healthwatch

Healthwatch Hartlepool

Hospital Discharge Report

March 2023

Contents

Executive summary

Hartlepool is one of the most deprived areas in England, ranked 18th out of 326 local authority areas and with 7 of the 12 wards in Hartlepool amongst the 10% most deprived in the country.

Healthwatch Hartlepool recognises that many people in Hartlepool are significantly affected by health inequalities and high levels of ill-health. The delivery of supportive and appropriate hospital discharge services in the town are vital and play a major part in ensuring patients experience and subsequent recouperation are maximised.

Our survey and consultations highlighted the following key areas:

Our findings demonstrate that significant strides have been made in many aspects of the discharge process since our previous investigation in 2014. Most noticeable of these is the progress that has been made in developing integrated working practices which have resulted in a much-improved collaboration between health and social care stakeholders in the discharge pathway. The co-location of health and social care staff, the development of the Integrated Discharge Team and ISPA have all contributed to the development of closer working relationships and understanding of the various challenges and complexities different partners face in the delivery of an effective, patient centred discharge experience. Also, the development of services such as the Community Respiratory Service have ensured a seamless transition into post discharge patient support and ongoing condition based treatment.

Further to this, the continued use of SystmOne and the adoption of the OPTICA system, a secure Cloud application which tracks all admitted patients and the tasks relating to their discharge in real-time through their hospital journey has greatly enhanced the potential to plan and co-ordinate patient discharge. It also enables up to date information to be shared and utilised by partners from all sides.

However, our research also shows that there are still challenges to overcome. Our investigation has shown that a significant number of patients do not feel involved in the planning of their discharge and in some cases, arrangements have not been fully discussed until they are about to leave hospital. Some patients have told us that they were given little information about their forthcoming discharge and subsequent care arrangements, whereas others have said that they and their families were fully involved in planning their discharges from the early stages of their admission. As so often is the case, communication is the key to a successful discharge, ongoing patient recouperation and minimising the chance of re-admissions. Work has already started to identify improvements to patient communication through the NTH & ECIST improvement project “The 4 Patient Questions” which is looking at ways of improving consistency of information given to patients during non-elective inpatient stays.

Communication must be sensitive to the needs of the patient. If a patient is Deaf, interpreter support must be made available at all stages of the discharge planning process in order to ensure that the patient is involved in and aware of their discharge arrangements. Support must also be provided to patients with neurological conditions such as dementia to ensure they are aware of what is happening and helped at key times to avoid undue stress and anxiety. Family members and carers are key partners in such

cases and should also be kept regularly informed and involved. Johns Campaign already provides the framework around which good practice can be developed.

Some patients have reported delays in changes to care packages being implemented post discharge and long waits for equipment and adaptations. A particular area of concern are the long waits which some reported for OT assessments, again leading to delays in the introduction of much needed adaptations and equipment.

Communication issues are also highlighted by care homes and domiciliary care providers. Information often reported to be limited around patient discharge processes and arrangements. In order for care homes to be ready and prepared to receive residents back to their home adequate notice is needed to ensure paperwork is completed and changes to medication and care packages are implemented immediately and safely. The homes also expressed concerns that there had been occasions on which they were worried about the fitness of a resident to be discharged back to the home, again emphasising the need for good communication in the run up to discharge. Finally, some homes raised concerns about lack of clarity around medication changes in discharge letters and DNAR's not being returned with the resident, again highlighting the need for improved communication.

Visits to the Discharge Hub left us questioning the suitability of the current location. The staff and volunteers all provided excellent care and with the provision of snacks and drinks efforts have been made to make the patient stay as comfortable as possible. However, the design and co-location with cardiac patients is not appropriate and the long-term location of this service needs to be reconsidered. Patient dignity is paramount at all stages of their stay in hospital, and instances were observed during our visits in which the layout of the Hub limited the ability to deliver to the highest standard.

Many patients who attended the Discharge Hub, reported long waits for medication and transport. Timely availability of medication still appears to be a significant cause of extended stays in the Discharge Hub, and on one of our visits we observed the nurse on duty having to go to pharmacy to collect a patient's medicines. One would hope that the enhanced virtual planning tools which are now available and improved co-ordination could to some degree help ease these long-standing issues.

Background

Hospital Discharge Patient Experience Report

In 2014 Healthwatch Hartlepool conducted a major investigation of hospital discharge from North Tees and Hartlepool Hospitals following a high number of concerns received from patients, family members and carer providers with regard to experience of the discharge process and subsequent care provision. Following our investigation, a report was produced which made a series of recommendations around changes and developments we considered were needed in order to improve care provision and patient experience of the discharge process.

Many of the recommendations contained within the 2014 report have since been actioned, but it was always our intention that we would revisit the issue at some point. We had intended doing this in 2020 but the onset of the Covid pandemic made this impossible. With the gradual relaxation of Covid restrictions we were able to include

hospital discharge in our 2022 work programme and our investigation was conducted from early December until February.

It has long been recognised that once a patient has recuperated to a level at which they are clinically fit to leave hospital, discharge should happen quickly and safely, with full involvement of the patient and their family at all stages.

"The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed."

Hospital Discharge and Community Support Guidance (DHSC – March 2022)

Discharge to Assess is defined as –

"Where people are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer term care and support needs is then undertaken in the most appropriate setting and at the right time for the person."

Quick Guide: Discharge to Assess (NHS England Publications Gateway Reference 05871)

The guide goes on to state that Discharge to Assess is not about-

• Discharging people from hospital before they are clinically ready.

• Discharging people without assessment for services required for their safety at home or another community setting.

• Moving people home from hospital without the right support and without their consent or a best interest's decision.

• Creating an additional transfer in a person's care pathway in order to free up a hospital bed, without adding value to their experience of care or meeting good outcomes for the person.

• Moving people without clear pathways and processes, including an agreed care plan. Denying people, the right to an assessment for NHS Continuing Healthcare (NHS CHC) if they may have a need for this.

• Charging people for care they should receive free from the NHS.

• Moving costs from health to social care or vice versa. • Working only with people with low level or specific needs

Safe, effective, well planned hospital discharge is a fundamental necessity if long term recouperation and positive health outcomes are to be maximised. It is also a vital ingredient in reducing patient readmissions to hospital and the personal anguish this entails.

"People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes."

Hospital Discharge and Community Support Guidance (DHSC – March 2022).

Aim of study

- To provide constructive patient, family member and carer feedback of recent experiences of complex hospital discharge, in which ongoing care and support is required when the patient leaves hospital. The study focused on those patients whose experience of discharge falls into pathways 1 and 2 in the diagram below as no patients on pathway 3 were identified during our investigations. Pathways 1, 2 and 3 are usually referred to as complex discharge procedures as patients leave hospital with some level of ongoing health or social care need.

