

## **HOSPITAL DISCHARGE SCRUTINY REVIEW**

### **THE 'PATIENT EXPERIENCE' OF OLDER PEOPLE IN WIRRAL**



**A REPORT PRODUCED BY THE SOCIAL CARE, HEALTH AND INCLUSION  
OVERVIEW AND SCRUTINY COMMITTEE**

**FINAL REPORT**

**MARCH 2009**

**WIRRAL BOROUGH COUNCIL**

**HOSPITAL DISCHARGE SCRUTINY REVIEW**

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## **1. EXECUTIVE SUMMARY**

The review set out to assess the “patient experience” of hospital discharge in Wirral, with particular emphasis on those people aged over-sixty. This Report, therefore, aims to raise issues on behalf of residents / patients.

The bulk of the evidence for the review was gathered from the focus groups organised by Mott MacDonald (an external consultancy) and from ‘interviews’ with individual officers and representatives from the voluntary sector. The results of a survey undertaken by Wirral Older People’s Parliament regarding residents’ experience of recent stays in hospital were also used as evidence.

One of the challenges for the members of the Scrutiny Panel has been that, in recent months, considerable changes to health procedures have taken place. Inevitably, implications of the transformation have impacted on the discharge process. Given that the focus groups consisted of patients who had been discharged during June 2008 and September 2008, it is unavoidable that some of the experiences reflected in this report may have been ‘overtaken by events’.

One of the prompts for the changes which have taken place during the course of this review has been the Mott MacDonald report. The Scrutiny Panel is pleased that the review has produced evidence which has helped to inform these changed procedures. Some of the experiences and suggestions of patients identified during the focus group discussions have already been instigated. It is rewarding that issues highlighted during the review have already been acted upon.

The scrutiny Panel has made a number of recommendations. As stated in legislation, the responding organisations should make an initial response within 28 days of receipt of the report. It is anticipated that a more detailed response will be made to the Scrutiny Committee when the impact of any changes can be more fully assessed.

### **OUR RECOMMENDATIONS ARE:**

#### **A. To improve the patient experience from hospital to home through a consistent and planned discharge process by use of the following:**

- Planning for discharge should begin at the time of admission to the ward (or as soon as appropriate thereafter). The patient should be involved and be aware of how the discharge procedure will affect them. (See section 6.2.1 for details)
- Sufficient time must be available for care planning to be completed to enable successful post-discharge support. This should involve the patient / carers and, where appropriate, social workers at an early stage. (See section 6.2.1 for details)
- A ‘Personal / Home Circumstances Check List’ should be introduced. (See section 6.1 for details)
- Information, to explain the discharge process, should be made available to the patient and their family / carer in the form of a general leaflet. This will explain ‘What will happen while I’m in hospital and when I’m ready to go home’. (See section 6.2.2 for details)

- Advocates / support staff for patients with special needs (for example, learning disability, hearing impairment, visual impairment) should be included in the processes as soon as possible following the admission of the patient. (See section 6.7.2 for details)

**B. To improve the patient experience on the day of discharge and post-discharge support by use of the following:**

- Maximum use should be made of the Discharge Lounge at Arrowe Park Hospital for appropriate patients. (See section 6.3.1 for details)
- Delays in discharge due to the availability of medication must continue to be addressed as a high priority. (See section 6.3.3 for details)
- A personalised Discharge Information Pack should be established. It should be provided for every patient and their advocate / carer in an accessible format. (See section 6.3.4 for details)
- A protocol regarding transport home from hospital should be established and clearly explained to all patients. (See section 6.3.5 for details)
- All organisations are encouraged to support and make use of the 'Out of Hospital' scheme operated by VCAW (Voluntary Community Action Wirral), which is warmly welcomed. (See section 6.4.1 for details)
- GP surgeries should be informed of the patient's discharge within 24 hours in anticipation of Department of Health's proposed standard (due to commence in April 2010). The surgery should be encouraged to contact the patient on the same day that information is received. (See section 6.4.2 for details)

**C. To recognise that the principles and working practices of the discharge process should include the following:**

- No one should have to make a major and permanent life-changing decision while under pressure to vacate a hospital bed. (See section 6.4.5 for details)
- All agencies are encouraged to work together to provide better pain management services in the community. This should have the effect of reducing the number of admissions / re-admissions to hospital. (See section 6.5.2 for details)
- The patient's needs are central to the discharge process (and on-going community support). Even greater priority should be given to the provision of a "seamless" service involving staff from Acute Care, Primary Care, Social Care and the voluntary sector. (See section 6.6.1 for details)
- All sectors should continue to build capacity in primary and community care to provide alternatives to receiving care in traditional hospital settings. (See section 6.6.1 for details)

## **2. ACKNOWLEDGEMENTS**

For many people, particularly the elderly, a stay in hospital and subsequent recuperation can be a stressful, even frightening, experience and may contribute to re-admission rates. It is an event that many older people have experienced, either as a patient or as a carer. Hospital discharge is therefore an issue of great importance to many residents in our community. The Panel hopes that this scrutiny review has, in a small way, enabled some of the thoughts of residents to be heard and to be reflected in future decision-making.

