

Healthwatch Gloucestershire

*Hospital Discharge Task Group Report,
November 2015:*
Review of progress, March 2017



Disclaimer

Please note this report relates to findings between November 2015 and November 2016. This report is not a representative portrayal of the experiences of all service users, only an account of what was observed or contributed during the review by Healthwatch Gloucestershire.

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1 Executive Summary

1.1 Healthwatch Gloucestershire and discharge from hospital - 2016 review

In November 2015, HWG published a report on people's experiences of leaving hospital. Many people did not experience problems, and HWG received positive feedback. But HWG also heard from some people who experienced significant problems, including

- leaving hospital without appropriate care and support in place at home
- being discharged before they felt ready
- being discharged late in the evening or at night, and/or in night clothes
- a lack of timely and/or appropriate transport for people who needed it
- a lack of information-sharing with their families, carers or other health or social care professionals involved in their care, so that actions were not well-coordinated

In its report, HWG made a number of recommendations to the NHS and social care services in Gloucestershire. It also promised to conduct a review in 2016 to determine the extent of adoption of recommendations; this is the report of that review.

1.2 Action taken on the recommendations (Sections 4 & 6)

Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire Care Services NHS Trust (GCS), and ²gether NHS Foundation Trust (2G) have provided regular updates on their action on the recommendations:

1. *Whole-system ownership and oversight of the discharge process, with consideration given to a single integrated policy including overarching standards for the quality of experience that patients should be able to expect*

2. *Regular review of discharge performance against these standards*

- **GCCG** - The System Discharge Action plan has been incorporated within the System Improvement plan; GCCG continues to support/monitor system delivery of the SAFER CQUIN
- **GCS** - has a Community Hospital Discharge Action Plan; has a working group on the development of discharge standards; ran a 'Listening into Action' workshop in April 2016 for staff from different teams and services including partner organisations, and actions arising from the workshop included
 - Developing an acuity tool to support discharge planning and workload management
 - Discharge to Assess - further improve discharge involving Integrated Community Teams
 - Planning for future Multi-Agency Discharge Events
 - Continued communication between organisations to improve patients' experiences

3. *Measurement of qualitative aspects of discharge, including methods to capture real-time feedback during the course of the process; for instance, to determine whether patient dignity is maintained at all times during the discharge process by all those involved in it*

- **GCCG** - undertakes whole patient journey reviews within its Clinical Effectiveness forum; it expects providers to support real-time feedback mechanisms for discharge, and is following this through with provider organisations
- **GHNHSFT** - the Friends & Family Test is fully automated in the Emergency Department and all outpatient areas; from November 2016 this will extend to inpatient, maternity, and day surgery areas. All paediatric areas remain paper-based
- **GCS** - The Head of Community Hospitals meets regularly with HWG and GCCG's Community Hospitals Senior Commissioning Manager to review the Discharge Action Plan; plans are in place to capture feedback from patients and/or carers through a survey conducted in partnership with HWG

4. *Extending any schemes seeking views of patients about their experience of discharge and their suggestions for improvements to the families of those with dementia and those in receipt of end-of-life care*

- **GHNHSFT** - is participating in the National Dementia Care Audit run by the Royal College of Psychiatrists which includes capturing feedback from carers. The Trust End of Life Care group has been reviewed; the revised group will review experience and safety metrics relating to end of life care including discharge on a regular basis

5. *A single-point authority in hospitals to ensure compliance with all relevant procedures, to prevent a discharge where arrangements for subsequent care are not in place*

6. *Closer and more systematic dialogue with care homes*

- **GHNHSFT** - a joint summit was held in September 2015; regular communication mechanisms have since been established between organisations involved in patient discharge across the health and social care system, including regular meetings with Care Home Select, GCCG-led Care Home Stakeholders meetings, and establishment of care home manager's forum. The Integrated Discharge Team is involved in all discharges that involve care homes
- **2G** - A Service Plan objective this year is to strengthen care pathways across community and inpatient services, including emphasis on effective communication about admissions and discharges to service users, families, GPs and other providers

7. *The safety of elderly and vulnerable patients should be a priority; transport, food, heating and availability of support at home and effective liaison with primary care are all relevant to a patient's experience of hospital discharge and should be checked routinely and in a timely way*

- **GHNHSFT** - the Emergency Care Board has been working with partners on improving the quality and timeliness of patient movement throughout care pathways, and ensure discharge planning is considered as early as possible; a discharge planning communication resource folder for clinical staff to aid identification and meeting of discharge needs has been introduced; in August 2016, hospital and community clinicians worked in partnership with GCCG and expert patients to review discharge planning arrangements for complex patients

8. Agreement and enforcement of standards for the quality, content and timeliness of discharge information to be shared with GPs; in particular over clarity about future treatment, tests and changes in medication with clear indication of where the responsibility lies for further action

- **GHNHSFT** - Implementation for the first phase of the electronic patient information system TrakCare had been rescheduled to September 2016. The TrakCare discharge summary has been produced in consultation with GP representatives, and will contain an area for free text so that specific details can be conveyed more fully
- **GCS** - Feedback gathered from GPs about what would constitute a 'good' discharge summary, and a template agreed for GCS's electronic clinical record system. All community hospitals are now using the same template

9. Review of communication with patients about discharge (letters, leaflets, website etc), including the following key questions:

- a. Do these methods adequately prepare patients and families for what will happen to them?*
- b. Do they set realistic expectations?*
- c. Do they communicate effectively to a range of potential readers?*
- d. Do they signpost effectively to other services?*
- e. Are there opportunities for greater consistency between Gloucestershire's NHS providers in how they communicate with people about discharge from hospital?*

- **GHNHSFT** - The Integrated Discharge team Head is leading work during the autumn to review current discharge processes and communication systems and the current information available to patients and carers via leaflets or the Trust's website
- **GCS** - The review of patient information is being taken forward by the working group looking at the development of discharge standards (referenced under recommendations 1 & 2)
- **2G** - Electronic screens to supplement paper based information have been installed in all hospital facilities and in community bases. The introduction of Triangle of Care in 2015 focused all in-patient teams (and community teams this year) on the importance of the connected relationship between service user / carer / health care professional. The Trust is implementing the Triangle of Care for and with Young Carers this year also in partnership with Gloucestershire Young Carers

10. Consideration of whether the volume, mix and distribution of resources, including staff and beds is appropriate for the number of people being discharged and their likely care needs, both now and in the future

- **GCCG and GCS** - continue to work together to enhance community nursing provision.
- **GCCG and 2G** - working with Swindon Mind to develop additional resources in the pathway of support for people experiencing acute mental illness

1.3 Feedback collected about experiences of being discharged (Sections 5 & 6)

HWG collected 53 experiences of hospital discharges which took place between November 2015 and November 2016. HWG compared the nature of the feedback with that in its original report.

GHNHSFT (26 experiences) - Experiences of being discharged late in the evening or at night, and/or in night clothes, did not feature in the new feedback. There were positive experiences of discharge planning, the Discharge Waiting Area, and follow-up after discharge. However, some original issues continued to feature, including

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready, followed by readmission in some instances
- a lack of information-sharing with families, carers or other professionals involved in their care
- long waits for transport between hospitals and care homes
- delays waiting for medication
- lack of clarity in the discharge summary

GHNHSFT & GCS combined (3 experiences) - Some original issues continued to feature:

- a lack of follow-on care and/or support arranged
- re-admission shortly after discharge

One experience also reflected on the availability of community hospital beds in different parts of the county, and the impact this had on the family.

GCS (8 experiences) - Experiences reflecting a lack of District Nurse provision did not feature in the new feedback. There were positive experiences of discharge planning. However, some original issues continued to feature, including

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready
- poor communication with people and their families

2G - HWG heard from one person, who was being discharged before they felt ready.

Unspecified hospitals (5 experiences) - Some of the original issues continued to feature:

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready

Social care (10 experiences) - Some people shared positive experiences of follow-on support. Other experiences included

- a lack of on-going support available, once the time-limited follow-on support had ended
- a lack of assessment of the suitability of the home environment
- a lack of needs assessment once the time-limited follow-on support had ended
- delay to discharge due to a lack of home care available
- poor communication with people and their families

HWG visited the discharge waiting areas in Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH) in September 2016. The experiences of people using the DWAs when HWG conducted its visits were broadly positive. The key findings were

- Food and drink was available and offered to all patients
- Care at home had been arranged for most people who needed it
- Information about the Home from Hospital Service was not provided to eligible people
- Equipment had been arranged for most who needed it
- People's views about DWA staff were positive
- The majority of feedback about communication was positive, but some people had experienced problems
- A few people were experiencing long waits for Non-Emergency Patient Transport (NEPT). In one case, this impacted on a home care provider
- A few were ready to go home but were waiting in the DWA for medication to be prepared

1.4 Conclusions and Recommendations

This review reports on many of the system improvements that have been made, both locally and nationally, since this report was published. It also highlights the challenges that remain locally, which echo those identified nationally in Section 3.

By sharing individual's stories, this review demonstrates the impact these improvements and challenges have upon people leaving hospital, and their families and carers.

HWG recommends that

- **GCCG, NHS provider organisations and Gloucestershire County Council (GCC) continue in their ongoing work to address the recommendations made in the 2015 HWG report on hospital discharge**
- **GCCG, GCC and NHS provider organisations carefully consider the evidence presented in this review, to identify what the findings reveal about current system weaknesses**
- **NHS provider organisations acknowledge the value of the 'patient story', and look to gather patient stories of their journey through the hospital and beyond to illustrate patient experience that is not captured through the Friends and Family Test in enabling system learning**
- **HWG continues to monitor people's experience of being discharged from hospital, and conducts a further review in 12 months**

2 Introduction

In November 2015, HWG published a report on people's experiences of leaving hospital. HWG listened to patients and their families, to health and social care professionals, and to staff working for Voluntary and Community Sector organisations. It learned that Gloucestershire hospitals carried out around 150,000 discharges in the last year. It observed that there is no single, typical experience of being discharged from hospital. The process might involve one, or several, organisations; it may be straightforward, or complex; and it can take place quickly, or over a longer period of time.

Many people did not experience problems during the process, and HWG received positive feedback. But HWG also heard from some people who experienced significant problems.

