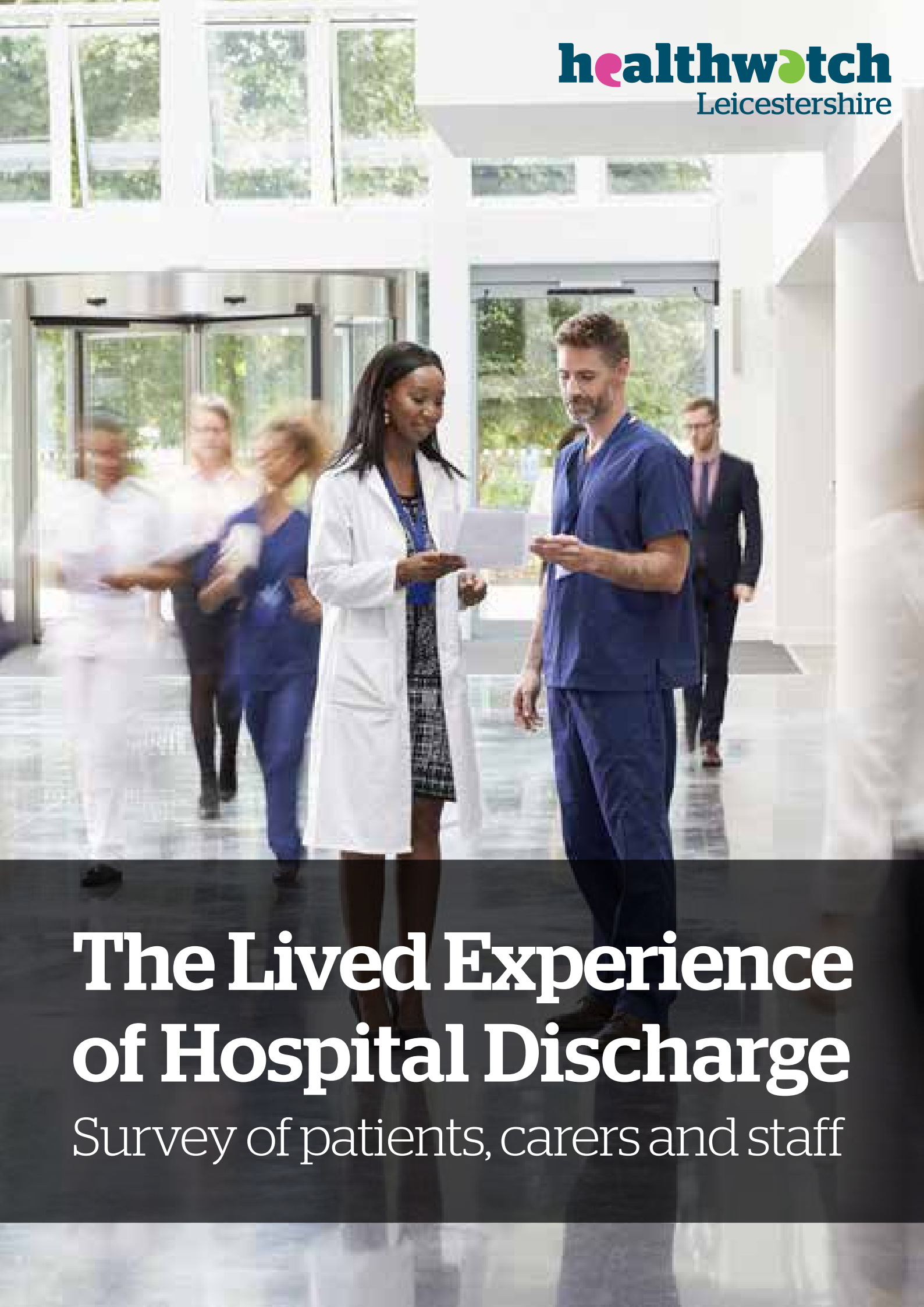

healthwatch Leicestershire

The Lived Experience of Hospital Discharge

Survey of patients, carers and staff

Foreword

This survey forms part of our programme of work in 2016/17 to highlight the views of health and social care service users about their experience of the local services offer.

From the key findings, we are reminded that discharge from hospital is a process that needs a strong commitment to joined-up policies, procedures and delivery to enable quality outcomes for patients, carers and staff. In addition, where scant regard is given to the impact of good and timely communication; we recognise how much this can result in a negative outcome for patients and carers.

We all need to do more to ensure action throughout the discharge pathway reflects a better understanding of its impact on patients and carers and to achieve better outcomes not only for patients and carers but for Trusts.

Patients, carers and staff working in partnership can enable the delivery of a better and more effective hospital discharge process. Clinicians and managers will need to show strong commitment, vision and leadership to assist in achieving these ambitions.

In January 2017, UHL declared a System Critical Incident[1] and cited that patients were experiencing very long waits for ward beds, delayed discharge and many patients experienced ambulance handover delays.

Our focus in this report is to capture related experiences from three key participants in the process of hospital discharge namely, staff involved with hospital care, patients and their carers, with an aim to help inform and improve the discharge processes.

Our findings reinforce the evidence gathered by University Hospitals for Leicester (UHL) NHS Trust in a spot check back in September 2016, which showed that there were 60 delayed discharges, half of which were due to internal factors. We are keen that they alongside other health and social care partners address the concerns outlined in this report.

The full report and recommendations will be shared with the UHL Trust Board, Leicester Partnership NHS Trust (LPT) Board and Leicester, Leicestershire and Rutland (LLR) subgroups and boards that have a remit to address discharge. The findings will also be presented at the Leicestershire Health & Wellbeing Board as well as other LLR stakeholders.

Our report will also be shared with local MPs, NHS England, Healthwatch England, neighbouring Healthwatch and respective local and district authorities.

We are grateful to the patients, carers and staff for sharing their stories and insights.

Pat Fraser MBE,
Healthwatch Leicestershire Board Member
Lead on Carers

Fiona Barber,
Healthwatch Leicestershire Board Member
Lead on Social Care

1 University Hospitals of Leicester NHS Trust press release http://alturl.com/j4rcg

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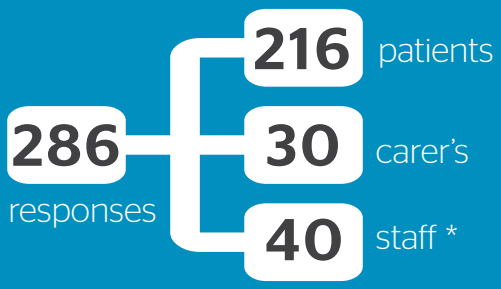
Executive Summary

Overview

Healthwatch Leicestershire (HWL) is committed to highlighting patients' experiences of health and social care services and believe that every voice counts when it comes to shaping the future of health and social care.

This Executive summary provides an overview of the qualitative and quantitative findings following our surveys with patients, staff and carers about their experiences of hospital discharge.

We aimed our surveys at 3 target groups from September to December 2016 and heard from 286 people, as follows:



* We heard from staff members based across various hospital sites as follows;

- 25 Leicester Royal Infirmary
- 4 Leicester General Hospital
- 9 Glenfield Hospital
- 2 Other

> "They tried to send me home the night before with no notice. I needed to see the consultant prior to discharge and I had no way of getting home as I live over 30 minutes away by car. I felt I had to really fight to stay the night, I felt they didn't understand my point of view and that the discharge would have been unsafe"
>
> **Melton, 25 – 35 years Female**

Key Headlines

The emerging headline findings for each target group highlight many similarities relating to their shared lived experience of hospital discharge.

Patients

Half of the patients had been an emergency admission with a third having been previously admitted/ discharged for the same reason.

Almost two thirds of patients told us that hospital staff had not discussed their discharge with a family member or carer.

Just over a third of patients told us they had their discharge delayed, with 41% stating this was down to waiting for medication.

Over two thirds of patients stated they were not offered any support for when they got home.

Carer's

Just under half of carers told us they were not given information about what would happen when the person they cared for was discharged from hospital.

Half of the carers we spoke to said that they were not involved in discussions or the planning of discharge for the person they care for.

From the carers we spoke to, over a third rated their experience of hospital discharge below average, with only five carers rating their experience above average.

We asked carers how easy or difficult is it to find time to get treatment or support for themselves. For example, to make appointments or take a break from caring. Half of the carers that responded told us it was very or extremely difficult.

