Safely “home” to the right care

The experiences of Older People being discharged from Hillingdon Hospital and the onward care they received in the community

February 2017

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We have produced a short film of patients lived experiences to accompany this report.

Watch it at: https://m.youtube.com/watch?v=5mgLI37uPzE

A special thank you to Save the Dog productions for volunteering their services to make this film

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Introduction

Healthwatch Hillingdon is a health and social care watchdog. We are here to help our residents get the best out of their health and care services, and give them a voice to influence and challenge how health and care services are provided throughout Hillingdon.

Healthwatch Hillingdon has very strong operational relationships with the local NHS, Council and Voluntary Sector organisations. We are an independent partner and a valued "critical friend" within health and social care.

Membership of the Hillingdon Health and Wellbeing Board and Hillingdon Clinical Commissioning Group Governing Body enables us to have considerable strategic input into the shaping of local commissioning and the delivery of services.

As a local partner, we are kept well-informed, can challenge and seek assurances on behalf of our residents, ensure that the lived experience of patients and the public are clearly heard, and are influencing decisions and improving health and social care in Hillingdon.

Reports and Recommendations

Healthwatch Hillingdon produces evidence based reports for commissioners and providers, to inform them of the views and experiences of people who use health and social care services in the London Borough of Hillingdon.

Commissioners and providers must have regard for our views, reports and any recommendations made and respond in writing to explain what actions they will take, or why they have decided not to act. [i]

Healthwatch have a duty to publish reports they share with commissioners and providers, and their responses, in public.

Our reports and recommendations are also shared with:

- Hillingdon Health and Wellbeing Board
- Hillingdon External Services Scrutiny Committee
- Healthwatch England
- The Care Quality Commission

EXECUTIVE SUMMARY

Overview

Nationally there is a recognition that health and social care services face enormous challenges because of financial pressures and a rising in demand, driven by a growing ageing population.

As statutory organisations look to address this challenge several initiatives and strategies are being implemented at differing rates across the country.

In Hillingdon, these include a number of programmes that initially concentrate on the adult population over the age of 65.

- The Better Care Fund
- Whole System Integration (Accountable Care Partnership)
- GP Networks (Federation)

With these local initiatives in their infancy and recognising that the pressures upon Hillingdon Hospital were dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded – Healthwatch Hillingdon decided to look at how this was affecting patient experience.

Objectives

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the effectiveness of the new programmes as they are embedded over the coming years.

Methodology

An extensive engagement programme carried out between June and October 2016 saw us interview and survey, 172 inpatients at Hillingdon Hospital, 52 of those patients post discharge and the professionals and staff from over 20 organisations.

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.

The satisfaction rate for discharge and the follow up care is varied. Patients expectations differ considerably resulting in polarised views on the same subject.

Service delivery is not always consistent and there are a number of areas which we found impacted upon the patient/carer experience.

The professionals and staff we spoke to during our engagement demonstrated that they are committed to providing the best care they can in their role.

They were candid in their responses.

It was sad to note that we found general dissatisfaction amongst professionals and staff. Many expressing frustration, as they highlighted a number of operational barriers and areas along the discharge pathway that required improving.

The evidence provided by both the staff and patients, and the impact upon their experience of the discharge pathway, broadly falls into 3 categories:

Communication and Information

Patient/carers said that they want to be fully informed across the whole pathway. They stated that the communication between them and professionals and the information provided to them is often poor. Many reported that they were not involved in the planning of their discharge and follow-up care and support. They have illustrated where they have been unable to speak to a doctor, have 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 decisions would empower them to become partners in the discharge process. This will improve outcomes for both patients, partner organisations and their staff.

Recommendations

1. 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[ii].

   We would recommend that this booklet is reviewed and updated to produce a ‘Patient Journey’ booklet that keeps patient/carer fully informed during the inpatient stay and outlines the details of the follow-up care and support arranged.

This will then act as a clear method of communication between patient/carers and professionals in hospital and in the community.

2. 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[iii]. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.
3. We would recommend that where an individual has substantial difficulty in being involved in the assessment process and their onward care provision, that an independent advocacy should be provided.

Processes 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 patient's needs. They also perceived a variation in care between the day and night shifts, and permanent and agency staff.

The use of agency staff and workforce pressures were also raised by staff in both the hospital and the community.

Several patients reported that they felt under pressure to leave hospital. With some highlighting that they had been told by staff that their bed was needed for somebody else.

Our researchers saw a marked difference in the discharge procedures on each ward and several 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.

Professionals and staff also echoed concerns around procedures not being uniform across the wards.

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

4. 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 consistent, 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.

5. 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.

6. 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, or blister packs. This will mitigate against possible unintentional overdose, improve patient safety and could avoid some readmissions.
7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:
   - the patient is the carer for their partner.
   - the partner is the sole carer for the patient.

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 domiciliary carers not knowing how to contact district nursing.

Timely communication between organisations is something the ‘system’ has been striving to achieve for some time. 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 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.

Recommendations

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
    - As a possible solution to providing wrap around and integrated care for the patient/carer.
    - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other's services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.

CONTEXT

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 the National Audit Office May 2016[iv]

England

With a growing population, people living longer and a rise in the number of people living with one or more long term conditions, the need for the health service and social care support is increasing.

30% of the population have one or more long-term condition and these conditions account for £7 out of every £10 spent on health and care in England.[v]

Currently, people aged over 65 represent 18% of the total population, up from 12% in 1966. It is projected that by

> With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

2039[vi] nearly a quarter of the population will be over 65, with 1 in 12 people being over 80.

It is reported that over 5 years there has been an 18% increase in emergency admissions for older people.[vii]

Nearly two-thirds of people admitted to hospital are over 65 years old. Accounting for almost 70% of emergency bed days.[viii]

On average, the over 65's tend to stay longer in hospital and they are more likely to have their discharge delayed, after they are clinically fit to leave.

In the last 2 years there has been an increase of 55% in the average number of delayed transfers of care that are attributable to social care.[ix]

For older people, longer stays in hospital can have adverse effects. They can quickly lose mobility and the ability to live independently. This can increase their long-term care needs and worsen their health outcomes.

In real terms 81% of local authorities have cut their spending on social care for older people over the past five years.[x] With a 30% drop in older adults receiving publicly-funded community based services, 18% fewer receiving home care and 50% less, day care.[xi]

With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

Hillingdon

The challenges in Hillingdon are no different.

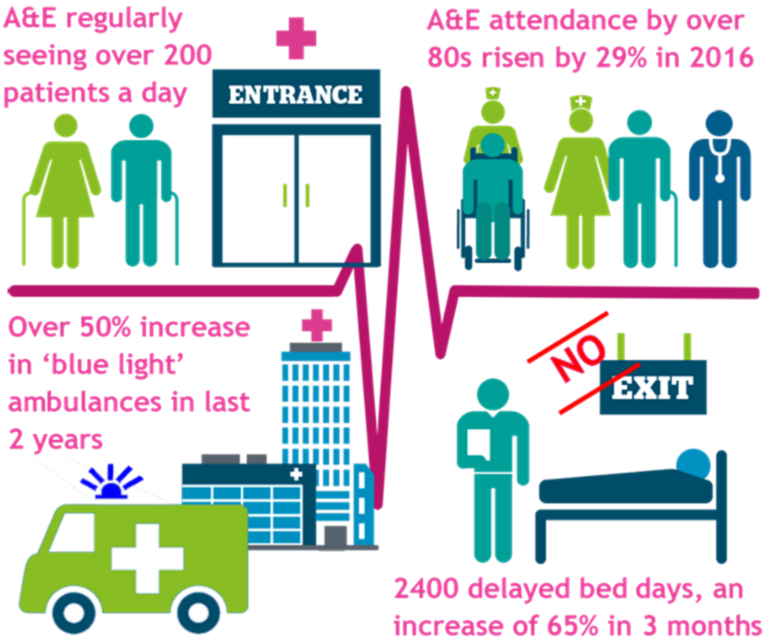
The Hillingdon Hospital's A&E department has a calculated daily capacity for 160 patients and is regularly seeing over 200.

In the last 2 years there has been an increase of over 50% in the arrival of 'blue light' category 1 emergency ambulances – who carry the sickest patients.

Attendance at A&E by older people is rising. Most noticeably in the over 80s which has risen by 29% in the last year.

With the development of Ambulatory Care Clinics[xii] the number of over 65s admitted into Hillingdon Hospital has actually reduced by 6% in 2016. However, delayed discharges of medically fit people have risen sharply. During the period of our engagement they rose 65%. With over 2400 delayed bed days recorded in that quarter (July to Sept 2016).

Although 15% of these delays are due to patient choice, the majority - 70% - are attributed to finding placements in residential or nursing homes.



