

Bath & North East Somerset Council		
MEETING/ DECISION MAKER	Policy Development & Scrutiny Panel Committee	
MEETING/ DECISION DATE:	28th November 2014	
TITLE:	Healthwatch Bath and North East Somerset update	
WARD:	All	
AN OPEN PUBLIC ITEM LIKELY TO BE TAKEN IN EXEMPT SESSION		
List of attachments to this report: Please list all the appendices here, clearly indicating any which are exempt and the reasons for exemption		

1 THE ISSUE

1.1 Update report from Healthwatch Bath and North East Somerset

2 RECOMMENDATION

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

5 THE REPORT

Report to the Wellbeing Policy Development and Scrutiny Panel 28th November 2014

Healthwatch Bath and North East Somerset: Issues and Concerns Year 2 Quarter 2: July – October 2014

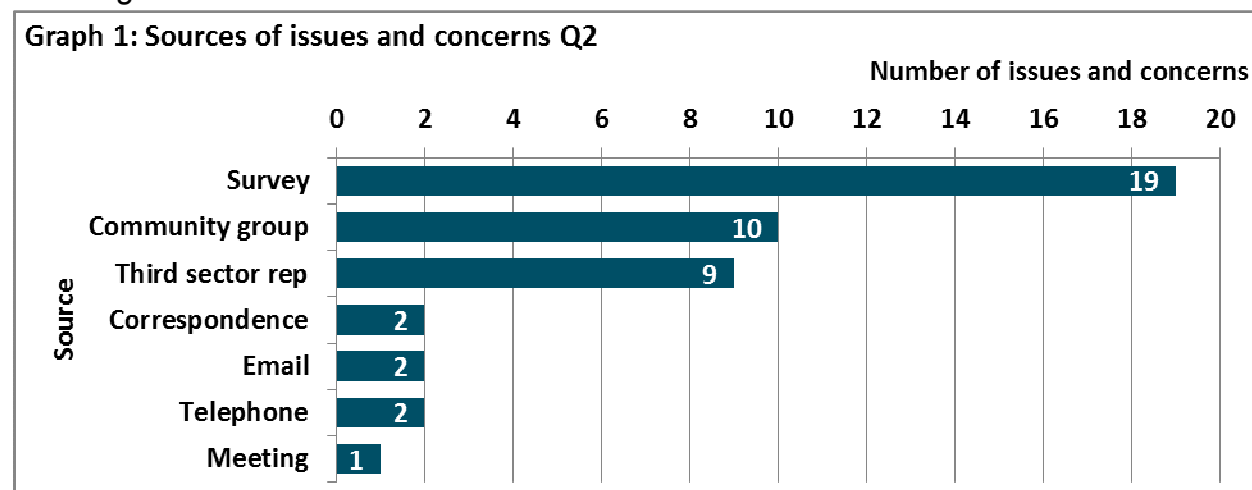
Healthwatch Bath and North East Somerset has heard 45 issues and concerns from health and social care service users, carers, family members, and service providers since July 2014.

This report considers the types of comments and the services they relate to, and the themes emerging from the issues and concerns heard between July and October 2014 (Q2).

1. Sources of Comments

Healthwatch Bath and North East Somerset uses several channels through which it hears issues and concerns about health and social care services from the public (see Graph 1).

In Q2, the most commonly used method of capturing service users' feedback was responses to a survey, which was carried out as part of a special inquiry into hospital discharge.

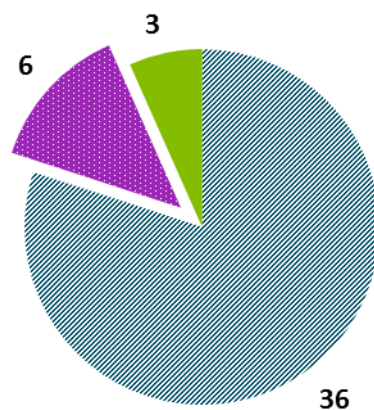


2. Sentiments of comments

The sentiments of the service feedback heard by Healthwatch Bath and North East Somerset are shown in Graph 2:

3. Comment types

Negative
 Mixed
 Unclear

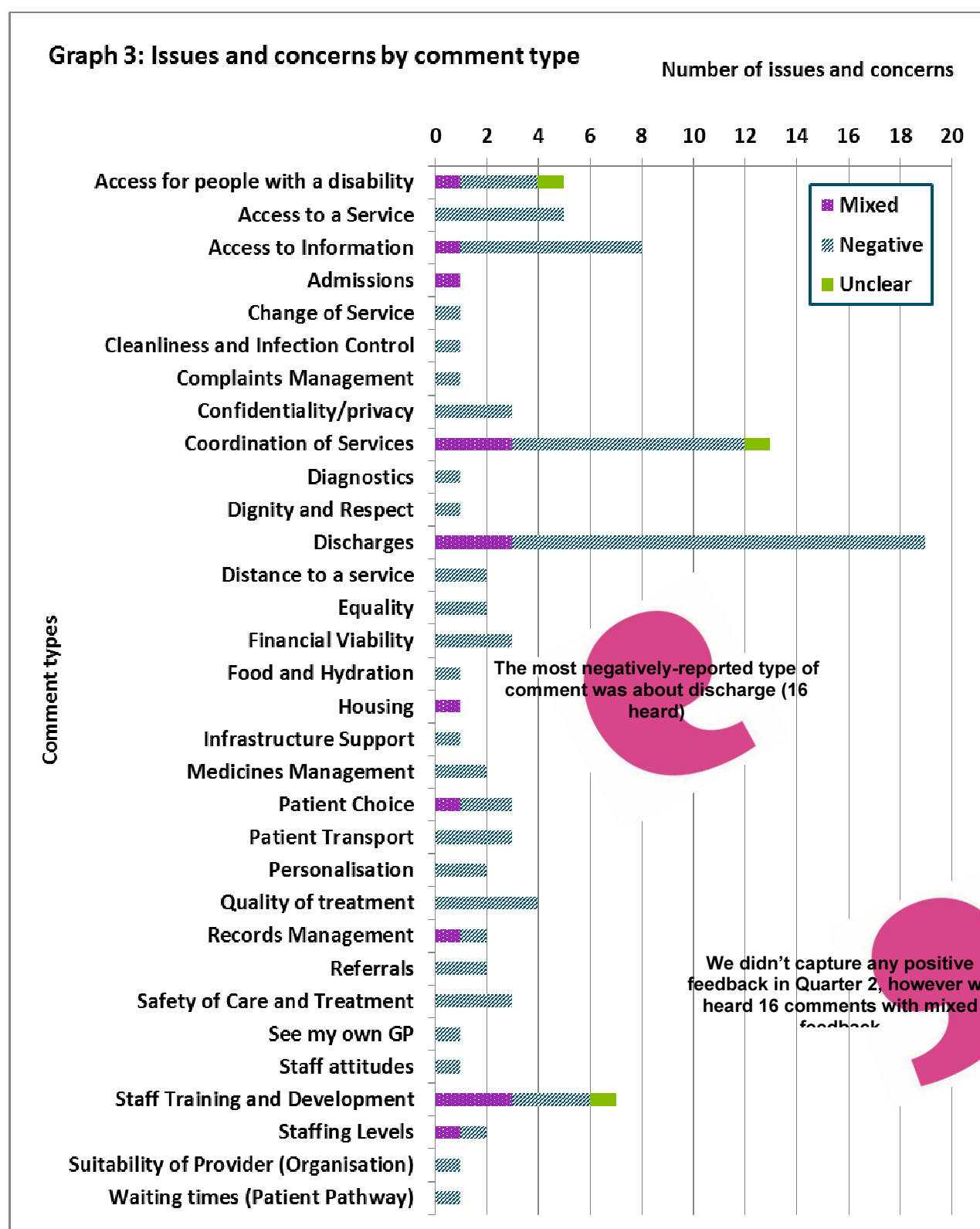


Graph 2: Sentiments of issues and concerns

Graph 3 shows the issues and concerns heard by Healthwatch Bath and North East Somerset, according to the type of comment. Some stories could be categorised by more than 1 type of comment.

