healthwatch Northamptonshire

Discharge from hospital and follow up support

Patient experience of hospital discharge and impact of home-based support following discharge

December 2017

Contents

Summary

In recent years there has been growing discussion and interest in the process of discharge from hospital, as well as concern about delayed discharges. Discharge delays can create problems for hospitals, such as a lack of beds for incoming patients, and cause issues for older patients in particular, who can lose mobility very quickly when kept in hospital longer than necessary. Conversely, discharging people too early or without the correct support in place can lead to them being readmitted to hospital, recently highlighted by Healthwatch England[1].

In June 2017, NHS England published an overview of the situation across England in their report 'Delayed Transfers of Care Statistics for England 2016/17'[2]. Reasons for delayed discharges reported included:

- Awaiting decision about social care funding
- Lack of availability of domiciliary care to support people in their own homes
- Delays in continuing health care assessments
- Problems in finding a care home placement
- Lack of 'step down' beds
- Family delays/disputes about readiness for discharge

Healthwatch Northamptonshire sought to find out the experiences of patients being discharged from the two general hospitals in Northamptonshire - Kettering General Hospital (KGH) and Northampton General Hospital (NGH). We heard directly from patients about their experiences and views of the discharge process.

Over a three week period in November/December 2016 we spoke with 89 people in hospital on the day they were being discharged - 53 patients at NGH and 36 at KGH. Some were waiting to be discharged from the discharge lounge and others directly from one of the hospital wards. Nearly half (47%) of the patients we spoke to were aged 75 or older. Over half (52%) of patients had been emergency admissions either via 999 or 111 and 65% of patients had been in hospital for one week or less.

[1] www.healthwatch.co.uk/news/nhs-needs-do-more-understand-why-people-are-returning-hospital-after-being-discharged

[2] www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/2016-17-Delayed-Transfers-of-Care-Annual-Report.pdf

The length of hospital episodes has reduced in recent years and this was the case with the patients involved in our survey. The majority of patients we spoke with had been in hospital for a week or less. This gives less time to prepare for discharge, and reinforces the need for the discharge process to begin on admission.

In general, the patients we spoke with were very aware of how busy the local hospitals were, and generally appreciative of the care and support received. However, the experiences of patients did highlight some areas for improvement or review.

Areas for improvement or review relating to discharge planning:

- Discharge planning to begin earlier, so arrangements are in place immediately after discharge.
- Greater promotion and encouragement of the involvement of patients' families/carers in discharge planning discussions.
- Ensuring communication is consistent, reducing the instances of patients and carers receiving 'mixed messages' from different professionals.
- Earlier referral to social care professionals for social care assessments, so that care packages are in place and do not delay discharge from hospital.
- Greater awareness of informal carers and their needs, so that more carers are referred for carers assessments.
- Earlier production of discharge letters and greater emphasis on clarity, with less use of abbreviations/jargon, so that patients are not confused.

When discussing the day of discharge, a number of patients felt honesty was the best approach. The following are the main areas they identified in need of improvement:

- Greater clarity about the process of being discharged, including advice to patients that it is not possible to give exact times for discharges, thereby avoiding unrealistic expectations.
- Ensuring medication is ready, so patients can leave more promptly.
- Ensuring discharge paperwork is available and staff to check patients are clear about next steps, medication, etc.
- Considering any improvements to the discharge lounge environment to improve the patient experience of waiting to be discharged.
- Periodic reviews of the discharge process to check the patient experience and identify areas in need of review or change.

Nine patients agreed to being interviewed to find out more about their post-hospital experiences. Those interviews took place in March 2017. All the people who talked to us about their post-discharge period were generally happy with the support and advice they had received, however, some did not know what to expect, lacked information or felt under-supported.

Areas for improvement or review relating to the immediate post-discharge period:

- Ensuring that patients have clear, easy to understand information about their condition, as well as instructions about medication, exercise, etc. and what they can and can't do after discharge.
- Ensuring patients have the necessary aids and adaptations delivered and set up ready for their arrival at home.
- Ensuring patients have contact details of relevant departments/services/key professionals, in case they have any difficulties or issues post-discharge.

The areas of improvement highlighted here support the findings recently published by Healthwatch England in their briefing '*What happens when people leave hospital and other care settings?*'[3], a report looking at whether experiences had changed since their 2015 report '*Safely Home*'[4]. Key findings from across the Healthwatch network highlighted included:

1. Patients still don't feel involved in decisions and often aren't given the information they need, such as about their medication or where to go for help out of hours.
2. Patients continue to experience delays and a lack of co-ordination between services. Many had to stay in hospital longer than necessary because of long waits for medication and transport, and because care homes or family members were not notified that they were about to be discharged.
3. Patient feel left without the support they need after leaving hospital. People told Healthwatch about leaving care without adequate care plans or ongoing support in place, which in some cases led to readmissions.

[3] www.healthwatch.co.uk/resource/what-happens-when-people-leave-hospital-and-other-care-settings

[4] www.healthwatch.co.uk/safely-home-peoples-experiences-leaving-care

Key Findings

Discharge and planning for discharge

- **Only 14% of patients** (17% of patients at KGH and 14% at NGH) **said the process began soon after admission or on admission** and **71% of patients** (61% at KGH and 77% NGH) **said preparation did not start until shortly before discharge.**
- **Social care needs or a referral** for an assessment was discussed with **26%** of patients.
- **66% of patients reported they felt either fully involved or partly involved** in the process.
- **62% of patients felt all the necessary people were involved in the discharge process - both professionals and family** (58% at KGH and 64% at NGH). **15% did not feel that all the necessary people were involved** (11% at KGH and 17% at NGH).
- **60% of patients felt that they were informed about their condition and what to expect** (58% at KGH and 60% at NGH). **Fewer, 42%** (44% at KGH and 40% at NGH), **were told who to call for advice.**
- **The majority of patients (81%) had waited up to three hours to be discharged** at the time we spoke to them (75% at KGH and 85% NGH), 2% had waited between three and six hours (3% at KGH and 2% at NGH) and 4% had waited between six and nine hours (8% at KGH and 2% NGH).
- Patients were **waiting for medication (42%), transport (36%), family and friends (37%) and paperwork or letters (26%)**. 34% were waiting for more than one of these reasons.
- **60% of patients felt the overall experience of discharge was good** (64% at KGH, 57% at NGH), 22% said it was adequate and 6% said the overall experience of discharge was poor.
- **68% of patients were discharged to their own homes** (78% for KGH and 62% for NGH). A smaller proportion were discharged to other locations (residential homes 8%, and relatives/friends' homes 6%).

The Post-discharge period

- **The majority of patients being discharged had up-to-date/amended prescriptions, appropriate paperwork, etc.**
- Patients who were prescribed **community equipment reported items were delivered in a timely manner.** However, one person reported difficulty in getting through to the provider on the phone, as well as problems in the past when asking for equipment no longer required to be taken away.
- We heard from a small number of people who received aids and equipment from the community equipment provider, and the general consensus was that it was a good service. One person received a large, complex piece of equipment and was not able to assemble it themselves. **It was not clear whether discharge planning discussions included checking whether patients are able to assemble equipment themselves, is a key issue for elderly patients and those with disabilities.**
- Patients referred to the **post-discharge cardiac courses** available at both hospitals and gave **very positive feedback.**
- We heard a good example of an effective and **creative approach to a longstanding addiction problem, with the use of a post-discharge placement in a specialist rehabilitation hospital.**
- In general, those **patients who lived alone and received post-discharge support reported the benefits** of it in terms of **building their confidence in the initial weeks after discharge.**

Recommendations

1. Discharge planning should start as early as possible, particularly where patients have complex needs and require assessment for social care support.
2. Greater involvement and inclusion of patients' families/carers in discharge planning as they are often crucial to ensuring patients carry out what is recommended for the post-discharge period.
3. Production of a simple guide to the discharge process to enable patients and their families to prepare for and participate in the discharge planning process.
4. Identification of patients who are carers prior to admission, where the admission is planned, so any necessary social care support for the cared person can be arranged in advance. In the case of an emergency or unplanned admissions, there should be early identification of patients with caring responsibilities, and where appropriate, referral made to Northamptonshire County Council for an emergency assessment and support package for the cared for person.
5. Identify patients who need advocacy support to help and support them through the discharge planning process and adult social care assessment process.
6. Timely referral to social care professionals for social care assessments to be undertaken prior to discharge.
7. Ensure all patients have their discharge letters, prescriptions and any other paperwork on discharge. All paperwork giving instructions, information, etc. for the patient/carer should be in clear, simple language which patients and carers can understand.
8. Liaise with both the commissioners of the community equipment services and the current provider to ensure policies and procedures are included in contracts which ensure large/complex aids and equipment are not left in need of assembly/construction by elderly/infirm/vulnerable patients, including those being discharged from hospital.
9. Development of 'social prescribing' with agencies such as Age UK, Alzheimer's Society, Stroke Association, etc. for patients not eligible for, or in need of a higher level of, social care support. They offer a range of valuable, community based support.
10. Provide patients/carers with key telephone contact numbers in case they have any post discharge queries or concerns.