A&E regularly seeing over 200 patients a day

A&E attendance by over 80s risen by 29% in 2016

Over 50% increase in ‘blue light’ ambulances in last 2 years

2400 delayed bed days, an increase of 65% in 3 months

For Social Services and NHS Continuing Health Care, securing sufficient capacity, in care homes and domiciliary care, to meet current need is a definite challenge in the borough.

And; for all care providers in Hillingdon the recruitment and retaining of staff continues to be difficult and is compounding their pressures.

Strategic Plans

There is a view shared by many that to address these new challenges, the NHS needs to adapt and change.

In the NHS England, Five Year Forward View[xiii] the NHS’ national leadership outline a clear strategic vision for the NHS to meet these challenges.

A plan to improve the nation's health, transform the quality of care delivery, and make the NHS financially sustainable[xiv]

The vision concentrates on prevention, supporting people to take control of their own health, GPs working together at scale and for new models of care.

A future, where organisational barriers are broken down and NHS organisations work closely, in collaboration, with the council, voluntary sector and local people to improve health and care for their population.

Local Plans

It had long been recognised that to improve the local health and social care system in Hillingdon, care would need to delivered differently.

Led by Hillingdon Clinical Commissioning Group and the Local Authority there have been a number of strategic initiatives that have been started in Hillingdon. The majority of these have concentrated on the care provided to Hillingdon's older residents:

- Integrated Care Programme
- Better Care Fund
- Whole System Integration - Accountable Care Partnership
- GP Networks

These work streams have all focused on collaboration and organisations working closely together, to change the way in which care is delivered.

This has led to mature relationships being built between organisation and Hillingdon being in a good place to build on the current initiatives as part of the Sustainability and Transformation Plan.[xv]

INTRODUCTION

Discharge processes cut across the responsibilities of multiple agencies and have long been recognised, as an indicator to assess the effectiveness of care in a local health and social care system.

In a 'perfect system', multi-agency working and collaboration is seamless. People are appropriately supported at home. Hospital activity is planned and when admitted to hospital for emergency unplanned activity, the patient is timely discharged back to being supported in the community.

The Healthwatch England report 'Safely home: What happens when people leave hospital and care settings?'[xvi], published in July 2015, provides evidence that health and social care systems across England are far from 'perfect'.

Healthwatch Hillingdon had already recorded many patient's stories relating to discharge and the provision of care and support in the community, for residents over 65. Through our strategic involvement, we were using this information to inform the change programmes.

With pressures upon Hillingdon Hospital dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded. Healthwatch Hillingdon decided to look at how this was affecting patient experience.

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the

effectiveness of the new programmes as they are embedded over the coming years.

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

We would also say thank you to all the organisations who we engaged with and the staff we spoke to. Their insight gave us a greater understanding of the patient journey, from hospital to ‘home’ and a further dimension to understand what works well and what could be improved.

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 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 patient's 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, or their advocates, were then phoned at home 30 days after their original interview. This contact asked 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 local 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.

Views were canvassed from the following:

- The Hillingdon CCG
- Continuing Health Care
- Hospital staff and managers
- London Borough of Hillingdon Social Care
- Age UK Hillingdon
- Hillingdon Carers
- Care homes
- CNWL Community Services
- GPs
- H4ALL
- Domiciliary care agencies

DIGNITY, CARE AND COMPASSION

Older patients arriving at THH are from a generation who express pride in what they regard as 'their' NHS.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble or be a nuisance'. They endure, and don't like to complain. They feel vulnerable as many have lost confidence with age.

81% of patients said that they were either satisfied or very satisfied with the way they were treated overall. They said staff were caring and trying their best, but wards were very busy, which led to lengthy waits in being attended to, long waits for medication and poor communication. It was no surprise therefore when asked what could be improved, 31% of these said they felt the hospital was understaffed and needed more doctors and nurses.

Of the 19% of patients who said they were dissatisfied or very dissatisfied with their care. The reasons given for their dissatisfaction were:

- requests made to staff were not completed
- no continuity of care
- night staff are less caring than day staff
- agency staff are not as good as permanent staff
- never see the same face
- having to frequently move wards
- personal care not carried out, like cleaning dentures
- anxiety over toileting and not being assisted to go
- not understanding what is happening to them

The professionals and staff that we spoke to also recognised that there is an inconsistency of care. Hospital staff pointed out that this is not helped by the high turnover of staff and the need to use agency staff, who lack a clear understanding of hospital procedures. They also recognised the lack of consistent discharge processes for staff to follow across the wards. Set processes and procedures are often not followed. Instead, organic procedures have developed on each ward.

10% of patients and their families expressed deep dissatisfaction in what they consider to be a major failure in the discharge pathway, again siting staff under pressure as being the reason for poor communication and procedures. Many felt under pressure to leave the hospital as they were very aware of the urgent need for beds. Professionals that we spoke to concurred with the view saying that they felt under pressure to discharge patients, as the hospital is under huge pressure from the demand coming through the doors.

Pain relief was a concern of patients, with many saying they had to wait lengthy periods to obtain authorisation from unavailable doctors for medication to be administered. This is an issue also recognised within the hospital, again attributed to pressure of demand and lack of available doctors and nurses.

COMMUNICATION

30% of patients and/or their carers referred to poor communication and lack of understanding about their condition. Professionals and staff also recognised the need for better communication and explanation for patients and families/carers, but see the need for better processes and management to be able to free up 'fire-fighting' time in order to invest in the necessary commitment to clearer communication.

Patients and families/carers wanted an understanding of their situation from a member of staff. They were often told they needed to speak to a doctor for this, but that could mean waiting a considerable time. Professionals and staff also felt there is a need for a communication process consistently applied. Some wards seem to allow an appointments system with doctors, others do not. It seems to be very hard to get any time with a doctor.

Patients sometimes forget, don't hear or get confused about what they have been told. This can lead to the family /carers being uninformed, which leads to family seeking information from staff which is often time consuming and frustrating. Patients and their families/carers would therefore like information from doctors explaining the current situation and what would happen next, written down.

Staff told us that this would also help them, as much of their time is taken up with enquiries from families, and not all staff roles are aware of the full situation on a patient to be able to effectively give an update.

Patients also felt confused by conflicting information from staff on their discharge. Physios may have told them one thing, the Occupational Therapist another, ward staff something else. Discharge dates kept changing, expectations were raised then dashed. Through all this patents felt they weren't communicated to adequately or listened to. Families/Carers felt anxious and didn't understand what diagnosis, prognosis or treatment had taken place or how to avoid the condition in the future. There was no one they could talk to who could tell them the whole co-ordinated picture.

65% of patients, carers or family members felt they were not given the chance to raise any concerns they had about their discharge or going home. They would have liked the opportunity to talk about their concerns and have information on how to manage their condition after going home. Many felt advice on nutrition would have helped but this wasn't necessarily available.

Families/Carers say there is poor communication of what 'Continuing Health Care' means, and what help they can get for their loved ones when they come out of hospital. Professionals and staff echoed this confusion and saw part of the solution as being a clear user friendly published discharge policy, which everyone can follow and refer to. Staff said that they are aware that families think they are not told about continuing health care options as the NHS wants to 'save money'. Transparency is key, and staff would welcome a clear process to guide patients/families through all the options for leaving hospital care.

PATIENT NEEDS ASSESSMENT

Relatives of patients expressed a desire to be included in discussions about their loved ones when the patient is incapable of contributing to an assessment of their needs. They felt that an assessment may not be accurate when relying on confused information from an unwell patient. Professionals also raised concern that both families/carers, and the right skillsets were not always present at meetings to fully inform a decision on care needs. Quite often, daily home carers who know the patient intimately are not asked for any input into understanding the patient’s on-going needs. Professionals also pointed out that the lack of joined up IT systems meant that not all the information is always available to make a fully informed decision.

Professionals also felt that sometimes needs could be met for patients at home by community services, but what may be available for a patient is not always understood. A better awareness of community services at the assessment stage could expedite an earlier discharge.

There was confusion amongst professionals about whose responsibility it was to find out the financial situation of a patient in need of continuing care. It was felt that staff required a greater understanding and training on the roles and responsibilities at assessment.

We found that assessments can be carried out on the same patient, by the hospital, social services and a care home. Which leads to confusion for patients and their families and disagreement between organisations.

Patients and their families/carers wanted to understand how the assessment was conducted and the conclusions arrived at. Families also wanted clarity around who makes the decisions on care going forward for the patient.

Families have told us about meetings that they have attended where recommendations for care packages have been made by medical staff but overridden afterwards by social workers. This we have found is also frustrating for professional staff who told us that their expertise and advice is overridden.

Patients and families/carers want accurate information on assessments and their entitlements. They feel the whole funding entitlement rules are very confusing. Many were worried that they must attempt to sell their parent’s house while they’re still in hospital, in order to pay for care when they come out.

Clear understandable written information explaining options would go a long way to alleviating the stress on families at such a difficult time. Professionals concurred with this view, and agreed that funding rules are complex and difficult to explain.

