Service Review of Discharge from St Helier Hospital
A joint report by the Local Involvement Networks in Sutton and Merton

October 2010
THE ROLE OF SUTTON LINK AND LINK MERTON IN THIS RESEARCH

LINk Merton and Sutton LINks are networks of local residents, voluntary and community groups. They are totally independent of the Council, Hospital Trusts and Primary Care Trust. LINks have been set up in every area of England to help local people influence and improve their health and social care services.

It is the role of the LINks to seek out the views of the public, service users, patients and carers to ensure their concerns and issues relating to health, and social care are heard. LINks can ensure these views are represented to the commissioners and providers enabling local people to improve and influence change in local services to improve people’s quality of life and independence.

ACKNOWLEDGEMENTS

Merton and Sutton LINks would like to express deep appreciation to members of the following groups for their valuable time and support during the various stages of this work:

- Sutton and Merton LINks Hospital Discharge Working Group
- Age Concern Merton
- Age Concern Sutton
- The User & Carer Involvement Group (Age Concern Sutton)
- Wimbledon Guild
- Merton and Morden Guild
- Alzheimer’s Society Sutton and Merton
- Carers Support Merton
- District Nurses in Sutton and Merton
- Friends in St Helier (FISH)
- Participating GP Practices
- Nelson Commissioning Group Management Team,
- Primary Care Commissioning Consortium
- Practice Managers meeting
- London Borough of Merton Re-ablement Service
- Epsom and St Helier Patient Experience Committee
- NHS Sutton and Merton - Engagement and Equalities Team
- Merton Seniors Forum
- Sutton Seniors Forum
- Benhill Residents Association
- SCILL
- Sutton EuroAsian Group.
## CONTENTS

**PART 1**  
**INTRODUCTION**  

**PART 2**  
**RESEARCH DESIGN & METHODOLOGY**  

**PART 3**  
**ANALYSES OF PATIENTS & CARERS FINDINGS**  
Section 1 *Profile of Interview participants*  
Section 2 *Initial Discharge Planning*  
Section 3 *Actual Discharge Process*  
Section 4 *Patients transition to home, GPs & Social Care Services*  
Section 5 *Challenging Hospital Decisions*  
Section 6 *Assessing Patients & Carers satisfaction with discharge planning*  

**PART 4**  
**ANALYSES OF GPs, DISTRICT NURSES & VOLUNTARY ORGANISATIONS FEEDBACK**  
Section 7 *GPs perception of St Helier discharge planning*  
Section 8 *District Nurses perception of St Helier discharge planning*  
Section 9 *Two Voluntary groups’ perceptions*  

**PART 5**  
**SUGGESTED IMPROVEMENTS BY RESPONDENTS**  
Section 10 *Suggested improvements by Patients & Carers*  
Section 11 *Suggested improvements by GPs, District Nurses and 2 voluntary groups*  

**PART 6**  
**CONCLUSION & RECOMMENDATIONS**  
**NEXT STEPS**  

Bibliography
PART 1

INTRODUCTION

A number of Department of Health (DOH) documents have stressed the importance of discharge or care transfer as a key part of patients’ experience in hospital care\(^1\). Whether the discharge is to home, rehabilitation facility, or a nursing home, a smooth transition is critical to the health and wellbeing of patients. Effective discharge planning can dramatically improve outcomes for patients as they feel motivated to participate in decisions towards their recovery and feel prepared to move to the next level of care. This principle applies to both emergency and elective cases, with equally large benefits to health and social care systems by ensuring efficient use of resources.

Since Sutton & Merton LINks have been in operation, feedback from extensive consultations, outreach visits, listening events and online surveys, has identified concerns over the lack of consistency in both the process and quality of discharge planning in the locality. It became clear that hospital discharge procedures were a significant concern not only to patients, but to GPs, District Nurses, and relevant voluntary sector organisations. Patient surveys conducted by the Care Quality Commission in 2008/09, also gave Epsom & St Helier NHS Trust ‘low to worse’ scores on many of the areas assessed on discharge (CQC 2008 & 2009).

As a result of this preliminary finding, a Hospital Discharge Working Group was set up by Sutton & Merton LINks to investigate the extent to which discharge pathways are working at the local level, and to assess linkages with social services, GPs, District Nurses, and community support services. St Helier Hospital was chosen for this research, because it is the largest hospital in both boroughs, and also serves the entire region of South West London and Surrey\(^2\). This report is the result of our investigation, with comprehensive analyses on:

- How well the aims and objectives set out in the *Epsom & St Helier NHS Trust Discharge Policy, 2007* are being implemented locally. We have identified stated policy guidelines in respective sections below, and established whether they are being followed in all cases based on our primary findings. Relevant Department of Health papers including *Ready to Go, Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care, 2010; Achieving Timely Simple Discharge from Hospital, 2004*, are also consulted throughout the report\(^3\). These

---

1. See for example *Achieving Timely Simple Discharge from Hospital, DOH, 2004*
2. Epsom & St Helier Hospitals serves at least 510,000 people. It is a large Trust with extensive range of acute services including 24 hour A&E. For more information see [www.nhs.uk](http://www.nhs.uk) or [www.epsom-sthelier.nhs.uk](http://www.epsom-sthelier.nhs.uk)
3. For other policy reports and relevant papers used, please refer to bibliography.
documents help to establish the framework within which discharge standards can be measured. Regardless of whether St Helier discharge policy is being followed, this report assesses whether current policy guidelines adequately meet patients and carers needs.

- Data analyses and final outcomes are based on interviews and other feedback from patients who were recently discharged from St Helier hospital, GPs, District Nurses, and members of staff/volunteers from voluntary sector organisations, who directly work with patients immediately discharged from St Helier.
- Responses from participating groups were designed to explore whether the transition between hospital discharge, social care services, and community services are effective. These services are in many cases vital to aid speedy recovery of a patient following discharge.
- A final conclusion is drawn identifying best practice, and outlining recommendations for improvements.

We would like to caution readers that issues emerging from individual hospital discharges are vast, making a complete coverage of the subject unattainable in a single piece research. The data in this report provides a valuable insight into how discharge is operating locally. Whilst it is neither conclusive evidence nor a reflection of every individual discharge experience, the findings from our research include evidence of:

- A lack of initial discharge planning when patients arrive in hospital.
- Delays between patients being discharged and leaving hospital.
- A need for better communication with patients, carers and relatives.
- A need for better communication with GPs, District Nurses and other agencies.
- A need for improved information in the hospital of the support services available when patients are discharged.

Our focus is to use this report to create an avenue for Commissioning Managers to effectively engage with the views of service users, health care professionals, and third sector organisations, to enhance the development and delivery of hospital discharge in our community. Both LINks strongly believe that in order to improve the quality of care and services provided locally, it is important for service providers to understand ‘what the people think’.
PART 2: RESEARCH DESIGN

METHODOLOGY

Research Aims

- To improve St Helier hospital discharge planning to benefit the people in the London Boroughs of Sutton & Merton.
- To provide comprehensive overview of St Helier’s discharge planning at the local level for all parties with interest in this area. This document can serve as a reference manual for campaigning or a source of authoritative primary data.

Objective

- To engage St Helier Hospital Discharge Service Providers with evidence of current discharge practices at the hospital, and seek further improvements.

The use of qualitative data in this report

The methods employed for the interviews were qualitative in nature. Members of the Sutton & Merton LINks Discharge Working Group met to agree on an approach for this exercise. Five separate detailed questionnaires were finally devised, with the view to explore the views and experiences of patients, carers, GPs, District Nurses, and relevant voluntary sector organisations. The carers consulted were relatives or spouses of patients, and not paid carers.

This report is based on the themes and issues arising from the analysis of the qualitative data from the overall feedback. Individual quotations are used throughout the report to illustrate points being made.

The use of quantitative data in this report

Graphs, pie charts, and computed percentages, showing responses to the questions appear throughout this report. A table detailing the characteristics of interview participants is also included.

