

Improving discharges from hospital in Oxfordshire

Healthwatch Oxfordshire

September 2015





Overall in-hospital care was excellent. After first night surgeon discussed with me the option of leaving that day or staying another night, leaving the decision to me and my carer (my wife, who is a nurse). Over course of the afternoon, with the support of the duty nurse, we decided that I was fit to be discharged and that was arranged promptly for late in the afternoon. The excellent aspect of this was that I and my wife were completely involved in the decision process, along with the very supportive duty nurse and the prior approval of the surgeon.

A resident with Parkinson's was going to be discharged and staff contacted hospital as they had not got the full history of client. By all working together a full package and with care and support was set up and also a move to alternative accommodation was authorised so client able to live independently with wife at home.

A Discharge Summary is precively that - a Summary, not the clinical narrative that lead to the test request e.g. obs, symptoms, signs etc... I currently am a clinician involved in a case where a patient was admitted and discharged three times in a row with no discharge correspondence at all - she died in the back of an ambulance on the way back to the hospital... This is an extreme example of where failure to provide discharge correspondence might have improved her assessment and prevented her death...

Not sure about how he will get home. Feel that he's been sitting on the discharge ward for 4 weeks. Could have been home earlier. Been a nightmare experience. He is weaker, lost hope, difficult for wife. Lots of false hope of discharge.



All quotes in this report are verbatim and unedited

Contents

1	Executive Summary	5
2	Background	9
2.1	Reasons for the report	9
2.2	Strategic drivers	9
2.3	Healthwatch England’s Special Inquiry: Safely Home	10
2.4	Methodology	11
2.4.1	Aims and objectives	12
2.4.2	Questionnaire Development	12
2.4.3	Enter and View	13
2.4.4	Data Analysis.....	14
3	Discussion of Findings.....	16
3.1	Patients: before discharge	16
3.2	Patients: after discharge	26
3.3	Recommendations arising from the patients who contributed to this study	45
3.4	Professionals: care providers.....	46
3.5	Recommendations arising from the care providers who contributed to this study:	54
3.6	Professionals: GPs.....	55
3.7	Recommendations arising from the GPs who contributed to this study	63
3.8	Professionals: pharmacies	64
3.9	Recommendations arising from the pharmacists who contributed to this study:.....	68
4	The gap between information given to patients and their experience. 69	
4.1	Recommendations relating to the gap between patient information and patient experience.	72
5	Recommendations.....	74
	Appendix 1: Discharge pathway flowcharts.....	74
	Appendix 2 & 3: Data tables & Questionnaires	79

1 Executive Summary

Oxfordshire continues to have a seemingly intractable problem with discharging people from hospital in a timely and effective way. At July 9th 2015 the year to date average is still for 158 people to be experiencing a delay in their discharge from hospital in any given week - and there has been no sign of consistent improvement in these figures for many years.

In this context Healthwatch Oxfordshire wanted to know what those affected by the discharge process thought about how it could be improved, and sought the views of patients, and of professionals who provide ongoing care after a patient has been discharged from hospital. We did not specifically focus on patients experiencing a delay in their discharge, as we recognise that they are a small subset of those being discharged from hospital.

This report presents the feedback Healthwatch Oxfordshire received about the discharge process from Oxfordshire hospitals from 212 patients, 14 care providers, 33 GPs and 44 pharmacists in the period March-April 2012, all of whom volunteered their views by choosing to participate.

We would like to thank and congratulate the staff and leadership teams in Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford Health Foundation Trust and Oxford University Hospitals Trust for their co-operation with this project. They all enabled senior staff to join the project steering group. This meant that the project design, the questionnaires, the sample sizes and other key decisions about the project methodology were co-designed with them - so that we could ensure the findings would be useful to them. All four organisations then voluntarily withdrew from the steering group when we began the analysis of the data, so that the public can be assured that the recommendations this report makes have been derived independently of any influence from the affected commissioners and providers.