The Panel would like to thank all those people who willingly agreed to contribute and to provide information to this review. In particular, the Panel thanks the staff at Wirral University Teaching Hospital who have facilitated a number of visits to Arrowe Park Hospital during the course of the review. The health community has been placed under severe strain over recent winter months as the number of admissions to hospital reached extremely high levels. The Panel recognises the tremendous effort that has been made during this time by staff at Wirral University Teaching Hospital, Wirral NHS (PCT) and the Department of Adult Social Services at Wirral Borough Council.

A major part of the evidence gathered during the review was generated by the three focus groups. The Panel is extremely grateful to the participants in those focus groups as well as to the staff at Mott MacDonald for facilitating those sessions and for producing such a detailed report. Furthermore, Wirral NHS (PCT) has supported the scrutiny review by providing the funding for that professional external support. The Panel members appreciate the support provided by Wirral NHS (PCT).

Recognition is also paid to the tremendous work that was completed by Wirral Older People's Parliament by undertaking a detailed survey of 200 residents who had recently experienced a stay in hospital. The results of their survey added a further strand to the evidence available to the Panel.

Thank you to all for your participation and contributions to this review.



***Councillor Ann Bridson (Chair)***

### 3. **PANEL MEMBERSHIP**

The Hospital Discharge Scrutiny Panel was appointed by the Social Care, Health and Inclusion Overview and Scrutiny Committee in February 2008. The purpose of the Panel is to carry out a scrutiny review of the hospital discharge process in Wirral and make any relevant recommendations for improvements.

The members of the Panel are:

Councillor Ann Bridson (Chair)



Councillor Sheila Clarke



Councillor Denise Roberts



Sandra Wall (Older People's Parliament)



#### **4. BACKGROUND AND ORIGINAL BRIEF**

During 2007, the Hospital Discharge process was recognised by Wirral NHS (PCT), Wirral University Teaching Hospital and Wirral Council as an important topic for review. Anecdotal evidence, from constituents, of issues arising during the discharge process had been highlighted to councillors. Members agreed to include this topic in the work programme of the Social Care, Health & Inclusion Overview and Scrutiny Committee. Simultaneously, Wirral Older People's Parliament were also receiving comments from residents regarding their experience of the discharge process.

A workshop was held, in October 2007, involving officers of Wirral NHS (PCT), Wirral Council and Wirral University Teaching Hospital as well as members of Wirral Borough Council. The workshop concentrated on the major issues arising from the discharge process.

The Social Care, Health and Inclusion Overview and Scrutiny Committee received a report on 26th February 2008 entitled 'Delayed Discharges from Hospital: Levels of delays and reasons and recommendations for action'. This report made recommendations for future actions and a revised discharge policy.

The Social Care, Health and Inclusion Overview and Scrutiny Committee decided to undertake further scrutiny work of this topic. As a result, the Hospital Discharge Scrutiny Panel was appointed by the Committee on 26th February 2008. A Scope document for the review, attached as Appendix 1, was agreed by the Committee in June 2008.

The Panel agreed that the scrutiny review would focus on an assessment of the 'patient experience' of discharge using a target population based on those patients who are aged over sixty.

## **5. METHODOLOGY FOR THE REVIEW**

The Panel has employed a number of methods to gather evidence, at all times recognising the importance of patient confidentiality.

### **5.1 Focus groups**

A professional consultancy, Mott MacDonald, experienced in market research, organised three focus groups with people who had been recently discharged from hospital. The patients had been discharged in either June or September 2008. In an attempt to achieve a geographical spread across the borough, the focus groups were held in Hoylake, Birkenhead and Liscard.

The broad objectives of the focus groups were to:

- assess patient satisfaction with the discharge process. Is the process as easy as it could be from the perspective of the patient?
- understand whether patients feel that they have adequate support on discharge from hospital.

A copy of the report produced by Mott MacDonald is attached as Appendix 2.

### **5.2 Meetings / Visits with officers**

A series of individual meetings has taken place at which the Panel members could discuss relevant issues with key officers from each of Wirral NHS (PCT), Wirral University Teaching Hospital and Wirral Council and from the voluntary sector. A list of individuals, with whom the Panel met, is listed in Appendix 3.

### **5.3 Representations from Wirral's Older People's Parliament**

During 2008, the Older People's Parliament has undertaken a questionnaire survey of Wirral residents who have recently experienced a stay in hospital. This survey included issues relevant to the discharge process. Although this activity was independent of the Scrutiny Committee, Sandra Wall was instrumental in organising the work of the Older People's Parliament as well as being a member of the Hospital Discharge Scrutiny Review Panel. We were, therefore, fortunate to be able to include relevant information to inform the findings of the Scrutiny Review. The Wirral Older People's Parliament report is attached as Appendix 4.

### **5.4 Written Evidence**

Written evidence was received from a variety of sources.



## 6. EVIDENCE AND RECOMMENDATIONS

Older people are the biggest client group in the hospital; most adult patients are over 60 years of age. With an ageing population, the proportion of older people in the hospital is likely to increase. It is important to recognise that many patients acknowledge having had a reasonable or good experience in hospital, including the discharge process. This is borne out by the Mott MacDonald focus groups which found that:

*“some participants had had a positive experience”.*

Comments from respondents included:

*“It was quite straightforward. I found everything was fine”.*

*“I went in from the out of hours and they were absolutely wonderful”.*

With specific regard to the discharge process, the Older People’s Parliament reported that:

*“about half of our sample were very happy with their treatment and discharge”.*

Although much of the following sections will highlight concerns and some negative experiences, it is very important to stress that these are not the majority of cases and a sense of balance must be retained.