Responses from the hospitals

Northampton General Hospital

"Thank you for your recent report received on 22nd November, which details the findings and recommendations following your survey of Discharge from Hospital, conducted in November/December 2016.

I would like to express my thanks to you and the other representatives from Healthwatch Northamptonshire for taking the time to visit our organisation, and for sending us a very comprehensive report.

It was pleasing to note that only 6% of patients said the overall experience of discharge was poor, with 57% of patients stating they felt the overall experience of discharge was good.

It was also good to hear that the majority of patients being discharged had up-to-date/amended prescriptions and appropriate paperwork as this is an area we have been focusing on at NGH.

I would like to address the recommendations you make within your report specifically for NGH.

Discharge planning should start as early as possible, particularly where patients have complex needs and require assessment for social care support.

We aim to commence discharge planning on admission and we are currently reviewing our electronic systems to support this. We are also recruiting further Discharge Coordinators to support wards with early discharge planning.

Greater involvement and inclusion of patients' families/carers in discharge planning as they are often crucial to ensuring patients carry out what is recommended for the post-discharge period.

The aim of recruiting further Discharge Coordinators is to help develop relationships with patients and next of kin to support discharge from admission. The Discharge Coordinators will be a single point of contact for discharges, once recruited they will have their own phones and contact cards. New Leaving Hospital leaflets have also been completed to support this process outlining patient and family expectations.

As part of our Patient Engagement and Experience Strategy we are planning to undertake an experienced based co-design project looking at the discharge process at NGH. We would value your feedback on this as representatives of patients.

Production of a simple guide to the discharge process to enable patients and their families to prepare for and participate in the discharge planning process.

We have recently developed Discharge Pathway leaflets aimed specifically at the various discharge routes, for example, rehabilitation, continuing healthcare and

placement or home with a package of care. Leaflets will be issued once the discharge pathway has been agreed.

Since this survey was undertaken NGH have issued the Patient and Carer Information Folder to all Adult and Paediatric Inpatient beds in the hospital. The folder contains a section on leaving hospital which provides information on the process for going home, what to expect before they leave, the Discharge Suite, Transport and Support at Home.

NGH have also put together a Leaving Hospital leaflet for patients and carers which includes a helpful checklist, what to expect on the day of discharge and a section on Medication. The leaflet has recently been updated (please find attached copy) and we would appreciate your input on the latest version before we go to print.

A Medicines and Side-Effects notice is included in all the To Take Out (TTO) bags which contain a helpline for patients to enable them to contact Pharmacy staff after they have left hospital if they have any queries regarding their medication.

Identification of patients who are carers prior to admission, where the admission is planned, so any necessary social care support for the cared person can be arranged in advance. In the case of an emergency or unplanned admissions, there should be early identification of patients with caring responsibilities, and where appropriate, referral made to Northamptonshire County Council for an emergency assessment and support package for the cared for person.

Our aim is to automatically offer Social Services carers support and advice to all patients who require this service. We also aim to ask all carers if they would like a referral to Northamptonshire Carers. The recruitment of the additional Discharge Coordinators will help to ensure we offer these services to all those patients who require them.

Identify patients who need advocacy support to help and support them through the discharge planning process and adult social care assessment process.

Our aim is to identify all patients who need advocacy support early. A referral is sent to Social Services who in turn will complete an assessment and refer to the Advocacy Services. The additional staff currently being recruited to the Discharge team will help to ensure the referral is made for all patients who require advocacy support.

Timely referral to social care professionals for social care assessments to be undertaken prior to discharge.

Patients who are identified as requiring social care assessments are referred to the hospital social services team, referrals are made from the ward.

Ensure all patients have their discharge letters, prescriptions and any other paperwork on discharge. All paperwork giving instructions, information, etc. for the patient/carer should be in clear, simple language which patients and carers can understand.

It is a requirement for all patients to have all their paperwork available on discharge. Although this is currently the Ward's responsibility to ensure this happens, the Discharge Coordinators, once in post, will be able to support this. As previously mentioned we are developing Discharge Pathway and Leaving Hospital Leaflets to provide patients with clear and easy to understand information on their discharge.

Liaise with both the commissioners of the community equipment services and the current provider to ensure policies and procedures are included in contracts which ensure large/complex aids and equipment are not left in need of assembly/ construction by elderly/infirm/vulnerable patients, including those being discharged from hospital.

The majority of equipment is sourced through Therapy or Social Services and arrangements are made to deliver and assemble the equipment in the patient's home. We will ensure this feedback is passed to the relevant teams/departments.

Development of 'social prescribing' with agencies such as Age UK, Alzheimer's Society, Stroke Association, etc. for patients not eligible for, or in need of a higher level of, social care support. They offer a range of valuable, community based support.

We will ensure this feedback is passed on to the relevant teams/departments.

Provide patients/carers with key telephone contact numbers in case they have any post discharge queries or concerns.

A contact number is included in the Leaving Hospital leaflet. In addition a helpline number is included on the Medicines and Side-Effects notice included in all the TTO bags.

I hope that I have been able to respond to your recommendations, and I would like to take this opportunity to thank you again for your report.

As you are aware, all Healthwatch reports are shared via our Patient & Carer Experience & Engagement Group (PCEEG). Your report will be triangulated with other sources of patient feedback including the A&E National Survey and the Friends & Family Test data to ensure recommendations are taken forward and monitored for progress.

If you have any questions or require any additional clarification please contact Rachel Lovesy, Head of Patient Experience & Engagement."

Carolyn Fox
Director of Nursing, Midwifery and Patient Services
Northampton General Hospital NHS Trust

Kettering General Hospital

"Kettering General Hospital have recently introduced 'The Patients Journey: Admission and Discharge Pack', this is all the documentation that staff need to maintain a safe admission and discharge through the patients hospital journey.

This supports staff by giving examples of simple and complex discharge situations and asks key questions that support the highlighted areas for improvement within the Healthwatch discharge report, such as; what support is in place for patients leaving hospital, if the patient is happy with and understands the plans, if medication is arranged and if the discharge letter is completed. This also works to address suggested areas from improvement highlighted within the National Inpatient Survey 2016.

Kettering General Hospital have also launched a series of community engagement events to seek wider feedback about services which include the discharge process. This is with the aim to develop patient led user groups to involve patient and support with service development."

Leanne Hackshall
Director of Nursing and Quality
Kettering General Hospital NHS Foundation Trust

Method

A questionnaire was devised by a working group comprised of Healthwatch Northamptonshire staff and volunteers (Appendix 1 and 2). It was trialled at Northampton General Hospital (NGH) in the week beginning 24 October 2016. Healthwatch Northamptonshire staff and volunteer Authorised Representatives[5] talked with patients using the structured questionnaire and recorded their answers. Patients were spoken to in the discharge lounge from 10am–12 noon and 2pm–4.30pm on Monday, Wednesday and Friday. The questionnaire did not need any adapting after the trial so the responses already collected were kept and added to with a second week at NGH. During the second week we talked to patients who were being discharged directly from hospital wards as well as from the discharge lounge.

The same questionnaire was used to talk to patients at Kettering General Hospital (KGH) during one week, beginning 21 November. Healthwatch Northamptonshire staff and volunteer Authorised Representatives talked with patients in both the discharge lounge and on individual wards who were waiting to be discharged over five days from 10.30- 12 noon and from 1pm–5pm.

89 patients were spoken to - 53 at NGH and 36 at KGH. 22 patients initially agreed to a follow up interview to give their feedback on how well they were supported immediately after discharge. Nine of these still agreed to take part when we contacted them in March 2017. Seven people declined to participate, one person had passed away and we were unable to make contact with five others. Seven of the follow up surveys were undertaken in people's own homes, one was with the daughter of a patient who lived in a residential home and one with a patient who had been discharged to a local specialist rehabilitation hospital.