Finding a care home is particularly difficult regardless of funding, especially if the patient has dementia and behavioural problems. Relatives expressed anxiety over lack of help procuring a home, and the time it takes to get their loved ones placed.

Professional staff expressed frustration over families refusing care home placements which led to beds being unavailable for acute medical need.

They felt that having a joint placement board for patients needing a care home would be more efficient than the Local Authority and Clinical Commissioning Group working separately. A joint board would stop duplication of effort and competition for a scarce resource.

When asked to determine whether they can meet the needs of an individual, care homes are sent a FACE assessment form[xvii], outlining the care and support the patient requires. Care homes felt that the process could be made more efficient and it would benefit patients, if the assessment form did not contain acronyms, and was always dated to confirm it was current.

CARE PLANS AND DISCHARGE INFORMATION

Although the NICE[xviii] regulations state that a patient leaving hospital in need of on-going care should have a fully documented plan, this rarely happens. Only 14% of our sample said that they had been given anything that explained what care they would be getting on discharge.

Staff told us that they would welcome a consistent template for providing discharging patients with a plan, as currently there is a mixture of different methods: some provide written advice for the patients, while most just issue the discharge summary.

e Discharge & Discharge Checklis

Please affix patient's label or fill in here
Name: ……………………………………………
PID: ……………………………………………

Social Worker's Na
Tel. No of discharge
Discharge Address:…
Destination: Own
Interm

Please commence completion 48 hours pri

Estimated date of discharge: ………………/…………/………………

Pre Discharge	Yes	No	N/A
• Medically fit for discharge (documented in the medical notes)	○	○	○
• Is intermediate Care arranged?	○	○	○
• MDT agreed and aware of discharge/transfer	○	○	○
• Equipment ordered	○	○	○
ext of Kin/Carer informed of discharge	○	○	○
k access to: keys clothing and provisions	○	○	○
discussed with Patient/Carer	○	○	○
agencies eg: District Nurse, Macmillian	○	○	
	○	○	
	○	○	

sultant follow-up ○ GP follow-up
e.g. Physio, Specialist Nurse, C.P.N.)__________
s to be removed on: ______________________________

sport Arrangments

of transport arranged? Ambulance ○ 2 man li
Please Specify: ………………………

Patients who left with a 'Discharge Summary' said it probably meant something to their doctor but it meant very little to them as it is written in medical language.

Care professionals told us that in the absence of anything else the Discharge Summary was a useful document, but found it to be inaccurate in some cases, and often written too early and therefore not documenting recent issues.

A Discharge Summary document is given to the patient and a copy sent to the GP. However, there are other services caring for the patient in the community that would benefit from having this information. On occasions patients are attended at home for the first time without any prior knowledge of a person's condition.

Care homes told us that they would welcome a clear plan, arriving with the patient, written in plain English, without acronyms. They saw inconsistency in the information they received with a discharged patient, with some wards giving care homes no information, making it difficult to provide initial effective care.

Some families said they were shocked at the care package received, not being what was agreed at discharge meetings, and would have challenged this had there been a published care plan in place.

We found that little regard, or help, is given to the family carers of the patients returning home. No support or signposting is offered. Quite often carers are not aware of the help they can get and are often the frail elderly partners of the patient. Or, the patient is the carer themselves, returning home whilst still in need of recovery to look after a partner with a chronic condition.

Professionals told us that a referral for a carers assessment at the point of discharge would ensure that the family carer was contacted and offered support. Lack of joined up communication and processes were often given as examples of where the 'system' is failing the discharging patient and their family carer.

Whilst some treatment areas of the hospital are good at providing information on discharge and on how to manage a condition, this is not consistent throughout the

hospital. Many patients/family/carers say they left not knowing how to manage a condition, or what to do. Professionals concurred that information was patchy.

Patients/families/carers would like written information at discharge which clearly shows:

- the details of the patient’s condition
- what has been done to them in hospital
- who they can contact if they have a problem
- medicines needed and frequency
- what support they can expect when they get home
- who will be providing this support
- how they can contact the support
- what they can do to manage their condition
- details of useful community and voluntary services who can support them

Professionals felt a care plan on the discharge of a complex case was invaluable, but advised that there needs to be just one unified plan. Currently the patient can be provided one by both the NHS and Social Services. We were given an example, where assessments are carried out in hospital for patients who are already known to Social Services and on a plan. This is confusing for patients and felt to be a duplication of resource.

MEDICATION

Medication is a big issue for patients. Whilst 95% of patients said they were discharged with the necessary medicines, many were unclear about dosage or frequency.

Many commented on being given a big bag of tablets which they had no idea how to cope with. Many elderly patients do not have the memory to manage tablets as prescribed.

Medication is also confusing for care agency staff, who often rely on family members (who are also confused) to administer the correct medication.

> I think provision of an updated dosset box by the hospital will be the single most improvement in quality of care for this elderly group of patients.

Relatives who have a good relationship with their local pharmacist told us that they were too concerned about giving the wrong dosage to their loved ones and so took the bags of tablets to their local pharmacist, who have in many cases sorted out Dosette boxes to help.

Two patients had been previously admitted for inadvertently overdosing on their loose tablets.

It was the general consensus of all parties, that blister packs, or Dosette boxes, should be provided at discharge to ensure that patients take the right medicines and the correct dosage.

Under the current process, blister packs and dosette boxes are prescribed by GPs and not stocked at the hospital. Hospital staff told us of a number of occasions where discharges were delayed by days, whilst a blister pack was obtained.

One GP said **"I think provision of an updated dosset box by the hospital [at discharge] will be the single most improvement in quality of care for this elderly group of patients."**

Patients, families and carers also want to fully understand what the medicines are for.

Many were confused about old medicines used before their hospital admission, whether they should continue to take them alongside the new medication prescribed. This is again also confusing for both family carers and carers from agencies.

Another big issue is medication not being ready when a patient is ready to leave the hospital. This can mean a patient is waiting for hours in the discharge lounge, day room, or their bed.

Patients want a discharge process where the pharmacy is fully aligned with time of discharge. This of course is impacted by finding a doctor to sign off medications needed for discharge.

Both patients and professionals highlighted incidents where inefficiencies in providing medication led to patients, who were medically fit, staying in hospital longer.

Professionals in the hospital recognise timely medication at discharge as being an issue. A frustrated staff member cited “like many issues, due to the demands, there isn’t the time to stand back and address the processes”.

There is also a clear consensus that the pharmacy should have opening hours to match the hours of demand, especially at the weekend.

Finding an available doctor to sign off medication is also an issue for patients needing medication during their stay. Pain relief is often delayed awaiting doctor sign off.

TRANSPORT

Half of our patients surveyed after discharge went home by hospital transport. Many of them commented on the long wait times for transport.

Those waiting in the discharge lounge commented that there are no facilities for long wait patients. There is no entertainment (TV or magazines), no hot meal provision, Professionals and staff in the hospital raised with us this issue and were equally concerned that it had no provision for patients who cannot sit in a chair and need to lie down, and support for confused patients who wander.

If patients want a co-ordinated discharge process which means they do not have to wait for up to 8 hours for a vehicle to take them home. They want a seamless discharge process where medication and transport comes together in time for a patient to go home. Especially when family, or agency carers, have been informed and are there waiting to receive them.

Families and care homes described transport to transfer patients being arranged for late in the evening. Care homes spoke about patients arriving as late as 11pm which isn’t good for the resident, or the care home. A few expressed concerns that patients can arrive unannounced when they are not prepared for a new admission.

Again, professionals in and out of the hospital recognise that the transport process is ‘poor’. It is expected to be ‘unreliable’. They give examples of poor joined up working and communication, which often results in delayed discharges, as patients miss their ‘slot’ and must wait another day(s) for re-scheduled passage home.

The more experienced transport crews do communicate with the care agencies directly, to ensure they rendezvous with carers when taking a patient home. But this is not standard process and vulnerable patients can be left at home without carers present.

Poor communication has been cited for transport turning up to collect patients for follow-up outpatient appointments, when the appointment was the following or previous week, or the patient was now deceased.

Hospital transport is currently being retendered and is under review. This opportunity needs to be taken to ensure that, the service for patients at discharge is safe, efficient, and that methods are devised for timely communication between the transport, and family or carers when the patient is being taken home.

DISCHARGE

42% of patients thought it was the right time to leave hospital when they did and were extremely grateful for ‘fantastic medical treatment’.

36% of patients felt they left hospital too early, some felt this was due to the hospital’s urgent need for beds. Patients want to be discharged when, and only when they are medically fit. They want to be discharged when everything is in place for a safe return home. They wanted to feel that their own health situation is the primary concern, not the need for their bed.

