healthwatch Wiltshire

Better Care Plan engagement report:

Evaluation of the Choice Policy at Salisbury District Hospital

Local health and care shaped by you

Notes:

Carers

Where we talk about carers in this report we are referring to unpaid carers:

"A carer is anyone who cares unpaid for a family member or friend who cannot always manage without their support. They might look after someone with a physical disability, long-term health condition, mental health issue or a problem with substance misuse." (Carers Support Wiltshire[1])

Where the report refers to paid care workers, we will make this clear, for example by stating "agency care worker."

---

[1] https://carersinwiltshire.co.uk/are-you-a-carer

Any enquiries regarding this publication should be sent to us at info@healthwatchwiltshire.co.uk

You can download this publication from healthwatchwiltshire.co.uk

Contents

Background

This report is part of Healthwatch Wiltshire's Better Care Plan work. Healthwatch Wiltshire is working with the Better Care Plan programme partnership (Wiltshire Council and the Clinical Commissioning Group) to assist in meeting its aim to see health and social care integrated by 2020. The vision for better care is based on the four priorities set out in Wiltshire's Joint Health and Wellbeing Strategy:

> "I will be supported to live healthily, I will be listened to and involved, I will be supported to live independently and I will be kept safe from avoidable harm".

To be successful, services need to improve in these areas:

- admissions to residential and nursing care
- success of reablement and rehabilitation
- delayed transfers of care
- avoidable emergency admissions
- patient and service user experience

Overview of the hospital discharge process

The aim of this project was to gather views on the discharge process with a particular focus on choice, involvement and information provision. The information gathered will be shared with Salisbury District Hospital to enable them to ensure the best possible discharge outcome for every patient.

The majority of patients who are admitted to Salisbury District Hospital will have simple discharge needs, meaning that they will be discharged to their usual place of residence and have simple ongoing care needs which do not require complicated planning and delivery. However, a small but significant number of patients will have complex needs, particularly those on wards with a large number of elderly and/or frail patients who require detailed assessment, planning and whose length of stay may be more difficult to predict. These patients may need to be discharged home or to a carer's home with a package of care and support or may need to go into intermediate care or to a nursing or residential care home. Effective discharge involves a wide range of agencies including the NHS, adult social care services, housing providers and care providers.

During the period of time that we visited Salisbury District Hospital, it was widely being reported nationally that the NHS was facing a "crisis" with unprecendented pressure on beds and resources. There were warnings that the service was struggling to cope with record demand and social care services stretched to the limit.

Because of the unprecedented pressure on beds across the health community in January, Salisbury along with the other acute hospitals that serve the residents of Wiltshire, issued serious alerts about their ability to meet patient pressures. In addition, adverse weather conditions in February compounded the situation with high admissions for flu and other winter related pressures.

When we initially visited the hospital in January they were faced with the following circumstances:

- 40 beds closed due to infection (flu & norovirus)
- Increases in A&E waiting times
- High levels of staff sickness
- A high number of outliers throughout the hospital (outliers are patients that are moved from their speciality inpatient beds into beds in a different speciality ward/bed during times of peak bed pressures)
- Several patients who were medically fit and ready to go home but nowhere for them to go

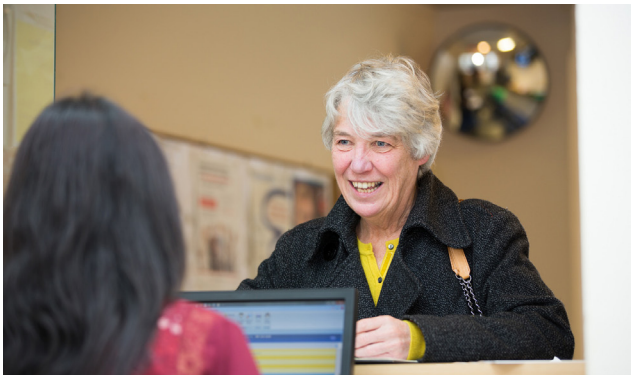
Although the number of patients that were ready for discharge but were unable to leave hospital without extra support (delayed transfers of care) is a relatively small proportion of the total number of beds, the impact of these patients on the hospital is significant. Delays in discharge from hospital can impact on a patients quality of life and lead to an increased dependence on institutional care.