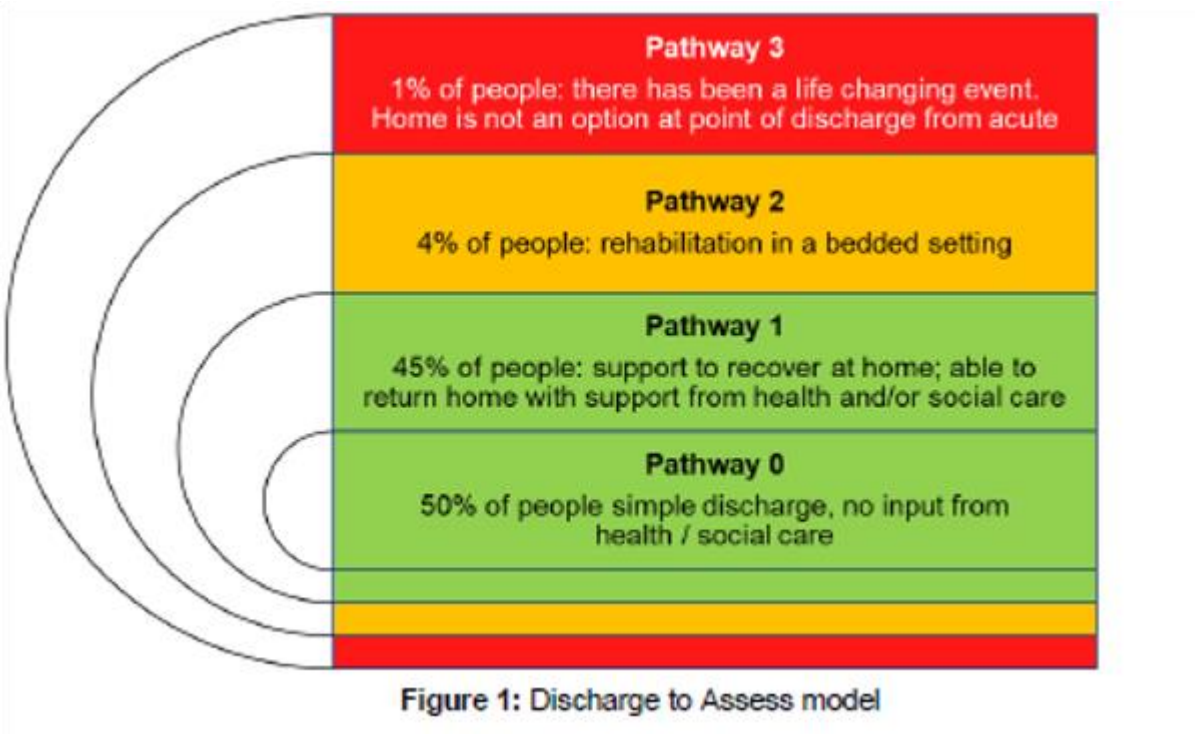


Figure 1: Discharge to Assess model

- To provide feedback from local care providers of their recent experiences of recent resident and care service user discharge from hospital and the effectiveness of the process from their perspective.
- To consider current discharge practice at North Tees and Hartlepool NHS FT in light of guidance contained in Hospital Discharge and Community Support Guidance (DHSC – March 2022) and the Trust's Inter Agency Discharge Policy which states –

  "This policy sets out general principles and specific procedures for the discharge of patients clarifying roles and responsibilities of health and social care professionals with consideration of people with additional needs. Maintaining the respect and dignity of patients their relatives and carers is of paramount importance throughout the discharge process."

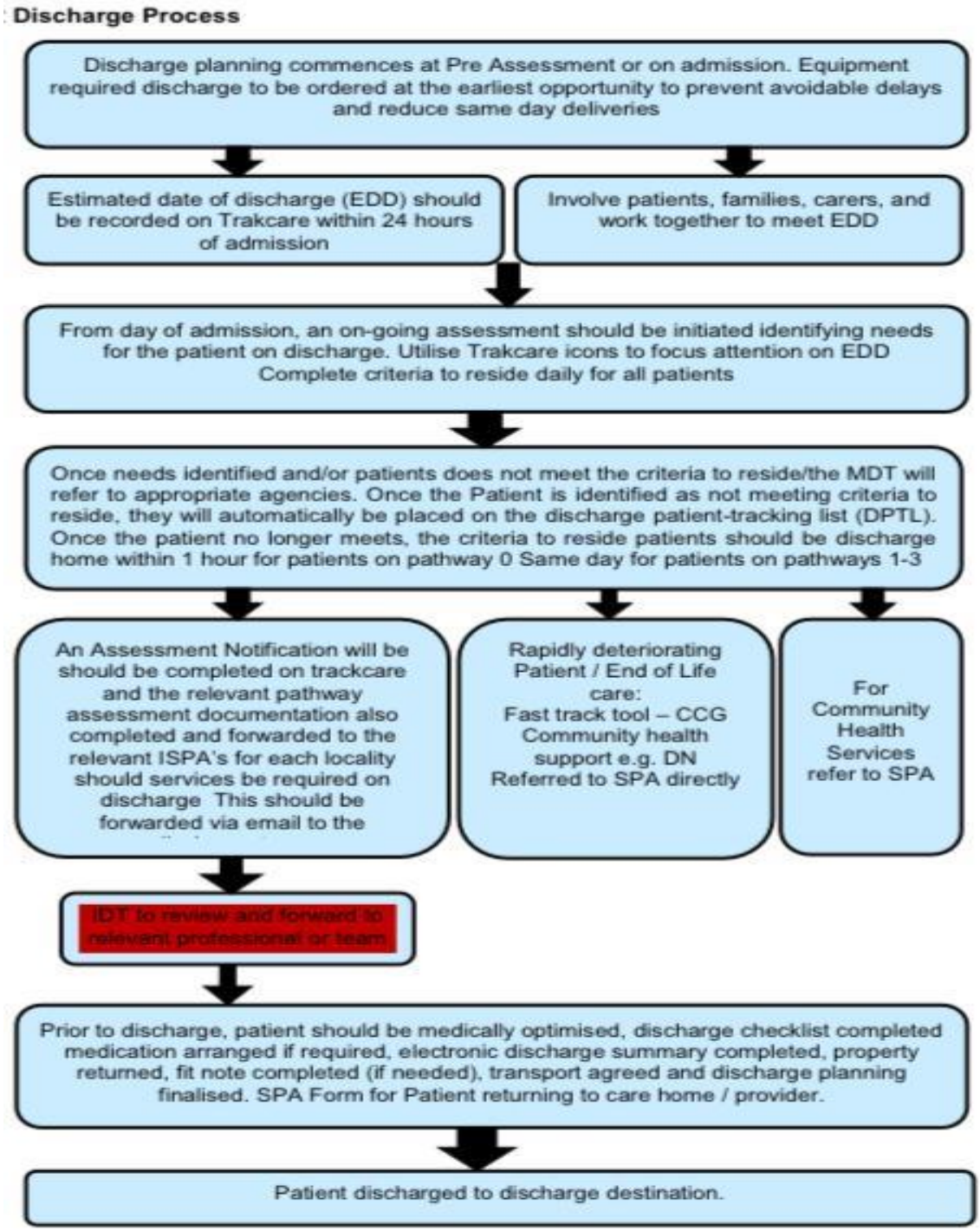
- To make recommendations as necessary based on feedback received and findings made during our investigations.

Methodology

Stage 1 - Preliminary Research

Presentations from hospital and HBC staff which outlined discharge processes and procedures which currently operate and collaborate working practices between the two sectors. This allowed staff and volunteers involved in the investigation to familiarise themselves with discharge processes and current working arrangements in this area.

The process diagram below is taken from the Trust's Inter-Agency Discharge Policy and summarises the approach which is taken to planning and co-ordinating discharge arrangements.