[5] Healthwatch Northamptonshire Authorised Representatives are trained volunteers who can 'enter and view' health and social care settings in Northamptonshire and help to gather the experiences and views of patients, consumers, carers and the wider public. They have been through a recruitment process, had a Disclosure and Barring Check, and received Enter and View and safeguarding training.

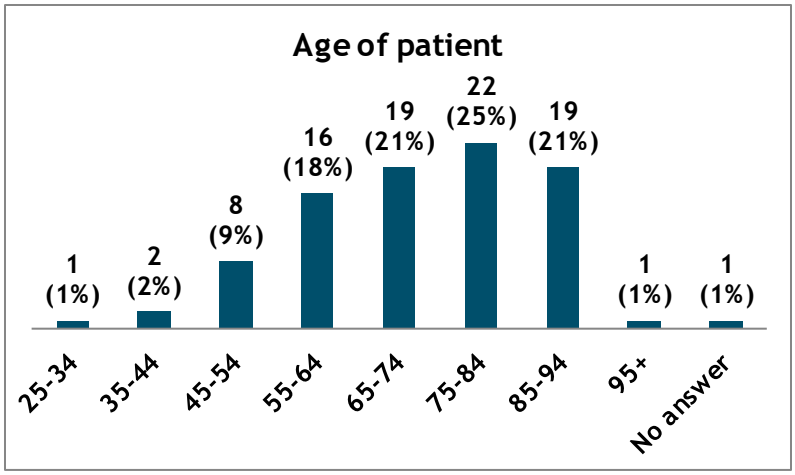
What people told us

89 people spoke to us while in the process of being discharged - 53 at NGH and 36 at KGH. Nine people took part in follow-up interviews. All percentages are based on the total number of responses from each questionnaire.

Demographics

Age:

Over two-thirds of the patients (69%, 61) we spoke to were 65 years old or over and nearly half (47%, 42) were 75 or older.



Gender:

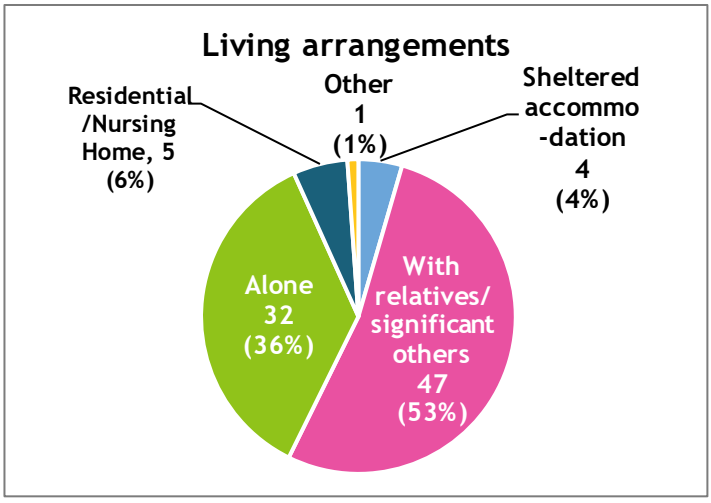
54% of patients (48) were male.

Ethnicity:

94% of patients (83) were White British. Two patients were White European and one was Black African.

Living situation:

53% of patients (47) lived with relatives and 36% (32) lived alone. 10% (9) lived in a residential or nursing home or in sheltered accommodation.



Carers:

36% of patients (32) had an informal/family carer. Five patients (6%) were themselves carers.

Disability and long-term conditions:

60% of patients (53) said they considered themselves to have a disability or long-term condition which affected their day to day living. The most common conditions mentioned were:

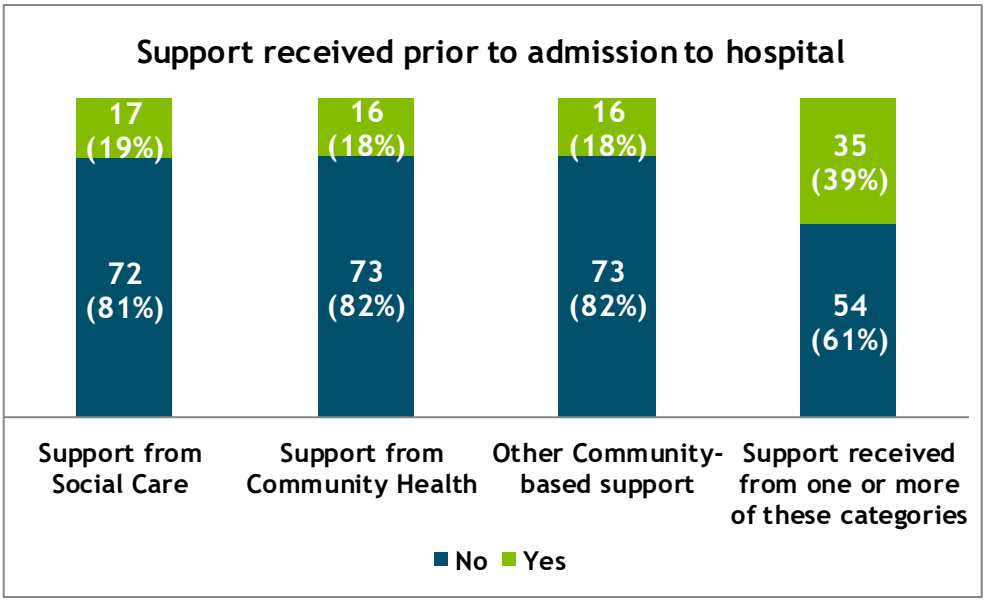
Condition	Number	Percentage
Heart problems	11	12%
Diabetes	10	11%
Respiratory problems /COPD	10	11%
Arthritis	7	8%
Ailment causing mobility issues	7	8%
Back/muscular/joint problems	4	4%
Blood pressure	4	4%
Hearing difficulties	3	3%
Post-operative issues	3	3%
Stroke	2	2%
Cancer	2	2%
Stomach/bowel problems	2	2%
Other conditions (one person per condition)	15	17%

Before admission and length of stay

Support received prior to admission to hospital

We anticipated that a number of patients would either have a disability or a long-term condition prior to their admission to hospital (60% did, see above) and would be receiving some kind of ongoing support.

39% of patients (35) received support from a least one social care, community health or another community-based support service.



19% (17) received support from social care, 18% (16) from community health and 18% (16) from other community-based support services. Eight patients (9%) received support from two or three of these categories.

Examples of the type of support received included:

- Home care support up to help with washing, bathing, meals, etc.
- Regular community nurse visits
- Ongoing support from community psychiatric nurse (CPN)
- Attendance at Northamptonshire Association for the Blind meetings and receipt of regular literature/information.
- Restart scheme organised by Northampton General Hospital, for people with chest problems
- Support from CAN (voluntary drug and alcohol service)
- Physiotherapy support
- Social groups within the community, e.g. Women's Institute, Derby and Jones Club, coffee mornings/groups

Patient experience of admission to hospital

In both hospitals over half of patients (52%, 46) had been emergency admissions either via 999 or 111.

Admission Type	Number	Percentage
Emergency - 999	39	44%
Advised by GP	14	16%
Planned	11	12%
Emergency ref by 111	6	7%
Walk in via A&E	6	7%
Emergency -111, then referred to Nene Doc (out of houses GP)	1	1%
Other	5	6%
Don't know	1	1%
No answer	6	7%

The following comments show the range of situations/reasons for admission to hospital:

- Arrived Saturday after visit to Nene Doc via A&E (thought I had a stroke)
- Daughter rang 999 after I had a fall at home and hurt my back. Feared I might have broken hip but this was not the case, it was heavily bruised

- 12 days ago was admitted in the early hours, as I was struggling to breathe. Neighbours came to help and we decided I needed an ambulance
- Pressed emergency button in the flat and they advised they would get paramedics out
- Came in ambulance after a fall at home
- Rang 111 who said I need out of hours doctor. She came and said I ought to go to A&E to be checked out. Was seen in A&E and admitted to MAU (Middleton Assessment Unit)
- GP advised to go to A&E
- Came by taxi to A&E. Had phoned 999 who said condition not severe enough for ambulance

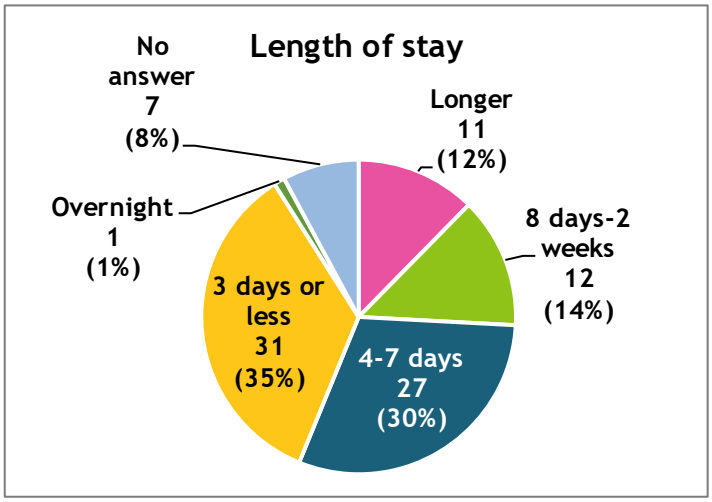
Length of stay in hospital

65% of patients (58) had been in hospital for one week or less.

