healthwatch
Wigan and Leigh

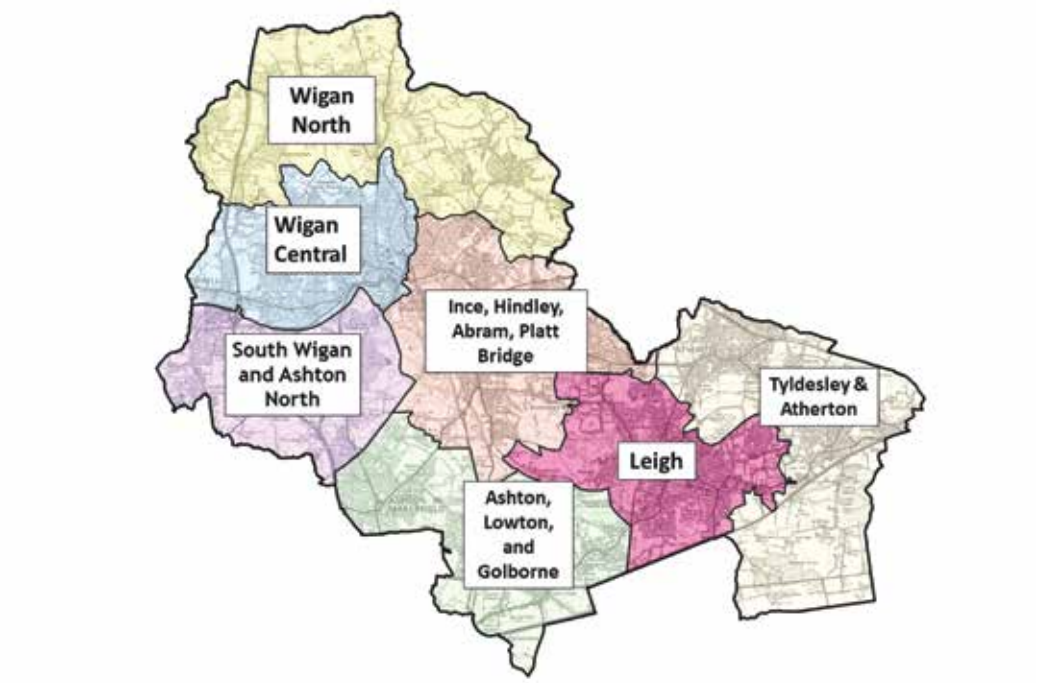
Delayed Discharge from Hospital

‘No Right To Reside’ - An Exploration of the experience of patients awaiting discharge from hospital and their relatives

www.healthwatchwiganandleigh.co.uk
01942 834666

About Us

Healthwatch Wigan & Leigh is your local health and social care champion. Healthwatch Wigan and Leigh are the independent voice for the people of the Wigan Borough. We are the independent 'consumer champion' for health and social care. We exist to help the people of this borough to have influence and a powerful voice in how services are run and how they can be improved. The map shows the seven Primary Care Networks (PCN's) across Wigan Borough. A PCN is where General Practices work together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups of practices.



Healthwatch Wigan and Leigh exist to:

- Help people to make informed choices about health and social care options that are available to them.
- Listen to the views and experiences of local people about the way health and social care services are commissioned and delivered.
- Allow the people of this borough to have influence and a powerful voice in how services are run and how they can be shaped and improved.
- Influence how services are set up and commissioned by having a seat on the local Health and Wellbeing Board
- Share local intelligence with Healthwatch England and Care Quality Commission.

Executive Summary

This was a detailed project aimed at seeking the views of those patients and their relatives considered to have 'no right to reside' in hospital as they had completed their medical treatment and were fit to be discharged. The focus was specifically on the hospitals and community bed-based provision run by Wrightington, Wigan and Leigh NHS Trust.

We spoke to patients on wards at the Royal Albert Edward Infirmary, Leigh Infirmary and the two-community bed-based services commissioned by Greater Manchester Integrated Care Board providing Intermediate Care, Discharge to assess services and stroke rehabilitation. Patients were identified to us from the 'No right to reside' list and were able to give their consent to share their story. Patients and relatives told us that the discharge process was complex and confusing. Communication proved to be difficult, and it felt that there was no joined up working or coordination. Multiple moves around the hospital and into community services led to confusion, miscommunication and lack of any continuity which inevitably led to duplication. In addition, patient and relatives made comment about deconditioning and the impact on mood as patients lack stimulation in hospital.

Executive Summary Continued...