Analysis of the data collected

The qualitative data from the interviews were entered into an Excel database developed for this research. Responses to each question from patients and carers were analysed by producing tables to give cross tabulations of answers to the sub-questions. The aim was to paint a picture of commonalities and differences between answer types. This approach was used to also analyse responses from GPs, District Nurses, and voluntary sector organisations.
**Number of interviews**

Questionnaires were administered by professionals and volunteers at Sutton & Merton LINks, and a number of local organisations including: Age Concern Sutton, Age Concern Merton, Wimbledon Guild, User & Carer Involvement Group, Merton and Morden Guild, Carers Support Merton, District Nurses in Sutton and Merton, Friends in St Helier (FISH), GP Practices, Practice-based Commissioning Groups, Primary Care Commissioning Consortium - Practice Managers meeting, London Borough of Merton Re-ablement Service, Epsom and St Helier Patient Experience Committee, NHS Sutton and Merton - Engagement and Equalities Team, Merton Seniors Forum, Sutton Seniors Forum, Benhill Residents Association, SCILL, and EuroAsian Group. In addition to distributing questionnaires, many of these organisations provided us with relevant discharge information, and allowed us to present our work in their forums. Questionnaires received were as follows:

- 58 completed questionnaires were received from patients (or their carers) who have recently been admitted to St Helier Hospital. All respondents lived in the boroughs of Sutton and Merton.
- 14 responses were received from GPs, either directly or collectively via group meetings.
- 7 questionnaires were completed by District Nurses.
- 9 questionnaires were completed by volunteers and staff from Age Concern Merton, and Friends in St Helier (FISH).
- In total, 88 questionnaires were analysed for this report.

**Recruitment of Participants**

The Sutton & Merton LINks Hospital Discharge Working Group decided to first consult its members and contacts across both boroughs. A schedule of potential respondents was then devised to include attendees at the groups mentioned above. An online survey at the Sutton & Merton LINks websites was also included. The aim was to ensure we reach a diverse group of local people including under-represented and vulnerable groups. A good ethnic and gender mix was targeted.

**Geographical Area**

The entire boroughs of Sutton & Merton were chosen for this research. These areas have marked differences in health inequalities and deprivation levels. Collecting data across both boroughs was necessary to capture the profiles of affluent and under-represented groups in the sample size.

**Conduct of the interviews**

The questionnaires were distributed by the Hospital Discharge Working Group members, and members and contacts of both Sutton & Merton LINks who are volunteers or representatives of local organisations. Many of the LINk volunteers have extensive
experience of conducting qualitative interviews, and have received sufficient training. They have a good understanding of the need to ensure a methodological and consistent approach was adopted.

The questionnaires were given to participants to complete by themselves. However, where respondents were unable to write or had difficulty assimilating the process, help was available to support them to record their views. The District Nurses and staff from voluntary organisations completed the questionnaires themselves. Some GPs in Sutton had group discussions about the questions and elected one GP to respond on their behalf.

**Structure of Report**

This report is divided into 6 different parts, with 11 sub-sections. A list of bibliography consulted can be found at the end of the report. A summary of findings is also attached.
PART 3: ANALYSES OF PATIENTS & CARERS FINDINGS

SECTION 1 – PROFILE OF INTERVIEW PARTICIPANTS

Age ∑ 100%

<table>
<thead>
<tr>
<th>18 – 25</th>
<th>26 – 40</th>
<th>41 – 59</th>
<th>41 – 59</th>
<th>60 +</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>10%</td>
<td>23%</td>
<td>60%</td>
</tr>
</tbody>
</table>

- Total percentage of females: 76%
- Total percentage of Males: 24%
- There were 44 females and 14 males in the sample group. 83% of all respondents were over 60 years of age.

Hospital attended

<table>
<thead>
<tr>
<th>St Helier</th>
<th>Admitted into A &amp; E</th>
<th>Pre-booked</th>
<th>Elective cases</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>74%</td>
<td>14%</td>
<td>0%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Length of Hospital stay

<table>
<thead>
<tr>
<th>1 – 3 days</th>
<th>3 days – 1 wk</th>
<th>1 wk – 2 wks</th>
<th>2 – 3 wks</th>
<th>3 wks – 3 mths</th>
</tr>
</thead>
<tbody>
<tr>
<td>24%</td>
<td>31%</td>
<td>21%</td>
<td>10%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Geographical Area

The entire boroughs of Merton and Sutton were chosen for this research. These areas have marked differences in health inequalities and deprivation levels.

Reasons for admission

Many of the respondents were admitted due to a fall. Other reasons cited were, heart attack, broken wrist, knee replacement, bowel tumour, gastroenteritis, chest infection, bowel haemorrhage, fainting and dizziness, trauma, stroke, broken back, gynaecological issues, etc.
The DOH guidelines and Epsom & St Helier Discharge Policy both emphasise the importance of discussing estimated length of stay with patients, and setting a discharge date within 24 hours of a patient’s arrival in the hospital. In case of pre-booked or elective care, discharge could be discussed before admission, and must be communicated to carers and all staff in contact with the patient. The expected date of discharge is then managed against the treatment plan by ward staff on a daily basis and changes communicated to the patient. In these interviews, we sought to assess if this policy was being effectively practiced.

1. **Was discharge date given before or within 24 hours of admission?**

   ![Graph showing discharge planning](image)

   - According to the above findings, 62 percent were not given a discharge date before or within 24 hours of admission. A significant number of them were informed about discharge on the same day they were asked to go home.
   - Although 35 percent were given a discharge date within 24 hours of admission, more than half of these people stayed in the hospital for one day or night only. None of the respondents that had a pre-booked arrangement, was given a discharge date before admission, although staff are required to set a discharge date prior to admission for pre-booked patients.
   - Overall, effective early discharge procedures were applied to only 16 percent of respondents.
These findings contradict St Helier’s discharge policy. The benefits of discussing discharge at the earliest opportunity must not be understated. It is vital to reducing delays, ensuring efficient management of hospital beds, reducing waiting lists, re-admission, and leads to greater patient and carer satisfaction (DOH 2004).

2. Who discussed the discharge plans with you?

When we asked the respondents who discussed their discharge plans with them, we got very mixed answers.

- 40 percent said it was conducted by a Doctor or Consultant.
- 20 percent said discharge was discussed by a Nurse.
- 7 percent said it was conducted by Social Services.
- 2 percent mentioned a Discharge Co-ordinator.
- 12 percent said discharge was discussed with a Physiotherapist, Registrar or Administrator.
- 10 percent said nobody discussed discharge with them.
- 9 percent were not sure or did not answer the question

Whilst all the above members of staff are well qualified, the broad range of professionals co-ordinating discharge for patients invokes the question as to how effective the entire discharge process is conducted and communicated to relevant parties. In theory, St Helier discharge policy states that the responsibility for the process of discharge planning should be co-ordinated by the Ward Manager, commencing at the start of admission until
discharge is completed, with ultimate discharge resting with the Consultant in charge of the patient (ESH/POL/ 2007). This was however not the case in practice.

Although the current system may reflect the hospital's approach to multi-disciplinary discharge planning, it is often observed by health professionals that the most dangerous period for a patient is the handover between one clinical team and another. It is therefore vital that a key member of staff is identified to readily provide comprehensive individual discharge information. This is especially relevant to external parties including GPs and District Nurses, who expressed frustration with the current system, where multiple members of staff conducting discharge result in poor communication and information on discharged patients (see Part 4 below).
3. What time were you discharged?

The time that discharge takes place is important to many patients, and to the hospital, by helping staff to resolve the mismatch between admissions and discharges. This ensures that beds are made available before the peak demand for them builds up, hence, reducing pressure on beds and waiting lists. For vulnerable patients who may require immediate support services, a weekend or bank holiday discharge may not be favourable, unless there is an absolute agreement by relevant parties, and the risk to the patient is avoided. This caution is highlighted in St Helier’s discharge policy. The GPs, District Nurses, and the voluntary sector staff we interviewed concurred with this view.

