

Healthwatch Dudley Russells Hall Hospital

Patient experience of hospital journeys:
How can we make communications work
better?



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Contents	Page
Tables and Pictures	2
Acknowledgements	3
Executive summary	4
Introduction	6
Background	6
<i>Policy and context</i>	7
<i>Views on communications</i>	8
<i>Healthwatch Dudley</i>	9
Methodology	9
<i>Scoping work</i>	10
<i>Conversation themes</i>	10
<i>Volunteers and patient journeys</i>	12
What were patients saying?	13
<i>Codes and categories</i>	14
<i>Patterns and concepts</i>	15
Context and communications	16
<i>All the staff have been marvellous</i>	16
<i>Nurses understandably do not have time to chat</i>	18
<i>I like to know what is happening to me</i>	20
<i>Discussed stepdown but don't know where or when</i>	21
<i>Volunteer reflections</i>	22
Getting to the heart of the problem	22
What next?	25
Appendices	26

Tables and Pictures

Page

Tables

1	Typical Patient Journeys	11
2	Volunteer Requirements	12
3	Ward Location	14
4	Age	14
5	Health Condition	14
6	Patients and Times Visited	14
7	Communications Themes	16

Pictures

1	Sorting Coded Data into Categories	15
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Executive summary

This project was designed to collect patients' views and experiences of their journeys during their stay on hospital medical and surgical wards and to gain their views on possible discharge options.

The aim was to have a number of in-depth conversations with patients during half-day sessions. These were held weekly over a six week period between 26 January 2015 and 5 March 2015. Healthwatch Dudley staff and trained volunteers met with new patients but as time went by and because some patients had longer lengths of stay some patients were able to have more than one conversation (giving a longitudinal aspect to the study). There was a focus on gaining an understanding of hospital procedures and patients experiences of being in hospital by examining relations between patients, staff and other relevant persons.

Methodology

The research comprised a number of in-depth semi-structured interviews or conversations between patients and Healthwatch Dudley staff and volunteers on their stay in hospital and communications between them and staff about their care. Themes were identified, in conversation with Clinical Commissioning Group and Intermediate Care Team staff, to facilitate conversations and maximize the opportunity for patients to tell their own stories. Importantly, the themes explored patient views on how they felt about the arrangements in place for keeping them informed about events impacting on their hospital journey and the way that communications about care and plans for discharge had worked (or not).

Main findings

Four themes were identified that helped to improve understanding of what patients were saying about their hospital journeys and communications with staff on their care and discharge arrangements.

Theme one elaborates on how staff were viewed by patients, in most instances, to be delivering good care. Consequently, there needs to be an emphasis on conversations and interactions between patients and staff building trust, encouraging and effectively dealing with questions and helping to foster the genuine co-production of decisions about care and wellbeing.

Theme two was about the time that hospital staff have to interact with patients and have conversations with them about their care and wellbeing. It is important to get the balance right between providing high quality care and the time and space needed for meaningful and productive conversations and communications.

Theme three focuses on patients knowing what is happening to them. Good conversations and communications between staff and patients will keep patients informed about what is being planned for them and why. Clear two-way communication also helps staff to better understand how patients feel about what is happening to them and how their hospital experience and discharge might be improved.

Theme four recognises that a patient's move to a stepdown or intermediate care placement can be particularly stressful and problematic unless care is taken to get communications about such arrangements right. There must be clear information provided from the outset on options for leaving hospital or discharge that is regularly reviewed and updated to avoid unnecessary patient anxiety or surprises in terms of care that is provided or discharge planning.

What next?

Patient satisfaction is not the same as overall patient experience of their time in hospital. High quality communications are mutually beneficial for patients and staff and are likely to work best in situations where there is clear leadership on roles and responsibilities of staff.

Good communications will help to reduce frustrations and sometimes disappointment with care received and also helps to ensure there is a holistic approach putting the patient at the centre to improve their experiences in hospital. A balance must be achieved between providing good patient care and creating opportunities for good patient and staff conversations. In turn, effective patient and staff communications can prevent problems from arising in the future by helping patients to feel well cared for and secure.

Clear communications need to start from the outset - when a patient is admitted to hospital. Most patients want to know what is happening to them and require information tailored to meet their individual circumstances. Meanwhile, the timing of conversations about care is also crucial to patients' understanding of their situation and explanations are needed when things do not go as planned. Patients need to be reassured about the quality of the information on care and discharge they receive in a coordinated way that means there are no contradictory messages and instead the genuine co-production of decisions about care and wellbeing.

Introduction

This project was designed to collect patients' views and experiences of their journeys through hospital medical and surgical wards and possible discharge options. The aim was to have a number of in-depth conversations with patients during half-day sessions held weekly over a six week period between 26 January 2015 and 5 March 2015. Healthwatch Dudley staff and trained volunteers met with new patients and as time went by they also met with a number of patients that they had had previous conversations with (giving a longitudinal aspect to the study).

There was a focus on gaining an understanding of hospital procedures and patients experiences of being in hospital by examining relations between patients, staff and other relevant persons. There is anecdotal evidence that suggests that in the hospital situation there are staff that have been told by patients that they were unaware of proposed changes to their care or discharge arrangements. Sometimes a patient and family members may be left feeling anxious and upset by this state of affairs. One view is that the issue might be mainly about communications and how patients, carers and family members are told (or not) about developments in their ongoing care and any planned changes to that care during their time in hospital. The research comprised a number of in-depth conversations with patients to better understand their experiences of being in hospital.

The main findings from the project comprised four themes that help to improve understanding of a patient's journey in hospital and how communications about their care and discharge arrangements work for them or not. Theme one elaborates on care and conversations between patients and staff that build trust, encourage and effectively deal with questions and help to foster the genuine co-production of decisions about care arrangements and how to ensure future wellbeing. Theme two was about the time that hospital staff have to chat with patients about their care and wellbeing and getting the balance right between providing care and being involved in meaningful conversations with them about their care. Theme three focuses on patients knowing what is happening to them and conversations between staff and patients that help to improve a patient's hospital experience. Theme four recognises that a move to a stepdown or intermediate care placement can be stressful for a patient, their carers and family and good communications about options and plans are important.

Background

There is a lot of material published on how, in the hospital situation, staff and patients interact regarding care and discharge arrangements. If the communications process does not work a patient, their carers or family members may be left feeling anxious and upset by this state of affairs.

Policy and context

It is important to have efficient processes and good clinical outcomes to ensure a good experience for patients in hospital, but how patients feel about the care they receive and how staff interact will also impact on whether they have an excellent experience or not.¹ Between 2010 and 2014 a Commonwealth Fund appraisal of healthcare services in seven countries shows the UK moved from a ranking of seven to a ranking of one for patient-centred care, where one is the highest rank possible.² In 2010 the Conservative and Liberal coalition government's public health white paper 'Healthy lives, healthy people: our strategy for public health in England', proposed that, for patients in hospitals and other healthcare settings, there would be 'No decision about me without me' in terms of their care and wellbeing.³ Following the failures in hospital systems and patient care at places like Mid Staffordshire NHS Foundation Trust and University Hospitals of Morecombe Bay NHS Foundation Trust there has been an intensified focus on all hospitals clearly setting out how patients and their families can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.⁴ In addition, the government introduced a statutory duty of candour on individuals to improve the detail on care provided for patients.

