Hospital Discharge Project 2016

Report for

Social Services, Housing and Public Health Policy Overview Committee

Social Services, Housing and Public Health Policy Overview Committee

14 December 2016

PART I – MEMBERS, PUBLIC AND PRESS

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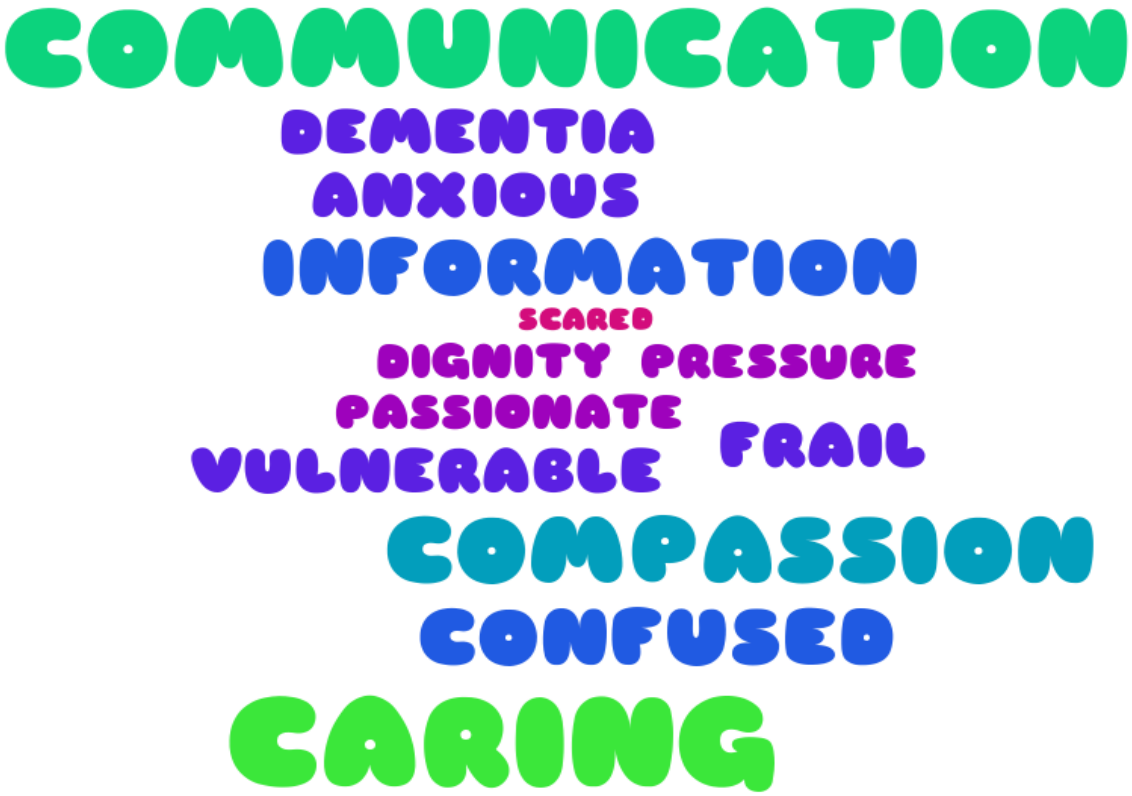

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PART I – MEMBERS, PUBLIC AND PRESS

Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems.

The number of people aged 65 and over in England is increasing rapidly. The relative growth in numbers of older people is important. The number of older people with an emergency admission to hospital increased by 18% between 2010-11 and 2014-15. In 2014-15, the percentage of older people admitted to hospital after attending accident and emergency (A&E) was 50% compared with 16% for those aged under 65.

Although overall length of stay for older patients following an emergency admission has decreased from 12.9 to 11.9 days between 2010-11 and 2014-15 – suggesting improved efficiency – the overall number of bed days resulting from an emergency admission has still increased by 9% from 17.8 million to 19.4 million days.