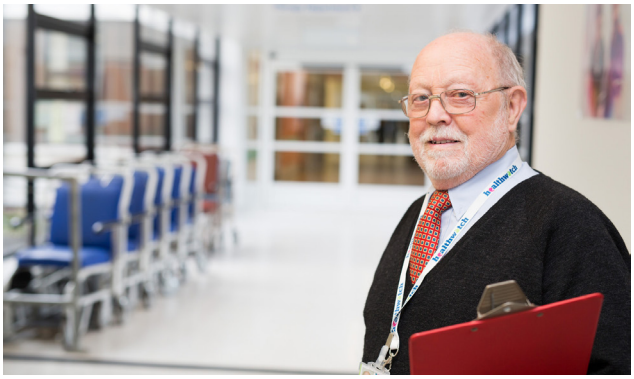
In March, Salisbury District Hospital was impacted by a major local incident which took place, severely restricting the teams access to the hospital.

What we did

During January, February and March 2018, we engaged with people in a number of different ways.

- We had discussions with the Head of Integrated Discharge about the effective discharge policy and the choice policy.
- We prepared information for local people which included an overview of the project and details of how they could get involved.
- We prepared a survey which was available online and in hard copy, and discussion questions to use in interviews.
- We worked with the hospital to identify inpatients who were ready for discharge.
- We worked with the hospital to identify patients who had been subject to the choice policy.





Salisbury District Hospital identified six patients who were currently, or had recently, been subject to the ***Wiltshire Choice Policy***. We approached them to see if they would be willing to speak to a trained Healthwatch Wiltshire Volunteer or a member of the Healthwatch Wiltshire engagement team to share their experiences of going through the discharge process and in particular, their reasons for deciding not to accept the care package/discharge offered as part of their original discharge package. Unfortunately there were no responses to this request.[2]

How we engaged with people

- We visited the hospital on 4 different occasions
- We conducted informal interviews with 21 patients
- We spoke to 3 relatives
- We interviewed 8 staff
- We visited 7 wards across the hospital, these included both acute surgical and medical wards, orthopaedic and reconstructive plastic surgery

Our volunteers

Healthwatch Wiltshire has a team of trained volunteers. Nine of our volunteers were involved and contributed about **35 hours** of their time. They supported the engagement by:

- helping to promote the engagement
- supporting the visits to the wards and focused discussions
- distributing hard copy information and surveys
- typing up the focused discussion notes
- proof read the report and suggested amendments

[2] On occasions individuals decline the options that are available and continue to remain in hospital beyond the time that their care needs require. The Wiltshire Choice Policy defines how the Acute Hospitals, including Salisbury District Hospital will manage Choice through a patient's inpatient stay with regards to discharge planning, particularly at the point when a patient no longer requires the level of care provided by the Acute Hospital or when a patient's medical condition or treatment could be managed in a community setting.

The key messages

An analysis of the survey responses and what people told us during the focused discussions suggests the following key messages:

Discharge works well for patients who are facing a 'simple discharge' process and require no further support when they leave hospital. Staff are very proficient at anticipating the patient's needs in advance of them being discharged and organising equipment, transport and medication.
A small but significant number of patients who are medically fit face delays in waiting to be discharged because they need support out of the hospital to help them recover. There are numerous complex factors impacting on the hospital discharge planning, such as a lack of coordination between services, waiting for medication or transport with no one easy solution.
The introduction of a range of partnership initiatives such as ***Home First***, ***Home from Hospital*** and an Integrated Discharge Team (IDT), appear to have produced positive outcomes for patients.
The introduction of an IDT, with pathways for patients that may require additional support at home, patients with no previous social care needs and those with ongoing or increasing care needs has resulted in better planning and co-ordination of existing resources, and is helping to ensure that the patient is returned to the most appropriate setting with a support package in place.
Patients are rarely discharged by 11am in line with the ***Home for Lunch*** initiative due to delays with medication or transport.
Nursing and clinical staff providing care for outlying patients are faced with several challenges which may have a detrimental effect on patient experience.
The involvement of patients and their relatives/carers is key to the timely and appropriate discharge of older patients.

