Over 65s Hospital Discharge Public Meeting Report

17 February 2016

In association with

Healthwatch Croydon is the official consumer champion for users of health and social care services in the borough. Established as part of the Health and Social Care Act 2012, Healthwatch Croydon acts as the 'patient voice', and in doing so, addresses key health and social care related issues.

As part of its work, Healthwatch Croydon has scrutinised the local experience of Over 65s being discharged from Croydon University Hospital, engaging with residents and service users in the community.

On 2 February 2016, Healthwatch Croydon published *Experiences of discharge from Croydon University Hospital by patients aged 65 years and over*. The report, commissioned by Healthwatch Croydon and undertaken by Age UK Croydon presented some good news with four in five patients not delayed at all and of those that were, most only experiencing a short delay of around an hour.

However, most patients were more concerned about a lack of knowledge about the whole process, lack of time to discuss issues with doctors, and lack of communications between pharmacy, GP and social care services.

To launch the report, we planned a public meeting on 9 February at Age UK Croydon's Scratchley Hall to gain further insight on these issues.

In this report, we present some recommendations based on the experience of 40 people that attended which included former discharge patients, carers, residents, service providers, which further support the research report.

We note that members of the Croydon Health Services NHS Trust and Croydon Clinical Commissioning Group also attended the event and thank them for their contribution. The trust in particular made some announcements and comments which we had included.

Overall Themes

At the event, there were four discussions on four tables concerning understanding the discharge process, communications between hospital and patient, communications between hospital and GPs/Pharmacies, and communications between hospital and social care services.

Each suggested some priority issues to be considered and recommendations focusing around three areas.

- Information
- Process
- Communication and contact

The following define key issues and suggestions and Appendix One shows the wider examples of experiences and discussion from which the priorities were defined.

Table A: Understanding the Discharge Process priorities

Information

- The amount of information given on discharge is limited.
- People are not always aware of delays.

Process

- Capability and inconsistencies in home visits – sometimes they are available and at other times not.
- Discharge decisions should be based on clinical need.
- Better co-ordination with social care.
- Focus on preventing re-hospitalisation.
- Better use of hospital passports – people should know what to expect.
- Dementia requires a more holistic approach.

Communication and contact

- Family and carers need better access to staff in order to co-ordinate the discharge and care package.
- Named contacts in hospitals would be useful.
- Provision of advocates.

Table B: Patient-Hospital Communication priorities

Information

- Rules on confidentiality are not adequately explained to patients, family and carers.
- Letters sent containing incorrect information.

Process

- Not sure that services are there to support people with dementia.
- People without family are all too often left isolated, therefore discharge advocates could be a 'discharge friend' for lone people.
- Email is a good alternative to the phone, but reassurance is needed that emails will be picked up and actioned.
- Information is not passed on from shift to shift.
- Praise for staff – nurses are great!

Communication and contact

- Getting that initial contact is difficult, but fine once you are in the system.
- Being able to get through on the phone can take a lot of time and appointments can be missed due to lack of communication.
- Communication on the ward itself has been noticeably improved.

Table C: Hospital-GP/Pharmacy Communication priorities

Process

- The medication process needs to be speeded up.
- Prioritise older patients in particular so they don't have to wait so long.
- Some processes could be undertaken by administrative staff.
- What happens if a pharmacist doesn't have medication in stock?
- Better dementia awareness and support.

Communications or contact

- Doctors to liaise better with community pharmacies.
- English is not everybody's first language and communication needs to be precise.

Table D: Hospital-Social Care Communication priorities

Information

- The discharge process needs to be clear, and advertised widely to more people in the borough.