According to the DOH, the preferred time for discharge is early in the day before the peak demand for admissions (DOH 2004). DOH cites examples in Nottingham City Hospital and Royal Devon where discharging patients in the morning has been made a standard, with effective impact on managing capacity. In these interviews, we sought to assess the time the respondents were discharged from St Helier.

- 81 percent of the respondents told us they were discharged on a weekday, with 34 percent of these people clarifying that they were discharged late afternoon; 17 percent said they were discharged in the morning; 16 percent said they were discharged in the evening.
- 14 percent of the respondents did not specify whether they were discharged on a weekday or weekend.
- 5 percent said they were discharged late afternoon on a weekend.

According to the above, a minority of the respondents were discharged on a weekend, which seems to suggest a good practice of avoiding weekend discharges or keeping it at a minimum. Whilst majority were discharged on a weekday, not many of them were discharged in the morning. It is unclear in St Helier’s discharge policy, whether goals have been set to increase discharges in the morning or at any particular time.

A few respondents expressed dissatisfaction about the time they were discharged:

“It was atrocious. More care is needed and no last minute decisions should be made. I was discharged in the night when the weather was bad. I think all patients should be discharged in the morning”.

“I wanted a bit more notice of discharge so that preparations could be made”.
4. *Do you think you could have been discharged sooner or later than you were? How confident did you feel about being discharged, did you feel ready to leave hospital?*

Premature discharge can leave a patient with unmet needs, poorly prepared for home, with the likelihood of re-admission or using inappropriate or more costly social care services, such as intensive home care or residential care (DOH 2010). It is therefore vital that patients feel prepared to go home.

In these interviews:

- Half of the respondents told us they were discharged at the right time, with a majority of 55 percent saying they were ready to leave hospital.
- It was however interesting to note that 12 percent of the respondents wanted to leave hospital because they were dissatisfied with the care they were receiving. This suggests that patients’ readiness to leave hospital may not always be motivated by the right reasons. Comments recorded from these people include:

  - “I couldn’t wait to leave the hospital, I was starving. The meals were not good”
  - “I wanted to leave because things were so bad”
  - “I hated the hospital”
Some of the respondents said they wanted to be discharged later than the time they were asked to go home, with 28 percent saying they were not ready or confident to leave hospital. These people said they were anxious about coping on their own. The GPs we interviewed raised concern about this, stressing that some patients are discharged too soon leading to re-admissions because they are unable to manage on their own. Comments recorded from the respondents include:

“I was worried about how I could cope on my own, but not confident to tell the doctor”.

“I was not given any choice, I had to go home”.

“I was not ready, I couldn’t walk”.

“I felt very unsafe and vulnerable”.

A minority of patients said they wanted to be discharged sooner.

5 percent did not answer this question.

5. After being told you could be discharged, how long was it before you actually left? Were you told the reason for any delay?

The CQC scored Epsom & St Helier among the low performing Trusts in relation to long delays to patients following discharge (CQC 2009). This finding seems to be reinforced in this research.
In the above graph, 43 percent of respondents experienced 2 to 20 hours of delay after discharge. The most frequent reasons cited for the delays were long wait for medication, busy doctors, nurses, and ambulance. Comments recorded include:

“I was waiting for a doctor - doctors were on training”.

“Waiting for medication from pharmacy - they took 6 hours”

“Awaiting an available doctor”.

“Waiting to be dressed up - nurses said they were busy and were rude”.

“Patients were ahead of me”.

14 percent were delayed between 1 day to 1 week. Not all of these people knew why they were delayed for that length of time. Others however stated the following:

“They told me the ambulance was busy, and there weren’t enough drivers”.

“A doctor had to sign the discharge papers, and they couldn’t find one”.

“Further observations were carried out”.
• 3 percent were delayed between 1 to 3 weeks. The explanations included:

“Poor liaison between departments, over DST reports. The reports were the problem, they didn’t correspond with actual errors made, and dragged out too long”.

• 31 percent of respondents said they left the hospital immediately after discharge.
• 9 percent did not answer this question.

The DOH highlights that delays after discharge is usually a reflection of an overall poor discharge planning, from the time of admission, getting timely tests done, and a lack of setting an advanced expected date of discharge (DOH 2004). In order to avoid delays, the DOH stresses that discharge medication for example, should be prescribed as far in advance as possible, or at least 24 hours before intended discharge.
SECTION 4 – PATIENTS TRANSITION TO HOME, GPs & SOCIAL CARE SERVICES

Medication

6. Did you need any medication to take with you when you left hospital? If yes, were you provided with the medication and told how to use it?

- 78 percent of respondents said they needed medication when they left hospital. Out of these people, 85 percent were provided with the medication before leaving the hospital, or it was sent to a care or rehabilitation home, where they were being transferred to. 7 percent were not provided with any medication. 8 percent said they were given the wrong medication.
- Majority of the respondents who received medication were given instructions on how to use it. Only a few said they were not told how to use their medication. The CQC patient survey in both 2008 and 2009 scored Epsom & St Helier Trust ‘low to worse’ in this area (CQC 2008 and 2009). This finding could suggest an improvement.
- 17 percent of respondents did not require any medication.
- 3 percent did not answer the question, and the question did not apply to 2 percent of respondents who already had medication.

Transport arrangements
7. What were the transport arrangements? Were you happy with them?

- On leaving hospital, 43 percent of the respondents said a family member transported them home or they drove their own car. Many of these respondents were satisfied with their mode of transport. However, a few complained that they asked a family member to transport them because they were told an ambulance was not available. Others said they would have liked some help getting into the car.
- 37 percent said the hospital provided an ambulance or arranged a taxi for them. Some of these patients were transported to a care home. A few were unhappy that they were dressed in night gowns, and would have liked to wear ‘proper’ clothing.
- 10 percent of the respondents said the hospital did not arrange any transport for them, although they would have liked one. These respondents arranged their own transport including resorting to public transport.
- 5 percent did not answer this question. Another 5 percent said the question did not apply to them.

Home adaptations or provision of equipment
8. Were you told about the availability of aids or adaptations in your home to help you get around - and how to get them?

- 21 percent of the respondents said they were informed about the availability of aids or adaptations to their home following discharge.
- 35 percent said they were not given this information. It was not clear whether the hospital omitted this information because the patients did not require aids or adaptations.
- 41 percent of respondents said this question did not apply to them because they either had the necessary equipment or did not require any adaptation.
- 3 percent did not answer this question.

9. Did you get all the help and equipment you needed?

- 34 percent of respondents said they did not receive all the help and equipment they needed in their home.
- 24 percent said they got all the help and equipment they needed.
- 28 percent said they did not require any equipment or further help.
- 14 percent did not answer this question.

10. Did the hospital give you enough information on:
    a) The length of time it would take you to recover
    b) The problems you might have to face up to
    c) Things you might need help with
    d) Things you may have to give up doing?

The responses above indicate that:

- 26% - Received info on all 4 options
- 5% - Received info on 3 out of 4
- 21% - Received info on 2 out of 4
- 16% - Received info on 1 out of 4
- 26% - Did not receive info on any of the 4 options
- 3% - Info not required
- 3% - No answer
• About a quarter of respondents, 26 percent received information on: a) the length of time it would take for them to recover; b) the problems they might have to face; c) things they might need help with; and d) things they may have to give up doing.
• The same percentage of respondents, 26 percent did not receive any information on all 4 options.
• A significant majority, 42 percent received some, but not all the information on the options indicated.
• A minority of respondents did not require any information.

It is possible that people with minor cases could be discharged without requiring information on all the 4 areas highlighted. Nevertheless, 83 percent of the people we interviewed were above the age of 60 years, with many of them disclosing that they were admitted for serious illnesses (see profile of interview participants on page 9). As a result, comprehensive information on the length of time they might take to recover, things they might need help with, or the things they might need to give up doing, will not only reassure older people, but is in line with recent DOH package on preventative care (see DOH, Prevention Package for Older People. Government’s new Ageing Strategy, 2009).