Professionals felt that individually each hospital department was working robustly to ensure a timely and safe discharge. It is acknowledged that most staff are working flat out, under great pressure to care for patients and ensure they go ‘home’ with a positive outcome. However, staff acknowledged that this has led to a ‘blame culture’ where patients and families are being told ‘we’ve done our bit, we are now waiting on them” and they are not seen as a united team. This is giving patients a negative impression and a perception that their care is disjointed.

Both patients and families/carers felt that there needs to be more joined up working between the hospital and social services as there are delays and confusion over what care is being provided and who will be providing it.

Patients want to know when they are going to be discharged and for the date/time to be met, not postponed. They want a seamless service, to leave on time without waiting, and they want to leave with a care plan and clear written advice on what is going to happen next. Professionals also want a more effective discharge service. They want discharges spread evenly over a 7 day week, and a discharge plan for all professionals to see and work towards.

POST DISCHARGE

68% of patients felt the right care was in place on leaving hospital. However, 32% felt care was only partly in place or not in place at all.

Patients wanted to be discharged to a safe place with the supporting equipment implemented before they got there. This wasn’t always the case.

They wanted to know exactly what the expected care package was, and what community services they would be receiving, when these were going to arrive and how to contact them if they didn’t.

Professionals in the community also said that although the GP is provided with a copy of the discharge summary it would help them to receive a copy to have more understanding of the patient’s condition and circumstances.

Relatives and patients were unsure of what happened when re-enablement care finishes. They were anxious about who would care for them and whose responsibility it was to arrange.

They wanted to understand what outpatient appointments they would need to attend, and when, and how they would get there.

They also wanted to know who they could contact if they found themselves in difficulty after leaving the hospital.

Going forward patients and relatives/carers wanted to know how to manage their condition so that they could avoid hospital admissions in the future.

Professionals who gave their view on post discharge services, agreed that agency carers require better training to help them identify signs of deterioration in the person they cared for, administer medication more effectively, and be able to seek relevant help from the right agencies to prevent a hospital admission.

It was acknowledged that some care agencies provide a robust training programme for their carers, but sadly this is not always the case. Regulations to ensure carers are sufficiently trained and given the tools to do the job effectively, would be welcomed by some.

Professionals inside and outside the hospital also felt that there needs to be greater education for relatives of dementia patients, to understand the end stage of the disease and how it can be eased with palliative care at home rather than in a hospital setting.

It was felt that this also applies to Care Home staff who need training to better understand end of life stage of dementia and support to have confidence that the home can provide the palliative care and hospital intervention is not required.

Professionals felt the post discharge planning process could be improved by better co-ordination of GP and community services to ensure a patient has a considered plan of care available to them.

Communication and Information

1. 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.

   This will then act as a method of communication between patient/carers and professionals in hospital and in the community.

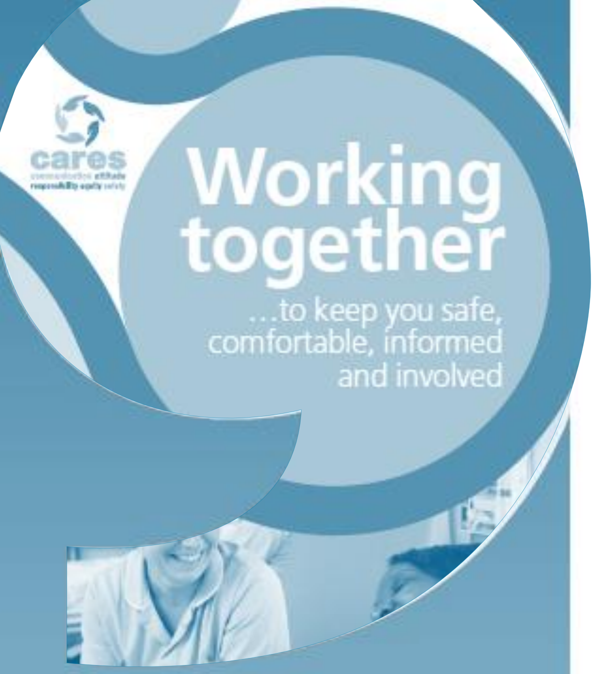
2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

3. We recommend that an independent advocacy service should be provided for individuals who have substantial difficulty in being involved in the assessment and discharge planning process.

Processes and Procedures

4. 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 consistent, 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[xix]. 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.

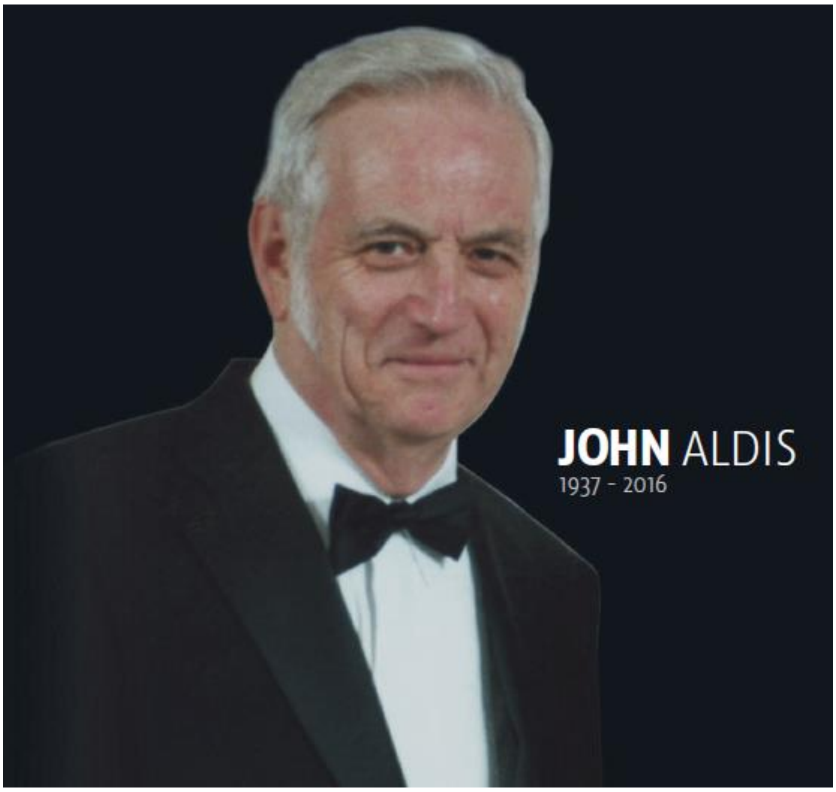
5. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment, we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.
6. 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.
7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:
    - the patient is the carer for their partner.
    - the partner is the sole carer for the patient.

Closer integration and joined up working

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
    - As a possible solution to providing wrap around and integrated care for the patient/carer.
    - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other’s services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.

PATIENT'S STORIES*

*Stories are of the lived experience of patients and their family members. They are their own accounts and written in their own words. Some names have been changed to protect anonymity.



My Big Brother John

Background

First of all, let me offer some background information and my opinion as to what led to his premature death.

Around six years ago, my brother suffered a stroke from which he never fully recovered. This led to mobility issues which became more evident approximately six months ago. He was often having falls inside his home which inevitably led to hospital admissions ...and they were becoming more frequent. There were also very early signs of dementia setting in.

Just after his 79th birthday in January, I suggested to him that he took out a Lasting Power of Attorney for his Health (LPH) naming his only next of kin (me) as his executor. I also asked him did he wish to stay in his own home for the remainder of his days. He replied "Yes". I also explained to him that the LPH would not kick in until he was mentally unable to make his own decisions. He said he would think about the LPH.

By April, he was back in Hillingdon with a urine infection. He was incontinent (mainly because of his mobility issues) and prone to this kind of infection. By this time Social Services had decided he need full time care which was duly implemented. 4 visits by two carers every day. By this time, I had also asked Age UK to take care of his house cleaning (one hour a day, Monday to Friday). They had taken care of his shopping once a week for the last two years. John also asked me to apply for the LPH which I did.

For the next two months he was often getting into difficulties getting up and down stairs and suffering falls as a result because his mobility was getting worse. So, I had some of the downstairs area cleared and a hospital bed and hoist were installed by the district nurse’s department of Social Services. His doctor paid him a visit and diagnosed that he had rheumatoid arthritis in his hands and arranged for him a visit to the hospital for some time in July. The rheumatoid arthritis condition made it difficult for him to hold things plus he was pretty much a “dead weight” with his limbs. He never got to that appointment because the doctor’s practice (Medical Centre in Ruislip) forgot to mention that he couldn’t walk by himself to the hospital transport that had come to pick him up! I contacted the practice to discuss my brother’s health and to get the transport changed so he could meet his appointment at a later date. I did say that I would soon be getting the LPH - their answer was they would not discuss my brother’s health and would only discuss it once I had it in my possession and they had proof that I in fact had the LPH - not very helpful to say the least.