The most often-heard types of issue and concern in Q2 related to discharges (19 in total, 3 mixed, 16 negative).

Graph 3: Issues and concerns by comment type

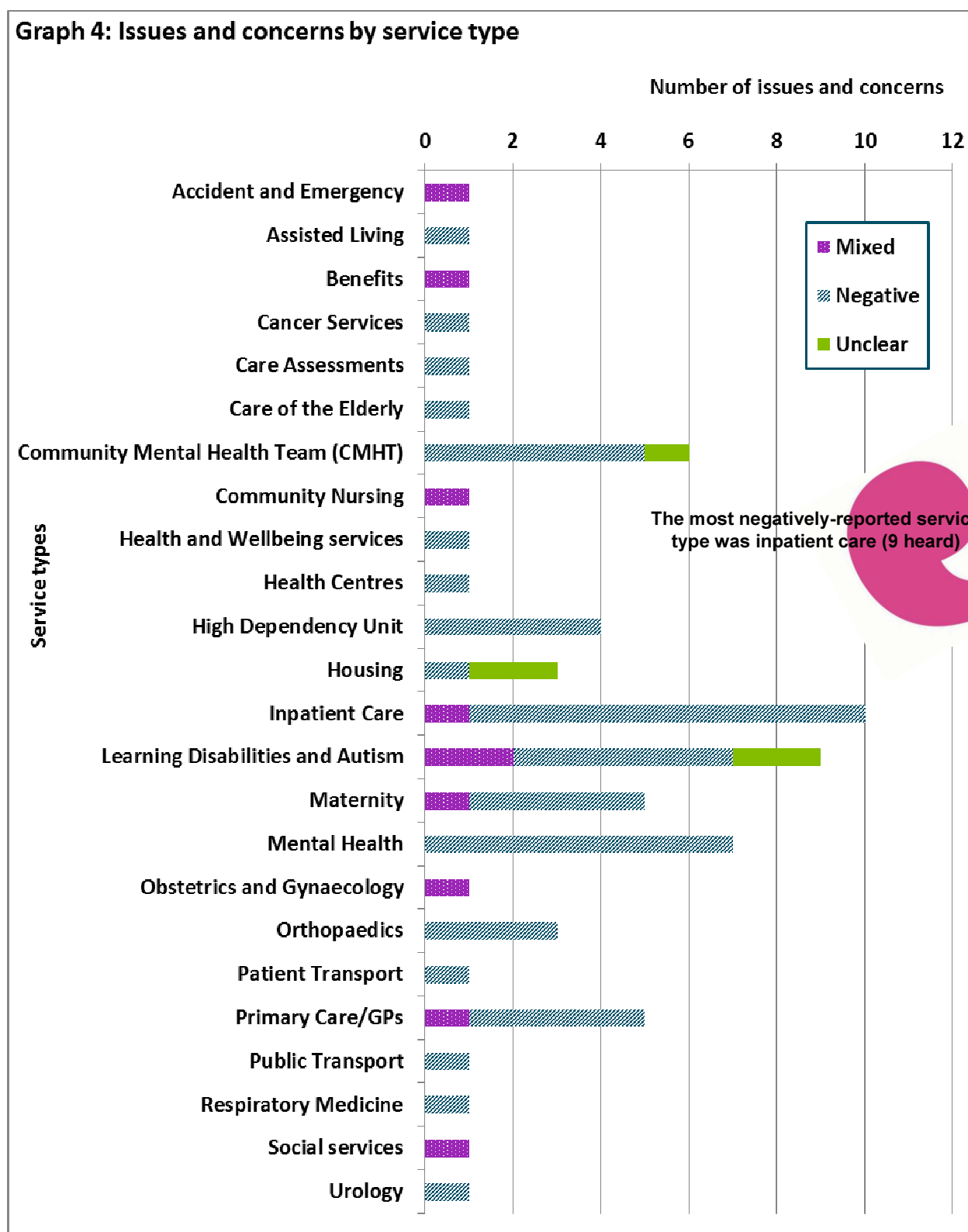


4. Service types

Graph 4 shows the issues and concerns heard by Healthwatch Bath and North East Somerset, according to the service they refer to. Some stories could be categorised by more than 1 type of service.

The most commonly referred-to service in Q2 was inpatient care (10 in total, 1 mixed, 9 negative).

Graph 4: Issues and concerns by service type



5. Themes

From analysis of the issues and concerns heard in Q2 of Year 2 of Healthwatch Bath and North East Somerset, the following themes have been identified:

(* these themes are likely to have emerged as a result of direct, targeted engagement with specific service user groups, as part of Healthwatch Bath and North East Somerset's community development remit with priority groups in the area, and involvement in Healthwatch England's first Special Inquiry into hospital discharge)

- **A perceived need for training in the needs of people who have autism***

Commentators report that health and social care professionals need to demonstrate increased awareness of the needs of people with autism, in order to ensure that services are meeting their needs. An example of this is that proformas used within services should be designed and used that a) enable people to identify themselves as having autism where necessary/appropriate, and b) meet the communication needs of people with autism.

- **A perceived need for improved communication between services and carers of people with mental ill health***

Commentators report a variety of issues they have experienced as carers of people with mental ill health. These include difficulties in navigating mental health services, for example being able to access services, being able to continue to access these services, and knowing how to address any issues or concerns they may have with those services.

In Year 1 Quarter 4, carers' issues was also identified as a theme. This was more broad feedback but highlighted similar issues reported by carers:

'Several commentators have reported a lack of easily accessible information on care options and carers' issues. They have identified a lack of signposting to this information, and reported difficulties in having to navigate the system to find out about, and gain clarity on, their options.' (from **Healthwatch Bath and North East Somerset Year 1 Quarter 4 Issues and Concerns report**).

- **Discharge from secondary care***

A clear theme has emerged around the efficacy and efficiency of current discharge processes. An emerging 'sub-theme' is identifiable specifically in the context of maternity services. Commentators have reported a lack of information about after care following discharge, particularly following caesarean section procedures.

As mentioned above, the issues and concerns heard in Quarter 2 were collated as part of the Healthwatch England inquiry into hospital discharge. A report on the findings of this inquiry in the region covering Bath and North East Somerset, Somerset, South Gloucestershire and Bristol is available on the Healthwatch Bath and North East Somerset website: <http://tinyurl.com/lo7mdx3>. This sets out the main results of the inquiry, which are based on issues and concerns heard in Bath and North East Somerset and by Local Healthwatch in the other 3 areas, which were triangulated and found to substantiate each other, resulting in the following key findings:

- Approximately 90% of respondents received little or no Voluntary and Community Sector (VCS) support post-discharge. Many felt that an effective referral into the VCS would have improved their experience.
- The discharge process should be quicker and more streamlined, with more effective planning.
- The majority of respondents were happy with the quality of care they received but felt that they and their families/carers should have been more involved in their discharge process.

