healthwatch Greenwich

Hospital Discharge Enter and View Report 2017: Queen Elizabeth Hospital

We know that you want local services that work for you, your friends and family. That's why we want you to share your experiences of using health and care services with us – both good and bad. We use your voice to encourage those who run services to act on what matters to you.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Contents

1 Introduction

1.1 Context

Hospital discharge was raised as a priority for Healthwatch Greenwich. The main acute hospital in Greenwich is Queen Elizabeth Hospital which includes an Emergency Department and an Urgent Care Centre. Residents of Greenwich also use services in neighbouring boroughs, including Lewisham Hospital. Lewisham & Greenwich NHS Trust provide Queen Elizabeth Hospital & Lewisham Hospital services, apart from the Urgent Care Centre services which are provided by Greenbrook Healthcare[1].

Poor quality discharge processes, delayed discharge, being discharged too early or not having the correct support in place prior to discharge from hospital can all have a profoundly negative effect, especially with vulnerable patients. Patients who are discharged too early are more likely to be readmitted, without suitable care in place[2]. Those who are discharged too late are at a higher likelihood of acquiring infections and have poorer recovery rates. For the purposes of this report, vulnerable groups include:

- Older people
- People with a disability
- People who are homeless
- People with mental health issues
- People who are socially isolated
- People requiring ongoing care and support
- People with dementia

Queen Elizabeth Hospital has a Discharge Policy in place as well as 'Discharge Lounge Standard Operating Procedure' guidance. An up to date copy of these documents can be obtained by contacting the Patient Advice & Liaison Service[2] team at Queen Elizabeth Hospital.

These documents specify that when admitted to hospital, a treatment plan with details about discharge or transfer, should be developed and discussed with the patient. A discharge assessment should determine whether further care will be needed after leaving the hospital. It is essential the patients are fully involved in the assessment process. Ideally, family or carers should also be kept informed and given the opportunity to contribute, (assuming the patient consents).

If the assessment determines that little or no care is needed after discharge, it is called a 'minimal discharge'. If more specialised care is needed after leaving hospital, the discharge or transfer procedure is referred to as a 'complex discharge'. If a complex discharge is identified then a care plan should be developed, detailing the health and social care needs of the patient. This should again be completed with the patient and they should be fully involved in the process.

A care plan should include details of:

- the treatment and support required after discharge,
- who will be responsible for providing the support, and how to contact them,
- when and how often, support will be provided,
- how the support will be monitored and reviewed,
- the name of the person co-ordinating the care plan,
- who to contact if there's an emergency or things don't work as they should,
- information about any charges that will need to be paid (if applicable).

1.2 Strategic drivers

The Care Quality Commission (CQC) carried out a routine inspection of Queen Elizabeth Hospital from 26th - 28th February 2014 and published the report on 13th May 2014[4]. The medical care at Queen Elizabeth Hospital was rated as Requires Improvement and the Emergency Department was rated as Inadequate.

CQC did a follow up unannounced inspection on 7th, 8th and 18th June 2016 to assess if improvements had been made. The report was published on 3rd November 2016[5]. This report noted that although improvements had been made more work was still needed. Medical care was rated as Requires Improvement and the emergency department was now also rated as Requires Improvement (although better than previously rated). The number of beds available is an ongoing issue throughout the hospital and has an impact on the emergency department. The safe and effective discharge of patients is essential for the smooth running of the hospital.

Some key findings from the CQC report:

- Over 50% of patients had a delayed discharge, and patients had extended stays on the acute medical unit which had also been found during the previous inspection.
- There were limited resources and support for staff to meet the individual needs of patients, for example those living with dementia or patients for whom English was not their first language.
- The CQC recommended that the hospital ensure patients are cared for in areas that are appropriate, meet all their needs, and have sufficient space to accommodate the potential number of people using the service at any one time.

- The hospital should continue to work to reduce the number of delayed discharges, and;
- Ensure staff fully understand the role of the dementia lead nurse and how to access services available to patients.

The CQC undertook another visit and full reassessment of Lewisham and Greenwich NHS Trust in March 2017. The results of this have not been published by CQC at the time of publication of this report.

In addition to the CQC findings, there has been added complexity around hospital discharge in Greenwich, due to a recent reduction in the number of care and nursing home beds available within the borough. Recent CQC inspections have led to the temporary suspension of up to 68 beds, increasing pressure on QE hospital by reducing the number of discharge option available to older and more vulnerable patients (see paragraph 2.2.5 below).

1.3 Methodology

To consider the issues around hospital discharge in Greenwich we held a focus group to discuss experiences with patients, carers, and residents. We also scheduled Enter and View visits to the discharge lounge at QEH to talk with and gather feedback from patients who are preparing for discharge.

1.4 Acknowledgements

Healthwatch Greenwich would like to thank the service provider, service users, visitors, and staff for their contribution to this report and the work of Healthwatch Greenwich.

1.5 Disclaimer

Please note that this report relates to findings observed on the specific date(s) stated. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and fed back at the time.

2 Focus Group Event

2.1 Methodology

We held a focus group event on February 16th from 2:00-4:30pm at Charlton House. The event aimed to bring patients, carers, residents, and professionals together to discuss their experiences of hospital discharge, share concerns and raise issues. Stories that were shared and key issues discussed are included below. We set up round tables to discuss personal experiences and ideas about best practice.

Word cloud from table discussion notes from the focus group event

2.2 Discussions

2.2.1 Homelessness

Jane Cook, Clinical Lead Health & Homelessness (Pan-London), from Healthy London Partnership came to talk about homelessness and health, and the effect of poor hospital discharge on homeless people. Jane stressed the importance of safe and suitable discharge for people who are homeless (for example, rough sleepers, hostel dwellers, sofa surfers and those with chronically insecure housing).

Nationally there has been a rise in the number of homeless people. In London, the percentage of rough sleepers has risen 106% from 2010 to 2016[6]. The number of recorded rough sleepers in the borough of Greenwich between July – September 2016 was 99[7]. Research indicates that homeless people are four times more likely to seek help from acute NHS services like A&E than the general population[8].

It is essential that the housing situation of patients is considered upon discharge. More than 70% of patients who are homeless at discharge are not identified as homeless, with their housing needs not recognised. Housing not being considered or assessed does not just affect those who are homeless, it also affects those who may not be in the right housing situation to meet their needs after discharge. Planning for discharge should happen upon admission to allow time for suitable planning.

2.2.2 Impact on carers

The impact of poor discharge from hospital on carers was highlighted. It is important for carers to be kept up to date with, and involved with the patient's care and planning of their discharge. According to figures, published in the 'Joint Strategic Needs Assessment (JSNA): Burden on Carers[9], there are estimated to be over 22,000 carers in Greenwich (9% of population), over a quarter of whom provide a minimum of 50 hours care a week. Fewer than 1200 carers (just 4% of the estimated total) receive a Carers Assessment which can result in a service, information or advice, and only an estimated 10% of carers are recognised by their GP.