The length of stay in hospital was 3 days or less for 31 patients (35%). 12 patients (14%) had stays of longer than 2 weeks.

The longest inpatient stay was seven weeks.

> "Initially I was told I could go home quickly, but then they said I was very weak and not capable of looking after myself. Have been waiting for an assessment to be done to go to a nursing home."
>
> Patient comment, Kettering General Hospital



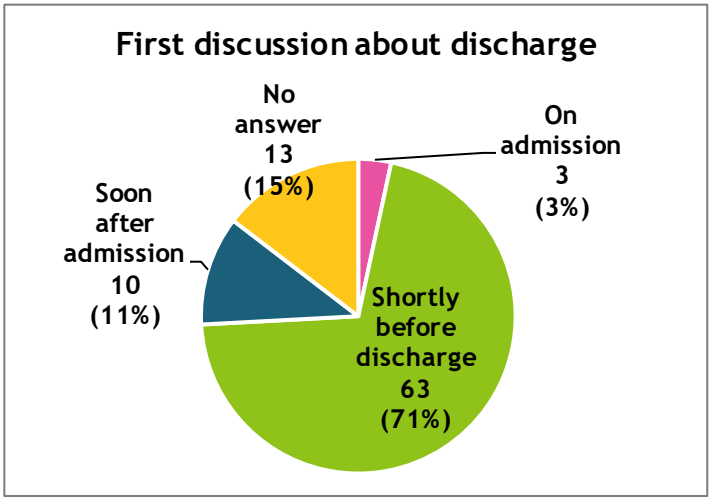
Discussions about discharge

Ideally discharge planning should begin on admission and patients should not be in hospital unnecessarily. However, there can be complications, especially if patients have fluctuating/complex conditions, or cannot be discharged back to their home without support because they have social care needs or it is felt they cannot return to live independently at home. They may also need some specialist equipment or home adaptations, or require a permanent residential home placement.

In such circumstances, whilst a definite date for discharge may not be appropriate, discussions and planning for discharge should still begin as early as possible. Significant family members/carers, relevant health professionals and other agencies, such as Adult Social Care should be contacted so they can input into the discharge planning process.

First discussion about discharge

We asked patients when discharge was initially mentioned to them and just 14% (13) said discharge was mentioned on admission or soon after admission, whilst 71% of patients (63) said it was shortly before discharge.



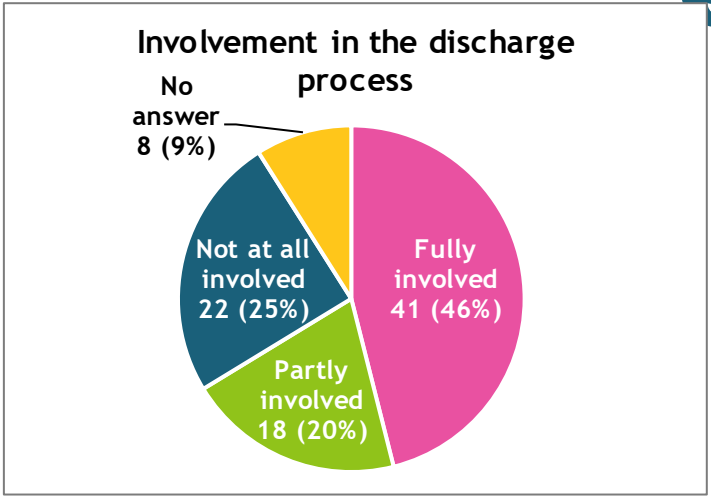
More patients at NGH (77%, 41) reported discharge being first mentioned shortly before discharge than patients at KGH (61%, 22) and a similar smaller proportion of patients in each hospital reported being informed about discharge on admission or soon after admission (NGH 14%, 7 and KGH 17%, 6).

Patient involvement in the discharge process

There is now a common acceptance that patient, and where appropriate, carer involvement in discharge preparation is very beneficial, so we asked patients how involved they felt in their discharge process.

We found the majority of patients felt either fully involved (46%, 41) or partly involved (20%, 18). However, a quarter of patients (25%, 22) did not feel at all involved

56% of patients (20) at KGH felt fully involved in the discharge process compared to 40% (21) at NGH. Three patients (8%) at KGH felt partly involved compared to 28% of patients (15) at NGH. A similar proportion of patients at KGH (22%, 8) and NGH (26%, 14) did not feel at all involved.



Positive comments made by patients about their involvement in the discharge process included:

"Talked to me and got my views." - Northampton General Hospital

"Felt doctor was open, suggested earlier discharge, but this would have been difficult for me, so we agreed today was better."
- Northampton General Hospital

"Everything was very good and they answered my questions."
- Northampton General Hospital

"As involved as I needed to be. I'm prepared to say if unhappy about anything, so if I had felt unwell, then I would have said."
- Northampton General Hospital

"There was a two way dialogue. I was asked if I felt ready to go home."
- Kettering General Hospital

"Brilliant they explained and answered questions. Now waiting for transport home. Had a questionnaire to fill in." - Kettering General Hospital

"Felt full involved and assured I have a telephone number if I have any problems." - Kettering General Hospital

"they were very nice and explained things to me properly. Said they would send me some lunch before I went. I thoroughly enjoyed it."
- Kettering General Hospital

Comments made by patients who did not feel fully involved in the discharge process included:

"Just told me that I was going to be discharged and sent me to the discharge lounge after lunch" - Northampton General Hospital

"Just told I was going home today by a nurse. Not very happy because don't feel I am very well. Did not get an opportunity to see doctor."
- Northampton General Hospital

"Just told I'm going home… had no idea why this date was fixed. Not involved at all – not important." - Northampton General Hospital

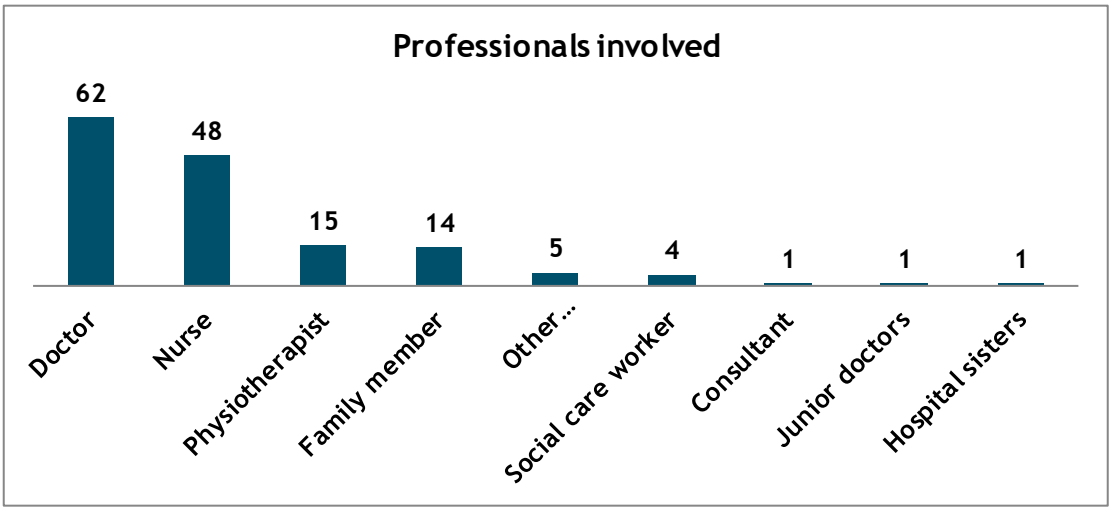
"Just told that I would go home and then the porter came to take my things to discharge. I then phoned for my daughter to pick me up. It's been rush, rush, rush!" - Kettering General Hospital

