Healthwatch Richmond

Discharge from Hospital

April 2016

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Introduction

In November 2014 Healthwatch Richmond conducted a review of 'Compassionate Care' at West Middlesex University Hospital (WMUH). One of the most significant issues arising from this work was a concern amongst patients about the process of discharge from Hospital.

Delays to discharge have a high media presence, and are often referred to as one of the key causes of capacity issues and crisis within A&Es and are often referred to as bed blocking. It is an issue that places significant stress on the system. From a more human perspective, problems with the discharge process are the source of significant anxiety and stress for patients, families and even other areas of the NHS and Social Care system.

'What happens when people leave hospital and care settings' was also a focus for Healthwatch England's Special Inquiry, 'safely home: what happens when people leave hospital and care settings?', which was launched in July 2015. Their report found that there are five core concerns to why patient discharge was not handled properly. These included: delays and a lack of co-ordination between services; a lack of support after leaving hospital; stigmatisation and discrimination; a lack of respect due to their condition; not being involved in decisions about their care; and not having their full range of needs considered. The volume, nature and geographical spread of evidence they collected shows that problems with discharge is a significant, complex and wide reaching issue.

This project aimed to address the concerns raised by people we have previously engaged with, predominantly through our work at WMUH. Additionally, it provided us with another opportunity to reach people currently using NHS and Social Care services in the borough and to gather more local patient experiences. We were also able to work collaboratively with Healthwatch Kingston regarding patient care and the discharge process at Kingston Hospital via their Enter and View visits to the Hospital in November and December 2015.

Project Scope

The process of leaving hospital is complex. There are several different pathways out of hospital, differing between the acute and mental health trusts, and there are many stakeholders involved. This provided us with a significant challenge in gaining access to patients who have experienced this process. Due to these complexities it was necessary to place limitations on the scope of the project to ensure that it remained a manageable size.

In the initial stages of the project it became clear that discharge from the mental health trust was a very different process from that of an acute trust. We therefore limited our focus to the challenges faced by the acute trusts in the borough, recognising that an area of future work may be to focus on patients leaving the care of the mental health trust. We were however keen to engage with mental health service users to find out their experiences of being discharged from acute settings.

Discharge in Richmond

In preparing this plan we mapped the process of going home from hospital in Richmond. To do this, we read through the discharge policies from Kingston Hospital, Hounslow and Richmond Community Healthcare NHS Trust (HRCH), WMUH, South West London and St Georges Mental Health Trust and the Memorandum of Understanding between the Council and the acute trusts. Additionally we looked at data on Delayed Transfers of Care into the borough, and met with:

- Kingston Hospital
- Kingston Healthwatch
- West Middlesex Discharge Governance Group
- Hounslow and Richmond Community Healthcare Trust
- South West London and St Georges Mental Health Trust

There are several challenges to the current system. Richmond has a high number of delayed transfers of care (DToC) and ranked among the bottom 8 London boroughs for DToC between November 2014 and February 2015. It also has the second highest DToC's in South West London over the same period. Delayed transfers of care are an issue that the council and Richmond Clinical Commissioning Group are investigating, with discussions on the ground and at more strategic levels. Since April 2015 there has been a re-launch of the Memorandum of Understanding between the Council and the acute trusts on DToC.

Each trust has highlighted concerns with discharging patients. These include, but are not limited to:

- Housing (for example if the patient becomes homeless whilst in care and has nowhere to go when they leave and have to apply for housing)
- Nursing care placements
- Home support
- Social care assessments and funding (Self Directed Support/Direct payments)
- Non-emergency patient transport
- Medications
- Patients not wanting to leave hospital
- Lack of interim beds; and,
- For HRCH, some of the problems included poor provision of information on patient cognitive conditions from the acute hospitals, as well as inappropriate discharge to Teddington Memorial Hospital (TMH) for patients without rehabilitation needs.

All these issues cause distress to patients and delay transferring care of patients to the appropriate setting for their needs.

Methods

The wider Healthwatch networks have conducted a range of projects which look at shaping the discharge process across the country. The projects have ranged from online and paper surveys to enter and view visits to discharge lounges and wards.

We conducted a multi-faceted project to ensure that we gave as many people as possible the opportunity to provide us with their experiences of the discharge process and gain a broad perspective of the process and the issues. Due to challenges in accessing patients who have gone through, or are going through, the discharge process, we used our local network of contacts to connect with a wide variety of patients going through the discharge process.