- Complex discharge e.g. where a patient is moving into a care home, should be better managed to avoid gaps in medication provision etc.

Intelligence gathered from other organisations in Bath and North East Somerset corroborates with these findings. For example, the Sirona Health and Care Complaints and Concerns report (May 2014), identifies premature discharge from Sirona services as a theme emerging from their complaints data.

6. Next steps

Healthwatch Bath and North East Somerset will take this information to their partners, stakeholders, and to their Advisory Group, who will advise on any further work to be undertaken to investigate these themes further. Individual issues that have been 'acute' or ongoing at the time they were fed back to Healthwatch Bath and North East Somerset, have been considered by the Project Coordinator or Development Officer, and remedial action taken where necessary/possible/appropriate.

For 5 of the issues and concerns heard, we have been able to capture the specific 'next steps' taken by or advised to the commentator:

- Table 1: Issues and concerns - next steps

Next step	No. of cases	Outcome
Signposted to advocacy	3	Unknown
Signposted to VCS organisation	1	Unknown
Forwarded to Bath and North East Somerset Council Safeguarding Team (Adults)	1	Email 28/8/14 from BathNES Council: Concerns being managed through the safeguarding process

Where issues and concerns heard in Quarter 2 specify a service, Healthwatch Bath and North East Somerset will contact the service provider and request a response on that issue or concern. Responses will be reported on in Quarter 3.

7. What we heard, who we told, what they did

Where issues in Quarter 1 specified a service, Healthwatch Bath and North East Somerset contacted the service provider and requested a response on that issue. Of the 23 issues and concerns reported in Q1, the relevant service was identifiable from 7 comments. We wrote to the service commissioner and the responses gathered are detailed in Table 2 (page 6).

8. What we heard in Quarter 2

The issues and concerns heard in Q2 are presented in Appendix 1. They have been sorted by service type, as feedback has stipulated that this would be the most useful format for commissioners and service providers to access and use meaningfully in service planning and improvements.

Table 2: What we heard, who we told, what they did

Issue/Concern	Organisation - Provider	Response
<p>Commentator recounted an issue that she witnessed recently at RUH Audiology - a patient was upset because she thought that was due to have an appointment at Audiology, however it appeared that she was registered with Sirona. It took a long time for the hospital staff to sort it out; at one stage there were 4 members of staff trying to help, which was very annoying for other people that needed to book in.</p>	<p>Royal United Hospital Bath NHS Trust (RUH)</p>	<p>We would wish to apologise to the patient and the other people waiting to book into the Audiology clinic for this delay and any embarrassment caused to those present at the time. From the account quoted from the report, it does seem that several staff did at least try to help the patient with their appointment booking; the issue is that it was not carried out as efficiently as it might have been and this feedback will be relayed to the appropriate staff working in the Audiology team to ensure that they learn from the comment and make changes to practice in future. There are changes currently being made to improve the RUH Audiology service to patients.</p>
<p>Commentator raised a concern about their GP's handling of a serious complaint. A meeting was arranged to discuss the matter, but the GP didn't seem to know the circumstances, he wasn't aware that any concerns that had been raised (despite the commentator having written a letter) and didn't really listen. A second, more formal meeting was arranged including a rep from SEAP, the GP, a senior nurse and the Practice Manager. Again the commentator felt that the Practice representatives didn't listen, weren't prepared (they seemed unaware of the commentator's letter written, or the circumstances surrounding her husband's case), they didn't answer the commentator's concerns, repeated themselves, and argued with her. The commentator wrote a similar letter to RUH, who immediately apologised and have taken steps to improve. They wanted to listen and learn from the commentator's experiences and she felt very</p>	<p>Royal United Hospital Bath NHS Trust (RUH)</p>	<p>Thank you for this positive feedback on the RUH response to the complainant. It is very helpful to know when a situation goes well, as well as when things require improvement and this feedback will be relayed to the relevant staff. There is currently a project taking place to improve the experience of people using the RUH complaints process, which includes patients and ex-complainants in the work that is progressing. We will use this positive feedback, as well as any other feedback that we receive on the complaints process, in order to continuously improve the service to patients and the public.</p>

reassured that every effort would be made to make sure her experience wouldn't happen to other people. They showed her how they would use her experience to influence future care.		
South Bristol Hospital have set up a system whereby community transport drivers can pass on their vehicle/ registration details, enabling them to park 'legally' in non-emergency ambulance bays when dropping off patients. This allows them to accompany patients into the building, particularly useful when transporting frail patients.	University Hospitals Bristol NHS Foundation Trust (UHB)	This initiative is in response to feedback from patients and carers living in more rural areas to enable them to access services at the hospital more easily.
Commentator had a routine mammogram and was told to arrive at the BRI for 2pm. Upon arrival she discovered it was a first come first served system so lots of people had turned up at 1pm to be at the front of the queue. Due to her position in the queue she wouldn't have been seen until 4.30pm, which meant she would be late to collect her children from school in BaNES. As a result she had to leave and was probably recorded as a no-show.	University Hospitals Bristol NHS Foundation Trust (UHB)	UHB are pursuing a response to this feedback.
The commentator's husband woke in the night bleeding. They called 999 and an ambulance arrived. Patient was taken to RUH A&E, treated quickly, offered clear advice and discharged. GP promptly referred him to a specialist and an appointment was made for the following week at Southmead, available at a variety of times. The appointment was kept and an operation was booked - a very positive experience so far. The couple made their way to Southmead for the operation	North Bristol NHS Trust (NBT)	A meeting is planned with NBT to discuss this response.

<p>(5am start to get there for 7.30am) only to be told that the operation had been moved to the afternoon. The hospital were unable to say when in the afternoon it would take place, and in the meantime the husband was nil by mouth. The couple were offered the option of going home to return later but they live too far away. The couple spoke to other patients there who had also had their appointments changed. Commentator queries why appointment times are so thoughtless for those that live a long way away, and why hospitals have block appointments.</p>		
<p>Commentator was under a Frenchay Hospital consultant for MS and has received a great service.</p>	<p>North Bristol NHS Trust (NBT)</p>	<p>A meeting is planned with NBT to discuss this response.</p>
<p>Commentator was under a Frenchay Hospital consultant for MS and has received a great service. Trying to find an effective painkiller has been very difficult, but for the last year she has found a method which has worked (1gm suppository of paracetamol). Harptree Surgery have said this approach is too expensive and won't let her have anymore. They suggested an alternative, which she has tried and found ineffective. The GP surgery have also tried to change her statin medication to a cheaper alternative, but again she has found this ineffective and has fought her case to remain on the same one.</p>	<p>NHS England – Bath and North East Somerset, Gloucestershire, Swindon and Wiltshire Local Area Team</p>	<p>If patients are not happy with a change in their brand of medication, they should talk to their GP who can advise on their condition, treatment options and medication issues. The other professional that people can gain advice from is the community pharmacist who will understand how the different medications are made up and work. This NHS Choices article (http://tinyurl.com/njbrrzt) explains the national strategy to use non- branded medication when possible as this is an effective and efficient way for the NHS to better use its resources. Generally the active ingredients are the same across different medication brands, however, in rare cases the medication may not be as effective and in these circumstances it is a good idea for patients to discuss this with their GP or local pharmacist.</p>

Appendix 1

Accident and Emergency

- Commentator described concerns about admissions to RUH Bath, particularly people with dementia. Concerns around safety, falls prevention and staff awareness/ understanding of the condition, particularly if admitted via A&E. Discharge liaison nurses are excellent.