The 14 main recommendations arising from our study are that:

1. Hospital trusts should take immediate action to increase the percentage of patients whose Estimated Date of Discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway¹. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.
2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.
3. The “Planning for Discharge” ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.
4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place.
5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about ‘involving’ others and not just about ‘informing’ them.
6. That the Discharge Co-ordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed.
7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to

¹ See Appendix 1 for the summary pathway

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

use any specialist provision, and whether there might be any costs to patients for these services.

8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically:
 - Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.
 - Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.
 - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary.
 - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.
9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.
10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.
11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.
12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.
13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.

14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.

2 Background

2.1 Reasons for the report

Healthwatch Oxfordshire is concerned that the voices of patients and carers have not been sufficiently heard, or responded to, in the ongoing debates between health and social care providers and commissioners about how to improve the discharge of patients from Oxfordshire's hospitals.

This report aims to bring the voices of those being discharged, and those caring for them, into the debate. We hope that commissioners will take its findings into account when setting quality standards - and that providers will respond to the recommendations. The quotes included have been carefully selected to reflect the balance of comments made by respondents.

2.2 Strategic drivers

Discharges from Oxfordshire's hospitals are an area of focus for Healthwatch for a number of reasons, including:

- Patient Voice, an experienced and active patient group, identified the need to carry out an initial study into Discharge arrangements and submitted a proposal to the Healthwatch Project Fund. As they were ineligible for funding, Healthwatch Oxfordshire decided to carry out an extensive and detailed study, incorporating the views of patients, carers, GP's and pharmacists.
- Oxfordshire is one of the worst performers in the country for Delayed Transfers of Care.
- Local GPs have raised the issue of the quality of the discharge process as an area of concern with Oxfordshire Clinical Commissioning Group.
- Healthwatch England has been sufficiently concerned about this issue to undertake a national special inquiry on the topic.

2.3 Healthwatch England's Special Inquiry: Safely Home

Concurrent with Healthwatch Oxfordshire's work to understand the discharge process from the patient perspective, Healthwatch England launched a special inquiry into hospital discharges. They heard from over 3000 people on their experiences of discharge and used available data to better understand the discharge process.

They highlight a June 2015, YouGov poll which outlines that:

- 18% did not feel they received all the social care support they required after leaving hospital.
- 1 in 4 (26%) felt their friend/relative did not receive the social care support they needed.
- 1 in 5 (21%) did not feel they were involved in decisions concerning hospital treatment and planning discharge, and the same proportion (22%) felt their friend/relative was not involved as an equal partner.
- 1 in 8 (12%) did not feel they were able to cope in their own home after being discharged from hospital. 1 in 4 (24%) did not feel their friends/relatives were able to cope.
- 14% did not know who to contact for further help following treatment, 18% of people felt their friend/relative did not know who to contact.²

In their findings Healthwatch England list five reasons things that go wrong, including:

1. People are experiencing delays and a lack of coordination between different services;
2. People are feeling left without the services and support they need after discharge;
3. People feel stigmatised and discriminated against and that they are not treated with appropriate respect because of their conditions and circumstances;
4. People feel they are not involved in the decisions about their care or given the information that they need; and
5. People feel that their full range of needs is not considered.³

² Poll carried out by YouGov June 2015

³ Healthwatch England, Safely Home: Special Inquiry. Published July 2015 available at <http://www.healthwatch.co.uk/safely-home>

Healthwatch Oxfordshire contributed evidence to the national special inquiry and some of the overall findings are echoed within our report. We hope that this report brings a greater depth of understanding to the local issues experienced in Oxfordshire.

2.4 Methodology

The project used a mixed qualitative and quantitative questionnaire methodology.

Questionnaires were made available online and shared through the media, the Healthwatch Oxfordshire website and through existing mailing lists.

The patient Before and After discharge questionnaires were completed either online or through interview with Enter and View volunteers.

The three 'professionals' questionnaires (Care Providers, GPs, and Pharmacies) were completed online and shared through the appropriate local professionals' organisations.

The project originally aimed to gather data that would allow recommendations to be made to each provider separately. However the project methodology relied on voluntary participation, and the cohort of those who chose to participate were overwhelmingly patients who had been discharged from an OUHT facility. Too few respondents were discharged from services run by other providers to make analysis by provider valid.