Greenwich Carers Centre offers information, advice, practical and emotional support services for adult carers who live (or care for someone who lives) in Greenwich, via telephone, face to face or home visits. Respite was also highlighted as important, although some carers noted that they only choose this as a last resort[10].

Case study 1

A carer of an elderly women recounted a time last year when she was discharged from Queen Elizabeth Hospital before the carer was ready for them. The carer felt a lot of pressure to be there even though it was unsuitable for them. They were not told about the planned discharge in enough time to ensure that they could be there to provide the support needed. The health care staff made the carer feel like the hospital bed was more important than the person in it. The patient was sent home with a hospital-acquired infection which resulted in the patient having to return to hospital for treatment.

2.2.3 Communication

Lack of communication from health care professionals with the patient, throughout their stay was raised as a concern. Not enough information was given about support services available to individuals after discharge or how to access them. The importance of good communication with family and friends of the patient and the positive effect this can have on the continued care of the patient care was noted. It is important for the views and experiences of the patient, carers, and relatives to be considered as this ensures that the patient is kept at the centre of a well-rounded treatment plan.

Patients should be asked early on about the support they will have post-discharge, and this should be re-assessed just before discharge to ensure it is still suitable. This includes any physical support they may need (for example, support keeping wounds clean and getting to the toilet), as well as personal and social support to help prevent isolation. In 2014/15 only 40% of adult social care users in the Royal Borough of Greenwich felt that they had as much social contact as they would like[11]. Greenwich is ranked 30 out of 32 London Boroughs against this outcome (32 being the worst).

Case study 2

Hilda shared her experience of when her mother was recently in Queen Elizabeth Hospital. Her mother lives in sheltered housing and has carers who come in four times a day. She had been admitted several times over the previous 12 months. On the last occasion, she was on the Acute Medicine Older People Ward for eight days. Her mother had a bandage on her arm and said it had not been changed for several days, despite her raising it with the nursing staff. A health care assistant eventually came to change it the day before her discharge. Hilda said the communication throughout was very poor and she felt that unless she asked questions, no information would have been given to her. She understood that hospital was not the best care environment for her mother who was better off at home, but she felt like was not

told anything or included in the decision making. All the information she received was asked for not given spontaneously.

"Communication needs to be improved as it feels so disjointed. Pathways are unclear and difficult to navigate and are hard for the individual, carers and relatives."

Hilda (name changed)

2.2.4 Continuity of care

Continuity and communication between different agencies was raised as an issue. The use and role of care navigators and how the introduction of these has made an impact to the integration of health and social care was questioned. There was uncertainty as to who they supported and if they were still available.

Health and social care services not using the same IT system was also raised. Patients records can't be shared easily or seamlessly, which can lead to information not being updated, and even gaps or mistakes in people's records.

The 'Health and Wellbeing Strategy 2015/2018: Make every opportunity count'[12] lays out the priorities for the Greenwich health and well-being board. Priority four seeks to oversee and improve the effectiveness of the health and care system in Greenwich. This includes the further development of integrated care arrangements such as the shared management of teams, the Greenwich Co-ordinated Care 'Pioneer' programme[13], the implementation of the Better Care Fund, and the more effective sharing of data through the Connect Care programme, and monitoring the effectiveness of these on patient care.

The Better Care Fund[14], a £3.8 billion pooled budget, was launched to support service redesign for joined up care. This came about because the government expects integrated health and social care to become the norm in England by 2018.

Greenwich Joint Emergency Services (JET) [15] works in the local community to make sure that patients who can receive treatment at home or in short term residential care do not have to go into hospital unnecessarily.

Care pathways for stroke and cancer were also raised. Patients must be referred for diagnosis from the GP, but then must return to the GP for the results before they can be referred for treatment. Better coordination is needed is to make the process quicker, simpler, and easier to navigate for, by definition, vulnerable people.

2.2.5 Beds available

Pressure on beds at Queen Elizabeth Hospital is high which has been reflected in the CQC reports. However, there has been several care homes that have recently received ratings of 'Inadequate' by the CQC (e.g. Gallions View Care Home). These care homes are then unable to receive patients from Queen Elizabeth Hospital as the beds are embargoed. This means there are less beds in the community to take patients who may be clinically fit but still need on going care.

Hospital is not the best place for patients to stay once they are clinically fit for discharge, due to the high numbers of hospital-inquired infections. Once a patient is assessed as 'clinically' fit it is best for them to be transferred to a suitable place. It is important to ensure patients are only kept in hospital if they are not clinically fit.

Queen Mary's Hospital, Sidcup allowed terminally ill patients from Queen Elizabeth Hospital to use the 10 bed Foxbury Ward[16] (until the end of March 2017). The Foxbury Ward is provided by Bridges Healthcare[17]. This was a temporary solution whilst care home beds were not available due to embargos in place by CQC.

The use of Eltham Community Hospital[18] was discussed and the impact this has had on bed usage at Queen Elizabeth Hospital. Eltham Community Hospital was opened on 17 September 2015, and in March 2016 the Greenwich Intermediate Care Unit (GICU) moved there from the Bevan Unit, meaning patients will no longer be transferred to Bevan Unit.

The perception of home care services has improved following the recent re-tender of the service. It was noted that this could be a result of an increase in wages due to the London living wage now being applied, more staff or better recruitment.

Case study 3

Sarah broke her ankle and went to Queen Elizabeth Hospital where she was sent straight to theatre. After surgery, she was placed in a bed in the basement, which felt inadequate. She was given no communication as to how long she would be there. Her daughter was not told anything about Sarah's length of stay or why she was staying in an unsuitable bed. After two days, she was transferred to Eltham Community Hospital to recover. She had brilliant care at Eltham Community Hospital but felt it would have been better for her if she been transferred there earlier.

2.2.6 Medication

Changes can often be made to medication that was prescribed to patients prior to admission into hospital. If changes are made it is essential that these are communicated to the patient or their carers to avoid confusion and mistakes. Also, some patients may have to contact their GP after discharge to notify them of their stay in hospital, changes to medication and to arrange on going care. This should be made clear to the patient so they know the appropriate was to follow up.

Case Study 4

George was supposed to be in an isolation room during his stay in Queen Elizabeth Hospital.

During his stay 37 people came into his room. Four of these were not medical staff (utilities/ maintenance etc.) and three of the medical staff had slight colds. The result was that George had to stay three days longer and still left with a chest infection which took seven weeks to get rid of, with three different antibiotics being used.

On the day George was discharged from Queen Elizabeth Hospital, he was not told that he would have to contact the nurses to dress his legs at home, nor was he told that he had to contact his doctor to tell him what medication changes had been made.

It was 10 days before George found this out and only after he telephoned the hospital to ask when the nurses would come. He was not given any contact details for the community nurses. This was the first time in his life that he had been in hospital.