We are now into late July and I noticed that my brother had an irritable cough, but thought no more of it. Approximately three weeks later I went to visit him again and he still had the cough - but he said he was OK. A few days after that I get a call to say that John was admitted to hospital (Friday 12th August I think) because he had slipped off his chair (which sets off an alarm) and the attending carers noticed that his urine was a really dark colour.

The following is mostly from conversations I had with Ward Staff at Hillingdon Hospital and other parties:

So, he was in Hillingdon Hospital for the urine infection.

His stepson had a call about this time from the hospital to ask whether he was a heavy drinker because of the colour of his urine. John had not touched any alcohol by choice soon after his Wife died some four and a half years earlier. It is more like dehydration!

The Discharge Fiasco

The urine infection got cleared up in about four days. On the Wednesday, a doctor who noticed his cough, checked him out and diagnosed that he had the early signs of pneumonia. His throat had swollen up as a result and his diet had to be changed to soft foods.

The medical staff at the hospital suggested that he recover in his own home and would be discharged the next day (Thursday) taking with him medication from the hospital pharmacy. Hillingdon Hospital notified Social Services who in turn notified John's carers that they would be "back on" as he was coming home on the Thursday.

Well, he never got there. Why? Because pharmacy didn't have the medication that was prescribed. Meanwhile the carers were at the house, but no John.

The next day (Friday), pharmacy supplied the medication required. The carers showed up again. However, Hospital Transport couldn't spare anyone until nearly 11pm at night. I was told he should get home around midnight. I said to the ward nurse she must be joking because who was going to get him into the house as there wouldn't be anyone there to greet him. She said OK, it'll have to be Monday now.

(I would suggest: that unknown to me, he was getting no antibiotics for the pneumonia condition, because the ward staff saw him just as a patient waiting to go home. It is conjecture, but I 'm putting two and two together and making four. Of course, there is another scenario - he was getting the medication, but despite him getting worse, they still discharged him because all they were interested in was the availability of his bed - if that was the case then I don't know how the management can sleep at night)

Monday changed everything. Finally, he got driven home by Hospital Transport, with his medication. Problem was, John was gasping for breath because he could hardly breath. It was also the hottest day of August. The driver noticed the difficulties my brother was having and pointed it out to the two awaiting carers at his home. They took one look at him and called for an ambulance. The ambulance got there within 30 minutes. The Paramedics took a look at him and were heard to say 'which idiots let this one out'. They tried to take him back to Hillingdon but were informed there were no beds available. So they took him to Northwick Park Hospital where he was transferred into the intensive care ward.

He was on near enough, pure oxygen for four days. But a patient cannot stay on pure Oxygen forever. So he was transferred out of there to another ward where he was put on half-oxygen.

(Sunday, 28th August) That was the last time I saw John alive. To be honest he seemed quite cheerful but struggling to speak. I thought 'he's over the worst; he'll get better and through it OK'.

I kept in touch with Northwick Park just about everyday from that point onwards. Towards the end of that week the staff at Northwick Park were saying that his heart was becoming a problem because of the pneumonia and that if he got into difficulties they would not try to revive him. By the Sunday (4th September) the hospital said he was in pain from breathing difficulties and that they were going to administer Morphine. When hospital staff tell you they are going to administer Morphine, you know it's the beginning of the end but you live in hope.

Thursday 8th September

John died at 7am on the morning of Thursday 8th September of Bronchial Pneumonia. Northwick Park had obviously tried to contact me early in the morning, but I hadn't picked up. So they phoned John's stepson in Wigan. He sent me a text to say that I should call "Vill" at the hospital. I did so about 8.30am to enquire what the problem was with John. He told me "John has expired". I didn't quite catch the last word and asked him to repeat it. He repeated it: "John has expired".

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

That made me so angry, I replied "He's not a Packet of Cornflakes or a robot -he's a human being! Try died, deceased or passed away, not frigging expired!" Shocking to speak to the bereaved like that!

I said I wanted to see him to say good-bye to the body. He said "How quickly could you get here". I said "It takes approximately one and a half hours but I probably won't get there until 12 noon and please do not leave him in the ward - because they were going to until I got there. I said it's unfair to the other patients".

Oh incidentally, one more thing- The LPH came through on the 8th September, the day he died.

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

Mary's Story

My Mum was in Hillingdon hospital for 7 and a half weeks. She was moved during this time from one ward in the hospital as they needed the bed, to Hawthorne. On the day she was moved to Hawthorne, they said there was a referral for my Mum to go there but that they hadn't accepted her, and so didn't know why she had turned up. There doesn't seem to be any joined-up communication.

Whilst in Hawthorn mum had to be sent to A&E at Northwick Park. Mum stayed in a ward there for a few days and then was discharged back to Hillingdon's Stroke Unit. Yet again a ward she was being moved to who were not expecting her, another breakdown in communication, this time between hospitals.

Before Mum came home for a home visit I asked to speak with the doctor. I was told that there was no need to speak with a doctor as she wasn't being discharged, it was just a home visit to assess how she would cope at home.

Mum came home for a visit with the OT who was assessing her, and she stayed home that day. There was no discharge, the ward didn't realise she was going to stay home. So, I had to go back to collect her medication and a commode. I asked to see a doctor as I had questions but there wasn't one available.

The ward eventually gave me a discharge summary note which a doctor had written under the heading 'Under relevant legal information'- "I have not seen or assessed this patient, I have only been involved in preparing this discharge summary from medical notes".

There were no adaptations or equipment in place, no medication ready and the care hadn't been confirmed. I am caring for my mother but I won't be able to do it by myself forever. I tried to speak with a doctor as I have not had an update on Mum's condition or how she has been treated or why she was discharged so abruptly. I was told to ring at 9am the following morning, but there was no doctor to talk to.

I was told that Mum needs physio but that there was a 6-week waiting list of physio which Mum needs.

As it turns out Mum's unplanned early discharge meant that she came home with an infection level that was increasing again (something that had been monitored since 10th Aug). Her own GP got the rapid response team to do further tests, which showed the infection level had increased further and mum was put on antibiotics. Surely, she shouldn't have been discharged with a growing chest infection???

An outpatient's appointment was sent to us for her to attend the Elderly Day Hospital clinic with arranged hospital transport. I rang the hospital transport the day before to check what time they were coming.

When I phoned up I was told that she wasn't on the list to be picked up for any appointment. The upshot of this was that Mum couldn't have a new appointment for another two weeks. The ironic thing was the hospital transport turned up at our home the next day to take her to the appointment. There is just no joined up thinking.

> Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there.

Kate's Story

My Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there. She had been in Hillingdon before this incident and had to stay in for an extra 10 days while the care package was sorted out. This was a long time for her to be in there just waiting.

Mum went in again in September this year with fluid on her lungs. While this seems to have been addressed, I kept asking to speak to a doctor to find out what had been done, and how we can avoid it again. It seems the actual Doctors have no intention of speaking to family members and certainly make it impossible to speak to them, I never got to speak to a doctor, I kept asking but one never updated me with any information.

Mum was given the Friday as a discharge date. I arranged with the hospital that she would be brought home in the hospital transport ambulance at 4pm as I had arranged for 2 carers to receive her at her house. This was necessary as Mum cannot walk, is very deaf, diabetic and needs support. For some reason the hospital transport ignored this instruction and took her home at 2pm. They took the key out of her key safe and let themselves in, dumping my Mum on the bed. They left her alone without a drink or any support.

She rang my Aunt who lives far away. My Aunt tried to get hold of the carers to go around straight away but they couldn't, so she was left disorientated and alone for 2 hours. I'm really not happy about this as my Mum is 80 years old and it is disorientating enough coming out of hospital, but to be dumped on a bed and just left is not how an elderly person with multiple health conditions should be treated.

Harry's Story

My mother-in-law was in Hillingdon Hospital for 3 months this year following a stroke. The outcome of her current condition is that she cannot eat food unless it is pureed as there is a risk of choking. In considering her discharge, we went to a discharge planning meeting where I thought we would be discussing her needs and deciding what would be best for her on her return to home.

The meeting had multidisciplinary staff there, and on the advice of an OT, it was decided that my mother-in-law would need carers 3 times a day. This would ensure she is fed and cared for appropriately. This is the understanding that I had on leaving the meeting.

However, on the day that my mother-in-law was discharged it became clear that a carer would only be visiting twice a day. I was very concerned about this and thought they had made a mistake, as it wasn't what was agreed at the planning meeting. I rang the hospital and was told that Social Services who did not turn up at the planning meeting, had overridden the planning meeting decision, and had changed the care package to a carer twice a day.

It seems that Social Services had done their own assessment without any of my mother-in-law's family being present. As her main carer, and the one who knows her best, I feel that my concerns about my mother-in-law were not taken into account. After contacting Social Services on the day of discharge and explaining that care at mealtimes was essential, the care package was amended to 3 times a day, but we shouldn't have had to go through that stress to ensure my mother-in-law was discharged safely. The carers visiting my mother-in-law were the re-enablement carers who attend for 6 weeks after discharge. Social Services Manager arranged for a Care Agency to take over after 6 weeks as it was clear that my mother in law was not going to cope on her own. We were given no advice where to go for private carers if this agency was not suitable. I was not given any advice on support for carers which I desperately needed as I was overwhelmed with all the different arrangements that needed to be sorted out. I think that the hospital should do an automatic referral to Hillingdon Carers as this would trigger a contact to enable some support.