It is also important to highlight the enormous progress that has been made regarding delayed discharges in Wirral. Whereas three years ago, it was not unusual to experience sixty delayed discharges per week, that figure is now typically in the range of three to five per week. The progress reflects the priority jointly given to delayed discharges by the Acute Trust, Primary Trust and the Department of Adult Social Services (Wirral Council). It is, therefore, predictable that delayed discharges did not feature as a significant issue in the “patient’s experience”.

The evidence and recommendations in the following sections are structured to follow the patient’s journey from home to hospital and back home again, that is, ‘The Patient’s Experience’.

### 6.1 Day of Admission (and ‘Personal / Home Circumstances Check List’)

Based on the interaction with the focus group participants, the Mott MacDonald report commented that:

*“It was clear that, for these elderly patients, being admitted to hospital can be a frightening time for patients and a feeling of vulnerability can continue through to and following their discharge”.*

Understanding the personal and home circumstances of a patient is essential to a good recovery from a stay in hospital and a successful return home. If a patient does not settle back into their home environment comfortably and safely then the possibility of re-admission to hospital is greater. A clear picture of the patient’s personal and home circumstances is, therefore, crucial in establishing whether additional support will be required either during and / or after their stay in hospital. It is proposed that a specific check list be incorporated into working practices to ensure that all relevant facts are collated. This is an issue that has already been raised by the Older People’s Parliament and a number of questions has been suggested. The use of the check list gives an opportunity for social needs to be assessed. Anecdotal evidence has shown examples of

patients having initially struggled during their hospital stay because of the lack of personal items such as glasses and false teeth. A proposed Check List is attached as Appendix 5.

It is recognised that hospital staff do collect data regarding home circumstances for some patients. Details are already collected for planned admissions using the 'Pre-Admission Assessment' form, as at Clatterbridge. However, all of this information is less likely to be collected for emergency admissions. The Check List may, therefore, be of greatest benefit for unplanned admissions. It is suggested that the Check List will be particularly useful in identifying those patients who may benefit from the recently established 'Out of Hospital' scheme operated by VCAW - Voluntary Community Action Wirral. (For further details, see section 6.4.1).

When focus group participants were asked for suggestions regarding possible improvements to the discharge process, Mott MacDonald reported:

*"Participants thought that it should be checked that all patients have support at home following discharge, it should not be assumed".*

It is hoped that introduction of the Check List will provide information for early decisions on the likely needs of patients at discharge.

**Recommendation 1 – A 'Personal / Home Circumstances Check List' should be introduced.**

**This will identify patients who may require additional practical assistance during either their stay in hospital or following discharge. Designated staff should complete the check list with the patient as soon as possible after admission and should organise appropriate actions.**

## **6.2 Planning for discharge during the stay in hospital**

The Mott MacDonald report concluded that:

*"Overall, it was apparent that the success of the discharge process varied wildly from patient to patient. Many felt they were left in the dark about the process while a smaller number were clearly well informed".*

Over recent months, changes have been introduced by Wirral University Teaching Hospital and by Wirral NHS (PCT) which will have a direct impact on the "patient's experience" of the discharge process. It is recognised that it is likely that the process will improve with the introduction of such changes as the Discharge Policy and Procedures document, the Discharge Action Plan and Patient Flow Practitioners. However, it is too early for evidence of improved "patient experience" to be collected for this report.

Nevertheless, significant challenges will remain. As a member of the medical profession commented:

*"80% of discharges from the Acute Trust are "simple". However the remaining 20% are increasingly complex and accomplishing a timely discharge from hospital for this group of patients is reliant on a number of factors, not least the coordination of different teams".*

### 6.2.1 The patient's view of the discharge process

In the summary of the Mott Macdonald report, it is stated that:

*"The main concern was the lack of consistency in the discharge process and the apparent lack of structured repeatable process and a lack of communication about the process. Often patients were left 'in the dark' as to whether they had been discharged and how long the process would take".*

Furthermore, the Older People's Parliament report quotes a respondent:

*"Explain procedures and what is going to happen. Waiting for things to happen stresses a patient. It's like waiting for a bus that never comes".*

It is clear from the evidence that different patients had very different experiences during discharge from hospital. Some patients reported good experiences; others reported poor experiences. This strongly suggests that there is not a consistent, repeatable process which is followed by staff. Reference was made at the Heswall focus group to:

*"the whole process appearing random and ad hoc".*

However, the patient needs to know what they should expect to happen and when it is likely to happen. It is often the uncertainty that can make a situation stressful for a patient.

It appears that there is recognition among professional staff that the discharge of a patient is most likely to be successful if planning commences as early as possible. This approach is welcomed by the review Panel. However, evidence from patients suggests that, as yet, this is not always carried out.

**Recommendation 2 – Consistent planning for discharge should begin at the time of admission to the ward (or as soon as appropriate thereafter). The patient should be involved and be aware of how the discharge procedure will affect them.**

**Recommendation 3 – Sufficient time must be available for care planning to be completed to enable successful post-discharge support. This should involve the patient / carers and, where appropriate, social workers at an early stage.**

### 6.2.2 Information available to the patient

Some participants in the focus groups indicated that that they did not receive adequate advance information about the discharge process and others commented that they were not prepared for discharge and going home. It is suggested that improved information flow to the patient during their stay in hospital may reduce the anxiety of the patient and better prepare them for going home. Anecdotal evidence also suggests that it can be hard for family / friends / carers to talk to anyone on the ward who had answers to their queries. Clearly, patient-specific issues can only be resolved on an individual basis.