As older people come out of hospital after having suffered a stroke, heart attack, or a fall, they may likely have to embrace a complete change of lifestyle, food choices, disability, loss of independence etc. Early preparation at the hospital to help them face up to such changes is vital.

How to get help from your GP, Social Services or Housing

11. Did the hospital give you enough info on the sort of additional help (eg from your GP, social services, housing) that would be available to you when you returned home – and how to get it?

• Half of the respondents, 50 percent said they were not given any information regarding additional help that may be available from their GPs, social services, housing etc, and how they could access it. Whilst many of the respondents later told us they felt all the help they needed was in place during discharge, it is still necessary that such information is passed on, especially to older people who formed a predominant proportion of the people we interviewed. Many older people tend to be more vulnerable as highlighted in St Helier’s discharge policy (ESH/POL/2007). Therefore such information is crucial to ensure continuity of care after discharge.

Comments made by some of these respondents and their carers clearly indicate that they would have liked such information.
“Just a very long wait and not very clear who to contact if problems occurred - did not get an information leaflet about what to expect or what to do if problems occur - who to contact - GP or ward”.

“I was 63, living alone but caring for my 94 year old mother who lived a mile away. I could not bend, drive etc (hip replacement). I was given a ‘pick-up stick’ & a raised toilet seat - to fit myself. It was not until I arrived home that I had any contact with social services even though I had tried to explain in the hospital beforehand that I would need someone to take over care of my mother. I had to get a taxi to visit her each day and pay someone to do our shopping. I was given the impression that I would be charged approx £13 per hour for help given so I cut visits as short as possible and ended the visits at the first opportunity. Weeks later I discovered that I could have had help for 6 weeks with no charge. I paid for a cleaner to come in and give some extra help. I feel my discharge was a disgrace”.

“I needed more advice on aftercare”.

“I wanted to know where to get after help from home”.

“To have someone to talk to that gives awareness of patient responsibilities when in hospital, e.g. what kind of services is available to them through their GP”.

“When patients with dementia are discharged, care like meals on wheels, carers etc, should be arranged for them before they reach home”.

- 29 percent of the respondents received this information.
- 5 percent did not answer this question.
- 16 percent said the question did not apply to them.

12. On leaving hospital were you given a letter to take to your GP?

- 45 percent of respondents were not given a letter to send to their GP following discharge.
- 36 percent said they were given letters.
- 5 percent said the letters were sent by the hospital directly to their GP.
- 9 percent did not answer this question.
- 5 percent felt the question did not apply to them.

According to St Helier discharge policy, “the patient’s GP will be involved, where appropriate, during the admission and in every case the patient’s GP practice will be informed of the patient’s discharge” (ESH/POL, 2007p9). In our questionnaires to GPs in
Merton and Sutton boroughs, 14 GPs expressed their consensual interest in receiving effective information on patients’ discharge at all times. The GPs stressed the clinical importance of giving patients clearly written and accurate discharge summaries, and sending copies to them, to be able to provide effective and timely after care. In the CQC 2009 patient survey, Epsom & St Helier Trust scored fairly low in this area. It appears there has not been much improvement. The impact of such practice is especially felt in the frustration expressed by the GPs as seen in the analyses in Part 4 of this report.
SECTION 5 - CHALLENGING HOSPITAL DECISIONS

13. Were you told that if you were dissatisfied with any aspect of your care or treatment, both in hospital and afterwards, then you had a right to complain?

Were you told who to complain to and how to go about it?

- A very high proportion of respondents, 86 percent were not told that they had a right to challenge any aspect of the hospital’s decisions they were dissatisfied with, neither were they given information on how to complain and who to complain to.
- Only 9 percent were given this information.
- 5 percent did not answer this question.

14. Did you feel able to challenge any of the decisions you did not agree with during discharge? If so what was the outcome?

- 48 percent of the respondents said this question did not apply to them, because they got what they wanted during discharge. Whilst this is a fair number of respondents who were satisfied with their discharge, it is not a reflection that they would have been able to challenge the hospital’s decision, should they have been dissatisfied with their care. It is therefore important that the hospital empower patients by giving them information about their right to complain and how to complain.
- 26 percent said they challenged decisions they were dissatisfied with. A few of them indicated that the outcome of their complaint was favourable. Others said challenging the hospital’s decision made no difference to the outcome. One respondent said the staff went ahead to discharge her although she challenged the decision. They however realised it was a mistake and re-admitted her the same day.
- 23 percent said they did not feel able to challenge any of the hospital decisions. Some of these respondents said although they wanted to complain, they found it difficult to identify the person responsible for the issues they were unhappy with, because no member of staff wanted to take responsibility. Others said they lacked confidence in the system, and did not believe their complaint would be taken seriously or anything would be done about it.
- 3 percent did not answer this question.
15. Have you made a formal complaint or do you intend to? If yes, when and to whom?

- With respect to making a formal complaint about their overall hospital experience, 83 percent said they did not make any such complaint. The reasons explaining why they did not complain varied. Whilst some of these people were satisfied with their hospital experience, others did not have the confidence to make a formal complaint, or thought they would be perceived as being confrontational. Others said there is too much bureaucracy involved, and did not feel they would be listened to.
- 5 percent felt this question did not apply to them.
- 12 percent said they made a formal complaint. When we asked who they complained to, their responses were as follows:

  “I complained to the physio department”

  “To the CEO”

  “To hospital management”

  “To PALS, and then to the CEO”

  “To another doctor”
16. Do you think you got what you wanted by way of discharge arrangements?

When we asked the participants whether they got what they wanted out of the discharge arrangements:

- 54 percent said they got what they wanted.
- 3 percent did not answer this question.
- 43 percent said they did not get what they want from the discharge process.

Some carers said:

“My wife couldn’t walk”.

“The social worker forced a nursing home on my mum”.

17. Did you think all the help you would need was in place?

- 3 percent of respondents said this question did not apply to them.
- 50 percent said they felt all the help they needed was in place when they were being discharged. This must not be interpreted to mean that they were satisfied with every aspect of the discharge process.
- Some of these respondents had praise for St Helier staff:

“I was totally satisfied with the hospital experience and do not think anything could have been done better”.

“I was given a full explanation on all the findings whilst in hospital”.

“The doctor was very caring and clear in explanation. He even offered a cup of tea”.

“Signed a form on discharge with clothes and articles worn on entry itemised, I thought this a good idea”.

“I was made to feel comfortable enough to ask questions and express my feelings about it – not just told”.
• 47 percent said all the help they needed was not in place when they were being discharged. They expressed dissatisfaction as follows:

“There should be less delay from the time on the day you are told - to the time you actually go. We waited from 11am - 5pm too long when you are 80 yrs of age”.

“I have an ongoing bowel problem but I still don’t get any information.”

“While in hospital I fell out of bed and I had to have stitches in my lip. This happened on A5 ward but was not told how to complain”.

“I was a homeless person suffering from alcoholism and depression. St Helier hospital would not give me access to the duty psychiatrist so as to gain admission to the mental health team. I also had a valium addiction which was caused by 15 years of prescription. I had started to have fits and blackouts and was forever been taken there by ambulance for head injuries after a fall they would monitor me for 24 hours then discharge me, still homeless with no follow up referrals, so I carry on rough sleeping as they said my illness was a mental one not clinical. This went on for 2 years until I had to leave to find the help in another borough through housing benefits. If they had helped me in the first place, I may not have ended up at 48 with arthritis, 60% loss of vision unemployable, on DLA and income support. So if anyone in Sutton has a substance misuse problem or depression they should go to get the help needed”.

“Was taken by porter to the discharge lounge, from the ward, my daughter went ahead to open up the house, this was at 3pm. I finally arrived home at 8pm. I had to make a fuss, before anyone took any notice of an old lady sitting in a wheelchair, shoved in a corner, and ignored, does wonders for your blood pressure, when you have just suffered from a heart attack!”.