2.2.7 Alternatives to A&E

Better knowledge is needed by the public of alternatives to A&E and how to access them. This would hopefully relieve the pressure on the emergency department and ensure that A&E is used by those who need it. In addition to the GP Access Hubs, which offer weekend appointments, some GP practices have extended opening hours and reserve a number of emergency appointments per day. Out of hours healthcare services and information can be accessed in Greenwich via:

- Urgent care centre[19] (at Queen Elizabeth Hospital)
- Call 111[20]
- GP access hubs[21] (appointments can be made via 111 but you must be registered with a GP in Greenwich)
- Health help now[22] website and downloadable app

A recent survey carried out by the six South-East London Healthwatch spoke to nearly 500 people across the region. Of these, only 25% had heard of the GP Access Hubs. This number fell to less than 19% for Greenwich residents. Similarly, only 61% of Greenwich residents were aware of NHS111 and its purpose, compared to an average of 67% across the region.

3 Enter and View

3.1 What is Enter & 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 legislation protects them if they raise a concern.

3.2 Details of visit(s)

Details

Service Address:	Discharge Lounge, Queen Elizabeth Hospital, Stadium Road, London SE18 4QH
Service Provider:	Lewisham & Greenwich NHS Trust
Date(s) and Time(s):	22.02.2017 from 2:00pm-5:00pm 23.02.2017 from 9:00am-12:00pm 11.03.2017 from 11:00am-2:00pm (scheduled) 17.03.2017 from 2:00pm-5:00pm

Authorised Representatives:	Baeti Mothobi – Authorised Representative, Healthwatch Bexley Emily Eady – Authorised Representative, Healthwatch Bexley Rikki Garcia – Chief Executive, Healthwatch Greenwich Clive Mardner - Volunteer Development and Outreach Officer, Healthwatch Greenwich Sophie Patterson – Community Research Officer, Healthwatch Greenwich
Contact details:	Healthwatch Greenwich Gunnery House, 9-11 Gunnery Terrace, Woolwich, London SE18 6SW Tel: 020 8301 8340 Email: info@healthwatchgreenwich.co.uk Website: www.healthwatchgreenwich.co.uk

3.3 Purpose of the visit(s)

The visits to the Hospital Discharge lounge at Queen Elizabeth Hospital were scheduled as an opportunity to gather feedback from individuals who are scheduled for discharge. They allowed us to engage with people who have experienced being admitted and are in the process of being discharged from hospital.

3.4 Methodology

We developed a patient interview tool (See Appendix 1) for our authorised representatives to use to gather feedback and experiences from patients in the discharge lounge. This patient tool was developed with the support and feedback from Healthwatch Bexley, Healthwatch Lewisham & Healthwatch Bromley. We spoke with 10 patients across our four scheduled visits. We also spoke with staff and in particular, Matron Sue Brassington, who has responsibility for the Discharge Lounge.

The four visits were scheduled and announced to the service provider. However, the visit on Saturday, March 11th, 2017 from 11:00am-2:00pm did not take place as the discharge lounge was closed. We were not notified of the closure on the day. When we returned on Friday, 17th March 2017 staff explained that due to a low number of discharges scheduled for that day it was decided to not open.

We ensured the reasons for our visits were transparent prior to our coming, i.e. that we were there to observe a snapshot in time, speak to patients about their experiences, and report the facts. Authorised representatives would also check with staff on the day, to see if there were individuals in the discharge lounge who should not be approached or are unable to give informed consent.

We explained the purpose of our visit and the questions we are asking to everyone we spoke to, we also made it clear that staff and patients were under no obligation to answer any of our questions.

3.5 Summary of findings

- Environment & cleanliness
- Treatment by healthcare staff
- Readmission
- Bed usage & delays
- Communication/Information about discharge and support services
- Housing and family/community support after discharge
- Medication

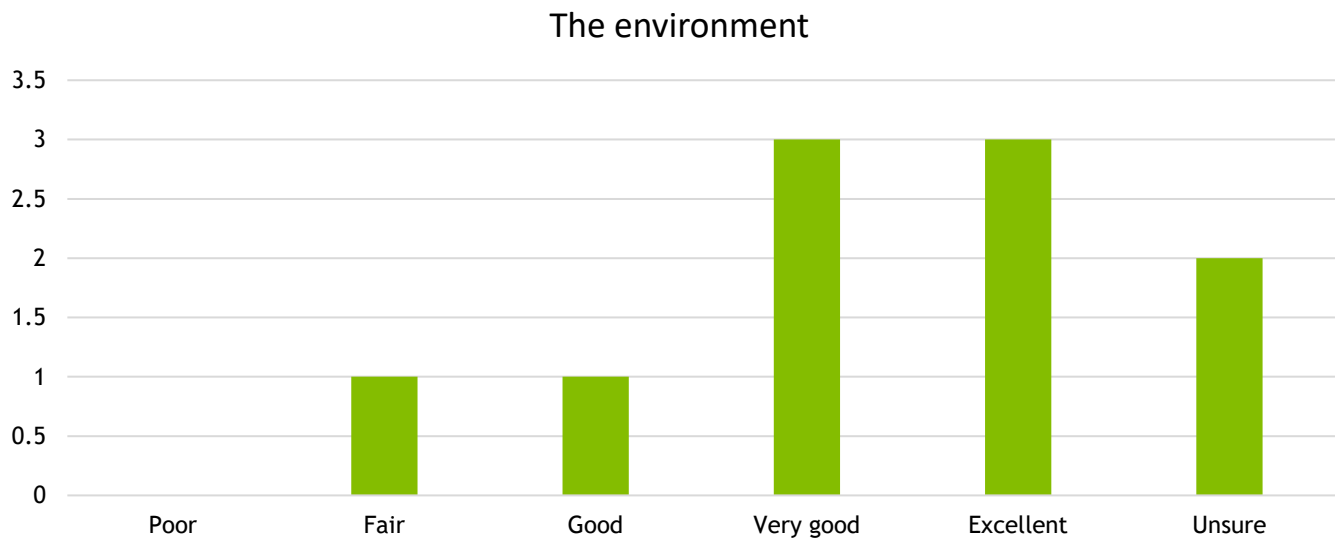
3.6 Results of visit(s)

3.6.1 Premises

The discharge lounge is a 10-seat waiting area which includes a TV, and a table with magazines and newspapers. There are five beds available which all have curtains that can be drawn around them for privacy. The staff desk is located between the seating area and beds and has a good view of both. It is a low desk and there was at least one member of staff there throughout our visits.