Nevertheless, a general leaflet could be used to explain issues such as:

- the discharge process.
- the patient may be discharged by a nurse rather than a consultant / doctor (Criteria-led discharge).
- the discharge lounge and the facilities.
- car pick-up point for users of the discharge lounge.
- transport protocol.
- explanation of the Home Assessment Reablement Team (HARTs) and community care services.

The Mott MacDonald report concluded that:

*“Patients clearly felt a little abandoned during the process and requested a formal written procedure be given to all patients – how long the process will take, who makes the decision, when they will receive results and any outpatients appointments they will require”.*

**Recommendation 4 – Information, to explain the discharge process, should be made available to the patient and their family / carer in the form of a general leaflet. This will explain ‘What will happen while I’m in hospital and when I’m ready to go home’. The bedside television system may also deliver this information. This will supplement the verbal explanation given by staff, particularly the newly introduced Patient Flow Practitioners.**

### **6.3 Day of discharge**

#### **6.3.1 Use of the Discharge Lounge**

Statistics (for August to November 2008) show that the monthly level of usage of the discharge lounge at Arrowse Park is less than 15% of the total discharges. However, the figures also show an increasing trend, which is welcomed. The figures are supported by the fact that many participants in the focus groups were not aware of the discharge lounge. It had clearly not been part of their journey. During a visit to the discharge lounge at Arrowse Park, it was stated by an officer that:

*“Across the country, Discharge Lounges do not always work well because of hearts and minds. There is a need to change culture as well as physical facilities. Sometimes nurses on wards need to be persuaded to ‘let patients go’. However, real progress is being made”.*

As well as providing a formal route for patients exiting from hospital, it is understood by the Panel that greater usage of the discharge lounge should also help the Hospital Trust to better manage bed capacity. Although it may not be recognised by all patients, there does need to be a balance between maximising early admissions to an appropriate ward and the patient’s ‘right’ to stay on the ward until the final point of discharge.

One comment from a focus group participant was:

*“I was in the way and I felt that could have been sorted.”*

This is less likely to be the case if the patient is moved to the discharge lounge, having previously been informed that it is the normal process. It is important that the use of the Discharge Lounge ought to be seen by the patient as a standard part of the process rather than a “dumping ground” to leave patients when their bed in the ward is required by someone else. Nevertheless, there may be resistance from some patients as it was reported by an officer that older people can be reluctant to use the discharge lounge:

*“Older patients often like to be discharged from the ward.”*

Equally, it is fully recognised that the discharge lounge is not suitable for all patients.

Positive comments were received from those patients who had used the discharge lounge, including the comfort of the facilities. It is recognised that the Hospital Trust has made, and is continuing to make, efforts to improve the facilities in the lounge. The Panel suggests that a greater selection of newspapers and magazines may be beneficial. The Panel also welcome the support already given to more vulnerable patients by offering milk and bread for them to take home.

**Recommendation 5 – Maximum use should be made of the Discharge Lounge at Arrowse Park hospital for appropriate patients.**

### 6.3.2 Timeliness of the discharge process

The focus groups indicated that there is often a delay between the time that patients are told that they can be discharged to the point that a doctor actually discharges them. Indeed, a representative of the third sector commented that:

*"Many patients develop considerable anxiety resulting from them not knowing their discharge date".*

However, it is understood that the implementation and higher usage of criteria-led discharge will reduce this problem as, in particular cases, a senior nurse will be able to authorise the discharge rather than having to wait for a doctor.

On the other hand, the questionnaire undertaken by the Older People's Parliament found that:

*"almost half of the respondents claim to have had a day or less notice of the time of discharge. Twenty four of them (out of 200) said that they had one hour or less warning".*

This is of particular importance in cases where care planning through social services is necessary or where the patient lives alone and is less likely to have adequate support at home.

These two conflicting findings from Mott MacDonald and from the Older People's Parliament are perhaps a reflection of an inconsistent discharge process or perhaps as a result of the distinction between simple and more complex cases.

### 6.3.3 Availability of medication to take home

One of the specific reasons for a delay in discharge reported from both the focus groups and in the Older People's Parliament questionnaire relates to the timely availability of take-home medication. Although all focus group participants acknowledged receipt of the correct medication, there was concern regarding delays in the medication becoming available. Comments include:

*"Two or three hours for medication."*

*"Mine was for the physio but when the physio said I could go well that's it, I waited two hours then [for medication]"*

*"Waiting for your medication. Yes, for two hours, over two hours."*

*"I had to go back the next day."*

*"Three hours later I was still there and so I left and I had to come back for it."*

It is recognised by the Panel that the perceived delay in discharge due to the availability of medication is a difficult issue. The focus group participants also identified this as a key problem. As an example, a consultant will conduct a ward round in the morning. During the ward round, Mrs A may be informed that she is ready to go home. However, at that point, there are still preparations to be made. Patients can get the wrong impression that they are able to go instantly. Hospital audits show that most medication is ready within about two to two-and-a-half hours of being ordered. However, as the doctor may not authorise the prescription until the end of the ward round, it may be lunchtime before the prescription is ordered.