Staff

The majority of staff we spoke to **(34 out of 40)** admitted that there are areas that could be improved to benefit the patient's discharge journey.

Almost all the staff members we spoke to **(39 out of 40)** told us that discharge processes are delayed due to internal practices.

Over three quarters of staff **(33 out of 40)** said they are involved in the care planning and discharge of patients on a weekly basis. However, almost half of the staff told us that they have never had discharge training.

We asked staff how confident they were when discharging patients and found that just over half felt very or extremely confident.

Just under a quarter of staff **(9 out of 40)** said they are always supported with discharge planning, whilst seven staff members told us that they are rarely supported.

Insights and Emerging Themes

From the survey responses of patients, carers and staff, the following themes were identified as common:

Remove the barriers

Featuring alongside all the feedback surrounding hospital discharge, patients, carers and staff talked about their lived experience of delayed discharge. For example, having to wait for test results, medication or discharge letter so that patients could be discharged with their care plans involving their family/carer. On too many occasions patients have been waiting because internal systems, processes and protocols were not aligned resulting in wasted energy and inefficient use of resources.

The barriers that prevent timely sign off of discharge paperwork, dispatching of medicines for patients and the planning of effective care packages must be identified and removed.

Coordination is key

Patients and service users assume that all health care professionals act as 'one team' working together and sharing relevant information. Therefore, it is bewildering to them as to why joined up working does not happen at staff handovers between nurses and doctors, when getting medications from the pharmacy and arranging transport. There is a need for better coordination and recognition that this needs to be a specific responsibility.

Staff members and senior management within hospitals and external partners are already aware of the many of the issues that affect patient discharge. Patients, carers and staff need all those involved to adopt consistent standards. The logistics and complexity of the issues for hospital discharge must be managed to provide patients with better experiences, free from unnecessary delays resulting from ineffective joint working.

> "I was woken up at about 2.00am and was moved to another ward. The next evening at about 11.00pm I was moved again to a day ward. Then discharged from the day ward the next day. In fairness to the staff they were stressed and didn't have a clue about my requirements. All of us on our bay were forgotten about for Breakfast and lunch"
>
> **Hinckley and Bosworth**
> **55-64 years old, Female**

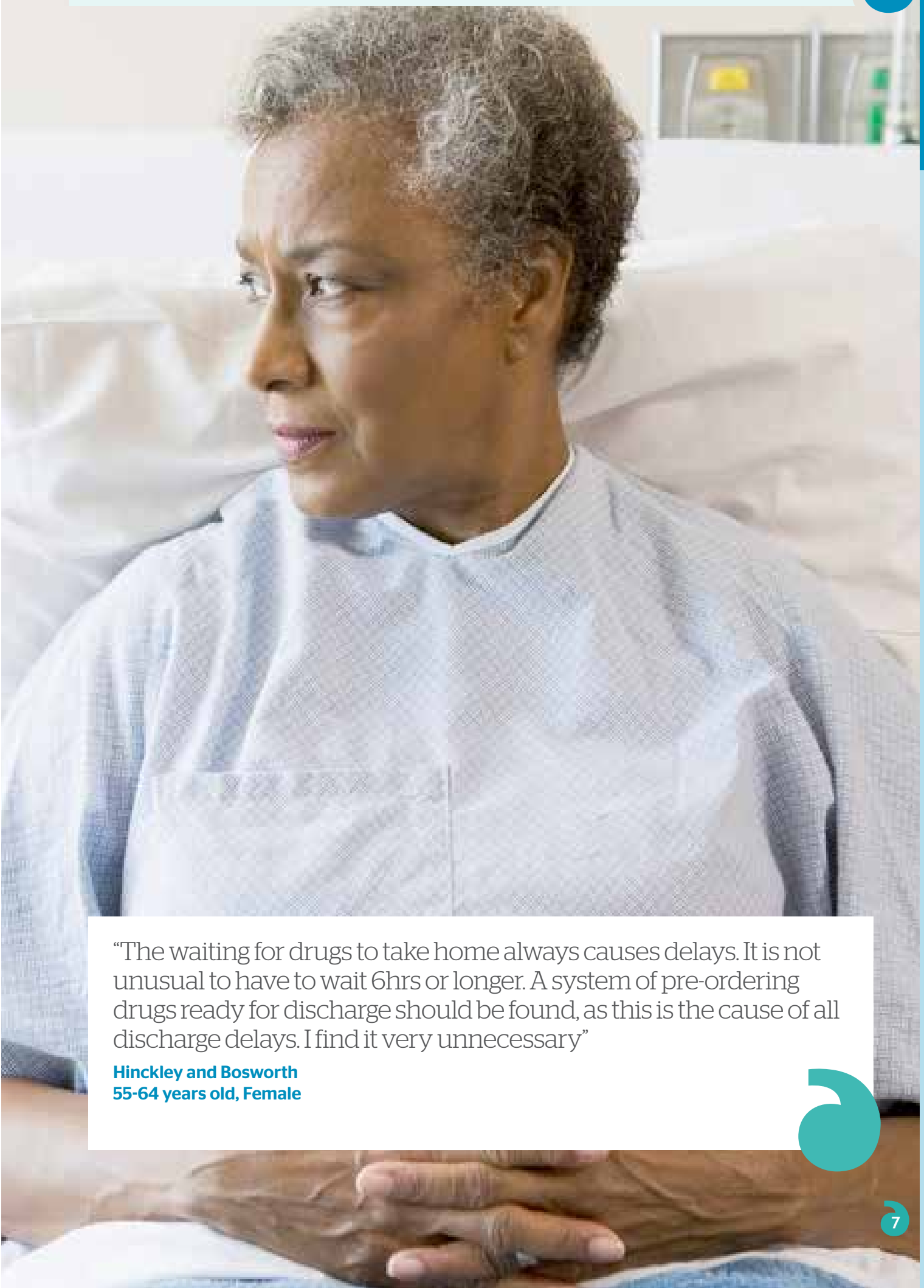
Talk to patients

Keeping patients and their carers up to date with timings for discharge can often place the patient more at ease. On many occasions, patients were not given any clear information as to why their discharge was delayed or when issues would be resolved. They are simply left not knowing when they will be going home. The uncertainty increases anxiety and also takes up energy that should be used for recovery.

Ward staff expressed concerns that they could not confidently explain why in many cases discharge processes are so time consuming, this leaves the patient feeling helpless and less confident about further messages from the staff.

Patients and carers express their frustration with 'you said that 2 hours ago!' resulting in high levels of stress. This is not conductive to the environment for recovery. This in turn impacts on staff who are then having to deal with their uncertainties as well whilst providing care for patients.

Health professionals need to explain discharge processes and timelines to all patients, their family and carers to manage expectations.



"The waiting for drugs to take home always causes delays. It is not unusual to have to wait 6hrs or longer. A system of pre-ordering drugs ready for discharge should be found, as this is the cause of all discharge delays. I find it very unnecessary"

Hinckley and Bosworth
55-64 years old, Female

Recommendations

This report highlights experiences and insights into how patients, carers and staff feel about hospital discharge services.

We provide both strategic and practical recommendations as follows:

1. **Timely medication**
   The issue of timings for medication to take out (TTOs) should be addressed with some urgency, including more immediate practical steps to examine how the overall discharge process can be speeded up and improved.

2. **Training**
   The experience of hospital discharge should be the same whichever hospital setting the patient is coming from. **There should be an improved schedule and a consistent approach to staff training relating to discharge. This training should have an element of multi-disciplinary and multi-agency focus.**

3. **Cultural change**
   There are many processes, people and procedures that are intertwined with hospital discharge. **There needs to be a cultural shift that leads to greater communication between staff teams, departments and partners working toward an effective pathway and process for discharge.**

4. **Inclusive approach**
   Carers and family members often feel on the margins and left out when it comes to the care of the patient. **Better information for carers and family members, in terms of processes, timings and care should be made accessible and explained.**

5. **Feedback loop**
   Hospital discharge affects people's lives in many different ways. **There should be a timely follow up survey specifically around hospital discharge so that the system can continually be improved to benefit patient and carer's experiences.**

"The feedback from my operation took place while I was still heavily under the influence of anesthetics and as a result was unsure what the outcome of the operation was"

Oadby & Wigston
25-34 years old, Male

Introduction

In this report, we present our findings from the data and responses gathered from three separate surveys of patients, carers and staff into hospital discharge.