Stage 2 – Survey Design

Following the initial information gathering and scoping phase three surveys were developed. The first was for patients and family members who had recent experience of being discharged from hospital. This survey could be accessed via the Healthwatch Hartlepool website, and the link to the survey was kindly shared by Hartlepool Borough Council and several community sector partners via their websites.

The other surveys were aimed at care homes and care service providers and enabled them to give feedback on their recent experiences of the discharge process as experienced by care home residents and people receiving care packages in their own homes.

Stage 3 – Visits and Meetings

In order to ensure that those who did not have access to the on-line survey had an opportunity to tell us about their recent experiences of hospital discharge, we visited the following sheltered accommodation and attended gathered feedback at several community events/meetings –

- Saint Joseph's Court (Anchor Housing)
- Meadowfield Court (Anchor Housing)
- Hartfield's Manor Retirement Village (Joseph Rowntree Trust)
- Community Led Inclusion Partnership/Healthwatch Hartlepool Joint Meeting
- Hartlepool Carers Wednesday Coffee Morning
- Hartlepool Young Onset Group Thursday Coffee Morning

Stage 4 – Discharge Hub Visit

Finally, two visits were made to the Discharge Hub at North Tees Hospital at which visitors were able to observe the discharge process first hand and have discussions with patients.

Particular attention was given to ensuring that the consultation primarily focused on patients who had experience of pathways 1 and 2 and who were discharged from hospital with ongoing health and/or social care needs.

All research was undertaken between 12th December 2022 and 24th February 2023.

In total, 40 surveys were completed and returned via our on-line survey or at the events listed above.

Key findings from patient/family questionnaires

A total of (40) questionnaires were completed and returned.

- A high number of patients (21) said that they were discharged from the ward on which they were staying rather than the Discharge Hub or Transport Hub. During the course of our investigations, it was reported that some wards were reluctant to send patients to the Discharge Hub due to the possibility they may face a long wait in the Hub before going home.

- A high number of patients (18) reported that their discharge arrangements had not been discussed with them or family members until their actual day of discharge and (19) patients reported that they had received no information about discharge procedures or what would happen on their return home during their stay in hospital.
- (10) patients reported that they had waited over 2 hours in the Discharge Hub before being formally discharged and able to return home.
- The main reasons given for delays at the Discharge Hub were having to wait for medication, having to wait for transport or having to wait for both medication and transport issues to be resolved.
- (9) patients reported that they had found their stay in the Discharge Hub to be uncomfortable, and (8) said that it lacked privacy as confidential discussions could be overheard.
- (14) patients reported that they considered the supply of medication they had received when discharged to be insufficient and, in several cases, not immediately available.
- Several patients reported delays in post discharge OT visits and subsequent delays in receiving necessary equipment. This led to some patients reporting that they had to purchase equipment privately as they were unable to wait for the OT visit and assessment.
- Feedback on post discharge care and support arrangements were variable, and (7) patients said that new care and support arrangements were not immediately actioned following their discharge home.
- It was reported that interpreters are not always present to assist Deaf patients to participate in their discharge planning arrangements and vital information, such as discharge letters are not provided in a format which is accessible to Deaf patients.
- Overall, patient rating of their discharge experience varied considerably, with (15) patients rating the experience as excellent or good, and (15) patients reporting their experience as being poor or very poor.
- A similar picture emerged regarding experience of post discharge health/social care with (10) patients rating the experience as excellent or good and (10) patients reporting their experience as being poor or very poor.

Overall findings/comments from questionnaires

1) In what capacity are you completing this questionnaire?

Capacity	Number
Patient	28
Carer or family member	11

Other	1
Total	40

Comments

- Deaf Centre Worker

2) At which hospital were you staying prior to discharge?

Method	Number
North Tees	35
Hartlepool	1
Other	4
Total	40

Comments

- RVI Newcastle x 2
- James Cook x1.
- Not specified x 1

3) Where were you discharged from?

Location	Number
The ward I was staying on	21
Discharge Hub	17
Other	2
Total	40

Comments

none

4) When was your discharge from hospital first discussed with you and/or a family member?

Time	Number
Before going into hospital	1
During my stay	17
On the day of discharge	18
Other/don't know	3
No Response	1
Total	40

Comments

- Rarely fully discussed with patient due to language barriers in place, Deaf people stay in hospital for longer because of this.

5) Were you provided with any information about what would happen when you were discharged from hospital?

Yes	No	Total
21	19	40

Comments

- People are given a discharge letter with a landline telephone number so they cannot make contact if they have any health problems following discharge. Hospitals are not routinely booking BSL Interpreters for discharge so the Deaf patient do not understand what information they must follow because this is only explained in English.
- That a care home would be most appropriate, and support would be given to find one. (This support was in fact dreadful, and family had to find the care home)
- An A4 page document, giving out of hours call number if needed. A booklet on Lymphedema.
- I was told earlier in day I was going home, but at no time prior to discharge day did any member of medical team discuss patient discharge needs with family, only the patient, who told them family would support. This is correct, however depends on patient needs!
- Some information about blood thinning, injections but nothing on dos or don'ts
- Information on my condition and my thoughts on resuscitation
- I was not informed of my discharge date or time.
- Arranged discharge plan and date to attend respiratory clinic, meds also sorted, care package at home in place.
- Not clear about arrangements or where being discharged to.

6) When you were discharged from hospital where were you discharged to?

Location	Number
Back to own home	30
Sheltered or extra care home	3
Residential care home	4
Rehabilitation Unit	2
Home of a family member	0
Total responses	39

Comments

none

7) How long did you wait in the Discharge Hub before leaving hospital?

Time	Number
0-30 minutes	1
30-60 minutes	4
1 – 2 hours	6
2 – 4 hours	6
Over 4 hours	4
Total Response	21

Comments

- Told ambulance due at 10am and taken to Discharge lounge, arrived within 30 minutes.

8) If your discharge was delayed, what was the reason/s?

Reason	Number
Waiting for medication	12
Waiting for discharge letter	5
Waiting for transport	13
Waiting to see doctor or consultant	3
Total Responses	33

Comments

- Deaf patients are not getting BSL Interpreters on ward rounds, this impacts on their treatment, recovery and discharge - they wait much longer and suffer as a result.
- At discharge all my medications were wrong so had to wait even longer the nurse was not happy and called her manager to sort it out we had boxes of open tablets and antibiotics which we shouldn't have.
- I had to wait for medication and discharge letter. (2)
- I had a long wait for medication and my discharge letter.
- Had to wait for medication and transport.
- Transport! I had to wait from 9am to 8pm before I was picked up.
- Long wait for transport. (3)
- My medication was not ready so long wait. (3)
- Waiting for volunteer driver.
- Wait for volunteer driver and medication.

- Discharged from ward at 9am but didn't leave North Tees until 7pm due to having to wait for prescription from hospital pharmacy.
- Waited 6hrs for pharmacy, resulting in patient anxiety, 89yrs old.
- I got discharged the day after I was supposed to, consultant was really busy and didn`t get round to doing discharge notes.
- Waiting for equipment to be delivered to West View Lodge.

9) When waiting in the Discharge Hub were drinks/snacks available?

Yes	No	Total Responses
17	6	23

Comments

none

10) If you have any dietary requirements were these considered (e.g., diabetes)?