The focus groups highlighted a need for further clarification and support regarding the taking of medication as it can be a source of delay and confusion. The hospital recognises this as an issue and a working group is actively searching for solutions. The Panel notes that some progress has already been made.

**Recommendation 6 – Delays in discharge due to the availability of medication must continue to be addressed as a high priority.**

#### 6.3.4 Information following discharge

A clear message from the focus group participants was that they felt that not enough support is available post-discharge. Their interpretation was that the information available was general rather than condition or patient specific. Although some participants had been given some information, it was not of a consistent level amongst all participants. Mott MacDonald concluded that:

*“The lack of information was a key concern for many. A majority in the sample left hospital with a lack of understanding about the next step in the treatment”.*

And that:

*“To receive key information in a written form enables easier digestion of conditions, treatments and consequences but also can serve to allay many fears about subjects not fully understood”.*

As one focus group participant put it:

*“No one ever explained anything but I knew, that’s why I was saying to them give me a discharge letter, you don’t have one, I said yes I do, no you don’t, your GP will get one and that’ll do sort of thing. I said no, I should have one with all the medication on.”*

A member of the medical profession explained:

*“Improved information given to the patient at the point of discharge would help. Patients can often become anxious at the time of discharge, which results in them being readmitted quickly due to the lack of support at home”.*

**Recommendation 7 – A personalised Discharge Information Pack should be established. It should be provided for every patient and their advocate / carer in an accessible format. The pack should include:**

- **key information specific to the patient’s condition, treatment and medication and its relevance to that patient.**
- **contact numbers or helplines.**
- **a copy of information sent to the GP.**
- **details of next appointment.**
- **appropriate information sheets regarding the patient’s condition, for example, Stroke Association.**
- **appropriate contact numbers for care in the community and voluntary groups.**

### 6.3.5 Transport home from the hospital

Transportation is an important issue to many patients. The availability of wheelchairs was an issue highlighted by a number of focus group participants including:

*"Well I went in for a hip replacement, complete and I didn't get my wheelchair on the way out."*

*"I walked out and nobody offered me anything."*

*"You would think they would provide a wheelchair regardless of what you've had done really."*

*"It's a basic need yeah. And the same thing I had a cholecystectomy on my gall bladder and like this lady I was discharged the next day and it was a terrible walk from the ward, the car park but nobody said ..."*

Mott MacDonald reported that:

*"Participants perceived the fact that they were not offered wheelchairs as a sign of the staff's apparent disregard for patients once they have left their ward".*

In addition, there appears to be a discrepancy between expectations of patients regarding transport facilities and the ability of the hospital to meet those expectations. As one officer explained:

*"There is a cultural issue whereby some members of the public tend to use ambulances as a taxi. Some people think that it is the hospital's responsibility to get people home from hospital, but it is not".*

It is, therefore, suggested that improved communication with the patient regarding transport facilities may help to change those expectations. It may be possible for this to lead to a form of publicity campaign to improve understanding.

A key point raised by the Older People's Parliament survey was the great concern of respondents regarding the availability of short-stay car parking at the main entrance. The Panel is pleased to note that a convenient exit and pick-up point with limited parking has now been established close to the discharge lounge.

As Mott MacDonald concluded:

*"Participants recognise that hospital staff are busy but often elderly patients can be confused or lacking in confidence or expertise in arranging their own transport".*

**Recommendation 8 – A protocol regarding transport home from hospital should be established and clearly explained to all patients. The protocol could include:**

- **availability of wheelchairs and support (where appropriate) to escort patients to their transport.**
- **clarity of when it is the responsibility of the patient or family to provide their own transport.**
- **explanation of the designated pick-up points, including routes to the discharge lounge car park.**

## 6.4 Support Post-Discharge

The Older People's Parliament report concluded that there were "far more adverse comments about medical needs after hospital" (as opposed to during the hospital stay). As an example, the Mott MacDonald report draws attention to one lady's experience as follows:

*"She found herself in a situation whereby she had an operation and was sent home the next day when she had no one at home to help her or look after her, she had no discharge letter, she had no information about what she needed to do at home to care for her wound, no information about what she should do if she needed assistance and no transport arranged for her to get home. Furthermore, she had been told that she would be in hospital longer and had informed a relative as such and then when she was discharged early no one was aware she was home alone. She felt that the hospital could have taken responsibility to inform someone she was coming home early and upon realising she would be at home alone, provide some care or keep her in hospital".*

Mott MacDonald found that:

*"It was felt strongly that there is a lack of support for those recently discharged patients".*

Their report concluded that:

*"Support post-discharge was generally viewed negatively with many reporting little or no help".*

Some of the comments from participants included:

*"I think we need more aftercare for patients."*

*"But I would have thought that on things like major surgery, which unfortunately I seem to always end up doing - major surgery - that there should be a group of people that 24/7 you can ring up on call. And they will sort you out."*

*"You don't know what's going to happen to you. You've got no idea what's going to happen to your body."*

*"Yeah. And I'm only asking for major surgeries, and I'm only asking for four days or five days afterwards. But it's a whole lot better than me ending up back in hospital for another couple of days."*

*"Your really worried, and really frightened - and that's what it comes down to - it's fear in the end. You're really frightened."*

### 6.4.1 Support at home following discharge

One issue raised during the focus groups was that some patients felt that adequate support was lacking following discharge. Although participants were pleased that most had been asked if there was anyone at home to help look after them during their discharge, Mott MacDonald reported that:

*"there were some participants, who needed assistance, who were sent home alone, but did not have any support at home".*

Furthermore, a medical professional commented that:

*"There is a key interaction between the hospital and social services. It is difficult for the hospital; a patient cannot be kept in hospital because they have not got clean laundry but there is a duty to make sure they are safe".*

In addition to existing processes, the introduction of the 'Personal / Home Circumstances Check List' should help to highlight those patients who are most likely to need assistance at home once they have been discharged. Subsequent 'sign-posting' of available services would help to give additional confidence to the patient. The availability of information to the patient, in the form of a Discharge Information Pack, is covered elsewhere in this report. (See section 6.3.4 above).