The report highlights the main themes that emerged from the analysis of the qualitative and quantitative responses and presents this information by target group; Patients, Carers and Staff.

Background and context

Healthwatch Leicestershire (HWL) conducted a study in the summer of 2014 to understand in greater depth the impact unsafe discharge can have for patients[2]. The study forms part of the Healthwatch England's Programme of research[3].

The findings from the 2014 Survey revealed in detail that there was an inconsistency in how hospitals and healthcare settings approached discharge planning resulting in a disjointed/ disconnected offer.

In 2015, HWL's Carers Reference Group (HWL CRG) worked closely with University Hospitals of Leicester (UHL) NHS Trust the Specialist Discharge Team (UHL SDT) to increase the level of carer and family member involvement in the patient discharge process.

The exercise highlighted the need for a joined-up approach between all the discharge teams, who are all based at different sites across the hospital Trust.

In January 2016, HWL surveyed its members and invited the general public to inform us about what areas of health, wellbeing and social care people consider a priority. This information we used to help shape our future work plan, campaigns, activities and programmes.

In September 2016, there were **60** delayed discharges

A number of priorities emerged from this exercise and informed our dedicated work streams as follows:

- **Hospitals and Care in the Community;** care and treatment, waiting times, safe discharge into community, accessible care in the home, domiciliary services and care packages.

The aim of this project was to capture the discharge experiences of patients, carers and staff with a focus on hospitals as a care setting.

UHL completed a random spot check in September 2016, which showed that there were 60 delayed discharges. Half of these were due to internal factors such as;

- TTOs (to take out medicines)
- Diagnostics
- capacity issues with staff and medical resource.

The remainder were delays due to external factors such as care plans or NHS delays regarding community hospitals.

2 Unsafe Discharge for Vulnerable People http://alturl.com/5487t

3 Safely Home: What happens when people leave hospital and care settings http://alturl.com/r7qnh

The remainder were delays due to external factors such as care plans or NHS delays regarding community hospitals.

Leicestershire has one of the biggest NHS Trusts in the country[4], and as with other similar institutions, hospital discharge process can have significant influence on the frequency that a patient returns to hospital. We want to better understand the barriers and various perspectives of hospital discharge locally.

According to NHS England[5], a 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so (the patient is safe to discharge/ transfer).

Our Approach

To capture the different perspectives of the target groups, we developed three separate Questionnaires specifically targeted at different groups.

In developing the surveys, we were able to gather invaluable insights, expertise and experiences to shape our questionnaires and understand the key issues by involving HWL Board and HWL Carers Reference Group members: -

- HWL Board members with many years' experience of working in the public and voluntary sector, experience in social care, service development, commissioning and contracting, primarily around services to support carers of people living in Leicestershire.
- Local Carer support organisations across LLR
- Expertise from the Specialist Nurse for Discharge at UHL
- Their valuable feedback gave us assurance that we were asking the relevant and meaningful questions.

4 University Hospitals of Leicester NHS Trust

5 Delayed transfers of care: a quick guide http://alturl.com/wrfgc

The challenges

Our challenge was to promote the different surveys aimed at the three different target groups and then combine the findings into a coherent narrative.

Our aim was to approach various voluntary, public and statutory organisations to help disseminate the surveys. There were some challenges in involving service users, staff and carers because we did not have access to them directly and therefore relied on the support from providers to cascade and promote.

The online survey was the main vehicle to capture target groups feedback. To promote the survey,

- we issued a media release that was sent to various stakeholders, which was also featured in the Leicester Mercury[6]
- UHL cross promoted the surveys to their members and social care partners.
- UHL also posted information for their staff on their Intranet
- we cascaded the surveys to voluntary groups that support carers
- we promoted the survey and project on our social media page and website

6 http://alturl.com/kqdci

Main Findings - Patients

Gathering the patient's experiences of hospital discharge has enabled us to gain insight in to how hospital processes are affecting the lives of patients. From the data collected, we have highlighted the key messages that has emerged.

What we found

Half of patients had been an emergency admission with a third having been previously admitted/ discharged for the same reason. This is a deeper issue than it may seem on the surface as there may be many reasons for a patient to be readmitted to hospital for the same illness. What cannot be ignored is the fact that many people are repeatedly presenting at hospital. For example, this may be due to people with long term conditions or maybe partially due to poor discharge. This is something that may need further review.

Just over a third of patients told us they had their discharge delayed, with 41% stating this was down to waiting for medication.

Patients and staff have both commented that due to internal factors within the hospital, patient discharge has been delayed. Staff commented that this due to many factors such as, lack of pharmacy staff or shortage of medication, medical staff availability to write/ sign discharge letter and delay in transport, just to name a few. However, the delay in obtaining medication to take home (TTOs) is an issue that is consistently raised by both patients and staff.

Almost two thirds of patients told us that hospital staff had not discussed their discharge with a family member or carer. This is consistent with the comments from carers that saw almost half tell us they were not involved in discussions around the discharge of the person they cared for.

Over two thirds of patients stated they were not offered any support for when they got home. There is a mixed message when it comes to support. From those that were not offered any support, a quarter did not have anyone at home to support them. We also know that patients and carers have commented that more information to support groups and services would be beneficial.

"The worst of it is waiting for the medication to reach you. I know the dispensary can be very busy, but do they not have a team dedicated to doing discharge medication? It seems to take much longer than a normal dispensary in the community. Maybe the system of dispensing needs looking at for people being discharged from hospital"

North West Leicestershire, 75 years or older, Male

What patients told us

We provided an opportunity for suggestions and improvements to be shared by patients, we then collated those suggestions and ideas, and summarised them under headings. The following is what emerged from patient experiences.

Waiting times

Delay in discharging patients from hospital is a known and long-standing issue. For many patients, being in hospital is a sensitive time and the thought of going home is often prevailing in the minds of patients and carers.

Over a third, **(36%)** of patients told us that their discharge was delayed with **41%** percent (of the 36 percent) telling us that the reason for the delay was getting medication. In many cases, patients are waiting the entire day with minimal updates as to the progress of the discharge.

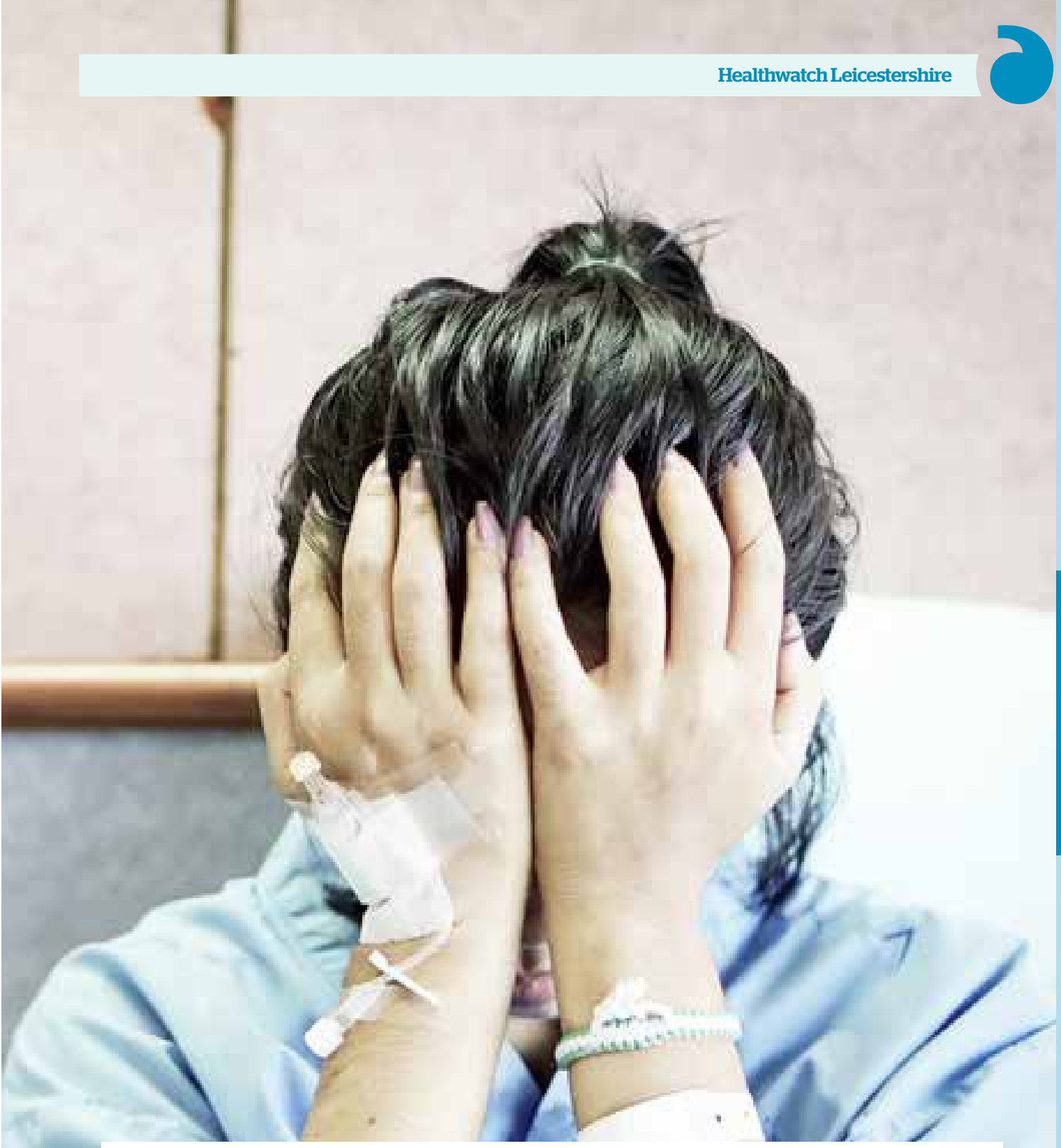
"I was told at 8.00am I could go home today and it was 8.00pm when I told them I would not wait any longer for medication or a discharge letter and that I would come back the next day for them when all of a sudden they printed the letter from a computer in the ward and realised that the medication was already there but they had not checked".