We conducted 11 outreach sessions to the following organisations, engaging around 100 people:

- Linden Hall Daycentre for Older People
- The Vineyard Community Centre
- FISH at Barnes Green Community Centre
- Elleray Hall
- Sheen Lane Day Centre
- Hampton Wick and South Teddington Older Peoples Welfare
- Twickenham Wellbeing Centre
- SPEAR

Additionally, we visited the inpatient unit at Teddington Memorial Hospital, conducted an online and paper survey which was sent to contacts in organisations across the borough, conducted three visits to three wards at West Middlesex University Hospital, collaborated with Healthwatch Kingston on visits to Kingston Hospital and teamed up with the Community Nursing team from Hounslow and Richmond Community Healthcare NHS Trust to gather views and experiences of the discharge process. We also conducted semi-structured interviews with several patients.

In total we gathered 120 patient experiences of the discharge process between July 2015 and January 2016.

Summary of Findings: Patient experiences of the Discharge Process in Richmond

Communication

Information

We received very mixed responses when asking patients about their experience of the communication around their discharge. Some patients were really positive about their experience:

> *"I had all the papers when I left, everything was explained and showed me how to give medications. It was really good. All phone numbers were printed for me. I was very impressed. It's a lot to take in - especially if you're elderly. They were good at communicating with patients and family."*

Charing Cross hospital was also highlighted as somewhere patients had positive experiences. One patient commented:

> *"I was very happy with Charing Cross hospital. They spoke to my daughter about care, and she took me home. Their communication with my daughter was very good"*

> Equally, a patient at Kingston told us:*"I was given lots of leaflets, information and a comprehensive discharge summary. I didn't feel like I had been rushed out of the hospital at all."*

However, across hospitals in the area we received comments suggesting that there are challenges around keeping patients informed of their discharge. There were patients who told us that they were not aware they were going home until they were told on the day of discharge, there was no information provided and "*no one tells you much*". Others told us that they had been informed that they would be sent home soon, but weren't sure when: *"I will hopefully be told today."*

The majority of patients we spoke to during our visits to West Middlesex were happy with the overall communication about their discharge. Most seemed aware of their position in the pathway and for patients who were more uncertain, it was clear that their situation had been explained, for example "*they're waiting for some more test results*". When asked about communication from staff, responses were broadly positive. Patients told us that they were "*happy with the communication with doctors and nurses*" and "*I've been kept very well informed*". Some felt that the communication could be improved, with one patient saying "*No, I have not had enough information*". A patient who had been readmitted within a few days of discharge told us "*This time the communication about discharge has been much better and the problem I was having has been solved, I think. I feel better about going home*".

Of the patients we spoke to at Kingston Hospital, very few were aware of their discharge date or arrangements for going home. One patient told us that they were leaving that day, but they weren't aware of the arrangements. Another common concern shared was that patients didn't know what day they would be discharged. Whilst the changing nature of care for patients can make it challenging accurately to predict a date when patients will leave care, the number of patients unaware of when they may be going home suggests that there are challenges in successfully communicating with patients about these arrangements. This was also found by Healthwatch Kingston, who reported that a patient, who was unaware of the discharge date or arrangements, described the staff as "*evasive*" when responding to questions about going home.

Discharge Summary

Community nursing teams told us that they were not always provided with up-to-date information on a patient's discharge. Not being kept informed of the delays meant that nurses occasionally turn up to an empty house and find that the patient has been kept in hospital, and on other occasions patients have been discharged home without the community nursing care which they need being put in place. The nurses also said that they find patients are quite often sent home without any information on their care.

This was reflected in comments from patients, highlighting that this miscommunication is common across several services:

> *"I was due to be discharged from hospital on the Friday but there had been a miscommunication with the carer. My nephew and his wife came to stay to take me home on the Friday, but they were woken up on the Friday morning by the carer, who was a day early!"*

Staff

We were told by some patients that they had experienced problems with staff from Kingston Hospital around their discharge. One patient told us that:

> *"I didn't have any clothes or anything. I told the doctors I wanted to go home, but I was told that "if you self-discharge then you'll never be treated here again". So I stayed in hospital. The staff otherwise were fine."*

Another patient felt there weren't enough staff to provide adequate support to coordinate discharge and that staff had very little time. One patient staying at Kingston Hospital over Christmas described the delay experienced:

> *"When asked when a doctor might come to discharge [the patient] the answer was always curt, abrupt and dismissive. Several hours later, the registrar arrived and was amazed to see that [the patient] was still in the hospital. She said that she had no idea [the patient] was still there and [the registrar] had been in the ward earlier in the morning and not been told [the patient] was there."*

The Journey Home

Transfer between services

Some patients are transferred to another service following a stay in hospital before being sent home. In Richmond, patients are usually sent to Teddington Memorial Hospital, Queen Mary's Roehampton or occasionally to Greville House or another care home.