“On the 21st November we collected Margaret's post from her flat and in it was her discharge summary, which, had it been available when she was actually discharged, there were things I would have questioned regarding something on her liver and myeloma screening, which was never mentioned to us. I am waiting to speak to her GP about it”.
18. On the scale of 1 to 10 how would you rate discharge from hospital?

With 7 to 10 being the highest score, 4 to 6 as medium, and 0 to 3 as the lowest;

- 48 percent of respondents rated their overall satisfaction with St Helier discharge as high, with some respondents expressing complete satisfaction with their experience. However, other respondents, especially those who scored 7 or 8 were not entirely satisfied with their experience and asked for further improvements to be made.
- 19 percent rated their experience as medium.
- 30 percent scored it as low.
- 3 percent did not answer this question.
SECTION 7 - GPs PERCEPTIONS

1. As a GP Practice, what do you think of the quality of information on discharge given to patients?

Our objective for asking this question was to ascertain the extent to which the hospital supplied quality discharge information required promptly by GPs, and also served as a convenient source of clinical reference.

- As shown in the graph below, 21 percent of the GPs flatly stated that the quality of discharge information from St Helier is “very poor”. These GPs said discharge letters arrive late, with inaccurate or incomplete information about patients, which affect patient care.
- 22 percent rated discharge information as “poor”. These GPs said, often, the patients would not know which consultant attended to them or the outcome of their hospital admission, including why their medication was changed or discontinued.
- The majority of the GPs, 43 percent, said the quality of discharge information is variable, with some patients clearly informed about their diagnosis, treatment, and medication, whilst others are unclear and confused since different staff had given them conflicting information. One GP said where a patient is ill-informed about their sickness and medication they come to the practice unsure about what to expect, and any further information from the GPs created more confusion both for the patient and the practice.
- Only 14 percent rated discharge information from St Helier as satisfactory.
Comments recorded from the GPs include:

“The quality of discharge information is generally poor - illegible at times, no clear instructions, no consultant listed, when medication details commenced or stopped, duration etc – all not listed. The letter arrives too late as usually patient sees Dr before so very unhelpful. It seems patients are not really involved about decisions made. This is especially difficult when we get letters too late and often to call the patients in again”.

“Very Poor, often inaccurate and lacking detail”.

“Information on drugs is sometimes clear. However, they are often poorly informed as to outcomes of tests and do not understand diagnosis. Follow-up arrangements are often unclear”.

“I have no information as to what is given to patients”.

“Patients sometimes feedback they are unsure what to expect”.

“The quality of discharge information is mixed. The use of internet discharge summary is excellent and should be expanded to all Trust hospitals”.

“It is variable in quality. Some patients get more. Sometimes it is hardly legible or contains insufficient clinical info. When done properly it is very valuable”.
2. Do you have any comments about the communication you have as a GP Practice with hospitals and other health providers about discharge?

The NHS National Standard Contract requires hospitals to provide discharge information to GPs within 48 hours of discharge (DOH/ NHS/ 2010). The use of telephone should be considered by the hospital when early action is required by the GP, with final reports arriving as soon as possible.

In these interviews, we asked the GPs opinion about St Helier’s discharge communication with their practices.

- 57 percent of the GPs said discharge communication from St Helier is variable, and often not good. These GPs raised concerns about poor information in discharge reports about investigations carried out and the results. They complained that some discharges are never received and others sent to the wrong surgery. This led to GPs wasting considerable time to chase discharge reports, with patients wasting appointments because the GP will not have received the necessary information.
- 29 percent said the discharge communication is poor. These GPs complained that the prescribed drugs on the discharge letters are often unclear, and there are no contact names on the letters to be able to make further enquiries.
- 14 percent said it is very poor.

Comments recorded from the GPs include

“Often significant delay in receiving discharge letters, written by Junior staff, often no information about investigations or reason for drug changes. A & E discharge letters especially are very often inaccurate and therefore completely useless”.

“The other area of concern is clarity of written communication- we’re often told on a discharge summary that, for example, a gastroenterology referral is needed. However, it’s rarely clear whether this has been done by the admitting team, or whether they are expecting us as the GP to do this”.

“Information for emergency admissions is often scant and late”.

“We are now even expected to choose and act on results of tests done in hospital;
however discharge info is not helpful”.

“Some discharges are not received, incorrect GP name. Some go to wrong surgery”.

“Electronic discharges are good when they happen, but fail to arrive on a significant proportion of patients”.

“It is essential to get legible accurate and full information rapidly. This is often not the case and much time is wasted trying to get it. Patients often waste appointments as the GP doesn’t have the information”.

“Drugs on discharge unusually clear but we are often poorly informed regarding investigations carried out and their results”.

“Usually very poor, get letters quite late, often have to chase secretaries for letters and full discharge letters/reports months after initial discharge or attendances at out patient clinics, often don’t receive any communication from hospital colleagues”.

“Better with the new system of email discharged letters, but still getting letters very late”.

“A clear concise discharge summary provided on the next working day after discharge would be helpful. A designated area on the discharge sheet for 1) Contact name 2) Tel. Number or bleep and 3) Hospital Consultant (full surname & department- ie not initials)”.

“When electronic discharge summary is filled in well, with clear diagnosis and explanations of changes made, the system works pretty well. All too often, the changes aren’t explained, and we’re left unsure whether a drug has been stopped for good clinical reason, or just because it was missed off a list on admission”.

“However fast the electronic system is, it is still essential that we are contacted by phone if someone is being discharged, where we will need to take immediate action, or if they are terminally ill- and this often doesn't happen- we often find out from district nurses or social services a couple of days later”.

3. What do you think of the availability of suitable social care and support available to patients after discharge from hospital?
We sought to determine the effectiveness of discharge transition to social care services through responses from the GPs, District Nurses and the voluntary organisations.

- Majority of the GPs, 36 percent, said the availability of suitable social care services to discharged patients is variable. These GPs said they are usually good for palliative and cancer patients, but not for other patients. They added that patients discharged on Fridays tend to have poor access to social care services.
- 29 percent said it is satisfactory, clarifying that the involvement of intermediate care helps.
- 29 percent said it is poor, stating that the hospital’s handover to social services is especially poor for elderly patients who are often discharged without re-instating their care packages.
- 6 percent said it is very poor. These GPs said the hospital does not check if patients are safe to be discharged, and if social care support is readily available.

“Yet again variable, generally seems pretty good for palliative and particularly cancer patients. Often more patchy for others. Relatively easy for us to call social services or ICT, although we often don’t find out soon enough about a discharge to do this ahead of time”.

“Inconsistent-especially if patients are discharged on Fridays”

“Often lacking and we are sometimes asked to organise this by patient’s relatives prior to their discharge”.

“Poor, I often feel patients are not assessed from an OT point of view to see if they are ok to manage at home and find that they are discharged hurriedly without adequate social provision prior”.
SECTION 8 – DISTRICT NURSES

1. As a District nurse what do you think of the quality of information on discharge given to patients?

- Of the 7 District Nurses interviewed, 4 said the quality of information given to patients is very poor. They made the following comments:

  “It is very poor. Discharge information should have improved with the single point of referral as all documentation can be faxed centrally, and then able to print off at the bases. Usually, the ward staff will ask us to remove clips from the patient, without stating the kind of surgery the patient has had”.

  “Very poor generally- especially to patients who are newly catheterised”.

  “The information provided to patients on discharge is often very poor. Eg. Patient discharged without discharge letter or without clear explanation of follow up plans /appointments etc, frequently with no dressings or inadequate supplies”.

  “Very bad, single point of referral has not improved the quality of information”.

- 2 District Nurses said the quality of discharge information is poor. Comments include:

  “Information is poor and when hospitals are contacted for information, it’s difficult to get catheters. Particular problems are no dates of insertion, reason, follow up. Wounds often with no dressings supplied. Patients referred not housebound”.

  “It’s poor. Could be informative especially patients that are discharged with a catheter”.

- 1 District Nurse said the discharge information is variable.

  “It’s variable, dependent on nurse discharging patient, on quantity of discharge and cascading information to DN and team”.