Leicester City
65-74 years old, Female

"I was asked to vacate my bed space by 11.00am for a new admission, so I stayed in a day room for 6 hours only to be told that my medication and discharge letter was not complete. I had to prompt the staff to give me antibiotics whilst waiting in a day room so that no doses of medication were missed but they had nothing for me. I felt very unwell in the day room on chair for 6 hours and by the time I got home I felt more poorly than before I was admitted. My son took me home and had to pick up my medication at 6.00am the next morning from the hospital"

Charnwood
75 years or over, Female

There were times that medication could not be dispensed because discharge letters had incorrectly recorded the medication needed for the patient. This would be further delayed if the doctor could not be found to correct the error in a timely manner. Some patients who have experienced hospital discharge on various occasions have the mind-set that there are the 'usual delays' of waiting for the paperwork and medication.



"I required medication upon discharge (antibiotics and pain relief). Having been told at 09:30 I would be going home that day it wasn't until 22:00 that the medication was provided, meaning I waited in a bed for 12 more hours more than I needed, and didn't get home until nearly 23:00. Not ideal when recovering from surgery"

Charnwood
35-44 years old, Female

Mary's story – Medication

It is well documented that Leicestershire has an aging population with increased multiple illnesses and care needs. This has played an important part in the rising demand for services, combined with reduced finances, which has contributed to pressure on the capacity of local health and social care services.

- Mary is a retired, 65 – 74-year-old Female who lives in the Oadby & Wigston area of Leicestershire.
- Mary went in to hospital for immediate treatment and when asked about her overall experience of discharge, she rated this as average (3 out of 5).
- Although Mary was not offered any support at home whilst going through the discharge process, she would have liked her family to be involved in the discharge discussions.

Mary's hospital discharge was delayed due to waiting for medication to arrive from the pharmacy. A pharmacist visited her about 5pm and asked about a couple of items of medication to see if they were needed. Mary said no, although she was not asked about all of her medications.

The medication was finally delivered to the ward about 7.30pm. They contained laxatives, which she had taken in her first few days on the ward and no longer needed. Plus, dissolvable Paracetamol that makes her sick, as well as another item, which she couldn't remember but also, did not need. Mary told one of the nurses that she was not going to take them home as it would be a waste of medication, and left them in the bay on the bedside table. Although there was a slight delay in her discharge, Mary was fortunate that she did not have to wait too long as her husband was able to pick her up at 8pm.

Mary said,
"I would suggest that it would save a lot of wasted medication if either a nurse or a pharmacist went through the list of medication to be taken home with the patient and checked that they are all needed and that the patient understands what they are taking. If a patient was unable to answer the questions due to age or dementia, perhaps it could be checked with a family member or carer. It might take an extra bit of time, and I do appreciate that hospital staff are busy, but millions of pounds maybe wasted on medication that are not needed every year in the NHS".

The system of dispensing medicines to hospital wards must be reviewed and improved to benefit the patient experience. There is an understanding by patients that hospital staff are busy and that the system as a whole is stretched. However, obtaining medication to take home via a prescription seems to take much longer in a hospital setting compared to a normal dispensary in the community.

Communication

Good, clear and effective communication with patients plays an important role in enabling an effective discharge process.

A report by the Queens Nursing Institute[7] in 2016 found that there was poor communication between hospitals, social services and community based teams.

They also found that there were hurried and ineffective discharges due to the pressure on beds in hospitals and a lack of understanding of what is available in the community or 'step down' services to ensure optimum care of patient and suitable placement.

> "I was told I could go home and that I would have a follow up phone call which never happened and I was on my own feeling unwell and vulnerable, not pleasant"
>
> **Harborough**
> **55-64 years old, Female**

Family members that are caring for patients are still experiencing poor communication with clinical staff in regards to talking with them and receiving information. One family member told us that their father in-law who is well in to his 80's, does not like to be moved around, but had been moved to the discharge lounge without any communication to the family.

> "One time my father in-law had spent all day in the discharge lounge area, and then ended up being transferred from the Leicester Royal Infirmary to the Leicester General Hospital for a bed for the night, as they realised the care package that had been set up had expired because he hadn't reached home in time for the carers to see to him. So care had to be sorted out again the next day. His daughter only found out when she rang to ask were her father was".
>
> **Harborough**
> **55-64 years old, Female**

Some patients feel they are not properly informed as to why they are having tests or how long they are expected to be in hospital. Receiving some form of an update can often help patients and family members organise transport to coincide with discharge and to better understand their condition. One patient told us that it would help if better information about what support services were linked to the hospital, and what medical condition they support.

7 Discharge planning: Best practice in transitions of care. Queens Nursing Institute 2016 http://qni.org.uk/docs/Discharge%20Planning%20Report%202015.pdf

"I was told I could go home and that I would have a follow up phone call which never happened and I was on my own feeling unwell and vulnerable, not pleasant"

Harborough
55-64 years old, Female

Hospitals should introduce a system to keep their patients informed with all the processes and timescales during discharge.

Avoidable mistakes

When discharge goes wrong it can have negative physical and emotional effect on the patient and an increased financial expense for the health and social care system. For older people, in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs[8] . We heard from 82 older people (aged 65 or over), 13% of those patients spent 15 days or over in hospital. 42% said their discharge had been delayed, with many stating this was due to medication.

Being discharged safely is key to avoiding patient readmission. Almost a third (29%) of older people that we heard from had been previously discharged for the same illness. On numerous occasions patients, had been sent home with the wrong medication and in some cases with the wrong medical notes. Aside from having to make a special journey back to the hospital to return them, it is totally unacceptable and could be detrimental to their on-going health and care.

In 2015, Healthwatch England published a National report titled 'Safely Home: What happens when people leave hospital and care settings?'[9]

8 Department of Health, Discharging older patients from hospital http://alturl.com/fdbcg

9 Safely Home: What happens when people leave hospital and care settings? http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf

"I was admitted at night. My husband waited to be told if I could go home with him after my treatment. We waited several hours and eventually had to ask the doctor if I could go. She had decided to keep me in and not told us, even though she could see that my husband was waiting and it was the early hours of the morning. Doctors are sometimes not proactive when it comes to keeping patients informed"

Melton
55 - 64 years of age, female

"In our opinion my late husband was discharged too early, I spoke to nursing staff on 3 occasions the day following discharge telling them how he was but was told to 'keep an eye on him'. He passed away 3 days following discharge"

Harborough
65-74 years old, Female

Healthwatch England noted that people were either discharged before they were ready, or that they were kept in care for too long, which had a significant and detrimental effect on their lives. This reflects some of the experiences that were shared with us at a local level and that form part of this report.