Assisted Living

- Commentator contacted Healthwatch with concerns about a supported living facility in Bath for adults with learning difficulties.

Cancer Services

- Commentator has experiences of sitting waiting for patient transport for hours. Commentator has been picked up late in the evening so that they arrived late, tired and more confused at a strange destination. Commentator is concerned that, as an elderly person, they were the last patient to be dropped off - at 9.00pm which they feel doesn't take their needs into account. Commentator's family would have collected them if they had known of the poor patient transport service. No communication with them was undertaken.

Care Assessments

- Commentator received feedback from the group: the Community Care Assessment form is completely inappropriate for autism.

Community Mental Health Team (CMHT)

- Commentator would like time alone with the Care team to discuss her concerns/ issues regarding her son's mental health condition, before the Care team meeting. She feels there are things she often wants/needs to discuss in private, without having to embarrass or undermine her son in the meeting.
- The group stressed that they want to work with Community Mental Health teams to make their jobs easier, they feel they do excellent work and want to support this through collaboration.
- The commentator expressed frustration at the 'politics of access' for example mentalisation services are available in South Glos under AWP but not B&NES due to budgets. Concerns about lack of access to 'universal services for all'.

Health and Wellbeing services

- Commentator tells of a woman who lives in Whitchurch, who is a carer for her husband who has dementia. She is unable to access social care & health services because the appropriate services are in Bristol. B&NES offers only inadequate alternatives in Bath & Radstock which she cannot attend without transport - she doesn't drive & taxis are too expensive. She is severely stretched & sleep deprived, so is in no position to make a formal complaint, though intelligent, well informed & articulate.

Commentator has previously come across similar situations with people living on the Bristol/South Gloucestershire boundary.

High Dependency Unit

- Commentator would like to see more involvement of family in discharge process especially when they are providing post discharge care. Family found it hard to find the correct people to discuss patient discharge with. Staff seemed unwilling to facilitate meeting up or speaking on the phone to the family (who would be providing care post discharge).
- When discharged out of a patients' own GP area, commentator feels hospital should make sure satisfactory cover and follow-ups are in place. Poor assessment of where patient being discharged to i.e. is it suitable? will everyone be able to cope?
- Commentator experienced a lack of communication between staff about when discharge likely. Ultimately very last minute due to late communication with family.
- Commentator experienced problems with medication supplied on discharge (not labelled correctly).

Hospital Service

- Commentator received feedback from the group: Consultant at hospital didn't understand son's eating issues, i.e. as he doesn't like to have regular meals this affects his diabetes management.

Inpatient Care

- Commentator would like to see quicker discharge times. Commentator feels that the wait for medications was too long and unnecessarily delayed discharge.
- Commentator experienced unnecessary delays in effecting discharge. One patient in commentator's ward waited all day to be discharged!
- Commentator experienced lack of communication between staff regarding expected discharge dates. The hospital got their hopes up that they are going, then changed the story which caused distress.
- Commentator felt that there was insufficient consultation with family as to what the patient is capable of and not just taking patient's assurances at face value e.g. can she manage to climb stairs? Patient said yes, but her family would have responded that no, she can't manage this independently. Commentator was also concerned that they experienced insufficient occupational health assessments.
- Commentator experienced delayed discharge due to wait for medicine, but otherwise discharge went smoothly

Learning Disabilities and Autism

- Commentator received feedback from the group: It's not helpful to be signposted to services where the staff have not had autism training.
- Commentator received feedback from the group: autism social workers need to work closer with the clients and not just signpost to other services.

- Commentator received feedback from the group: Housing – must be consideration that some need their own space and can't share even if under 35.
- Commentator received feedback from the group: Need understanding that some with ASC just need sheltered accommodation which is very quiet, clean and safe.
- Commentator received feedback from the group: Housing forms are discriminatory and don't have a box in which to prompt disclosure of autism.

Maternity

- Commentator experienced two discharge processes following a C-section birth. On the initial discharge, commentator was given sanitary towels to put over bleeding caesarean cut. These are not sterile, could not be kept in place, and commentator feels sure contributed to the infection detected subsequently. Discharge from maternity ward after C-sections should make it very clear which dressings are needed, providing enough for the first few days, and make it very clear how to obtain more.
- Commentator was readmitted after potentially unsafe discharge following C-section with a painful haematoma. The care was fine in RUH but she had huge problems getting the right care afterwards. It was not clear who had responsibility for wound management. Commentator had 13 weeks of trouble before the wound closed. The midwives could not continue their care; district nurse came out but had wrong dressings.
- Commentator went to day assessment unit for help with wound following C-section, and was given a prescription for dressings to be dispensed by RUH pharmacy. That pharmacy then told them that RUH had not dispensed dressings for several years. Commentator then had to get a GP to convert the prescription to a GP one, so that a normal pharmacy could dispense it. Even then, the dressings were far too small for the size of the wound! In some pain, and with her new born in tow, commentator ended up with practice nurse who finally sorted them out, dealt with the 4 infections, prescribed antibiotics, and managed to set out a programme for wound cleansing and redressing twice weekly, she also gave correct sterile dressings. This was a stressful experience and the commentator is sure this delayed their recovery.
- Commentator feels that Hospital should ensure patients know basics of wound management e.g. commentator was not aware if she could shower and there was a distinct lack of information and support provided.
- Commentator feels that the hospital should make sure patients know who has clinical responsibility for care post-discharge. The baby comes under the midwife and health visitor but the commentator's wound was not managed by either.

Mental health

- Commentator expressed frustrations around confidentiality - he cares for his wife who has a mental health condition, however is not kept informed about the medication she is taking, why it's been prescribed, what the effects may be and how they might impact on other medications being taken. This is key information for him when trying to care for her, but he's not allowed to know.

- Commentator expressed huge concern and frustration about not being able to find out where her son is and if he is receiving treatment. He ran away due to his fears for his own safety and others. The commentator is trying to track him down but is not able to find out information due to confidentiality. Her son is over 18.
- The commentator explained that services are often decreased without negotiation, for example his son has been discharged from the Care team due to perceived 'improvement' without the carer being consulted. Commentator feels these decisions are made based on clinical evidence alone, without taking a holistic view of a person's mental and physical wellbeing.
- The commentator is concerned about fragmentation of services. They explained that carers have to be experts and be prepared to push for answers and action. This is exhausting on top of a stressful caring role.
- Commentator felt that complex diagnoses, such as personality disorders, are avoided to prevent financial commitment to management.
- The group explained that it is key to get a named person or contact within every service to get any action. PALS is not a productive/ constructive approach to problem-solving.
- A family-centred approach is really important but doesn't seem to happen most of the time. Family counselling was suggested as a positive option.