Furthermore, it is hoped that the new 'Out of Hospital' scheme, launched at the end of January 2009, will help to fill the gap in provision. The scheme, to be managed by staff working for VCAW (Voluntary Community Action Wirral) will be supported by a number of volunteers. A member of the 'Out of Hospital' staff will have a desk in the Discharge Lounge at Arrowe Park, resulting in close ties between hospital staff and the volunteers. It is inevitable that the scheme will only be successful if those patients requiring support are identified prior to their discharge from hospital. The aims of 'Out of Hospital' are to:

- initially visit the patient in hospital to check whether there are likely to be any practical issues to resolve.
- make sure that the house is satisfactory to live in and is warm.
- help with practical issues such as opening the post, ensuring that there is milk and bread, and so on.

**Recommendation 9 – All organisations are encouraged to support and make use of the 'Out of Hospital' scheme operated by VCAW (Voluntary Community Action Wirral), which is warmly welcomed.**

#### 6.4.2 Support from Community Practitioners

The Mott MacDonald report commented that:

*"Participants reported an apparent lack of communication between the hospital and the community nursing team/doctors surgery regarding aftercare. Many participants were shocked that after a stay in hospital, their recovery was not checked or facilitated by a community practitioner. They reported feeling confused, alone and unsure of how to treat wounds or gain advice if required".*

Furthermore, the report added:

*Some reported that their GP was not even made aware of their stay in hospital or the aftercare required. Others commented that their GPs did not seem to have all the information about their treatment".*

Comments have also been made to the review Panel regarding the process for 'handing back' a patient from the Hospital Trust to primary care. As an example, a patient may be in hospital and contracts C.difficile infection. Unless the GP is specifically informed of that secondary condition, they will not consider it in the future care / diagnosis of that patient. Establishing a good information link between the hospital and GPs is important. A further example is the discrepancy between hospital and the GP's records resulting from the use of 'Patient Own Drugs' at the point of discharge. As a result, these drugs will not be included on the Discharge Summary and may, therefore, not be apparent to the GP.

The Discharge Summary is produced electronically. Three copies are generated; one each for the consultant, GP and the patient. The summary is also available electronically through the electronic health record. Effort is made to try to send the patient home with a copy. Audit has shown that already 98% of the electronic Discharge Summaries are generated within 12 hours of discharge. However, it has been explained that the real issue is that "the quality of the letters is not what it might be". Some GPs may get a further letter, which may be very detailed, but it could be two weeks after the patient has been discharged. Therefore, events could have moved on.

One focus group participant commented that:

*"I think sometimes they're very slow in getting information to your GP."*

The information flow between the Hospital Trust and the GP should be improved. This, in turn, may lead to more integrated patient care. The Hospital Trust does recognise this as an issue and is aiming to improve the process. Furthermore, once the GP's surgery has received the information, the patient will only feel reassured if that information is acted upon. When asked for suggestions regarding possible improvements to the discharge process, the focus group participant responses included:

*"An automatic follow up by someone, either from your GP or from the hospital. A visit, a physical visit from someone within a week of discharge to make sure that the medication you're on ...is correct."*

*"I think it's essential that when you do get home that there is an immediate follow up. You can go on taking medication for too long and I found that."*

*"There should be an active follow up within a number of days in case there is any change of medication required."*

The Mott MacDonald report added:

*"There were widespread concerns from participants about the lack of support and advice following their discharge from hospital. Participants strongly felt that there should be a standard follow up by a medical professional from the community, even if only by phone, to all relevant people who have been in hospital".*

It has also been suggested that improved processes in primary care, for example, with the management of a blocked catheter or with the treatment of diabetes may help to avoid the re-admission of some patients.

**Recommendation 10 – GP surgeries should be informed of the patient's discharge within 24 hours in anticipation of Department of Health's proposed standard<sup>1</sup> (due to commence in April 2010). The surgery should be encouraged to contact the patient on the same day that information is received.**

### 6.4.3 Suitability of home environment following discharge

Most participants in the focus groups were positive although there were some inconsistencies in the experience. It is noted in the Mott MacDonald report that:

*"...Another participant was admitted via A&E and they stated that nobody discussed the issue that they had left the home in chaos following their emergency admission".*

It is hoped by the Panel that the 'Personal / Home Circumstances Check List' (see section 6.1 above) and other recommendations will help to check whether the home environment is suitable.

Reassurance can be drawn from the respondents reporting that, where necessary, adaptations had been fitted adequately. However, one participant raised the issue of short-term accessibility to a toilet, which had apparently not been checked prior to discharge.