Direct feedback from patients is likely to remain the core method to understand patients' experience. At the same time, on their own satisfaction measures are not sufficient to understand patient experience. The complex modern health care landscape and diversity of patients demands a more sophisticated exploration of their views and journeys in hospital or other healthcare settings.⁵ An NHS toolkit to support the improvement of in-patient care, published in 2015, indicated there was scope for more patient involvement in decisions about their care, better information giving and consistent discharge processes achieved through collaborative working with patients (especially those that are vulnerable, have a learning disability or mental health conditions are a frail older person or a child or

¹ Dainton, M. and Zelle, E.D. (2015) 'Applying Communication Theory for Professional Life', Sage Publications

² Davis, K., Schoen, C. and Stremikis, K. (2014) 'Mirror, Mirror on the Wall: How Performance of the U.S. Health Care System Compares Internationally', The Commonwealth Fund, www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

³ Public health white paper (2010) 'Healthy lives, healthy people: our strategy for public health in England, www.gov.uk/government/uploads/system/uploads/attachment_data/file/136384/healthy_lives_healthy_people.pdf

⁴ Hard Truths: The Journey to Putting Patients First, Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, (2014) Crown Copyright, www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

⁵ Coulter, A., Fitzpatrick, R. and Cornwell, J. (2009) 'The Point of Care: Measures of patients' experience in hospital: purposive methods and uses', The Kings Fund, www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf

young person).⁶ The benefits of ensuring a high-quality patient experience include improved healthcare outcomes, reduced healthcare costs and better indications of where there is poor care that facilitate the targeted improvement of services. In successful healthcare organisations patients and families are effectively involved in discussions and decisions about their care and the design and provision of services that they receive.⁷ National Voices, a coalition of health and social care charities in England, says it is about moving from consultation to co-production to create positive cultures of safe and compassionate care.⁸

Most patients know less about the technical aspects of their condition and about how the institution delivering their care works than do the people treating them. However, they are the experts on what it means and does to them. When this 'Imbalance of power is not mitigated by person-centred care that emphasises the development of trust and partnership, and learns from feedback it can lead to terrible outcomes'.⁹ Meanwhile, there is a need for a coordinated strategy for improving patients' experience, with regular monitoring, clear reporting arrangements at all levels of the organisation and an action planning process that closes the loop by reporting back up the line on changes and improvements.¹⁰ In turn, a variety of approaches are needed to involve different groups and individuals and ensure information and messages are appropriate to them and meet their needs.¹¹

Views on communications

According to communication theory there is a tendency to underestimate the complexity of the communication process. At the same time, good communications involve different ways of working and collaborating to create and sustain effective learning and actions to meet organisation and individual needs.¹² In particular, everyone who needs to be told about something should be told and the timing of

⁶ A Toolkit to Support NHS Commissioners to Reduce Poor Experience of In-patient Care (2015) NHS England, Publications Gateway Ref: No: 03195, <http://www.england.nhs.uk/wp-content/uploads/2015/04/ip-care-toolkit.pdf>

⁷ Feeling better? Improving patient experience in hospital (2010), NHS Confederation, www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Feeling_better_Improving_patient_experience_in_hospital_Report.pdf

⁸ National Voices (2015) people shaping health and social care, www.nationalvoices.org.uk

⁹ Hard Truths: The Journey to Putting Patients First, Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, (2014) Crown Copyright, p.29, www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

¹⁰ Coulter, A., Fitzpatrick, R. and Cornwell, J. (2009) 'The Point of Care: Measures of patients' experience in hospital: purposive methods and uses', The Kings Fund, www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf

¹¹ Feeling better? Improving patient experience in hospital (2010), NHS Confederation, www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Feeling_better_Improving_patient_experience_in_hospital_Report.pdf

¹² Conrad, C. and Poole, M.S. (1985) 'Strategic Organizational Communication into the Twenty-First Century, New York: Harcourt Brace.

communications must be appropriate.¹³ It has also been suggested it is important to recognise human rights in communications where patients, health care providers and everyone else have the same rights, which is essential to nurturing a culture of respect for human rights.¹⁴

Meanwhile, critical discourse analysis views language as a form of social practice and recognises that societal power relations are established and reinforced through language use.¹⁵ In turn, conversation theory regards social systems as symbolic and language-oriented where responses depend on one person's interpretation of another person's actions and how interactions lead to the 'construction of knowledge or knowing'.¹⁶ Then there is the process of sensemaking whereby people through individual and shared sensemaking and collaboration give meaning to experience in often complex and uncertain situations.¹⁷

Healthwatch Dudley

Local Healthwatch (LHW) are independent organisations operating across England as a result of proposals set out in the Coalition government's Health and Social Care Act 2012. LHW work alongside and support the activities of Healthwatch England the national consumer champion on health and social care matters. Healthwatch Dudley is the consumer champion on health and social care matters for people in the Dudley borough.¹⁸ It listens to people's views and experiences of using hospitals and services provided by care and nursing homes, doctors, pharmacists, dentists and opticians. These views are shared with decision-makers (including commissioners and providers of services) responsible for the procurement and delivery of health and social care services.

Methodology

The research comprised a number of in-depth semi-structured interviews or conversations between patients and Healthwatch Dudley staff and volunteers on their stay in hospital and communications between them and staff about their care. Themes were identified, in conversation with clinical commissioning group and intermediate care team staff, to facilitate conversations and maximize the opportunity for patients to tell their own stories. Importantly, the themes explored

¹³ Laswell, H. and Bryson, L. ed (1948) 'The Structure and Function of Communication in Society: The Communication of Ideas, New York: Institute for Religious and Social Studies.

¹⁴ Cohen, J. and Ezer, T. (2013) 'Human rights in patient care: A theoretical and practical framework', Health and Human Rights Journal, Vol.15, Issue 2.

¹⁵ Wodak, R. (2013) 'Critical Discourse Analysis', Sage Publications Ltd.

¹⁶ Pask, G. (1976) 'Conversation Theory: Applications in Education and Epistemology', Amsterdam-Oxford-New York: Elsevier.

¹⁷ Klein, G., Moon, B. and Hoffman, R.F. (2006) 'Making sense of sensemaking: alternative perspectives', IEEE Intelligent Systems, Vol.21, Issue 4.