2. Do you have any comments about the communication and involvement you have as a District Nurse with hospitals and other health providers about discharge?
5 of the 7 District Nurses said the quality of discharge communication is poor. They also expressed frustration about the level of their involvement in discharge process.

"Often staff at the hospital do not involve DNs soon enough to facilitate a safe discharge. Equipment needs to be ordered in a timely way. There is extra expense to DNs services if the order is made for urgent delivery”.

“Two way communications is sparse between the hospital and DNs - reasons being time, lack of appropriate staff to initiate call, lack of admin staff. Responsibility lies with person collecting referral to respond - normally DN”.

“DNs are not involved enough in discharge planning, it is poor”.

“Once we receive a referral from a hospital, we always try to contact the referrer, but it is usually very difficult to get hold of the referring nurse. And we have found other staff unwilling or unable to help”.

“Referrals via single point, common problem is equipment etc, ordered for discharge but hospital then do not phone to confirm discharge date. Wards phone to give DN contact when admitted but no further verbal contact”.

1 District Nurse said St Helier’s discharge communication is variable. And one said it is very poor.

“Very very poor generally. The hospital often fails to inform us at all about the patients who need help. Often there is no paperwork provided and scant information provided to SPR. Very often no prescription are provided when the hospital ask us to administer medication. Very few patients are sent home with dressings”.

### 3. What do you think about the availability of suitable social care and support available to patients after discharge from hospital?

In relation to District Nurses assessment of suitable social care support and its availability to patients following discharge:

3 of the 7 District Nurses interviewed said social care support is variable. Their comments include:

“Patchy, often patient will say they can manage whilst in the hospital and then
when it fails, it’s more difficult to get the right level of care in place to prevent re-admission. Ward staff takes the word of patients without using clinical judgement”.

“It varies widely from excellent to appalling”.

“Social care is variable, sometimes it’s very good. Often patients not referred”.

- 2 said the availability of social care support to patients is poor.

“It’s poor, most patients are discharged, none with a package of care”.

“Often find patients discharged without adequate care packages. This usually leads DN to have to manage the client as prevention and re-admission - rather than maintenance at home. It is poor”.

- 2 said the availability of social care support to patients is adequate.

“Adequate, but sometimes the patient will need re-assessment of needs as realistically in the home situation feels needs are realised and not met”.

“The START team is adequate”.
Age Concern Merton (ACM) & Friends in St Helier Hospital (FISH)

1. As a member of staff or volunteer at ACM or FISH, what do you think of the quality of info on discharge given to patients you might work with?

- Of the 9 volunteers and paid staff, 3 said the quality of discharge information from St Helier is variable. Their comments include:

  “It varies in quality and quantity - there seems little written info given; in our experience verbal communication is the most often used. This makes tracking who is leading the discharge and what options people were offered or not difficult for both patients and carers”.

  “Sometimes not enough info on day to day living. They probably think they can cope until they come home”.

  “From personal experiences the quality of information on discharge is very variable from quite good to poor. My mother went through 6 discharges from hospital over a 2 month period”.

- 5 of the respondents said the quality of discharge information given to patients is poor.

  “I have dealt with many clients who were struggling to cope indoors following their discharge from hospital. It makes me wonder whether they were offered any assistance preparing them for their return home. It is then left to us to pick up the pieces”.

  “I have taken a number of calls from patients and their relatives who have just been discharged from hospital and are now trying to get help with shopping, domestic tasks, meals etc. These issues do not appear to have been addressed adequately prior to discharge”.

  “Very poor. Many patients return home not understanding what to do with any discharge forms. Medication is not always clear and why they are taking certain meds”.

  “Treatment should be explained more fully. Medication should be explained and
written clearly on a sheet of paper and not just on the box”.

- Only 1 said the quality of discharge information from St Helier is adequate.

2. Do you have any comments about the communication and involvement you have as an ACM or FISH member of staff or vol with hospitals and other health providers about discharge?

In relation to the quality of discharge communication the staff and volunteers at ACM & FISH responded as follows:

- 4 of the 9 volunteers and paid staff said St Helier’s discharge communication and involvement of ACM & FISH is variable. Comments include:

“*The most regular contact is for help and support with practical issues such as cleaning, furniture moving (which we do not undertake) and befriending. Whilst those we hear from are often thoughtful staff who have used their skills and commonsense to call us, this does not seem to be on a regular basis to make it a common process used by all*”.

“*They involve us on odd occasions. They have rung us with questions on optional care*”.

“*I have found that there are questions to raise sometimes but no doctor is available to speak to. I think there should be an opportunity to speak to the doctor concerned on the day of discharge or the day after*”.

“*Not all the staff in hospital are understanding that the only means of contact nearby is FISH staff who can visit*”.

- 1 of the respondents said the discharge communication is poor.

“It’s poor. We are always happy to assist if possible. However, we are not an emergency care service (which is often what the clients need). Hospitals and health providers should be made more aware of services available in the borough”.

- 4 respondents did not answer this question.
3. What do you think about the availability of suitable social care and support available to patients you have contact with after discharge from hospital?

- 2 of the 9 respondents at ACM & FISH said the availability of suitable social care support for patients following discharge is variable. Their comments include:

"It is variable in many respects depending on when and why they have been admitted. Also the route they have been discharged through: ICT, Re-ablement, family carers or nothing. I sense that they are often asked if they need help when they get home - but not necessarily in the most appropriate way. If you were desperate to get home which many are they say no - simply to ensure they get out asap rather than delay this in anyway. If the conversation was held earlier and more proactively the patients and or carers answer could be very different. Secondly, if the last time you were at home (just b4 your fall in the kitchen) you did not need any daily help; how does the patient know if they will need it post fall, we all whatever age think things will be the same. This is especially true of non elective (emergency) admissions. When you extrapolate this to moving around the home safely and getting in and out of bed the problems multiply - they may be assessed for aids and adaptations but often non orthopaedic/falls admissions will not".

"Although social care is available it is not always "used" to its full potential - clients are not always aware of support on offer".

- 2 respondents said the availability and suitability of social care support following discharge is very poor and 3 said it is poor:

"Very poor at times. Many clients (or family of clients) contact us in a very distressed state as they simply cannot cope. Even social care staff contact us to ask what help or services are available in the borough. Shouldn’t they know this already”?

"Not sufficient information given to patients /carers about what is available”.

"I think that the hospital discharge patients too quickly, and many patients are taken back into hospital the next day, because they are unable to manage on their own. May be those who live on their own could have live in carer to help the patients on return from hospital”.

"Very poor; care packages should not only be put in place but also check to see
Only 1 respondent said it is satisfactory (one did not answer the question).
PART 5: SUGGESTED IMPROVEMENTS BY RESPONDENTS

SECTION 10 - SUGGESTED IMPROVEMENTS BY PATIENTS & CARERS

1. What do you think could be improved about the way people are discharged from hospital?
   a) For every patient discharged from hospital to be given a discharge plan
   b) Every GP e-mailed the discharge plan within 24 hours
   c) Discharge information typed and clear, not hand written and illegible
   d) Other (please specify)

- A total of 83 percent of the patients and carers interviewed wanted to see some kind of improvement in St Helier discharge planning, with 45 percent choosing all three options shown in a, b, and c above.
- Only 5 percent felt they were happy with the current discharge procedures at St Helier.
- 12 percent did not answer this question.

Apart from the above responses, we asked the patients and carers to personally suggest ways that discharge planning could be improved at St Helier.

- The number one request was for the hospital to provide comprehensive information. The patients and carers wanted this information to cover diagnosis, medication, referrals, follow up appointments, and services in the community.
- The second request was for the hospital staff to improve communication with GPs, social care services, carers, District Nurses, wardens, etc, including advanced care planning to ensure these services are sufficiently informed about the needs of patients being discharged.
- Some respondents wanted the hospital to involve carers, close family, friends, and wardens in discharge planning, where applicable. They added that, this was necessary to ensure their homes and support services are adequately arranged before they returned home from hospital.
- The fourth request was for the hospital to cut delays between discharge and the time patients left hospital. The respondents felt it was unacceptable to be delayed after discharge simply to collect medication.
- The fifth request was made by a minority of respondents, asking for the quality of hospital food to be improved and the quantity increased. These respondents also
wanted staff to help with simple tasks like helping them to drink water, opening cupboards etc.