3.6.2 Environment & cleanliness

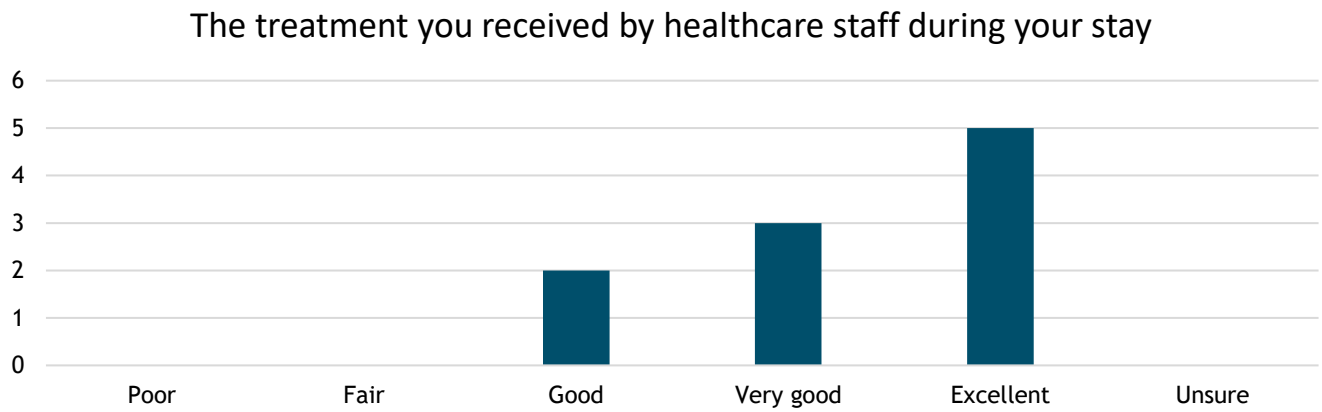
The discharge lounge appeared clean and we saw seats being wiped down thoroughly after visitors left. Of the 10 people, we asked about the environment, one person said it was 'Fair', one said it was 'Good', three said it was 'Very Good', three said it was 'Excellent' and two people said they were 'Unsure'.



One out of 10 rated the cleanliness as 'Fair, four said 'Very Good, three said it was 'Excellent', and four people were 'Unsure'.

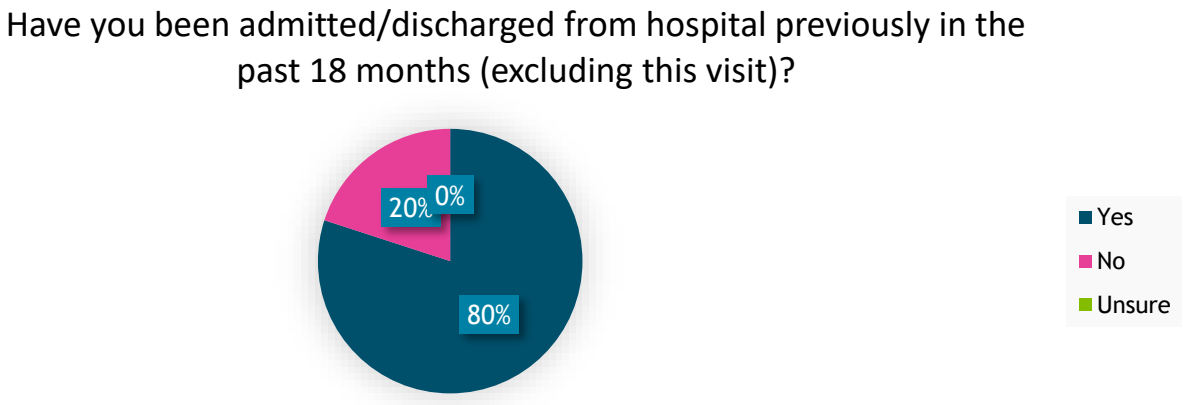
3.6.3 Treatment by healthcare staff

All 10 people who were asked about the treatment received by healthcare staff rated it as either 'Good', 'Very Good' or 'Excellent'. With five out of the 10 saying it was 'Excellent'.



3.6.4 Readmission

Of the people we spoke to, 80% had been admitted and discharged from hospital on a separate occasion in the past 18 months and 20% had not. One patient we spoke to had been admitted seven times in the past 12 months.



3.6.5 Bed usage & delays

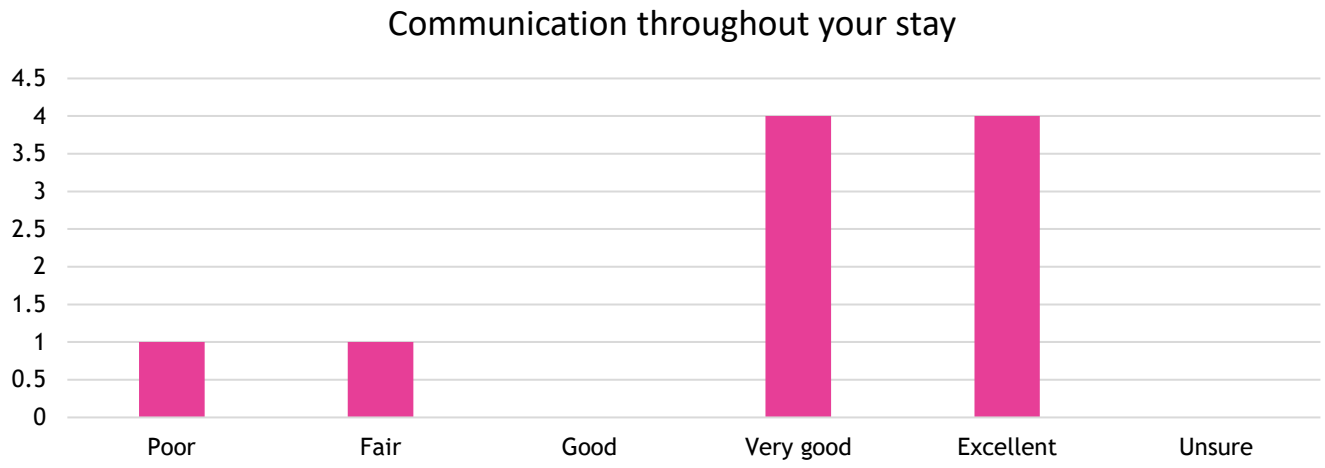
One man had been in the discharge lounge for nearly six hours (he arrived at 8am) waiting for transport to be arranged.

We spoke to a woman who was at Queen Elizabeth Hospital for a planned surgery due to take place later that day. She was not awaiting discharge but was placed in a bed in the discharge lounge due to no bed being available elsewhere. She did say that she had been told the reasons for this by the healthcare staff and had been communicated with well.

One woman had stayed in the discharge lounge overnight while awaiting test results. She was not eligible for discharge until she had results from her tests and could be assessed by the consultant. Her results come back at 10:05am and the consultants said she would be able to be discharged that day.