My mother-in-law left hospital with no care plan explaining her condition and what care she would get or who to contact if we had a problem. If she had left with

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

a care plan we would have known immediately that the package of care was inadequate.

Another thing that concerned me was the medication. My mother-in-law has to take a variety of tablets at different times of the day. It's confusing for anyone to administer, I don't know why Hillingdon Hospital couldn't put them in a blister pack. I had to dispense her medications into a Dosette box myself crushing them up before giving them to her. Eventually, I managed to get her GP to arrange for the blister packs with a new pharmacy.

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

Geoff’s Story

Over a period of three years I have been in Hillingdon Hospital twice for operations to remove cancers in my bladder, both operations went extremely well and I cannot fault the professionalism of the surgeons and the immediate after care staff.

After the first operation I was taken to a ward to recover where I was told to keep drinking several litres of water to flush out blood and clots until my urine ran clear, a doctor who was supervising me at the time advised me to call for him if my urine turned bloody and painful which it did during the night so I asked the duty nurse to call for the doctor, after waiting for at least 1 hour nobody came so I asked the nurse again as I was becoming anxious, after another hour a pharmacist turned up and gave me a bag of medications which puzzled me as I had not asked for this, he insisted it was for me, however I noticed the medications were addressed to a polish sounding name and suspected this medication was for the foreign sounding patient in the next ward who had been screaming 'Pain' all night, the pharmacist did apologise for the mix up.

> In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff

After the second operation three years later due to the same cancer returning I was again taken to a ward to recover and drink lots of water, when my urine ran clear I was surprised to be discharged early to return home, I suspected the hospital was desperately short of beds.

After being at home for several hours and drinking lots of water I began to experience pain and the urge to urinate but discovered that even using all my strength I could only squeeze out a few drops of blood.

I then started to worry that all the bloodied urine would be forced back up to my Kidneys or my bladder would burst causing further complications so in desperation I rang 111 who called me an ambulance to take me to A&E.

I was readmitted where the clots were removed and after an overnight stay I was discharged home wearing a catheter and urine bag for one week supervised by community nurses.

I have since completely recovered.

In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff, even some staff who cannot speak English.

Vera’s Story - “Isn’t it ironic…….”

Isn’t it ironic…that towards the end of my research as Healthwatch lead on the Hospital Discharge project my 83 year old mother-in-law, Vera, fell breaking her hip. This meant that I got to see at close hand, the end- to-end process of the elderly patient journey and share the experience with those I had interviewed.

I’d just like to say that I have a long and proud association with Hillingdon hospital having lived in Hillingdon all my life. I was born at Hillingdon Hospital, I had my children there, and my parents died peacefully there. I have nothing but respect and admiration for the men and women who work there and strive every day to restore health to the sick and the broken: they saved the life of my 3 year old daughter when she had a burst appendix, and they saved my friend whose organs failed due to infection. I have much to thank them for.

In carrying out research for the project I was able to see the immense pressure the hospital is under. They work relentlessly to deal with the hundreds of thousands of people coming through the door. There is no let up, no period of calm before the storm, it storms all the time.

It cannot be unexpected that the service has become almost completely reactive. There is little time to stand back and see the wood for the trees. Processes do not necessarily flow as originally planned, and this is what I saw when my mother-in-law started on her journey.

Monday 5th December 2016

We were away when we received a call explaining that Vera had fallen in her kitchen making a cup of tea. She doesn’t remember falling. She was admitted and operated on in the same day which we thought was excellent.

When we saw her the next day she was sitting up and although high on pain killers was relieved to have been fixed, she was very comfortable and happy with the care she was getting from ‘terrific’ nurses. She has previously had a stroke in 2013 but had recovered well and just needed a carer once a day to help her shower safely.

After a few days, physios had her up attempting to walk again which was great. On the third day of being there she had her hairdresser come in and set her hair. She was positive and looking forward to going home. We were pleased with her care, there were things like her teeth not being cleaned, or hearing aids not being put in but we were there every day and were able to do this for her. What was reassuring was the thoroughness of the staff to establish what caused the fall, her heart was tested and she was scanned.

As the days went on it became clear that surgically she was fixed and therefore could go onto the rehabilitation ward before going home. It wasn't clear how long she would be there, but the days turned into weeks. She was very distressed when she realised that she was going to be in hospital for Christmas but in the event the staff there were fantastic. They bent over backwards to make it a happy event for all patients.

We visited her twice a day whilst she was there, 3 times on Christmas day but never had the opportunity to speak with a doctor or clarify what was happening. We were told by a nurse that she had broken her hip and had had a hip replacement. We were told by the Occupational Therapist (OT) that she had broken her femur at the top and not her hip, and that it had been pinned. We were told by the physiotherapist that she had a partial hip replacement.

She seemed to be doing well, and the physio had her up and walking daily but apparently, the delay for discharge was due to a urinary tract infection - UTI, and the fact that the Civic hadn't allocated her a social worker. It was also delayed for the need to ensure the home environment was safe for her.

They were following the instructions for hip replacement care and therefore all seating at home had to be 2 inches higher than her knee to floor measurement. We had to measure all the furniture at home and provide annotated drawings of heights.

The OT said her sofa was too low and had to be raised by a company that comes in and does it. She also said a perching stool would be necessary for Vera to rest on her

way to the bedroom. And a commode would be necessary for the first few weeks. We asked if we could take her home in the car, but was told the seat would be too low and could cause damage to her hip, so hospital transport would be arranged.

We were told that at the ward meeting the UTI was discussed and identified 4 days before any medication was administered as it had taken time to get a doctor to write the prescription. During this period of no treatment Vera had frequently asked to go to the toilet. One night a nurse on duty refused to take her to the toilet causing her much distress. We raised this with the ward manager the next day and he was appalled that this could have happened.

On Wednesday 28th December the OT told us that they were still trying to get hold of the Civic to sort out a social worker and ask about re-ablement care. We were asked for her current care agency as they would ring them and sort out care for her.

We heard nothing more until Friday 30th at 11:30 when we received a call when we were out of the Borough from the OT asking for the keysafe number for her paperwork. During this conversation it became clear that Mum might be coming out on this day.

First Discharge

We received another call at 2pm from a nurse telling us Mum would be coming out at 5pm. We asked how this was possible when no alterations had been made at home, she didn't have any outdoor clothes to come home in, and no care was in place. We were told that she had a dressing gown that she could come home in, that care from Harlington Hospice had been arranged, and there was no mention of alterations at home.

We took clothes up to the hospital and sat with her until 5pm. There was no sign of any transport. We went to her flat at 6:30 to wait to receive her. At 7:45 the hospital transport eventually brought her home. She had missed an evening meal as she was supposed to leave at 5pm. My husband went to the hospital transport to greet her only to find her on the floor of the vehicle. The driver said she had fallen and was about to ring for an ambulance. My husband helped her up and got her into the flat. She was fine but very shaken. It would have been safer to bring her home earlier in the car! This was reported the Ward Manager on Tuesday 3rd January but there was no record of this incident.

Care After First Discharge

The care that had been arranged from Harlington Hospice had called twice earlier to an empty flat as it had not been communicated to them that there was a delay.

As there had been no alterations or OT home assessment, Mum's sofa was too low and her bed too high. This resulted in her falling during the night on 31st December whilst she was trying to transfer from her commode to her bed. Careline called us out.

Carers from Harlington Hospice were great, although due to scheduling pressures she was not helped out of bed until 10am which she found distressing. Before breaking her hip/femur she would have got out of bed herself, had a cup of tea and waited for her carer to help her shower, but after spending 26 days in hospital it was noticeable how weak she had got, and how her confidence has depleted, especially after falling in the hospital transport.

She had physio for 5 days after leaving hospital, which was extremely beneficial but not long enough to help her replace the decline in strength over her hospital stay. She did not qualify for re-ablement care although no logical explanation was given and we were never told who the assigned social worker was. No alterations were ever made to her flat to help her with the height of furniture. No phone call was made by the hospital to her care agency as we were led to believe, we sorted that out.

As a family we replaced the mattress to the right height, and we also bought her a new chair which was the right height. We did this as we were financially able to. Had there been conversations at the hospital, and we were there twice a day, we could have agreed between us what would be done before she came home, and who was going to do it in preparation for her to be safe on arrival.