"Talked to son and daughter but not me - all a bit confusing."
- Kettering General Hospital

"Told an hour ago 'You are going home'." - Kettering General Hospital

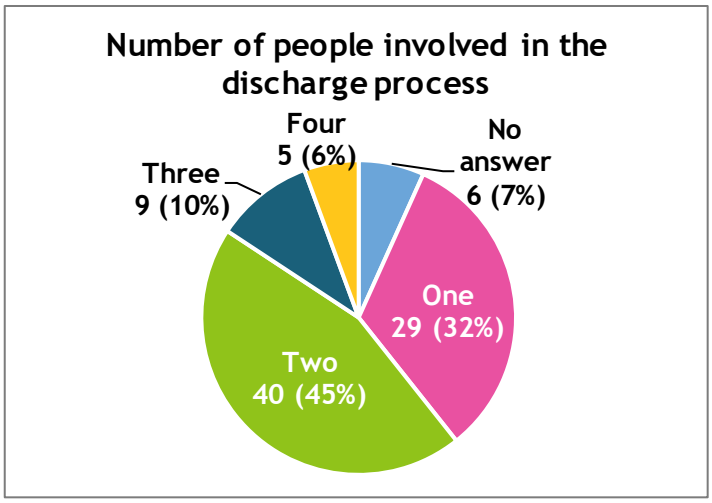
Professionals involved in the discharge process

We asked patients whether all the people they thought should have been involved in their discharge discussion were present. The majority of patients told us that the professionals involved in discharge discussions were primarily doctors and nurses.



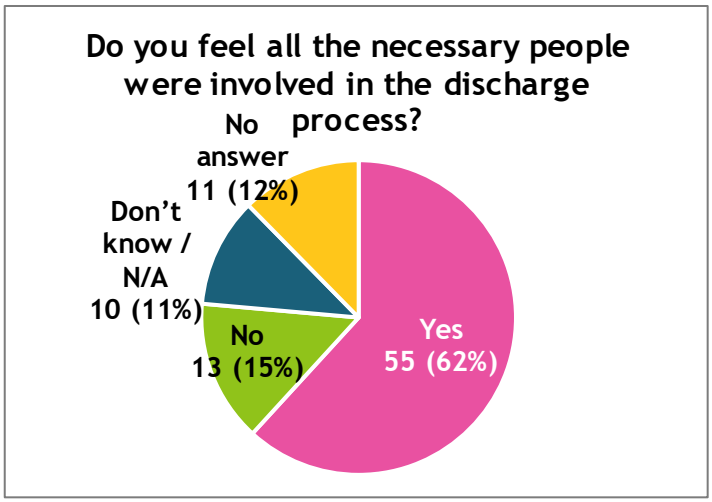
The involvement of necessary people in the discharge process

61% of patients (54) said that two or more people were involved in their discharge discussions, including professionals and family members.



62% of patients (55) felt all the necessary people were involved in the discharge process, and 15% (13) did not.

58% of patients (21) at KGH felt that all the necessary people were involved in the discharge process compared with 64% (34) at NGH. Four patients (11%) at KGH reported that they did not feel all the necessary people were involved, compared with nine (17%) at NGH.



Positive comments about the people involved included:

"Very good staff – got all the information needed."
- Northampton General Hospital

"Right people there with relevant information."
- Kettering General Hospital

13 people (15%) were not satisfied with the process. Comments included:

"No members of family at meeting just doctors." – Kettering General Hospital

"Would have liked other family members involved in the process"
- Northampton General Hospital

"Think the doctor should have been there. I expected a discussion about my condition with a doctor. Did not have results of tests they had done"
- Northampton General Hospital

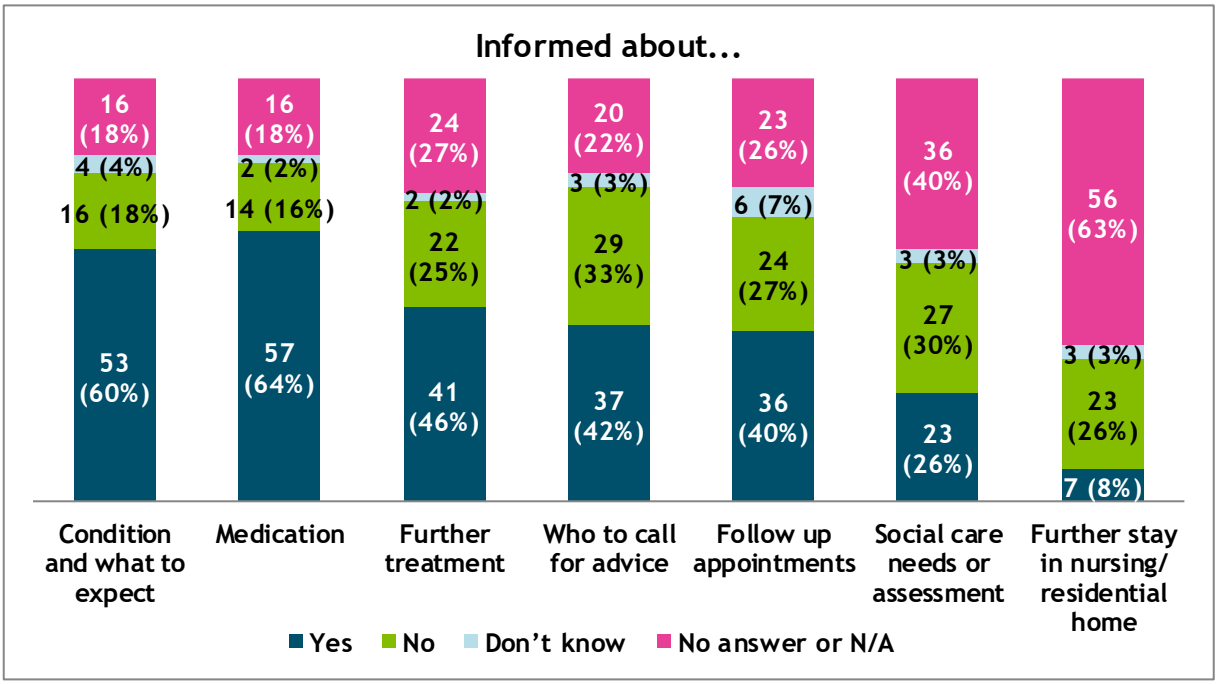
"Haven't seen anyone else other than the doctor. No mention of physiotherapist or occupational therapist. Didn't mention the need for single stay housing as didn't have the opportunity and no questions about home environment." – Kettering General Hospital

"I thought my daughter who is my main carer should have been involved. I had to ring her afterwards." – Kettering General Hospital

Information given

We asked patients about what information they had been given in the discussions about discharge. Not all topics were relevant to all patients, particularly discussions about further stays in nursing or residential homes.

Nearly two-thirds of patients (60%, 53) had been informed about their condition and what to expect and/or their medication (64%, 23). Fewer were given advice about further treatment (46%, 41), who to call for advice (42%, 37) or follow up appointments (40%). The discussion covered social care needs or a referral for assessment for 26% of patients (23) and a further stay in a nursing or residential home for seven patients (8%). Proportions were similar for KGH and NGH.



62% (55) of patients said three or more of the issues shown in the above chart were discussed but three patients (3%) said none were discussed.