¹⁸ Healthwatch Dudley: <http://healthwatchdudley.co.uk/>

patient views on how things felt to them, the arrangements in place for keeping them informed about events impacting on their hospital journey and the way that communications about care and plans for discharge had worked (or not). It was felt that no single conversation session was likely to last for more than half an hour. The conversations took place on medical and surgical wards, at the Russells Hall Hospital in the Dudley borough, on a half-day each week over a period of six consecutive weeks. Written notes were made (there was always a dedicated scribe accompanying the person talking to the patient) of the information provided by patients together with any key points or issues that emerged during conversations (sometimes with the same patient over a number of weeks). The project tasks comprised:

- Semi-structured interview schedule design
- Volunteer training and staff briefing sessions
- Hospital medical and surgical ward visits
- Conversations with patients and relevant others
- Collecting and interpreting patient stories
- Preparing a report on the project

Patients were told about the role of Healthwatch Dudley, the purpose of the project and how any findings would be used. At the same time, patients were asked for their (informed) consent to take part in the project. Any information or personal details provided would remain confidential and patients names would be changed in the report produced on the project and its findings.

Scoping work

Initial scoping work included making contact with key gatekeepers in the hospital to ensure that they were aware of the project and what it wanted to achieve. At the same time, this work provided an opportunity to learn more about some important aspects of the patient journey. In particular, there were meetings with Dudley Clinical Commissioning Group staff and Intermediate Care Team staff at the hospital. A clear aim that emerged was that the project was about the whole patient journey from arrival at hospital onwards through to eventual discharge to understand how communications about their care worked (or not) for them.

Conversation themes

It was necessary for volunteers having conversations with patients to make detailed notes. Volunteers worked in pairs with one involved in the conversation itself and the other taking notes. It was important to reassure a patient from the outset that any information they shared with Healthwatch Dudley volunteers would be confidential and they would not be named in any project report produced. Patients were asked:

- Do you understand what the project is about?
- Are there any questions you would like to ask?
- Are you happy to continue?

If a patient consented to have a conversation with a volunteer then the next step was for the volunteer to begin to build rapport with the patient at the start of the first conversation session. A volunteer would, for example, begin by thanking the patient for agreeing to take part in the project and then ask them to say something about themselves and why they were in hospital. The aim was to focus on listening to what they had to say about their time in hospital and communications between staff and themselves relating to their care. However, patients would, as far as possible, be allowed to tell their own stories with as few interruptions by the volunteer as possible.

Meanwhile, volunteers were advised on how to avoid asking leading questions that might encourage people to answer questions in a certain way to please the person asking them. An appropriate approach would include questions to get a patient to say how things had been going for them, encouraging them to say more on key points or issues or reflect on the implications for them of particular aspects of their hospital journey and experiences of communications between staff and themselves. Some prompts to help avoid yes or no answers to questions included:

- How was that explained to you?
- What was your understanding of that?
- How did that make you feel?
- What especially did you like or dislike about it?
- What do your carers or family members think?

Typically, there are three types of journey that a patient can have whilst in a hospital (see Table 1, below).

Typical Journey	Procedures
1	Arrival and assessment (Accident and Emergency or Emergency Assessment Unit) then discharge (to home or a referral to the Impact Team for Assessment) with move to home after assessment or move to step down (Care at Home)
2	Arrival and assessment (Accident and Emergency or Emergency Assessment Unit) then a move to a ward, ensuring care or Care Plan is in place, care started, then discharge
3	Arrival and assessment (Accident and Emergency or Emergency Assessment Unit) then a move to a ward, ensuring care or Care Plan is in place, then referral to Intermediate Care (waiting list) and assessment (if medically fit), care started or decision to commission care (patient and family agreement - if not review), then a move to an Intermediate Care bed or care at home

Table 1: Typical Patient Journeys

Typical journey 1 is the least complicated patient journey with a relatively straightforward arrival at hospital, assessment and then a move to step down or home.

Typical journey 2 involves a move to a ward and planning for care and eventual discharge.

Typical journey 3 includes a referral to and intermediate care team and decisions about the care needed made in consultation with the patient and where appropriate their carers and family.

A selection of common questions that volunteers could ask patients if needed - to stimulate a conversation includes:

- Do you know what to expect during your stay in hospital?
- How involved do you feel you have been in discussions about your care?
- What would you like to happen in terms of your care?
- Could anything be done differently to make things better for you?
- Do you feel able to ask questions about your care?
- If you have asked questions what was the response to them?
- What do you know about intermediate care (step down)?
- How was your assessment for intermediate care?
- How have you (and/or your carer or family members) been involved in discussions about your care?

A copy of the information on typical hospital journeys, conversation themes, how to get a conversation started and questions to use as prompts if necessary is provided in Appendix 1 on page 26.

Volunteers and patient journeys

It was necessary to ensure that volunteers involved in conversations with patients had the aptitude and temperament needed to effectively collect their stories. They needed to have an interest in health and social care services and patient views and be friendly, able to listen, non-judgemental and if possible have experience of note taking (See Table 2, below).

Essential	Desirable
<ul style="list-style-type: none"> • Interest in health or social care services • Interest in the role and work of Healthwatch Dudley 	<ul style="list-style-type: none"> • Understanding of health care systems • Understanding of social care systems • Previous volunteering experience

Table 2: Volunteer Requirements

A Healthwatch Dudley - call out (request) to possible volunteers was organised that included information about the project and details on the role of the volunteer having a conversation with patients and listening to what they said about their experience of being in hospital. The callout also elaborated on the anecdotal evidence suggesting some patients are unaware of intentions to change their care or discharge arrangements (see Appendix 2 on page 30). For example, some patients had told nursing staff that they, their carers or family members had not known they were going to be moved from hospital to a stepdown care or nursing home. Consequently, the patient, their carers or family members might be left feeling anxious and upset by the situation. It has been suggested that the issue may be one mainly of communications and how patients, their carers or family members are kept informed (or not) of developments in ongoing care and any planned changes to discharge arrangements.

Healthwatch Dudley staff and volunteers had in-depth conversations with patients to collect their views and experiences on being kept informed about events impacting on their care and hospital journeys. The conversations took place at weekly sessions at the hospital over a period of six weeks. In preparation all of the volunteers had a criminal records check. They were also required to have undergone Enter & View Training so they knew how to approach and talk to people about health and social care matters in different health and social care setting.

A letter was available to be handed to patients explaining the purpose of the project and conversations with patients about their time in hospital. It also contained information about Dudley Clinical Commissioning Group and their inquiry to Healthwatch Dudley requesting information to be collected on how communications between hospital staff and patients on their care and possible discharge arrangements was working (or not) (see Appendix 3 on page 32).

What were patients saying?