Put simply, without major change, these recent trends indicate that the more older people there are, the more pressure there will be on hospitals.

While NHS spending has grown by 5% in real terms between 2010-11 and 2014-15, local authority spending on adult social care has reduced by 10% in real terms since 2009-10.

Extract from "Discharging older patients from hospital" published by National Audit Office May 2016

https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf

INTRODUCTION:

Healthwatch Hillingdon has been carrying out a 'Discharge from Hillingdon Hospital' project with the aim of identifying and engaging Hillingdon residents who have recently gone through the discharge process at Hillingdon Hospital. Through their experiences we have gained a greater understanding of being discharged from hospital, ascertaining what works well and where improvements may be required.

The project has focussed on Adults over the age of 65 with complex needs or long term conditions who have been recently discharged from The Hillingdon Hospital, to home, or another care facility.

Healthwatch Hillingdon have been working closely with The Hillingdon Hospital NHS FT and we would like to thank them for facilitating access to the patients we have spoken to during our engagement program.

We also express a special thank you to all the patients and their carers or families that have taken the time to tell us about their experiences.

The findings of our engagement program have been summerised into this report for the Social Services, Housing and Public Health Policy Overview Committee and will inform our final report, which will be published in the New Year.

The Patient and Carer experience outlined in this report has been shared with local Partners who either commission or provide care to give them an opportunity to:

- assess the quality and effectiveness of discharge and the follow-up care we provide in the community
- consider how this evidence can inform current work streams
- consider how we can use this evidence to develop better services for Hillingdon's residents.

During our research we have identified possible solutions and outline these as recommendations for Partner organisations to consider.

If implemented, these recommendations may help towards improving:

- the patient/carer experience
- staff experience and job satisfaction
- quality and safety of care
- length of stay
- readmissions

METHODOLOGY:

Stage 1

172 patients were interviewed and completed a survey on 17 different wards (including the Discharge Lounge), over a period of 2 months. Patients gave written permission for Healthwatch to follow up the survey with another survey once they had been discharged from hospital. The second survey would ask about their experience of the discharge and how they were coping post discharge.

The survey was sometimes completed by a patients advocate, and permission was given for us to follow up with this contact.

The survey data was then recorded into a database for analysis.

Stage 2

Patients interviewed on the wards were then phoned at home 30 days after their on ward interview, or their advocates, to ask how the discharge process had gone, and if adequate care was in place for their needs. This was a more challenging aspect of the project as some patients were still in hospital, some had died, and some were no longer at the contact number.

52 discharged patients/advocates completed the second survey. These were recorded into the database for analysis.

Stage 3

We met with over 20 organisations, who commission, or provide care services for the over 65's in Hillingdon, within hospital and the community. This engagement, with senior managers and frontline staff, looked to identify and understand the processes and procedures involved in discharge; and the factors, barriers and enablers that contribute to providing patients with a safe transfer from hospital to being cared for in the community.

SUMMARY FINDINGS

The over 65's express an overwhelming feeling of pride in the NHS and hospital services. They are quick to praise Hillingdon Hospital for their caring and attentive staff, and give individual examples of exemplary conduct.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble', and as such some were reluctant to say anything against their care. We found that they were far more comfortable speaking to us after discharge, than they were on the ward.

There is no doubt that staff are strongly committed to their work. They do however feel under pressure and are wary that they cannot always necessarily deliver care to the standard they would like to and this is effecting moral.

Initial analysis of the data shows that, although we have seen that there are transfers of care which go well, the satisfaction rate for discharge and the follow up care is varied. Patients expectations vary considerably resulting in polarised views on the same subject. There is higher satisfaction on some wards than others, as there is with differnet care providers in the cimmunity.

It highlights that service delivery is not always consistant and there are a number of areas which impact upon the patient/carer experience, including specific comments directed at individual service delivery, that would normally be addressed by contract monitoring.