What patients and their carers said

What worked well

In general patients told us that they felt fully informed about being prepared for discharge, that they and their families were involved in decisions about their discharge, that they knew what would be happening once they got home and that they had been questioned about how they were going to manage at home.

> A patient who felt they had had a very positive experience of their time in hospital said, "the staff have looked after me very well."

> Another patient said, "I have received both swift and skilled care from excellent nursing staff."

> "Every time I have asked a question the staff have got back to me very quickly."

A number of patients that we spoke to that were being discharged had already received notification that equipment had been delivered to their homes and had received follow up outpatient appointments.

> "Everything has been very well organised from start to finish and I have had a very positive experience."

What didn't work well

We spoke to patients who were unable to make plans for their discharge and were uncertain about when they might be discharged. This was because they were waiting for social care support to be arranged or for intermediate care[3]. A number of these patients had been in hospital for a considerable length of time including one patient who had expected to be in hospital for two days, however, they had so far been in hospital for 11 weeks while they waited for a care package to be put into place.

We spoke to three patients who live outside Wiltshire who were faced with uncertainty about what would happen once they got home. They told us that they were waiting for their respective local authority area to conduct a social care assessment.

A carer told us that his wife lacked capacity and was unable to make decisions relating to her care needs, however despite this, the staff were still asking her questions about what will happen once she is discharged with the expectation that she is able to make a decision.

Two patients we spoke to had been readmitted to hospital after the care packages that had been organised at home proved to be insufficient to meet their complex ongoing health and social care needs.

Has someone talked to you about the arrangements before you can be discharged?

We received a mixed reaction when we asked patients if they were told about the arrangements needed before they could be discharged. The overwhelming majority of those patients whose discharge was relatively straightforward reported that they had been asked about their personal/home circumstances and that appropriate advice had been given to them about the arrangements. The hospital had also provided extra support where required such as providing equipment, and advice and information about where to access additional measures of support.

[3] Intermediate care is a specific type of short term support involving NHS and social care services..

A small number of patients reported that very little discussion has taken place about the arrangements needed before they could be discharged, a few had been told that care would need to be arranged but that they were unsure if it was in the process of being arranged.

One carer reported that he had been told that his wife could not be discharged until her mobility had improved. He stated that she has physio input once a day, but apart from that staff are so busy that they don't have time to support his wife to improve her mobility, for example, tending to bring a commode to her bedside rather than support his wife to walk to the toilet.

One patient told us that they were waiting for modifications to be made to the property they lived in before they could go home, but they were unsure when that would happen.

Another patient told us that they have been told they are medically fit and ready for discharge, however they were waiting for a care package from a neighbouring local authority to be arranged.

Have you been given any information about the discharge process and what you could expect when you no longer needed hospital care?

Only three of the patients we spoke to had received information about the discharge process and what they could expect when they no longer needed hospital care. Two of the patients had also received information leaflets about exercises they needed to undertake.

Has anyone given you or your family an estimated date of discharge?

A number of patients we spoke to had been given an estimated discharge date, having been told when they were admitted how long they were likely to remain in hospital.

We spoke to one patient who was initially expecting to stay for two days, however they had so far been in hospital for 11 weeks while they waited for a care package to be put in place by a neighbouring local authority area.

Other patients were in a similar position of uncertainty while they waited for care/physio assessments to be completed and for intermediate care beds to become available.

Have you been asked if you have any concerns about being discharged?

Most patients told us that they had no concerns about discharge as they felt they had been kept fully informed throughout the process and had been fully involved in the decisions.

A small number of patients felt uncertain about how they would manage once they were home however they felt reassured that they had received information from staff about who to contact for additional support.

Do you feel as involved in the planning for your discharge as you would like to be?