In total 31 patients were interviewed (15 female and 16 male - see Appendix 4, on page 33). They were mainly located within two wards (one medical and one surgical) in the hospital (see Table 3, on page 14) and tended to be aged over 65 (see Table 4, on page 14) and mostly in hospital for hip, leg or ankle fractures (see Table 5, on page 14). No specific information was collected on ethnicity since it turned out often to be difficult to incorporate the question sensitively into the conversations volunteers had with patients. The majority of these patients were visited on one occasion but a significant number were visited on two or more occasions (see Table 6 on page 14).

Ward	Specialism	Number of Patients
B2	Orthopaedic Trauma and Hip Suite	18
B3	Vascular and General Surgery Ward	1
B4	Elective Surgery	1
C3	General Medicine	9
C5	Respiratory Medicine	1
At home	Patient visited at home	1

Table 3: Ward location (N=31)

Age	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85-94	Not Given
No.	1	0	1	0	1	5	7	8	7

Table 4: Age (N=31)

Health Condition	No
Hip Fracture	8
Leg Fracture	6
Foot and Ankle Fracture	4
Pneumonia and Breathing	3
Balance and Dizziness	2
Urinary infection and Problems	2
Oncology (cancer)	1
Cognition (memory)	1
Shoulder Injury	1
Rib Fracture	1
Passing blood	1
Fall (unspecified)	1

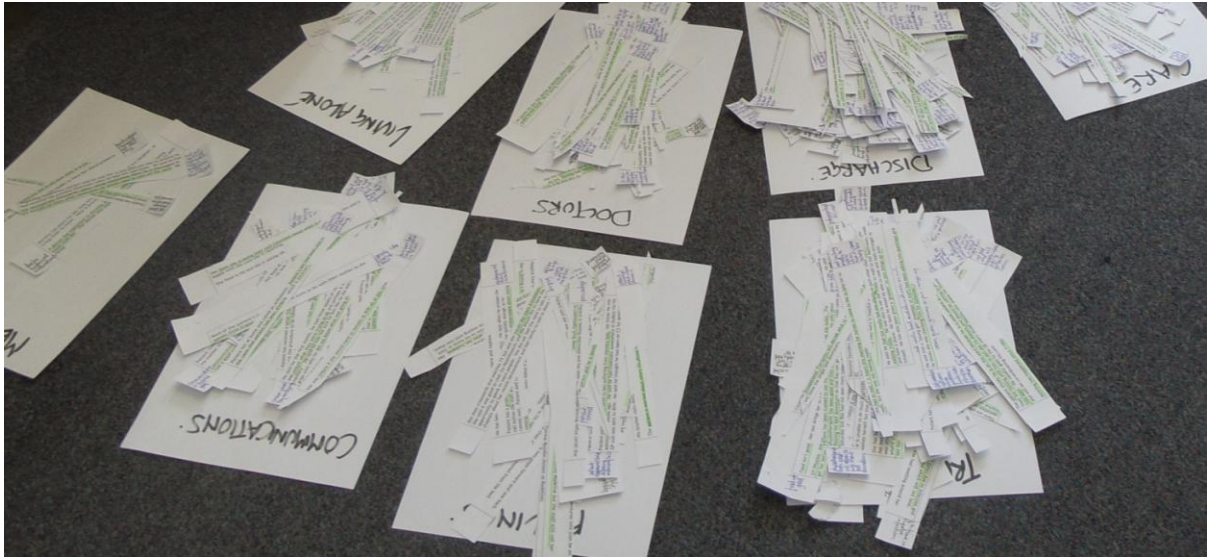
Table 5: Health condition (N=31)

Times Visited	1	2	3	4	5	6	7
No. of Patients	18	6	3	1	1	1	1

Table 6: Patients and times visited (N=31)

Codes and categories

A large amount of qualitative notes on conversations between patients and volunteers was collected. These notes were sorted into a number of categories after marking up each set of patient notes using a highlighter pen to start to identify interesting points and similarities in conversations (see Picture 1 on page 15).



Picture 1: Sorting coded data into categories

Finally, eight key categories explaining significant aspects of a patient's journey in hospital were identified. They are:

- Communications (between staff and patients)
- Questions (the ability to ask them and responses to them)
- Doctors (and their involvement in care discussions)
- Treatments (and how patients are informed about them)
- Medication (and information provided for patients)
- Care (and patient involvement in discussions about what happens to them)
- Living alone (and the implications for communications about care)
- Family (and their involvement in discussions about a patient's care)

Patterns and concepts

Having identified eight explanatory categories on aspects of the patient journey in hospital it was possible, through a systematic process of reflection to discern patterns and bring particular categories together into thematic or conceptually related groups describing patient experiences of care and communications. The different themes are set out in Table 7, on page 16.

Theme	Implications
Care, treatment and medication	Conversations and interactions between patients and staff need to build trust, encourage and effectively deal with questions and help to foster the genuine co-production of decisions about care and wellbeing.
Hospital staff and conversations with patients	It is important to get the balance right between providing high quality care and the time and space needed for meaningful and productive conversations and communications.
Patients want to know about their care and what is happening to them	Good conversations and communications will keep patients informed about what is happening to them and why and help staff to better understand how patients feel about what is happening to them.
Discharge and leaving hospital	There must be clear information provided from the outset on options for leaving hospital or discharge that is regularly reviewed and updated to avoid unnecessary patient anxiety or surprises in terms of care or discharge planning.

Table 7: Communications themes

The thematic areas or concepts help to improve understanding of patients' journeys in hospital and communications between patients and staff on care and options for discharge. In particular, how communications on care, treatments and medication, what patients need to know about their care, the time that is devoted to having conversations and their style and format is appropriate or not. Key issues emerged around building trust, involving patients in thinking about their care and decisions about it if this is what they want and the style and clarity of communications.

Context and Communications

This section provides details on the themes that were identified from the analysis of the rich information collected on patient journeys in the hospital through a series of patient and volunteer conversations. Patient names have been changed to maintain confidentiality.

“All the staff have been marvellous”

In describing the context in which conversations and interactions between patients' and hospital staff take place it is interesting to note that most patients talking to Healthwatch Dudley volunteers said they were satisfied with the care they had received. For example, Harriet, an older woman (age not given) with a hip fracture, said she “Felt cared for whilst in hospital ...”, and Frances, an older

woman (age not given) who had experienced dizziness and had had a fall at home, said “All the staff have been marvellous and she has had good care”. Likewise, Allan, aged 72 and in hospital with a hip fracture, said he had had “Good treatment during his present stay [at Russells Hall Hospital]”, Bill, aged 83 and in hospital with a hip fracture, said “Care has been good”, Sue (age not given), who had worked for the NHS as a lecturer and had had a fall at home, said “Staff were excellent” and Linda, aged 80 and in hospital with pneumonia, said “The care in hospital was very good”.