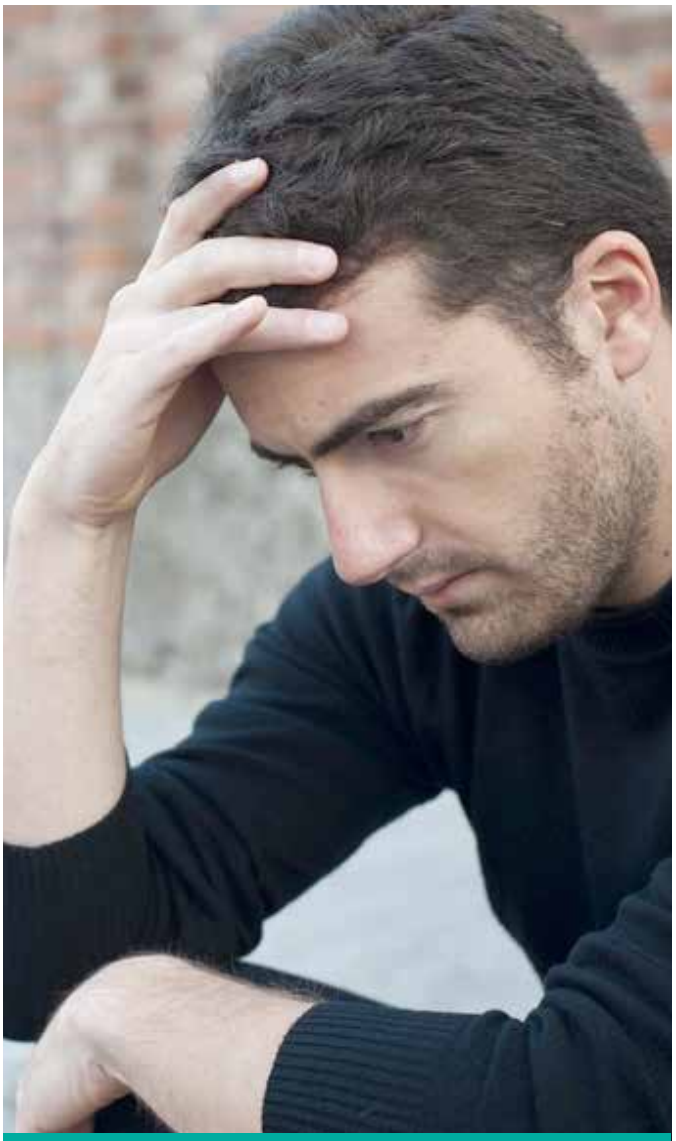
50% older people said that as far as they were aware, hospital staff didn't discuss their discharge with a family member/carer before discharging.

74% of older people were not offered any support at home before being discharged.

22% did not have anyone at home to help, i.e. a family member or carer.

"How long have you got? My medication was not ready, my blood test was delayed then the actual results were delayed. My medication wasn't correct as there was problems with the paperwork not being completed"

Charnwood
55-64 years old, Female



"I was admitted with severe tonsillitis; I also have no spleen so fighting infections is hard for my body. I was then sent home without my blood tests results being seen and with the wrong medication so had to be re-admitted the following day, which eventually got me the correct medication after being reviewed properly"

North West Leicestershire
25 - 34 years of age, Male

Julie's story – Poor discharge

- Julie is a retired, 75 year or over Female who lives in Leicester.
- Julie went in to hospital for immediate treatment and when asked about her overall experience of discharge, she rated this as poor (1 out of 5).

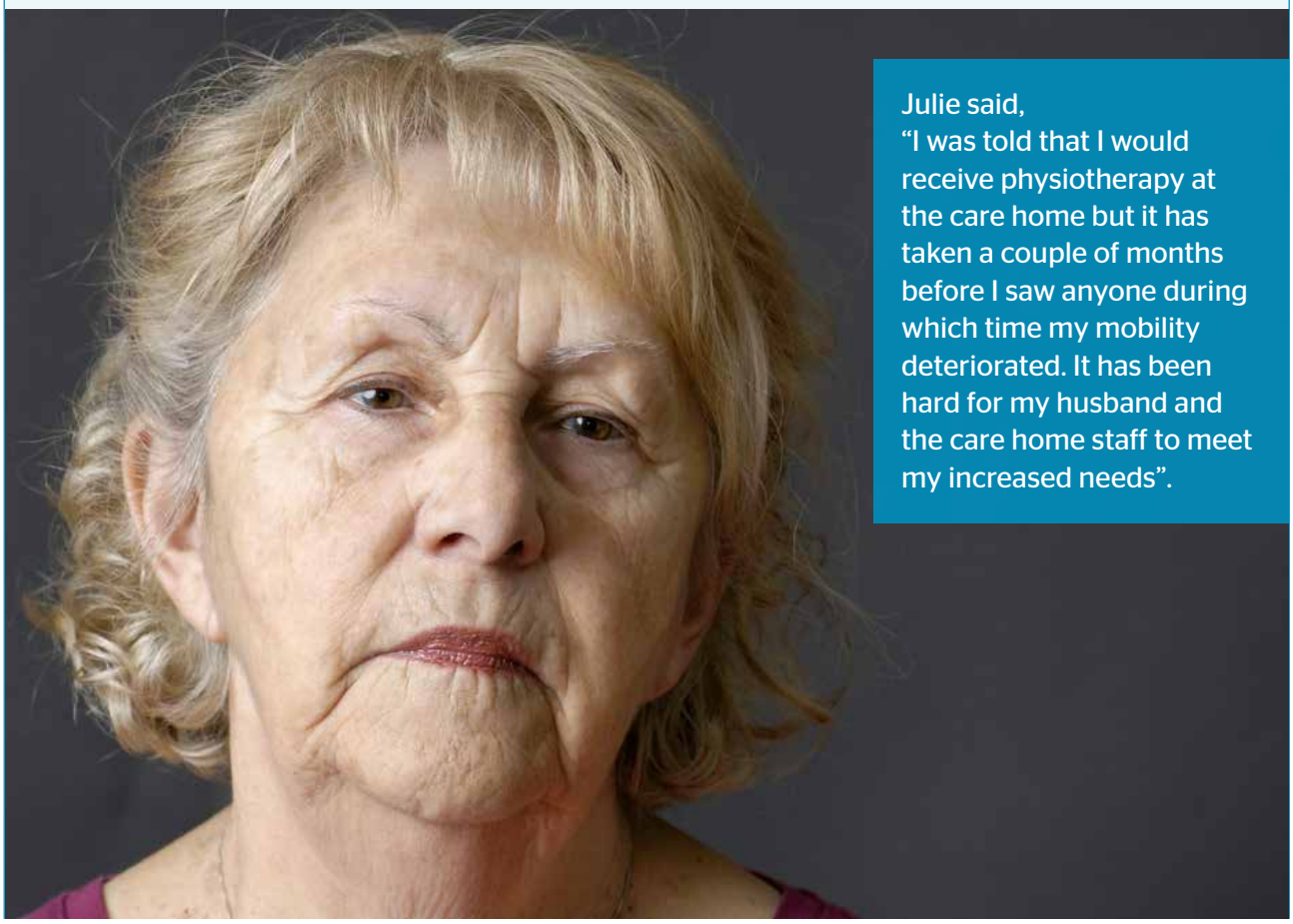
- Julie was not told how long she would be in hospital and ended up staying for 10 days initially.
- Julie is a resident in a care home and was offered Supportive Care Home Staff but felt that there were insufficient resources to meet her needs.

Julie had fallen at her care home and broken her hip. After 10 days of being in hospital she was discharged back to the care home but no one told her husband or the care home that she was being discharged and when to expect her. Within 48 hours of being back at the care home she had fallen again and broken her other hip, subsequently being readmitted spending a further 10 days in hospital.

Julie was once again discharged back to the care home, however this time she was not fit. She arrived back unresponsive and later that evening was readmitted to hospital by a GP via Accident & Emergency (A&E). She spent a further 15 days in hospital before being discharged successfully.