• The final request was for the hospital to give information to patients and carers about how to complain, and who to complain to.

Comments recorded include:

“It would have been more reassuring if the Radiologist had told me what to expect after leaving the hospital rather than the receptionist. I wanted information about diagnosis and what to expect following discharge”.

“The hospital should give patients correct medication and information on how to use it”.

“Patients should be fed sufficiently. The meals are not good; improve the quality and quality of the hospital food. They only served sandwiches every night”.

“I wanted contact numbers, more info like exercise leaflets, and information about who to contact - ie services after discharge”.

“Staff wanted me off asap, then I had a long wait for pharmacy. Speed up pharmacy”.

“While in hospital I fell out of bed and I had to have stitches in my lip. This happened on A5 ward, but I was not told how to complain. Staff should have told me about how to complain”.

“It was atrocious. More care is needed and no last minute decisions should be made. The hospital should contact close family or friend or warden when patient is going to be discharged, so arrangements could be made on their return”.

“Carers should be given at least 24hrs notice of discharge to get the patients house ready for when they return home. i.e heat up the house, get clothes and food ready”.

“They should improve communication with GPs, carers, physio, social care services etc”.

“I would have liked someone to sit down with me in person that I was being discharged rather than send me a letter”.
GPs

1. *As a GP Practice do you have any comments on what could be done to improve the patient experience with hospital discharge?*

- The GPs number one request was for St Helier to improve the quality of information in discharge summaries. They said the summaries must be clearer, detailed, with information about the patient’s diagnosis, tests undertaken with results, prescribed drugs, drugs discontinued, etc. The discharge letter must also be signed by a named member of staff to allow GPs to contact the person to make further enquiries where necessary.
The second request was for patients to be adequately informed about their diagnosis, medication, and what to expect in follow up care. The current system is causing patients to suffer as a result of lack of information.

The third request was for discharge letters to be sent to GPs immediately after a patient is discharged. The GPs stressed that patients safety are hugely compromised when discharge letters arrive long after patients are discharged. They also requested for both electronic and hard copies to be sent.

Some GPs wanted St Helier to improve communication with social care services, and plan referrals and support services in advance of the day of discharging a patient.

Others also stressed that the hospital must ensure that patients are capable of coping on their own before they are discharged, and have sufficient support in place.

**District Nurses**

2. **As a District Nurse do you have any comments on what could be done to improve the patient experience with hospital discharge, and enable DNs to offer the right kind of support and care?**

<table>
<thead>
<tr>
<th>Suggested improvements by DNs</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helier should involve DNs from the beginning to the end of discharge planning</td>
<td>6</td>
</tr>
<tr>
<td>Inform patients about diagnosis, medication &amp; follow up care</td>
<td>6</td>
</tr>
<tr>
<td>Clearly written &amp; detailed discharge plan</td>
<td>5</td>
</tr>
<tr>
<td>Hospital staff must have understanding of DNs role</td>
<td>3</td>
</tr>
<tr>
<td>Discharge patients with adequate supplies, ie, catheters, dressings etc.</td>
<td>5</td>
</tr>
<tr>
<td>St Helier must work closely with community services</td>
<td>3</td>
</tr>
<tr>
<td>Patients should be fit to be discharged</td>
<td>2</td>
</tr>
</tbody>
</table>

*Total of 7 DNs were surveyed*
• The responses in the above graph show that, majority of the DNs wanted to be involved in discharge planning right from the beginning to the end. The DNs said supportive discharges should be a joint responsibility, to ensure they have a better understanding of patients special needs, arrange appropriate equipment, have prior meetings with family members, sit in case conferences, etc. They said this is essential to ensure maximum patient care is delivered.

• Like the patients, carers and GPs, the DNs also requested for St Helier to produce clearly written, detailed and accurate discharge summaries, signed by a contactable member of staff. They also wanted the hospital to sufficiently inform patients about their diagnosis and medication.

• The next request by the DNs was for the staff at St Helier to understand what the roles of DNs are. The DNs said there have sometimes been unrealistic expectations as to what they are able to do for patients.

• The DNs again requested that patients must be discharged with adequate supplies. They complained that patients are sometimes sent home without catheters or dressings for their wounds.

• There was a request for St Helier to work closely with voluntary sector organisations, and to learn more about available community services.

• The final suggestion by the DNs was for the hospital staff to discharge patients who are sufficiently fit to cope on their own. They explained that there have been many occasions where patients are quickly re-admitted because they had not fully recovered. They added that elderly/vulnerable people should not be discharged on weekends.

Age Concern Merton & FISH

3. As a member of staff / volunteer at ACM or FISH, do you have any comments on what could be done to improve the patient experience with hospital discharge?

• Respondents at ACM and FISH pointed out many stages in discharge planning that require improvements at St Helier. Their first request was for the hospital to involve carers and relatives in discharge planning. They wanted to see a pack designed around the patient journey, where carers or relatives were told what was happening at each stage, including post-hospitalisation.

• The second request was for St Helier to ensure that vulnerable patients have adequate help and support at home before they are discharged. This includes making sure that a relative or a carer is present in a patient’s home before discharge. Patients should also be told what they might need help with when coming home. This is particularly vital for older and disabled people.
• The third request was for patients to be given more information about community services, how they can access social care services, and other sources of support. Like the GPs and DNs, these respondents were keen to see improvements in this area. This must include updating hospital notice boards with new information and leaflets.

• The next request was for St Helier to arrange for staff to learn more about community services to be able to refer patients appropriately. The respondents also wanted the ward staff to involve voluntary organisations where possible in referrals, as they can offer a wide range of services, and help arrange basic services for patients - eg cleaning, meals on wheels, etc.

• Respondents again asked that the multi-disciplinary team regularly update themselves with patient information to avoid giving conflicting information to patients. One respondent suggested that a key message system is used to communicate changes to patients discharge plans, information from carers, family, and professionals. She acknowledged that a communication system may already be in place, but it is clear that it lacks continuity and consistency of its application. She made the following comment:

“A key message system should be used. There have been cases where one nurse says a patient cannot go home because she is not well enough. Then 6 hours later another says she is coming home this afternoon”. This is a very common scenario”.

• The respondents asked for discharge letters to be signed by a member of staff who is named by the ward to the patient, as the appropriate person to answer or receive queries on the patient’s clinical discharge matters. This request echoes concerns raised by both the GPs and DNs, saying that discharge letters are usually not signed by a named person, making it difficult to conduct further investigations about discharged patients.

• For patients with continuing medication, the respondents requested that a written plan of action, together with a schedule of medication is provided for them. Apparently a schedule of medication is available to GPs only.

• The respondents emphasised that hospital staff should have more contact with wardens, and should involve them in discharge planning where applicable. They said that staff should not only call wardens when a patient is being discharged, but should give them advanced notice, and encourage wardens to visit the patient at hospital.

• The final request was for carers to be allowed to support patients in hospital if required. The respondents at FISH particularly emphasised this point, and said patients will be happy to see a familiar face, and hospital staff will also free up time.
“With this new way that carers are paid (direct payments) the hospital should allow the carers to support the patients while in hospital. The staff would have more time for other patients, and the patient would be happier and relaxed”.
PART 6: CONCLUSION & RECOMMENDATIONS

We started this report by making it clear that Sutton & Merton LINks exist to ensure that the voices of the people in our communities are heard and acted upon to improve services. The patients, carers, and professionals interviewed in this report have given us their views explaining their degree of satisfaction with current discharge planning at St Helier. Some of the patients we interviewed expressed complete satisfaction with the entire discharge process at St Helier, with praise for the members of staff.