3.6.6 Communication throughout admission

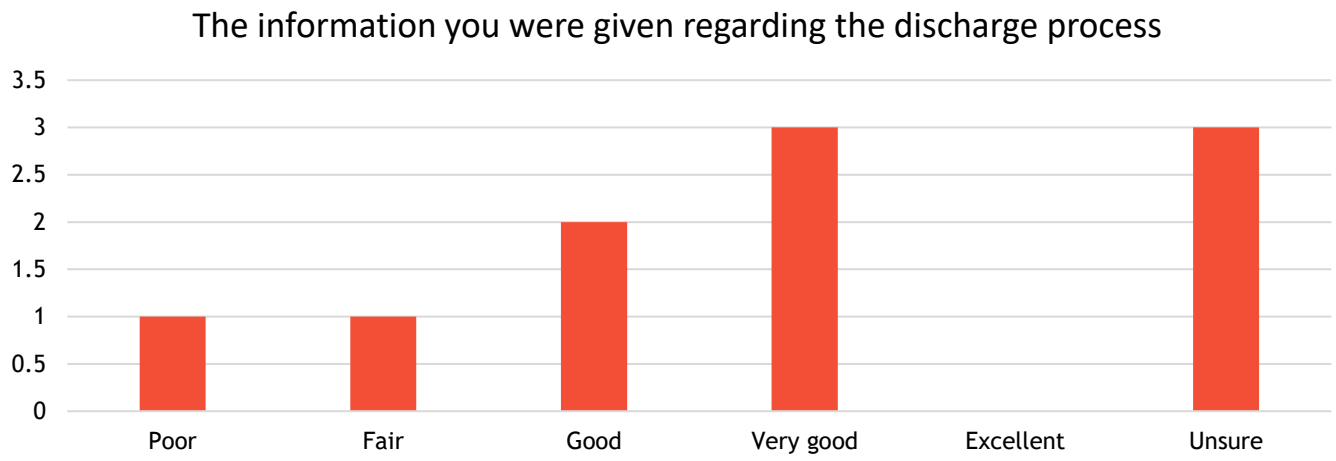
Four out of the 10 people we asked rated the communication throughout their stay as 'Excellent', four rated it as 'Very Good', one person said it was 'Fair' and one person said it was 'Poor'.



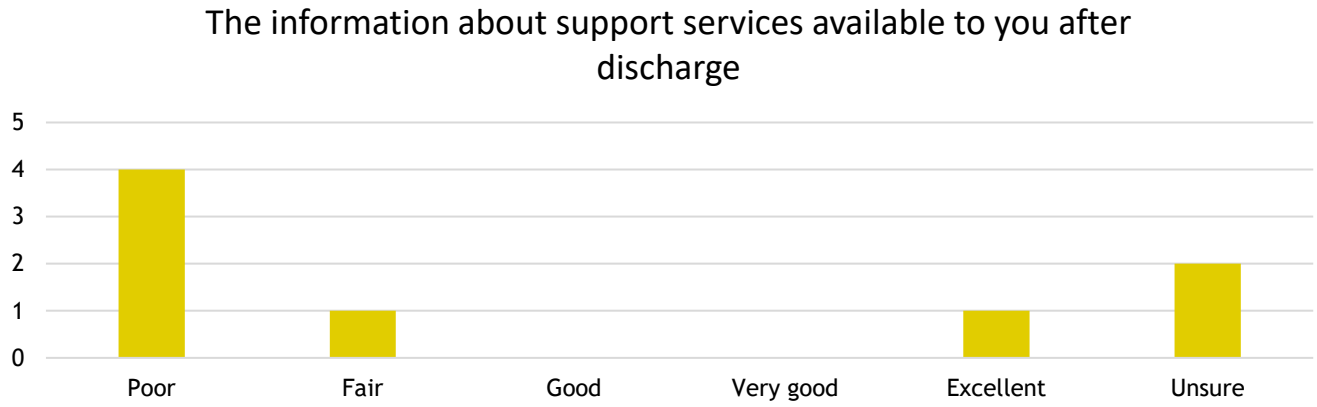
"Occasionally conflicting information was given" Anon

3.6.7 Information about the discharge process and support services available

Three out of 10 said they received 'Very Good' information regarding the discharge process, two people said 'Good', one person rated it as 'Fair', one person as 'Poor'.

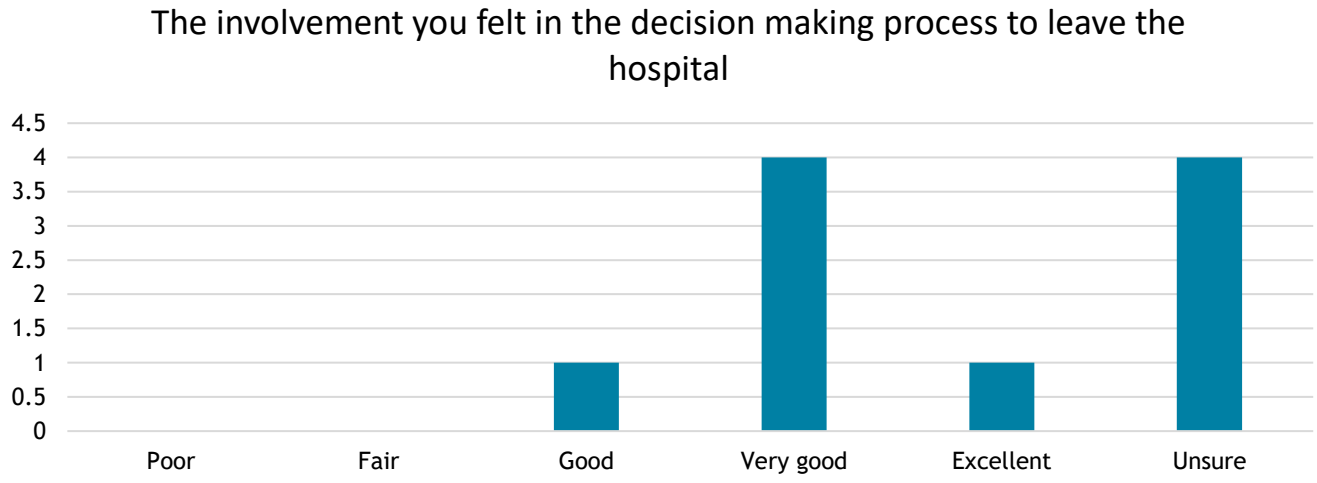


On the information that were supplied to patients about support services available after discharge four out of eight people said the information was 'Poor', one person said it was 'Fair', and only one person said it was 'Excellent'. Two people were 'Unsure'.



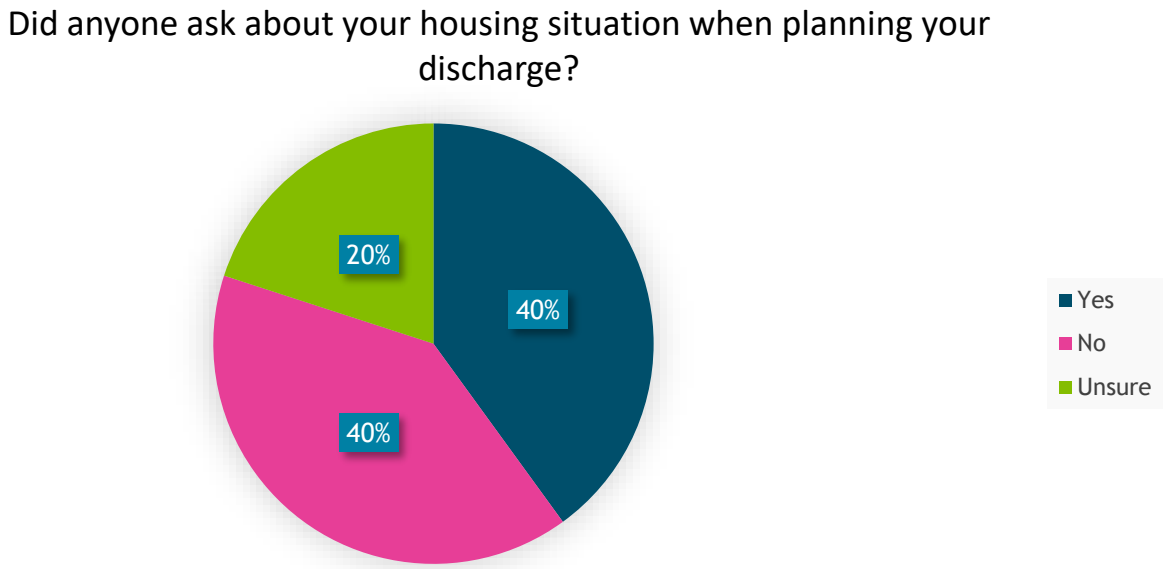
3.6.8 Involvement in the decision making around leaving hospital