Yes	No	Total Responses
3	7	10

Comments

none

11) Was your stay in the Discharge hub comfortable?

Yes	No	Total Responses
14	9	23

Comments

- The nurses were rude and off hand. I was being violently sick and felt like death and was considered dramatic and an inconvenience.
- It was stressful sitting around and having to wait so long.
- Felt lady in bed in discharge hub was very poorly and had no privacy, distressing.

12) Whilst in the discharge hub, could you overhear private and sensitive discussions?

Yes	No	Total Responses
10	8	18

Comments

- Curtains were drawn around bed, so no conversations were heard.

13) When you were discharged, what transport was used to get you to your destination?

Transport type	Number
Private car (family or friend)	22
Ambulance	6
Taxi	2
Volunteer driver	3
Other	3
Total Responses	36

Comments

none

14) Overall, how would you rate your discharge experience?

Rating	Number
Excellent	5
Good	10
OK	8
Poor	8
Very Poor	7
Total	38

Comments

- I was very unwell when I got home and did not know what to do so ended up getting taken back in by ambulance.
- My mam was discharged although still very unwell and had not eaten in over two weeks she also has cancer, and it was easier for the hospital for me to drive through and collect my mam and take her to James Cook and return her back to the ward daily because she was having treatment.
- The right time yes, the right place yes, but only because family did the work and found a suitable nursing home. The right equipment no - meds were only in place because family added pressure to make sure a person on end-of-life care was not discharged without strong pain relief. Pain relief only provided in discharge lounge because family member demanded. Relative was discharged to the hub with no plan for that day's medication and no walking aid. Relative was left without any walking aids to get to the care home building and manage within the care home despite being utterly dependent on them in hospital.
- Poor is harsh because the staff and volunteers in the hub were wonderful. Warm and friendly but the overall experience was incredibly difficult and stressful for a lady who only had weeks to live and was in severe pain.

- I was informed I was to be discharged. As I had no transport because I cannot drive and too ill to catch a bus, I was informed transport would be arranged for me. After a long wait I was informed the volunteering service was not available to me because I was getting over Covid, so a taxi would be called at the hospital's expense. Eventually I was taken downstairs to wait for the taxi which never arrived. I was left sitting out in the cold and dark in my night clothes for best part of an hour. Finally, a porter helped me, and another taxi was called. By then I was very cold and still unwell. Also, I was given wrong information on the discharge letter e.g., advised I was a man when I am a woman, the wrong diagnosis, a poor experience in hospital and the delay getting the taxi was very unsatisfactory. They were also unable to provide me with decaf tea which is all I drink. As most of this had happened on a previous admission, I sent a letter of complaint. This time it was satisfactorily answered.
- It was a nightmare a ward full of tents for very ill people. And every time they went in tent I was scared as I had no protection. I don't know if I have caught their illness or not. In all my life I have never seen the like of care that is in place now.
- We were told grandma was medically fit for discharge and had been assessed and would need no extra support after discharge. She was sent home at 10pm in the evening by 4am we were contacted by the on-site support staff to say she was extremely poorly and needed more support than they can provide. The following morning the hospital at home team advised she needed to return to hospital, but she refused. she was dead the following week following a short period of palliative care at home.
- I was told I was going home Monday by Ambulance as I couldn`t get in car, then Tuesday, Then Wednesday at 7pm I asked what was happening, they said ambulance had been cancelled, then about 9:30pm an Ambulance came. Next morning Rapid Response came.
- Rapid response nurse was excellent, arranged for other nurses to come and check on me.
- When discharged failure to provide necessary equipment No Compression Stockings provided No alternative to ensure reasonable care to ensure no blood clots Only advice was to "walk every hour", queried! During sleep answer was "should be okay!"
- Waited 6hrs for chest x ray, from 3pm - 9:30pm before discharge Also on day of discharge no water test or stool test has been done until Chemo nurse arrived to make sure this was ordered. Results given prior to discharge and 2nd antibiotic infusion.
- Being moved in early hours of the morning was disturbing and no information as to why!
- More after care should be given and guidance on how to dress infected areas following an operation. a simple phone call would suffice.
- Discharged at right time but no after care or support.
- Timings, people not aware of how long they are going to be waiting for, usually transport issue but also meds. More secluded bays, poorly patient and dignity.
- Everything went very smoothly.

- The Stroke team were very, very professional, and friendly. The support was smashing and very reassuring, I enjoyed their visits.

15) After discharge – Did you receive an adequate supply of medication to take home from hospital?

Yes	No	Total Responses
16	14	30

Comments

- They were not ready, so the nurse dropped them off after her shift as she lives in Hartlepool.
- No, I had to contact GP. In the end visited A&E and they sorted out for me.
- Not from North Tees, we had to ask James Cook to step in and help.
- The pills I had when I was admitted disappeared. I am trying to get to get my doctors to replace them if not I'm going to have no medication for blood thinners and my pills for cancer.
- I had to wait for my GP to prescribe medication.
- Some items were not available and had to be obtained the following day.
- No compression stockings available on my ward Nurse stated, "just keep walking around every hour at home, should be okay!" during sleep? No alternative discussed or given.

16) If you needed adaptations to your home or equipment, were they provided and in place before your return home?

Yes	No	Total Responses
5	12	17

Comments

- Visit arranged for minor adaptations.

17) If you were discharged to your own home, what arrangements had been made to ensure you were safe?

Arrangement	Yes	No
House warm and basic food stuffs provided	4	3
Care and support package immediately reinstated	1	1
New care and support package to assist my recovery immediately started	0	7

Comments

- Visit from therapist arranged.

18) Overall, how would you rate the care you have received since being discharged?

Rating	Number
Excellent	6
Good	4
OK	6
Poor	5
Very Poor	5
Total	26

Comments

- Rachel (Hartlepool Deaf Centre) recently got involved with a patient who was discharged from ward 41 (or 42?) following a stroke, he was blind in one eye and his good leg affected (he was born with cerebral palsy so already had mobility issues). The whole time he was on the stroke ward a BSL interpreter was not booked. When he got home, he had to go and purchase his own walking stick. He recently had a second stroke and Rachel was asked to help, made sure interpreters were booked and advised the family of his rights.
- My mam was not treated as a person and the lack of care given was disgusting. I'd never heard of someone going into hospital so poorly and being discharged in the same condition.
- There was no support once my relative was discharged. We were left to our own devices with the care home.
- Needed a casual comment to my GP practice nurse (who I was speaking to on a totally different matter) to set the ball rolling. She was surprised that no one had been in touch with me and set to and organised things.
- When discharged home, I was supposed to have OT assessment straight away, but this didn't happen, family purchased items needed, raised toilet seat, and grab rails for assistance getting on and off toilet, brought bed downstairs to be used, was chased up with GP/Social Services and told there was a list and we had to wait, when OT finally came approximately 6 weeks later they said they should have been told to come much earlier.
- Did not see OT until 6-7 weeks after discharge, equipment bought privately as needed straight away. My family looked after me, and called daily, they brought the bed downstairs, purchased grab rails, and raised toilet seat, OT came later and arranged chair raisers and another raised toilet seat for the other toilet.
- Not good, I have received no support whatsoever.
- Chemo Unit Nurses: follow up call twice on day of discharge I was given copy of Dr's ward notes by mistake, luckily no shocks, however part did say in palliative care, this thankfully wasn`t needed - but to see this B+W paper was disturbing. Correct papers given at 2nd attempt to discharge.