Julie's hospital discharge was delayed due to waiting for a care plan to be finalised.

In total Julie spent 35 days in hospital much of which was due to poor discharge and care planning.



Julie said,
"I was told that I would receive physiotherapy at the care home but it has taken a couple of months before I saw anyone during which time my mobility deteriorated. It has been hard for my husband and the care home staff to meet my increased needs".

Positive experiences of discharge

It is important to promote positive experiences and insights as these can also help to influence changes in culture. During our conversations with and feedback from patients, many positive experiences were shared, some of these are noted below:

"The amount of support and information I received was great. The only thing I have a slight gripe with is how long it takes to be discharged. Once they tell you that you can go home it seems a long time after that before everything's done"
Leicester City, 25 – 34, Female

""I was supported well and the nurses provided me with efficient care. I feel that my discharge planning should have been done with my family, as there were too many medications to remember especially as the surgery affected me psychologically and physically I was drained. Overall, the consultants and doctors looking after me were excellent"
Leicester City, 25 – 34, Female

"My discharge procedure went very well. I was told I was going to be transferred to another ward ready for transfer the following day. I told my family I was being discharged today, they went and spoke to the doctor who confirmed I was being discharged that day. They arranged for medication, discharge notes and also ambulance home. The ambulance arrived within 30 minutes to take me home. I was really impressed by the staff and Patient Transport Services"
Melton, 55 – 64, Male

"First of all, my whole experience in the Leicester General hospital was really good. It was my first child so I really didn't know what to expect. But all the staff was very supporting from the beginning till the end. We were discharged because baby and me where both well, so on the 4th day we were discharged"
Leicester City, 25 – 34, Female

"They even helped put my shoes on, couldn't get rid of me fast enough, 100% perfect"
Hinckley & Bosworth, 65 – 74, Male

The nurses were wonderful, in fact everyone was lovely but it took far too long for the pharmacy to sort and send my medication to the ward. I know it's a big hospital but there must be patients being discharged all the time. There were three patients discharged while I was on the ward and everyone was held up waiting for their meds which has a knock-on effect where arrangements for transport are concerned" **Blaby, 55 – 64, Male**

"The feedback from my operation took place while I was still heavily under the influence of anesthetics and as a result was unsure what the outcome of the operation was"
Oadby & Wigston, 25-34, Male

"I was told when I would be discharged then one of the nurses on the ward contacted a member of my family who would be picking me up so that they could come and collect me. Everything went well, nothing needed improving"
Leicester City, 65 – 74, Female

"Drugs were prescribed and delivered promptly. Staff were helpful and caring and I was discharged quickly" **Harborough, 55 – 64, Male**

"Following a check-up 13 days later, the surgery was pronounced a success and I was discharged. The treatment was timely and thorough. The surgeon was excellent, if, at times, somewhat brusque in manner"
Blaby, 65 – 74, Female

"My procedure was a little lengthy but thorough and staff ensured my health and wellbeing was priority"
Charnwood, 25 – 34, Female

"I was put under the care of a Consultant who I eventually met two weeks later when he returned from holiday and illness, and immediately found me fit to go home... His junior team were reluctant to discharge me... Had another consultant or senior doctor seen me in this time perhaps I could have left the hospital 5 days earlier and freed up the room/bed I was in. I was very grateful for the care I had but felt that the delay in discharge resulted in me blocking a bed..."

Leicester City, 65 – 74 years of age, Male

"The staff were all very friendly, attentive and informative. I felt reassured and better prepared for what to expect when I returned home. I had written information to refer to and a number to ring if there were any problems. The consultant also took the time to talk to me on the phone whilst I was still on the ward and prior to my discharge. I wasn't expecting that and felt it showed a real commitment to patient care". "

North West Leicestershire

55 - 64, Female

- Almost half of patients reported their overall experience of being discharged from hospital as above average, with a third rating it below average.
- We asked patients which hospital they were discharged from:

47%	Leicester Royal Infirmary
27%	Leicester General Hospital
19%	Glenfield Hospital
7%	Other

Main Findings - Carer's

We wanted to look at discharge holistically and recognised that carers are well placed to identify areas for improvements to services. Gathering the carers experiences of hospital discharge has enabled us to gain insight into how hospital processes are affecting carers and patients.

What we found

Just under half of carers told us they were not given information about what would happen when the person they cared for was discharged from hospital.

It is safe to assume that not every carer understands the workings of the health and social care system. We have identified that those who care for patients do not feel fully briefed on how a patients care will be addressed once they leave hospital.

Half of the carers we spoke to said that they were not involved in discussions or the planning of discharge for the person they care for. The majority of staff have suggested that they are involving carers in the discussions to discharge patients, however this does not reflect the general view from the carer. This has identified a breakdown in communication.

From the carers we spoke to, over a third rated their experience of hospital discharge below average, with only five carers rating their experience above average. From the comments that carers made, waiting times, communication and feeling uninformed were key drivers in the decision to rate their experiences below average.

We asked carers how easy or difficult is it to find time to get treatment or support for themselves. For example, to make appointments or take a break from caring. Half of the carers that responded told us it was very or extremely difficult. Only two carers found it extremely easy. From previous discussions with carers we know that the age of carers is varied and that many can have their own medical issues to manage. If health professionals do not communicate appropriately with regards to arrangements for people they care for, it makes it difficult to plan their own care. There is also the additional pressure of caring for someone and not having any additional support to provide respite.

What Carer's told us

We provided an opportunity for suggestions and improvements to be shared by carers, we then collated those suggestions and ideas, and summarised them under headings. The following is what emerged from carer experiences.

What support would you like to see more of?

We asked carers to tell us what support they would like to see more of. The following are reflections and comments that carers gave:

- Ensure that family members and carers are given relevant information about illnesses/ treatments and of the on-going plans for the patient's care and treatment. "I want to be kept informed of my mother's prognosis and treatment as the person who has cared for her whilst she was at home for the last 4 years. No attempt was made to do this even though we were visiting her most days". Carers want to receive information about discharge in good time and have the opportunity to speak to those carrying it out.
- Greater support to navigate Continuing Health Care services and for the services to connect better and share information with the hospital. "It's crazy, it's really hard to find someone in the huge machine that is the NHS to make a complaint, to get someone to listen to you, to get help NOW when you need it rather than having to wait 8 weeks for a complaint to be even acknowledged".
- Carers should have more flexibility to plan and coordinate appointments for themselves and the person they care for, as opposed to being given an appointment with no other availability.
- Affordable community and residential respite facilities that provide carers with more support and regular free time.
- Better information and support to allow carers to share their thoughts or perhaps attend a support meeting once a month. This would help with their mental wellbeing, provide peer support and reduce social isolation.

> "It was a difficult time for both my mother and myself. I felt no one at the hospital had the slightest interest in supporting us".
>
> **Leicester City**
> **55-64 years old, Female**

What would you improve?

Carers would like to see better communication across the board in terms of between staff and other staff, and carers and staff. Also, included in this joined up working/communication is Social Services and patient transport, as hospitals need to be able to work better with stakeholders for the benefit of patients. Somewhere within this mix, it is integral to communicate with the carer and to keep them informed and more involved in the process.

It is important when communicating, for hospital staff to be consistent with what patients and carers are told about discharge in order to not raise any expectations of timings and departure.

Also, to ensure that the discharge is planned to meet the patient's needs, taking into account when the carer is available to ensure a safe discharge.

Carers are experiencing inconsistency when it comes to receiving information, often a doctor would say one thing and a nurse would say another. There is no clarity or consistent answers to questions that a carer may have. In some cases, they are not being told anything and carers have felt like a nuisance for asking questions.

"At hospital they refused to let Mum go home until they had decided what care she needed. No one listened to us. At first they wanted her home with only 4 calls a day from a nurse. We said this wasn't sufficient then all of a sudden they changed their mind and now we have a live-in carer and 4 calls a day. On a Wednesday, we also have the shared lives carer. Why someone can't be sensible and cancel the Wednesday is beyond me. It should be looked at on an individual basis. Also, how am I supposed to hold down a full-time job and see consultants, when they refuse to meet me during evenings or weekends".

