ConnectED Briefing #10



Older people's experience of Hospital Discharge Link Workers

The issue

Section 91 of the Health and Care Act (2022)¹ introduced a new requirement for NHS trusts to involve adult patients and their carers in hospital discharge planning. This should be done as soon as possible once it is clear that the person will need care and support after their discharge. The Department for Health and Social Care² recommends the inclusion of professionals from the voluntary, community and social enterprise (VCSE) sector in multi-disciplinary hospital discharge teams and transfer of care hubs engaged in discharge planning. It does not identify a specific role for VCSE link workers.

Age UK Bristol operates a scheme in which link workers engage with hospital staff to support people to return home from hospital. They were interested in finding research evidence that might inform the development of this scheme.

What we wanted to find out

Does the involvement of a link worker based in a hospital rather than a community setting improve the experience of discharge for older people?

What we did

We searched PsychInfo and Google Scholar for relevant systematic reviews and studies published in English since 2017.

What we found

We found a number of studies of link workers, including some examining link workers based in GP practices, but we found only one study with a major focus on building relationships with hospital staff, and having a base within the hospital as well as within the GP surgery.

This was a small, qualitative study³ of the impact of hospital-based Personal Independence Coordinators (similar to Age UK Bristol's 'Link Workers') employed by Age UK to implement person-centred discharge for older people in two Pathfinder projects: one in Cornwall and the other in North Tyneside. The study focused primarily on the Cornwall site, which was the only one fully implemented during the evaluation period. The evaluation included interviews with key stakeholders and tracked the experiences of hospital discharge of five older people over a period of six months. The researchers observed and interviewed these older people, their carers and the Personal Independence Coordinators. They also interviewed other stakeholders, such as GPs.

Overall quality and completeness of the evidence

There is currently insufficient research evidence to draw reliable conclusions about the impact of link workers on the experience of hospital discharge. The included study was small and focused primarily

on issues of organisational process and implementation, and only provided details of the experiences of five older people and their carers.

What the evidence suggests

The study suggests that hospital-connected link workers can:

- facilitate improved communication between services, particularly between GPs and hospital staff;
- improve the experience of hospital discharge by attending to the preferences of older people, their particular situations, and providing a 'familiar face' throughout, and
- help to improve the wellbeing of older people following discharge by (re)connecting them with their local community and relevant services.

Improvements in the speed of discharge did not prove possible due to an absence of the timely provision of care packages, and the work required for those older people needing ongoing support often needed more than the two months nominally allocated to the Personal Independence Coordinators.

Some of the factors identified by the study as important to consider in developing a hospital-connected link worker service include:

- Establishing a base in a GP surgery.
- Identifying a key person or advocate capable of authorising decisions.
- Evidencing impact to all stakeholders.
- Taking time to build trusted relationships within discharge teams and services, and between all relevant stakeholders.
- Ensuring data governance, access and sharing agreements are in place and understood.
- Developing simple consent and privacy processes and applying them with sensitivity.
- Identifying non-medical issues and barriers that can hold up discharge and are outside the remit of hospital staff.
- Communicating to the person what to expect post-discharge and for how long (eight weeks was considered insufficient by some).

Contacts for further information

Jennifer DeKalb-Poyer (Age UK Bristol Evidence Champion): <u>JenniferDeKalb-Poyer@ageukbristol.org.uk</u> Linda Sumpter (Age UK Bristol Researcher in Residence): <u>linda.sumpter@bristol.ac.uk</u>

This briefing was co-produced with members of the ConnectED Service Users and Carers Group, Edmund Brooks and Graeme Dundas.

References

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² Department of Health and Social Care (2022). Hospital Discharge and Community Support Guidance.

³ Bashir, N. et al (2019). <u>An Evaluation of Age UK's Person Centred Discharge Pathfinder Programme</u>. Sheffield Hallam University Centre for Regional Economic and Social Research.