Rose is 67 years old and fell at home. A hip replacement was performed. She had not been advised when she should be able to go home and is waiting to be able to weight bear She is able to ask staff questions and said they are very helpful. Staff have been very good and nice ... She expressed concern about going home as she lives in a very large house ... which she loves and said her neighbours would not be able to help On a later visit Rose informed the Healthwatch Dudley volunteer that she had been informed half an hour before their arrival that she would be going to Netherton Green [care home]. The process had not been explained to her but she was just glad to be leaving hospital. She does not feel ready to go home ... she does not want to go to Netherton Green but would ‘put up and shut up’ to get better. The nurses and the care have all been very good She said she couldn’t complain about anything.

However, some patients had concerns about aspects of their care in hospital, what was happening to them and why it was happening. Sally, aged 71 and in hospital with a leg fracture, said “...There is no continuity with people working so many shifts” and David, aged 94 and in hospital with rib fractures, said “On occasions he has felt roughly handled ... by some but not all staff”. Meanwhile, Edward, aged 88 and a retired boilermaker and in hospital with breathing difficulties, said he “Did not like the hospital bed as they [staff] put the bars up which means he then cannot get up to go to the toilet and has to call for help” and Lizzie, aged 80 and in hospital with a leg fracture, said “A couple of the staff can be sharp” although she was not sure if this was because she herself was feeling down”. In one instance the daughter of a patient called Elana, aged 83 and in hospital with multiple health problems, said she had needed to deal with a “...Rude member of staff whose attitude and manner were not sympathetic”.

More specifically, there are the types of communications or conversations that occur between patients and hospital staff and the format of the information provided on care, treatments and medication. Patients made various comments on their interactions with hospital staff. Sally felt “They [hospital staff] do not take

her existing medical conditions into account and only see the condition that she is admitted for”, George, aged 73 and in hospital after a fall at home, said he “Has a catheter in place but was not sure why” and Shirley, aged 87 and in hospital with an ankle fracture, said she was “Worried about how she will be when she does get out of bed”. And Frances said her “Medication has been changed but she is not sure what it is for”.

Christine is 79 years old and was a secretary at an engineering firm. Her husband is 87 years old and frail ... She has been in hospital one month ... She got up at 3.00am to go to the toilet when she felt a bit dizzy. She said she saw a 'black flash' and fell back breaking the neck of her left femur. A doctor told her ... she would be going to step-down and then would have an x-ray ... She said she was not happy as she didn't want to leave hospital until it was right. Her son works in a ... hospital ... he rang to speak to [the consultant treating Christine] who talked to her and her son to explain that they would keep her in to ensure they get her leg right ... The hospital have spoken to her about step-down and explained what it is and said the level of care would be the same. They informed her that it would be for approximately two weeks She understands that if she is not happy with anything she just has to say and they will put it right. She also knows the names of the step-down accommodation and that they have different facilities. She said she would like to be closer to home. On a later visit Christine said the nurses had been wonderful and was feeling alright in herself ... Christine was hoping that the doctors would be coming round ... as her wound was still bleeding ... she did not feel reassured ... She is still waiting for a bowl to put her dentures into ... and she wants to be called Christine but the staff call her Lucy.

There were a number of comments about physiotherapy services. Some patients had had a good experience. Jane, aged 80 and in hospital with a hip fracture, said “Physio ... [is] pretty good” and Bill said he had “Been trained to use the walking frame and use the toilet ... the physiotherapist has been good and they are going to speak to his wife about moving his bed downstairs”. Other comments were less positive. Sally said she “Has not seen the physio very much” and Allan said he had “Not really had any physio as such other than help to use his walking frame”. Maureen, aged 86 and in hospital with an ankle fracture, said she “does not know if she will have to do exercises and said it seems they just want to get me home”.

“Nurses understandably do not have time to chat”

A number of patients felt hospital staff were very busy and had a lot of patients to care for and important work to do. Consequently, it was likely they would not have much spare time to spend with patients explaining why they were in hospital and

what was happening to them or listening to their stories and getting answers to their questions. Shirley said “Nurses understandably do not have time to chat” and Harry, aged 85 and in hospital with a hip fracture, said he had had “No communication about what is happening next ... [his] wife seems to know more than [he does] ...”. Elana’s daughter said she or her sister “Take it in turns to be with their mother as she speaks little English”.

Maureen said she “Did not know when she would be seeing the doctor next” and Frances, (age not given), said her “Doctor has been snappy with her on one occasion and she was reluctant to ask them [hospital staff] questions”. Bill said “The surgeon did speak to [him] and said that the operation had gone well ... he said he was going to come back but [he] has not seen him since” and Edward said “The doctor told him that he could go home ... however, the nurse said he couldn’t go home today... he was therefore confused”. Meanwhile, when a Healthwatch Dudley volunteer was having a conversation with Frances a doctor who came to talk to her did not ask her permission as to whether she felt comfortable with the volunteer being present.

Martin jumped down the steps at Sainsbury’s ... but he landed awkwardly and broke most of the bones and dislocated joints in his right foot ... Felt that things weren’t great on the ward initially ... He said that the nurses on the ward had been really nice but there can be a lack of communication. He was told at one point he could self-discharge but then someone else told him if he did that he wouldn’t have a bed when he came back in for the operation ... He was given someone else’s medication one day as they had a similar name, only realised as there were more tablets than he normally had so had queried it and they [staff] apologised. There are only two doctors in the hospital who can do the surgery. He is due to have an operation ... but not sure if it will go ahead as the surgeon wasn’t in hospital ... when the letter was supposed to be signed. He was told by a nurse specialist that the surgeon ... would see him ... but he didn’t visit. He should have found out ... if he is on the surgery list but the surgeon wasn’t in the hospital ... When he was first on the ward he felt like just a number ... He feels that there are too many staff involved with his care and there has been a lack of communication.

There were patients who felt they had received sufficient information about why they were in hospital and what was happening to them. Neil, a 35 year old with a fractured leg, said “Medical staff have explained things and I can’t fault it”, Harry said “The nurses have been extremely good and communication is good” and Andrew, a 23 year old with a leg fracture, said “Communication at the hospital has

been good and the staff are friendly”. Shirley felt she was “Being kept well informed about what is going to happen and is happy with the care she is receiving”, Linda said “The doctors have kept me informed about my progress” and Elana’s daughter said “The consultant has been very good and explained things”.

“I like to know what is happening to me”

Regarding patients’ different circumstances and feelings about their time in hospital there was a strong view from many of them that they wanted to be kept well informed about their care and what the future would look like for them. Frances said she “Likes to know what is happening to [her] and has found the staff willing to answer all her questions about [her] care and treatment” and Shirley said she is “Able to ask questions”. On the other hand there were some more anxious patients. George said he was “Worried about where his phone [was]” and David had a problem with incontinence and felt “Embarrassed about losing control”.

