the support system had broken down. When the community group support visited the patient after the the mental health team called them. The patient was terrified and nervous in their own home as that is where the incident that led to the hospital admission took place.

Social care providers view

When care providers were asked if they were satisfied with discharge plans for patients sent to your service either before the COVID pandemic or During the COVID -19 pandemic. Their responses were as follows:

"We were satisfied with the plans, given the situation. CCG were dealing with all discharges and assessments were done over the phone, which was not ideal as some details were missed. These were then picked up when the patients arrived at the care home. Normal procedure would involve the assessment taking place at the hospital, with a suitable slot being booked in advance."

"Yes, as they would normally speak with the discharge coordinator and there was not much paperwork involved"

"Yes, during the pandemic we were contacted by a Junior Registrar who explained that the patient was in a Green Zone and did not have COVID, so was safe to be discharged."

"Yes, as the Junior Registrar called to give them information about the patient and process."

CONCLUSIONS

The findings from the survey showed that hospital discharge peaked in July 2020. Most of the patients were discharged during the week and most patients were discharged during the day (8am to 8 pm).

However, 12.5% of patients were discharged at night and at weekends. We have anecdotal evidence from community groups and care providers that this is not an unusual occurrence.

Although 62.5% of patients were tested for COVID-19, they often did not know the test result. Care providers told us that this had been the case for them until Brent Council stepped in to insist that all patients being transferred to care homes needed to have the COVID test result.

75% of patients were not given information explaining the process of leaving the hospital. On discharge over a third (37%) of patients were not given information about who to contact if they needed further health advice or support after leaving hospital.

75% of respondents did not receive a follow-up visit and assessment at home and one third of these patients these reported an unmet care need.

There have been cases where the discharge of a patient from hospital to a care facility had not been communicated to families. Owing to the restricted access to hospitals during the pandemic, mental capacity assessments of patients were not carried out by social workers in hospitals. This led to difficulties obtaining mental capacity assessments and contacting social workers in the community.

Generally, patients and families were very positive about the care received from healthcare staff in hospital, praising their efforts during such a difficult time. Care providers were also grateful for the support given by Brent council.

RECOMMENDATIONS

Winter planning is currently being co-ordinated across the North West London system and through local A&E Delivery Boards.[9] Current planning assumptions are that the levels of attendances and admissions are similar to winter 2019. If another surge of COVID takes place equivalent to that experienced in the first wave of March/ April the bed capacity is limited to 92% occupancy in hospitals in Brent.

---

9 https://democracy.brent.gov.uk/documents/s101655/6.%20Brent%20NHS%20and%20COVID%2019%20Response%20and%20Recovery.pd

We are now in the period of anticipated winter pressures in the NHS, and COVID-19 cases are rising. Improvements need to be made to ensure people's needs are met effectively after they are discharged during both the next phases of the pandemic, and in the longer-term.

The following recommendations are areas where the health and care system in Brent must act quickly to appropriately implement existing policy.

For hospitals:

1. Provide everyone leaving hospital with a follow-up contact. Assign a single point of contact - Hospitals working with their partners to ensure patients are assigned a point of contact for further support, in line with national policy. Ensure families and carers also know who to contact, so they have a point of contact for the follow-up support of their loved ones or clients,

2. Ensure patients are tested and the results of the test known before they are discharged to a care home. Test results to be communicated with care homes prior to discharge, as set out in the Adult Social Care Winter Plan.

3. Ask about transport home, when discharging patients, checklists should be used to support conversations with patients, families and carers to ensure they have the immediate support they need to get home safely. No patient to be discharged at night unless transport can be arranged

4. Provide information about administering and managing medication to patients and carers to so that patients are supported appropriately after they are discharged. A suggestion is to link up with community pharmacists to help carry out post-discharge community assessments.

5. Post-discharge check-ins on every patient after discharge over the phone or in person.

For the Clinical Commissioning groups:

The British Red Cross has called for the inclusion of a five-part independence checklist[10] in the hospital discharge process to facilitate conversations between health professionals, patients, their families and carers about their physical, practical, social, psychological and financial needs

Clinical commissioning groups should consider commissioning a patient or voluntary sector organisation to conduct these calls. This may help provide flexible capacity

[10] https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/more-support-when-leaving-hospital/getting-hospital-discharge-right#Our%20recommendations

to respond to a second COVID wave and/or increasing demand in ITU due to winter pressures.