There are multiple teams involved in discharge planning and there seemed to be a lack of understanding of roles and responsibilities by some teams and ward staff. Ward staff expressed particular frustration at feeling distant from the discharge planning process for their patients. Patients told us of having to repeat their story many times, of feeling that their wishes were not listened to and often overruled either by family members or staff as 'they knew better'.

Concerns were expressed by patients and relatives about the amount of therapy available on both the discharge ward and in community services as this was not made clear. In fact, they were often led to believe they would receive more intervention than was the reality. There has been some informal feedback to WWL NHS who have welcomed our findings, and they have been given the opportunity to respond to the content of this report.

Introduction

Delayed discharges from hospital hits the headlines every winter when demand for acute hospital services increase. There are numerous studies relating to this issue, but these largely focus on what happens to patients on the day of discharge identifying problems relating to transport and awaiting receipt of discharge medication.

Once a patient has completed their treatment and is ready for discharge, they will be assessed against the 'right to reside' criteria. If they no longer meet this, they are deemed as having 'no right to reside' (previously known as bed blocking) in a hospital bed and need to be discharged to either their own home or alternative place of care as identified in the 4 NHS England pathways below:

- **Pathway 0:** discharges home or to a usual place of residence with no new or additional health and/or social care needs

- **Pathway 1:** discharges home or to a usual place of residence with new or additional health and/or social care needs

- **Pathway 2:** discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.

- **Pathway 3:** discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances.

Whilst it is acknowledged that most patients are discharged from hospital in a timely manner and with appropriate support arrangements in place, there is a group of patients who unfortunately become 'stuck' in the system through no fault of their own.

On the 29th of February 2024 there were 121 patients in hospital under the care of Wrightington, Wigan and Leigh that were deemed to have 'no right to reside' (NHS England). These patients were those following pathways 1 to 3 but most often in 2 and 3.

Section 74 of the Care Act 2014 states that:

'where a relevant trust is responsible for an adult patient and considers that the patient is likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after, begin making any plans relating to the discharge, take any steps that it considers appropriate and to involve the patient and their carer or family member'

It is known that delays in discharge to a patient's home or identified and agreed alternative setting can and does have a negative impact on the individual on both their physical and psychological well-being. Often this can result in deterioration in both health and function and may in some cases prevent a return to the patient's previous residence.

This project gives the opportunity for patients and carers to have their views heard by an independent organisation working specifically for the residents of Wigan. From the point of view of the patient, we wanted to hear what was going well and what, if anything, could be made better.

The aim of the project was to identify and engage with those patients and where appropriate, their carers, identified as having 'no right to reside' awaiting discharge from those NHS delivered and commissioned services in Wigan from Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary (Jean Hayes Unit) and Intermediate Care and Discharge to assess services at Richmond House and Bedford Care Home. In addition, the views and experiences of patients utilising the discharge lounge at the Royal Albert Edward Hospital were sought.

Our Key Objectives

• Enable local people to monitor and scrutinise the standard of provision of local hospital-based health services, particularly related to discharge from hospital.

• Obtain the views of patients and their relatives/carers regarding their experiences of discharge from local hospitals and to make these views known.

• Formulate views on the effects of delayed discharge on patients.

• Determine how patients' needs are met whilst awaiting discharge and make recommendations on whether the local services could and ought to be improved.

• Share these views with Wrightington, Wigan and Leigh Teaching Hospital NHS Trust, Wigan system leaders and Healthwatch England.

Approach

A project lead was identified from HWWL staff and supported by a group of volunteers who were also named HW Authorised Representatives. Members of the group visited the Royal Albert Edward Infirmary, Leigh Infirmary (Jean Hayes Unit), Bedford Care Home and Richmond House to meet patients and any relatives in attendance to talk about their experiences. A particular focus was on:

- **Did the patient have an expected or predicted discharge date?**
- **How long beyond this date had they been waiting?**
- **What were they waiting for (which NHS discharge pathway did they require?)**
- **Had they been involved in decisions about discharge?**
- **Did they feel their pathway could have been different?**
- **What was their experience of using the Discharge Lounge?**

Where relatives weren't present, information leaflets were left offering the opportunity to share their experiences with HWWL.
The patient interviews took place between July and October.
It very quickly became clear that the views of staff were important, and, in some instances, staff sought out the HW team to share their thoughts and experiences.