These included:

- leaving hospital without appropriate care and support in place at home
- being discharged before they felt ready, in some instances leading to readmission soon afterwards
- being discharged late in the evening or at night, and/or in night clothes
- a lack of timely and/or appropriate transport for people who needed it
- a lack of information-sharing with their families, carers or other health or social care professionals involved in their care, so that actions were not well-coordinated

HWG also found

- inconsistency in the effectiveness of discharges between organisations and in some cases between different parts of the same organisation
- the discharge process between different organisations could be fragmented, and no single provider organisation had oversight of all aspects of such a patient experience, or responsibility for action-planning whole-system improvements to those complex systems
- there was no source of qualitative feedback enabling people to evaluate their experience of the complex process of being discharged, that is then shared across organisations
- inconsistent standards, content, and timeliness of discharge summaries sent to GPs, particularly from acute hospital settings
- examples of insufficient and/or inaccurate information accompanying patients when they were discharged to care homes, adversely impacting on their subsequent care
- discharge planning and discussions with patients and families appeared to be difficult when resources were constrained in ward settings, and where complex conversations could divert time from other patients

In its report, HWG made a number of recommendations to the NHS and social care services in Gloucestershire:

1. Whole-system ownership and oversight of the discharge process, with consideration given to a single integrated policy including overarching standards for the quality of experience that patients should be able to expect
2. Regular review of discharge performance against these standards
3. Measurement of qualitative aspects of discharge, including methods to capture real-time feedback during the course of the process; for instance, to determine whether patient dignity is maintained at all times during the discharge process by all those involved in it
4. Extending any schemes seeking views of patients about their experience of discharge and their suggestions for improvements to the families of those with dementia and those in receipt of end-of-life care
5. A single-point authority in hospitals to ensure compliance with all relevant procedures, to prevent a discharge where arrangements for subsequent care are not in place
6. Closer and more systematic dialogue with care homes
7. The safety of elderly and vulnerable patients should be a priority; transport, food, heating and availability of support at home and effective liaison with primary care are all relevant to a patient's experience of hospital discharge and should be checked routinely and in a timely way
8. Agreement and enforcement of standards for the quality, content and timeliness of discharge information to be shared with GPs; in particular over clarity about future treatment, tests and changes in medication with clear indication of where the responsibility lies for further action
9. Review of communication with patients about discharge (letters, leaflets, website etc), including the following key questions:
 - a. Do these methods adequately prepare patients and families for what will happen to them?
 - b. Do they set realistic expectations?
 - c. Do they communicate effectively to a range of potential readers?
 - d. Do they signpost effectively to other services?
 - e. Are there opportunities for greater consistency between Gloucestershire's NHS providers in how they communicate with people about discharge from hospital?
10. Consideration of whether the volume, mix and distribution of resources, including staff and beds is appropriate for the number of people being discharged and their likely care needs, both now and in the future
11. HWG to conduct a review in 2016 to determine the extent of adoption of recommendations

This is the report of the HWG review.

3 Discharge from hospital in 2016 - the national picture

Discharge from hospital continues to be the focus of considerable national concern, activity and scrutiny, and local services are operating in this environment.

National concern, activity and scrutiny over the past twelve months includes:

3.1 Healthwatch England and the Department of Health's Discharge Programme

Healthwatch England's report *Safely Home: What happens when people leave hospital and care settings?* was published in July 2015 ¹. HWG contributed towards this report. Shortly before its launch, the Department of Health and Healthwatch England jointly chaired a meeting of key national and local government, health, care and voluntary sector organisations to map out a way forward. Discussions continued throughout 2015 and into 2016, informed by reports from NHS Providers (the membership organisation and trade association for the NHS) and the NHS Confederation's Commission on Urgent Care for Older People ².

The Department of Health Shared Delivery Plan presented opportunities for the Department and the NHS to tackle the challenges upon which *Safely Home* shone a light; and the Department of Health Discharge Programme was launched in December 2015. This programme is being overseen by a board representing the Department of Health, the Department for Communities and Local Government, NHS England, NHS Improvement, the Association of Directors of Adult Social Services and the Local Government Association. Its primary focus is on delayed discharge, but its scope also includes the need to improve patient experience and outcomes through more effective processes across health and care. Healthwatch England is represented on the programme's expert reference group.

3.2 NHS England 'Quick Guides' published as part of the Keogh Urgent Care Review

NHS England has published a series of 'Quick Guides' to support local health and care systems as part of the Keogh Urgent Care Review ³. The guides provide practical tips, case studies and links to useful documents, which can be used to implement solutions to commonly experienced issues; a number of them relate to discharge from hospital. *Improving Hospital Discharge into the Care Sector* and *Better use of Care at Home* were both published in November 2015; *Discharge to Assess* was published in October 2016. HWG attended an NHS England workshop in April 2016 to assist in drawing up the *Discharge to Assess* Quick Guide; and HWG members also provided feedback on a draft version of the Guide in July 2016.

3.3 National Institute for Health and Care Excellence guideline Transition between inpatient hospital settings and community or care home settings for adults with social care needs - December 2015

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE was originally set up in 1999 as the National Institute for Clinical Excellence, a special health authority, to reduce variation in the availability and quality of NHS treatments and care.

NICE published its guideline *Transition between inpatient hospital settings and community or care home settings for adults with social care needs* in December 2015 ⁴. This guideline aims to

improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.

The guideline includes recommendations on:

- Person-centred care and communication and information sharing
- Activity before admission to hospital: including developing a care plan and explaining what type of care the person might receive
- Activity on admission to hospital: including the establishment of a hospital-based multi-disciplinary team
- Activity during hospital stay: including recording medicines and assessments and regularly reviewing and updating the person's progress towards discharge
- Discharge from hospital: including the role of the discharge coordinator
- Supporting infrastructure
- Training and development for people involved in the hospital discharge process.

3.4 NHS England local Commissioning for Quality and Innovation indicator - March 2016

NHS England launched a new local Commissioning for Quality and Innovation (CQUIN) indicator aimed at increasing the proportion of patients who are discharged to their usual place of residence within 7 days of admission to hospital ⁵. NHS Improvement (an organisation launched in April 2016 to replace Monitor, the NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the advancing Change team and the Intensive Support Teams) said that using the framework could improve patient flow and lead to better patient outcomes while reducing the financial pressure within NHS Trusts.

3.5 NHS England/Academy of Medical Royal Colleges Standards for the communication of patient diagnostic test results on discharge from hospital - March 2016

NHS England published a set of generic standards, endorsed by the Academy of Medical Royal Colleges, describing acceptable practice for the communication of patients' diagnostic test results on discharge from hospital ⁶.

Three overarching principles guide this work:

- that the clinician who orders the test is responsible for reviewing, acting and communicating the result and actions taken to the General Practitioner and patient even if the patient has been discharged
- that every test result received by a GP practice for a patient should be reviewed and where necessary acted on by a responsible clinician even if this clinician did not order the test
- that patient autonomy should be respected, consideration given to reasonable adjustments for people with learning disabilities and mental health problems and, where appropriate, families, carers, care coordinators and key workers should be given the opportunity to participate in the handover process and in all decisions about the patient at discharge

3.6 Parliamentary & Health Service Ombudsman's Report of investigations into unsafe discharge from hospital - May 2016

The Parliamentary & Health Service Ombudsman (PHSO) is the final stage for complaints about the NHS in England and public services delivered by the UK Government. In May 2016, the PHSO published its *Report of investigations into unsafe discharge from hospital* ⁷. The report focused on nine experiences drawn from recent complaints, which the PHSO said best illustrated the problems it was seeing. It said it was publishing these cases to highlight the human costs of poorly planned discharge in terms of patient outcomes and experience, and the anguish it can cause families and carers.

The PHSO said the most serious issues it identified were:

- Patients being discharged before they are clinically ready to leave hospital
- Patients not being assessed or consulted properly before their discharge; while a person may be 'medically fit' to leave hospital, they may not be practically ready to cope at home
- Relatives and carers not being told that their loved one has been discharged
- Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

It highlighted three key areas warranting particular attention:

- Failures to check people's mental capacity and offer legal protections for those who lack capacity
- Carers and relatives not being treated as partners in discharge planning
- Poor co-ordination within and between services

3.7 National Audit Office's report *Discharging older patients from hospital* - May 2016

The National Audit Office (NAO) scrutinises public spending for Parliament. It published its report on *Discharging older patients from hospital* in May 2016 ⁸.

The NAO's key findings included

- Rising demand for services, combined with restricted or reduced funding, was putting pressure on the capacity of local health and social care systems
- Health and social care providers had made limited progress in adopting the three recommended good practice principles in discharge planning and delivery (early identification of needs, maintaining momentum of treatment and discharge planning, and assessment and rehabilitation at home)
- Workforce capacity issues in health and social care organisations were making it difficult to discharge older patients from hospital effectively
- NHS England had established system resilience groups as the main local forums for planning and coordination of health and social care services, but they were not yet effective
- Health and social care organisations were not sharing patient information effectively
- There had been a lack of coordination in central government work aimed at improving discharge practice

3.8 Public Accounts Committee's report *Discharging older people from acute hospital* - July 2016

Parliament's Public Accounts Committee scrutinises the value for money - the economy, efficiency and effectiveness - of public spending. It published its report *Discharging older people from acute hospital* in July 2016 ⁹.

The Public Accounts Committee found that, increasingly, older patients were experiencing delays in being discharged from hospital. Its report said that, while it was clear there had been improvements and that both the NHS and local government were making significant effort, the Department of Health and NHS England relied too much on differing local circumstances as an excuse for not securing improvement in performance. It recommended that they should do more to increase the pace of integration and make local accountability systems more effective. It said that the Department of Health, NHS England and NHS Improvement had failed to address long-standing barriers to sharing information and good practice between health and social care sectors and taking up good practice, resulting in unacceptable variation in local performance. It recognised there were significant pressures on adult social care and NHS funding, but said that NHS England showed a poverty of ambition in believing that holding delays to the current inflated level would be a satisfactory achievement, as patients and the NHS had a right to expect better.

3.9 Public Administration and Constitutional Affairs Committee report *Follow-up to PHSO report on unsafe discharge from hospital* - September 2016

Parliament's Public Administration and Constitutional Affairs Committee examines constitutional issues and the quality and standards of administration within the Civil Service; it also scrutinises the reports of the Parliamentary and Health Service Ombudsman. It published its report *Follow-up to PHSO report on unsafe discharge from hospital* in September 2016 ¹⁰.

The committee found that the discharge failures identified by the PHSO report were not isolated incidents, but rather examples of problems that patients, relatives and carers were experiencing more widely. It identified a need for more data to be gathered on the scale and impact of these discharge failures. It heard that pressures on resources and capacity within hospitals were leading to worrying and unsafe discharge practices, and called upon health and social care leaders to ensure that staff were operating in a culture where person-centred care is the undisputed priority.

It said that the historic split between health and social care meant that interdependent services were being managed and funded separately, which it considered to be political maladministration. It said that the problem of unsafe discharge required high levels of trust and openness between leadership and staff, to ensure that staff were empowered to make the decisions that put patients, their relatives and carers first. It expected the Healthcare Safety Investigation Branch (HSIB) to play a major role in investigating serious incidents of unsafe discharge and to ensure that learning was disseminated and implemented throughout the NHS.

3.10 Care Quality Commission report *The state of health care and adult social care in England 2015/16* - October 2016

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It published its report *The state of health care and adult social care in England 2015/16*¹¹ in October 2016.

This showed that, despite increasingly challenging circumstances, much good care is being delivered and encouraging levels of improvement are taking place. However, the CQC said that the sustainability of this position is in doubt. It was beginning to see evidence of deterioration in quality, and some providers were struggling to improve their rating beyond ‘requires improvement’.