As it was she came home to an unsafe environment. It took us a few days to procure a new mattress and riser chair for her. During this time she had her first fall on New Years Eve at 11pm transferring from her bed to the commode. She sank to the floor and no longer has the strength to get herself up. This now happens 3-4 times a week which is really distressing for her and us. She no longer has the confidence to go into the kitchen or do the things in the flat that she used to do before going into hospital.

There was also confusion over her medication. She left with a paper bag full of several different boxes of tablets, but a call from the ward after discharge informed us that she shouldn’t take one particular tablet at all.

She is surgically fixed but the 26 days in hospital has put back her capability to live a fulfilled independent life. We are now faced with an elderly lady who keeps sinking to the floor. We have requested an OT assessment through the GP, but don’t know if we are doing the right thing, or how long it will take to get help and advice. Unfortunately, my mother-in-law was readmitted to hospital within 30 days of her discharge.

Readmission - Saturday 28th January 2017

A week after her 84th birthday, she had the possible symptoms of a stroke, and a painful foot. We weren't too sure what was going on and so rang 111 for advice.

They talked us through diagnostic tests and said a paramedic would be on the way. 2 hours later there still wasn't a paramedic and we were getting further concerned as she was becoming more distressed. The operators on 111 upgraded the call to a 999 call and the ambulance arrived shortly after.

The lovely Hillingdon ambulance crew took us to Northwick Park as they said the stroke unit there was second to none. We arrived at 10pm and she was immediately assessed, had a cannula inserted, and assigned to a High Dependency Unit (HDU). From there she was taken for a CT scan, a foot xray and other tests. The speed of initial action was impressive. We waited for her to return from the scan/xray. She returned distressed as she has asked to urinate whilst away and her request had been ignored causing her to wet herself.

We waited then until 4:30am when a doctor came to update us on what was happening. The CT scan was clear, it didn't look like a stroke but he explained in detail how something else maybe going on in the body presenting stroke symptoms. We asked how her foot was as she said she couldn't put weight on it. He said he hadn't seen the xray so didn't know.

She was admitted onto the stroke ward at 5am on the Sunday morning, 7 hours after we arrived. On the Monday the consultant pulled up a chair and gave us a very positive account of what would happen. Mum would be dressed in her day clothes and frequently encouraged to walk about and gain mobility, she would have speech therapy and they would work hard on her rehabilitation to get her out as soon as she could walk to the toilet and back. We were very impressed with the level of care and energy that was being invested in her.

Wednesday, four days into her treatment there was a bit of a set back. Someone had at last looked at Mum's xray and the worsening bruising on her foot, and realised that she had in fact broken and possibly dislocated her big toe. There was another incident of a night member of staff chiding her for wanting to urinate again, which distressed her greatly, but on the whole her care was good. She wasn't in fact strong enough to walk to the bathroom and back but they had done all they could medically. It was explained that it is important to get an elderly person home so they don't loose further muscle function/get an infection/become institutionalised.

Second Discharge

Vera was due to be discharged on Monday 6th February, 8 days after her admission. We were hopeful that she had the right care in place. The hospital seemed very aware of the effect of an elderly stay in hospital and were extremely proactive in keeping her mobile on the ward, and ensuring that she would receive a course of rehab at home.

So everything was arranged, Vera was coming home at 1pm. We had got all her food in for the week, flowers etc and we were feeling positive. We received a call from the hospital discharge coordinator asking what time the carers were arranged for? I explained that I didn't know, as I was told twice by the hospital I did not have to worry about carers, as they would be arranging for us like the last time she was discharged. At Hillingdon Vera had received a supported discharge and we were under the impression this would be reinstated. The coordinator advised me Hillingdon Hospital have just told her Vera is a self-funder, so I needed to arrange something quickly today! I tried the carers who had been looking after Vera but they were not available until the following Saturday. I explained this to the coordinator, but was told if Vera doesn't come home today, they will be transferring her to Hillingdon Hospital.

Why no communication with Hillingdon Hospital before the day of discharge? I do not know. I am still not sure what assessment was done to see what Vera can afford. What I do know is that we do not want her going back to Hillingdon, when she is fit to go home, and I will be my mother-in-law's carer 4 times a day until permanent carers are arranged.

Shirley Clipp
Healthwatch Project Lead - Hospital Discharges

The Hillingdon Hospitals NHS
NHS Foundation Trust

Thank you so much for sharing the findings and recommendations from the Healthwatch Hospital Discharge Project 2016. This detailed project has provided our older patients and their carers an objective, supportive conduit to provide feedback regarding their experiences of discharge from the Trust. The information contained in the report is invaluable and will be used to help us improve discharge processes, and the support available for patients and carers, during this key part of the patient journey.

It was very pleasing to read in the Summary Findings that "the over 65's express an overwhelming feeling of pride in the NHS and hospital services" and that they are "quick to praise Hillingdon Hospital for their caring and attentive staff". Thank you for sharing this positive feedback.

However, it was disappointing to read that a significant number of patients experience poor communication regarding their discharge, and that many did not feel they were involved in the plans for their discharge. It was also concerning to read that some patients perceived a variation in care between day and night shifts and between permanent and agency staff. All our staff are expected to adhere to our "Cares" values and behavioural framework: the quality of care should not vary across different periods of time. The senior nurses for each division are giving this matter their close attention. We also noted the report highlighted marked variation from ward to ward in how discharge processes are implemented, and that inter-agency working is not always joined-up. These areas need addressing to ensure patients are empowered partners in care and that they experience a seamless transition from the hospital to their discharge destination.

We are keen to work in partnership with Healthwatch, Care Partners and other key stakeholders to progress the very helpful recommendations you have made in this report. Specific work already underway includes:

- Redrafting of our Working Together leaflet to encompass suggestions in the report.
- Developing written information for patients and carers in relation to NHS Continuing Healthcare Assessments.
- Continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of TTA medication and the format of Multi-Disciplinary Meetings to aid discharge planning.
- Developing an in-house survey to capture patient and carer feedback and satisfaction scores following discharge.

Other initiatives will be scoped and taken forward over coming months.

In conclusion, The Hillingdon Hospitals NHS Foundation Trust welcomes the findings of this report and looks forward to working with colleagues and service users in implementing the recommendations it contains to improve patient and carer experience.

Theresa Murphy
Director of Patient Experience and Nursing

Hillingdon Health and Care Partners

Thank you for sharing the Healthwatch Discharge Project - evidence report for local partners, at the last Older Peoples' Strategy meeting.

I have agreed to provide you a response on behalf of the Hillingdon Health and Care Partnership (HHCP) Accountable Care Partnership (ACP).

This is made up of:

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central and North West London NHS Foundation Trust (CNWL),
- H4All CIC, a federation of voluntary sector partners – Hillingdon Age UK, Harlington Hospice, DASH, MIND Hillingdon and Hillingdon Carers
- Hillingdon four GP networks, due to become Hillingdon GP federation from April 2017

Whilst providers may do their own individual responses (assume THH will be responding with regards to their specific in patient issues) the following input has been given from the HHCP partners with particular consideration of their work as part of an ACP.

The report sets out the key areas for consideration:

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

The recommendations fall into three categories:

1. Communication and information

- Working Together booklet – produce 'Patient Journey' (THH)

- Written information about Social services and continuing health care assessments (THH)

2. Process and procedures

- Standardising the discharge process across all wards (THH)
- Review of the discharge lounge (THH)
- Additional written instructions – for multiple medications (THH)
- Provision of Dosette boxes (THH)

3. Clear integration and joined up working

- Clearer communication between providers – ‘Patient Journey’ booklet (ALL)
- Joined up approach across all providers in coordinating discharge (ALL)
- Confusion of staff on who and when to refer to services – no signposting (ALL)

We are obviously very concerned to read of some such disappointing experiences people have had in the Hillingdon discharge system but we welcome the recommendations in the report as this provides material on which we can base our service design for older people. Through Hillingdon Health and Care Partners (HHCP), an Accountable Care Partnership (ACP), we have the opportunity to particularly improve the integration of services and provide patient centred care for older people in Hillingdon.

The aim of HHCP is to establish a truly integrated health and social care system. The areas we have identified we need to achieve:

- Addresses individual needs in a holistic way
- Offers more care in the community and in people’s homes rather than in acute hospitals
- Invests in prediction, prevention, early intervention and out of hospital services

- Joins up services across organisations and across care settings
- Adopts evidence based pathways
- Concentrates acute services to enable delivery of care in the most appropriate setting
- Offers better overall value for money

The discharge report clearly identifies some significant areas where the experience of people being discharged from hospital requires improvement and the recommendations will be used to influence the work streams that are currently being developed. We are really keen to see the ACP partnership tackle many of the issues you have highlighted that relate to the interface between hospital and the community and we are already working in some areas that we think will be helpful.

Since 2012 there have been developments within the intermediate care pathways and improvements in the admission avoidance (Rapid Response Team -RRT, intermediate care beds) and early supported discharge (RRT, Homesafe, Falls, Take Home & Settle, Early Stroke Discharge and respiratory outreach). However further work can be implemented to continue to build on improving community care with co-ordinated care planning and advance care planning.