A few of the comments we received mentioned experiences of being transferred between services. Patients were broadly happy with these experiences:

> *"I was transferred to Roehampton from Kingston and this was really good", "I was discharged to Greville house for Rehab, it was a good experience", "I was in Kingston then I was transferred [to Teddington Memorial Hospital], it's been wonderful."*

During our visits to West Middlesex University Hospital, we spoke to several patients who were due to be discharged to Teddington Memorial Hospital (TMH). When asked about how they felt about being transferred to TMH, responses revealed that patients were either happy not to be going home, or apprehensive about going to another hospital. One patient expressed concerns about going to TMH, and told us that the prospect of being transferred to another hospital was a source of anxiety. These concerns were down to insufficient information being given to them on what services are provided at Teddington and what they could expect from the hospital.

We received a couple of comments where patients had problems with being transferred, which led to delays:

> *"The morning came for my transfer, I was all packed up and ready to go…then the nurse came and said I wasn't being transferred because I needed to be on antibiotics for a week… but if I didn't go then I'd lose my bed at Teddington which I had been waiting for. I couldn't understand why I couldn't be on antibiotics at Teddington. My daughter made a fuss and thankfully I was transferred and spent 6 weeks [in Teddington]."*

In some cases, delayed transfers were caused through concerns over a lack of support or equipment at home following a stay in hospital. We spoke to a couple of patients whose discharge, or relative's discharge, had been delayed. One commented that their relative had been "*Planned to be discharged to Queen Mary's Roehampton and then home, but the day changed because adaptations [seat raisers and stair rail] were not ready.*" Another patient told us:

> *"When I was discharged to the home, equipment wasn't available. There were some communication problems between the hospital and the home that led to delays. I was discharged with a UTI."*

The Rapid Response and Rehabilitation Team (RRRT) told us of the difficulties in transferring and transporting patients and of the acute settings centre getting the patient "*medically* fit" to be discharged. The definition of medically fit however fluctuates, and some patients are sent home when they aren't entirely ready. Being transferred elsewhere can impact on a patient's health, and some patients can become confused by the change in settings which can affect the speed of their recovery, particularly if they are not well enough to go home.

Waiting to go home after Discharge

Timely discharge is important both for positive patient experience and for the hospital. Ensuring that patients are able to leave at a convenient time provides a more positive overall experience.

One patient felt that there wasn't enough notice for discharge, and they would like more. We were told by another patient that they had not being given the time of day that they could go home, making planning to be collected from the hospital really difficult - their home situation meant that after a certain time of night, being discharged would be really challenging. We were also told by a patient that "*My son had to cancel a business appointment one afternoon to collect me, and as I was told my bed was needed, we were not able to make other arrangements.*"

Delayed discharge from a patient's perspective often related to waiting for several hours after being told that they could go home. Predominantly comments around this kind of delay referred to waiting for medications. Some patients told us they were released but had to wait, up to 5 hours in one case, for discharge papers. Patients who told us that they had experienced a delay said that this caused them "*stress and anxiety*".

Additionally, there were concerns about elderly people being sent home on the Friday before a Bank Holiday weekend as this could result in delay to getting the care or services that the person needed:

> *"My neighbour, who lived alone and didn't have any immediate family, was discharged on a Friday of a bank holiday weekend. They didn't have any services or resources in place to enable them to be at home comfortably and there was little access to anyone to follow up with because of the Bank Holiday weekend."*

This was supported by community nurses. In discussions with the nurses, it was reflected that they face challenges accessing support from GPs when a patient is discharged on a Friday afternoon, meaning that the patient must either wait until the following Monday, or access urgent or emergency care in the meantime.

Transport

Transport was one of the causes of people experiencing delay in leaving hospital and the cause of some readmissions.

Patients from both West Middlesex and Kingston Hospitals told us that non-emergency patient transport was not available when they needed it:

> *"There was no hospital transport home for me, so I had to get a taxi"*
> *"I had to wait 3 hours, and in the end had to get a taxi at my own expense."*
> *"I was discharged in a dressing gown and had to get my own taxi home, as transport was not available."*
> *"I had to wait for 6 hours to be taken home, then it was too late."*
> *"I was taken home at 4am in an ambulance"*

One family member told us that they went to collect a relative who was booked for hospital transport; they waited hours for transport, and when the patient was finally able to go home, the family member was told they could not accompany the patient, despite the transport being otherwise empty. The patient finally arrived home, became unwell, and was readmitted within a few days.

