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ACUTE PERSPECTIVE

David Oliver: Getting defensive over patient experience in the pandemic

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In October, Healthwatch England published a report on the experiences of 590 patients and carers,¹ interviewed about leaving hospital under NHS England's "discharge to assess" arrangements from April to August 2020. Many patients and families reported that communication and implementation of discharge had been poor.

I can imagine that healthcare workers were hurt and surprised, believing that the report didn't represent their own practice, experience, or values and perhaps getting defensive over the findings. But, on reflection, I've seen several areas of cognitive dissonance between the lived experiences of clinical teams and patients in the pandemic.

First: "But I'd never do that," "Our service always checks that," or "We'd never let that happen." The Healthwatch report highlights instances of older patients being sent home late at night with no discussion of transport requirements, going home with no information on clinical contact for follow-up, or the promised community services never arriving. If patients continue to feel excluded or report delays in accessing care, it can't be going right everywhere, even if we or our local colleagues "wouldn't let it happen."

Second: "We're still working flat out—how can people say that surgeries are closed and hospitals are quiet?" Throughout the pandemic GPs have been forced to do much consultation and triage online or by phone, with fewer face-to-face appointments, and the same applies for hospitals. The GPs I speak to are clear that the bulk of appointments they offer are for the same or next day and that they do personalise appointments. Hospitals and GPs have never been "closed" to patients and have had to juggle acute pandemic demands while providing elective care safely. But none of this minimises the experience and worry for people who struggle to get appointments or advice or whose procedures or investigations are postponed.

Third: "But we did communicate all those things! How could they say we didn't?" In the Healthwatch report, findings of poor communication around discharge planning and support are as recalled or understood by patients and families, even though in our own practice we discuss and document decisions. These mismatches in perception, recollection, or documentation are common.

Fourth, the wider health system tends to conflate what we'd prefer people to want with listening to what they actually do want and trying to support their decisions. Notably, we'd largely prefer people

to remain at home (as suggested in NHS England's "discharge to assess" approach²) or to leave hospital sooner (which, happily, they often do want). Yet patients often don't feel ready to go home, are too frightened to remain at home, or feel a lack of support. This was clear in the latest Healthwatch report and its previous ones on discharge and emergency readmission.^{3 4}

We all want to deliver our best care for patients, and we also feel loyalty to our profession, colleagues, and organisations. It's only natural to feel defensive in the face of some patients' experiences or perceptions. But we'd be better off acknowledging their perspective and implementing system changes in our practice—or, when services are simply not staffed or resourced to give people what they want or expect, to be very honest about the reasons and limitations.

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- 1 Healthwatch England. 590 people's stories of leaving hospital during covid-19. Oct 2020. https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20201026%20Peoples%20experiences%20of%20leaving%20hospital%20during%20COVID-19_0.pdf.
- 2 NHS England, Department of Health and Social Care. Hospital discharge service: action cards. 21 Aug 2020. <https://www.gov.uk/government/publications/hospital-discharge-service-action-cards>.
- 3 Healthwatch England. Safely home: what happens when people leave hospital and care settings? Jul 2015. https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf.
- 4 Healthwatch England. Emergency readmissions: what's changed one year on? 14 Nov 2018. <https://www.healthwatch.co.uk/report/2018-11-14/emergency-readmissions-whats-changed-one-year>.