- Where applicable at least a time window of discharge some equipment provided. No home Occupational Therapist visit prior to discharge, when family inquired, the Doctor stated this would "hold up discharge" as only available twice a week!
- We got no paperwork or told if I would need any treatment in out-patients, so just wait and see!
- My care from Hartlepool Council has been excellent, carers have been excellent. Carers are friendly, kind and show great compassion. I was very impressed with the care I had; I am now with another group of carers who are always excellent workers in what they do!

19) Please tell us which age range you belong to?

Rating	Number
Under 18	0
18-24	0
25-34	1
35-44	4
45-54	1
55-64	7
65-74	6
75 +	15
Total	34

20) What sex are you?

Rating	Number
Male	8
Female	24
Prefer not to say	1
Total	33

21) Please tell us the first part of your postcode

Postcode	Number
TS24	12
TS25	14
TS26	7
Total	33

22) Please describe your ethnic origin

Ethnic origin	Number
White UK	36
Total	36

Key findings from care home questionnaire

- A questionnaire asking for feedback on recent experiences of hospital discharge was circulated to residential care homes in Hartlepool during our investigation.
- 5 completed questionnaires were returned.
- 4 homes reported that very little information/no is received regarding patient progress whist residents are in hospital. When wards are contacted, quite often calls are not picked up.
- 1 home reported that there had been occasions when residents had come back to the home without them being made aware they were being discharged that day.
- Cut off times for resident arrivals are frequently not adhered to, which can cause difficulties with the completion of necessary paperwork and medication. Homes reported that as a rule they do their utmost to take residents back. However, this can be particularly problematic if the person is a new admission to a rehabilitation setting.
- Changes to resident's medication are sometimes not correctly shown on the discharge letter.
- Wards do not always follow discharge protocols and occasionally Section 2 paperwork, confirming patient is medically fit is not forwarded to the discharge team.
- 3 homes commented that there had been occasions on which they had concerns about the resident's fitness to be discharged when they returned.
- 1 home commented that discharge notes are not always received, and that DNAR's are not always returned.
- Communication is a vital ingredient of safe and effective discharge.

Overall findings from care home questionnaire

Care Home Questionnaire

Five responses were received from care homes.

1) **While residents are in hospital/rehabilitation are you kept informed of their progress and made aware of when discharge will take place?**
Yes
No (b) (c) (d) (e)
Sometimes (a)
Comments

a) We will contact the hospital for updates on our residents. We will speak to ward for full handover when discharge has been agreed and gone through hospital discharge team. We will not expect anyone back unless they go through discharge team.
b) Families keep us up to date, but the ward does not. We do not hear anything from them until they try to discharge the resident, or they need information for us. When we try to ring the ward for an update either no one answers the phone or when they do, you just get told they are comfortable.
c) Usually given minimal information regarding discharge.
d) We do phone and enquire; we will be told when they are fit for discharge most of the time. We often get updates from the family.
e) We contact the hospital, sometimes the patients will turn up back at the home without staff being aware they are arriving back.

2) Is there a time in the day after which you do not accept discharges back into the home?

a) Yes 18.00
b) Yes 16.00
c) Yes, 18.00
d) Yes, 17.00
e) No response, see below.

If yes, are you ever asked to accept residents after this point?

a) No, they always ask when our cut off to accept residents into the home is.
b) On most discharges they ask us to extend the cut-off point. We have an early cut off point to allow us to be able to contact other health professionals or the ward if needed as their discharge notes are not clear or we have to query medication doses.
c) Residents often turn up on patient transport after this time.
d) Yes, often.
e) If the patient lives here, there are no set times for return. If it is a new admission, we ask for 5pm cut off time. A lot of times this is exceeded by the hospital, and they are turning up late which does cause difficulties for staff as they have all the medication to sign in and check as well as admission paperwork which needs completing on arrival. Yes, we are also asked to accept later.

3) Prior to a resident being discharged back to the home, are you informed of the following -
Changes to medication

Yes (a) (c)
No (e)
Not always (b) (d)
New therapy requirements
Yes (a) (b) (c) (e)
Not always (d)
New equipment requirements

Yes (a) (b) (c) (e)
Not always (d)

Comments

a) We are always asked if we have enough medication, and they will send a supply of any new medication.
b) Often the discharge letter says nil for discontinued medication, but when you look at the discharge note list of medications, half have changed or stopped.
c) Sometimes not advised of medication changes.
d) Yes, at times, but not often, we do try to go out to the hospital prior to discharge.
e) Medication changes are always on the discharge letter from the hospital and that is how we would find out.

4) **Do social workers contact you while residents are in hospital regarding care and discharge arrangements?**

Yes (e)
No
Sometimes (a) (b) (c)
Very Rarely (d)

Comments

a) Only when ready for discharge
b) Social workers do not contact the home whilst the residents are in hospital. A member of the discharge team contacts the home when the resident is ready for discharge, that is if the ward has followed the protocol and informed the discharge team that the resident is medically fit. Most of the time the home has to tell the ward to send the section 2 paperwork to the discharge team as we cannot accept them back without this if they have been in hospital over 72 hours. Even then, the ward will still try to get out of sending it 7 times out of 10.
c) No comments
d) Very rarely unless change of category.
e) Social workers are really good with communication and discharges and visit regularly. They sometimes struggle with care packages so some will go over their discharge dates.

5) **Have you ever had concerns about the fitness of a residents to be discharged back to the home?**

Yes (b) (c) (e)
No
No response (a) (d)

Comments

a) No comments
b) Often residents are sent home and are not fully medically fit and bounce straight back into hospital.
c) Resident needs are often not consistent with discharge information.
d) On occasion.

e) Yes, there have been quite a few occasions, where we have rung the ambulance back for the service user within a few hours as we have had concerns.

6) **Do you have any step down/rehabilitation beds?**
Yes (e)
No (b) (c)
No response (d)
Comments
a) We will accept residents.
b) No comments
c) We have stopped using these beds due to poor discharge information and compromising the care of existing residents.
d) Yes, if available.
e) Yes, to aim to see if service users need 24-hour care or if they can return home with support.

7) **Is there anything else you want to tell us about your experience of hospital discharge and any suggestions you have as to how the process could be improved?**
Comments
a) Better communication and more information around discharge especially family contacts.
b) The wards try to discharge residents without following protocol by not involving the discharge team at HBC. There should be the same processes for hospital discharge for both Hartlepool and Stockton councils, so that nurses fully understand what process to follow, especially as the hospital discharges are coming from a Stockton hospital. The wards become very annoyed when they are told they need to send a Section 2 to the discharge team before discharge back into the care home can be considered.
HBC discharge team should work weekends to support the care homes with hospital discharges as the ward will often sugar coat what is really happening to the resident and then the home has no one to contact for help or to check what the ward is telling us is correct.
c) Discharge is generally poor, discharge notes do not always appear, DNAR are often not returned to the home, information is often sparce when it is received.
d) Communication is vital.
e) No comments

Overall findings from care provider questionnaire

One domiciliary/home care provider response was received.

1) **While residents you provide care services for are in hospital/rehabilitation are you kept informed of their progress and made aware of when the discharge will take place?**

Yes ☐x
No ☐
Sometimes ☐
Comments

Sometimes residents are sent home without us being informed.