Areas Visited	Teams	Other
Astley Ward	Integrated Discharge	Discharge Lounge Nurse
Acute Stroke Unit	Acute Stroke Therapy Team	Medical Division Matron
Byrn Ward	Transfer Of Care Hub	Ward Based Staff
Standish Ward	Community Stroke Team	Community Matron
Shevington Ward	Intermediate Care Team	Richmond House Intermediate Care Staff
C.A.U	Bed Managers	Bedford CH Dishcarge To Assess Care Staff
Jean Hayes Unit		
Bedford Care Unit		
Discharge Lounge		
Richmond House		

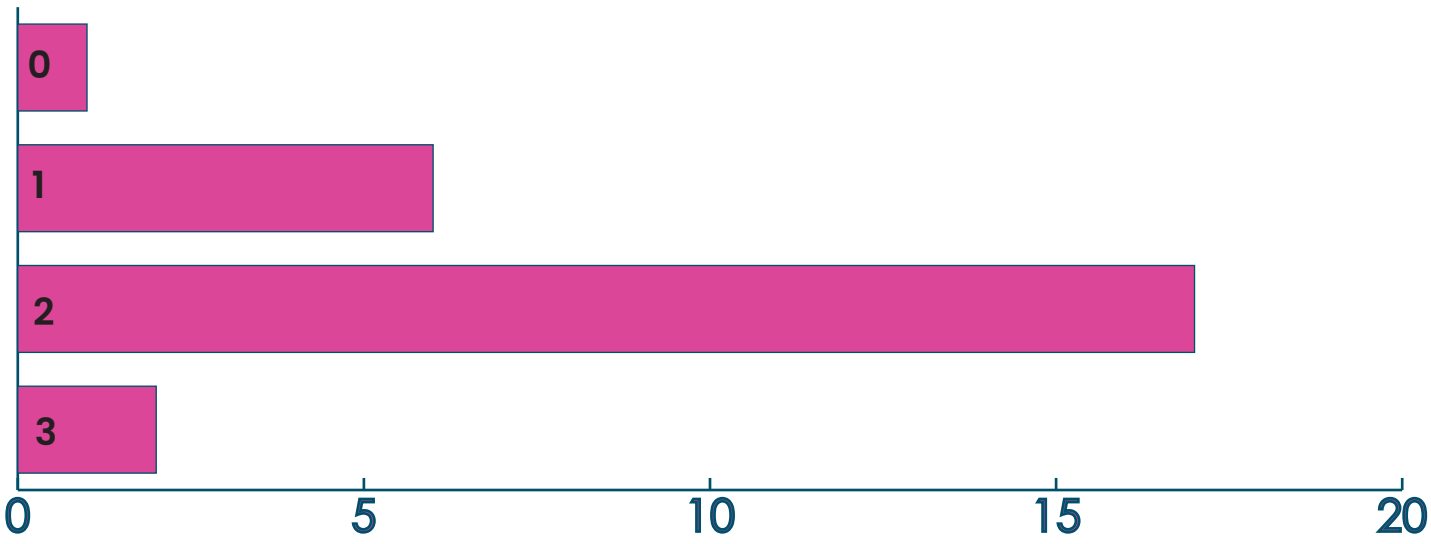
Findings

During this piece of work, we visited:

- Royal Albert Edward Infirmary on six separate occasions
- Leigh Infirmary once
- Bedford Care Home on 2 occasions
- Richmond House on 2 occasions

In total we gained feedback from 36 patients and relatives who were happy to share their experiences with us.
Of the 26 patients we spoke to on the wards at RAEI the discharge pathways were as follows:

- Pathway 0 - 1 patient
- Pathway 1 - 6 patients
- Pathway 2 - 17 patients
- Pathway 3 - 2 patients



Hospital sites (RAEI & Jean Hayes Unit Leigh Infirmary)

Jean Hayes Unit, Leigh Infirmary

The staff and volunteers from Healthwatch Wigan and Leigh were welcomed into the services and received very positive support from senior WWL staff who were happy to facilitate our visits. All the staff we met in hospital across all teams and areas were warm and welcoming. Staff appeared keen to share their thoughts and experiences of the discharge process. They were supportive of our visits and kindly directed us to those patients who were currently experiencing delays in leaving the hospital.

NHS England discharge guidance identifies the requirement to set an expected discharge date (EDD) early in the patient's admission changing to a predicted discharge date (PDD) once medical treatment is complete. However, HWWL noted that for those patients we spoke to, they were often out of date or even absent. The discharge wards were particularly noted not to have an expected or predicted discharge date on the board above their bed.