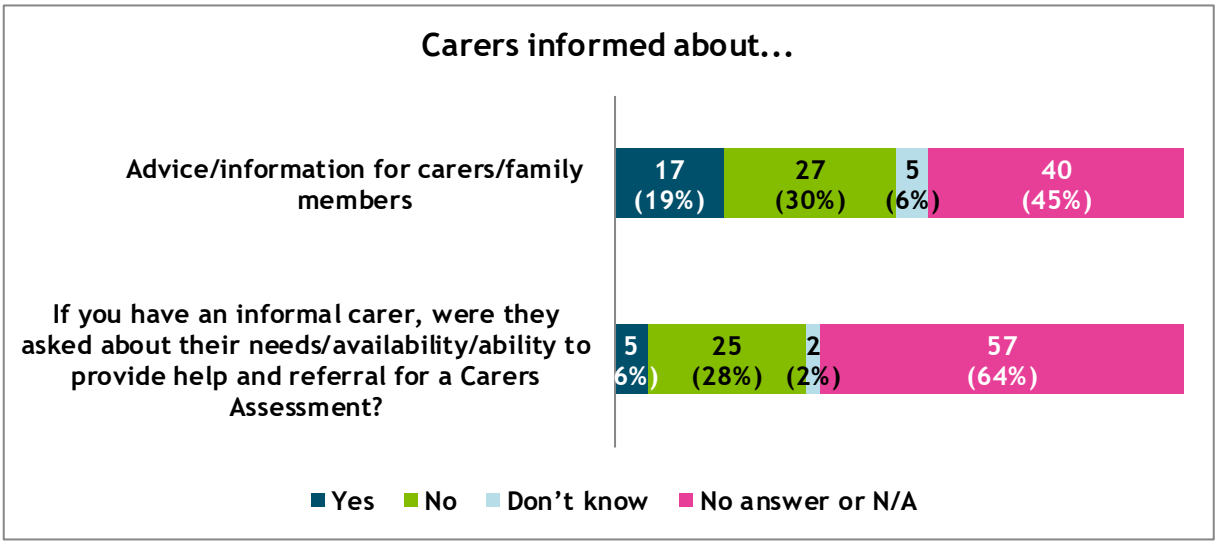
Number of issues discussed	Number	Percentage
0	3	3%
1	9	10%
2	9	10%
3	12	13%
4	15	17%
5	10	11%
6	6	7%
7	4	4%
8	7	8%
9	1	1%

We asked for more details about the discussions, such as how clear the instructions were. The following themes were most commonly discussed:

Theme	Mentions
Satisfied with discussion about condition/what to expect, etc.	12
Return for checks/further treatment	9
Support from GP	9
Family involved in post-discharge care	8
Support from care agencies	6
Unsure who to contact/unclear	6
Not satisfied	4
Home visits	3
Self-management	3
Nursing or residential home involved	3
Call hospital if required	2
Future breathing courses	1

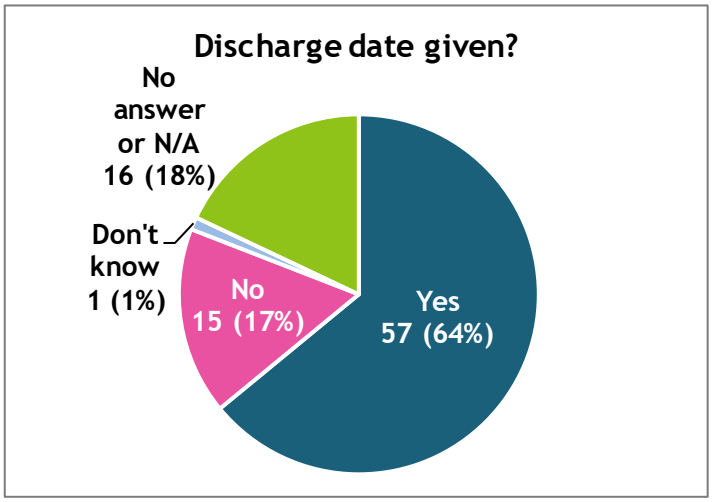
Information for carers

19% of patients (17) said that discharge discussions had included advice or information for carers or family member. This is only 53% of the 32 patients who said they had a family or informal carer, indicating that almost half of people who thought they were informal carers were not given advice.



Information about your discharge date

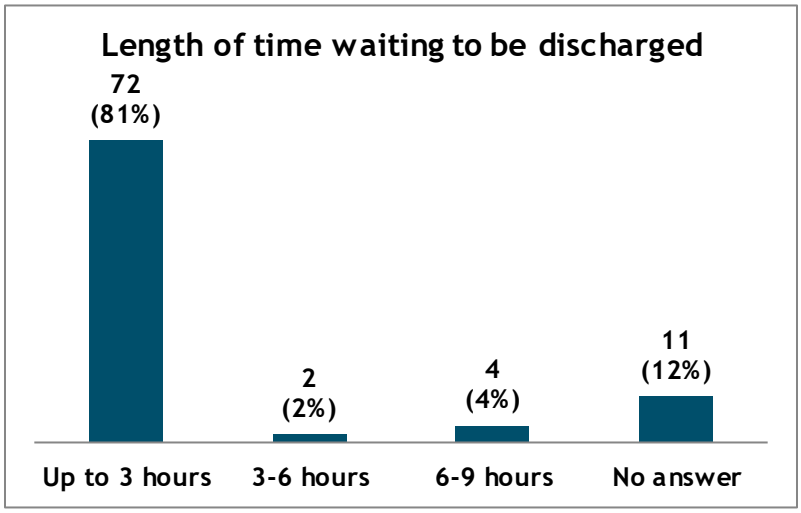
Nearly two-thirds of patients (64%, 57 patients) said they had been given information about their discharge date. 15 patients (17%) said they had not and a further 17 (19%) did not answer this question. 67% of patients (24) at KGH and 62% (33) at NGH reported that had been informed about their discharge date.



Day of discharge

Length of time patients waited to be discharged

We asked patients how long they had been waiting to be discharged at the time we spoke to them. Most (81%, 72) had been waiting up to three hours at that point. Six people (6%) had waited longer than this. This question was not answered by 11 patients.

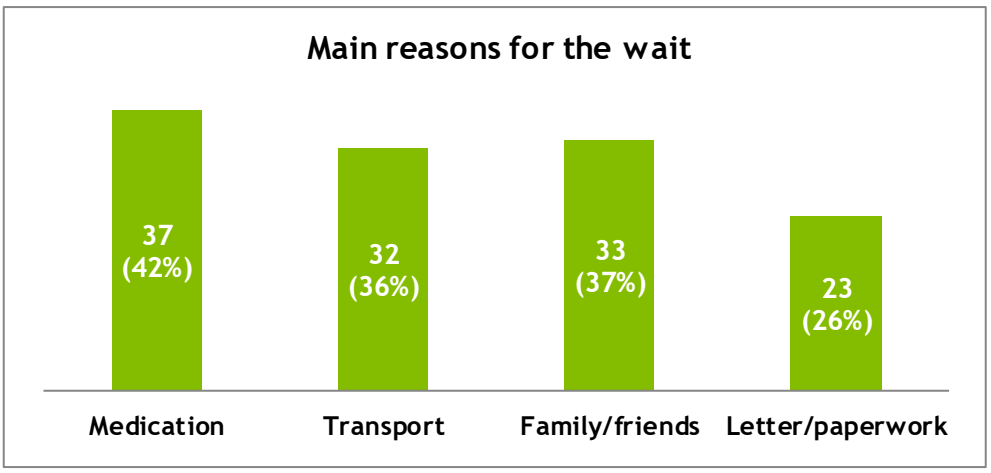


75% of patients (27) at KGH and 85% (45) at NGH had waited for up to three hours. Three patients at KGH and one at NGH had waited over six hours.

Reason for waiting to be discharged

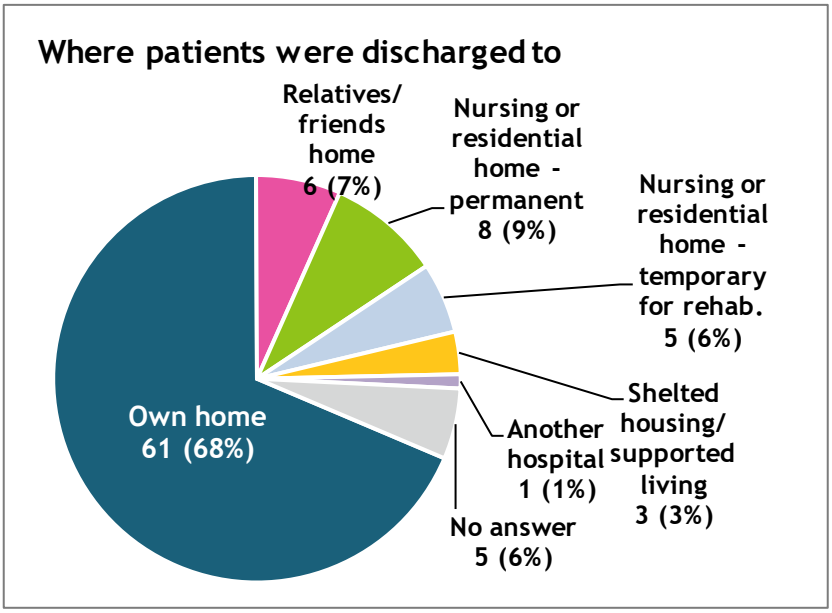
There were a number of reasons why people were waiting to be discharged. Whilst 42% of patients (37) said they were waiting for medication, 36% (32) were waiting for transport and 37% (33) were waiting for family/friends to pick them up. 26% (23) were waiting for letters or paperwork. 34% were waiting for more than one reason (20%, 18 for two and 14%, 12 for three reasons).