Overall, patients told us that they had been fully involved in the discharge planning process as had their family and friends.

A small number of patients told us that they did not want to be involved and preferred to leave the decisions to their family to make. One patient told us that they were unhappy with the plans that had been made and felt they were told what would happen rather than being consulted.

Are your relatives or friends as involved in the planning for your discharge as you would like them to be?

Apart from two patients everyone we spoke to told us that their family and friends had been involved in the discharge planning process and that there had been lots of discussion with family members about what support they were able to offer once their relative was discharged home.

Do you know where you will be going when you leave hospital?

The majority of patients we spoke to told us that they would be returning home when they were discharged.

Other patients told us they were waiting to go into an intermediate care bed to wait for a place in the nursing home of their choice.

Have you had to decide on a care home or care agency to support you when you leave hospital?

- How did you find the process of making a decision?
- Did you have enough information to make a decision about a care home or care agency?

A number of patients we spoke to were going home with a package of care in place. For other patients further support had been organised in addition to the care package they had in place prior to admission, but for others care was being organised for the first time. Most of the patients we spoke to had been involved in making decisions about the care that was being arranged. One patient however, told us that the outcome was not what she wanted, this was because she was reluctant to accept the support that had been organised in addition to the care package that she was already receiving.

We spoke to 10 patients who were waiting for a care package to be put into place before they could go home. Two patients had been readmitted to hospital as the care package that had been organised for them had proven to be inadequate. Both patients were concerned if the additional level of support they needed could be accommodated by the care agencies. Because of his previous experience, one of those patients was not feeling confident about his discharge.

How confident do you feel that the plans that have been put into place for your discharge will go smoothly?

A number of patients felt confident that things would go smoothly once they got home due to the level of involvement they had experienced. Some however, had reservations about how things would go once they had been discharged, particularly those patients who were waiting for care packages or additional support.

One patient who lived outside Wiltshire was very concerned about what would happen once they got home as they felt their local authority area had not kept them informed or involved them in decisions about their support needs.

What staff told us

What works well when planning for patients to be discharged?

Staff told us that it was important that they kept patients informed and that building up a good relationship with relatives is key to a successful discharge particularly for patients who had complex needs.

Staff told us that when planning for discharge good communication across the teams was aided by the use of daily whiteboard meetings that were attended by senior staff, OT, physio and the discharge coordinator.

For both planned and unplanned admissions an EDD (estimated date of discharge) is set on the day of admission.

The orthopaedic ward told us that they have access to an excellent orthogeriatric team who can assess patients who may have dementia / cognitive impairment. Staff also praised the early supported discharge team who they said can take patients with a hip fracture home to assess them.

We were told by staff that the ***'end PJ paralysis'*** initiative has worked well in getting patients into the right mindset about going home (patients are encouraged to wear their own clothes around the ward, however they are reliant on relatives to bring clothes in for patients). The team observed evidence of this initiative on a number of wards that were displaying information posters.

Some wards appeared to be very proactive in making sure that everything is in place before discharge takes place and one ward in particular told us that they actively chase up To Take Out's (TTO's) medication from pharmacy which appears to allow for the prompt discharge of patients on this particular ward.

What challenges are there in preparing patients for discharge?

All the staff we interviewed spoke about discharges that are delayed while patients are waiting for a package of care to be put into place, particularly for those who may have complex needs. Staff used the example of a current patient that social care had assessed as having capacity, however a further assessment by the mental health team assessed the patient as lacking capacity. Staff felt that a lack of communication between medical staff and adult social care can lead to a delayed discharge for a patient.

When we visited Salisbury District Hospital, the hospital had a number of outlying patients (outliers are patients that are moved from their speciality inpatient beds into beds in a different speciality ward/ bed during times of peak bed pressures). Staff told us that this meant that ward rounds could still be taking place quite late in the day, and any patients that were assessed as being fit for discharge were delayed due to being unable to organise medication or transport. We were also told that if a patient was being discharged to a care home they would not take them after 7pm.