APPENDICES

Appendix I

Freedom of Information (FOI) on where patients were discharged to

Discharge Destination Description	Number of patients	%of total
Local Authority foster care but not in Part 3 residential accommodation	1	0.02%
Local Authority Part 3 residential accommodation i.e. where care is provided	12	0.18%
NHS other hospital provider - high security psychiatric accommodation	6	0.09%
NHS other hospital provider - ward for general patients or the younger physically disabled	324	4.88%
NHS other hospital provider - ward for maternity patients or neonates	2	0.03%
NHS other hospital provider - ward for patients who are mentally ill or have learning disabilities	1	0.02%
NHS run NURSING HOME, RESIDENTIAL CARE HOME or GROUP HOME	35	0.53%
Non-NHS (other than Local Authority) run Hospice	10	0.15%
Non-NHS (other than Local Authority) run RESIDENTIAL CARE HOME	33	0.50%
Non-NHS run hospital	4	0.06%
Not applicable - patient died or still birth	585	8.82%
Penal establishment or police station	1	0.02%
Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)	18	0.27%
Usual place of residence unless listed above. This includes warden accommodation but not residential accommodation where health care is provided. It also includes patients with no fixed abode.	5604	84.45%
Total	6636	

Appendix II

Questions to Social Care providers about the discharge process prior/during COVID pandemic

A. Would you be willing to provide feedback on this aspect as a specific part of our HWB project to gather general feedback about discharge from hospital to appropriate care?

Any information they provide would be treated as anonymous in the report.

B. Did you have any patients transferred to your facility from hospital during this time (March onwards)? [Please note that this is about new patients not patients the social care provider transferred to hospital]

If NO- do you have any views about process of the hospital discharge into their facilities (social care provider) generally.

If YES ask:

1. Are/ Were you satisfied with discharge plans for patients sent to your service –
   a) Before the COVID pandemic?
   b) During the COVID -19 pandemic?
2. Were you able to cope, with the resources available during the pandemic?
3. When did the discharge happen? Time of day/day of week.
4. Did you have enough information?
5. Were you given any paperwork?
6. Did the patient/ their family know about the patients plans for discharge?
7. Any other comments?

Appendix III

Care Providers patients were discharged to from NWLHT		
ABBEY RAVEN CARE HOME	FINCHLEY MEMORIAL HOSPITAL, N1	PATIENT GONE TO COMMUNITY CARE
ALICIA CARE HOME, LUTON	GLOUCESTER HOUSE NURSING HOME	PATIENT WENT TO CLAYPOND
ASHTON LODGE	GREEN PASTURES CHRISTIAN NURSI	PETER WARD
ASHTON LODGE CARE HOME	HADLEY HOUSE NURSING HOME	PETERS WARD, HAMMERSMITH HOSP.
BARNET HOSPITAL	HAMMERSMITH	PRANAM CARE CENTRE, NORTHCOTE
BIRCHWOOD GRANGE NURSING HOME	HAMMERSMITH HOSPITAL	PRIMROSE N/H
BIRCHWOOD GRANGE, KENTON, MIDD	HAMMERSMITH HOSPTITAL/ITU	RAJ NURSUNG HOME
BRENT REHAB	HAREFIELD HOSPITAL	RESPITE KARUNA MANOR CARE HOME
BUCANNAN COURT FOR REHAB	HARFIELD HOSPITAL	ROYAL BROMPTON HOSPITAL
BUCCANAN COURT	HIGH MEADOWS CARE HOME	DENHAM MANOR CARE HOME UXBRIDG
BUCHANAN COURT CARE HOME	HILLINGDON HOSP	FINCHLEY MEMORIAL HOSPITAL
BUCHANAN COURT FOR FURTHER REH	HILLINGDON HOSPITA	NORWOOD GREEN CARE HOME
BUCHANNAN COURT	HILLINGDON HOSPITAL	OGILVY COURT NURSING
BUNCHANAN NUSING HOME	HOLLYBUSH NURSING HOME	ROYAL BROMPTON HOSPITAL/ICU
BUPA CROMWELL HOSPITAL PRIVATE	JADE WARD, EDGWARE COMMUNITY H	ROYAL FREE HAMPSTEAD HOSP
CHARING CROSS HOSPITAL	MAGNOLIA WARD CLAYPONDS	ROYAL FREE HOSPITAL
CHISWICK NURSING CENTRE HAMMER	MAGNOLIA WARD CLAYPONDS HOSPIT	RUISLIP NURSING HOME HA4 6LB
CLAYPOND FOR REHAB	MANOR COURT NH, BRITTEN DRIVE,	SANCROFT NH, 28B SANDROFT ROD,
CLAYPONDS	MANOR COURT NURSING HOME	SANCROFT, SANCROFT ROAD, HARRO
CLAYPONDS HOSPITAL	MEADOW HOUSE	ST GEORGES NH, ST GEORGES SQUA
CLAYPONDS HOSPITAL (JASMINE WA	MEADOW HOUSE HOSPICE	ST GEORGE'S NURSING HOME
CLAYPONDS HOSPITAL REHAB	MEADOWSIDE CARE HOME, N12 7DY	ST LUKES
CLAYPONDS, ROSEMARY WARD	MICHAEL SOBELL HOSPICE	ST LUKES HOSPICE KENTON 020838
COLLEGE HILL RESIDENTIAL HOME	MIDDLESEX MANOR NURSING HOME	ST LUKES HOSPICE KENTON ROAD
COPLAND CARE HOME	NAZARETH CARE HOME	ST LUKES HOSPIECE
COPLAND NURSING HOME - WEMBLEY	NEEM TREE CARE CENTRE	ST.DAVIDS HOME