At KGH the most reported reason was waiting for medication (39%, 14) and ambulance/transport (33%, 12). At NGH waiting for medication was also the most frequent reason (43%, 23), followed by waiting for family and friends (42%, 22).



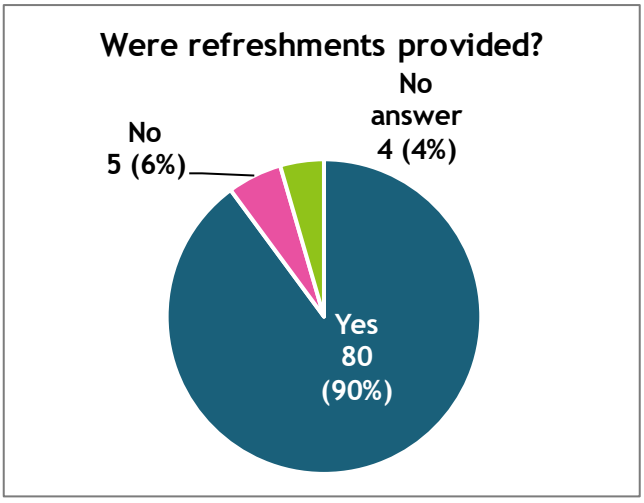
Where were patients discharged to?

Two-thirds of patients (68%, 61) where due to be discharged to their own home (78% at KGH and 62% at NGH). 18% (16) were being discharged to a residential home, nursing home, rehabilitation or supported living (17% at KGH and 19% at NGH).



Refreshments during the wait

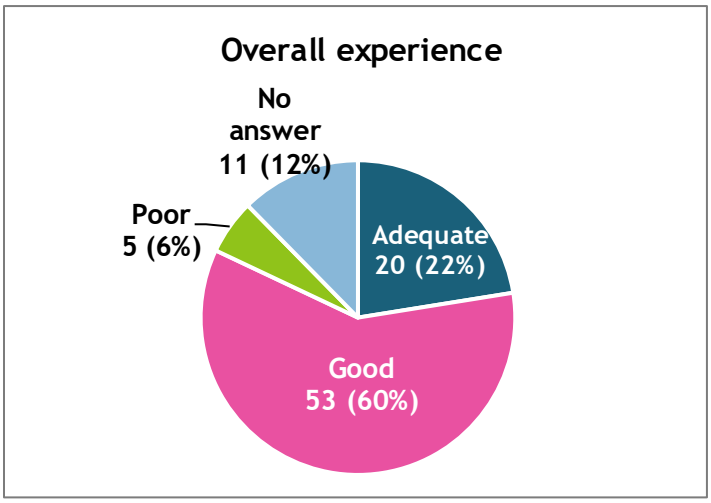
Whilst waiting to be discharged, 90% (80) patients said they had been provided with refreshments (94% at KGH and 87% at NGH). Healthwatch volunteers and staff also observed staff asking patients about drinks and food on arrival in the discharge lounge and at regular intervals.



The overall experience of discharge planning and day of discharge

Patients were asked to rate their overall experience of planning for discharge and the process as a whole. Most patients were quite positive. 60% (53) rated their experience as 'Good' and only five patients (6%) said it was 'Poor'.

64% of patients (23) at KGH and 57% of patients (30) at NGH rated their overall experience as 'Good'. 8% of patients (4) at NGH and one patient (3%) at KGH rated their experience as 'poor'.



We asked patients to give comments. Positive comments included:

"Good system. Waiting for medication/doctors letter."
- Northampton General Hospital

"Very efficient."
- Northampton General Hospital

"Relaxed atmosphere, not in bed, not hurried."
- Northampton General Hospital

"No problem, been offered drinks and snacks."
- Northampton General Hospital

"Treatment generally very good, staff all lovely and happy to be here"
- Kettering General Hospital

"Got TV, someone to talk to in next bed, asked if want a drink, etc."
- Kettering General Hospital

"Excellent….everyone has been absolutely wonderful throughout my stay and during discharge" - Kettering General Hospital

"This [Discharge Lounge] is more realistic. Much better here than Observation" - Kettering General Hospital

Negative comments included:

"Just said would be going home and that was that, just told me."
- Northampton General Hospital

"Pretty boring" - Northampton General Hospital

"They are contacting my husband. He doesn't know I am being discharged today" - Northampton General Hospital

"Frustrating and boring if only they had a nice comfortable discharge lounge" - Kettering General Hospital

"Expect to be able to trust doctor when they say how long it will be before discharge. However understand that they do not always have the real information. Have a better understanding of the system."
- Kettering General Hospital

Follow up interviews with patients

Nine people took part in a follow-up interview for the final part of the project, which was to find out about their post hospital discharge experience. We particularly wanted to know how many of them received post discharge health and/or social care support, and the difference this had made to their recovery.

Support received following discharge

Type of support	Number received
Received specialist equipment from the Integrated Community Equipment Service	3
Short-term support from a community nurse (one person to have dressing checked and the other to check blood pressure/measure chest)	2
Social care support (one received short term support and had to be re-admitted and the other was already receiving social care support, which was resumed on discharge)	2
Cardiac rehabilitation course	2
Support from GP	1
Placement at a private rehabilitation hospital offering ongoing support for an addiction problem	1
Offered short term social care (but refused as partner could care)	1
Telephone call from community nurse to check on progress after surgery	1

Comments about experiences of post-discharge care

All the people who talked to us about their post-discharge period were generally happy with the support and advice they had received:

> "I **was given information at the post-discharge cardiac course which was very good**. I was also **very pleased with the ongoing support and monitoring**. I didn't need any other support as I had **information about changing my diet and attending the course**." (Discharged from KGH)

> "Being discharged to this **rehabilitation hospital has really helped me** to recover more effectively than in the past, when I was discharged back to the community. I have been going to The Bridge regularly, three times a week. In the past I haven't been able to keep this up, but hope to keep going after discharge." (Discharged from NGH)

However, some did not know what to expect, lacked information or felt under-supported:

> "**No mention of aftercare when I was in hospital**, but **had a call from the community nurse** to see how I was getting on. **Difficult to find out information about heart condition and what to do/not to do**. However, after treatment I feel much better… got an exercise bike and now feel so much fitter." (Discharged from NGH)

> "I had **support from a community nurse, an OT**, who checked my stairs, and from a **physiotherapist**, but I **had to wait five weeks for the first visit**. I **felt 'abandoned' and was concerned that I might do harm**, as I hadn't received proper guidance on the exercises." *(This patient progressed from a Zimmer frame to using sticks. They reported it was sometimes difficult to get hold of physiotherapists. They were very pleased that all the other aids they required were delivered before they were discharged.)*
> (Discharged from NGH)

> "Couple of times **when the first physiotherapists came they were surprised I hadn't been given a form for them to record my progress**. I didn't know what to expect. **No-one mentioned initial help after discharge. Didn't realise it would all take so long**." (Discharged from NGH)

> "**Difficult to find out information** about heart condition and what to do/not to do." (Discharged from KGH)

"Short term support discussed at discharge meeting but **no mention of long term support**. Felt it would have been good to have information on how long term support would be." (Discharged from KGH)

The majority of patients being discharged had up-to-date/amended prescriptions, appropriate paperwork, etc. One person (discharged from KGH) reported needing a new prescription but just receiving a direction to ask the GP to reduce the dose, which caused problems both at the GP surgery and the pharmacy.

Patients who received aids and equipment from the community equipment provider, said the service was generally good and that items were delivered in a timely manner. However, one person (discharged from KGH) received a large piece of equipment and was not able to assemble it. Home care staff subsequently did this. Another person (also discharged from KGH) reported difficulty in getting through to the equipment provider on the phone, as well as problems in the past when asking for equipment no longer required to be taken away. **It was not clear whether discharge planning discussions included checking whether patients were able to assemble equipment themselves, a key issue for elderly patients and those with disabilities.**

The key issues raised relating to the discharge process and immediate post-discharge period were:

- The need for a co-ordinated approach to discharge involving key professionals, including social care staff, with a nominated co-ordinator of each case.
- Ensuring the discharge process begins as early as possible.
- Importance of patients receiving their discharge letter and all other relevant documents, including prescriptions available on the day of discharge.
- Early identification and inclusion of key family members/carers in discussions with professionals about their condition, treatments, medication, discharge process, and any post-discharge support arranged.
- The importance of clear, easy to understand information about the patient's condition, as well as instructions about medication, exercises, etc. when the patient leaves home.
- Ensuring patients have the necessary aids and adaptations delivered and set up ready for the patient's arrival at home.
- Identifying whether patients have any caring responsibilities and/or they receive support from an informal carer.
- Ensuring patients have contact details of relevant departments/services/key professionals, if they have any difficulties or issues post-discharge.