The CQC said that the fragility of the adult social care market and the pressure on primary care services were beginning to impact both on the people who relied on these services and on the performance of secondary care. It said that the evidence suggested “we may be approaching a tipping point”. The combination of a growing and ageing population, people with more long-term conditions and a challenging economic climate meant greater demand on services and more problems for people in accessing care. The CQC said this was translating to increased A&E attendances, emergency admissions and delays to people leaving hospital, which in turn was affecting the ability of a growing number of trusts to meet their performance and financial targets.

4 Discharge from hospital in 2016 - the local picture

4.1 The number of patients discharged from hospital in Gloucestershire

In Gloucestershire, the number of patients discharged in a 12-month period was

- 138,454 by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) - Cheltenham General Hospital, Gloucestershire Royal Hospital, and Stroud Maternity Unit - in the 12 months between August 2015 and July 2016 (excluding well babies and those people admitted for daily treatment such as chemotherapy) ¹²
- 3,095 by Gloucestershire Care Services NHS Trust (GCS) - the community hospitals ¹³
- 897 by the Together NHS Foundation Trust (2G) - the mental health inpatient services - in the 12 months between August 2015 and July 2016 ¹⁴

4.2 Health and social care initiatives/responses to HWG recommendations

4.2.1 Gloucestershire Clinical Commissioning Group (GCCG)

GCCG has provided HWG with regular updates on its activities through the year. Its latest update corresponds to the following recommendations in the report, as shown in Section 1 ¹⁵:

Recommendations 1 & 2

The System Discharge Action plan has been incorporated within the System Improvement plan for 4 hours. GCCG continues to support and monitor the system delivery of the SAFER CQUIN. For 2017/18, GCCG is considering the development of one system-wide CQUIN to support discharge, and it will look to work with HWG on this as it develops.

Recommendation 3

GCCG accepts that the information from Friends and Family test, PALS and Healthwatch can be historic. Alongside this, it undertakes whole patient journey reviews within its Clinical Effectiveness forum, of which Healthwatch Gloucestershire is a member. It is GCCG's expectation that providers support real-time feedback mechanisms for discharge, and it is following this through with all its provider organisations.

Recommendation 8

The timeliness and content of discharge summaries is a key requirement of the services GCCG commissions. GCCG continues to work on this area to ensure that it is developing and supporting resources within primary care.

Recommendation 10

Healthwatch Gloucestershire is represented on the Discharge to Assess working group, which meets monthly. This is a two-year programme of work. The CCG and GCS continue to work together to enhance community nursing provision. As of 1 August 2016, there are no substantive vacancies across the county at both Band 6 and Band 5 level.

4.2.2 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

GHNHSFT has provided HWG with regular updates on its activities through the year. Its latest update corresponds to the following recommendations in the report, as shown in Section 1¹⁶:

Recommendation 4

The Trust continues to capture feedback from carers of patients with cognitive impairment including dementia and is currently participating in the National Dementia Care Audit run by the Royal College of Psychiatrists which includes capturing feedback from carers and staff who care for patients with dementia and memory impairment.

The output from its visits to three Alzheimer's Society-run memory cafes during winter 2016/17 was reported to the Trust Dementia Care group in February 2016, with the report also shared at that time with the Alzheimer's Society and Carers Gloucestershire. The main themes that were identified related to provision of support for carers - both inside and outside of the hospital environment. The Trust works closely with Carers Gloucestershire and hosts a Carer Liaison Officer who provides support and advice to carers in both outpatient and inpatient settings. Since the report findings, it has worked with Carers Gloucestershire to revise its internal methods of identifying carers and signposting for support and guidance. As a result, its "carer's passport" was launched in June as was its continued commitment to John's Campaign; information for staff and carers regarding overnight facilities can now be found on the carers pages of its website and all ward areas now have a carers resource folder for staff. It is also currently working with Gloucestershire Young Carers to develop an information resource for younger carers of patients.

With respect to End of Life Care, senior clinical representatives of the Trust have been involved in the Gloucestershire CCG led county-wide End of Life Care group which has been developing a countywide strategy for End of Life Care. This group has involved representation from patients and HWG and the development of the strategy has drawn on the feedback from families and patients both national and local including those comments captured from HWG engagement events. The Trust End of Life Care group has been reviewed with the initial meeting of the revised group due to take place in September. This group will be responsible for implementation of the county strategy and will also review on a regular basis experience and safety metrics relating to end of life care including discharge.

Recommendation 6

Following a joint summit held in September 2015, a number of regular communication mechanisms have now been established to facilitate improved working between organisations across the health and social care system that are involved in patient discharge. These include regular meetings with Care Home Select, membership of the GCCG-led Care Home stakeholders meeting and attendance at the newly established care home manager's forum.

The Trust clarified that the Integrated Discharge Team is involved in all discharges that involve care homes not just the complex discharges. Individual ward areas communicate with care homes around individual patient needs. The Head of the Integrated Discharge team will be leading further work during the autumn reviewing the current discharge processes and communication systems and will involve care home partners in this work. This review will include a review of the current information available to patients and carers via leaflets or the Trust's website.

In relation to the process for enhanced communication, Trakcare (the new Electronic Health Record) has the facility to allow nursing noting to be incorporated as part of the discharge summary which will improve communications with GPs and care homes about individual patient needs.

Recommendation 7

GHNHSFT has been working with partners throughout the past year on improving the quality and timeliness of patient movement throughout their care pathways, and to ensure that discharge planning is considered as early as possible. This programme of work is directed and monitored by the Emergency Care Board and is overseen by the Quality Committee. It cited recent examples of success, including the introduction of a discharge planning communication resource folder which assists clinical staff in identifying and meeting discharge needs; and in August 2016, teams of hospital and community clinicians in partnership with the Gloucestershire CCG and expert patients worked together to jointly review discharge planning arrangements for complex patients.

Recommendation 8

The implementation date for the first phase of Trakcare had been rescheduled from May 2016 to September 2016. The TrakCare discharge summary has been produced in consultation with the discharge group co-chaired by Dr Janet Ropner, Associate Medical Director at the Trust and Dr Hein Le-Roux, GP and GCCG-Board member and which includes membership from primary care and other healthcare providers. The format and much of the content of the discharge summary is dictated by the Department of Health's Health and Social Care Information Centre (HSCIC). The discharge summaries will contain an area for free text so that any specific details can be conveyed more fully.

The Trust explained that the NHS England contractual standard relating to Discharge Summaries is 85% issued within 24 hours. Its performance so far this year has exceeded that target and reflects the continued focus within the Trust on this important communication.

Collecting patient feedback - the Friends & Family Test (Recommendation 3)

In the October edition of GHNHSFT's newsletter *Involve*¹⁷, Chief Executive Deborah Lee announced that the new Friends & Family Test system was now fully automated in the Emergency Department and all outpatient areas; and from November, inpatient, maternity, and day surgery areas would go live too. All paediatric areas would remain paper-based and the team would be continuing with the 'Monkey Wellbeing' and 'Pants and Tops' child-friendly theme.

Patients will be contacted within 48 hours of discharge and will be invited to leave their feedback using either SMS or Interactive Voice Messaging (telephone). Cards will still be available to patients who wish to continue to use this method. Posters have been put up throughout the Gloucester and Cheltenham sites to ensure that patients are aware that they will be contacted.

4.2.3 Gloucestershire Care Services NHS Trust (GCS)

GCS has provided HWG with regular updates on its activities through the year. Its latest update corresponds to the following recommendations in the report, as shown in Section 1¹⁸:

Recommendations 1 & 2

Two actions arising from GCS's Community Hospital Discharge Action Plan were: to run a workshop for staff; and to develop a set of standards for discharge including the quality of experience that patients and their carers should be able to expect.

The workshop took place in April 2016, as a GCS 'Listening into Action' event. The staff who attend identify the actions they wish to take forward. It was attended by Trust colleagues from a number of different teams and services including partner organisations.

Actions that emerged from the workshop included

- Developing an acuity tool to support discharge planning and workload management
- Discharge to Assess - further improve discharge involving GCS's Integrated Community Teams (ICTs)
- Planning for future Multi-Agency Discharge Event (with GHNHSFT in August and GCS-organised in October and December 2016)
- Continued communication between organisations to improve the movement of patients and their experiences to best effect

Because the development of discharge standards was not one of the actions identified at the workshop, GCS has a separate working group to progress this further.

Recommendation 3

The GCS Head of Community Hospitals meets regularly with HWG and GCCG's Community Hospitals Senior Commissioning Manager, to review the Discharge Action Plan. Plans are in place to capture feedback from patients and/or carers through a survey conducted in partnership with HWG.

Recommendation 8

Following feedback from GPs about what would constitute a 'good' discharge summary, it was agreed to use the template on GCS's electronic clinical record system. An audit in April 2016 indicated that this template was not being used in one locality; this has since been addressed and all community hospitals are now using the same discharge summary template.

Recommendation 9

The review of patient information is being taken forward by the working group which is looking at the development of discharge standards (referenced under recommendations 1 & 2).

4.2.4 Together NHS Foundation Trust (2G)

2G has provided HWG with updates on its activities. Its latest update corresponds to the following recommendations in the report, as shown in Section 1¹⁹:

Recommendation 6

The Trust is progressing initiatives to empower people who use its services to co-produce their plan of care with practitioners and family members wherever possible. Work is ongoing with all clinicians to ensure that letters are copied to service users/carers (wherever appropriate) to ensure effective engagement and communication.

An objective of the Trust's Service Plan this year is to strengthen care pathways across community and inpatient services. This will include further emphasis on effective communication about admissions and discharges to service users, families, GPs and other providers.

Recommendation 7

The safety of elderly and vulnerable people of any age must be a priority in relation to discharge practice, so that people are supported to continue with their recovery, habilitation and/or care with attention to their everyday needs and environment. To support this and enable the Trust's Board to gain assurance of best practice, it has a Key Performance Indicator which is routinely monitored to ensure that patients are followed up after discharge from its hospital services.

This requires that at least 95% of service users discharged from our inpatient units receive follow up within 48 hours. The metric for the year to date suggests that 96.8% of people who have been discharged have been followed up in this way. This approach forms part of the Trust's discharge planning pathway and requires liaison with community services (2G) services and others) to ensure safe and successful hospital discharge for our service users.

There are two underpinning Trust policies that guide this; the Assessment and Care Management Policy and the Discharging from In-patient Units including 48 Hour Follow Up Policy.

Recommendation 9

Electronic screens to supplement paper based information have been installed in all hospital facilities and in community bases. Patients and their families are encouraged to ask questions and to be involved in planning discharge.

Patients are also invited to take part in a questionnaire on discharge from hospital. These are offered in addition to other surveys (for example Friends and Family Test) and are offered to patients either at the pre-discharge Multi-Disciplinary Team or at a Section 117 meeting just prior to leaving Wotton Lawn Hospital. The same process is in place for Charlton Lane Hospital with the exception of Willow Ward where an adjusted process is undertaken to accommodate the cognitive needs of people experiencing dementia.

The introduction of Triangle of Care in 2015 focused all in-patient teams (and community teams this year) on the importance of the connected relationship between service user / carer / health

care professional, as partners in care. The Trust is implementing the Triangle of Care for and with Young Carers this year also in partnership with Gloucestershire Young Carers.