Obstetrics and Gynaecology

- Commentator reports that discharge was ok but the staff were not able to give her a discharge note as no doctor was available at the time to do it. She is still waiting for it to arrive. She will be contacting the hospital about this.

Orthopaedics

- Commentator recounted an issue that has been on-going since 2009 when he had an accident and shattered his femur, which required surgery to rebuild. Since then his walking ability has deteriorated and in June 2012 he had a second operation during which the surgeon hit his bone with a chisel and hammer. Attended clinic 2 weeks later for a scan and was told that his hip bone was cracked (possibly from the impact of the surgical procedures carried out). In November 2012 the commentator had a hip ball replaced and contracted a serious infection. In December 2013 this operation was done again, and again the commentator contracted an infection. He had to take antibiotics and stopped in late spring/ early summer. He is still not able to walk very well.

Outpatients

- Commentator used hospital transport which took four and a half hours to arrive, to take them 5 miles home. Very frustrating indeed. Wouldn't ever want to use this service again.
- Commentator feels that hospitals should ensure that meds are ready on time when due to leave, to avoid delayed discharge process.

Patient Transport

- Commentator reported that people have been asking Well Aware if there are any transport schemes linking Bath and Bristol so they can attend appointments at the BRI or Southmead. Arriva have not been able to help them (because they don't travel to Bristol). The Dial-a-Rides only cover their own local area and the small community schemes don't serve Bristol, so unfortunately Well Aware haven't been able to help them. We have told them that they can use the HUB service if they can get to Temple Meads, but that really isn't much help.

Primary Care/GPs

- The commentator explained that from 2005 - 2013 he went to ADP Oldfield Park Dental Practice, where he saw several dentists. He described several incidents where he was in extreme pain after treatment, needing to arrange emergency appointments as a result. He has had fillings fall out, several teeth become temperature sensitive, deterioration in gum health and regular abscesses. In 2013 he joined a new surgery (Green Park Dental Practice) but was told that due to the extensive damage caused by ADP they would not treat him in case legal action arose. The new dentist advised contacting the Citizens Advice Bureau, who then signposted the commentator to the General Dental Council and a solicitor. The new dentist arranged for the commentator to see a Dental Surgeon at Bristol Dental Hospital but the surgeon said the damage was too extensive for his students to work on. The new dentist then signposted the commentator to NHS Riverside Drop In centre where X-rays confirmed that his teeth had been damaged through incompetence. The NHS advised seeking compensation and private care to get the problems resolved. Commentator can't afford this process.
- Commentator visited the dental practice for an emergency appointment. The dentist said she needed root canal treatment, but failed to do this successfully as he was unable to locate her root canals, and said she should 'visit another dentist who was more qualified'. The commentator was sent away with a patched up tooth. The temporary seal on the tooth was poorly done and she had 4 weeks of painful recurrent tooth infections, requiring several visits to the Riverside walk-in centre for antibiotics (costs were incurred). The commentator missed valuable days at university prior to her exams. In an X-ray taken by another dentist, she was shocked that the tooth had been drilled down the middle and almost clean in two. She eventually returned home from university to her family dentist, who agreed that her tooth should be extracted. The commentator has had to spend £4000 on dental implants through private treatment - the NHS won't fund this as it is considered cosmetic. The dentist in question admitted that he was newly qualified and lacked experience in root canal treatment - the commentator wonders why he didn't consult his supervisor instead of causing more damage.
- Commentator received feedback from Group members: No consistency in seeing the same GP. This situation improved for one group member when they sent a letter to the GP with information on their son's sensory issues.
- Commentator received feedback from Group members: GPs need training on benefits & how the sensory issues, dyspraxia, OCD etc. of a person with autism affect

their ability to work or cooperate if on Job Seeker's Allowance and so may need access to Employment & Support Allowance.

Urology

- Commentator's father-in-law is in his nineties and suffers from many ailments but is still mentally alert. He has been admitted to RUH many times in the last few years. Mostly they are for UTI which result in him becoming detached from reality. Some are for breathing problems and some for spasms resulting from a past hiatus hernia. He is also grossly overweight which means he needs hospital ambulances to get him in and out of hospital. On more than one occasion he has been discharged when it was clear to the commentator that he still wasn't well, but these concerns were ignored and within days he had been taken back in almost as an emergency. The discharge process from the RUH is poorly handled as father-in-law cannot be returned home until all his care packages have been restarted and his pharmacy informed to supply new dosette pill boxes. Commentator has to repeatedly nag the hospital staff to do this properly as every time it seems to be different staff involved, who do not seem to know what has to be done. All in all the RUH discharge process could do with some considerable improvement.

Healthwatch England has undertaken a National Inquiry in to unsafe discharge and Healthwatch Bath and North East Somerset with other Healthwatch have worked through July and August to contribute to the national inquiry. Eventually there will be a national report from Healthwatch England, but below is the local Healthwatch contribution for information.

Healthwatch Discharge Report: July and August 2014

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Introduction

The Healthwatch Special Inquiry into hospital discharge took place during July and August 2014. The theme of this work was identified nationally by Healthwatch England, and implemented locally by Healthwatch in Bristol, BANES, South Glos and Somerset.

This document will refer to the four local Healthwatch contracts above as ‘Healthwatch’, and to the national organisation as ‘Healthwatch England’.

This work will be conducted in four phases:

- Phase 1 – evidence gathering and focus groups
- Phase 2 – surveying and analysing themes
- Phase 3 – reporting to local Trusts and making recommendations
- Phase 4 – ongoing monitoring of whether, and if so how effectively, recommendations are implemented at a local level

Engagement

In keeping with our local and equitable approach, Healthwatch provided patient and public groups and individuals with many and varied ways to share their feedback about discharge experiences:

We utilized our *Network of Networks* to appeal for feedback via our volunteer Champions and Representatives.

We contacted partner organisations within the Voluntary and Community Sector (VCS), e.g. the Deaf Health Partnership, who referred members to us.

Hospital Trusts and other providers, for example Bristol Community Health, worked with us to signpost patients to have their say.

We continued to ensure that patients were given the opportunity to make confidential freepost submissions to us – for example, via a stand in the Urgent Care Centre at South Bristol Community Hospital. We also reviewed any recent feedback we had already heard, and included this in the report.

We provided an online questionnaire, as well as printed hard-copies of for those who do not or cannot use the internet.

Healthwatch also organised a series of in-depth focus groups with the following groups and communities:

- People who are carers
- People who have had a brain injury
- The Chinese and Vietnamese community
- People who have had a stroke, and/or who are living with the long-term effects of stroke, and their families and carers
- People who have a history of mental ill-health or who are currently living with mental ill-health
- People who have Multiple Sclerosis

A wide range of groups were approached and invited to take part in this work. Groups were approached according to whether they aligned with the Healthwatch priorities as outlined in the workplans. The above groups took the decision to engage with this particular investigation.

Consultation Approach

Healthwatch employed a range of qualitative methodologies using a variety of questioning techniques in order to optimise the accessibility and reach of this enquiry.

Questionnaires

The questionnaires contained a number of structured questions which were used to identify details of the respondents' experience and which allowed us to structure our analysis according to location of discharge and several other factors as dictated by Healthwatch England.