Royal Albert Edward Infirmary

Whilst all the patients we spoke to had completed their medical treatment and were considered ready to leave hospital, they reported they received little if any 'rehabilitation'. When moving to the discharge ward, they were often told they would receive more therapy which they perceived to be untrue. Patients told us they hadn't been seen by a therapist for days after moving to the ward and then only once or twice a week. The HW team noted patients were often sitting dressed in hospital gowns, occasionally in unsuitable chairs and situated away from facilities. Rehabilitation was very much viewed by patients as relating to therapy staff and it was unclear what if any role nursing and other staff played in preparing patients for discharge home. Patients said:

'I'm fed up'
'The days are boring'
'I feel like I'm waiting for God'

Patients told us they had little involvement in planning their discharge. Some indicated staff had been in contact with their families and whilst some patients were clearly happy with this arrangement, others felt they should be more involved, or that their views were not considered. One family reported:

'We think mum could go home with support, but staff tell us she needs to go to Richmond House or Bedford Care Home'.

One patient reported having her wishes overruled by her family as in the example below:

'A patient who was admitted following a fall and sustained a fracture. Received prompt surgery and rehabilitation on the orthopaedic ward. Recovery went well and the patient was transferred to the discharge ward after one week as deemed ready to go home. The patient had been on the discharge ward for two weeks when a HWWL representative visited. The patient told the HWWL representative they had been expecting to go home more than a week ago, but this plan had been cancelled. The patient wanted to go home, and arrangements had been made with the provision of a bed, chair, commode and care package during the previous week but cancelled as the family felt that the patient wouldn't manage. They wanted further rehabilitation elsewhere, but the patient was mobilizing well on the ward with supervision of 1 person due to the distance to toilet. The next discharge destination was unclear as was the timescale. There was no predicted discharge date noted on the board above the bed. The patient had not been spoken to by staff but said someone had spoken to the family but didn't know who. The HWWL representative spent some time with this patient who was very aware of the situation and was able to fully engage in the conversation. There was no indication that there was any cognitive impairment therefore concern regarding capacity. The patient was very upset that their wishes had been overlooked.'

Communication was of significant concern to both patients and their families. When waiting for transfer to a community service, patients and relatives may have known they were moving elsewhere but didn't always understand where to and why. In fact, one patient thought she was being moved to Bedfordshire not Bedford Care Home in Leigh. Patients and families didn't feel they have any control of the situation or understand the process associated with discharge. They told us: There is no coordination – relatives often felt that they spoke to a number of individuals but said that no one comes together to discuss the situation and agree decisions. When decisions were made, they could then be cancelled without explanation. Some comments include:

- **The doctors don't tell you anything, the nurses and therapists will if you ask them.**
- **We must ask each time we visit. It doesn't feel like there is a plan.**
- **Told there is a plan for mum and equipment will be provided for home but don't know who told us. Now that's changed and she is going somewhere in Leigh!**
- **'We don't know who to speak to about our wishes'.**
- **The plans change when moving wards.**
- **'I don't know what's happening, I just want to go home'**
- **'It's like they speak a foreign language – they use words the common man can't understand'**

One patient raised the issue of repeatedly telling their story to numerous staff:

'I have to keep telling my story to everyone that comes, every day they ask the same questions, with these modern things (? computers) I don't know how they work but don't they look at them? I keep telling them the same thing'.

Patients told us that they were moved around wards within the hospital. Many of the patients reported having been on 3 or more wards by the time we spoke to them. Only two could recall being told why they were moving.

Both patients and staff told us about delays in accessing some services to facilitate a timely discharge. Delays in referrals to Social Workers, Reablement services and waits for mental health assessments were of note. The current system largely limits referral to a SW until the medical staff deem the patient medically suitable for discharge. This inevitably, builds in a delay as there can then be a wait for allocation and assessment, yet it is often obvious to staff earlier in the patient journey that services will be required for discharge. Whilst there is the opportunity to submit an advanced notice for SW assessment, it is unclear if this is always utilised when appropriate.

There was particular concern raised by many staff in ward and discharge focused teams about the number of staff involved in the discharge process. Whilst the Integrated Discharge Team (IDT) coordinate discharges of patients on pathways 0 and 1, the Transfer of Care Hub (ToCH) coordinate those on pathways 2 and 3. Many felt that this led to a fragmented service which at times contributed to delays in supporting patients to return home. There were significant concerns expressed about the functions and relationships between the Integrated Discharge Team and The Transfer of Care Hub. Hospital based staff felt the off-site location of the ToCH staff did not lend itself to timely assessment, appropriate decision making and communication.