Out of the 10 people we asked how involved they felt in the decision-making process to leave the hospital, six said it had been 'Good' or better and four were 'Unsure' how involved they had been.

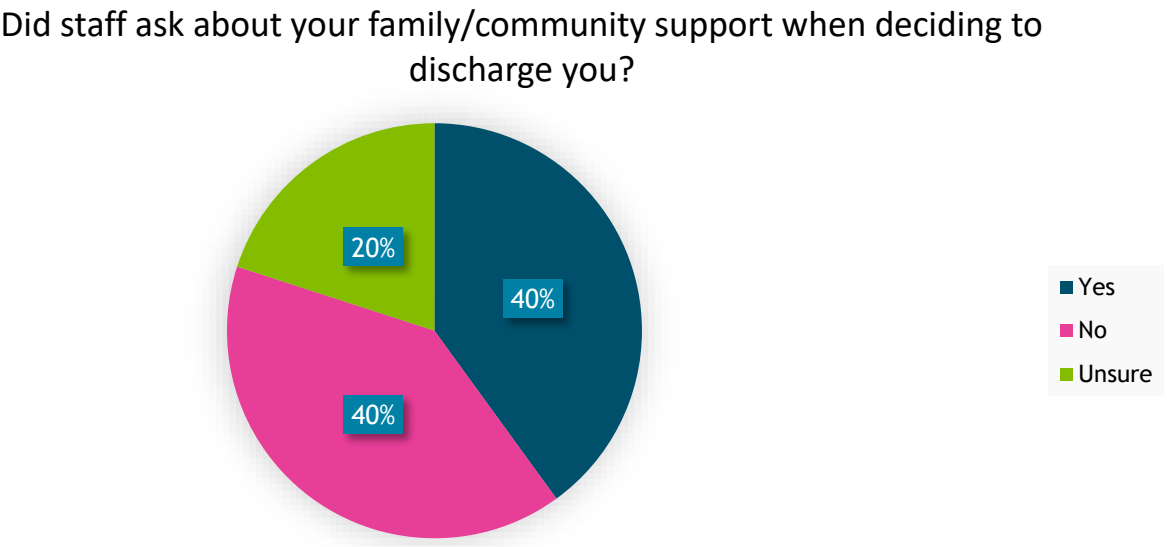


3.6.9 Housing and family/community support after discharge

40% of the people we spoke to said they had been asked about their housing situation when planning their discharge, 40% said they hadn't been asked. 20% said they were 'Unsure'.



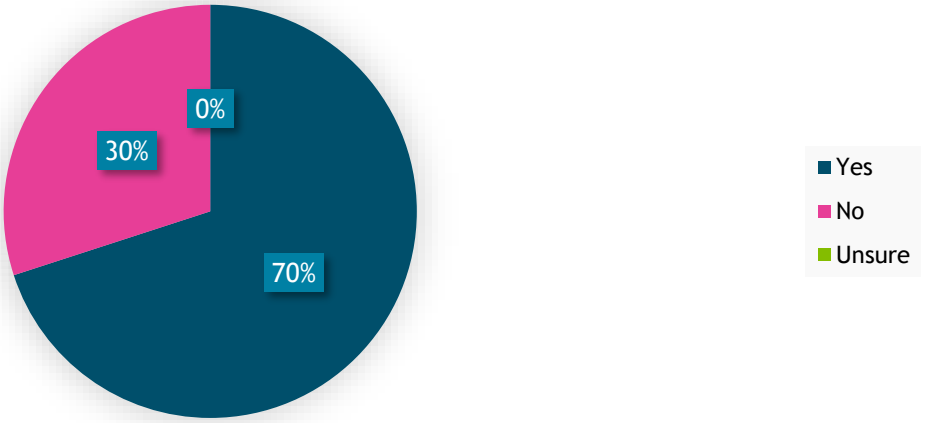
40% of the people we spoke to said they were asked by staff about their family/community support when deciding about discharge, 40% hadn't been asked and 20% were 'Unsure'.



3.6.10 Medication

Of the people who were prescribed medications after discharge from hospital, 70% said they were given clear instructions on how and when to take them and 30% said they were not.

If you were prescribed medication(s) were you given clear instructions on how and when to take them?



4 Additional findings

4.1 Queen Elizabeth Hospital procedures

The introduction of a care card (Discharge Lounge Transfer Form – see appendix 2) has been developed to be completed on the ward prior to the individual coming to the discharge lounge. This ensures information is available when needed. Also, informing patients (where possible) the day before discharge, has been introduced to ensure the patient is aware and can plan ahead. This has been encouraged to manage the expectations of patients who are due to be discharged.

Guidance around the 'Core Roles & Responsibilities of the trained nurse in the Discharge Lounge' is also available for all staff in the Discharge Lounge to follow (see appendix 3).

A patient satisfaction questionnaire is available for individuals to give their feedback and share their experience (see appendix 4).

Further information about hospital discharge from Queen Elizabeth Hospital can be found on their website: https://www.lewishamandgreenwich.nhs.uk/discharge-information-qeh

4.2 Guidance on discharge

Information available online regarding advice and information about hospital discharge in Greenwich can be found on both the Royal Borough of Greenwich website[23] and the new Greenwich Community Directory[24]. This website has been developed to help residents find and access health, wellbeing, and social care services in Greenwich. It also provides advice and information and support to carers, family, friends, and those acting on behalf of vulnerable people.

It also has advice for those who are going into hospital with a learning disability[25]. It includes tips for carers or relatives to follow to make a hospital stay go more smoothly.

The Greenwich Community Directory also gives information about how to access the Reablement Service[26] by contacting the Royal Borough's Contact Assessment Team. There is no charge for the Reablement Service but if you still require support after the service has ended you may need to contribute to the cost of ongoing care.

4.3 'My right to access healthcare' cards

The Healthy London Partnership & Groundswell have produced a 'My right to access healthcare' cards to help people who are homeless register and receive treatment at GP practices in London. If those who are homeless, or have concerns about their immigration status, are more able to access primary care, this could lead to lower number of people presenting at A&E with health concerns. The plastic cards are designed to be carried by people who are homeless across London, including people who sleep rough, live in hostels, sleep on family and friend's sofas, or who are chronically insecurely housed.