About Healthwatch Northamptonshire

Healthwatch Northamptonshire is the local independent consumer champion for health and social care. We are part of a national network of local Healthwatch organisations. Our central role is to be a voice for local people to influence better health and wellbeing and improve the quality of services to meet people's needs. This involves us visiting local services and talking to people about their views and experiences. We share our reports with the NHS and social care, and the Care Quality Commission (CQC) (the inspector and regulator for health and social care), with recommendations for improvement, where required.

Our rights and responsibilities include:

- We have the power to monitor (known as "Enter and View") health and social care services (with one or two exceptions). Our primary purpose is to find out what patients, service users, carers and the wider public think of health and social care.
- We report our findings of local views and experiences to health and social care decision makers and make the case for improved services where we find there is a need for improvement
- We strive to be a strong and powerful voice for local people, to influence how services are planned, organised and delivered.
- We aim to be an effective voice rooted in the community. To be that voice, we find out what local people think about health and social care. We research patient, user and carer opinions using lots of different ways of finding out views and experiences. We do this to give local people a voice. We provide information and advice about health and social care services.
- Where we do not feel the views and voices of Healthwatch Northamptonshire and the people who we strive to speak on behalf of, are being heard, we have the option to escalate our concerns and report our evidence to national organisations including Healthwatch England, NHS England and the Care Quality Commission.

MRS Evidence Matters™ Company Partner

Appendix 1 – Day of discharge questionnaire

Section A – About you

Age:

Gender: Male Female Other Prefer not to say

Do you live:

- Alone
- With relatives/significant other
- Sheltered accommodation
- Residential /nursing home
- Other (please specify)

Do you consider yourself have a disability/long term condition, which affects your day to day living? Yes No

(i.e. Diabetes, Parkinson's, Multiple Sclerosis, Arthritis, COPD, Hypertension)

If yes, please specify:

Do you have an informal/family carer? (i.e. not a paid care worker) Yes No

Please say who this is: Family member Friend Other

Are you an informal/family carer? Yes No

Prior to admission did you receive?:

Social care support services	Yes	No	Don't know
Community health support services	Yes	No	Don't know
Other community based services	Yes	No	Don't know

(Please give more details):

Please indicate which of the following best describes your ethnic group:

White: English/Welsh/Scottish/ Northern Irish/British

White: Gypsy – Irish Traveller

White: Gypsy – Roma Traveller

White: Other

Mixed/Multiple Ethnic Groups: White and Black African

Mixed/Multiple Ethnic Groups: White and Black Asian

Mixed/Multiple Ethnic Groups: Any other mixed/multiple ethnic background

Asian/Asian British: Indian

Asian/Asian British: Pakistani

Asian/Asian British: Bangladeshi

Asian/Asian British: Chinese

Asian/Asian British:

Any other Asian Background

Black/African/Caribbean/Black British: African

Black/African/Caribbean/Black British: Any Other Black/African/Caribbean background

Other ethnic group: Arab

Any other ethnic group (please specify):

Prefer not to say

Section B – Details of hospital episode

B.1 Name of hospital and ward

KGH ward NGH ward

B.2 Were you in any other ward/s prior to the one mentioned above?

Yes No

B.3 If you answered yes to question B.2, what was the name of the ward/s?

B.4 Type of admission to hospital

- Planned
- Emergency ref by 111
- Emergency ref by 999
- Advised by GP surgery
- Walk in via A&E
- Other

Please give more details:

B.5 Length of stay:

3 days or less 1 week and under 2 weeks Longer

Please give more details:

Section C – planning/preparation for discharge

C.1 When was your discharge from hospital first mentioned/discussed?

On admission Soon after admission Shortly before discharge

Please give more details:

C.2 Were you given an estimated discharge date?

Yes No Don't know N/A

Comments:

C.3 How involved did you feel in planning for discharge?

Fully involved Partly involved Not at all involved Other

Please give more details:

C.4 Who else was involved in the discharge discussion?

- Hospital doctor
- Hospital nurse
- Physiotherapist
- Occupational therapist
- Social care worker
- Other professional
- Family member
- Friend
- Other (e.g. care home)

Please give more details (including if the family member, friend or other was their informal carer):

C.5 Were all the people you thought should have been involved at the discharge discussion?

Yes No Don't know N/A

Comments:

C.6 Did the discussion with medical, nursing and social care staff include:

Instruction/information on your condition and what to expect	Y / N / DK / NA
Instruction/information about medication	Y / N / DK / NA
Information about further treatment	Y / N / DK / NA
Instruction/information on who to call for advice	Y / N / DK / NA
Further period in residential/nursing home	Y / N / DK / NA
Follow-up appointments	Y / N / DK / NA
Social care /other needs	Y / N / DK / NA
Advice/information for carers/family members	Y / N / DK / NA
Referral for a social care assessment	Y / N / DK / NA

If you have an informal carer, were they asked about their needs/availability/ability to provide help and referral for a carers assessment

Y / N / DK / NA

Please give more details (draw out main points of discussion including how clear any instructions were):

Section D – Day of discharge

D.1 Location of patient waiting to be discharged?

- Hospital ward
- Discharge area on a ward
- Discharge lounge/suite

Other (please specify)

D.2 Were you informed of the likely length of the wait to be discharged?

Yes No Don't know

Comments

D.3 How long have you been waiting to leave the hospital so far?

Up to 3 hrs 3 – 6 hrs 6 – 9 hrs 9 – 12 hrs
12 hrs+

D.4 Is the main reason you are waiting one or more of the following?

- Waiting for discharge medication/prescription
- Waiting for a discharge letter/other paperwork
- Waiting for family/friend to take you home
- Waiting for ambulance/passenger transport

Comments

D.5 What form of transport will you use to get home?

- Own or family car
- Taxi
- Hospital
- Ambulance
- Public
- Other

Comments

D.6 Have you been offered drinks/refreshments whilst waiting to be discharged?

Yes No Don't know

Comments

D.7 How would you describe your overall experience of waiting to be discharged?

Good Adequate Poor

Comments

D.8 Where were you discharged to?

- Another hospital
- Relative/friend's home
- Residential home (temp/rehab basis)
- Residential home (permanent basis)
- Nursing home (temp/rehab basis)
- Nursing home (permanent basis)
- Own home
- Other

Comments

D.9 Any other comments you would like to make about the discharge process+

Appendix 2 - Post-discharge interview questions

Section A - Post discharge help and support

A.1 Did you receive up to 6 weeks intermediate care/support after discharge?

Yes No Not applicable

Comments:

A.2 Were the services/support package provided as planned, and how satisfied were you with them?

Fully Partly Not at All

Comments:

A.3 Did you receive any community equipment either:

Before admission, Yes No

or on discharge? Yes No

Please give details:

A.4 Did you require any long term support following the initial 6 weeks support you received or was this identified after you were discharged?

Yes No

Comments:

A.5 Have you had contact from either an NHS Professional or a Social Care Professional to discuss and assess your longer term needs?

Yes No Don't know/Can't remember

A.6 If yes, who was the Professional?

Community Nurse Social Care Worker Other (please specify)

Comments:

A.7 What was the outcome of this meeting?

a) Assessed as in need and eligible for social care support services (e.g. Domiciliary care, attendance at a day service, etc.).
b) Assessed as not eligible for social care support services, and given information/signposted to community and voluntary support services.
c) Assessed as not eligible for social care support services but no discussion about community and voluntary support services.

Comments:

A.8 Were you asked if you had an informal carer, or you yourself was an informal carer and informed about being eligible for a Carers Assessment under the Care Act 2014?

Yes No Don't know/Can't remember

Comments:

A.9 If you answered yes to the above, was a Carers Assessment offered/undertaken?

Yes No Don't know Not Applicable

Comments:

Section B – opportunity to feedback/comment/complain

B.1 Were you given the opportunity to provide feedback about your hospital and discharge experience? (i.e. Family and Friends Questionnaire)

Yes No Not Sure

Comments:

B.2 Any other comments you wish to make

Contact us

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