The arrangements for booking patient transport was mentioned by a number of staff who felt that the current four hour slot caused delays. For example, the ward may be planning a ***Home for Lunch*** discharge for the patient but because of the four-hour window the transport may not arrive until mid afternoon.

What challenges are there in communicating discharge plans to patients and families?

Staff told us that the challenges come for those patients who may have cognitive impairment and in those cases a good relationship with relatives is key. Where there are no relatives staff told us that there are systems in place that involve taking steps to support the person to make the decisions. Where staff may suspect that the person lacks capacity to make a decision, patients are specifically assessed in accordance with the Mental Capacity Act.

Staff felt that sometimes patients and relatives may have high or unrealistic expectations of what the hospital can do for them, which is particularly difficult when the health of the patient has declined since they were admitted and is unlikely to improve to the same levels prior to when they were admitted.

It was felt by some staff that there are sometimes communication difficulties between patients/relatives and the social work team.

What sort of concerns do patients and their families have when you talk to them about preparing to be discharged?

The concerns that staff say patients and their relatives have around preparing for discharge are based around the length of time they have to wait for a care package. Relatives want reassurance that their relative is ready to be discharged and information about what to do if they are concerned or if something happens.

What would make planning discharges easier for you and the team?

Most of the comments made by staff were around the social care team and wanting a quicker assessment process (they stated that the current assessment process can take 7-10 days to complete). One ward felt it would be helpful if a member of the social work team were able to attend the daily discharge/whiteboard meeting. Staff generally felt that the social care team was under resourced.

One member of staff told us that in cases where there are a number of family members who want involvement in the decision making about their relative, that sometimes there was conflict within the family and disagreement over what should happen to the relative.

Staff told us that it would be useful to have a universal referral form to request social care input. Currently each local authority area uses a different form. They also stated that the IDS (integrated discharge scheme) form was lengthy to complete.

How well does the effective discharge policy work?

Staff felt that the effective discharge policy was a good policy that worked well.

How often are patients discharged out of hours?

On the whole staff told us that during the week patients are not often discharged out of hours, however there are planned weekend discharges particularly for those patients whose home circumstances allow for discharge at the weekend.

How often are patients discharged by 11am in line with 'Home for Lunch'?

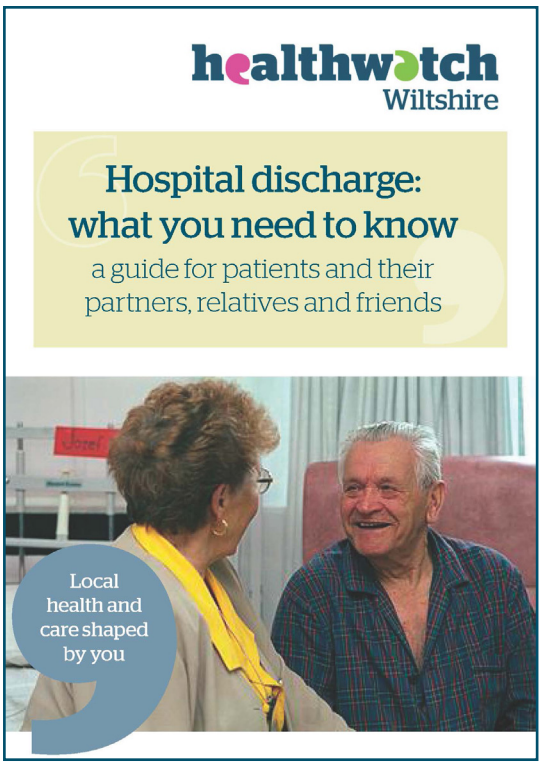
We were told that patients are rarely discharged by 11am, especially if they are waiting for hospital transport or for a package of care to start. Salisbury District Hospital has an information leaflet available called ***Coming into Salisbury District Hospital, planning to go home*** that states that patients will need to leave the ward by 10am on the day that they leave hospital. The information also states that if patients are unable to travel this early they will be transferred to the Discharge Centre on Level 2, however staff told us that the discharge lounge is no longer used for that purpose. Some staff told us that if needed they are able to find a quiet lounge area on the wards where patients can sit and wait to go home.