The West Middlesex discharge governance group told us that a safeguarding concern had been raised after a patient with dementia had been booked hospital transport to be taken home, but the transport provider had arranged a taxi to complete the journey. The patient had then been dropped somewhere other than at the home address, and was later found wandering around. West Middlesex told us that following a full review *"additional safeguards have been put in place to ensure that this does not occur again."*

However, transport was not always a concern for patients: "*In the last few weeks I have been in Charing Cross hospital four times and the care in taking people home by transport has been exceptional.*"

Medications

We received a significant number of comments from patients about hospital pharmacy and medication. The majority of these comments related to the time spent waiting for medication before being discharged: "*When you're in hospital and told you can go home you spend all your time hanging around for medication. It's always down to pharmacy not bringing medications. It takes too long*".

A couple of patients said that the purpose of medications was not always explained, and that overall there was not enough time dedicated to discussing medication. One patient told us that they did not have an organised review of their medication, as *"the nurse arrived just before discharge with little time to check medication or ask questions."*

During our visits to West Middlesex in December 2015 we found that most patients were happy with the information they had been provided around medication for discharge: *"Meds info is getting sorted"*. One patient told us that everything had been discussed with them around discharge and medication. Two patients told us that no-one had mentioned a change in their medications, but they would either ask or were expecting to be told if their medications had changed. Patients at Kingston Hospital are reported in Healthwatch Kingston's Enter & View reports as saying that changes in medication were well explained, and they felt reassured by the communication from staff.

Occupational Therapy and Equipment

Occupational Therapists are professionals that, amongst other things, undertake assessments of people's homes and arrange for equipment to assist them with activities of daily living such as using the toilet and having meals. The Occupational Therapist (OT) checking a patient's home to see if it is suitable was, across the borough, generally viewed as a positive experience:

> *"I'm hoping to go home soon - the physio said they're going to get me mobile. They're going to test my home and see if it's OK to go back. Then we're just waiting to hear about X-rays."*

Teddington Memorial Hospital's discharge process was highlighted as a very positive experience by patients there:

> *"I'm apprehensive about leaving, but looking forward to going home. I'm glad they've checked everything. I was taken home yesterday and we checked everything was in place. I've got a carer coming in morning and afternoon to help with everything."*

One patient told us that

> *"The Occupational Therapist came to prepare things at home for me – I was given items to make the transition home easier. Some of the things I had to pay for. I had a few things fitted by Medequip, this was all good. The occupational therapist told me I'd be having a carer and gave me the dates. I also had physio appointments booked and was given exercises to do."*

However, problems were experienced by some patients following occupational therapy assessments of their home, in having equipment fitted to ensure their discharge could take place:

> *"I needed somebody to be home for workmen, my son had to take a day off work to wait for Medequip but they never showed up. I will need him to take a further day off work to be able to let in Medequip to make the necessary changes to my house, then I will be allowed home. The problem with the workmen from Medequip isn't just something that affects patients. It affects the family as well."*

Finally, we received a comment from a double amputee who said that the treatment at Queen Mary's had been exceptional. However when it came to being discharged the patient was provided with one day's notice and sent home without their prosthetics. They also experienced challenges with their home environment, which was not suitable for their condition, but it took over a year for modifications to be made.

Community Nursing Supplies

Community Nursing teams told us that one patient came home with an empty oxygen canister and that some patients are discharged without the right dressings or without enough dressings. We were told that the nurses need at least a week's worth of dressings to be able to order the right supplies. They also felt that the families needed basic information on how equipment works.

Nurses also commented that a common issue with information provided about equipment is that when a patient is fitted with a catheter, the teams are not given the date of when the catheter was inserted in order to know when to change it. They also commented that patients aren't provided with enough information about catheters.

One of the problems highlighted by the community nursing teams was that the hospitals don't take into account the cost of ordering equipment, and that there is a higher cost of ordering equipment within 24 hours of discharge. They also told us that there is often not enough information provided about requirements for the equipment, for example the weight of a patient, which can be important in ordering the correct items for the patient.

Sending patients home alone

A number of people we spoke to had reservations about going home. Most were concerned that the hospital had not consulted with their family or carers, and they were going to be discharged without anyone knowing. A frequent comment collected was: "*The hospital didn't offer any other help, and they had no idea my friend existed*".

Patients and relatives also expressed fears that the hospitals hadn't checked whether the patient had any help at home before discharging them without support arranged:

> *"When it came to going home, the ambulance came to collect me and I asked if anyone had told my next of kin that I was leaving the hospital. They couldn't tell me. It appears that no one had been told that I was going home. In the end I was kept in an extra day. The following day they were going to send me home at 2pm but I wasn't collected until 3:30pm. The ambulance came to take me and I got home at 4pm. My carers and next of kin had been expecting me just after 2pm so by the time I got home they had gone. They had left me some milk and food etc. which was good. It also transpired that my next of kin had been told about my discharge the previous day but the information hadn't trickled through and I didn't want to be sent home to an empty house with no milk."*

In this case, the patient could have gone home earlier had appropriate communication taken place. On another occasion we were told that Kingston hospital did not consider the kind of familial support available to an elderly patient, who was discharged home to be cared for by another elderly relative, and was not granted any extra support.