Recommendation 10

The Trust is working with GCCG and Swindon Mind to develop additional resources in the pathway of support for people experiencing acute mental illness. The details of the service are yet to be agreed. However, the Trust is interested to replicate a similar resource to that provided for and with people in Swindon, which offers planned accommodation for people where, without support at a set point in time, a crisis might be anticipated. A planned stay would be part of an individual's plan of care. This facility is being developed with people who have expertise by experience.

5 Feedback collected about people's experiences of being discharged

5.1 Feedback collected by HWG through community engagement

HWG routinely collects comments from people about their care through community engagement. These comments are anonymised and reported to commissioners and providers of care on a quarterly basis. For NHS organisations in Gloucestershire, key themes are then reported to their respective quality assurance committees.

Through the Gloucestershire Voluntary and Community Sector (VCS) Alliance and through its own links, HWG liaises with voluntary and community organisations and other organisations across Gloucestershire, which provide support and/or advice to people leaving hospital, and their families and carers. Staff and volunteers from these organisations share comments about people's experiences of being discharged.

HWG collected 53 experiences of hospital discharges which took place between November 2015 and November 2016. 16 of these experiences were shared with HWG by front-line staff including voluntary and community sector staff.

These experiences are summarised below - those which were shared with HWG by front-line staff are identified as such.

5.1.1 GHNHSFT. 26 experiences: 8 at Cheltenham General Hospital (CGH), and 18 at Gloucestershire Royal Hospital (GRH)

	location	date	experience
1	GRH	December 2015	Discharge was attempted before the person (who has a terminal illness) felt ready.
2	CGH	January 2016	Delays to discharge following transfer from one ward to another; a lack of care provided (including medication and food) while waiting to be discharged; further delays associated with medication needed to take home; and problems associated with the information in the discharge summary.
3	GRH	January 2016	A lack of follow-on care/support arranged for a gentleman in his 80s; re-admission to hospital the following day.
4	GRH	January 2016	Discharge before the person felt ready; re-admission to hospital the following day.
5	GRH	March 2016	A 24-hour wait for discharge.

6	GRH	March 2016	Re-admission of an elderly lady within 24 hours of leaving hospital; a lack of follow-on care/support arranged when the person was discharged again; a lack of reablement support available. (shared by Village Agent)
7	GRH	April 2016	A positive experience of discharge planning in hospital for a lady in her 80s; a lack of dignity experienced in the Discharge Lounge; a lack of clarity about medical responsibility and responsibility for medication administration in the Discharge Lounge; 5¾ hours between leaving the ward and leaving the Discharge Lounge for transfer to a nursing home.
8	Bristol Heart Institute and CGH	April 2016	Discharge from Bristol Heart Institute before the person felt ready; a lack of follow-on care/support arranged; admission to CGH five days later; discharge from CGH was originally attempted before the person felt ready; a lack of follow-on care/support arranged.
9	CGH	May 2016	A lack of options offered for care on discharge of a person at the end of life; re-admission within two weeks. (shared by Village Agent)
10	GRH	May 2016	A positive experience in the Discharge Lounge.
11	GRH	May 2016	A lack of information/communication with a young patient and their family about on-going treatment required; re-admission to hospital within a week.
12	GRH	May 2016	Discharge was attempted before follow-on care/support had been arranged for a lady in her 80s; when she was discharged home, the follow-on care/support which had been arranged was not forthcoming.
13	CGH	June 2016	A lack of follow-on care/support arranged for an elderly gentleman; re-admission to hospital within a week.
14	GRH	June 2016	Limited support offered at home for a person at the end of life.
15	GRH	July 2016	Hospital staff encouraging the friend of a patient to organise the support required at home.
16	GRH	July 2016	11½ hours between arrival in the Discharge Lounge and arrival at home for a vulnerable gentleman in his 90s with cognitive impairment who lives in a care home; a lack of information available about whether food or medication had been provided in the Discharge Lounge; the discharging ward was unable to tell the family whether or not the gentleman had left the hospital; given the incorrect medication to take home.
17	CGH	July 2016	A positive experience of discharge planning.

18	GRH	August 2016	Medication for a vulnerable patient to take home was not provided in blister packs. (shared by sheltered housing scheme manager)
19	CGH	August 2016	A lack of follow-on support arranged for a gentleman at the end of life; re-admission within 3 days. (shared by Village Agent)
20	GRH	September 2016	Discharge delayed because a care home was unable to provide the higher level of support now required by an elderly lady; a lack of communication with her husband. (shared by Village Agent)
21	GRH	September 2016	A positive discharge experience for a young person and their family, including a follow-up call the next day.
22	CGH	September 2016	Discharge plan for an elderly lady was changed, and she was discharged home instead of to a community hospital; a lack of follow-on care/support arranged; re-admission soon afterwards. (shared by Village Agent)
23	CGH	September 2016	A delay to discharge, caused by delays with arranging medication to take home, and the discharge summary.
24	GRH	September 2016	Re-admission of an elderly lady to hospital within 24 hours of being discharged. (shared by sheltered housing scheme manager)
25	GRH	October 2016	An inadequate level of follow-on care/support arranged (shared by Out of Hospital staff team member)
26	GRH	November 2016	A positive experience of discharge with timely assessment, joint agency working and good communication between services and family (shared by Out of Hospital staff team member)

5.1.2 GHNHSFT & GCS. 3 experiences

	location	date	experience
1	GRH and North Cotswolds Hospital	September 2016	Elderly gentleman discharged to a community hospital a long way from the family home; consequently, his wife was unable to visit every day, which both found distressing.

2	GRH and Stroud General Hospital	2016 (month unspecified)	Re-admission to hospital within 3 days of being discharged.
3	CGH and North Cotswolds Hospital	2016 (month unspecified)	A lack of follow-on support arranged.

5.1.3 GCS. 8 experiences

	location	date	experience
1	Vale Community Hospital	November 2015	Positive experience of discharge planning and implementation. (shared by housing support worker)
2	Stroud General Hospital	November 2015	Poor communication with an elderly lady's family; she was sent home alone by Non-Emergency Patient Transport, before occupational therapy equipment required for independent living had been delivered, instead of contacting a family member as arranged to collect her.
3	Stroud General Hospital	November 2015	A delay to discharge due to cancellation of a care package for a person at the end of life; poor communication with the family.
4	Stroud General Hospital	February 2016	Poor communication with the family of a gentleman in his 80s.
5	Tewkesbury Community Hospital	February 2016	A lack of reablement support available for an elderly gentleman.
6	Cirencester Hospital	June 2016	A lack of reablement support available for an elderly lady.
7	North Cotswolds Hospital	September 2016	Positive experience of discharge.
8	Stroud General Hospital	October 2016	A lack of adequate follow-on care/support arranged for a person with a terminal illness. (shared by sheltered housing scheme manager)

5.1.4 2G. 1 experience

	location	date	experience
1	Wotton Lawn	May 2016	Discharge before the person felt ready.

5.1.5 Hospital not specified. 5 experiences

	date	experience
1	January 2016	Discharge Information Pack provided.
2	March 2016	Discharge attempted before the person felt ready.
3	April 2016	A lack of ongoing care/support available for an elderly lady with limited mobility; and aids and adaptations at home were not checked. (shared by Village Agent)
4	June 2016	A lack of reablement support available.
5	August 2016	A lack of follow-on care/support arranged for a person with disabilities.

5.1.6 Social care. 10 experiences

	date	experience
1	November 2015	No assessment or care provided, when a 4-week period of care following hospital discharge ended. (shared by front-line staff member)
2	November 2015	Positive experience of follow-on care and support.
3	November 2015	No assessment was made before discharge of the suitability of housing for a person who cannot walk. (shared by housing support worker)
4	January 2016	A delay to discharge for a gentleman from CGH, due to lack of availability of home care.
5	February 2016	No ongoing care available, once a 6-week period of support following hospital discharge ends. (shared by front-line staff member)
6	April 2016	Poor communication with a lady in her 80s and her family, affecting access both to on-going support and respite care.

7	May 2016	A cross-border problem: Gloucestershire residents unable to access follow-on care/support services following discharge from Warwickshire hospitals. (shared by Village Agent)
8	June 2016	An elderly lady becoming increasingly frail at home after leaving acute hospital (CGH), with limited support at home provided due to a waiting list for reablement support; no occupational therapy assessment of her home environment; and limited information shared with her family about ongoing care needs and options.
9	August 2016	No ongoing support provided for a lady with dementia home from hospital.
10	September 2016	Time-limited support provided following discharge from Tewkesbury Community Hospital.

5.2 Examples of the feedback collected by HWG

These anonymised stories are extracts from the 53 experiences listed above in section 5.1 above. The description of the experience in the individual's own words, or the words of their families or carers, provides excellent insight into the human impact of the different ways that discharge is handled.

5.2.1 B's story

"My 87-year-old Aunt recently spent a month being treated at GRH following a stroke. Whilst on the Ward, my Aunt received excellent care from all of the staff - nothing was too much trouble. Despite having full mental capacity, my Aunt was almost blind, very hard of hearing, unable to walk, experienced regular pain and was very frail weighing about 5 stone requiring full nursing care so a very vulnerable adult. She required a pressure relieving mattress, feeding with pureed food and the provision of complete personal care. Whilst on the ward she had been placed on the Palliative Care Pathway but rallied with a desire to eat.

The decision was made to transfer my Aunt to an escalation bed at a Nursing Home. Because of the excellent care she received combined with not wanting to go into a care home, my Aunt was not keen on leaving the ward. She also felt that she was not well enough so this was a delicate situation. My wife and I worked with the Ward and the Discharge Team and spent several days preparing my Aunt for the transfer, supporting and reassuring her that there would be a review in a month which would definitely take into account her views and that we would be with her every step of the way. On that basis she agreed to go..."

5.2.2 S's story

"...I was not given any information about planning for discharge when I was on the ward, or any leaflets. When I was discharged, I was given a copy of the discharge summary which was sent to my GP. One of the conditions of my discharge was that I would see a GP on the Monday following - I called the surgery to explain this requirement, and arranged it before I left the hospital.

My discharge summary was sent to my GP electronically, within 24 hours of my leaving hospital. I saw my GP on the Monday as planned.

The summary said that I would be having a follow-up appointment two weeks after my stay in hospital, and have my stitches removed. I rang the hospital at the 2-week point, to say that I hadn't had a date through for this appointment. My consultant's secretary said she didn't know about this follow-up appointment. I was offered an appointment on 14 February, which would have been over a month since I was discharged - so I asked for an earlier one. I was offered an alternative appointment on 2 February. When I attended this appointment, I was told "your GP surgery could have taken the stitches out". But they had left them alone specifically because the discharge summary had said that this should be part of my follow-up at the hospital. I was formally discharged after this follow-up by my consultant.

I also had a heart monitor appointment on 10 March, which was arranged while I was still in hospital in January. The letter I had about this said that the results would be sent 'to the referring doctor', which was my consultant. The results were sent to my GP surgery but there

were no follow-up instructions given on actions for them to take. The GP surgery have suggested that I ring the consultant's secretary to ask - even though I have been formally discharged. There just seems to be breakdowns in communication."

