healthwatch Brighton and Hove

Healthwatch Brighton and Hove Hospital Discharge Wellbeing Project (HOPs)

April 2020 to January 2022

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The Healthwatch Brighton and Hove, 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 of March 2022 - with oversight from these organisations and Sussex University Hospitals NHS Trust. The project has been funded for 2021/22 on the understanding that during that time NHS and City Council Commissioners will be looking at this and several other projects in the City that seek to support hospital discharge and discharge to assess [D2A].

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, Together Co, and the Carers Centre supporting this project.

People are phoned by Healthwatch trained volunteers within a few days of discharge from hospital, often in the first week or ten days. 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

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 Brighton and Hove residents 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 19th March 2020, The Department of Health and Social Care (DHSC), published its guidelines for the NHS and local authorities for hospital discharge in the context of the COVID-19 pandemic: 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. The process is known as Discharge to Assess [D2A], see: quick-guide-discharge-to-access.pdf

- ✓ 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.

In October 2020 Healthwatch England and the Red Cross published a report into Hospital Discharge across England, see hospital-discharge-must-be-improved-manage-covid-19-second-peak. The Healthwatch Brighton and Hove HOPs project was cited as a national exemplar of good practice, capturing a moment soon after hospital discharge for a quick, friendly, and supporting phone call. One of the recommendations of that national report was that similar services should be established nationally.

On the 9th and 11th of February 2021 the Local Government Association [LGA], The Red Cross and Healthwatch England held national webinars on hospital discharge to share the lessons from the October report and encourage improved and joint Commissioning in this area. Over 700 people attended the webinars. The HOPs project was one of three exemplars of good practice presenting.

Following the HWE & Red Cross-national report and the LGA webinars 6 different health and care Integrated Care Systems around England, and one on Scotland, have contacted Healthwatch Brighton and Hove to learn more about the project and to receive free advice and copies of all our materials to help them establish similar services. At the time of writing this report Healthwatch are seeking charitable funds to promote locally and nationally the simple but effective 'friendly phone call' after hospital discharge or other major health and care events.

Performance summary

April 8th 2020 to January 21st 2022

- 6530 people have been referred to the project with 4279 allocated to our volunteers for phone contact.
- 2404 successful contacts = 56%
- 1874 people we could not reach, 857 attempted but unsuccessful calls – 992 referrals had wrong information, or we were unable to contact for other reasons; patient in a care home or deceased, readmitted to hospital
- At any one time around 100 - 150 referrals will be active, in the hands of volunteers or waiting to be allocated to volunteers.
- Average of 204 referrals passed to volunteers each month.
- 681 people 30% had concerns, 542, 23% were referred for some additional community support
- 553, 23% of people had some issue or concern related to their hospital discharge

1776 referrals were not allocated because a 3-week deadline on making calls post discharge was exceeded, a measure we put in place to handle capacity issues when referrals peaked. The remaining 475 not allocated were for issues such as out of area, or incorrect data.

HOPs actively supported 2404 people from April 2020 to January 2022. An additional 262 were referred but were living in a Care or Nursing Home by the time we contacted them, 153 had been re-admitted to hospital. A relatively small number of people 201 were referred without the information we need to contact them.

People we have called several times but who have not responded to calls or messages 857 represents 19% of all referrals. That has remained steady over the life of the project as we settled into a routine of 100-150 referrals a week. Of the people we were unable to contact 172 were passed onto their GP surgery for follow up care that could be provided or arranged by primary or community health care services.

From the 2404 people actively supported 542 people, 23%, were proactively referred on by Healthwatch for some form of community support, 1862, 77% people were supported during the phone conversation, signposted to advice or information, or needed no further assistance. 95 to Possibility People, 56 to the Aging Well Service, 55 to Together Co for befriending, 96 to the Carers Hub, 52 to the Brighton and Hove Community Hub, 144 to their GP, 162 to unspecified Voluntary and Community sector services [reflecting the diverse VCS offer in the city].

373 people 17% identified as having mental health problems with 50 being referred on for urgent support.

We had 64 safeguarding issues and 167 people identified as having additional communication needs, due to dementia, sensory or learning disability.

553 [23%] people – had questions or issues post discharge. This % has reduced over time and was 28% between April 2020 and April 2021. Of the 553 people with questions and issues post discharge of these. 95 = Care Package, 95 = a physical issue, 113 = a service or appointment, 80 = pharmacy or medicines, 36 = equipment, 270 = unspecified [we need to investigate this group further, it includes a variety of comments from volunteers = complaints, missing paperwork, COVID Test queries, confusion, financial benefits queries]

181 [8%] people were redirected back to the Hospital Discharge hub either signposted or we referred on their behalf.

681 people told us they did not have the support they needed: 909 concerns registered [some folks with multiple concerns] 44 needed food supplies, 110 needed help paying for food, 74 people were concerned about COVID, 109 felt lonely or isolayed,90 required social care to support their health needs, 41 were unable to exercise and 35 were worried about being unable to support someone else.

Of those Healthwatch interacted with, 56% were Female, 43% male 1% preferred not to say/unspecified, non-binary or Cisgender.