They can be used to remind GP receptionists and other practice staff of the national patient registration guidance from NHS England[27]. This states that:

- people do not need a fixed address or identification to register or access treatment at GP practices
- where necessary, the practice may use the practice's address to register the patient if they wish.

Front (left) and back (right) design of the 'My right to access healthcare' cards

These are available to download or can be ordered via the website[28].

5 Conclusions and recommendations

5.1 Treatment by healthcare staff

The treatment received by patients admitted to Queen Elizabeth Hospital was highly rated. Individuals said they were treated with respect and compassion throughout their stay. There was some concern from patients that although they may have been clinically fit for discharge they did not feel ready.

- **Recommendation 1:** Consideration should be given to the patient's own feelings about whether they consider themselves ready for discharge. If a patient is physically ready to be discharged but they do not feel they are, the Hospital must work with the Royal Borough of Greenwich adult social care team to ensure that not only their physical support needs are catered for, but also their emotional and social needs.
- **Recommendation 2:** The hospital should produce a discharge checklist, which lists all services that the patient could be referred to with contact details and how to access them. The discharging Nurse can then tick and sign the services recommended for the patient.

5.2 Readmission

Readmission of patients we spoke to was high, with 80% having been previously admitted within the last 18 months. The discharge patients we spoke to were complex discharges and more simple discharge patients may not need to transition through the discharge lounge.

- **Recommendation 3:** Clear information about the discharge process should be given to all patients when they are first admitted. Their housing and support needs should be identified early to ensure a suitable discharge plan is developed with the patient. Where additional needs are identified, these should be assessed for and put in place well before discharge.
- **Recommendation 4:** More effective and consistent use of the 'care card' (Discharge Lounge Transfer Form – appendix 2) well in advance and just prior to discharge will help to ensure patients feel ready to go.

5.3 Bed usage & delays

We found beds were not always used appropriately, and the discharge lounge was sometimes used as an overflow for other wards. This reduces the effectiveness of the lounge as a place of transition, placing an increased workload on the staff, which may reduce the amount of time they have ensuring the discharge patients receive the support and information they need.

In addition, spreading patients around the hospital increases the amount of time consultants spend 'on safari' looking for their patients, reducing the amount of time they can spend with each patient. It also means the patients may not be receiving the specialist nursing care they would receive on the appropriate ward. More effective use of the discharge lounge by the hospital should in theory help to relieve pressure on beds by ensuring people are moved on as efficiently and safely as possible.

- **Recommendation 5:** Although we recognise the pressure on space across the hospital, the discharge lounge should not be used as an overflow for other wards in the hospital.

Care home bed embargoes following poor Care Quality Commission (CQC) inspections are contributing to delayed discharge from the hospital.

- **Recommendation 6:** Lewisham and Greenwich NHS Trust, Greenwich CCG and RBG must work together to jointly commission and fund an increase in suitable short and long-term beds to ensure that patients can get the care they need outside of the hospital setting in a timely manner.
- **Recommendation 7:** The Trust, CCG and RBG could work with the CQC and local care home providers to identify and commission a 'task force', made up of improvement specialists to go into services recently rated inadequate and tackle the identified issues, with a view to returning the embargoed beds into full use more rapidly.

5.4 Communication/Information about discharge and support services

Communication was probably the single most important issue we picked up throughout this programme. Generally, communication throughout a patients' admission was found to be good, with patients mostly feeling involved and informed when it came to the discharge process. However, there were several aspects of communication that were felt to be lacking, particularly around the information given to patients about their medication, the support available after discharge and more importantly, how to access that support.

- **Recommendation 8:** Prior to the discharge process, patients should be asked about their housing situation and the care and support they have in place. If the post-hospital situation is unsuitable, an expedited, jointly commissioned, assessment should be carried out to ensure that a package can be rapidly put in place. This will help prevent prolonged and unnecessary hospital stays and reduce readmission rates.
- **Recommendation 9:** LGT should have a patient representative sitting on the discharge planning group.

5.5 Housing and family/community support after discharge

40% of the people we asked said they were not asked about their housing situation or about their available family/community support when planning their discharge, and 20% said they were 'Unsure'.

- **Recommendation 10:** The hospital, Greenwich CCG and RBG should develop a homelessness discharge pathway and protocol that reflects the multiple needs and complexity of homeless discharge. Feedback from people who are homeless is key to ensuring that this happens effectively. There should be a named person at the hospital with responsibility for identifying people who are homeless on admission, to then work with RBG Housing Options and/or Adult Social Care teams to identify a safe and suitable discharge plan.

5.6 Medication

Of the people who were prescribed medications after discharge from hospital, 30% said they were not given clear instructions on how and when to take them.

- **Recommendation 11:** Patients being discharged, who have been prescribed medication by the hospital, must be fully informed of how and when to take the medication. Ideally, this would be written in an easy to understand format that the patient can take with them.

- **Recommendation 12:** Similarly, if patients are taking prescribed medication prior to admission which is then changed during their hospital stay, the reason and the implications of the change must be clearly explained to the patient, and ideally written down in an easy to understand format.

6 Service provider response

Lewisham and Greenwich NHS Trust provided us with the following response to our report on the 8th June 2017:

Healthwatch Hospital Discharge Enter and View visit to Queen Elizabeth Hospital Discharge lounge:

Details of visits

- 22.02.2017 from 2:00pm-5:00pm
- 23.02.2017 from 9:00am-12:00pm
- 11.03.2017 from 11:00am-2:00pm (scheduled)
- 17.03.2017 from 2:00pm-5:00pm

Trust Response to the Recommendations

This is a response to the recommendations set out in the report 'Hospital discharge Enter and View Report' 2017: Queen Elizabeth Hospital Discharge Lounge, Enter and View visits carried out on Wednesday 22nd February 2017, Thursday 23rd February 2017, Saturday 11th March 2017 and Friday March 17th 2017. The report was written by the local organisation Healthwatch Greenwich.

Lewisham and Greenwich NHS Trust welcomed the report by Healthwatch, the final version of which we received on 22nd May 2017.

We were very pleased to note the many positive comments about our service including comments on:

Premises

- The staff desk is located between the seating area and beds and has a good view of both. It is a low desk and there was at least one member of staff there throughout our visits.

Environment & Cleanliness

- The discharge lounge appeared clean and we saw seats being wiped down thoroughly after visitors left.

Treatment by healthcare staff

- All 10 people who were asked about the treatment received by healthcare staff rated it as either 'Good', 'Very Good' or 'Excellent'. With five out of the 10 saying it was 'Excellent'.

Communication throughout admission

- Four out of the 10 people we asked rated the communication throughout their stay as 'Excellent', four rated it as 'Very Good', one person said it was 'Fair' and one person said it was 'Poor'.