Process

- One person living in sheltered housing was discharged at 2am, without support – this should not happen.
- Inconsistencies in physiotherapy – some patients get a good service, others none at all.
- Some people are not able to keep their homes clean and infection is a risk.
- People left in the discharge lounge for 1.5 hours, waiting for medication, then sent home as it wasn't required. This should not happen.
- People in the discharge lounge should be supported – not just left.
- People should be discharged earlier in the day.
- Do people 'at the top' know what is happening (in respect of the discharge lounge)?
- People sent home with no help whatsoever.
- An intermediate convalescence service is required.
- Age UK and Croydon CCG need to work more closely together.
- Advocates required for lone people in particular.

Communications or contact

- Lack of communication between doctors and inpatients.
- Doctors talk across patients and not to them.
- Needs to be better communication with patients about timings.
- The discharge process is not joined-up enough and there is not enough input from patients themselves.
- Communication is missing – it needs to be 360 degrees between patients, carers and staff.
- Patients should be asked what they need – not dictated to.
- Better input from patients and families!

Q&A session – other priorities:

Process

- There's a noticeable gap between the hospital, community and social services, and services appear to be stretched.
- A lot is dependent on observers.
- A greater role is required for community services (ie; Age UK, Red Cross).
- Age UK is working well with care managers at the hospital.
- Who holds the purse strings for continuing care (the CCG or Local Authority)?
- Assessments are not being done properly, by qualified people.
- After care is very dependent on the money – is there enough?
- There is confusion over continuing care – even legal experts are not clear on the process.

Response from Croydon University Hospital

- There is 'no excuse' for people being discharged at 2am without their consent.
- £170,000 is being invested in the discharge lounge – it is acknowledged that it is not warm enough.
- Senior managers are on the shop floor during 'Visible Wednesdays'.
- Delegates are invited to get involved in the 'Patient Experience Team'.
- The trust are trialling 'Patient Discharge Advocates' to support patients.

Existing good practice by Age UK (in Croydon and elsewhere)

- Age UK and the hospital work together to provide support to people before they go home to make sure the place is safe.
- Age UK get patients referred via 'Staying Put' to receive 6 weeks free homecare post discharge.
- Age UK have a falls service who can assess/fit grabrails and handrails.
- Age UK have hospital discharge and reablement services that can provide up to 6-8 weeks support post-discharge.

Appendix One – Table Notes

Table A: Understanding the Discharge Process

Delegates experiences:

- Brilliant, they saved my life.
- Taken ill whilst house-sitting - it was like a holiday camp, very smooth.
- I broke my arm 3 years ago, the discharge was very different.
- My experience in the discharge lounge is very positive.
- No complaints, but support from my husband helped.

Issues:

People's understanding of the discharge process is limited (ie; not always aware that there have been delays).

Myths:

- Facilities prior to discharge are available.
- Capacity for home visits
- Decisions always led by clinical need.

Potential issues around complex co-ordination of primary & social care (for dementia):

- Personalised approach.
- Discharge managed carefully.
- Efforts to engage with services already in place ie; domiciliary care and family.
- Holistic approach.

Top priorities for better understanding of services?

- Communicating discharge plans with family and carers.
- Designated staff and time to discuss plans and concerns ie; Oldham NHS have allocated a day when Age Concern visit.
- Use of 'Mylife' and 'Health Passports' more and consistently.
- Possibility of a hospital pathway/map through the hospital journey, with possible dates and contacts.

Suggestions:

- More money.
- Better information and communication with discharge co-ordination.

Table B: Patient-Hospital Communication

Table Notes

Delegates experiences:

- After my hip operation, and in spite of my efforts to explain my circumstances, I was returned to my home, which I had not been able to clean since moving there because of my health issues and I got an infection and ended up in Mayday. My hip operation was in Epsom.

Issues:

- Lack of proper discharge between patient and doctor.
- Problems with after care service.
- Limited opportunity for physio while in hospital.
- Help doesn't exist for patients when they have been discharged.

Table C: Hospital-GP/Pharmacy Communication

Table Notes

Delegates experiences:

- I manage a community pharmacy and one of my customers was admitted to hospital without our knowledge and discharged, also without our knowledge. We dispensed the usual medication, but it turns out it could have reacted badly with medication given on discharge.