This report has been authored by Healthwatch Oxfordshire based on the findings of the questionnaires and Enter and View activity. The quotes that have been selected for inclusion represent the balance of comments made in free text sections of the questionnaires. The report has been reviewed for accuracy, before publication, by key stakeholders, including Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust and Oxfordshire County Council. Their comments and feedback have been taken into account in finalising the report for publication.

2.4.1 Aims and objectives

The project was designed to find out more about how we discharge people from hospital in Oxfordshire with a focus on the experiences of patients and of those supporting patients after discharge (care providers, pharmacists and General Practitioners).

The project originally aimed to discover and share information about:

- i. People's experience of being discharged from Oxfordshire's acute and community hospitals.
- ii. The impact that their discharge experience has had on their health and wellbeing, and the health and wellbeing of their families and/or carers.
- iii. The impact of poor discharge processes on on-going care from the perspective of other care professionals.
- iv. Examples of well managed discharge that the whole health and care community can learn from.
- v. Examples of poorly managed discharge, and the key things local providers and commissioners need to work to improve.
- vi. How the quality of the discharge process impacts on people's ability to live independently at home after a stay in hospital.
- vii. The extent to which the discharge process is meeting the quality standards and/or processes agreed in contracts between commissioners and providers.

As the project was developed by the steering group the focus moved very much onto addressing the first five of these aims.

2.4.2 Questionnaire Development and Project Design

The patient questionnaires were authored by Healthwatch Oxfordshire and after significant review, amendment and addition by members of the project Steering Group, were approved for use. The project Steering group included representatives from Healthwatch, and representatives from Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, the Oxfordshire Association of Care Providers, the Local Pharmaceutical Council, the Local Medical Council and Oxfordshire County Council.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

The Care Provider questionnaire was authored by Healthwatch Oxfordshire and the Oxfordshire Association of Care Providers (OACP), reviewed by the project Steering Group (as above) and approved by OACP.

The GP questionnaire was authored by Healthwatch Oxfordshire and the Local Medical Council (LMC), reviewed by the project Steering Group (as above) and approved by the LMC.

The Pharmacy questionnaire was authored by Healthwatch Oxfordshire and the Local Pharmacy Council (LPC), reviewed by the project Steering Group (as above) and approved by the LPC.

Decisions about methodologies, sample sizes, locations for Enter and View and strategies for encouraging participation were all agreed collectively by the steering group.

Supporting materials, including consent forms, information leaflets, posters, and staff briefing documents, were all reviewed and agreed by the project Steering Group before publication and use.

After the completion of fieldwork, the project steering group stopped meeting. Representatives from OUHT, OHFT, OCC and OCCG voluntarily withdrew from the steering group when we began the analysis of the data, so that the public can be assured that the recommendations this report makes have been derived independently of any influence from the affected commissioners and providers.

2.4.3 Enter and View

The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Local Healthwatch authorised representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. This activity is called Enter and View.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation - so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they will inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to CQC where they are protected by legislation if they raise a concern.

The Enter and View interviews with patients used the 'Before discharge' questionnaire as the basis of the interview. Interviews were carried out by pairs of trained Healthwatch Oxfordshire volunteers and/or staff - with one person conducting the interview and the second person acting as a 'scribe', noting the answers on a paper copy. These notes were later typed into the online questionnaire tool by Healthwatch Oxfordshire volunteers.

Enter and View visits took place on the following NHS hospital sites between 27 February 2015 and 31 March 2015:

- Abingdon Community Hospital (Oxford Health NHS Foundation Trust)
- Churchill Hospital (Oxford University Hospitals NHS Trust)
- John Radcliffe Hospital (Oxford University Hospitals NHS Trust)
- Horton General Hospital (Oxford University Hospitals NHS Trust)
- Nuffield Orthopaedic Centre (Oxford University Hospitals NHS Trust)
- Wallingford Hospital (Oxford Health NHS Foundation Trust).