In addition, respondents were given an opportunity to complete an unstructured and free-text section. These statements were analysed qualitatively and informed the findings within this report. Using questionnaires enabled the Special Inquiry to reach a larger cohort than would have been reached using only face to face methods, as a questionnaire approach is less limited by time and resource limitations.

Focus Group Approach

Focus groups were conducted with a semi-structured approach. Participants were encouraged to lead discussion, and Healthwatch facilitators only prompted when discussions began to lose focus.

Prompts from facilitators involved questions about discharge as recommended by Healthwatch England, including questions about safety of discharge; provision of medication; involvement of carers and family members; and links with primary care and the voluntary and community sector.

This face to face approach enabled the Special Inquiry to explore subjects related to discharge in more detail. This mixed-methods design facilitated the collection of good quality, complementary data from which recommendations have been made.

Summary of Findings

Although specific groups of patients have differences in their discharge experiences, there are common themes that affect everyone who spoke to us.

The vast majority of those surveyed felt that their discharge would have been improved with effective referral into the Voluntary and Community Sector (VCS) following treatment in a secondary care setting. This was especially true of those living with long-term conditions, and those discharged following mental health treatment or support.

Many of those surveyed felt that the discharge process should be quicker, and that more effective planning of the various elements involved in their discharge would streamline the process. We spoke to many patients who had experienced excellent discharge; however, a more significant proportion shared experiences which included delays of many hours – in some cases an entire day - waiting for medicines to be dispensed or for transport to be arranged.

The majority of those who spoke to us praised the quality of care they received and the attitude of staff. However, this feedback was often qualified with unhappiness over rushed conversations with medical staff and a general perception of a lack of patient and family involvement in decision-making. This trend was especially true among patients for whom English is a second language and was a concern that was often shared by carers and those for whom they are caring.

Less-common but more serious concerns were raised regarding potential gaps in discharge and medication provision in some instances. This was true in cases involving a patient moving into a care home or being discharged back to an area in which they did not previously live, for example. Healthwatch will work with local Trusts and stakeholders to identify whether any such gaps exist and if so how to close them.

1. Survey Feedback

The findings of the questionnaire into discharge have been listed below.

The findings below were prompted by the following question:

‘What do you think could be improved for people when being discharged from a hospital, health unit or care home?’

Efficiency of Discharge and Planning for Post-Discharge Care (110 Comments)

The procedural element of discharge needs to improve and discharge needs to happen faster.

Discharge should be planned more carefully, and earlier in the care pathway, to ensure that when necessary the patient can be discharged with relatively little delay.

Procedural accuracy for complex discharge (weekend or holiday discharge, discharge into a care home, discharge to another part of the country or discharge for those with continuing complex needs) should improve, including a proper and robust system to ensure the safe provision of notes to the patient and to their GP.

The following elements of discharge need to be planned out and organized ahead of time to expedite the process:

1. Transport, where needed should be booked in advance and ready at the point of discharge
2. Medication should be ready upon discharge. No patient should be waiting several hours for pharmacy services in order to be discharged
3. Staff should provide a thorough and honest assessment of the ongoing needs of the patient post-discharge, which should include input from carers and family members where appropriate
4. Discharge must include provision of information on how to access support post-discharge, including charitable or voluntary sector support
5. The links between secondary care, and primary and social care need to be examined to ensure smooth transition post-discharge.

Communication and Discussion (45 Comments)

A significant proportion of patients feel that clinical staff do not listen meaningfully to their views, and that decisions are sometimes rushed in order to move them out of hospital and back into the community.

Patients want to feel that families and carers are being consulted and kept informed.

Where a patient does not fully understand something, they want to be given time, space and support to understand it better.

Patients who have specific requirements or needs want compassionate and sensible recognition of their needs (this includes people with sensory impairments, older people, people with learning difficulties and others). If a translator is required, then the Trust should identify this quickly and act to provide translation services, with the consent of the patient.

Some patients would like to be helped to understand 'what happens next' after they are discharged, via verbal discussion rather than written materials.

Recommendations

1. Hospital Trusts to examine how the speed of discharge can be improved. This should take the form of a survey or questionnaire provided to patients so that discharge can be planned in advance, preferably as early as practically possible. Transport, destination of discharge and post-discharge support should all be included in this planning.

Many respondents to the Healthwatch Special Inquiry felt that timely planning in advance of discharge would have helped to improve their experience of the process:

"Involve me and my Carer from the beginning. If discharged after procedures done by a consultant who is not in the hospital then for there to be a forward

plan discussed with me and my carer so that the junior doctor who discharges me knows what the consultant wanted to happen next”.

2. Hospital Trusts to outline how they ensure safe discharge when discharge is complex. Several reports were heard by Healthwatch about patients being discharged and discharge notes not getting to their GP. This is often the case in instances where patients are discharged into care homes in other local authority areas or in instances in which staff do not appear to have followed the correct procedure for processing and forwarding discharge notes.

“Discharge into a care home means that sometimes notes about medicines cannot go to a local GP or pharmacist as patient has moved to another location... on each hospital discharge, (carer) has had to chase round the pharmacist to ensure each new medication package is... delivered”.

3. Patients and carers should be helped to be aware of what constitutes good quality and safe discharge to encourage them to feel more in control of the process:

“Give patients a written tick list of all the processes/gateways that have to be completed to reach discharge. Make sure that all staff needed to carry out the processes are available at the right time...”

4. Patients have reported that they want to be provided with options for post-discharge support. Healthwatch can provide a free and comprehensive support service via the WellAware database. WellAware leaflets can and should be provided to patients upon discharge. Hospital staff should be trained in what the database does and how to proactively refer into it:

“It would have been nice to be offered support or charities I could contact. But I'm young and savvy so I suppose it wouldn't occur to them...”

5. Where possible and applicable, more time should be taken to make patients and carers feel involved in the discharge process. A discharge liaison employee or similar, or even a trained volunteer in some circumstances, could provide this kind of communication and support.

“I was under the impression I would be in for the weekend from the nurses, but consultant was very keen to discharge me and made me feel pressured and difficult when I was anxious about it...”

Positive Statements / Complements

Positive statements received from the public about their discharge generally corroborate the recommendations taken from the negative or mixed feedback, as above.

For example, we received some feedback about how pleased patients were with family and carer involvement in their discharge, and about how valuable it was to be given some information on post-discharge support. Many people fed back to us about the good quality of care they received from hard-working nurses, doctors and other staff.

Respondents valued being treated compassionately and being made to feel cared-for.

“Staff explored my social and family set-up before discharge”

“I was given excellent information on how to get post-discharge clinical support”

“I was ordered a taxi to get home”

“I received compassionate and effective care”

“I was generally happy with the service”

“The care on the ward was excellent”

“The (hospital) staff were excellent”

“The care agency and nurses made my experience a good one”

2. Complaints Advocacy Feedback

Part of the Healthwatch contract involves supporting patients to make an NHS complaint.

We have not deliberately sought to include information from ongoing complaints in this report, but have provided a summary of the themes taken from ongoing complaints below:

There is a common theme of premature/inappropriate discharge from all acute services, often with very serious outcomes including emergency readmission and in some cases the death of the patient. This theme is particularly prevalent in the elderly population.