2) **Prior to a resident being discharged back to their home, are you informed of the following -**

a) **The time and date of their return home**
Yes ☐
No ☐
Sometimes ☐x
Comments
Sometimes not notified.

b) **Changes to medication**

Yes ☐
No ☐x
Sometimes ☐

Comments

Quality Officer checks discharge papers.

c) **New therapy requirements**
Yes ☐
No ☐x
Sometimes ☐
Comments

d) **New equipment requirements**
Yes ☐x
No ☐
Sometimes ☐
Comments

3) **Do social workers contact you while residents are in hospital regarding care and discharge arrangements?**
Yes ☐
No ☐
Sometimes ☐x

Comments
Sometimes social worker, sometimes discharge team.

4) **Have you ever had concerns about the fitness of a resident to be discharged back to their home?**
Yes ☐

No ☐X
Comments
Couple of incidents in the past Quality Officer has gone to first visit and CIAT or OT need to be contacted.

5) **If a resident needs to spend time in a step down/rehabilitation bed before returning home, are you kept informed of their progress and discharge date?**
Yes ☐
No ☐
Sometimes ☐x
Comments
Progress no, discharge yes

6) **Is there anything else you want to tell us about your experiences of hospital discharge and any suggestion you have as to how the process could be improved?**
Care provider must be kept in the loop especially on discharge to their home or short stay/residential care.

Key findings from Discharge Hub visits

During the consultation period two visits were conducted to the Discharge Hub at North Tees Hospital. These visits took place between 10am and 1pm on Wednesday 25th January and 1pm and 4pm on Thursday 26th January. The visits gave us the opportunity to speak directly to patients about their time in hospital and their discharge arrangements.

We were made aware that a Transport Hub had also recently opened, located near to the main entrance to North Tees Hospital. On both visits occasions we visited the Hub, but no patients were present to speak to. The Transport Hub is specifically for patients who are just waiting for transport and already have medication and their discharge letter. We heard informally that patients who have used the new transport hub have given favourable feedback as it is located close to the shop and Costa Coffee and when relatives pick up patients this can usually do so without having to pay for parking.

A summary of the key findings made during our visits to the Discharge are shown below -

- All the patients we spoke to were very positive about their experience of care whilst in North Tees Hospital. They also felt well cared for by the staff and volunteers within the Discharge Hub.
- The Discharge Hub is in a former gymnasium and is a shared facility with cardiac patients. The toilet is accessed via the cardiac section of the facility. It gives the impression of being a clinical environment, seating is of one type and not ideally suited to all patient needs.
- The Hub was staffed by 1xnurse and 1xHCA on the first visit, and 1xnurse, 1xHCA and 2xhospital volunteers the second time we visited.
- On our first visit an elderly female patient was in a hospital bed in the Discharge Hub. She was waiting for transport by ambulance back to a care home. She

appeared to be very frail and was asleep most of the time. Concerns were expressed by other patients about lack of dignity of the patient.

- On our second visit an elderly male patient was brought to the lounge. He was unclear about where he was being discharged to or of ongoing post discharge care arrangements. He was somewhat confused as to the reason he had been in hospital, but said he thought he was admitted about ten days ago.
- There are no private areas in Discharge Hub and all conversations can be overheard.
- There was a good range of information on the noticeboard relating to hospital discharge and what will happen next, but no newspapers or reading material for patients, although there is a TV.
- Most of the patients we spoke to were wearing night clothes and dressing gowns.
- The most frequent causes of delay were waiting for medication to arrive or waiting for transport. Patients who were being picked up by family members or friends commented that not having a time when they would be discharged made this difficult to co-ordinate.
- Most patients on the days we visited were in the Hub for at least 90 minutes, with several experiences waits of two hours or more. Waiting times when patients required ambulance/hospital transport were particularly long.
- No patients were discharged from the new Transport Hub over the course of the two visits.

Summary of Findings from Discharge Hub Visits

A summary of our discussions with patients awaiting discharge over the course of our two visits is shown below, together with some general observations about the Discharge Hub.

Discharge Hub Visit – 25th January 202310am -1pm (Stephen Thomas & Bernie Hays).

On arrival when visiting the Discharge lounge, we were greeted by Stacey Rutter {clinical lead). Introduced to the nurse in charge and HCA. We then discussed the discharge process, from the patient's admission to discharge and the five stages of the discharge triage process.

Observation of Discharge Lounge

As you entered the entrance door, on the right was a fridge with snacks for the patients and hot drink facilities. The cold-water machine was behind the nurse station.

In the centre of the room was the nurse station. Behind the nurse station it was partitioned of for patients who required cardiac medical input.

The seating area for the patients awaiting discharge had four chairs with a round table in the middle, with the same seating arrangements with another four chairs and a table.

Within the patient waiting area, there were posters, information, contact numbers for support service and outside agencies.

There were three hospital beds to the left of the seating area within the discharge seating area.

All conversations could be heard from the nursing/clinical staff discussing patients discharge. Also, conversations could be heard from patients speaking to family members etc due to the seating arrangements.

Patients were brought down from the ward to the discharge lounge in their night wear and dressing gown.

One patient had come from A&E transported in a hospital bed to the discharge lounge. There was only one Nurse in charge and one HCA who was looking after that patient as well as looking after the patients awaiting discharge.

Patient A

Consent gained: introduced self and reason for the visit.

Patient was admitted to hospital for further investigations. They had been informed the day before that they were to be discharged home the following morning and an ambulance had been booked to take them home. Very happy with the ward staff and discharge plans.

On the morning of discharge, the patient had been up from 7am washed/dressed sat out on the ward in a chair, unable to give time for ambulance transport home.

Taken to discharge lounge at 11.00am sat out in chair, had medication and discharge letter.

Discharge arrangements had been discussed with a family member and a hospital profiling bed and a commode had been delivered to patient's home for discharge.

Found it distressing as liaising with family member and unable to inform them when ambulance transport was to arrive.

Patient suggests if they had a time frame for ambulance transport, they would feel better as all they wanted to do was to return home.

Drinks and snack had been offered. Patient was still awaiting ambulance transport at 1pm

Patient B

Consent gained: introduced self and reason for the visit.

Patient B arrived in the discharge lounge appearing distressed and tearful. Able to hear the conversation between patient and clinical lead. The patient was asking for a taxi to go home, however had to await medication. The clinical lead reassured the patient that they would go and collect the medication for the patient.

The patient eventually settled, and I asked the patient if they required a hot drink as noted that the Nurse and HCA were busy seeing to another patient who had been brought to the discharge lounge in a hospital bed, observed getting fed by the HCA and assistance from the nurse in charge.

Patient had been in hospital three days. On the second day the patient was informed they were going to be discharged home the next day. On that evening the patient was transferred onto another ward, however, would have much preferred to stay on the same ward as was going home the next day.

Family members were informed of the discharged plan as they were to transport them home.

The patient was taken to the discharge lounge as awaiting medication and informed it would be ready when they were to be taken down.

You could hear the patient's conversation with the family member. Informing the family member that they were waiting for medication.

The family member arrived to collect the patient, however, was informed by the patient was still awaiting medication. The medication arrived within 5 minutes,

The patient was supported by family member and staff to the family members car.

Patient C

Consent gained: introduced self and reason for the visit.