2.4.4 Data Analysis

In order to stimulate responses, access to the questionnaires was made available through a public link online. Due to the public access to the questionnaires, up to a third of responses to some of the questionnaires have been excluded from the data analysed.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

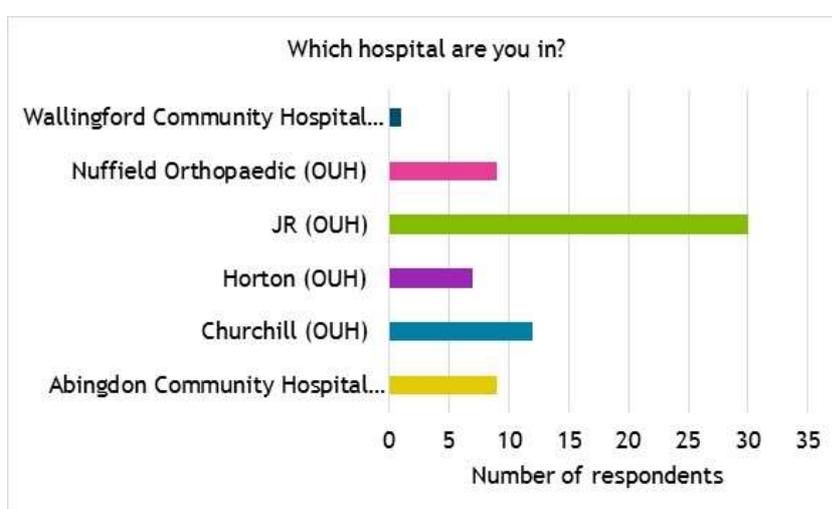
Criteria for exclusion included partial completions where there was too little data for analysis or where responses were clearly not valid patient responses (e.g. responses marked as 'test'). All figures reported on in this report are from 'cleaned' data.

3 Discussion of Findings

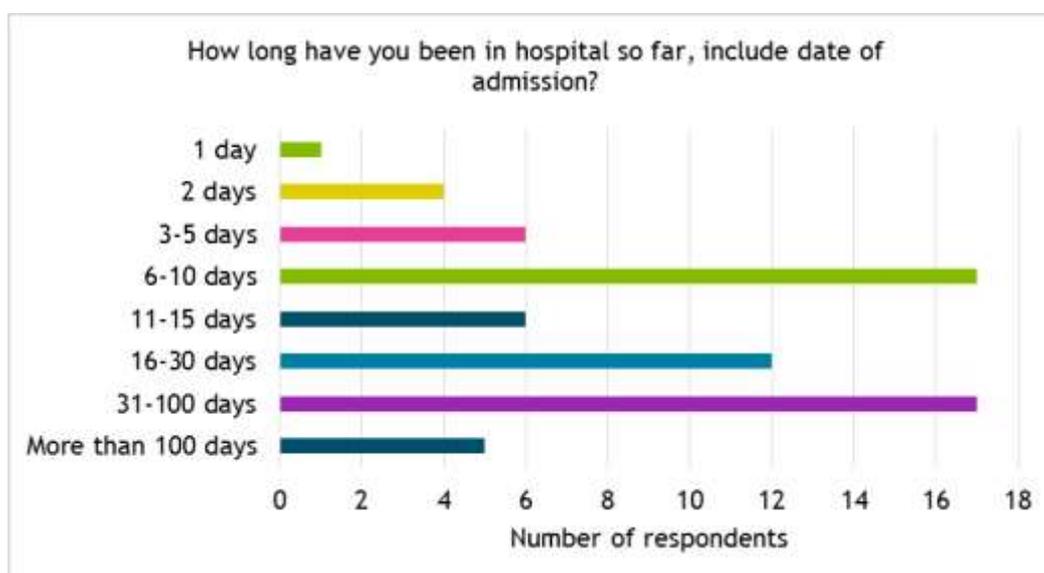
3.1 Patients: before discharge

3.1.1 About the respondents

68 patients completed our survey during a current hospital stay, and the focus for this group of patients was to explore their experience of the discharge pathway up to that point. Some described discharges from a previous admission and others described their current experience.



44% (30) respondents were in the John Radcliffe, 41% (28) were in other OUHT sites and 15% (10) in OHFT community hospitals. 28% of respondents (19) were in hospital following a planned admission, most had been admitted via A&E or their GP requiring urgent care.