Advocacy services are supporting cases in relation to premature discharge of Mental Health service users to primary care. The Independent Mental Health Advocates (IMHA) service has observed that patients under section of the Mental Health Act can sometimes be discharged too early for appropriate arrangements to have been made, such as accommodation or a comprehensive support package.

3. Focus Group Feedback

Carer's Support Centre

Summary

Commentators felt that more care should be taken to involve carers and patients during the discharge process and that discharge should be planned more effectively.

Pre-discharge Communication

More or improved communication between hospital staff/community services staff and patients, carers, neighbours of the patients who can support them.

“Ask the patient/carer, ‘is there someone we can notify that you’re coming home?’”

Carers would like to be better served by a dedicated staff member in the hospital... who can liaise between staff and the patient/ their carers.

Post-discharge Support

Participants would like post-discharge support to be well-connected and more thorough. There were concerns raised about arrangements around medication post-discharge, as well as a sense that once someone has been discharged, support tails off too quickly.

“Hospital to provide appropriate amounts of equipment and medication for the patient on discharge”.

“Hospital should telephone the patient at a pre-determined time one week after their discharge and check that the support in the community that was arranged in the discharge plan is actually being provided. They should ask: How are you? Is the support we included in your discharge plan working? Do you need any signposting to support services..?”

In addition, what could be termed ‘customer service’ could be better thought-through across sectors.

“Send the prescriptions straight from hospital to GP so patient doesn’t have to book an appointment with their GP after discharge”.

And;

“Give the patient a number for the ward that they can use if there are any issues after they’re discharged”.

Finally, participants wanted a single point of access into the Voluntary and Community Sector (VCS), which fitted with an overall desire for services to treat the ‘whole person’ rather than the specific condition that led to hospitalisation.

“Have one contact number the patient/ carer can contact to find out up to date support available from community and voluntary based services”.

And;

“Look at the whole person, not just the specific illness/ injury they’ve been admitted to hospital for or are receiving treatment in the community for”.

Recommendations

Better and timelier planning for what happens when a patient is discharged.

This should include provision of a single point of entry into the VCS for support, better arrangements around medication and the provision of a friendly 'check-up' for patients who hospital staff decide would most benefit from this service. This phone call 'check-up' could potentially be provided by a trained volunteer.

Headway (Somerset)

Participants had been discharged from a variety of sites, as follows:

Musgrove Park Hospital, Yeovil District Hospital, Bristol Heart Institute, Frenchay, Yeatman Hospital Sherborne, Williton.

Summary

Participants felt that the overall quality of care that they received in hospital was good. However, serious concerns were raised about post-discharge support and planning, and about the sometimes chaotic nature of the discharge process.

"None of the respondents felt well enough and ready to leave hospital when they were discharged. Most individuals... felt disorientated, especially those with brain injuries".

Post-discharge Planning

Perhaps of greatest concern were reports of a lack of clear instructions around medication.

‘...gave me a bag with tablet in but no instructions’.

All participants stated that they had not received a treatment or care plan upon discharge, and that no ongoing rehabilitation or therapy services were arranged for them. Those questioned felt that they had no input into the discharge process, and that it was something done to them, rather than with them.

“A score of 1/10 was given when asked if they felt involved in the decision-making process to leave the hospital”.

Some participants felt that their discharges had been delayed as they expressed that the nurses were overworked and did not have time. There was no memory of any offer to arrange transport.

When asked if family or community support were asked about on discharge, the universal response was an emphatic ‘no’.

Voluntary and Community Sector Support

When the respondents were asked if they had been told about WellAware, or any charities or community groups that could support them after discharge, the collective response was ‘no’, with the exception of some who had family members who had been put in contact with Headway by the Neurology team at Yeovil District Hospital.

Recommendations

Hospital Trusts to examine whether they are offering appropriate discharge support to patients with a brain injury and their families or carers. This should include referring into the VCS in all instances.

Chinese and Vietnamese Community

Summary

The majority of feedback at this focus group was regarding Bristol hospital services. Many themes that came out of this focus group fit with the general themes that arose from the questionnaire results - for example, a lack of referral to the VCS after discharge and concerns about a lack of involvement in the discharge process.

However, some culturally-specific findings were also uncovered which underpin much of what was discussed, and which are detailed below.

Language Barriers

People from the Chinese and Vietnamese community are not sufficiently supported to understand what is happening during care, discharge from care and post-discharge. Translation services need to be more widely available, including for those who are conversant in basic English, but who struggle with medicalised English. Services should not assume that a person who can hold a basic conversation will understand pharmaceutical or medical terminology.

“When she asked for interpretation the respondent was told that her English ‘is fine’”.

And;

“At first she asked for an interpreter but was told that this service was not provided, there was no budget and she would have to pay. They did eventually get an interpreter but they spoke Mandarin not Cantonese. They had to communicate by writing things down...”

Patient Involvement and Staff Attitude

Feedback regarding the attitude of staff was very mixed. Many participants went to great lengths to praise the quality of some of the staff that had helped them. However, many participants felt that language barriers resulted in more cursory consultation and less involvement in decision-making. Some also felt that they were discharged earlier than was appropriate, without really understanding the process.

Post-discharge Support

Participants felt that it would be good to have a source of culturally-appropriate support after being discharged, that they could access themselves.

“There is only one Chinese link worker for the whole of Bristol and she only works 2 days per week. This makes it difficult for Chinese speaking people to access support after discharge”.

Recommendations

Interpretation services should be planned before discharge, and then made available during the process. Staff should take the time to decide with a

patient whether they are able to understand more complex English, including medical and pharmaceutical terminology.

A method of providing culturally-appropriate support following discharge should be made available to Chinese and Vietnamese patients. The WellAware database includes a translation feature which would fulfill this need.

MS Therapy Centre

Summary

Generally, feedback about staff attitudes towards participants was positive, and standards of care were felt to be good. However, participants did feel that consultants were often brusque and did not give them enough time to discuss their health during consultations.

Post-discharge Support

All participants were grateful for continuing support received following discharge, but the provision of and quality of support varied hugely from person to person.

All participants felt that more VCS referral information should have been provided upon discharge to empower them to find out about things like home adaptation services, the MS therapy centre and other services.

Feedback about physiotherapy services was generally poor. Access to the service was said to be difficult, and the waiting list was observed as being too long.

“Another member said they had to break a bone before they could access physio”.

Communication

The group discussed specialists and consultants and agreed that these professionals only gave each person 10 minutes of their time. Participants were concerned that a lack of support was contributing to readmission in some instances.

“One person felt ‘fobbed off’ and was told to direct any questions to the MS Nurse”.

One participant thought it was bad that his specialists had not informed him of the diet people with MS should follow. The participant had to research this on their own. He was worried that the time spent not following dietary advice had resulted in poorer health and potential readmission into hospital for MS-related problems.

The Discharge Process / Dignity

One participant had an experience of discharge being delayed for eight hours because of the wait to see the pharmacist. They had been moved out of the hospital bed, and so had to wait in the family room instead.

Another participant said they were discharged only one day after their stoma operation. They said that they were not ok to leave to the Stoma Care Nurses at the BRI and had to learn how to change their stoma on their own.

Recommendations

Better post-discharge VCS support should be provided to patients with MS, and could reasonably be expected to address other issues raised during this focus group - such as a perceived lack of time to discuss health matters and access to physiotherapy.

Stroke Support Group

Summary

The discussions at this focus group were regarding local Bristol hospitals.