Information about the discharge process and support services available

- Three out of 10 said they received 'Very Good' information regarding the discharge process, two people said 'Good', one person rated it as 'Fair', one person as 'Poor'.

In addition we note your recognition of various initiatives we have introduced to improve communication and information around the discharge process for both staff and patients/carers, namely;

The introduction of a 'Care Card' Discharge Lounge Transfer Form, to be completed by the ward prior to discharge. The Care Card enables staff in the discharge lounge to provide the appropriate documented care to their patients.

Development of guidance around the 'Core Roles and Responsibilities of the trained nurse in the Discharge Lounge'.

Use of a patient satisfaction questionnaire which is available for individuals to give their feedback and share their experiences. Information is collated by the patient experience team and any themes or trends identified feedback to the Discharge Lounge team via the Matron for the area.

The patient experience team have developed a leaflet for carers and patients with resources for both QEH and Lewisham sites. This is in the final vetting process and will be available in the summer. It includes information about local services, charities and support groups.

Additional information on discharge can be accessed via the QEH website.

We also noted the areas identified by patients/carers where improvements are required and we note your recommendations relating to these issues.

Response to the recommendations:

Treatment by Healthcare Staff

Recommendation 1

Consideration should be given to the patient's own feelings about whether they consider themselves ready for discharge. If a patient is physically ready to be discharged but they do not feel they are, the Hospital must work with the Royal Borough of Greenwich adult social care team to ensure that not only their physical support needs are catered for, but also their emotional and social needs.

Actions

- Develop information pack to sign post & inform of external resources.
- We will work in close collaboration with the RBG to ensure that the information we provide is current and up to date
- Educate staff regarding external agencies/resources
- Actively engage with these agencies e.g. "The Stables" for carers support & befriending and the Greenwich Integrated Volunteers (GIV) project and ensure that the in-patient wards are well versed with the services that they provide.
- The complex discharge co-ordinators will continue to work with the hospital integrated discharge social care team to ensure that patients' holistic needs are met prior to discharge.
- Any themes that are identified by the Patient Experience team through the Friends and Family Test around discharge will be acted upon.

Readmission

Recommendation 2

Clear information about the discharge process should be given to all patients when they are first admitted. Their housing and support needs should be identified early to ensure a suitable discharge plan is developed with the patient. Where additional needs are identified, these should be assessed for and put in place well before discharge.

Actions

- Home First policy has been agreed by community partners. Information leaflets are currently at print stage. The leaflet will be given to every patient on admission to an in-patient ward. It will describe to patients and relatives why it is important that you do not remain in hospital once you are medically fit. Furthermore the leaflet explains what patients can expect from the Trust as their discharge is planned, what the Trust expects from patients and carers and how to contact people within the Trust who would be able to advise patients and carers about their discharge.

Recommendation 3

More effective and consistent use of the 'care card' (Discharge Lounge Transfer Form) well in advance and just prior to discharge will help to ensure patients feel ready to go.

Comment

- The Care Card was developed primarily for the communication of care between the ward and the Discharge Lounge staff, whilst it is accepted that the more discharge related information, and earlier it is received will help to ensure patients feel 'ready to go' this recommendation will be covered by Leaflets provided as part of the Home First policy.

Action

- Trial the discharge lounge coordinator visiting patients the day before their discharge to relieve anxiety about the process. (This will also help manage the patient's expectations about early transfer to the lounge.)

Bed usage & delays

Recommendation 4

Although we recognise the pressure on space across the hospital, the discharge lounge should not be used as an overflow for other wards in the hospital.

Actions

- The Trust now has a daily monitoring and tracking process to ensure that patients are not placed within the discharge lounge as part of the Trust escalation process and since March 22nd only patients who are ready for discharge within 12 hours have been placed there. The Trust does have a documented escalation process which includes clinical assessment and review of patients.
- As part of the Trust Quality and Safety improvement programme, the Trust is working with CCG, Community and local authority partners to strengthen the clinical pathways for patients and to ensure that where patients are medically fit, they are appropriately placed and discharged to maximise flow and bed capacity.

Recommendation 5

Lewisham and Greenwich NHS Trust, Greenwich CCG and RBG must work together to jointly commission and fund an increase in suitable short and long-term beds to ensure that patients can get the care they need outside of the hospital setting in a timely manner.

Actions

- As part of the jointly owned (Trust and CCG) Quality and Safety Improvement programme, this action is being taken forward to review out of hospital capacity and services and also to review community based services. There are current initiatives in the process of being progressed through this work, such as the use of Eltham Community Hospital, Hospital at Home services (care provided in patient's home) and work with nursing care and residential homes to maximise out of hospital capacity.

Recommendation 6

The Trust, CCG and RBG could work with the CQC and local care home providers to identify and commission a 'task force', made up of improvement specialists to go into services recently rated inadequate and tackle the identified issues, with a view to returning the embargoed beds into full use more rapidly.

Actions

The Trust is working with CCG partners in support of challenges faced in the out of hospital services, including local care homes. The Trust is an active participant in the Care Provider Forums for the RBG.

Communication/Information about discharge and support services

Recommendation 7

Prior to the discharge process, patients should be asked about their housing situation and the care and support they have in place. If the post-hospital situation is unsuitable, an expedited, jointly commissioned, assessment should be carried out to ensure that a package can be rapidly put in place. This will help prevent prolonged and unnecessary hospital stays and reduce readmission rates.

Actions

- As part of the admission assessment process the social care history and assessment takes place, whilst circumstances and clinical conditions may change the ability of a patient to return to their usual place of residence, the Trust is working on ensuring it commences the discharge planning as soon as is possible and appropriate. Work is already in progress as part of the discharge work stream included in our Joint Quality & Safety Improvement programme

Housing and family/community support after discharge

Recommendation 8

The hospital, Greenwich CCG and RBG should develop a homelessness discharge pathway and protocol that reflects the multiple needs and complexity of homeless discharge. Feedback from people who are homeless is key to ensuring that this happens effectively. There should be a named person at the hospital with responsibility for identifying people who are homeless on admission, to then work with RBG Housing Options and/or Adult Social Care teams to identify a safe and suitable discharge plan.

Actions

- The complex discharge co-ordinators work within the hospital to ensure that those patients who are identified as homeless are signposted to the most appropriate place of help. For those patients who lack capacity the discharge co-ordinators work closely with the Hospital Integrated Discharge social care team to meet the complex needs of these patients.

Medication

Recommendation 9

Patients being discharged, who have been prescribed medication by the hospital, must be fully informed of how and when to take the medication. Ideally, this would be written in an easy to understand format that the patient can take with them.

Recommendation 10

Similarly, if patients are taking prescribed medication prior to admission which is then changed during their hospital stay, the reason and the implications of the change must be clearly explained to the patient, and ideally written down in an easy to understand format.

Comment

- The Trust has processes in place to ensure patients/carers are aware of all relevant information relating to their medications. As part of patients discharge information all patients receive a printed copy of their discharge letter detailing instructions/information related to their medication needs. On-going work is in progress with this, to re-enforce information provided to patients upon discharge.

Contact us

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