Bill is 83 years old and a retired production engineer in the motor industry. He had been shopping on a Saturday and was putting waste into a bag in the garage when he turned and fell and cracked his hip ... The surgeon had spoken to Bill and said that the operation had gone well. Bill had just come back from x-ray but at that time the surgeon had not seen the results. He said he was going to come back but Bill has not seen him since ... The physiotherapist came on Saturday but Bill had not seen them today [Monday] - he feels he is progressing ... Nobody has spoken to him about any arrangements for going home ... Bill hopes he is going home ... Bill presumes he will receive ongoing support at home ... Bill is waiting to go home and knows or assumes that he is just waiting for the okay on everything so he is in limbo. Bill said he is bored. The occupational therapist has discussed ongoing care in terms of his bed, walking frame and stool for the bathroom ... Bill said he just wants to know when he can go home. He said no follow up appointments had been mentioned yet. He was aware that there is a liaison meeting today [Monday] so should know more later.

There are implications for how communications and the provision of information about care and hospital discharge works for patients who are dependent on carers or family members. In particular, for some of the older patients carer or family support or help from friends was important during their time in hospital and their ongoing recovery at home. Edward was living “On his own with no family [but] receiving support from his neighbour ... and her husband who do his cleaning and

shopping”. Peter, a 72 year old with a hip fracture, was living “Alone with family close by” and Lizzie “Normally lives alone in a flat for the disabled and has a friend, June, who she talks to every day”. Shirley said her “Carer ... became a friend ... her soulmate as well” and Maureen was living “Alone at home and normally walks with a stick ... home is a three bedroomed semi-detached property without a downstairs toilet”. George was living alone and had been admitted to hospital after a fall in the bathroom, he “Managed to get up and rang the doctor” and Jim, an 89 year old with hearing and balance problems lives alone and has been having falls for several years and been to hospital on a number of occasions.

There were older patients who relied on carers or family members to liaise with hospital staff and help to keep them informed about plans for their care and eventual discharge from hospital. Shirley, despite feeling able to ask questions, said her daughter, who lived in Suffolk, had ‘Talked to her about what will happen when [she is] eventually released to go home’. Margaret, in her 80’s and in hospital after passing blood, said she was ‘Happy for communications to be handled by her daughter on her behalf’ and Frances said she had ‘Good neighbours and family’. Sue said her ‘Daughter ... kept her informed at all times’, Allan had ‘A cousin and she and her sons have been very good’ and David felt his ‘Niece and nephew will sort out the help he needs’.

“Discussed stepdown but don’t know where or when”

Regarding patient views on leaving hospital some made positive comments. Ellen, an 84 year old with cancer, said “The doctor had explained [I] needed a stepdown bed and would benefit from it before going home ... had a further discussion with the physio about the benefits of stepdown ... communication about stepdown arrangements have been good”. Harry said ... “I will be moving with the flow. I don’t know anything about my future care ...”, Jane said she had “Discussed stepdown but [did not know] where or when” and Sue “Had not been told about stepdown ... at least [she] couldn’t remember ... but they [hospital staff] might have told her daughter”. Lizzie had “Not heard about going to stepdown yet ... has asked the nursing staff whether they had any information but this could not be provided”, Shirley said the “Doctor has visited ... does not know if she will be going to stepdown but ... is not able to go home yet” and Allan had “Not heard anything specific about stepdown but had a general discussion ... does not have any details yet ... the hospital have other patients to see to”.

Other patients were concerned about what would happen once they got back home. Sally was “Worried about toilet arrangements”, Graham, a 56 year old with a leg fracture and a domiciliary care package in place, remained “Frightened to go home” and Bill presumed he would receive “Ongoing support at home”. Stan, an 88 year old with memory problems, said he was “Awaiting a care package ... but not sure what or when ... needs had not specifically been discussed” and George

was “Unsure about whether a care package was in place”. Edward was “Not sure if there was a care package in place to enable him to go home”.

Volunteer reflections

The staff welcomed us onto the ward and were happy for patients to talk quite freely. Overall the majority of patients seemed quite content with the level of nursing care and perceived staff to be busy which meant they had limited time to spend talking with individual patients. A number of patients seemed to have some understanding of what Intermediate Care was but did not know who had spoken to them about it. Most patients seemed more than able to cope with information themselves. There were some questions about how effective the process was for alerting relevant staff that a step-down bed for a patient was required (including communications between different members of clinical staff). At the same time, there were issues concerning cross-boundary working. And what happens to patients living outside the Dudley borough admitted to Russells Hall Hospital and requiring step-down that needs to be funded by neighbouring organisations. Effective communications between patients and staff and different staff members were vital to avoiding delays in discharge.

There was evidence of good communications between patients and staff. For example, on one ward on two consecutive days a senior clinician visited a patient and explained what was happening including arrangements for them to go to a step-down facility for further treatment. It was noted that due to circumstances outside of the control of staff communications with a patient’s family members could be difficult. In instances where older patients do not have family members or friends who can help to support them there may be an opportunity for help to be provided from the voluntary sector. In addition, voluntary sector support might be available to help support patients who are not feeling at their best and are feeling lonely and bored. Several patients mentioned that they felt frightened about going home. It is worth reviewing how hospital and social care services staff can best work together to reduce such feelings of anxiety.

Getting to the heart of the problem

Despite talking to a mainly older group of hospital patients it is possible to surmise that by getting communications right for them they will also work well for other patients. Opportunities exist for transferable learning that uses findings from this project to think about communications issues more generally. High levels of patient satisfaction with the way that staff communicated with them and the care they received was noted. But care must be taken not to conflate patient satisfaction with overall patient experience of their time in hospital. This fits with the idea in communication theory that often the many different components that constitute the communication process are not well understood when people are

thinking about how to collect rich information on activities and experiences. In turn, it is necessary to understand what levels of service different groups of patients are satisfied with, whether it is appropriate or not and the implications for conversations where different care and discharge options are discussed.

Meanwhile, there are issues to do with communications and the possibilities for staff to build rapport with patients in situations where there is change caused by staff turnover or the use of bank or agency staff. There might also be implications for who has responsibility for ensuring communications work or providing information for patients, their carers and family members on healthcare matters and their wellbeing. In particular, as communication theory stresses, it is necessary to think about how the timing of communications and how everyone who needs to be is involved in relevant conversations and decision-making processes. Patients' recognised staff were busy and that they themselves might be off hand sometimes. Nevertheless, if communications do not work well this is ultimately likely to lead to frustration for both patients and staff. Patients will be ill-informed as to what is happening to them or be unable to properly understand what is happening to them.

A holistic approach to patient and staff communications will help to ensure that all of the matters that are important to each person in a conversation about care and wellbeing are considered. It is not sufficient to simply focus on the primary reason for a person being in hospital. Rather, by embracing a broader human rights approach to communications it should be possible to eliminate artificial demarcations between the patient and hospital staff and focus on what everyone is entitled to expect in terms of communications working well for them. In addition, a patient's life experience and home circumstances are important in determining how communications need to work for them to ensure they are reassured about their care and what will happen when they leave hospital. An appropriate balance needs to be achieved between the time that is available for communications between patients and staff and the time that needs to be devoted to providing necessary clinical care. The benefits associated with having good communications from the outset between patients and staff could include an improved patient experience of their time in hospital, less likelihood of problems around care and discharge arising and taking up valuable staff time, and increased levels of patient trust in the care they are receiving.