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

16% (11) of respondents to this part of the study had a stay of under 5 days, 25% (11) had a stay of 5-10 days, 27% (18) were in hospital for between 11 and 30 days, 25% (17) had a stay of 30-100 days and 7% (5) were in hospital for more than 100 days at the point they completed the survey.

As the numbers are so heavily weighted towards those being discharged from OUHT facilities it was not possible to undertake a valid analysis by provider.

3.1.2 What worked?

This group had a high rate of overall satisfaction with their experience of discharge planning during their current stay.

- 80% (46) described their experience of planning their discharge as satisfactory or better.

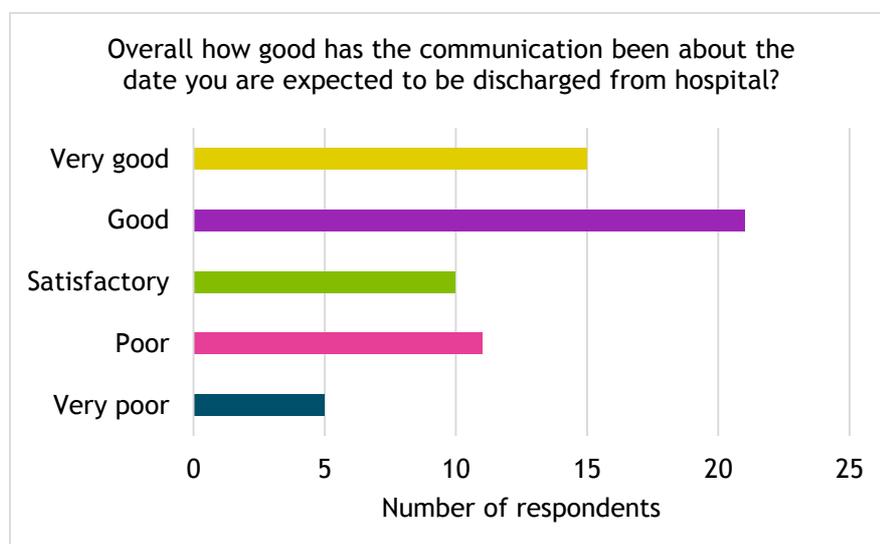
Cannot speak well enough of them - kindness has been great

No date yet agreed but happy with discussions and plans for discharge.

Values were heeded. Voice was heard and my dignity was respected. I was made to feel like a human being.

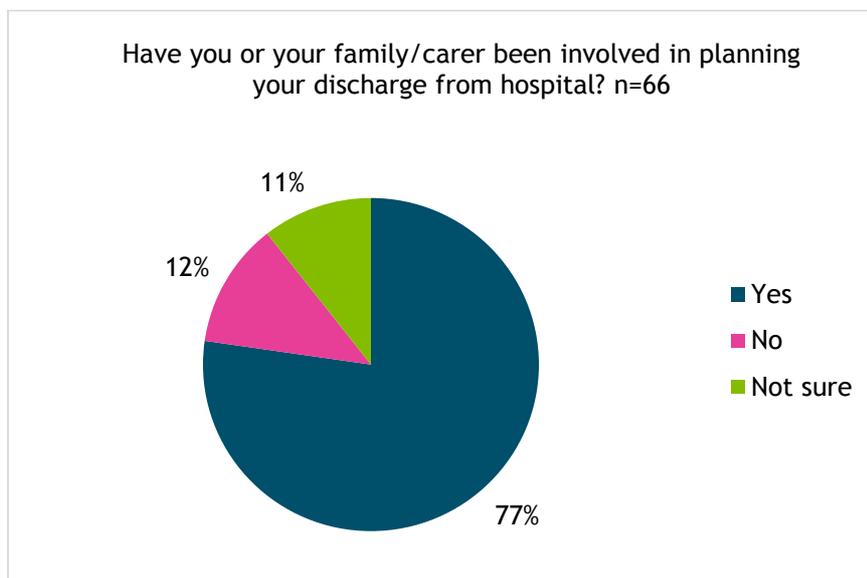
Preparation has been excellent - given lots of information - know what we are doing

Can't think of anything. It has all been brilliant.