Blaby
35-44 years old, Female

Rob's story – poor communication

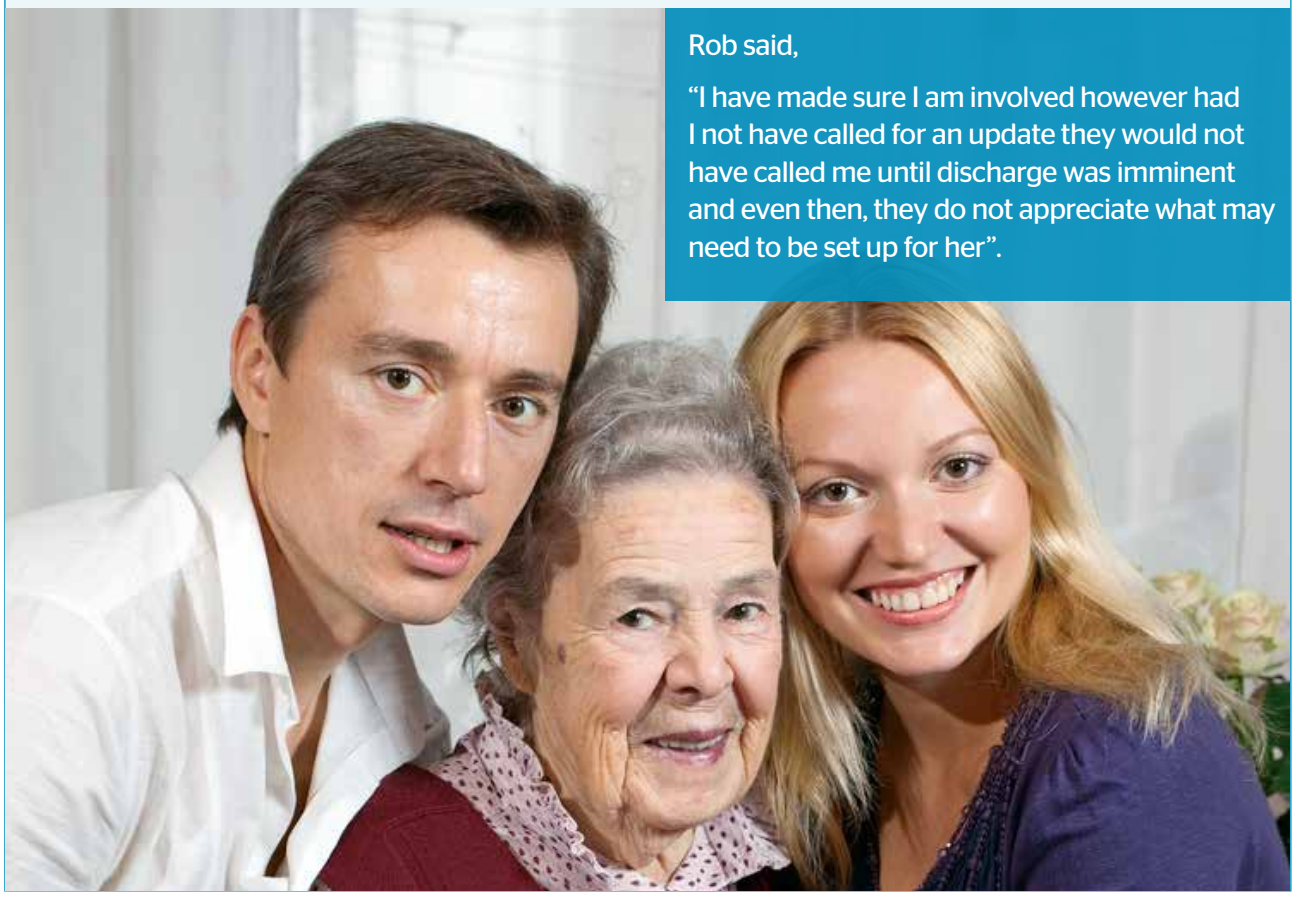
Rob's aunty is 75 years or over and was admitted, then discharged the next day and readmitted again due to uncompleted assessment and treatment of pain.

- Rob is employed full time, 35 - 44 years of age, Male, who lives in Blaby.
- Rob was told on the same day that his aunty went in to hospital for immediate treatment.
- As a carer, Rob rated his overall experience of discharge as a 1 out of 5.

Rob told us that the patient's discharge was delayed to incomplete Continuing Health Care (CHC) assessment. Rob said, "I was informed that she was ready for discharge, so they went to assess her in order to return her to the care home. The next day I was told a CHC assessment was going to be completed, two weeks later she was still in hospital. Finally, I was informed she was ready to be discharged.

Rob was pleased that one of the nursing assistants took it upon herself to inform him that the bay his aunty was in had a contagious disease. "I believe her colleagues where not too impressed, as they wanted me to continue with the assessment in order to get my aunty discharged. Would other staff have told me that there was a contagious disease? Would they have discharged my aunty without informing us if I had not had gone in to see her?"

Consistent communication from staff and discharge specialists is something that Rob would like to see improved. Rob would like to go back to the old system of nursing where the patient had a named nurse that cares for all aspect of the patients care from admission to discharge. "At the moment no one seems to know what anyone else is doing for the patient and a lot of time is wasted in trying to find out and information gets lost in translation".



Rob said,

"I have made sure I am involved however had I not have called for an update they would not have called me until discharge was imminent and even then, they do not appreciate what may need to be set up for her".

Carer's experiences and suggestions for improvements:

Older people

The number of times an elderly dementia patient uses the emergency services should be monitored and discussed within the system and with patients/ carers to try to prevent multiple admissions for one person.

Medications

To have set times for discharge and collection of medications from the pharmacy.

Care

For each nurse to be responsible for the care of specific patients from admission to discharge, in order to help with a consistency of care.

Planned timings

For patients, especially elderly to be discharged at a reasonable time of the day. If this overlaps with lunch/ dinnertime, the patient should be provided with a packed lunch or a meal to take home.

Dignity

Patients should be adequately clothed when being discharged. There has been feedback to suggest that elderly patients have experienced being discharged on a cold day, wearing a hospital nightgown and pyjama bottoms despite having had their own clothes available. Incidences such as this should not happen.

From the data collected, we have highlighted the key messages that have emerged.

- We heard from 30 carers across Leicestershire and when we asked their employment status, 16 carers told us that they were employed, 6 were retired and 1 was unemployed (7 did not answer).

- Two thirds of patients being cared for by a carer, were admitted to hospital in an emergency as opposed to a planned admission.

- We found that almost all of the carers we spoke to (18 out of 20) do not live with the person they care for.

"My mother stayed longer than planned in hospital because her wound took longer to heal (she is diabetic). [The hospital transport] eventually turned up at the same time as the lunch trolley. So, my mother was sent home without lunch... The ward did not contact me to tell me she was being sent home so the first I knew about it was when my mother phoned me at work... I still find it incredible that an elderly diabetic was sent home after 16 days with nothing to eat".

Charnwood
35-44 years old, Female

Main Findings - Staff

Gathering the staff experiences of hospital discharge has enabled us to gain insight into how hospital processes are affecting not only staff, but the lives of patients. From the data collected, we have highlighted the key messages that has emerged.

What we found

The majority of staff we spoke to (34 out of 40) admitted that there are areas that could be improved to benefit the patient's discharge journey. This is reflected by carers and patients who have also commented that staff had not communicated with them sufficiently in regards to the expectation of their care and support as they leave hospital. Staff have also observed that the various departments of the hospital do not often work in alignment for the benefit of the patient or the wider staff team.

Almost all the staff members we spoke to (39 out of 40) told us that discharge processes are delayed due to internal practices. Staff are a crucial part of the puzzle to any practices that may need improvement. Staff have made it clear that they observe a disjointed picture, which may indicate a lack of communication or departments not understanding how they fit in to the bigger picture. This is then filtered down to patients who feel the effects of a broken system and have also commented on the lack of communication around their care as well as delays in their discharge due to internal issues.

Over three quarters of staff (33 out of 40) said they are involved in the care planning and discharge of patients on a weekly basis. However, almost half of the staff told us that they have never had discharge training. This supports the need for a thorough fundamental approach to discharge training for all staff. If the majority of staff are involved in the discharge process (as we have found) at some point and hospitals consistently face issues around discharge. It would seem to be crucial for staff to have a tighter grip and understanding of how processes may improve their discharging of patients.