5.2.3 E's story

"I have been with my daughter three times to A&E in the last few weeks, she is 19 years old. You wait at GRH for hours and then eventually you get admitted. My daughter had a catheter fitted while she was on a stay at GRH last week. When she was discharged they left it in but did not tell us what to do about it, no information or plan! It has caused her an ongoing issue. So we went back to our GP yesterday and he sent her direct to Cheltenham General Hospital and she has been admitted because of the urology issue. The lack of information on discharge from GRH was appalling and led to further doctor appointments and now an admission to CGH."

5.2.4 S's story

"My wife had cause to be admitted again to Cheltenham on the Saturday, and after being kept in overnight, she was told at 11.00am on the Sunday that she could go home. I went to fetch her and we finally left the hospital at 3.45 pm. It was the same story regarding lack of staff at the weekend, closed pharmacy and long waits while a Doctor eventually wrote up her notes, drugs were located etc."

5.2.5 J's story

"My father-in-law (in his 90s) lives in a care home. He has mild cognitive impairment. A year ago (before he moved to the care home) he fell over at home and spent several hours on the ground before anyone found him - he has had problems with his legs ever since.

Last Saturday morning, he was complaining of pains down his legs, and after seeking advice an ambulance was called and he was taken in to GRH. We went in to visit him late in the afternoon. By then he had had an x-ray, but he hadn't seen a doctor yet. He also had not had any lunch. He stayed in hospital overnight, and on Monday they tried to arrange transport to get him but for some reason this wasn't possible. So on Tuesday, he was taken down to the discharge ward at 9 am. He didn't get back to his care home until 8.30 pm. We don't know whether he had had anything to eat or drink during that time - he's not able to tell us - but he was very hungry when he arrived at home.

Because it had got so late and we were expecting him to be back home, my husband rang the hospital late in the afternoon and spoke to staff on the ward where he had been until Tuesday morning - but they said they did not know whether his father was still in the hospital or not"

5.2.6 L's story

"In November, a friend's elderly mother was in Stroud Hospital following surgery on her hip. A number of family members were involved in organising support for this lady. She already had a chair lift in place at home but needed some additional equipment, in particular for use in the bathroom and toilet.

I visited the lady together with my friend on a Friday. The lady was suggesting that she might return home on the Saturday, but we encouraged her to stay in hospital until the Monday, as at that time the arrangements for delivering the equipment she needed had not been made. My friend spoke to the nurse who agreed that she would contact my friend to let her know when her mother was to be discharged, so that she could make arrangements to take time off work to collect her, take her home and make sure she was settled back in.

In fact what happened was that my friend's mother was discharged over the weekend after all; the hospital staff called another family member to say she was being discharged, and she was sent home using the non-emergency patient transport service instead of being collected by my friend as arranged.

The equipment and adaptations required by my friend's mother had not been delivered in time for her return home; the family were thrown into panic by this sudden change in arrangements. There was no communication between the OT and the family."

5.2.7 T's story

"My father was discharged from hospital (Tewkesbury) after three and a half months in CGH and Tewkesbury. On the Friday, he was told that he would be discharged on the Monday. We were then told that although originally Dad had been told he would have the reablement team in to help him at home, they were not able to help, and we would have to pay for care. It was impossible to get any services involved over the weekend of course, so we were worried. Dad is only going to need it for short period of time, but they told us that we would have to pay for the full package. They had known for 2 weeks that he would be discharged, and I feel that they needed the bed, so Dad was out."

5.2.8 F's story

"My Mum was discharged from CGH at the end of June after being admitted due to pneumonia. The reablement team were unable to support her at home - there was a waiting list of 4 weeks. I felt under pressure by the hospital to accept alternative arrangements for Mum, who lives in a retirement property with limited support from a warden/manager.

The social worker persuaded me that the best option was to have a package of care from carers from Cleeve Link, three times a day to give Mum breakfast, lunch and dinner. At the time, I felt that my views on the best interests of Mum were not listened to. Mum has had increasing memory loss, and since she has been in hospital I feel this has got worse.

Mum felt that the social worker had reassured her enough to believe that this was a good thing for her to be out of hospital and back in her own home, and that the care should be the best quality to protect her.

Once Mum was at home, she was getting more and more frail and weak. I went in on afternoons/early evenings to visit, and found that she had not eaten the sandwich that had been made for her at lunch. I could not get information from the carers about what Mum had eaten in the morning or evening, and only occasionally found empty/used bowls or cutlery. I came in one morning to find that Mum had gone to bed in her clothes.

I decided to move Mum into her sister's house short term, to build her strength up. I was concerned, and focused on keeping stability in Mum's day-to-day life. Mum has had a memory assessment done, and the results of this are that we have been advised that she does not have 'full capacity', and has been referred for a brain scan for a full diagnosis.

I feel that the carers did not go in to see Mum at times that were convenient/suitable for her, and this did not help with Mum's eating. The carers were allocated half an hour in the middle of the day, I feel that this should have been enough time to make a sandwich and also sit with her to encourage her to eat.

I called the hospital social worker to explain that I was not happy with the care package and that the family had now stepped in. I don't feel that I've had adequate feedback for this. There have been no assessments in Mum's flat, to ensure she is safe or that she has everything available to her that should be there. I feel that if the reablement team had been caring for Mum after her discharge, then assessments would have been completed and they could have made judgements about Mum's living conditions and how she was not able to live as independently as she once had.

I feel that as a family, we have been given little information about the care system or options that were available after discharge from hospital, and that Mum's care has not been the priority."

5.3 'Enter and View' visits made to the Discharge Waiting Areas at CGH and GRH

HWG Authorised Representatives visited the Discharge Waiting Areas at CGH and GRH in September 2016. The report of these visits is shown overleaf.



Details of visit:	Discharge Waiting Areas Cheltenham General Hospital (CGH), 19 September 2016 Gloucestershire Royal Hospital (GRH), 20 September 2016
Authorised Representatives:	CGH: Sophie Ayre and Judith Rudzki GRH: Julia Butler and Fred Ward
Local Healthwatch contact details:	Healthwatch Gloucestershire Community House, 15 College Green Gloucester GL1 2LZ

Acknowledgements

Healthwatch Gloucestershire (HWG) would like to thank staff at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for their contribution to the ‘Enter and View’ programme.

Disclaimer

Please note that this report relates to findings observed on the specific dates set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed during the visits.

What is Enter and View?

Part of the local Healthwatch programme is to carry out ‘Enter and View’ visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation - so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit. In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.

Purpose of the visits

HWG visited the discharge waiting areas at Gloucestershire Royal Hospital and Cheltenham General Hospital as part of the review of the recommendations made in its *Hospital Discharge Report* published in November 2015.

The purpose of these visits were to

- Observe patients and their families and carers engaging with the staff and their surroundings
- Capture the experience of patients and their families and carers, and any areas for improvement or change

Background

In November 2015, HWG published a report on people's experiences of leaving hospital. HWG listened to patients and their families, to health and social care professionals, and to staff working for Voluntary and Community Sector organisations. It learned that Gloucestershire hospitals carried out around 150,000 discharges in the last year.

Many people did not experience problems during the process, and HWG received positive feedback, but also heard from some people who experienced significant problems.

These included:

- leaving hospital without appropriate care and support in place at home
- being discharged before they felt ready, in some instances leading to readmission soon afterwards
- a lack of information-sharing with their families, carers or other health or social care professionals involved in their care, so that actions were not well-coordinated

HWG made a number of recommendations to the NHS and social care services in Gloucestershire, including:

- Whole-system ownership and oversight of the discharge process, with consideration given to a single integrated policy including overarching standards for the quality of experience that patients should be able to expect
- Transport, food, heating, the availability of support at home, and effective liaison with primary care were all relevant to the safety of patients, particularly those who are elderly and vulnerable, and should be checked routinely and in a timely way
- A review of the ways in which patients are told about their discharge (in letters, leaflets, websites etc), considering whether these methods adequately prepare patients and families for what will happen to them

As part of its review of progress, HWG was keen to capture recent experience from patients about discharge from hospital. It arranged Enter and View visits to the discharge waiting areas (DWAs) at Gloucestershire Royal Hospital and Cheltenham General Hospital, as they are locations where HWG representatives could meet people waiting to be discharged.

Methodology

These were announced 'Enter and View' visits.

Two HWG Authorised Representatives visited each DWA. They explained the nature of their visit to staff. They observed patients and their families and carers engaging with the staff and their surroundings.

The HWG representatives provided patients and their families and carers with an information leaflet about HWG, explained its role, and asked if they were happy to talk to them. They invited feedback to the following questions:

- Have you been in the discharge lounge for long? Do you know how long?
- Have you been able to get drinks/food?
- Has lunch been provided, if you left the ward before lunchtime?
- Has any on-going care you will need at home been arranged (e.g nursing or personal care)?
- Has any equipment required at home been supplied in preparation?
- (patients over 65) Were you offered information about the Age UK Gloucestershire Home from Hospital service?
- Do you have any views about the staff in the discharge lounge?
- Did the hospital staff communicate well with you/your family/carers about what would happen after you leave?
- Do you have any other comments you would like to make about your experience, either about your discharge or about your stay in hospital?

Each visit lasted for 3 hours, and took place in the afternoon.

What we learned

The DWA environment: CGH

The main lounge had 9 easy chairs arranged in a horseshoe, with additional chairs available. It had a window, and was well-lit at the time of the visit. The nursing station was at the entrance to the lounge. There was an adjacent ward with three beds in cubicles, each with solid partitions providing some privacy and dignity, and a cubicle for an additional bed if required. There was a kitchen, toilets, and washing facilities.

There were 4 members of staff on duty; Sister, staff nurse and 2 healthcare assistants (one of whom was bank staff). The DWA staff visited the wards to collect each patient.

This was a mixed area, used by both men and women. Toilet facilities were unisex. 2 people using the main lounge were in night-clothes, and 1 person in a bedded cubicle was in a hospital gown.

The DWA had easy access to the outside area where ambulances, cars or taxis could pull up to collect patients.

There were 3 patients in the DWA when the HWG representatives arrived. During the 3-hour visit, 5 patients were admitted, and 6 were discharged. 3 people were collected by the Non-

Emergency Patient Transport Service (NEPT); 2 people left with friends or relatives, and 1 person left by taxi.

6 patients and 1 relative shared feedback with the HWG representatives. This feedback was shared in full with GHNHSFT.

The DWA environment: GRH

The main lounge had easy chairs arranged in a horseshoe, with additional chairs available. There was an adjacent ward with four beds around the room, each with curtains that provided some privacy and dignity if required. There were extra chairs provided in a sitting area along with tables for patients. There was an area in the bay with access to hot drink-making facilities, water and squash. Toilets, and washing facilities were outside the bay. A private room could be made available if necessary for 'barrier nursing' for patients with contagious diseases, to prevent infection passing to other people.

The chairs and beds in the bay were used for patients with higher care needs, less mobile or needing closer observation. This ensured that they were closer to the toilets and nursing staff that were placed in the bay at all times. There were posters on the wall advertising 'Welcome Home from Hospital' packs (food packages).