Some of the key work areas within our clinical design work include:

- **Information sharing** to prevent the repetition of basic information to several teams (with initial work around due to lack of joined up IT). Some improvement in information sharing from community has recently been noted through access to GP records for hospital staff via Hillingdon Care records.
- **Development of the ICP and development of fifteen care connection teams**

  A centralised care plan is key to coordinating care. The model for the Care Connection Teams (CCT) is based on this principle. Where a patient attends or is admitted to hospital for information is automatically transferred from the hospital to GP via Docman. These patients are then discussed with the CCT and GP with a view to need for telephone contact / visit to ensure they are stable. This might include proactive calls to the hospital team from the Guided Care Nurse where the patient /family were well known and this information would support safe planning of discharge. In complex cases when a discharge summary was accessed suggesting changes in physical status, care needs, medication and need for follow up (blood tests / clinics / GP review), the patient was contacted.

The new Guided Care Matron (GCM) role enables a holistic review (in the patient home if needed) to ensure understanding of the changes and follow through on actions. This review includes medication reconciliation and compliance (an area being focussed on with hospital pharmacy and community pharmacy support), follow up with other services to support if problems became more apparent post discharge (care connection team / voluntary sector especially) and advice and update of care plan with GP and when needed geriatrician / other specialist. With reduced lengths of stay the requirement for improved timely community support is essential and this service provides a contact and link which was much appreciated by patients as per the pilot feedback.

We will look to promote co-ordinated and advanced care planning.

- We are also supporting THH with **'Patient Journey' booklet** and how this can be successfully implemented and used across all providers
- **Medications issues;** One of the key aspects of concern highlighted in the report is around understanding of new health problems, medications and ongoing follow up post discharge plus physical support / social care input. Whilst there are clearly processes and communication within the hospital trust to improve on, some of this work will be captured through the role out of care connection teams across the borough especially for those complex patients with longer stays.

- **Escalated care plan and workstreams** are based upon the initial Whole systems integration work in the North of the borough and patient voice input about less repetition of story, increased collaboration between differing service and simplification of processes. As a result, those receiving care will have an improved experience and seamless transition between services according to need. Those delivering it will also better understand how to provide optimal care and refer to other services and support appropriately, ensuring less silo working and greater confidence in services available.

- **Review of the current Rapid Response service and step down beds** to be able to support patients with more complex needs, creating access to timely diagnostics and exploring intravenous treatments – the introduction of the geriatrician posts is a start but exploring further options especially around diagnostics and OOH support. We are already seeing a closer working between rapid response team and the hospital for both admission prevention and supported discharge.

- **Streamlining pathways and establishing single point of access (SPA) for community support services including rapid response.** This will include increased ability to provide escalated care in the community (intravenous antibiotics, blood tests) and safely avoid unnecessary admission, assist early discharge. We hope a single contact will make it easier to give patients details of where to call, should they have any problems with access to community services after discharge. We aim to simplify the number of different commissioned Rapid Response pathways to enable the service to take patients according to their needs rather than fitting pathway criteria.

- **Increased community support for patients with more complex needs through enhanced RRT service, ambulatory care pathways and rapid access clinics.**

- **Increased frontline geriatrician support at interface (ED and AMU, telephone support for GP and RRT).**

- **Better integration of intermediate care services** within the borough to enable patients to flow more seamlessly through the pathway. The introduction of a Single Point of Access proposed as part of the escalated care work stream will help in providing a solution to wrap around and integrated care for the patient/carer and act as an information hub for professionals.

Through implementing the above key areas of improvement we aim to have an overall positive impact on the delivery and quality of care for Hillingdon's residents. The key words we need to keep focused on to ensure this succeeds are – Communication, Integration, Ownership and Responsiveness.

We believe that HHCP will be able to offer a really positive contribution to those issues raised in your report relating to the interface between acute and community care and look forward to getting more feedback following redesign.

Jo Manley: ACP Programme Director on behalf of Hillingdon Health and Care Partners

HILLINGDON
LONDON

Thank you for sharing your report at November's meeting of the Older People's Strategy Group and I think that this will be helpful in supporting the drive for change within the local health and care system.

The purpose of this letter is to respond to some of the key issues raised that are pertinent to Adult Social Care.

PRE-DISCHARGE

Patient Information

The report reiterates importance of having available clear information for patients about the discharge process so that they know what to expect and what choices are available to them.

You will be aware from the November meeting of the Joint Hospital Discharge Pathway Group that a task and finish group is being established that will look at the information available and how this can be improved, including the development of a 'Patient Journey' booklet. The level of detail about access to social care to be included in this, including an explanation of the National Eligibility criteria and also about the fact that social care support is subject to a financial assessment, is something for this group to consider. What is clear is that we collectively need to ensure that clear information is available and distributed in a consistent way to patients.

Processes and Procedures

The need to standardise discharge processes across all wards has been acknowledged by health and care partners and there is work in progress through the Hospital Discharge Pathway Group to develop a formal procedure intended to support patient choices that will provide clarity about roles and responsibilities across all partner organisations. The aim is to have this sign-off by partner organisations by the end of 2016/17.

Joint Discharge Team

It is interesting that some staff expressed confusion about the role of the Integrated Discharge Team and again identifies communication issues. The intention for 2017/18 is for the Hospital, the Council and the CCG to work together to secure a decision about funding in Q4 2016/17. This will then provide an opportunity to ensure that staff are fully briefed to avoid continuing confusion going into 2017/18.

POST-DISCHARGE CARE

There were a number of points highlighted in your report about post-discharge care that I think can be summarised under the headings of information and communication, roles and responsibilities and the local homecare market. I will address each of these in turn.

Information and Communication

The issues identified in your report about people being supported by the Reablement Team not knowing what would happen to them after their period of reablement and also people not understanding what package of care to expect relates very much to the general theme about the availability of suitable information and also about communication. This is something that will be looked at as part of the patient information task and finish group referred to above.

Roles and Responsibilities

The Council has noted that for some service users the number of care workers providing their care and the frequency of attendance did not match their expectations. We believe that this relates to the blurring of lines of responsibility between medical and social work staff. The new policy and procedure referred to earlier will help to clarify the decisions that properly sit with the respective professionals and this should assist in relieving scope for service users being left confused.

Local Homecare Market

Your report identified an issue about care workers not attending at times that fitted in with service users' routines. This is not an unreasonable request from service users and the Council has done a lot of work with homecare providers to improve capacity and stabilise the local market to help deliver this. Unfortunately, where a lot of people require calls at particular times of the day, e.g. early morning, this is not always possible, especially as priority has to be given to those whose circumstances necessitate calls at specific times of the days, e.g. because of medication needs.

The Council will continue to work with providers to improve the capacity and quality of homecare provision and Healthwatch will continue to have a vital role in providing feedback on the service user experience of care. However, you will be aware that the nature of the homecare market in a high employment area such as Hillingdon means that this is not an easy issue to address.

The final point in respect of homecare was about care workers not staying for the allocated time. This is an issue when the care worker charges for care that has not been delivered; if they manage to complete what is required within a shorter period of time and only charge for the time present then this is not an issue. Where a care worker claims for time delivering care that has not been provided then this is likely to constitute fraud and there have been criminal prosecutions in Hillingdon in recent years where this has occurred. Where the Council becomes aware of these instances we will liaise with the Police to ensure that there is a thorough investigation and prosecution where there is sufficient evidence.

Going forward all of the Council's homecare providers will be required to use electronic call monitoring systems and this means that they will then only be paid for the time recorded. This should reduce the scope for this to occur in the future.

I hope that you have found this information useful and please do not hesitate to come back to me if you have any further queries or if you think there are any points that have not been addressed.

Gary Collier
Health and Social Care Integration Manager

CONCLUSION

The evidence we have collected during our research has provided us with a valuable insight into older people's experiences of being discharged from Hillingdon Hospital, and the care and support provided to them in the community.

We acknowledge that health and social care services are under extreme pressure. However, we believe that to maintain high quality services in these challenging times, it is even more important to focus on patient experience.

By engaging with our residents we have provided a rich source of information for commissioners and providers to gain a better understanding of the care delivered to Hillingdon's older residents, and how local people feel the quality of their care can be improved.

Our insight suggests that it is overwhelmingly clear that better information and communication between patients, care staff and organisations, are key if services are to be developed and improved. It could be argued that achieving this maybe the most important factor to transforming care services in Hillingdon.

Organisations have responded positively to our report and have acknowledged that improvement is needed.

A number of the recommendations outlined in the report have already been implemented.

Our evidence has also informed the Better Care Fund and additional actions have been added to the delivery plan, which is monitored at the Hillingdon Health and Wellbeing Board.

We look forward to continually working with, the public, commissioners and providers to improve care for our older residents.

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