We were told that many elderly people live alone in the borough and about the importance of ensuring that care is in place for these people when they are discharged; that there is food in the fridge, a neighbour is informed, and that patients are provided with a number to call if they need help. We heard several accounts from patients where this had not happened. Similar concerns were also identified by Healthwatch Kingston in their November and December Enter & View visits to Kingston Hospital.

Care after Discharge

Coordination of care following discharge was one of the issues patients highlighted when asked about their experiences, particularly from Kingston Hospital. One patient told us:

> *"I went into hospital having had a stroke. They tried to discharge me before my house was ready - with my relatives constantly saying that basic things weren't in place to help. There seemed to be very little co-ordination for the discharge - particularly since I had just had a stroke."*

A patient's relative told us that they may have to give up work to care for their father. We also heard that one patient had been on the ward for 6 months while a care home place was sought for them.

Another patient told us:

> *"When I was discharged from hospital the care and advice was non-existent. I was promised carers and nothing happened as it should. No one seems interested in your circumstances i.e. is there anyone to help you when you get home? Give info about your medication, see if you need more, if you can manage to look after yourself, advise you to get you a taxi card or get a Disabled Badge etc. I managed because I made it my business to ask around for help and advice before I went into hospital as my operation was planned, but this is not always easy. Not everyone would do that - it is too often assumed that the hospital will sort this out."*

During a brief conversation with a staff member at Teddington Memorial Hospital, they mentioned that "*it'd be good to have an advocate or someone who can call after discharge, a week or two later, to check up on the patient.*" This was echoed by a patient who had been sent home from Kingston Hospital "*I would have appreciated a phone call from the ward to check my situation immediately post-discharge.*"

Communication from hospital to patient, especially from Hospital to GP, is crucial but is very variable between different hospitals, departments, consultants and services.

We received mixed comments about the GP involvement following discharge. One patient felt that "*Once sent home from hospital, the doctor's surgery do not take any interest.*" But equally another patient told us that *"I had to see the nurse at my GP. All my notes went through - they were all on my discharge papers. Good follow up."*

One commenter felt that a key person is needed who speaks to the GP and speaks to people. "*We need better communication. E-mails these days don't always get a response; it's very impersonal. The key people don't speak to each other – this is not what used to happen.*"

Referrals

We spoke to all the community nursing teams across the borough. Nurses told us that they often don't get referrals, or the referral goes through after the patient has been discharged. They also told us that when a referral does come through, information on it can be illegible, missing or incomplete. The nurses also told us that abbreviations have been used on the summaries which they do not understand. Without enough specifics and relevant information, nurses are unable to put in place appropriate care.

We were also told that the acute trusts occasionally assume that previous community nursing patients will automatically receive services following hospital discharge. In reality, when these patients go into hospital they are discharged from the community nursing teams and require re-referral. Additionally, the nurses often find they are not informed when a patient goes into hospital.

During our conversation with the Rapid Response and Rehabilitation Team (RRRT), we were told that there is not always good communication between the acute trust and RRRT over the patient's condition when transferring them. This is particularly important regarding information on a patient's cognitive behavioural issues, their mobility and their treatment as not having this information causes problems with care and treatment after discharge.

A possible solution to the problems of referral is being implemented to improve communication between the wards and the community nursing teams. The Discharge Governance Group at West Middlesex informed us that each ward within the hospital has a dedicated mobile phone for queries from community nursing teams to enable them to clarify any information missing from referrals or to answer any queries about patients recently discharged from care.

Outpatient appointments

Some patients expressed concerns about the care they received following discharge. We received several comments from patients concerned with the number of their outpatient follow-up appointments that had been cancelled, or turning up to outpatient clinics which *"didn't have any notes or any idea of what has happened."*

In looking at the wider data which Healthwatch Richmond has collected on services in the borough, outpatient appointments appear as a significant concern to Richmond patients. The majority of comments about outpatient care relates to poor experiences of administration, particularly problems with the appointment booking system. Sometimes this can leave people concerned about whether they have had the care they need or whether they still need care. Some people had to chase appointments, others encountered problems if they needed to change an appointment or could not attend (even for medical reasons). Patients also told us of issues with the communication between GPs and hospitals leading to significant delays for patients receiving care. Additionally, patients seem to be pushed to the back of the queue when things go wrong, and some people felt that it took too long from referral to appointment.