Care Providers patients were discharged to from NWLHT		
TEMP:-COPLAND CARE HOME HA0 2E	WILLEDENE HOSP ROBERTSON HOUSE	WILSMERE HOUSE CARE CENTRE
THE PATIENT WENT TO BUCHANNAN	WILLESDEN	WOODLAND
THE PATIENT WENT TO CLAYPONDS	WILLESDEN COMMUNITY HOSPITAL	WOODLAND CARE HOME
TRANSFERED TO JEWISH HOME IN I	WILLESDEN HOSPITAL	WOODLAND CARE HOME.STANMORE
TRANSFERED TO RUISLIP NURSING	WILLOW HOUSE	WOODLAND HALL
VICTORIA CARE CENTRE	WILS HOUSE CARE HOME - SEE DRY	WOODLAND HALL CARE HOME
VICTORIA CARE CENTRE ACTON LAN	WILSMERE CARE CENTRE	WOODLAND HALL REHAB
WELLIGTON HOSPITAL	WEXHAM APRK HSOPITAL	

The care providers HWB contacted:

Enter & View -Provider Name
Tulsi House
Arran Court
Avonhurst
Rosemary House,
Willow House,
Christ Church Court,

Name of Supported Living Scheme Providers		
167 Willesden Lane CMG	Precious Homes	Brianwood House, Voyage Care
Rugby Avenue CMG now known as Aspire Together	Precious Homes	Visram House,

Care Providers		
16 Balnacraig Avenue (The Leaves)	Franklyn Lodge.	Pettsgrove Care Home
24 Fortune Gate Road,	Homefield Court	Preston Lodge
Ashton Lodge, London,	Jerome House	Randall House
Birchwood Grange Nursing Home	Jude House	Real Life Options
Boniville House	Kenbrook	Riverview Lodge
Brook House	Kenton House	RNID Action on Hearing Loss Brondesbury Road
Carrick House Nursing Home	Lawnfield House	St Mungo's Broadway - 53 Chichester Road
Chalkhill Road	Lee Valley Care Services Limited	Tanfield House
Choice House	Matthew Residential Care Limited	Towerhouse Residential Home
Clarendon House Residential Dementia Care Home	Meera House Nursing Home	Victoria Care Centre
College Road Care Home	Middlesex Manor Care Home	Willesden Court
Coplands Nursing Home	Milverton Road	
Dana House	Ogilvy Court	

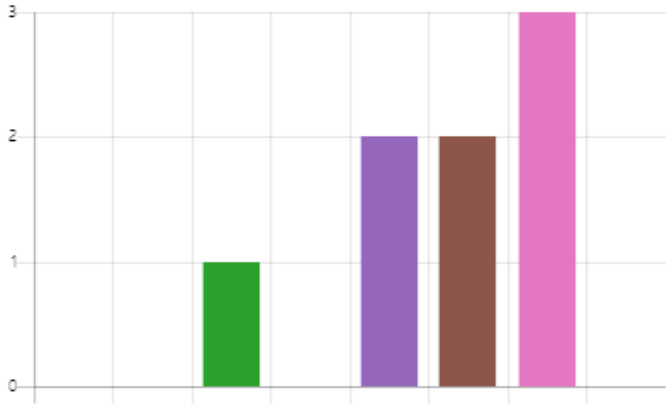
Appendix IV

Demographic of survey respondents

Age Profile

Please tell us which age category you fall into Please note that we cannot accept responses from anyone aged under 13 years.

13 to 15 years	0
16 to 17 years	0
18 to 24 years	1
25 to 49 years	0
50 to 64 years	2
65 to 79 years	2
80+ years	3
Prefer not to say	0



Ethnicity

Please select your ethnicity from the list below

Arab	0
Asian/Asian British: Bangladeshi	0
Asian/Asian British: Chinese	0
Asian/Asian British: Indian	1
Asian/Asian British: Pakistani	1
Asian/Asian British: Any other ...	0
Black/Black British: African	0
Black/Black British: Caribbean	1
Black/Black British: Any other ...	0
Gypsy, Roma or Traveller	0
Mixed/Multiple ethnic groups:...	0
Mixed/Multiple ethnic groups:...	1
Mixed/Multiple ethnic groups:...	0
Mixed/Multiple ethnic groups:...	0
White: British/English/Welsh/S...	3
White: Irish	0
White: Any other White backg...	1