Nevertheless, the majority of patients, carers, and almost all the GPs, DNs, and voluntary organisations expressed dissatisfaction, and in some cases, were clearly frustrated with the current discharge procedures. Their complaints centred mainly on poor information, communication, lack of advanced discharge planning, long wait and delays after discharge, feelings of anxiety and uncertainty about after care, poor referrals to follow up services, etc. This evidence falls short of standards set out in the hospital’s discharge policy and several DOH discharge policies.

According to the people we interviewed, the quality of discharge at St Helier could be summed up as variable or inconsistent. Where discharge procedures were followed, all parties including the patient appeared completely satisfied. However, where procedures were not followed, patients and professionals alike were disgruntled, which in some cases impacted on patient after care.

We would therefore like to see good quality discharge planning become a standard for all discharges at St Helier. As a result, our immediate request would be for St Helier to develop an action plan to be devised between key partners that have an impact on patients discharge.

We have also taken a further step to list a number of recommendations below. There is no doubt that budgetary pressures, especially in the present financial climate, would make it difficult for St Helier to introduce vast resources to improve discharge. We are therefore mindful that potential changes in discharge must be simple, cost effective, but should significantly improve the discharge process. Our recommendations are based on requests made by the respondents and are summed up as follows:

RECOMMENDATIONS

1. Initial Discharge Planning:
   - What appears to be lacking is that majority of patients in this survey were not given a discharge date within 24 hours of admission, which is contrary to DOH criteria on discharge. We recommend that a discharge planning checklist is introduced by the
hospital. This must be checked within 48 hours into admission, to ensure discharge has been effectively communicated to the patient, including setting an expected date of discharge.

- The checklist must also have a separate and distinct section to inform everyone involved in the discharge (ie carers, family, GPs, DNs, social services, wardens, etc) about the patient’s condition and possible discharge date. Any changes to the initial plan must be updated and communicated thereafter.
- Should St Helier already have a discharge checklist in operation, we suggest that its use is reviewed and improved to reflect the above.

2. Actual Discharge: Long delays between discharge and patients leaving the hospital

- Two key concerns were recorded under this section. Majority of the patients said actual discharge was conducted on the day they were leaving hospital. This caused significant delays after discharge, due to limited time to arrange medication, transportation, social care services, inform carers or relatives, etc. Many of the respondents expressed deep frustration about having to wait up to 20 hours or more. The second concern was related to patients being discharged late in the evening, which made it difficult to arrange and put in place immediate support services in their homes or respective destinations.
- In order to improve the above experiences, we recommend that sufficient time is allowed by staff to review and order medication, arrange transportation, make the necessary referrals, and ensure bandages, catheters, equipment, etc, are supplied. Enough time should be built into discharge to fully involve and update carers, relatives, social services, wardens, DNs, GPs etc. Patients should also be informed about their medication and what to expect once they leave hospital.

3. The need for effective discharge information and communication with patients, carers and relatives.

- Interviewees, including those with unplanned admissions, short stays, and long stays all requested to be sufficiently informed about diagnosis, the use of medication, referrals, what to expect after discharge, useful numbers on community support services, social services, clearly written discharge plan, and to have information about their right to complain. Many respondents felt that St Helier’s communication and information to patients and carers must improve in order to reduce stress and uncertainty. They made it clear that shortage of help and basic information after discharge made them feel anxious and unsupported.
- The above issues could be partly rectified by adhering to the recommendation made in point 2 above.
- Majority of the respondents however requested that a clearly typed, detailed, and accurate discharge plan be given to patients. Patients also wanted a standard leaflet
4. The need for effective discharge information and communication with GPs, District Nurses, social care services and relevant voluntary sector organisations.

- The respondents who were most disappointed about current discharge planning at St Helier were the above groups. There was a resounding frustration in the feedback from these interviewees. Their key concerns were that discharge letters were mostly illegible, inaccurate, lacking in detail, and without a signed member of staff, who could be contacted to make further enquires.

- The GPs complained that discharge summaries arrived late rendering them useless, as the patient may have already visited the surgery. The DNs felt they were not sufficiently involved in discharge planning, and most patients were sent home without adequate supplies. The voluntary organisations said there was a lack of information to patients about community services, and lack of involvement of carers and relatives to help patients manage at home after discharge.

- We recommend that St Helier use the feedback from GPs, DNs, and voluntary organisations in this report to improve discharge information and communication. We believe this will further require two steps
  - To involve GPs, DNs, social care services, and relevant community support services throughout the entire discharge process.
  - To put in place a system whereby a qualified member of staff will check discharge reports to ensure they are accurate, with effective information to GPs, DNs, and other recipients. The member of staff will also oversee the immediate dispatch of electronic and hard copies of discharge reports to relevant professionals.

5. Information to ward staff about services available in the community.

- Our investigation also indicated that people working and volunteering in organisations supporting discharged patients, felt their services were in many cases either unknown to, or not well understood by health care professionals at St Helier hospital. Where there is poor awareness of community services, it can lead to patients missing out on help available to them, or inappropriate referrals - such as people with high level needs being referred to a service which is designed for people with low to medium care needs.

- We recommend that ward staff are provided with a general level of awareness of services available in the community. Voluntary organisations have wealth of experience and a wide range of services to offer discharged patients.

- Ward Managers should also work closely with staff at the St Helier Patient Information Centre to signpost patients who require information on community services. This could be a good avenue to promote the Patient Information Centre.
Specialist wards could also select appropriate leaflets and keep them in their wards for patients, carers, and family to access.

**NEXT STEPS**

What would Sutton and Merton LINks like to see happen after this report?

1. We request that the conclusion and recommendations in this report is cascaded to relevant staff teams at St Helier, highlighting the key concerns raised by the respondents, and placing emphasis on the improvements that patients, carers, GPs, DNs and the voluntary organisations want to see in discharge planning.

2. We request an internal audit to review current discharge planning, and to report with an action plan developed by multi-disciplinary actors who have an impact on discharge. The action plan must suggest ways that discharge planning will be improved by St Helier.

3. The final action plan must be communicated to Sutton & Merton LINks within 3 months of submitting this report to St Helier Hospital.

4. Following receipt of the action plan, Sutton & Merton LINks will organise a stakeholder event to formally share the outcome of this report, and St Helier’s response and plans to improve discharge planning.

5. Sutton & Merton LINks will finally develop a plan to monitor, evaluate, and report on actions that will eventually be implemented by St Helier to improve discharge planning.

We expect that St Helier Hospital will show leadership and commitment to respond to the concerns raised by the people in our community by putting the patient at the centre of NHS care.
BIBLIOGRAPHY

- CQC, “Epsom & St Helier University Hospitals NHS Trust, Inpatient Survey”, Care Quality Commission, 2008
- CQC, “Epsom & St Helier University Hospitals NHS Trust, Inpatient Survey”, Care Quality Commission, 2009
- DH, “Achieving Timely Simple Discharge from Hospital, A toolkit for the multi-disciplinary team”, Department of Health Publication, 2004
- Paterson M, Smith T & Rosling B., “Epsom & St Helier University Hospitals NHS Trust, Discharge Policy 2007
- SPLG, “Ready to Go, Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care”, Department of Health Publication, 2010

This report is produced jointly by the Local Involvement Networks in Merton and Sutton. Copies of the report and a summary are available at [www.mertonconnected.com/link](http://www.mertonconnected.com/link) and [www.suttonlink.org.uk](http://www.suttonlink.org.uk).

LINk Merton is hosted by Merton Voluntary Service Council, a Registered Charity and Company Limited by Guarantee No. 4164949 England and Wales. Merton Voluntary Service Council, The Vestry Hall, London Road, Mitcham CR4 3UD Tel: 020 8685 1771 Fax: 020 8685 0249 email: info@mvsc.co.uk

Sutton LINk hosted by SCVS, a Registered Charity No: 1063129 and Company Limited by Guarantee no 03336660. SCVS, Granfers Community Centre, 73 -79 Oakhill Road, Sutton, Surrey, SM1 3AA Tel 020 8644 2867 email: link@suttoncvs.org.uk www.suttonlink.org.uk