Readmission

The patients with the most to tell us about their experience had been readmitted following a recent discharge. The reasons for the readmission varied, from a patient feeling that they were discharged too early without their problem being solved and were told to "*get a referral from a GP for treatment*", to a patient developing an infection from surgery which required further inpatient treatment. One patient said they had "*been in and out of Kingston Hospital twice in the last two months and both times I have been sent home very unwell.*" Another patient told us that:

> *"I couldn't walk - but I couldn't use a commode (because I thought it was undignified, I would rather use a toilet) so I dragged myself to the toilet. Because of this, they thought I could walk so they discharged me. I had a friend who came and helped at home - not everyone has this, I was lucky. The hospital didn't offer any other help and they had no idea my friend existed. I was in pain but determined. I am sure I was discharged too early. No one looked into why I was unwell in the first place. We didn't know what was wrong. I was then readmitted again later the same day as I was unwell. I was only there for a day, then I insisted I went home."*

The relative of a patient who had been readmitted to the hospital felt that there was so much pressure on beds that the *"bed management people are just interested in getting rid of people as soon as possible."*

Several people we spoke to had actively delayed relatives' discharge. One relative did so because *"I considered my 86 year old mother unfit to leave"*, and other patients told us they had been discharged from hospital before they should have been, leading to their being readmitted, often within a day.

One patient felt they had been in danger of being discharged from West Middlesex for a second time without properly resolving their issue. They told us that their family fought for them to stay in hospital the second time around as they weren't well enough to carry out their role within the family at home. They were eventually booked in to a bed in Teddington, and felt much happier about this. They said that, had they been told to go straight home, they would've ended up back in hospital.

When discharges go well

Whilst the coordination of care can be challenging, it doesn't always affect a patient's experience negatively. We spoke to many patients who had very little to say about their discharge experience, other than saying it was "*fine*" and "*no problems at all*". Several people we spoke to were happy with the service they received following their discharge:

> *"They were more than helpful. Therapy was arranged when I got home, and I had lots of help from my son and neighbours. I was well cared for."*

> *"I had a lot of help. Social Services cared for me until I settled at home, then physiotherapy came to help me. I have a lot of faith in Kingston Hospital. I was treated very kindly and was helped greatly."*

One patient told us that, despite the carer arriving the day before their discharge, *"the carers were fantastic. I had a really good experience."*

West Middlesex University Hospital Discharge Governance Group

In April 2015 West Middlesex University Hospital set up a group dedicated to discussing discharge cases across the hospital. The West Middlesex University Hospital Discharge Governance Group consists of hospital staff from Nurses, Matrons, Occupational Therapists and Physiotherapists to District Nurses, Social services (from both Richmond and Hounslow) the Rapid Response and Rehabilitation Team, and organisations from the voluntary sector. The group currently meets every six weeks. The purpose of the group is to highlight recent challenging cases of discharge, and discuss around the table and across organisations how any problems arising can be resolved and how similar situations could be prevented in the future. Through this group a new discharge checklist has been drafted and implemented and a variety of actions, from improving communication between ward staff and families to improving connections between the wards and district nurses, are ongoing. Other concerns have been highlighted through this group, such as patients being sent home in hospital gowns, and issues surrounding Medequip installing equipment.

Help from hospital to home

The new Age UK Richmond 'Nightingale Service' was mentioned as a potential bridge in ensuring a dignified and timely discharge for patients. The Nightingale Service has been working predominantly with Occupational Therapists to assist in discharging patients from the hospital wards, and discussions with staff at West Middlesex hospital revealed it to be a positive step towards improving discharge for elderly patients. Similar services exist in other areas and are provided by other organisations.

There were calls from patients and staff at providers for a service which provides non-clinical support, to act as a patient's "*advocate*" or to "*to check [the] situation immediately post discharge.*"

Conclusions and Recommendations

We acknowledge that there are significant pressures on hospitals and staff in successfully discharging patients, and there are challenges in needing to ensure that discharge works effectively for the hospital as well as patients. We also acknowledge that the discharge process is complex and that implementing system wide changes presents a significant challenge. Through this report we hope to highlight areas which would benefit from improvements, and pose questions to providers about how these changes could be achieved.

We found that a number of our overall findings correlated with Healthwatch England's Special Inquiry findings. We identified that people were experiencing poor coordination between services and lengthy delays; that patients felt they did not have the support they needed following discharge; and some patients did not feel that they had been given the information they needed about their care and discharge.

Information about, and support following, Discharge

An overarching theme throughout the data is the lack of information provided to patients; for example "*I couldn't understand why I couldn't be on antibiotics at Teddington*". Additionally, throughout the report we have provided examples of patients who have experienced challenges with communication, transfers between services and care following discharge.