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<sup>1</sup> Since April 2008, the NHS contract has contained a national standard (but not a target) that hospitals must issue a discharge summary within 72 hours of a patient's discharge. This will go down to 24 hours on 1 April 2010. (Source: Health Service Journal 26.01.09)

#### 6.4.4 Caring responsibilities

There was a clear message from the focus groups that carers would like to be more involved in the discharge planning of the patient. Comments included:

*“And as I said - for a carer - for my husband - he's just completely left out of the loop altogether.”*

*“Yes. You're not really in the loop. You're outside the loop. So it would help if you could”*

*“You're not really kept informed as the carer.”*

*“I think just to be accepted as a carer would go a long way. You know, if somebody said oh, are you the carer”*

Further evidence from the focus groups highlighted that:

*“Some of the sample were also carers as well as recent patients. None had been asked if they were a carer for someone else and most had to arrange for someone to take over their caring responsibilities while they were in hospital”.*

As a consequence of this evidence, the Panel encourage the involvement of family / carers in discussions on the ward to help plan for the discharge of the patient. Furthermore, those patients who are either cared for or have caring responsibilities need to be identified early during their stay in hospital. This should be done either by the ‘Personal / Home circumstances Check List’ (see Recommendation 1 in Section 6.1) or through the care planning process (see Recommendation 3 in Section 6.2.1).

#### 6.4.5 Care Plan

The focus groups did not specifically comment on the care package received. This is borne out by the comment in the Mott MacDonald report that:

*“A large majority of participants were unaware of any care plan put into place”.*

Of the 200 respondents to the Older People’s Parliament survey:

*“Only sixteen reported a home care support package arranged by the local authority”.*

The report added that:

*“There were several remarks of this type – ‘I wasn’t well enough to look after myself. Knowing somebody would come in to do some little jobs for me while I was recovering would have been nice”.*

Therefore, only limited evidence was obtained regarding care plans. Most of the evidence was from health / social care professionals, rather than from the ‘patient experience’.

Assessment and Care planning can involve several members of the multi-disciplinary team and may bring significant pressures on the discharge process, notably in terms of time and capacity. On rare occasions it can take weeks for care packages to be established, especially in complex cases. The Adult Social Services Care Management team, based at Arrowe Park, deal with a large volume of cases. Short notice of discharges can add pressure to the system, leading to delays. Early identification of those patients likely to need care planning is more likely to improve the ‘patient experience’. A positive outcome is less likely to be achieved if the Care Management team are informed of a requirement at short notice, for example, when a package is needed with almost immediate effect on a Friday afternoon.

In addition, although it is recognised that the family / carer should be included in the process, it can sometimes be difficult for this to be totally achieved. Again, limited involvement of family / carers can lead to frustrations (on both sides) and a less positive “patient experience”.

Close working relationships and good information exchange between hospital staff and the Care Management team are clearly beneficial. For instance, if an individual has a care package and is admitted to hospital, the package can be retained for a maximum of two weeks. If the Care Management Team is not informed of the length of a patient’s stay, a costly waste of resources may result. Improved processes whereby the Care Management Team is able to continually monitor such cases would be beneficial.

It is recognised that recent changes to procedures regarding the use of intermediate beds, ‘Integrated Care at Home’, the Home Assessment Reablement Team (HARTS), the new Community beds and the Virtual ward approach should provide more flexibility in the care packages that are potentially available. One comment made by an officer was that:

*“...there are too many hospital beds occupied by residents of nursing homes and residential homes. More support is needed to keep these patients in their normal residency”.*

It is hoped that these changes will lead to an improved “patient experience”.

In terms of the timing of the decision-making process, there were a number of comments from staff, from the different organisations, all along the lines of:

*“It is clear that long-term decisions regarding the future of a patient should not be made when they are in an acute bed”.*

**Recommendation 11 – No one should have to make a major and permanent life-changing decision while under pressure to vacate a hospital bed.**

## **6.5 Avoiding Unnecessary Readmissions**

Analysis undertaken by Wirral University Teaching Hospital has confirmed that there is not one major cause of readmissions. Almost half of the readmissions come back within three days. In particular, two areas of concern have been highlighted.

### **6.5.1 Alcohol**

A significant number of readmissions are those with hazardous drinking behaviour, of which older people are well represented. Wirral University Teaching Hospital does recognise this as a serious and growing issue. Continuing work needs to be done with other services to get messages out to the public.

The Panel have suggested that further scrutiny should take place into issues surrounding excessive alcohol consumption.

## 6.5.2 Palliative Care

It is estimated that 8% of all readmissions are for palliative care. Most of these cases are as a result of poorly controlled pain. Many of these patients do not necessarily need to be in hospital. The availability of better pain control in the community would reduce the need for readmission. One medical professional remarked that:

*"Hospital is not the right place for such patients to die, especially in emergency wards where many of these patients may be. Although nurses and doctors will always do their best, the bustling atmosphere of an emergency ward is not where such patients should be".*

Another professional commented that:

*"A major issue for those families providing care at home is the family's ability to cope emotionally and physically. This can lead to readmission due to a lack of understanding of how difficult the circumstances can be. The real issue is one of the capacity of district nurses and social services to pick up the cases. However, some packages of care are very complex".*

A further issue may arise from a perceived "reluctance" of residential care homes to keep 'end of life' patients in their home. It was suggested to the Panel that:

*"Too many residents in care move to hospital to die. As an example, too many patients go to hospital to receive adequate pain control and stay there. The aim is to implement the Gold Standard for End of Life Care into some of the Care Homes in the borough".*