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

- 74% (50) rated communication about the date they expected to be discharged as satisfactory or better.
- 77% (51) said either they or their family or carer had been involved in planning their discharge.



Someone who described their overall experience as good commented that they had:

Had a big meeting with daughter, senior district nurse, OT, neighbour, physio and care agency and previous care agency

It is this kind of approach that characterised a good discharge for this group.

3.1.3 What could be improved?

This group of patients also identified key areas for improvement. The comments made when they were asked more detailed questions and were given the chance to suggest ways to improve the process, suggest that the overall satisfaction ratings are masking some important areas for improvement:

I felt like a hamster on a wheel

Need clear information, it's like being in a fog

No-one has clearly sat down and said I want to talk to you about your wife's discharge

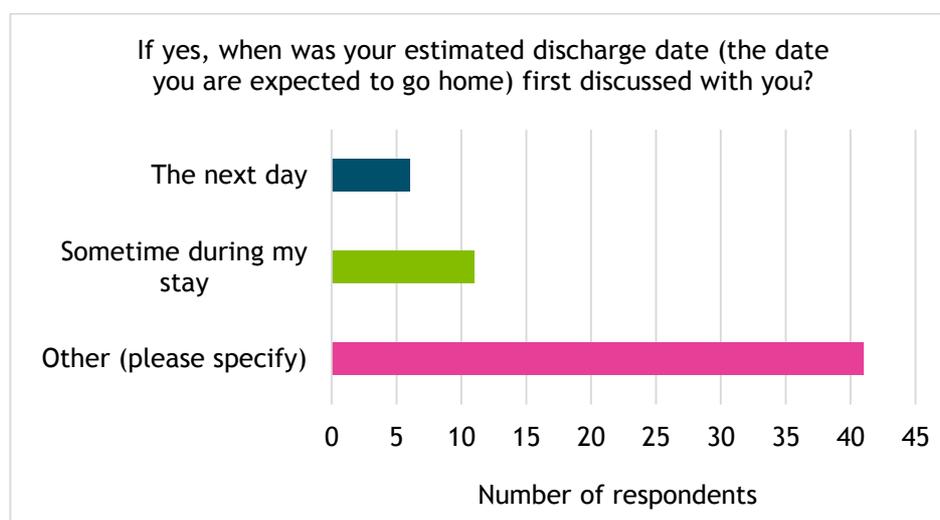
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Too many "busy bees" but no Queen Bee to organise things. The computer does not feel anything but the patient does!!

Not sure about how he will get home. Feel that he's been sitting on the discharge ward for 4 weeks. Could have been home earlier. Been a nightmare experience. He is weaker, lost hope, difficult for wife. Lots of false hope of discharge

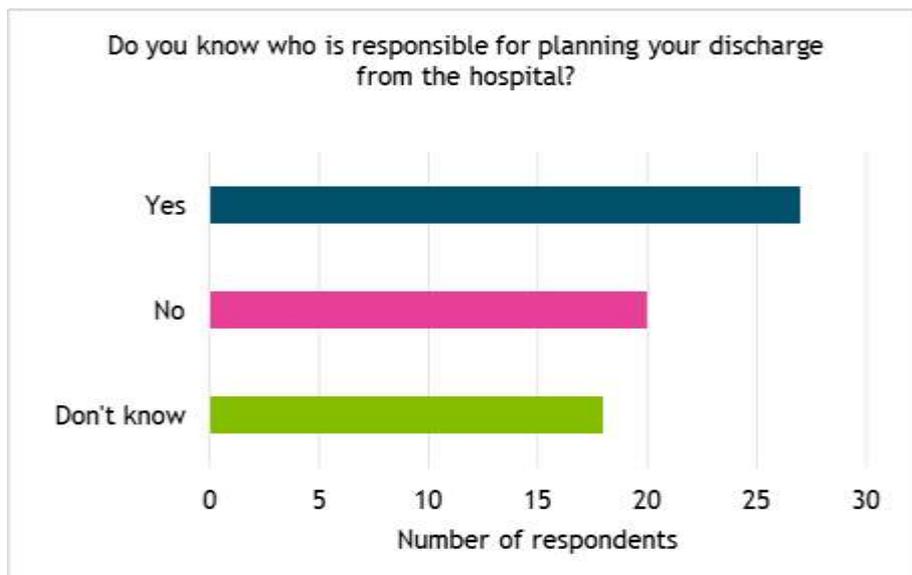
3.1.3.1 Planning and communication with the patient