There were usually 5 members of staff on in the morning and the afternoon; the Sister explained that this was not always possible. The majority of the team were bank staff. There had been a Transfer Team in place until recently, managing transport; but now, a healthcare assistant was in the office most of the time to answer the phone and organise transfers and transport. The DWA staff visited the wards to collect patients.

This was a mixed area used by both males and females, with unisex toilet facilities. There were no patients using the beds, and all patients in the DWA were mobile and appeared to be independent.

The DWA had easy access to the outside area where ambulances, cars or taxis could pull up to collect patients.

When the representatives arrived, there were 4 patients in the DWA. During the 3-hour visit, 5 patients were admitted and 3 were discharged.

7 patients shared feedback with the HWG representatives, including 2 patients who shared feedback alongside a relative. This feedback was shared in full with GHNHSFT.

Time spent in the DWAs

8 people had been in the DWA for less than half an hour when they spoke to the HWG representatives.

Of the remaining 6 people:

- 2 people had been there for 1 hour
- 2 people had been there for 2 hours
- 1 person had been there for 5 ½ hours
- 1 family member didn't know how long their relative had been there


Reasons for being in the DWA:

- 6 people were waiting to be collected by the NEPT service
- 6 people were waiting to be collected by family, friends or taxi
- 2 people were waiting for medication to take home

Food and drink

Everyone who shared feedback said that they (or their relative) had been offered a drink, and a meal if they were present at mealtimes.


One patient arrived in the DWA at 4pm from the Emergency Department. Staff offered her a drink and she asked if she could have a sandwich. The Sister said that teatime was at 5pm. A minute later, the Sister returned and said "You've obviously not had lunch - would you like something now?" Staff then brought a selection of sandwiches, and the patient chose one.



"I've got a drink. I was offered a hot meal here for lunch, but I chose a sandwich as that was my preference"

Arrangement of care at home

- 4 people said they didn't need anything at home
- 3 people said that support or care had been arranged for them
- 2 people said they had arranged for family to help
- 2 people said they only needed medication
- 1 person was returning to a care home
- 1 person said that hospital staff did check whether they needed any support
- 1 person said no-one had asked if they needed help, so they organised some themselves



"They have arranged Meals on Wheels for me, and I have 2 weeks' support at home in place"


Age UK Gloucestershire Home from Hospital Service

Age UK Gloucestershire Home from Hospital service provides reassurance and essential practical support following discharge from hospital. There is no charge for this service as it is funded by Gloucestershire Clinical Commissioning Group (GCCG). It is available to vulnerable older people over 65 years, living within Gloucestershire County Council (GCC) boundaries and registered with a Gloucestershire GP, who are discharged following a stay in hospital.

No one eligible for this service who shared their feedback with HWG had been told about the service during their stay in hospital.

Supply of equipment at home

- 8 people said they didn't need any equipment
- 4 people said that equipment had been supplied or was being supplied
- 1 person said they had bought equipment themselves
- 1 person said that they needed some equipment, but they did not know who to ask

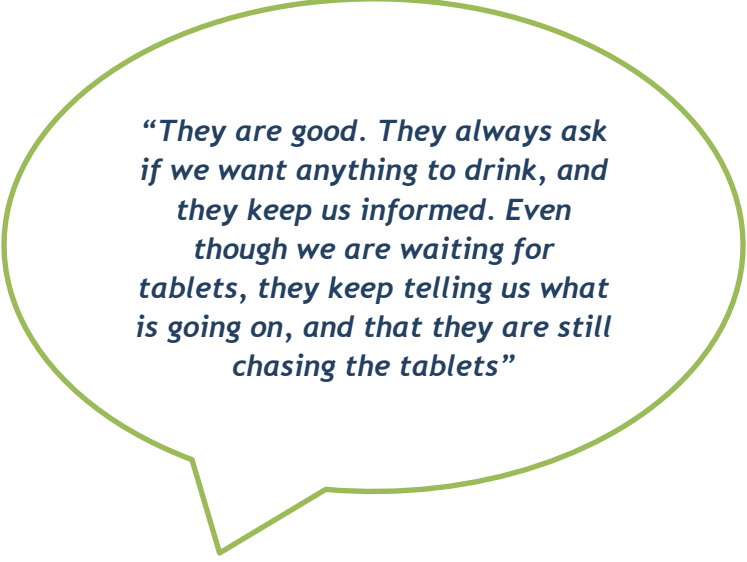


"I have a temporary use of a walker. I hope to be able to walk unaided"

DWA staff

Everyone who shared feedback was very positive about DWA staff.

All interactions observed by HWG representatives between patients and DWA staff were respectful. Conversations were unrushed, with staff responding calmly and clearly to questions, and asking open questions themselves.




"They are good. They always ask if we want anything to drink, and they keep us informed. Even though we are waiting for tablets, they keep telling us what is going on, and that they are still chasing the tablets"

Cleanliness

The DWA staff kept the area clean and tidy, cleaning chairs and beds when they had been vacated, and clearing away cups and plates.

Communication by hospital staff about what would happen after discharge

- 6 people said that communication with them had been good
- 2 people said that communication with them and their family had been good
- 3 people said there had been some communication problems
- 2 people said that staff had not spoken to members of their family
- 1 person did not provide feedback



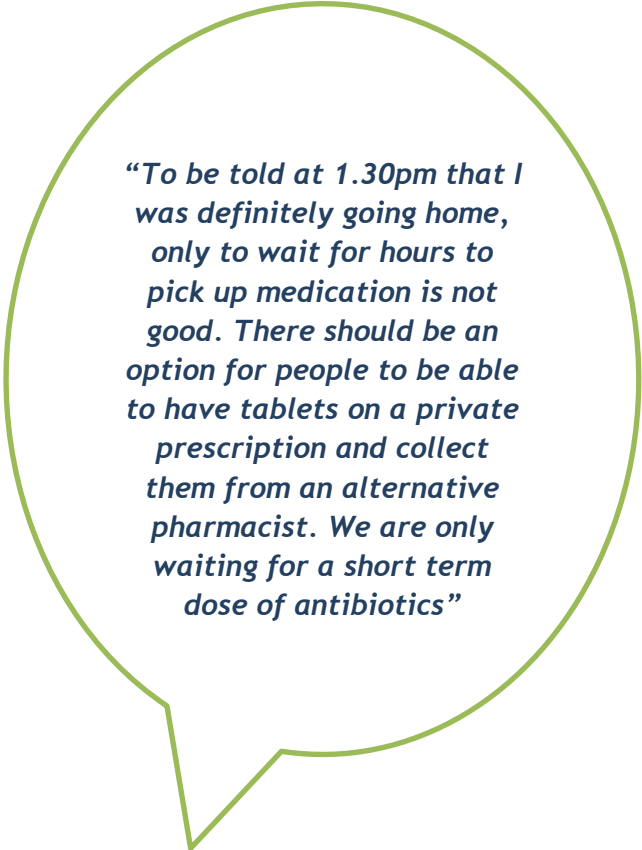
“They told me this morning that I could go home, which was a bit surprising”

Medication

2 people were waiting in the DWA because they were waiting for medication to take home.

HWG representatives observed staff checking with patients about medication. For instance, a patient arrived at the DWA in CGH and the Sister checked that he knew what was in his medication to take home; asked whether he had any other medicines at home, and if he was happy with what he had to do. She checked his bag of medication and explained that he would be receiving a discharge summary shortly, as there wasn't one in the bag.

One patient was given her medication by the nurse to take in the main lounge. She was very frail and struggled to swallow it so the nurse returned, and helped her to take a drink.



“To be told at 1.30pm that I was definitely going home, only to wait for hours to pick up medication is not good. There should be an option for people to be able to have tablets on a private prescription and collect them from an alternative pharmacist. We are only waiting for a short term dose of antibiotics”

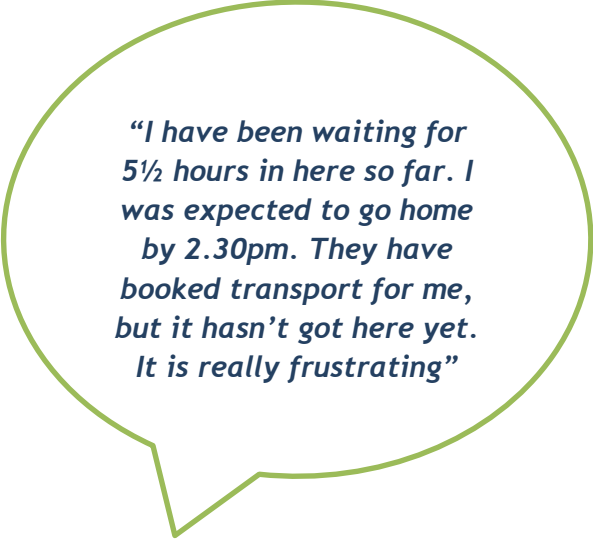
Non-Emergency Patient Transport (NEPT)

When patients arrived at the DWA to wait for the NEPT service, staff explained to each of them that the service operated a '4-hour window' for responding to transport requests.

3 people were collected by the NEPT service while the HWG representatives were in the DWA at CGH. 2 of these were collected within half an hour of arriving at the DWA.

At 3.20 pm, the Sister at CGH contacted the NEPT service for an update on a patient who had arrived at the DWA in the morning. The transport arrived at 4 pm.

One patient required NEPT including transfer by stretcher and this had been booked before she had left the ward. She was still in the DWA several hours later. Staff said that the '4-hour window' had been breached. A home care package was in place, so DWA staff contacted both the NEPT service and the home care provider to coordinate her time of arrival at home with a care worker being there, to help her with her care and support needs when she got in.



"I have been waiting for 5½ hours in here so far. I was expected to go home by 2.30pm. They have booked transport for me, but it hasn't got here yet. It is really frustrating"

One patient required NEPT with bariatric provision. Staff said that the '4-hour window' had been breached.

One frail patient needed to transfer from her chair to a wheelchair to get into the NEPT vehicle. The staff nurse was gently verbally encouraging the patient to transfer, which she was managing slowly, when one of the NEPT staff moved her manually. He did not explain what he was going to do.

Key findings

- Food and drink was available and offered to all patients
- Care at home had been arranged for most people who needed it
- Information about Age UK Gloucestershire's Home from Hospital Service was not provided to eligible people
- Equipment had been arranged for most who needed it
- People's views about DWA staff were positive
- The majority of feedback about communication was positive, but some people had experienced problems
- A few people were experiencing long waits for Non-Emergency Patient Transport (NEPT). In one case, this impacted on a home care provider
- A few were ready to go home but were waiting in the DWA for medication to be prepared, which they found frustrating

5.4 Information about feedback about discharge from other sources

Information about collection of feedback about people's experiences of being discharged from hospital is shared by GCCG, GHNHSFT, GCS and 2G in Section 4.2 above. In addition, HWG contacted each Trust to find out about any complaints that they had received in the past 12 months, relating to discharge experiences.

5.4.1 GHNHSFT

The Trust received 96 complaints between August 2015 to July 2016 that relate to discharge ²⁰.