Patient happy with discharge plans. All discharge plans discussed with patient and family.

Patient was discharged from the ward to the discharge lounge.

Discharge letter and medication was issued for discharge.

They were given all information and happy with discharge process.

They were informed that they would have to wait for patient transport and would be taken to the discharge lounge.

They were offered drinks and snacks and felt that the room was warm and happy to wait for transport to take them home.

Patient appeared to be tired, had been up early although happy to have a short conversation. Was really looking forward to going home back with family.

Patient D

Consent gained, introduced self and reason for visit.

The patient was male and aged 65-75. He had been in North Tees Hospital for one week with gastro-intestinal problem (Ward 27?). His discharge had been discussed with him several days earlier and he was aware of the arrangements. He was very happy with the treatment he had received and said, "it couldn't have been better." He said that he was taking warfarin that there may need to be changes for a short period due to the medication he would have to take during his recovery. The doctor from the ward from which he had been discharged had not been able to speak to him before he came to the hub but did call in to explain what would be happening regarding medication. The patient had a pre-existing warfarin clinic appointment the following day at which adjustments would be confirmed.

The patient had arranged for his son to pick him up and was going to phone him and ask him to come as soon as he received his medication. On leaving the patient was still waiting and had been there for over 1 hour.

Discharge Hub Visit – 26th January 2023 1pm-4pm (Stephen Thomas and Tony Leighton)

On arrival we were greeted by the nurse in charge. There was also an HCA, and two hospital volunteers present. We had a short discussion about Healthwatch, the work we do and our current activity around hospital discharge.

Observations of Discharge Lounge

As above for general layout and detail. Two hospital volunteers were also present for most of the visit.

Patient A

Consent gained, introduced self and reason for visit.

The patient was female and aged 75+. She had been in North Tees for approximately five weeks after collapsing at home and said they also had memory issues. They had been on several wards but could not remember which. They said that their discharge arrangements had been discussed during the last few days and that they were initially being discharged to a care home for a period of rehabilitation but were unsure of its name. They were very happy with the care they had received but said the food had been "awful" and felt they had not been given much information about their discharge.

The patient had received their discharge letter and medication and were waiting for transport (ambulance) to take them home. They were still in the lounge when we left and had been there for over one hour. They said that they had been offered refreshments and had been well looked after by staff and volunteers in the hub. They were however not happy that they had not been given a time at which their transport would arrive.

Patient B

Consent gained, introduced self and reason for visit.

The patient was male and aged 75+. He had been in North Tees for around 10 days but was unsure about the exact length of time. He was unclear as to the reason for his admission but thought it was "memory" related. He was very unclear about his discharge arrangements, he said he thought nurses had spoken to him about arrangements but could not recall details. He also said he was not sure whether he was being discharged to a care home or to stay with his daughter. (Asked nurse who said the patient was being discharged to Sheraton Court).

He had received his medication and was waiting for transport which was being provided by a volunteer driver. (Not sure about discharge letter). He said he had been treated well during his stay in hospital and had been offered refreshments on arrival at the hub. He said he was comfortable, but very anxious about what would happen next and how long he was going to be in the hub.

Patient C

Consent gained, introduced self and reason for visit.

The patient was female and aged 75+. She had been in North Tees for approximately 18 days, initially in Ward 24 and then on to Ward 28. She had initially been admitted with pneumonia and respiratory issues and her discharge arrangements were first discussed about 4 days ago. She said her discharge plan had been arranged, she had her discharge letter and dates had been arranged for her to attend respiratory clinic. She lived alone and was due to be discharged back to her home with a care package in place. She said

her care had been very thorough and both wards had been very helpful and lots of information had been provided.

The patient was waiting for her medication to arrive, and a volunteer driver was going to take her home. She had been offered drinks and a sandwich on arrival in the Hub but had not been told how long her stay was likely to be. She said she was fairly comfortable but really wanted to be back at home and said she was hoping for a "quick getaway!"

When we left at 4pm she had been in the Discharge Lounge for around one hour and was still waiting for medication to arrive.

In addition to our two visits to the Discharge Hub in January, we were also able to have a discussion with a patient during a preliminary visit in November.

Discharge Hub – Introductory Visit: 9th November 2022 (11am – 11.30am)

Patient A

Consent gained, patient awaiting discharge in the discharge hub.

Introduced self and reason for the visit. Patient (A) happy to discuss discharge plans. Patient (A) was sitting in the Discharge Hub. They had been in hospital approximately five days.

Patient (A) was happy with the care provision on the ward and the discharge plan. Patient had arranged with a family member to transport them home and would collect them at a certain time when finished work (within a 2hr window). Patient discussed this with the ward and was told that their medication would be issued to them on time.

Patient suggested that she had her discharge letter and pointed to a yellow envelope. However, I was aware that was not the discharge letter and was DNAR. Spoke with patient and with prompts was aware had spoken with doctors about DNAR and made aware that this was in the yellow envelope.

Patient stated that they were offered hot drink and snack while they were waiting.

They said that this time their experience of discharge had been excellent, but previously they had been in the discharge lounge for several hours awaiting medication and discharge letter.

Left patient comfortable awaiting discharge letter and medication and to be collected by a family member.

Recommendations

1) Communication and involvement of patients in planning their discharge and subsequent post discharge care arrangements happens consistently as per the requirements of the North Tees and Hartlepool Discharge Policy Framework and guidelines contained within the Hospital Discharge and Community Support Guidance (DHSC – March 2022).
2) Improved information outlining the discharge process is produced and made available to all patients entering North Tees and Hartlepool Hospitals for non-elective procedures. We recommend that the Wirral NHS Leaflet – Your Discharge Explained as an example of good practice. A copy of the leaflet can be found at Appendix 1.
3) Ensure Patients are informed of the availability of post discharge support services such as the Community Respiratory Service that is available specifically for those with breathing difficulties and COPD. This will help to reduce patient readmissions to hospital and facilitate effective recouperation.
4) Alternative/easy read formats should be produced of all discharge related materials and support such as interpreters booked to ensure Deaf patients and patients with other languages and support needs are not excluded.
5) Ensure that the principles of John's Campaign are consistently integrated into discharge arrangements in order to maximise support for patients who are living with dementia and similar conditions.
6) Wherever possible, patient transport and medication requirements should be finalised and in place in advance of the day the patient is due to be discharged.
7) Current operational practices relating to the Discharge Hub and Pharmacy should be reviewed, and the potential to use of Hospital Volunteers to collect medication maximised in order to reduce medication related discharge delays.
8) Unless there is a justifiable reason not to do so, patients discharge should be via the Discharge Hub or Transport Hub in line with national guidance.
9) Consideration should be given to the suitability of the current location of the Discharge Hub, and efforts made to find a more appropriate bespoke location which gives patients a more comfortable and dignified experience.
10) Staffing levels should be reviewed together with the wider review of the Discharge Hub arrangements recommended above. Levels of occupational therapy and physiotherapy support should also be at a level which ensures equipment required by patients to assist their recuperation is in place and available when discharged home in order to minimise the possibility of re-admissions.
11) Consideration should be given to improving communication with care homes and care providers to ensure the best possible transfer of care arrangements are always in place. We suggest that a workshop should be considered, at a future Care Managers Forum which is facilitated by Hartlepool Borough Council, focusing on how future communication processes between the Trust and care sector can be developed and improved in relation to discharge and other shared arrangements. Healthwatch Hartlepool are willing to be involved in the design and facilitation of the event if required.
12) That Healthwatch Hartlepool and health and social care colleagues involved in the delivery of the patient discharge pathway meet in six months to review progress.