The IDT staff tended to be linked to specific wards. Given that patients were moved sometimes multiple times, this disrupts any chance of continuity as the patient is passed on to another member of the IDT.

HWWL felt that there was tension between ward and IDT staff due to competing pressures and possible lack of understanding of each other's roles. Particular frustration was expressed by IDT around the ward staff not always booking transport, arranging discharge medications and letters. However, the IDT reported they have a good relationship with Therapy teams, Reablement and Home First Teams.

Ward based staff expressed their frustrations as to what they viewed as exclusion from involvement in discharge decisions and planning for their patients. They told us that they often faced conflict with relatives as they felt they were unable to provide accurate up to date information. There were also requests for repeated assessments from ToCH when there had been little if any change in a patient's condition. One ward sister told us:

'I know him (patient) really well. He has been on my ward for 7 weeks; they never see him. He hasn't changed from the last assessment'.

The IDT and ToCH use different IT systems for recording information. ToCH can view the Hospital Information System (HIS) but IDT can't view MOSAIC which the ToCH team use. This has led to considerable frustration and time spent chasing people for information. A particular source of frustration for hospital-based staff (both ward and IDT) was when referrals had been made to named Care Homes by ToCH, but this hadn't been shared with IDT and the ward.

Patients who are sent to the Jean Hayes Unit for rehabilitation are on occasions then referred to Bedford Care Home for Discharge to Assess adding further time away from home and potentially adds further duplication as yet another team took over their care.

There were multiple assessment forms to be completed dependent on the location of the patient the referring team. Some use the Discharge to Assess form whilst others require specific referral documents. There appears to be little if any consistency across the services. Staff also reported that each referral inevitably resulted in a delay to the patient as forms were reviewed, triaged and allocated for action.

Community Services (Bedford Care Home and Richmond House)

We made 2 visits per home to Richmond House and Bedford Care Home where discharge to assess, intermediate care and stroke rehabilitation beds are funded via the Integrated Care Board.

In both these facilities, nursing, care and ancillary (catering/domestic services) staff are provided via the care home organisation with visits from NHS therapy teams and District Nurses where required (residential beds at Bedford Care Home).

We spoke to:

- 10 patients at Bedford Care Home on both the residential and nursing units, some had family members present.
- 3 patients at Richmond House

Discharge planning was largely driven and delivered by the NHS health staff with input from ToCH where needed.

There are multiple teams involved:

- Intermediate Care Therapy
- Community React team therapy
- Community Stroke Team
- Moving and Handling Team

NHS community staff told us they use a different IT system to the hospital site. They can access the Hospital Information System but can't contribute to it. The community-based therapy and nursing staff use System 1 which can't be accessed or contributed to by the hospital staff. This creates duplication as assessments that have already been carried out by other teams are often repeated. On the occasions when patients are readmitted to hospital from one of these facilities, hospital staff had no information about the progress made by the patient in the community and therefore the record of their care and treatment is incomplete.

When speaking to patients and relatives in these facilities, there were similar views. Patients often didn't understand why they had been transferred and on occasions informed us that their wishes to go straight home had not been taken into consideration.

'I went to the Jean Hayes Unit from hospital and then was sent here. I think discharge has been done to me – when I was first on the hospital Ward the OT said I was fit to go home as I could walk up and down stairs – but I only did that when supported by two physios. The OTs had visited his house to see how he could cope and arranged for a commode, some fixed handrails and two Zimmer frames (upstairs and down). In Jean Heyes unit the physio support is poor, I was in bed all the time. As I had been in a small room in RAEI for 4 weeks with little movement my mobility was being impaired. I was assessed by an OT whilst there but no real physio support to address my weakening legs.
Working with Bedford Care Home around my discharge seems very positive. However, moving from both RAEI and Jean Heyes I had no real notice or discussion about what was to happen.'

'I went to A&E as I was exhausted and not coping. I wanted to go back home but they sent me here. Physio has talked to me about going home but I don't know when. I think I could have gone straight back home from hospital; I asked to go home. Nothing has changed since I came here. The nurses change the dressings on my legs and physio has taken me up some stairs. Therapy have done a home visit, but I don't know the outcome. I'm well looked after here but it's difficult to talk to people. I'm also missing my glasses and hearing aid as they were left at home.'

Relatives reported having little understanding of the reasons for transfer and had little notice of transfer, and on occasion were not told when a relative had been moved.

'I thought I was going home from RAEI and my granddaughter had arranged a taxi to take me. However, staff on the Discharge Lounge did not think I was fit enough and so I was sent here by ambulance arriving about teatime. My children were away but the staff refused to tell my granddaughter where I had been sent to, which made life difficult for her to arrange to visit me.'