Many patients, including those in their eighties and nineties, want and are able to deal with quite complicated information about their care and time in hospital. The key is to tailor the information presented to meet the needs of each patient in terms of the level of technical medical language or jargon that is used. Most patients want a reasonably detailed explanation of what is happening to them in hospital that is reviewed and updated on a regular basis.

As postulated by the critical discourse view of social relations power and language are often linked and there is a need to understand and deal with power dynamics in conversations to ensure different voices are properly recognised and heard. Sometimes there was confusion over when communications about care arrangements should happen and who had responsibility for ensuring they did happen. It was not always as clear as it could be for patients when visits by doctors or other members of hospital staff would take place and sometimes promised visits were postponed or cancelled without any explanation. In some instances patients were not sure about whether the best person to deliver information was giving it to them. Patients need to be reassured about the quality of information and the authority of the person delivering it.

Conversation theory stresses it is how communications and the messages they contain are interpreted by different individuals and facilitate (or not) learning about a situation that must be assessed. More specifically, contradictory communications can be a problem and leave a patient feeling confused and sometimes worried about the care they are receiving.

A patient centred approach must involve properly understanding individual patient backgrounds and circumstances and staff capacity to adapt to find the best way to keep them informed about their care. There are unequal power relations between the patient and hospital staff that must be recognised and dealt with so that they do not impact adversely on the quality of patient and staff conversations. The aim should be to genuinely empower patients and involve them, wherever possible, in the co-production of decisions about care and eventual hospital discharge.

In sensemaking (or making sense of different people's views and experiences) terms it is about improving the chances of patients being able to easily identify useful meaning in communications that happen between them and staff in complex and uncertain hospital environments. At the same time, patients need to feel able to complain or ask questions and know they will get an appropriate and carefully considered response. The timeliness of communications is particularly important when planning and preparing for hospital discharge.

Sometimes patients' with complex needs will have to rely on effective communications with carers and family members (although it should be noted that many older patients were living alone with little or no support from family or friends). In such instances a coordinated approach to communications between different hospital staff teams and external health and social care agencies is likely to be crucial in determining whether high quality outcomes are delivered for a patient.

What next?

- Patient satisfaction is not the same as overall patient experience of their time in hospital. Conversations between patients and staff can capture more on what actually happened in terms of care received.
- Find ways to mitigate the possible adverse impacts on the quality of patient and staff communications caused by staff turnover or the use of bank and agency staff.
- Identify who has responsibility for ensuring communications between patients and staff happen and work well.
- Good communications can reduce frustration for both patients and staff
- Adopt a holistic approach to communications that seeks to understand a patient's background and circumstances and any implications for care and hospital discharge.
- Find an appropriate balance so that there is both good patient care and equally good patient and staff communications.
- Effective patient and staff communications can prevent problems from arising and save staff time in the future.
- Clear and concise patient and staff communications can help patients to feel well cared for and secure. They can also assist patient recovery and the achievement of beneficial longer-term health outcomes.
- Good patient and staff communications about care and planning for discharge need to start from the outset when a patient is admitted to hospital.
- Most patients want to know what is happening to them. The key is to tailor information to meet individual patient needs.
- There needs to be clarity about when and how conversations about care and discharge will happen and explanations provided when things do not go to plan.
- Patients need to be reassured about the quality of the information on care and discharge they receive and the qualifications and authority of the person providing it.
- Avoid contradictory communications through more coordinated communications activity within and between hospital teams and also between hospital teams and external health and social care organisations.
- Patient and staff communications should aim, wherever possible, to be about the co-production of decisions about care and hospital discharge.
- Patients need to feel they can complain or ask questions and get a timely and appropriate response.
- The timeliness of communications between patients and staff is important to maintain patient, carer and family member trust in care and hospital discharge arrangements.

Appendix 1

Healthwatch Dudley - Russells Hall Hospital Patient Journeys

Guidance for volunteers

Healthwatch Dudley has been asked to gather the experiences of patients in Russells Hall Hospital, in particular the information they receive up to the point when they are ready to be discharged. Volunteers and staff will present on surgical and medical wards from Monday 26 January 2015 to mid-March 2015, to have conversations with and listen to the views of patients and their carers. Conversations will be informal, voluntary and can be as long or as short as patients feel comfortable with. Experiences gathered will help to improve information and inform decisions involving patients, relatives and carers in the future. We are not asking for questionnaires to be completed and do not want conversations to be scripted. These notes are intended to help you to introduce yourself and to inform patients about our research so that we can get the most out of conversations that take place.

Conversation Themes

Introductions and getting to know each other

Something about the project - what it aims to do and how findings will be used

Healthwatch Dudley has been asked to gather patient views and experiences, in particular the information received up to the point where patients are ready for discharge. We will be having conversations with patients over a number of weeks. Findings will help to inform discussions and decisions on how to change or improve information and communications with patients, family members and carers in the future.

Something about Healthwatch

Healthwatch is the independent consumer champion, for both health and social care for children and adults living in England. Healthwatch Dudley supports people who access services in the Dudley borough. It listens to members of the public and patients and works with them to improve health and social care services for everyone.

Something about informed consent and confidentiality:

You will be either recording conversations or making detailed notes. The patient needs to be reassured that the information they share is strictly confidential and they will not be identifiable in any of our reports.

You should ask:

- Do you understand what the project is about?
- Are there any questions you would like to ask?
- Are you happy to continue and take part in a conversation about information and communications and your time in hospital?

The aim is to build rapport and empathy with patients and others in conversations. A key point to remember is to focus on **listening** to what people have to say with as few interruptions as possible to allow them to tell their own stories. At the same time, try to avoid asking leading questions that might encourage people to answer questions in a particular way to please the person asking the questions (for example: have you had a talk with someone about discharge, have you had a leaflet explaining things). Instead you could say tell me about how things have gone for you, say something more about that, can you describe how you feel about what is happening to you.

If you the person you are listening to mainly gives you yes and no answers these conversation prompts might help you:

- How was that explained to you?
- What was your understanding of that?
- How did that make you feel?
- What especially do you like / dislike about it?
- What do your family or carers think?

Getting started...

You may choose to start your conversation with something like: “Thank you for agreeing to take part in the conversations we are having with patients. To start things off let me tell you something about myself..... Now can you tell me something about yourself and why you are in hospital?”

Conversations

Typical journey 1

Patient arrives at hospital and there is an assessment (Accident and Emergency or Emergency Assessment Unit) followed by discharge (to home or referral to the Impact Team for Assessment) then home after assessment or a move to step down (or care at home).