By 8th September 2016, 78 had received a formal response. 58 of them had been fully or partially upheld (22 fully upheld, 36 partly upheld).

The reasons for the complaints are given as follows (using standard NHS HSCIC categorization):

- discharge planning (26)
- premature discharge (19)
- medication (18)
- discharge summary problems (11)
- care package (9)
- time of day (5)
- safety concerns (3)
- communication (2)
- delayed discharge (2)
- diagnosis not given (1)

GHNHSFT asked HWG to note that an individual complaint may include concerns about a number of aspects of care; also, that any complaints that relate to discharge problems caused by other providers or transport are passed directly to those organisations, so are not reflected within these figures.

GHNHSFT added

“With respect to learning from complaints that relate to discharge, actions taken in response may relate to system-wide issues such as discharge delay due to transport problems or may relate to particular issues within the discharge pathway. Complaints are considered at a divisional and specialty level and in addition, the Trust Head of Integrated Discharge Team now sees all complaints that relate to discharge so that awareness and learning can be strengthened”

5.4.2 GCS

The Trust received 11 complaints in the last 12 months that relate to discharge ²¹.

By 30 August 2016, 10 had received a formal response. 7 of them had been fully or partly upheld (3 upheld, 4 partly upheld).

The reasons for the complaints included

- Premature discharge (2)
- Poor discharge to intermediate care
- Communication, medication on discharge and onward care required
- Communication with family and a lack of care package in place on discharge
- Communications with family
- Poor discharge planning with dates changing and lack of meetings with family members
- Inadequate planning and communication with family
- Delayed discharge to home
- Pressure on family to accept discharge home
- Inadequate care package arranged

GCS added

“Any learning from complaints is disseminated as part of our work to develop discharge policies and procedures and this continues to be articulated within our discharge action plans which is led by our Head of Community Hospitals”.

5.4.3 2G

The Trust received 3 complaints in the last 12 months that relate to discharge²². 2 of these initially suggested that there were inadequate planning arrangements in place for the individuals concerned post-discharge. However, both of these complaints were withdrawn.

The third complaint related to poor communication with family. This was upheld. The Trust said that an apology to the family was offered and, as a result of this complaint, colleagues have been reminded of the importance of effective communication.

2G added

“All of our ward environments are participating in the Triangle of Care initiative to create a stronger partnership between staff, service users and family members”.

5.4.4 Care Quality Commission (CQC)

The CQC uses surveys to find out what people think of the NHS healthcare services that they use. The results help assess NHS performance. The CQC also use them for regulatory activities such as registration, monitoring ongoing compliance and reviews.

The CQC's Inpatient Surveys include questions about people's experiences of being discharged from hospital. However, its most recently published survey results (published in June 2016) relate to experiences in July 2015, prior to the publication of HWG's Hospital Discharge report and recommendations.

6 Key findings and conclusions

The conclusion to the HWG Task Group report in November 2015 included the following observation:

“Many people in Gloucestershire do not experience problems during the process of being discharged from hospitals. However, our study has demonstrated that there are people who do experience such problems, and in some cases these were significant. Some of the evidence reassured us as to how much is being done to support patients well, but some of the examples seemed completely unacceptable... We note that our findings appear to confirm other sources of evidence about discharge concerns... This report should now be considered carefully by commissioners and providers of care, inspectors of services and those responsible for overseeing safeguarding arrangements to determine where further system improvements are necessary and how to implement them”.

This review reports on many of the system improvements that have been made, both locally and nationally, since this report was published. It also highlights the challenges that remain locally, which echo those identified nationally in Section 3.

By sharing individual's stories, this review demonstrates the impact these improvements and challenges have upon people leaving hospital, and their families and carers.

6.1 Local health and social care system activity

HWG is encouraged by all the activity being undertaken by commissioners and providers on the recommendations made in its 2015 report, as described in Section 4.2 above - for instance:

Recommendations 1 & 2 - Whole-system ownership and oversight of the discharge process, with consideration given to a single integrated policy including overarching standards for the quality of experience that patients should be able to expect; and Regular review of discharge performance against these standards

HWG is encouraged that GCCG is considering a system-wide CQUIN to support discharge, and seeks to work with HWG on this. It also welcomes the update on the GCS Community Hospital Discharge Action Plan, including actions arising from its 'Listening in Action' staff event.

Recommendation 3 - Measurement of qualitative aspects of discharge, including methods to capture real-time feedback during the course of the process; for instance, to determine whether patient dignity is maintained at all times during the discharge process by all those involved in it

HWG welcomes news of the new automated Friends and Family Test in place at GHNHSFT from November 2016, contacting all patients within 48 hours of discharge and inviting them to leave feedback. It is also looking forward to continued working with GCCG and GCS on the planned survey to capture feedback about discharge from patients and carers.

Recommendation 4 - Extending any schemes seeking views of patients about their experience of discharge and their suggestions for improvements to the families of those with dementia and those in receipt of end-of-life care

HWG is encouraged by news of GHNHSFT activity on gathering, analysing and acting upon the outcomes of feedback from people with cognitive impairment, people at the end of life, and their families and carers, including young carers.

Recommendation 6 - Closer and more systematic dialogue with care homes

HWG welcomes the news shared by GHNHSFT about the establishment of regular communication mechanisms between organisations across the health and social care system involved in patient discharge, including Care Home Select, GCCG's Care Home Stakeholders meeting, and the newly established Care Home Managers Forum. The involvement of the Integrated Discharge Team in all discharges that involve care homes is also a positive step. HWG also welcomes the emphasis on effective communication about discharge to other providers among 2G's Trust Service Plan objectives.

Recommendation 7 - The safety of elderly and vulnerable patients should be a priority; transport, food, heating and availability of support at home and effective liaison with primary care are all relevant to a patient's experience of hospital discharge and should be checked routinely and in a timely way

HWG welcomes the introduction of a discharge planning communication resource folder for clinical staff at GHNHSFT; and news of the joint work between hospital and community clinicians in partnership with GCCG and expert patients to review discharge planning arrangements for complex patients.

Recommendation 8 - Agreement and enforcement of standards for the quality, content and timeliness of discharge information to be shared with GPs; in particular over clarity about future treatment, tests and changes in medication with clear indication of where the responsibility lies for further action

HWG is pleased to learn that discharge summaries associated with GHNHSFT's new electronic health record will include an area for free text so specific details may be conveyed more fully. It is also encouraged by GCS's activity including its audit of discharge summaries and the action taken on its outcome, to further improve its performance.

Recommendation 9 - Review of communication with patients about discharge (letters, leaflets, website etc), including the following key questions:

- *Do these methods adequately prepare patients and families for what will happen to them?*
- *Do they set realistic expectations?*
- *Do they communicate effectively to a range of potential readers?*
- *Do they signpost effectively to other services?*
- *Are there opportunities for greater consistency between Gloucestershire's NHS providers in how they communicate with people about discharge from hospital?*

HWG looks forward to continued updates on GCS's working group which is looking at this recommendation, along with recommendations 1 and 2 relating to standards of patient experience.

Recommendation 10 - Consideration of whether the volume, mix and distribution of resources, including staff and beds is appropriate for the number of people being discharged and their likely care needs, both now and in the future

HWG was encouraged to learn that, by August 2016, there were no substantive community nursing vacancies at Band 6 and Band 5 level. It also welcomed news that 2G is working with GCCG and Swindon Mind to develop additional resources in the pathway of support for people experiencing acute mental illness.

6.2 Feedback collected about people's experiences of being discharged

HWG compared the nature of feedback gathered about people's experiences since November 2015 with that in its original report.

6.2.1 Experiences of GHNHSFT (26 experiences)

It was really encouraging that experiences of being discharged late in the evening or at night, and/or in night clothes, which featured in the original report, did not feature in the feedback collected since its publication.

There were also positive experiences of discharge planning, of the discharge lounge (also known as the Discharge Waiting Area), and of follow-up after discharge.

Some of the other issues raised in feedback in the original report continued to feature in people's experiences, including

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready, followed by readmission shortly after in some instances
- a lack of information-sharing with families, carers or other health or social care professionals involved in their care
- long waits for transport between hospitals and care homes
- delays waiting for medication
- lack of clarity in the discharge summary

These issues correlate with the issues raised directly with GHNHSFT through its complaints process, as shown in Section 5.4.1.

6.2.2 Experiences of GHNHSFT & GCS (3 experiences)

Experiences included issues which featured in the original report:

- a lack of follow-on care and/or support arranged
- re-admission shortly after discharge

One experience also reflected on the availability of community hospital beds in different parts of the county, and the impact this had on the family.

6.2.3 Experiences of GCS (8 experiences)

It was encouraging that experiences reflecting a lack of District Nurse provision, which featured in the original report, did not feature in the feedback collected since its publication.

There were also positive experiences of discharge planning.

Some of the other issues raised in feedback in the original report continued to feature in people's experiences, including

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready
- poor communication with people and their families

These issues correlate with the issues raised directly with GCS through its complaints process, as shown in Section 5.4.2.

6.2.4 Experiences of 2G (1 experience)

HWG heard from one person, who was being discharged before they felt ready.

6.2.5 Experiences of unspecified hospitals (5 experiences)

Some of the issues raised in feedback in the original report featured in people's experiences of unspecified hospitals, including

- a lack of follow-on care and/or support arranged or available for people leaving hospital
- discharge taking place before a person felt ready

6.2.6 Experiences of social care (10 experiences)

Some people shared positive experiences of follow-on support.

Other experiences included

- a lack of on-going support available, once the time-limited follow-on support had ended
- a lack of assessment of the suitability of the home environment
- a lack of needs assessment once the time-limited follow-on support had ended
- delay to discharge due to a lack of home care available
- poor communication with people and their families

6.2.7 'Enter and View' visits to the Discharge Waiting Areas (DWAs) at Cheltenham General Hospital and Gloucestershire Royal Hospital

The experiences of people using the DWAs when HWG conducted its visits were broadly positive:

- Food and drink was available and offered to all patients
- Care at home had been arranged for most people who needed it
- Information about Age UK Gloucestershire's Home from Hospital Service (now the Out of Hospital service provided together with the British Red Cross) was not provided to eligible people
- Equipment had been arranged for most who needed it
- People's views about DWA staff were positive
- The majority of feedback about communication was positive, but some people had experienced problems
- A few people were experiencing long waits for Non-Emergency Patient Transport (NEPT). In one case, this impacted on a home care provider
- A few were ready to go home but were waiting in the DWA for medication to be prepared, which they found frustrating

6.3 A note on quantitative and qualitative evidence, and patient feedback

Quantitative evidence provides an overall picture based on large numbers; but one of its limitations is that instances that do not match overall trends can risk being overlooked. Qualitative evidence is more subjective and provides rich, detailed information; but inevitably, it focuses on the experiences of a small number of people.

HWG acknowledges that the feedback contained in this review is largely qualitative evidence. Nevertheless, taken together it highlights important issues which need to be brought to the attention of providers and commissioners as they work to strengthen discharge arrangements.

As HWG said in its 2015 report, someone's experience of their care is very personal to them and can be very subjective. Patient experience data is perhaps more challenging to use than other types of "evidence" in the health and care system.