Members of the therapy teams informed us that a lot of their time was taken up with discharge planning to the detriment of clinical rehabilitation. This was particularly stressed to us by the Community Stroke Team. Whilst they input into the 4 stroke beds at Richmond House, they were only able to visit the unit twice per week. There was no gym area or stroke equipment therefore input was very limited. They have reported to HW that they feel these patients are at a disadvantage to those who are discharged directly home where their visits concentrate on therapy. There is also a view held by staff that the current service does not adhere to either the NICE guidelines for stroke or the GM stroke care pathway. We spoke to 3 patients at Richmond House who were on the stroke pathway.

We spoke to 3 patients at Richmond House who were on the stroke pathway. Whilst there was some considerable disappointment about the level of therapy input, there was a more positive view of discharge planning. 2 patients were ready for discharge and had been very involved, 1 patient had only recently been admitted so not yet at the point of discharge.

I went first to Salford Royal for about a week from where I was sent to Wigan. I spent approximately 10 weeks on the stroke unit and have been here now for 4 weeks. I waited 2 weeks to come here. I'm going home next week. I've been very involved in planning going home. Had a meeting with staff and my family. The staff have been lovely and listened to what I think I need and want. They have delivered equipment today and I am having carers four times a day. I've not really had much therapy as they only come here twice a week. Care has been quite good here, especially having my own room. Mealtimes were difficult on the ward due to the odour and the food is better here.

Salford Royal Hospital

One of the biggest criticisms of the community services where that they were all based in Leigh. This created some difficulty for some families, particularly those without access to their own transport.

Issues with communication where similar to those experienced in the hospital, with patients and relatives not knowing who to speak to, who was coordinating the discharge or the identity of the person they had spoken to. There were similar issues with long waits for social workers and mental health assessments.

'I came into A&E via ambulance as couldn't get up at home. On the floor for 5 hours. In A&E 2.5 days on IV infusion. No beds – so I was sat on a recliner all that time. Admitted to a ward – high number of dementia patients, then to CAU then sent to Bedford. Going home Wednesday next week; I'm going to live with my nephew and my twin sister. Informed of discharge date yesterday, but it's a week away but I don't know why. Thinks coming to Bedford Care Home has given her time to sort out going home but otherwise doesn't think she has gained anything from it.'

Discharge Lounge

We visited the Discharge Lounge on two separate occasions and spoke to:

- **5 female patients**
- **6 male patients**
- **Pathway 0 - 4 patients**
- **Pathway 1 - 3 patients**
- **Pathway 2 - 2 patients**

One patient had no idea where she was going. Example below:

Patient had been admitted from home with infection in her knee and was unable to walk. Informed HW that she had no idea where she was going. She had been moved to DL this morning but had not been involved in any discussions about her discharge. Her house was being renovated and she had no key and was unable to walk as her feet were so swollen. She had been told yesterday that she would be in for a further 7 days. She has now lost her walking stick. Very unhappy as to what was happening to her and the lack of communication. HW referred her to the DL staff for support and information.

On both of our visits, the patients on pathways 0 and 1 were, overall, happy to be on the Discharge Lounge. They were waiting for either medications or transport via Patient Transport System or a family member. On our first visit, waits were not excessive; patients had been moved from the ward to the Discharge Lounge that morning and discharged home within a few hours.

On our second visit, patients told us they had been there overnight.

Patients on pathway 2 were being discharged to either Bedford Care Home or Richmond House for further rehabilitation or assessment. Again, transport and medications were required. Satisfaction in this group tended to be lower but mostly related to communication as in the next example:

'Having fallen in the shower I was brought to A&E by ambulance. They also brought my husband, who has dementia and for whom I am the carer, since there was no-one to look after him at home. We have been on adjacent wards. Not much involved (in discharge planning). Told a couple of days ago that I would be going to Richmond House, but don't know for how long. Not told what to expect when there. Have been given a Zimmer frame which I'm not used to – I have grab rails through-out the house. I only found out that I was going out today when I was brought down here to the Lounge. I would have liked more information about what to expect at Richmond House and why that was seen as the more appropriate venue. Not told what alternatives there were. Of greater concern to her was where her husband was going to go – no talk with her about that at all even though he was in the next ward to her, and she is the next of kin. They had been married for well over 55 years and rarely separated in that time. She expressed how concerned she was as to what was going to happen to him, and now that she was in the Discharge Lounge and going out of hospital, she would be more difficult to contact.'