43% – had long-term health or disability issues lasting more than 12 months.

503, 22% – are unpaid carers or have someone supporting them, of those 76 people wanted to get additional support from the Carer's Hub.

84% 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 99%, No 1% - for those who answered 'No' the call was ended].

There were 4 instances where the hospital discharge did not seem to have been managed well and issues were escalated for investigation, these were all resolved quickly and satisfactorily, none since August 2020. This provides a high level of assurance that despite the pressures of COVID the hospital discharge system remains safe. 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.

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 23% of people referred on for some sort of community support, note that is has remained almost the same irrespective of the varying impact of COVID over 20,21 and now the beginning of 2022 and 28% having issues post discharge, and 23% having issues or questions post discharge hospital discharge. 16% of people telling us they do not have the support they need with over 900 responses made indicating some multiple needs. There is some evidence that hospital discharges and subsequent community support are not always managed well, see: 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 manged without this, without doubt Healthwatch have prevented hospital readmissions."*
>
> A senior nurse

> *"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 worked with the BSUH Discharge Hub 2020/21

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 4297 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, 43% had long term health conditions and 22% had unpaid carer responsibilities or someone helping them, 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 HOPs 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.

1.2 Public and Patient confidence in the service

Client accepting the call = 99%
Call was helpful = 97%; extremely or very helpful = 66%

Permission to check back in a few months = 75%

1.3 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 were running at 160+ per week by mid-September 2020. There was dip in referrals in May, June and July 2021 possibly associated with administration staff at BSUH being on leave, perhaps demonstrating the vulnerability of the project. The progress of the COVID challenge to the NHS acute system has caused referrals to vary over time and we expected these to settle down at 50-100 referrals a week. Referral numbers have been stable since October 2021.But early indications are that the numbers have risen in January and will continue to rise this year.

Forward projection of likely demand, in consultation with BSUH indicates a 'new normal', likely future routine level of demand at 50-100 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

See attached:

- Referral summary tables April 2020 – January 2022
- Activity summary tables April 2020 – January 2022

1.4 Are people made aware of the 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 80% seems to be too large a proportion for there not be some lesson to be learnt.

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, Age UK, MIND, Community Roots, the Food Partnership and many others serving communities of common interest. Social prescribing and support for people receiving direct payments and personal care budgets. As a city we have multiple serviced that support discharge to assess and social care at home.

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.

2.2 Improved experience of hospital discharge and integrated care

People welcome the HOPS calls - over 98%, only 1% 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. 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 – Discharge Coordinator, 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 was 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: Matron Integrated Discharge Team (IDT), Brighton and Sussex

"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

- 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 initial team of 5 volunteers has been expanded. We have had 55 over the life of the project. During the peak from Nov 2020 to April 2021 we had 20 volunteers per month several times. Since Sept 2021 we average 10 volunteers per month and currently have 13 active volunteers making the calls. New volunteers were recruited from the Universities, from the volunteer teams at the Royal Sussex County Hospital [RSCH], and Sussex Community Foundation Trust who provide community health services in Brighton and Hove. We have also approached the local mental health trust to include some of their volunteers and people with lived experience of mental health services. Sussex Partnership Trust have provided liaison and training support for volunteers and Healthwatch staff. 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. Many of our volunteers are also active in the local Patient Participations Groups (PPG's) that support Primary Care/GP Practices in the City, see: get-involved/ppgs.

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 approximately 8560 hours of volunteering from April 2020 to January 2022, equivalent to 245 weeks of a nurse's time and worth approximately £165,000 financial value to the public sector.

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"

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The independence of Healthwatch and the HOPs volunteers is crucial - sometimes we have to say really clearly 'This person is not getting the care they need or deserve".

5. HOPs Case Studies

Case Study 1

Mary came out of hospital without the wheelchair they went in with (mislaid 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 2

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 3

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 4

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 5

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.

6. Interview with a HOPs Volunteer

What difference do you think HOP's make to people in Brighton and Hove?

"I think for some people a call means a lot. The majority of the patients that I contacted say they are very grateful and appreciative; they say it's a nice touch to actually receive a phone call from someone who genuinely care about their wellbeing. I think HOP's is a great idea."

Have you been involved with any follow ups where you think it was able to reduce harm or potentially prevent a readmission for patients?

"So far, I haven't had any case like such. If it was for any medical reason, I would not discuss anything medical with the patient, I only encourage them to get in touch with their doctors / consultants for certainty."

When you have contacted patients / carers as part of the follow up how has it gone?

"Normally it went rather well, people are normally very open to discussions about their wellbeing, even to the extent of their medical complaints. And some carers were very grateful that we called to check in with the patients."

What do you think the risks are of not following up patients after discharge?

"I personally encountered a couple of cases that needed extra attention where the patients were very depressed and lonely, in need of some reassurance. We are living in a very difficult time and for some it is detrimental to their emotional and mental health. I honestly feel that if we could continue giving this service, it would be great for the community. It is like an extended arm of care and support."

David Liley
Chief Officer, Healthwatch Brighton and Hove

6/2/2022

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