Poor communication between services and the patient can also lead to delays in discharge, as highlighted by the patient who told us that:

> *"…it also transpired that my next of kin had been told about my discharge the previous day but the information hadn't trickled through, and I didn't want to be in an empty house with no milk."*

This shows that there is a need for extra, non-clinical, support for discharge into the community. Patients and staff across organisations mentioned the "*need for an advocate*" and there is a clear gap in support where people require assistance to transition from hospital home, who may not have that support through their family.

Recommendation 1

We recommend to West Middlesex and Kingston hospitals that they ensure that patients are kept informed about their discharge as this can reduce the stress and anxiety often felt by patients who feel left in the dark, even when there is no new information to share.

In December 2015 Healthwatch Kingston recommended that Kingston Hospital "***inform/reassure elderly, vulnerable patients as early as possible about carers/help at home schemes upon discharge***".

West Middlesex University Hospital told us that they are *"developing an information leaflet explaining the discharge process to patients. There is also a daily Discharge Meeting which looks at patients who are due for discharge over the following three days. This helps to provide a focus for the nurse in charge of the ward to ensure that discharge dates are effectively communicated to patients and families."* We were also told that work was underway to ensure that *"appropriate Estimated Dates of Discharge are set at the point of admission and these are communicated to the patient and family... led by the Medicine Bed Management Steering Group.*

Kingston Hospital told us that *"a programme of improvements will be incorporated into the refresh of the annual inpatient experience plan due in spring 2016"*. We look forward to seeing this plan and the greater clarity it will provide on how Kingston Hospital will improve communication with patients around discharge.

Recommendation 2

We recommend that information about Teddington Memorial Hospital is given to patients being transferred there; as this was a source of concern for patients at West Mid.

West Middlesex Hospital told us that *"Since October 2015 the RRRT have been providing in-reach to West Middlesex Hospital to support the smooth transfer of patients to Richmond services in a timely manner [and] that patients being transferred to other establishments such as Teddington Memorial Hospital are fully informed about the experience they can expect."*

Both Kingston Hospital and West Middlesex Hospital told us that they are producing written information that is given to patients regarding Teddington Memorial Hospital.

The hospitals should note the crossover around producing information for patients and avoid duplication by ensuring that only one leaflet is produced.

Recommendation 3

We recommended to the hospitals that they provide patients who live alone with additional support to transition more successfully from hospital to the home.

Both Hospitals told us that they already had some provision for ensuring that there are basic amenities in the home, such as a pint of milk, including making referrals to the Nightingale Service. In addition Kingston Hospital have a *"hospital to home scheme"* delivered through its volunteering strategy – something that they are seeking funding to continue into 2016/17. **West Middlesex Hospital** report that they have *"approached Waitrose social responsibility programme to provide provision packs for patients on discharge."*

Poor coordination between services

Communication with professionals

A significant challenge highlighted throughout this report has been the clear gap in effective communication between services, predominantly from the hospitals, to care provided in the community (Nurses, GPs and occasionally care homes).

The nursing teams spoke of not having enough detail about the treatments that are being provided, finding that a patient has been kept in hospital after their expected discharge date, or has been discharged without their knowledge.

The RRRT spoke of the challenges in communication between providers when transferring patients with cognitive behavioural issues, or information on rehabilitation treatment provided in the acute settings.

Patients spoke of poor communication between services leading to problems, including care plans not being in place in time for their discharge, community care not turning up, and GPs not having information about changes to prescription medications following a stay in hospital.

Whilst we acknowledge that patients care is complex and things don't always go to plan, it is particularly important in these situations for good communication to keep those involved aware of any changes that have been made.

Recommendation 4

We recommended to hospitals that they will improve the communication between services, particularly with GP practices and community care staff and asked them to explain any actions that they are already taking in this area.

West Middlesex Hospital told us that their Discharge Governance Group has been a positive step towards improving communication methods between providers and this is something that will be extended across their other sites. We recognise that this has contributed to creating an open forum for connections to be made across organisations and an environment where concerns can be raised and resolved and see this as a positive process.

Kingston Hospital referred us to their *"Faster Flow, Safer Care"* programme as their process for improving communication which included the implementation of a structure for managing delayed transfers of care involving hospital and staff working in health and social care in the community. Whilst this is a very positive programme we note that Kingston Hospital's programme predates this report. The patient experiences collected in this report demonstrate that further improvements still need to be made.

Equipment

The comments received regarding equipment and the installation of equipment suggest that this area is a cause for concern. We acknowledge the challenges in the provision of equipment and understand that, at West Middlesex, there is work being undertaken to review this.

Equally, effective timing of services is also important when, for example, equipment has to be installed. This is particularly true for patients whose family members have had to make special arrangements to enable the equipment to be installed.