Participants shared experiences of discharge which corroborate much of the questionnaire feedback detailed above, such as a desire for better communication from medical staff, and for the discharge process to be streamlined. However, several issues emerged that were of importance to this group, as detailed below:

Medication and Safe Discharge

Three specific concerns were raised around safety of discharge and safe provision of medication.

“Medication was ordered by hospital, GP contacted commentator to tell her it was ready to collect, but... it’s the wrong medication. Lots of changes to medication in hospital and after discharge is confusing. Commentator worried she might have started taking wrong medication and been ill”.

And;

“Commentator’s father was given a double dose of medication on discharge. He was not told it was a double dose. Home care agency were confused by the dosage and had to double check with the hospital”.

And;

“Commentator had a stroke in June 2014. He was discharged and went home on the bus. Hospital staff did not check he got home safely even though he travelled home alone”.

Post-discharge Care and VCS Referral

Participant feedback about support provided following discharge was mixed. Several felt that they were not sufficiently supported, whereas another participant had an excellent experience of discharge.

“Commentator found it difficult to get through to (hospital) staff on the phone after their discharge from the hospital. They were not given a contact name and this made it hard to speak to someone who could help”.

And;

“Commentator had a wonderful discharge experience. First 4 weeks after discharge someone visited her at home every day to help and signpost her to services that could support her. On the day she arrived home, workmen came and made alterations to home. She thinks all this was organised by the hospital following treatment for her stroke. They also referred her for physiotherapy. ‘I am so grateful for the care’”.

The group was unanimous that there should be a more regular and organised system for referring to the VCS, as any referral that was made appeared to be the result of individual good practice rather than robust systems.

“The HITU receptionist recommended (commentator) went to Headway. Commentator has been volunteering at Headway and has found the volunteer work very beneficial to their recovery. Commentator does, however, worry that if it hadn’t been for the receptionist, they would not have got support from Headway. Referral to Headway should be in an official discharge pathway”

And;

“Group felt information about support services (e.g. Voluntary sector services) should be given out on discharge. At the moment group members felt they only found out about support services through word of mouth not from professionals”.

Recommendations

All staff involved in discharge should ensure that stroke patients are properly assessed and supported during discharge. Where possible, a check-up phone call or service should be offered to ensure that the patient has been discharged safely.

Referral to VCS support services should be offered to patients who have had a stroke as part of every discharge process. Information could be given to patients and their families or carers about the Well Aware health and wellbeing database which has up to date information and contact details for VCS support services.

People with a hearing impairment, or who are deaf

Summary

We received feedback regarding discharge services from a cohort of people who are deaf and/or have a hearing impairment. This cohort were generally happy with the quality of care received and responses about staff attitudes

and clinical quality were similar to responses received from respondents who are not deaf or hearing impaired.

Several common themes emerged from this feedback which align with the general trends seen throughout the data, such as delays in the discharge process relating to pharmaceutical provision and transport.

However, several cohort-specific issues were also identified, as below.

Information Provision

People who are deaf or who have a hearing impairment reported experiencing particularly poor provision of information throughout their care pathway, and also post-discharge.

“Staff had no idea how to communicate with me”.

And;

“It would be more helpful if the consultant and nurse could inform me of the next stage rather than just move me into a position they want me to be in”.

In addition, some respondents were concerned about a lack of information sharing between agencies and sectors involved in their care.

“Better information sharing. I was told by the optician that I had a low risk of glaucoma, but the hospital didn’t tell me this”

This group reported that they were sometimes unsure about medication, and unsure of what to do in an emergency or where to go to get further information and support.

“I should have been informed of post-discharge support”

Reasonable Adjustments

This group also reported significant frustration over the lack of reasonable adjustments made by hospital services to cater for their requirements.

“The hospital was unable to send texts to arrange for transport home, this is a problem for deaf families”.

And;

“It would be helpful if there was an electronic display... as I have to constantly watch out for my name each time the nurse calls out”.

And;

“Equipment in the hospital was inaccessible e.g. no subtitles on the TV”.

Provision of Interpretation

Several respondents reported that they had not been offered interpretation- in some cases even after specifying that they needed it. It was clear from those who had received this support that it was highly valued.

“Interpreters must be provided for deaf patients”.

And;

“I was fortunate that I had a sign language interpreter with me during discharge – this helped. I was able to access information and ask questions”.

Recommendations

Trusts should sign up to the Deaf Health Charter which has been locally commissioned by Bristol CCG (Clinical Commissioning Group).

Recommendations within the charter should be implemented to ensure that the needs of deaf people are met.

Men

Summary

A proportion of respondents were happy to specify their gender, and as a result it is possible to examine male-specific themes that emerged from the feedback.

VCS and Other Post-Discharge Support

Men were only half as likely as women to be offered a referral into the VCS during discharge (5% of men stated that they had been offered this service, compared to 10% of women).

Follow-up contact from primary or secondary care was very similar regardless of gender, with one third of men and women stating that they had received contact.

Discharge Process – Delays

Men were less likely to experience delay during discharge than women (36% of men reported 'no delay' compared to 27% of women).

4. Healthwatch – Continued Monitoring

Healthwatch will continue to monitor the issues raised within this piece of work as part of our ongoing role as patient and public champion.

We will continue to invite patients and the public to feed back to us their experiences of discharge, and will monitor and publicise improvements that arise from this report.

5. Conclusions and Implementation

Healthwatch is happy to recommend the following to all hospital trusts. We will work with trusts and trust patient experience groups to monitor whether these recommendations are implemented and whether they are having the desired effect.

This report and recommendations will also be publically available and disseminated widely throughout the region.

1. The discharge process for many patients needs to be planned and implemented more efficiently. Where possible, planning should begin early in

the patient pathway, and should include and incorporate all elements of safe discharge to avoid any delays. Where the exact date of discharge is uncertain, as much planning as possible should be completed in advance of discharge.

2. Discharge processes must include a thorough and effective process for ensuring that patients can access voluntary and community sector (VCS) support within their community. Patients should be empowered to maintain and improve their wellbeing post-discharge to avoid the potential for distressing and unnecessary readmissions. Healthwatch can provide a VCS signposting function for local Trusts as part of our commissioned service.

3. Where possible, and especially in circumstances that involve vulnerable and/or older people, the hospital should examine whether they could provide a 'check-up' service to patients after discharge. It is clear that many patients will not require this service, so the discharge process should include an assessment as to whether the patient would benefit from a 'check up' in order to avoid using resources unnecessarily.

4. Hospitals should consider whether they are doing enough to listen to the views of patients, families and carers during the discharge process. Views should be meaningfully incorporated into decision-making in order to empower patients to feel in control of their care.

This report was produced by Healthwatch Bristol, B&NES, South Gloucestershire and Somerset.

For copies in another format, or to find out more, please contact us using the details below.

6 RATIONALE

7 OTHER OPTIONS CONSIDERED

8 CONSULTATION

9 RISK MANAGEMENT

- 9.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

Contact person	Pat Foster – General Manager The Care Forum Tel: 0117 9589344 Email: patfoster@thecareforum.org.uk
Background papers	<i>List here any background papers not included with this report because they are already in the public domain, and where/how they are available for inspection.</i>
Please contact the report author if you need to access this report in an alternative format	