On both occasions staff were very welcoming and willing to share their experiences. The Healthwatch volunteers witnessed very caring, attentive and positive interactions between staff and patients. However, staff did share with HW some of their frustrations with the current arrangements within the discharge lounge. On our first visit, there seemed to be some issues with portering, and the discharge Matron was bringing patients to the lounge from the wards. We were informed the system for booking a porter had recently changed and they were experiencing some teething problems as the telephone held by the porter had a poor signal, hopefully this has now been resolved. The lounge staff would hold an 8am call with the Bed Managers and check the 'No right to reside' list and ambulance booking information and from there they identified appropriate patients and would ring the wards for a handover.

For patients who were being discharged on pathway 1, there is often a time pressure to ensure the patients are home to coincide with carer visits. This could be difficult to coordinate with NWAS therefore the staff would resort to booking a private ambulance. The staff report they spend considerable amounts of time attempting to contact the ward doctors to complete the discharge letters and prescriptions (Electronic Patient Record). When seeking to get discharge medications the discharge lounge staff were required to contact each individual ward pharmacist. Previously there had been a Pharmacy Technician dedicated to the Discharge Lounge who would liase with pharmacy, but this is no longer available.

There were occasions when a patient's medical condition changed, and they were no longer fit for discharge. There is no clear protocol for action in these situations. Sometimes the on-call or ward doctor would respond but often the patient was sent back to the ward they came from. At times of acute pressure within the system, the lounge would be converted to a ward. This means it then becomes 'single sex' which impacts on who they can take from the wards for discharge. The facilities available are limited and there is a significant challenge for staff to maintain any level of privacy or dignity when needing to administer personal care or providing toilet facilities especially when commodes were required. When this happens, these patients rarely have any discharge arrangements made and this falls to the lounge staff to organise who do not know the patient.

Conclusions

When predicted discharge dates were recorded on the board above the bed, many had passed and not been updated. However, few if any were recorded for those patients who were on the discharge ward.

Most of the patients we spoke to had been delayed by at least 5 days but there were patients who had been waiting 2-3 weeks.

The most common delay we noted was awaiting transfer to either Richmond House or Bedford Care Home and these resulted in the longer delays. Additional delays included awaiting equipment (specialised wheelchair). Many patients were unable to tell us what they were waiting for as they were unaware of discharge plans.

The process for arranging discharge is very confusing. It has been difficult to understand the patient journey from admission to discharge. There are so many different 'teams' and 'locations' with abbreviated and/or unfamiliar names e.g. TOCH / IDT / Home First /HAPS / Reablement / Therapy Team / OT / Physiotherapy / Rehabilitation /Jean Heyes / Bedford. This is difficult for patients and relatives to understand.

HW volunteers were left with the impression that many staff members didn't know and/or understand the roles and responsibilities of these different 'teams' or 'locations'. At times staff report overlaps of roles or instances where staff take on the responsibility of another team as they lack understanding of the team function or boundaries are misunderstood. This results in duplication or wastes precious time.

It seems that there are several different IT recording systems that either do not 'talk' to one another or that can only be accessed by 'certain' staff within the system. This does little to provide clear information about the discharge plan, care or treatment and can lead to confusion and misleading information.

The different teams are disconnected i.e. physically at different locations both on and off site: and disjointed. At times these staff would go to a ward to meet patients but at other times are making decisions about individuals without having ever met them. This leads to tension and at times conflict between the teams that are on and off site.

Patients report being very bored on the wards. This was particularly evident on the discharge ward where patients tended to spend long periods of time by their beds. There are no communal facilities or even a TV on the ward.

There were missed opportunities to better prepare patients for discharge during the time they are delayed. This time could be utilised to prepare patients for home and to move from the sick role that patients in hospital understandably adopt to a more normal reablement approach, encouraging everyday activities e.g. wearing day clothes as a starting point. It is acknowledged that some areas e.g. CAU are trying very hard to implement this but face many challenges associated with provision and laundering of clothes.

A requirement for early referral onto other services is often known by nursing and therapy staff but current policies prevent this. This is an area that causes obvious delays further along the patient journey and is used as a way of allocating resources. However, this is a system that is focused on process rather than the patient.

Stroke rehabilitation is currently inequitable between the acute stroke unit, medical wards and Richmond House. There is a lack of rehabilitation facilities at Richmond House which limits the activities therapy staff can carry out.

Recommendations

1. HWWL recommend a review of the number and roles of the teams currently involved in discharge planning; mapping roles and responsibilities and reducing duplication.