Do you use the Wiltshire Choice policy?

We spoke to staff on three wards where the ***Wiltshire Choice Policy*** had been used. Staff told us that they relied heavily on the Head of Integrated Discharge for support. On one ward, staff that we spoke to who had been involved with a patient subject to the choice policy, told us that while the process was very efficient they found it to be emotionally challenging and time consuming due to the complex needs of the patient. We were told that staff are able to use a 'management of behavior agreement' for patients with challenges such as a substance misuse issue.

Do you use the 'Planning for Discharge – Home for Lunch' leaflet?

We only saw evidence of the ***Planning for Discharge – Home for Lunch*** leaflet on one of the wards we visited. Staff told us that because of delays with medication and transport they rarely are able to discharge someone before lunchtime.



Feedback on the draft hospital discharge guidance leaflet

Healthwatch Wiltshire have developed a ***Hospital Discharge: what you need to know guide for patients and their partners, relatives and friends***. We showed the guide to both staff and relatives and the overall feedback was that it was comprehensive and contained lots of useful information.

Conclusions

Over the last 12 months Salisbury District Hospital has taken a number of steps to improve the hospital discharge process. One of the areas that has seen improvement has been in the development of a multi professional IDT which was established in February 2017. It is clear that a great deal of work has been undertaken by the Head of Integrated Discharge in building up networks with local care homes, and has strong links with local care homes and home care providers. While there has been significant progress in recent years on getting people home from hospital faster, it is important that this is done safely with people able to get the support they need to recover.

A number of additional initiatives have also been developed in Salisbury District Hospital and across Wiltshire that will make a difference to the discharge experience for patients and allow for earlier discharge home such as:

- ***Home First***. The Home First service is a new initiative aiming to support early discharge of patients who are medically fit. Wiltshire Health and Care manage the service and have employed Rehabilitation Support Workers to work alongside therapists to support people on discharge from hospital, providing care for up to 10 days before this is transferred to a home care agency if needed.
- A ***Home from Hospital*** service has been developed by the hospital and provides a service for patients who have no family to support them on their discharge.
- An Early Supported Discharge team for patients with hip fracture.
- The development of an information leaflet for patients whose discharge may be more complex (currently in draft form)..

Recommendations

1. Raise with Commissioners the difficulties with patient transport and the need to introduce a responsive patient transport system, with timeslots available for booking on the day (not the current 4hr window).
2. Ensure that all patients and carers are involved directly in the assessment and discharge process.
3. Carry on the good practice of further developing a multi disciplinary IDT who collaboratively work together to improve coordination between different services to ensure the safe and timely discharge of patients from Salisbury District Hospital.
4. Continue to work with partners to reduce delayed transfers of care, particularly cross border partners.
5. Continue the good practice of initiatives such as ***Home First***, ***Home from Hospital*** service and ***'end PJ Paralysis'*** and ensure that all ward staff are aware of their existence.
6. Improve communication between patients, families, adult social care and other professionals.
7. Review and amend patient information using Healthwatch Wiltshire's guidance as a starter.

Thank you

Healthwatch Wiltshire would like to thank the patients and staff at Salisbury District Hospital for sharing their views with us.

Thanks also to our dedicated volunteers and staff at Salisbury District Hospital who helped support the engagement activity. Without them we would not have been able to undertake this project.

Response from Salisbury District Hospital

It is so helpful to get this feedback and the recommendations. We will be sure to look at how we can improve things using your document. Please take this as we are all very happy with the report.

This page intentionally left blank

Why not get involved?


healthwatchwiltshire.co.uk


info@healthwatchwiltshire.co.uk


01225 434218


Unit 5, Hampton Park West, Melksham, SN12 6LH


HealthwatchWiltshire


@HWWilts


healthwatchwiltshire

healthwatch Wiltshire

The Healthwatch Wiltshire service is run by Evolving Communities CIC, a community interest company limited by guarantee and registered in England and Wales with company number 08464602.

The registered office is at Unit 5, Hampton Park West, Melksham, SN12 6LH.