**Recommendation 12 – All agencies are encouraged to work together to provide better pain management services in the community. This should have the effect of reducing the number of admissions / readmissions to hospital.**

## 6.6 The 'Holistic Approach' to Discharge

### 6.6.1 A seamless process

A health professional has commented that:

*"It needs to be acknowledged that discharge is only one element of a whole system economy approach to care and that development in one area can and will have an impact on another service. It is important therefore to take this into account when discussing how to resolve the issues".*

Professional staff from the different organisations (Acute Care, Primary Care and the Department of Adult Social Services) have indicated that while there are good examples of working together and much has been already been achieved, there remains much to be done before a seamless process is provided. Two comments from different staff in different organisations were:

*"There is a need for more joined-up thinking".*

*"There needs to be a coordinated approach to the discharge process that requires full cooperation from all the services involved".*

However, another professional commented that:

*"In practice, the teams are not integrated but it is an improving situation".*

The point has been made strongly and on several occasions that major steps have been taken to ensure that the Acute Trust, Primary Trust and Social Care organisations in Wirral do work together effectively. Progress has been and continues to be made. Nevertheless, greater cross-departmental working would help to provide more effective communication

and interaction between different teams. Some small examples that have been noted include:

- early participation by social workers in the discharge planning process is not always apparent.
- the lack of automatic downloads of information from hospital to social care computer systems. Consequently data has to be re-entered manually.
- the daily Trust bed meeting could involve a manager responsible for the social worker team.

The Older People's Parliament report, referring to joined-up working, commented that:

*"Several patients thought that they had been told to expect Occupational therapy or physiotherapy follow-up which did not materialise. One respondent reported a week at home before the OT aids were delivered".*

**Recommendation 13 – It is recognised that the patient's needs are central to the discharge process (and on-going community support). However, even greater priority should be given to the provision of a "seamless" service involving staff from Acute care, Primary Care, Social Care and the voluntary sector.**

**Recommendation 14 – All sectors should continue to build capacity in primary and community care to provide alternatives to receiving care in traditional hospital settings.**

## 6.7 Needs of Specialist Groups

### 6.7.1 Dementia patients

Evidence, particularly from the voluntary sector, has raised a number of issues relating to patients with dementia and their treatment in hospital. A representative of a third sector organisation commented that:

*"As a society, there is a need to look at creative alternatives to keep people at home. At present, people are being admitted into residential care earlier than they really need to".*

The discharge process for dementia patients is often longer than average. To many such patients, the environment is confusing and they do not understand why they are in hospital. However, the point was made to the Panel that the real issue is that there is often no adequate support available to keep the person with dementia in their own environment.

The Panel have suggested that further scrutiny, involving Cheshire and Wirral Partnership Trust, should take place into issues for patients with dementia. Some specific points that the Panel would like to consider further include:

- ensuring as short a stay in hospital as possible for a person with dementia.
- reducing the number of admissions of people with dementia, that is, try to treat them in their own home.
- speed up the Social Services processes for this client group.

With respect to the ability to assist patients with dementia from having to go into hospital, a professional from the third sector commented that for some patients, a 'virtual ward' approach would be more suitable:

*"Sometimes there is no alternative to a stay in hospital, for example, a broken leg. However, it can often be the case that people with dementia end up in hospital because a carer is no longer able to look after them, for example, because the carer is ill, stressed, and so on. The real issue is that there is no support to available to keep the person with dementia in their own environment".*

## 6.7.2 Patients with communication issues

Evidence collected from a variety of sources (the focus groups, the Older People's Parliament survey and from meetings with representatives of the third sector) suggests that specific needs of particular groups could be improved. It is noted in the discharge policy that advocates and / or other support should be included in the process as soon as possible. However, evidence suggests that this is not necessarily the case.

As an example, the Mott MacDonald report includes several quotes from a lady who described herself as "profoundly deaf". She felt that a signer should have been available to help her communicate. She commented that:

*"I didn't have an interpreter on my discharge. They didn't find an interpreter it was just me and my partner there. They didn't check things like am I ok on my own, how was I getting home. No."*

Likewise a lady with visual impairment, who completed the Older People's Parliament questionnaire, commented that her stay in hospital had been extremely difficult.

With respect to those people with learning difficulties or disabilities, a professional from the third sector argued strongly that:

*"The main issue is frustration over the lack of time available to deal with issues before a client is due to be discharged. For instance, we may become aware that a person is due to be discharged in two days. The admission plan for each patient should include a discharge plan, that is, planning for discharge should start at the time of admission."*

A further comment was that:

*"It is important to stress the need for advocates to get involved as soon as possible. For people with learning difficulties, it is important to have the chance to get to know the client. A better service for the client would be more likely if there was more joint working between Social Services and Health"*

A detailed example can be used to illustrate the point:

*"A patient had been in hospital for five months with end-stage Multiple Sclerosis. The patient was not communicating. However, an advocate was able to start communicating within two minutes. That patient would have been better off in nursing care than in hospital. If a trained advocate had been called at the time of admittance to hospital, the bed could have been cleared much earlier"*

**Recommendation 15 – Advocates / support staff for patients with special needs (for example, learning disability, hearing impairment, visual impairment) should be included in the processes as soon as possible following the admission of the patient.**

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***This report was produced by the Hospital Discharge Scrutiny Panel.***

***11<sup>th</sup> March 2009***