Do you know what to expect during your stay in hospital?
How involved do you feel in discussions and decisions about your care and time in hospital?
What is your experience?
How have things been for you?
How do you feel about how your care is going?
What do you want to happen in terms of your care?
What has been good or bad?
What do you know about how your stay in hospital should progress?
What do you know about the care you will receive?
How much do you know about when you might leave hospital?
How much do you know about what should happen when you are ready to leave hospital?
What do you want to happen when you are ready to leave hospital?
How have staff been when talking to you (doctors, nurses, others)?
How do you feel people are listening to what you have to say?
How do you feel about what is happening to you?
Could anything be changed or improved to make it easier to understand what is happening to you?
What do you know about any medications you are taking?
What is your experience of waiting for medication while being discharged?

Do you feel able to ask questions about your care or time in hospital?
Have you asked any questions about your care or time in hospital?
What was the response to your questions and the outcomes for you?

(If relevant) has anything changed for you since the last time we spoke?
- In terms of information and communications there might be issues to do with the language used (its style and format), how easy it is to understand.

Typical Journey 2

Patient arrives at hospital and there is an assessment (Accident and Emergency or Emergency Assessment Unit) with a move to a ward, ensuring care or a Care Plan is in place, then care started and when appropriate discharge from hospital.

As typical journey 1 with the following additions

How was your move to the ward?

How have matters been regarding your ongoing care?

How have family members been involved in discussions and decisions about your care?

How have carers been involved in discussions and decisions about what happens when you leave hospital?

Typical journey 3

Patient arrives at hospital and there is an assessment (Accident and Emergency or Emergency Assessment Unit) and a move to a ward, ensuring care or a Care Plan is in place. If appropriate referral to Intermediate Care (waiting list) and assessment (if medically fit) then care started or a decision to commission care (with patient and family agreement - if not review) and move to Intermediate Care bed or care at home.

As typical journey 1 & 2 with the following additions

What do you know about intermediate care (step down)?

How was your assessment for intermediate care?

How have you (and/or family members) been involved in discussions and decisions about your care?

How have you (and/or family members) been involved in discussions and decisions about what happens when you leave hospital?

How was consent obtained from you (and/or family members) to undergo assessment?

Appendix 2: Volunteer Recruitment

Patient journeys at Russells Hall Hospital

Healthwatch Dudley has been asked to collect patient journeys through Russells Hall Hospital. We are inviting our volunteers to help us to listen to people's views and experiences of hospital surgical and medical wards, during January and February 2015.

Why are we involved?

Local evidence shows that hospital patients are sometimes unaware of intentions to change their care arrangements. Some patients have told nursing staff that they or their families did not know that they were going to be moved from hospital into a care home or nursing home. The patient and family members may be left feeling anxious and upset by this. It has been suggested that the issue may be one mainly of communications and how patients and their families are kept informed (or not) of developments in ongoing care and any planned changes to that care during a stay in hospital.

What we will be doing

Healthwatch Dudley volunteers and staff will have in-depth conversations with patients. We will listen to patients' own stories about how they have been kept informed about events impacting on their hospital journeys and record their views and experiences of how things have been for them. Each conversation will last for between thirty minutes and one hour on average and will take place on a hospital ward.

How we would like volunteers to help

We think it is important for patients to be listened to by local people who are not biased in any way. Our volunteers will bring independence and will help us to present a clear and true picture of how patients really feel. For consistency and to build relationships with patients, carers and staff, ideally people who volunteer will need to be:

- Available for a six week period between mid-January and the end of February 2015
- Prepared to volunteer for one three hour session each week
- Friendly with the ability to put people at ease
- Happy to talk to people and have really good listening skills
- Happy to undertake a criminal records check (DBS) as you will be working with potentially vulnerable people

- Prepared to work with another volunteer with the support of Healthwatch staff to record what you hear
- Have undertaken Healthwatch Dudley's Enter & View Training
- a half-day each week over a period of six consecutive weeks. Written notes will be made of the information provided by patients together with any key points and issues that emerge. The research tasks comprise:
 - Design of a semi-structured interview schedule
 - Volunteer briefing sessions
 - Hospital ward visits
 - Collection and analysis of patient views
 - Prepare a draft report
 - Comments on draft report
 - Prepare a final version of the report

Appendix 3: Letter for patients

Dear patient

Healthwatch Dudley has been asked to gather the experiences of patients in Russells Hall Hospital, in particular the information they receive up to the point when they are ready to be discharged.

Trained, friendly volunteers and staff will be in the hospital from Monday 26 January 2015 to mid-March 2015 and may ask you to have a chat. Conversations will be informal, voluntary and can be as long or as short as you feel comfortable with.

Experiences gathered will help to improve information and inform decisions involving patients, relatives and carers in the future.

Healthwatch Dudley is an independent consumer champion for health and social care. We listen to people about their experiences of local services and we feed back issues to decision makers and care providers to improve services for everyone. We also signpost to relevant local services and organisations.

Conversations may be recorded and notes will be taken but anything you share is strictly confidential and you will not be identifiable in any of our reports.

If after today, you would like to talk to a member of the Healthwatch Dudley team about this project, or share your views about any other local health or social care service, please do get in touch.

Thank you for your time.

Jayne Emery



Chief Officer
Healthwatch Dudley

Appendix 4: Patient details

No.	Name	Ward	Gender	Age	Condition
1	Ellen	B4	F	84	Cancer
2	Allan	B2	M	72	Hip fracture
3	Bill	B2	M	83	Hip fracture
4	Jim	C3	M	89	Balance problems
5	Lizzie	B2	F	80	Leg fracture
6	Rose	B2	F	67	Hip fracture
7	Elana	C3	F	83	Hip fracture
8	George	C3	M	73	Urinary problems
9	Mary	B2	F	88	Ankle fracture
10	Maureen	B2	F	86	Ankle fracture
11	Linda	C5	F	80	Pneumonia
12	Stan	C3	M	88	Memory loss
13	Graham	B2	M	56	Leg fracture
14	Neil	B2	M	35	Leg fracture
15	Jane	B2	F	80	Urinary infection
16	Olive	At home	F	-	Shoulder problems
17	Margaret	C3	F	80's	Passing blood
18	Norman	C3	M	-	Breathing problems
19	David	C3	M	94	Rib fracture
20	Peter	B2	M	72	Hip fracture
21	Sally	B2	F	71	Leg fracture
22	Colin	B2	M	85	Hip fracture
23	Andrew	B2	M	23	Leg fracture
24	John	B2	M	-	Ankle fracture
25	Sue	B2	F	-	Fall at home
26	Edward	C3	M	88	Breathing problems
27	Christine	B2	F	79	Leg fracture
28	Frances	C3	F	-	Dizziness
29	Harriet	B3	F	-	Hip fracture
30	Harry	B2	M	85	Hip fracture
31	Martin	B2	M	-	Foot fracture

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