Issues

- English is not everyone's first language.
- Dementia awareness.
- Medicines out of stock - problems and delays in re-stocking.
- Prioritising patients in need.
- Lack of staff.
- Communication and aftercare.

Top priorities for better understanding of services?

- Asking doctors or hospital pharmacists to liaise with community pharmacy for medication to be transferred and delivered.
- To look at speeding up processes.
- Let community pharmacies follow up – it often does not require a medical professional.

Table D: Hospital-Social Care Communication

Table Notes

Delegates experiences:

- Live in sheltered housing (Elizabeth Court). 1 resident discharged at 2am with no support. Seems to be a common occurrence. Need someone to notify scheme manager and to keep them informed.
- Fed up hearing Jeremy Hunt and MPs saying people are living too long.
- No older person should be discharged after 7pm at night and after midday or at weekends.
- Hospital does not notify GPs, pharmacy etc.
- Lack of communication between doctor and patient in hospital.
- Physiotherapists didn't understand long term issues with legs, mobility following accident.
- Doctor knew I was on my own and couldn't keep home clean. There was a risk of infection at home. I was discharged and about month later had infection in left foot/ankle. Spent Christmas/New Year in CUH. Could have been avoided if they had listened. Eventually I got help from Age UK Croydon. Could have been avoided if I had been listened to.
- On discharge from CUH I had a certain amount of physio but not enough.
- Husband had neurology at St. Georges - had a letter and GP copied in. Husband had to email surgeon to follow up on the 2nd operation.
- Physiotherapists don't touch you.
- Had 2 operations on leg. Referred to community physiotherapist and had 6 weeks of intensive exercise and aqua physiotherapy. First class.
- Contact in CUH following stroke. Discharged on 16 December. Husband had dementia but came to meet her. Left in discharge lounge at 8pm. Cold and no communication for 1.5 hours, waiting for medication. Then decided she didn't need medication and sent home. People at the top have no idea what's happening as they aren't walking about.
- People of all ages experience different levels of physiotherapy.
- At Shirley Oaks had physiotherapy with heat lamp and shown exercises. Experience at Purley/Norbury different. Very mixed.
- Someone went in for minor treatment. Sent home after lunch. Had swollen tummy and wet where sat. Her bladder was still under anaesthetic. Taken back into hospital and had catheter and had to stay in overnight.
- Woman had gall bladder operation. Sent home with no help or visitors.
- Friend was given convalescence as she needed a care package but would not accept it after a very serious operation.

Top priorities for better understanding of services?

- Could have card which explains procedure.
- When I was waiting in freezing cold outpatients, I overheard the doctor saying "we can't send him home if he can't walk" but I was discharged without being able to walk. There shouldn't be so much pressure to discharge people.
- Less pressure on staff.
- Should people be discharged later in the day?
- Years ago, if someone was due for discharge on Friday but it didn't happen, do Social Services pick up the tab?
- Things should be better joined-up.

What is missing about communication?

- Doctors and nurses talking across the patient (dialogue going on in the background that the patient knows nothing about).
- Discharge process not fully understood or fully explained.
- Lack of joined up working with GP's and pharmacies.

What could improve communication?

- Ask us.
- Better/more input from patients/families (my last job was to talk to patients who had been discharged in Lambeth and they thought it was wonderful).
- Four years ago social workers/doctors sat round table with us to discuss. I was angry because social worker said what she was going to do. We said no, you don't decide, we are family but they didn't talk to us.
- The equipment given to me to help with walking was taken from me long before I was ready.
- Issue now about who holds and decides on continuing care budget. Assessments being cut back and not being done by qualified social workers.
- Joined-up/clearer processes.
- Communication towards patients/staff/carers.
- Communicate to a much wider area so people know what to expect.
- Ensure patients understand.
- Checklist for patients, staff, carers pre-discharge.
- If someone is on their own their needs should be taken into account.
- Patients should be asked what they want/need before discharge is planned.