Acknowledgements

Thank you to everyone that has helped us with our consultation including:

Members of the public who completed our survey and shared their views and experiences with us.

People who attended and contributed at our various consultation events.

Staff from North Tees and Hartlepool Foundation Trust and Hartlepool Borough Council who have assisted us at every step of our investigation.

Our amazing and dedicated volunteers without whom this investigation would not have been possible.

References

1) Hospital Discharge and Community support Guidance
   DHSC – March 2022
2) Quick Guide: Discharge to Assess – Transforming Urgent and Emergency Care Services in England.
   NHS England Publication – Gateway Reference 05871
3) NICE Guidance ng27 - Transition Between in Patient Hospital Settings and Community or Care Home Settings for Adults with Social care Needs
   www.nice.org/guidance/ng27
4) NHS England London Region – Discharge Improvement Programme
   Emergency Care Improvement Support Team – December 2022
5) Nice Guidance ng74 – Intermediate Care Including Reablement – September 2017
   www.nice.org.uk/guidance/ng74
6) North Tees and Hartlepool NHSFT
   Integrated Discharge Policy
7) Healthwatch Hartlepool
   Hospital Discharge Report – 2014
   www.healthwatchhartlepool.co.uk
8) John's Campaign
   https://johnscampaign.org.uk
9) Developing a Capacity and Demand Model for Out of Hospital Care
   Local Government Association 2021

Appendix 1

WIRRAL NHS

Your hospital discharge explained

Planning your hospital discharge together

Our number one priority is to support you in your safe recovery so you can return home as soon as you are medically well and able. It is important that, together, we plan for your discharge right away.

We will give you a 'targeted discharge date' and agree your discharge plan with you within 48 hours of you being admitted. This will cover anything that you might need such as transport, equipment and any other areas of support and help.

Planning your discharge with you, your family or carer helps us to make sure you leave hospital in a safe and timely manner. You will only leave when you are medically well and it is considered safe to do so by your medical team, as we all know that, when you no longer need hospital care, you will recover far better at home or in your community location.

Why your hospital discharge is important

When you no longer need hospital care, it is better to continue your recovery at home or at another location in the community. This is because:

Nobody wants to stay in hospital any longer than is necessary.

Being in hospital with others who are unwell can sometimes expose you to infection.

Extremely poorly patients may not be able to access an urgent hospital bed if they are occupied by patients who no longer need them.

Meaningful and accurate assessments of your needs, as well as long term decisions about your care, are better made when you are outside of the hospital.

For people who are aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting.

How you can help with your discharge

It is very important that you ask 4 questions every day when you see the team caring for you:

It would also help if you could make sure you have outdoor clothes and your house keys available for when you do go home. We can arrange a packed lunch for you to take home (just ask) and we can provide a Statement of Fitness for Work (sick note) if you need one. If there is anything else that we can help you with to ensure a speedy return home, please let a member of the care team know straight away.

On your discharge day

We will always aim to get you home early on your day of discharge rather than keep you in hospital for longer than necessary. The exception is if you are using hospital transport, which will mean you will be transferred to our Discharge Hospitality Centre where you might wait for your medication or transport.

Hospital transport

This is only available for people who meet very strict medical criteria, something your nurse will be happy to discuss with you.

Please remember that if you are not eligible for hospital transport, you will need to arrange your own transport home.

Your medication

Medication you brought into hospital and still need will be returned to you before you leave. If you started new medication during your stay, you will be given a supply to take home. Your GP will prescribe more if required.

We will explain your medication to you before you leave. Each new medicine will have an information leaflet telling you what it is used for and possible side effects.

What you can expect as our patient?

1. A named person to coordinate your discharge

You will be given the name of a person on the ward who will answer your questions and support you throughout your stay in hospital.

2. Right to high quality information and support

If you are discharged to your home with support, or to a community based location, the NHS and local authority will do all they can to help support you in your decision making and keep you informed. This means:

- You will be involved in all decisions about your ongoing care and treatment and given clear information. While NHS care is free, certain types of social care are not. A hospital social care worker or discharge coordinator can discuss what this might mean for you.
- You will be informed about where you can access information including support services by your healthcare team. Advice can also be sought from hospital and Healthwatch staff who work in the 'Information Bank' located on the ground floor of Arrowe Park Hospital.

3. Interim care arrangements

If you cannot be discharged to the place you were admitted from, we will arrange a short term placement for you at one of our partner care locations, until you can return home. We also arrange short term placements if your package of care is not available in time for you to return home. You will not be able to remain in a hospital bed as this will be needed for other unwell patients. This will also happen if:

- Your preferred choice of care home is not currently available
- You have not yet made a decision regarding your long term care
- You are waiting for assessments to be carried out or funding agreements to be made.

After you are discharged...

Follow up appointments

If you need a follow-up appointment or any further investigations, we will arrange this before you leave, or will contact you as soon as we can when you get home.

When you are discharged, we will send a letter to your GP explaining the reason why you were in hospital. This will tell your GP everything they need to know about your stay in hospital, your medication and your discharge location.

Help at home

If you need help at home when you are discharged, community support services will be arranged before or upon your return.

Information for carers and family members

If a family member or a friend cares for you on a regular basis, they can access free support and advice from Wirral charity WIRED and may be eligible for a carer's grant.

For information **call 0151 670 0777** or text the word **CARER** to **87007**.

If you would like a copy of this leaflet to be given to someone else, please speak to your nurse or discharge coordinator.

Further assessments

Once you have been declared medically well, you may require further health and social care assessments. These will be completed outside of the hospital setting and wherever possible, within your own home. Our 'Home-first' pathway has a range of services in place to help you to return safely to your own home. If we can't assess you in your own home, your assessment will take place in one of our 'Transfer to Assess' bed-based locations in the Wirral community.

If you prefer, you can complete an on-line social care self-assessment or a carer's assessment at **wirral.gov.uk/needsassessment** or via telephone on **0151 514 2222**, option 3.

If you have a concern

We hope you are happy with the way we have cared for you during your stay. If you have any concerns with the information, support and options you have been given and want to make a complaint during your inpatient stay, our ward staff will be able to advise you what to do.

The NHS Friends and Family Test

We want to make sure you have the best possible experience of care with us, so it is extremely important that you let us know how well we are performing. The NHS Friends and Family Test is an easy-to-understand feedback questionnaire that we ask you to complete either before you leave hospital or soon after discharge. Completing it helps us to make meaningful improvements to our services.

If you have any questions about The NHS Friends and Family Test please ask a member of staff.

Infection control

To protect yourself and others, we ask that you clean your hands with soap and water, or with the hand gel provided, especially after using the bathroom and before any meals. Please encourage your visitors to clean their hands too. And finally, if any friends or family are unwell, they should not visit you until they are fully recovered.

This information is provided to you by:
Wirral University Teaching Hospital NHS Foundation Trust
Wirral Community NHS Foundation Trust
NHS Wirral Clinical Commissioning Group
Cheshire and Wirral Partnership NHS Foundation Trust
Wirral Council