7 Recommendations

HWG recommends that

7.1 GCGG, NHS provider organisations and Gloucestershire County Council (GCC) continue in their ongoing work to address the recommendations made in the 2015 HWG report on hospital discharge

7.2 GCGG, GCC and NHS provider organisations carefully consider the evidence presented in this review, to identify what the findings reveal about current system weaknesses

HWG considers that the following issues in particular would benefit from continued efforts to understand performance:

- Information-sharing and communication with patients, their families and carers
- Arrangements for care/support for people when they get home from hospital, including the availability of reablement support
- Arrangements for organising medication for patients to take home when they leave hospital
- Arrangements for non-emergency patient transport (provided by Arriva Transport Services Ltd)*
- Communication and integration between different elements of the health and care system, including discharge summaries

7.3 NHS provider organisations acknowledge the value of the ‘patient story’ to enable system learning, and look to gather patient stories of their journey through the hospital and beyond to illustrate qualitative patient experience that is not captured through the Friends and Family Test or other surveys

HWG considers that there would be value in the establishment of a targeted research fund to commission a series of structured interviews with patients and their families and carers, to gain greater insight into experience in this sensitive and complex area of health and social care commissioning.

* With regard to non-emergency patient transport, HWG notes that, at the meeting of Gloucestershire’s Health and Care Overview and Scrutiny Committee held on 10 January 2017, GCGG reported that *“Significant improvement is required in order to achieve all performance targets on a sustainable basis. A performance notice was issued in December 2015 and the CCG is closely monitoring the Arriva Transport Services Ltd (ATSL) remedial action plan and performance improvement trajectory”*

7.4 HWG continues to monitor people's experience of being discharged from hospital, and conducts a further review in 12 months

The experiences shared with HWG by people and their families and carers in the last twelve months, and the strong national focus on discharge from hospital suggests that there is a continuing need to keep this issue under review locally. In particular, it might be appropriate to focus on

- Communication and integration between different elements of the health and social care system
- Communication with patients, their families and carers
- Arrangements for medication for patients to take home when they leave hospital
- Care/support for people when they get home from hospital, including the availability of reablement support
- Arrangements for non-emergency patient transport
- The impact of the introduction of the Trakcare electronic patient record system at GHNHSFT on people's experience of being discharged
- Capturing a greater breadth of experience from people leaving hospitals provided by 2G

8 Acknowledgements

In particular, HWG would like to thank everyone who has contributed their personal experience to this report. HWG is also grateful to staff and volunteers in the Voluntary and Community Sector, in Gloucestershire's three NHS trusts, Gloucestershire Clinical Commissioning Group, and Gloucestershire County Council, for their generous support to our work, responding to our questions, providing us with information and sharing their knowledge and reflections with us.

HWG has prepared this review very much in the spirit of contributing to the efforts of commissioners and providers to improve the hospital discharge system.

9 Formal responses to the review received from Commissioners and providers

HWG submitted this review to the Commissioners and Providers listed below on 28 February 2017, and invited them to submit formal responses to the recommendations:

- Gloucestershire Clinical Commissioning Group
- Gloucestershire County Council
- Together NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Arriva Transport Services Limited

The responses received by 28 March 2017 are shown overleaf.

Barbara Piranty (by email)

Mark Branton
Shire Hall
Westgate Street
Gloucester
Gloucestershire
GL1 2TG

Phone: 01452 328483

Our Ref: MB/hr

Your Ref: n/a

Date: 23 March 2017

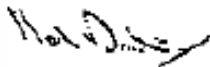
Dear Barbara,

Hospital Discharge Task Group Report, November 2015: Review of progress, March 2017

Thank you for forwarding to Margaret and me a copy of this report, which I am responding to in her absence. It was good to note the progress that has been made across a number of fronts in improving practice following your initial report. However, there are clearly areas where we can continue to improve, both from the limited feedback for us as a specific organisation and as a system, so we are happy to support the recommendation that we will continue in our ongoing work to address the recommendations made in your original report.

We are also fully supportive of the need to carefully consider the evidence presented in this latest review, to identify what the findings reveal about current system weaknesses. Indeed this is most timely given the Government's announcement of additional funding for social care, at least part of which will be invested following discussion with system colleagues as to how best to make further progress in this arena.

Yours sincerely,



Mark Branton
Deputy Director
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Our Ref: SCUMDCR/Let 220317 HealthWatch Report

23rd March 2017

Barbara Piranty
Chief Executive
Healthwatch Gloucestershire
Community House
15 College Green
Gloucester
GL1 2LZ

Dear Barbara

Re: *Hospital Discharge Task Group Report, November 2015: Review of progress, February 2017*

Thank you for your letter of the 28th February 2017.

Firstly, I wish to acknowledge the significant volume of work that has been undertaken by Healthwatch Gloucestershire over several years to compile this important insight into people's experience of hospital discharge in Gloucestershire. Whilst the main examples provided in the report relate to partner NHS organisations in Gloucestershire, I am pleased that the scope of the review also considered hospital discharge in relation to people's experience of mental ill-health (both from physical health hospitals and mental health hospitals). As a major part of our local NHS system, 2gether NHS Foundation Trust is committed to working in partnership to develop integrated solutions that serve to work for people who use services and their families.

I note that you have requested a formal response to your report and, as such, I offer a response to each of the four recommendations made.

Recommendation 1

Gloucestershire Clinical Commissioning Group (GCCG), NHS Provider organisations and Gloucestershire County Council (GCC) continue their ongoing work to address the recommendations made in the 2015 HWG report on hospital discharge

It is clearly from the findings of the HWG review that, as a whole system of health and care, there is more work to do in relation to hospital discharge. Together NHS Foundation Trust remains fully committed to working in partnership with our commissioners, other NHS Providers, community and voluntary sector organisations in addition to people who use our services, to guide the development and delivery of our mental and physical health care services for the future.

Recommendation 2

GCCG, GCC and NHS Provider organisations carefully consider the evidence presented in this review, to identify what the findings reveal about current system weaknesses

Please be assured that the important experiences shared through this HWG Review will influence our contribution to the developments being progressed by the Sustainability and Transformation plans for Gloucestershire. There is much to be gained from reviewing pathways of care to ensure that hospital discharge plans are considered with patients and families before and immediately at admission to hospital as well as at the conclusion of their hospital stay. Playing our part in leading in the further development of the health and care system is our responsibility and we are committed to that in order to make life better for the people that we serve.

An example of work that we are engaged in leading includes a pilot in Stroud and Berkeley Vale to reduce avoidable admissions for people with dementia and strengthen support in the community. We are working with Primary Care and Social Care colleagues and anticipate that if successful, we will extend across the scheme across the County.

Recommendation 3

NHS provider organisations acknowledge the value of the 'patient story' to enable system learning, to look at gathering patient stories of their journey through the hospital and beyond to illustrate qualitative patient experience that is not captured through the Friends and Family Test or other surveys.

We wholeheartedly support the value of hearing patient and caregiver stories.

The Friends and Family Test is a relatively small part of the way in which we gather and learn from patient and carer experience. Evidence of a range of ways that we utilise patient feedback can be found in our quarterly, published Service Experience reports to the Board. In addition, our Service Experience Committee structure and our Expert by Experience Program enables us to engage with a range of stakeholders who advise us and are often involved in developments that need to be made.

For over three years we have heard narratives from individuals who use our services at Trust Board meetings. We have shared our process with other members of the health care system in Gloucestershire as well as further afield. In addition, we facilitate a system of Expert by Experience visits to hospital and community sites to give their 'first impression' views using the 15 Steps Challenge method. Experts by Experience also get involved in training our staff.

Recommendation 4

HWG continues to monitor people's experience of being discharged from hospital and conducts a further review in 6 months.

We welcome this scrutiny and will co-operate fully with a further review.

I hope that the information provided in my response offers you full assurance that we are committed to ongoing development of practice to achieve collaborative, integrated, safe, effective and high quality experience of discharge from hospital. If you have further comments or question, please do not hesitate to contact myself or Jane Melton, Director of Engagement and Integration.

Yours sincerely



SHAUN CLEE
CHIEF EXECUTIVE
2gether NHS Foundation Trust

Cc Ruth FitzJohn, Chair, 2gether NHS Foundation Trust
Jane Melton, Director of Engagement and Integration, 2gether NHS Foundation Trust

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24th March 2017

Barbara Piranty
 Chief Executive
 Healthwatch Gloucestershire
 Community House
 15 College Green
 Gloucester GL1 2LZ

Dear Barbara

Re: Hospital Discharge Task Group Report, November 2015: Review of progress, February 2017

Please find by way of this letter GHNHSFT's formal response to the recommendations made to the review of progress report.

Recommendations	GHNHSFT's formal response to the recommendations made
7.1 GCCG, NHS provider organisations and Gloucestershire County Council (GCC) continue in their ongoing work to address the recommendations made in the 2015 HWG report on hospital discharge	The work is ongoing to address the recommendations made in the 2015 HWG report.

Chair: Peter Ladbeckl
 Chief Executive: Deborah Lee



Recommendations	GHNHSFT's formal response to the recommendations made
7.2 GCCG, GCC and NHS provider organisations carefully consider the evidence presented in this review, to identify what the findings reveal about current system weaknesses	The Trust has carefully considered the evidence presented in this review which has revealed continued system weaknesses and will work to make system improvements in the areas identified within the report.
7.3 NHS provider organisations acknowledge the value of the 'patient story' to enable system learning, and look to gather patient stories of their journey through the hospital and beyond to illustrate qualitative patient experience that is not captured through the Friends and Family Test or other surveys	The Trust already acknowledges the value of the "patient experience story" and will continue to use this methodology to ensure feedback is gained about service user experience. The Trust intends to work with the CCG in this area. The Trust will also look for any potential funding possibilities to carry out research in this area.
7.4 HWG continues to monitor people's experience of being discharged from hospital, and conducts a further review in 12 months	The Trust would welcome a further focused review in 12 months and will support any HWG activity in this area.

Thank you once again for the report.

Yours sincerely



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Healthwatch
Barbara Piranty
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Dear Barbara

Re: Hospital Discharge Task Group Report, November 2015: Review of progress, March 2017

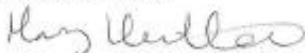
Thank you for sending the final HWG Hospital Discharge Task Group Report, Review of progress March 2017 for our comment.

We note the recommendations of this Review and those in the original 2015 report and previous review. We can confirm that, as the local commissioner of NHS funded health services and joint commissioning responsibilities of adult social care, we will continue to maintain our focus on working with providers and others to improve the quality of discharge from our local hospitals.

We recognise the issues identified by this Review and are grateful to Healthwatch Gloucestershire for raising these; it is important to all of us that the patients' experience, and your observations as the patients' champion, form part of the ongoing dialogue between commissioners and providers of health and care services within the county.

We have adopted the NHS England onward care policy and are working towards its implementation locally, which will support effective and timely onward care.

Yours sincerely



Mary Hutton
Accountable Officer

10 References

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- 13 GCS response to HWG Request for Information, letter received 30 August 2016
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