Conversations with the community nurses also stressed the importance of being provided with more warning and information when equipment, such as a hospital bed, is required because of the higher cost of ordering equipment within 24 hours of discharge. This view was reflected in conversations at the West Middlesex Discharge Governance Group meeting.

Recommendation 5

We recommend that providers review the provision of equipment for patients in the home. Additionally, we recommend that the acute settings provide more than 24 hours' notice to community nurses on equipment that they need to order for patients due to be discharged.

Kingston Hospital reported that they endeavour to provide sufficient notice when patients need equipment, but that patients are sometimes in hospitals for less than the time it takes to order equipment.

West Middlesex Hospital told us that providing patients with smaller items of equipment from an on-site store can minimise delays and that the discharge governance group has also developed a checklist to ensure that equipment is ordered in time to reduce late notice costs.

The Nightingale service was also cited as having *"proved extremely beneficial in reducing delays in terms of equipment provision through their willingness to accept equipment on a patient's behalf"*.

Medication

We note that there is a significant delay on the day of discharge for patients waiting for medications to come through from the pharmacy.

The West Middlesex Discharge Governance Group acknowledged this as a problem and identified an action to enable pharmacy to have a patient's dosette box ready 48 hours before, where possible. The work in improving the delivery of medications for discharge is ongoing.

Recommendation 6

We recommend that providers review the length of time it takes for pharmacy to deliver medications to patients being sent home, identify the underlying the main causes and improve the process.

Kingston Hospital told us that they have expanded the pharmacy service in the Acute Assessment Unit, including at weekends, which has improved dispensing. They also note the importance of doctors completing prescriptions promptly, and have implemented a patient tracker to identify the expected date of discharge.

West Middlesex Hospital told us that improving the delivery of medication for discharge was raised by the CQC following their recent inspection of the site. As a result of this, there are several specific actions taking place:

- A working group established to review the process for medications to take home
- Involvement of Pharmacy within the Discharge Governance Meeting to discuss medication administration and assessment.

Non-emergency patient transport

We received a number of comments regarding non-emergency patient transport from all providers, with the most concerning comment collected being a safeguarding concern. Non-emergency patient transport is an important part of discharge, supporting patients to return home safely. Flexibility around patient circumstances is important, particularly for older patients.

Recommendation 7

We recommend that the hospital reviews the provision of non-emergency patient transport and provides us with assurance that transport is being delivered appropriately.

Kingston Hospital told us that *"The Trust has recently undertaken an extensive review and retendering of non-emergency transport provision. A new supplier of non-emergency patient transport commences on 29th February 2016. We will continue to monitor the performance of this provision going forward."*

West Middlesex Hospital told us that *"with improved discharge planning a more co-ordinated approach should be possible with transport. This would also enable, where possible, relatives and carers to be involved in supporting transport home. This may include patients being taken home by relatives where possible."*

Outpatients

A few patients provided us with comments and concerns about outpatient appointments. Whilst this falls outside the scope of this project, when looked at alongside other comments collected it is clear that there are some significant concerns around outpatient appointments. This may be an area of future work for Healthwatch Richmond to explore.

Conclusion

The responses to our recommendations provide us with some assurance that discharge may improve for local people. A key driver for improvements seems to be the Discharge Governance Group and the specific and targeted actions that are delivered by this group. This may be an important piece of good practice from which others can learn – and indeed it appears that Chelsea and Westminster NHS Trust (the wider organisations in which West Middlesex Hospital sits) are already adopting this model. Good examples of outcomes from this group include the improvement of communication with community nursing teams through the use of low cost dedicated mobile phones for queries on patients recently referred.

The future development of a better information leaflet for patients going into intermediate care at Teddington Memorial Hospital is to be welcomed in supporting people discharged there.

Much however is still to be done to improve the experience for people being discharged from local hospitals. We encourage our local hospitals and their boards to place improving discharge at the heart of their future plans, and to consider the findings of this report in their monitoring of their hospital's performance.

We shared the feedback collected through our work with NHS England, who are due to publish good practice guidance on reducing delays to discharge during spring 2016. It is expected that this will set out practical actions that local providers can take to improve performance. We will ask hospitals to meet with us once NHS England's report is published, to discuss how they will adopt good practice in relation to the findings of our report.

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- The Richmond Performance and Quality Assurance Team
- Linden Hall Daycentre for Older People
- The Vineyard Community Centre
- FISH at Barnes Green Community Centre
- Elleray Hall
- Sheen Lane Day Centre
- Hampton Wick and South Teddington Older Peoples Welfare
- Twickenham Wellbeing Centre
- SPEAR

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