In general, impact broadly falls in to 3 catergories:

1. Communcation and information

Patient/carers say they want to be fully informed across the whole pathway. They state that the communication between them and professionals and the information provided to them is often poor. They have illustrated where they have been unable to speak to a doctor, forgotten or become confused about what they have been told, do not know what medicines to take, who is coming to see them at home, or how to arrange a private care home placement, or care package. This leads to them being uncertain and anxious which becomes a barrier between them and staff. This promotes a situation which is not positive for either party. When uninformed, patients/carers persistently seek answers and this increases the number of interactions with staff, which in turn impacts negatively upon already stretched staff, by taking them away from other activities.

Evidence would suggest that by providing clear written information to inform patient/carers and support them to make decision and would empower them to become partners in the discharge process. This will improve outcomes for both patients, partner organisations and their staff.

Recommendations

a. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements.

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed and acts as a method of communication between patient/carers and professionals in hospital and in the community.

b. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care. Where an individual has substantial difficulty in being involved in the assessment process, the need for independent advocacy should be provided.

2. Process and procedures

Throughout the course of our engagement patient/carers informed us that during their inpatient stay the staff were working hard to provide them with good care.

There was a general observation that they often felt staff were stretched and did not have the time they would like to attend to the patients needs. They also perceived a variation in care between the day and night shifts, and permanent and agency staff.

Our researchers saw a marked difference in the discharge proceedures on each ward and a number of patient/carers who had experienced multiple inpatient stays also identified this to us. This is exampled by the discrepancy in how patients

awaiting medication and transport are processed. Depending upon which ward, patients of a similar condition, could either, wait in their bed, be asked to sit in the ward's day room, or will be sent to the discharge lounge.

From the conversations we had in the discharge lounge we found that patients often waited for many hours, without hot food or other facilities. This was particularly apparent for those awaiting patient transport.

Although waiting for medication at discharge remains a frustration for both patients and staff, on the whole all patients went home with the medication they required. Some patient/carers did highlight to us that they were confused about their medication; especially those who were dispensed multiple drugs at discharge.

Recommendations

a. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistant, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment and retention and positively affect the quality of care provided to patients, as staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

b. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are

   waiting there. Without any pre-emption of this assessment, we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.

c. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide

dosette boxes. This will mitigate against possible unintentional overdose and improve patient safety

3. Closer integration and joined up working

We have already spoken about communication and how written clear information is needed to aid patient/carers in the discharge process. Patient/carers also pointed out to us that organisations do not necessarily communicate with each other well, or work as closely together as they could. They have told us about their GP not receiving a discharge summary, not being accepted on transfer to intermediate care and being sent back to the hospital, assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings and domicialiary carers not knowing how to contact district nursing.

Timely communication between organisations is something the 'system' has been striving to achieve for sometime. Patients tell us it is something they want too. The 'Patient Journey' booklet we propose could go part way to connecting organisations who are currently providing care for an individual, but more work needs to be done to connect up the whole 'system' and for the 'system' to have a joint way of keeping patients/carers involved and informed.

Ensuring the organisations that will be providing care, are all involved in the discharge process is a key element for patients and their ongoing care. Patients and their families do not always see this and that needs to be embedded in the discharge process. Patients/carers tell us they want this to include domiciliary care agencies and care homes directly.

Although not picked up in our conversations with patients it should also be noted that our researchers were told of confusion amongst ward staff of the function of the Joint Discharge Team, and it was questioned whether it was being fully effective.

Organisations need to know about each other's services and know how to signpost patients/carers effectively to each other.

The Accountable Care Partnership is an opportunity to deliver this closer understanding of the different organisations and improve our joint working but again close working relationships need to be built with organisations providing 'social' care.

Although currently we would not see this as one of our recommendations, we would like to see the ***single point of access for discharge*** explored further, as a possible solution to providing wrap around and integrated care for the patient/carer and as an information hub for professionals.