We asked staff how confident they were when discharging patients and found that just over half felt very or extremely confident. This is a good baseline but we must remember that just under half the staff felt moderately, slightly or not at all confident when discharging patients. Patients and carers have mentioned the lack of consistency with discharging patients, and staff have also identified that training must improve in order to raise the standard and confidence of hospital discharge.

Just under a quarter of staff (9 out of 40) said they are always supported with discharge planning, whilst seven staff members told us that they are rarely supported. This is based on a sliding scale of always, often, sometimes, rarely and never. The varying spread of answers suggests that there is some inconsistency in the process of support and what that support looks like.

What Staff told us

We provided an opportunity for suggestions and improvements to be shared by staff, we then collated those suggestions and ideas, and summarised them under headings. The following is what emerged from staff experiences.

Overall improvements to benefit patients and carers from a staff point of view

Being discharged from hospital is the final part of the process for the in-patient and often the last thing they remember is waiting for hours to go home. To help with this, there must be a more comprehensive discharge process that ensures all pertinent issues are identified on or near to date of admission and an appropriate plan of action is subsequently formulated. This should not be left until the patient is being discharged.

"Ensure that baseline information is confirmed initially after admission and confirm with family or carers of any concerns for returning to their community before planning discharge".

NICE (National Institute for Health and Care Excellence) has recommended[10] that, a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital or community based multidisciplinary team responsible.

Similarly, staff had also commented on the need for greater responsibility around patient discharge. Creating a process where doctors are available to write prescriptions (TTOs) on the wards would help to ensure patients are discharged swiftly. This is also linked to the turnaround time for the pharmacy to dispense medicines, along with a suggestion to have a pharmacist available from 7.30am - 8pm 7 days a week or based on the ward.

10 Transition between inpatient hospital settings and community or care home settings for adults with social care needs https://www.nice.org.uk/guidance/NG27/chapter/Recommendations#discharge-from-hospital

Patients can be seen by multiple consultants at different times, which can prove frustrating for the patient and their carer. Staff told us that discharge co-ordinators have helped to improve communications, by meeting regularly with patients and carer and acting as a family link between specialities.

Proactively communicating with patients about their care is important. Improving communication between teams would undoubtedly be of benefit, including internal and external partners.

Staff comments around what would improve patient experience:

- Discharge letters to be issued in a timely manner.
- More pharmacists with faster turnaround and greater discharge team support per ward.
- An area designated for 'fit for discharge' patients in an environment away from the acute setting. It would be cheaper to use a hotel style system e.g. in a residential home than to keep them in an acute hospital setting.
- A lead person in oncology to facilitate the discharge process for Continuing Health Care funded and end of life patients. This would give a better service and experience to the patients.
- Good communication within the medical team and the medical team plans that document discussions with family and ward staff.
- Speedier and more joined up working with social care. A 7-day a week working culture for both hospital and social service staff.

"Increased pharmacy technicians and pharmacists on the wards to facilitate discharges. Being proactive rather than reactive. Increase the number of computers on the wards to aid discharges".

Anonymous staff member

- A smooth transition from secondary to primary care. Integrate the services to enable staff to in-reach or outreach. This would be particularly beneficial in Therapies (OT specifically).

Why discharge is delayed

Internal issues

Pharmacy medication, 'To Take Out' (TTOs) and Discharge letters

Issues causing the worst delays are:

- Completion of discharge paperwork by medical staff
- Prescription and dispensing of medication, which may at times be done after the doctor has completed his/her ward rounds.

Staff told us that some doctors attitude regarding discharge letters is often that they are not seen as a priority therefore letters are written late. Although staff have said that they do identify at least 48 hours in advance the patients who are being discharged.

Delay in completion of discharge paperwork impacts the pharmacy and can create a bottleneck in terms of preparing medication for the wards and patients. This can be further exacerbated by incorrect prescription writing and a lack of communication between the staff in terms of timescales. This mix can, in many cases, result in late discharges or no discharge at all.

The time of day that the decision is made to discharge a patient can ultimately effect when the patient finally leaves the hospital. If for example a doctor does not complete the discharge letter until 5pm, patients may have to wait for medication, which could mean that from being told they are going home to when they actually do go home, may be many hours.

On any given day, a doctor on his/her ward round may tell the patient he/she can go home, the nurses may then wait several hours for the discharge letter, then more hours for the pharmacy to prepare medication. Some wards do have a

medicine cupboard but it often needs to have a larger selection of stock and also a pharmacy staff member per ward.

General

Staff mentioned a lack of specialist discharge sisters and that there is not enough time for complex discharges. On occasion, poor assessments of a patient's discharge needs take place, along with a lack of knowledge of discharge processes and poor communication between teams.

There is poor communication amongst medical staff when dealing with patients and carers and, messages are often mixed if given at all.

Although there appears to be initiatives to support constant learning within hospitals around discharge, 45% of the staff we heard from, told us that they had never received discharge training. 20% of staff last received training over 2 years ago. In order to truly improve at a pace that is needed, there must be consistent and continuous development of those who are clinically and administratively responsible for delivering effective hospital discharge.

"Patient packages of care are sometimes cancelled which means that they often need a full reassessment by occupational therapy... Patients who need a rehabilitation bed or a nursing/ residential bed have to wait for assessment and a bed to become available. Needing to give 48 hours' notice to care agencies also delays discharge as well as waiting for care providers to have allocated staff..

Anonymous staff member

Why discharge is delayed
External issues
Transport

Delayed discharge has a massive impact on ambulance transport. There is a large patient base that comes from nursing and residential homes and if discharge is late, the cut off times are missed to get patients back home in a timely manner.

Staff often delay discharge as there is not enough available transport to take patients home or to their place of residents. Communication of pick up times to hospital staff could be improved, and often there is a long wait for staff to know definitely when the ambulance will arrive, which creates anxiety and uncertainty for patient and relatives.

Care package

Staff being able to confirm a package of care for a patient is another hurdle that has to be overcome. There can often be a delay in sourcing appropriate and timely care in the community, i.e. continuing health care (CHC).

Delays in discharge can also affect new packages of homecare and can mean that planned care is either put on hold or stopped. The aim should be to restart packages to coincide with the scheduled discharge. There is a lack of availability of care Providers to start care packages at short notice and a lack of capacity to bridge service provision to enable transfer of care to the community.

There are occasions when care homes refuse patients and, family members refuse for patients to return home, intentionally leaving them in hospital for longer than they need to be.

"Patient care packages are at times unable to start for a week with no option or availability of services to bridge the gap. We need a safe ward to send patients that are ready for discharge awaiting nursing homes, rest homes and packages of care. The acute setting is not ideal for these patients".

Anonymous staff member

Summary of additional staff suggestions:

Discharge should include preventing readmission; there is a lack of clear communication and appropriate knowledge of the patient that also slows down discharge.

Doctors should be more available to complete discharge paperwork on the wards and the Pharmacy should be able to respond more quickly to expedite TTO prescriptions.

There is a need to communicate more accurate timings around hospital discharge and to provide the patient with realistic timeframes of when they are expected to leave hospital.

Foster a culture to create better access for relatives to collect patients, which would include a fuller and timely involvement and better communication between hospital staff, carers and families.

There appears to be a lot of schemes within the hospital doing the same thing or something very similar. Streamline all discharge services/processes within the hospital and work more strategically across departments.

We heard from 40 staff members across various hospital sites. The following is a breakdown of where they were based:

- **25** Leicester Royal Infirmary
- **4** Leicester General Hospital
- **9** Glenfield Hospital
- **2** Other

Conclusion

Our research has identified a significant frustration from all parties around consistent delays in hospital discharge. Although at times there appears to be a lack of internal ownership as to who is responsible for improving the system of discharge, we find that there is a desire from staff to tackle the issues and move forward.

Ultimately the people who commission and provide services must deliver improvements in a timely manner, taking into account the views of patients, carers and staff during any process.

Acknowledgements

We would like to acknowledge the support of University Hospitals of Leicester NHS Trust in working closely with Healthwatch Leicestershire to share and listen to patient, carers and staff voices. In particular, the Patient Experience Team and the Communications Team that continue to provide an open door for our engagement.

We would also like to acknowledge the support of our stakeholders who continue to allow us to work through their networks and who welcome the insights of Healthwatch Leicestershire.

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February 2017