2. WWL and Wigan Adult Social Services review the current electronic patient record systems to either align systems or review access to provide appropriate information. This would improve the sharing of information to allow all staff caring for the patient to communicate effectively with the patient and their relatives.

3. Provide accurate information to patients and relatives about the WWL services available in the community. Provide or update any patient information leaflets relating to Richmond House and Bedford Care Home.

4. Explore the possibility of providing rehabilitation/discharge to assess bed-based services in other parts of the borough. The current provision in Leigh has been raised by many patients and their families as a significant challenge for visiting.

5. Develop a discharge passport which can be held by the patient and contributed to by staff, patient and family. This would act as an 'aide memoir' for:

a. patients who at times may struggle to remember everything they are told,
b. a useful communication tool for relatives who can only visit 'out of hours'
c. provide an opportunity for two-way communication with staff.

6. Utilisation of multidisciplinary meetings especially where there are differences of opinion between all parties. This is particularly relevant where patient and families or staff and families have differing views on discharge plans. This would allow all to air their views and consider mitigation of risk etc.

7. Improve involvement of ward staff with discharge plans to aid communication with families and reduce opportunity for conflict.

8. Consider a review of the way IDT work with a more patient centred approach rather than ward allocation. Explore the possibility of linking staff to patient throughout their journey therefore better supporting continuity, communication and formation of relationships.

9. Work with Adult Social Services to review the possibility of identifying criteria that could trigger an early referral into their services to reduce length of stay and support more timely discharges.

10. Discharge of patients from Richmond House and Bedford Care Home is planned in advance. Therefore, patients awaiting transfer to these facilities to have their admission planned in accordance with known upcoming bed availability to better prepare the patient and their family for the move.

11. Review the current commissioning of the stroke beds at Richmond House and consider if there is a more appropriate facility which could better accommodate these patients to give more frequent and specialist therapy interventions.

12. Consider reviewing the current admission criteria for Bedford Care Home as many of the patients and families we spoke to had considered that they could be managed at home.

Provider Response

Thank you to Kevin Parker-Evans WWL Chief Nurse for the response below on behalf of WWL NHS Foundation Trust:

'Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust extends its gratitude to both Healthwatch and system partners for their collaborative efforts in conducting this review. The report highlights several areas for improvement, which the system is collectively addressing to enhance patient care by ensuring that patient planning and discharging are patient-centred, safe, and timely.

WWL is a key stakeholder in the Better Lives Programme, a borough-wide transformation initiative aimed at ensuring our patients are in the right place at the right time with the appropriate support. This programme runs concurrently with several internal Trust executive-led transformation initiatives that aim to streamline and centre the discharge process around patients, relatives, and carers, ultimately benefiting both patients and staff.

Patient flow and the discharge process are critical quality indicators. The Chief Nursing Officer, Chief Operating Officer, and Executive Medical Director are working closely with the clinical and operational teams to drive the ongoing transformation efforts. These efforts are crucial for improving patient flow within the hospital and facilitating their return to their homes.'

Acknowledgements

This would not have been possible without the full support from Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, Richmond House and Bedford Care Home both in Leigh.

We would like to thank all the patients and relatives who kindly spoke to us to share their story for which we are very grateful. Thank you to the staff at the Royal Albert Edward Infirmary, Leigh Infirmary, Community Therapy staff, Richmond House and Bedford Care Home who made us very welcome and were willing to share their experiences of the current discharge processes. We appreciate your time, openness and honesty.

Also, a very special thank you to Healthwatch Wigan and Leigh staff and volunteers who supported and gave up their time to work on the project and to our Advisory Committee Volunteer Sponsor for support-ing the project

Ann Lloyd

Glossary

A&E	Accident and Emergency Department
AHP	Allied Health Professional
CAU	Community Assessment Unit
DL	Discharge Lounge
EPR	Electronic Patient Record
HAPS	Heathside Assessment and Pathway Service
HIS	Hospital Information System
HW	Healthwatch
HWWL	Healthwatch Wigan and Leigh
IDT	Integrated Discharge Team
ICB	Integrated Care Board
IT	Information Technology
IV	Intravenous Infusion
MOSAIC	Wigan Adult Social Services IT system
NHS	National Health Service
OT	Occupational Therapy
PCN	Primary Care Network
RAEI	Royal Albert Edward Infirmary
TOCH	Transfer of Care Hub
WWL	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Thank you to all our volunteers, staff and stakeholders - *and especially those who shared their stories.*