The key messages we heard from this cohort of patients about planning for their discharge and how well they were involved in this were:

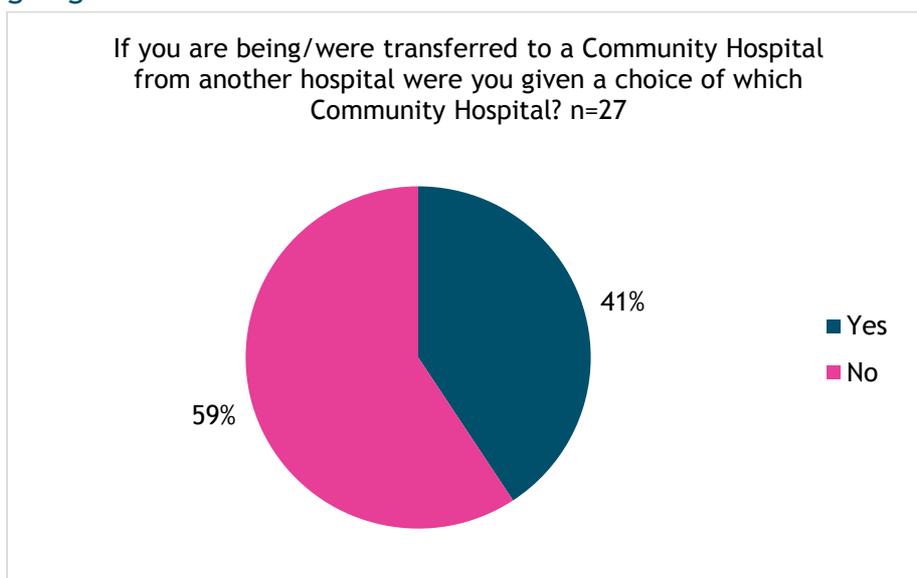


- 9% (6) reported an estimated date of discharge (EDD) being given to them when they were admitted or the next day. The stated local target is for all patients to have their EDD within 36 hours of admission - see Appendix 1.
- 12% (8) reported that they were not involved in planning their own discharge.
- 11% (7) reported that they were not sure if they had been involved in the planning of their discharge.
- 20% (11) felt the experience of planning their discharge was poor or very poor.
- 42% (27) of these respondents knew who was responsible for planning their discharge, and 50% (30) of this group knew how to contact that person.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



- Of those being discharged to a community hospital, 59% (16) said they had not been given any choice about which hospital they would be going to.



When we asked these patients how the discharge process could be improved the following were typical of the comments we received:

Someone should be in charge. Needs someone responsible. A co-ordinator monitoring.

Need a discharge planner, who sets out clearly the process and timings and responsible person named for each stage if not the

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

discharge planner - plan also needs to be kept up to date Medical side very good. Administrative side very poor

Provide more information so that patient can be more involved with discharge process and understand what is going on at every step

Better, earlier involvement in planning - need time to understand implications

I would like to have clearer information. Information confused. Mixed messages which I find very disturbing. Doctor says one thing, nurse says another

Communication - people need to be trained in communication as a 2 way process

If there was one person whose job it was to instigate and arrange for getting patient home it would be better. Nurses too busy and do not have all the information

Have not got any meaningful conversations with regard to any discharge plan

3.1.3.2 Communication between professionals

This cohort of patients also clearly felt that the discharge process, as they experienced it, could be significantly improved if communication between professionals about a patient were to be improved. When we asked them what would improve the discharge process we received comments like:

Need a link between hospital and GP

I would like to see them working together as a team. Mixed messages which I find very disturbing. Doctor says one thing, nurse says another

Consistency with answers - 4 different staff, 4 different answers

Better communication between departments improved preparation of discharge paper

GP surgery and Churchill MUST communicate much better. In fact they are making it more difficult

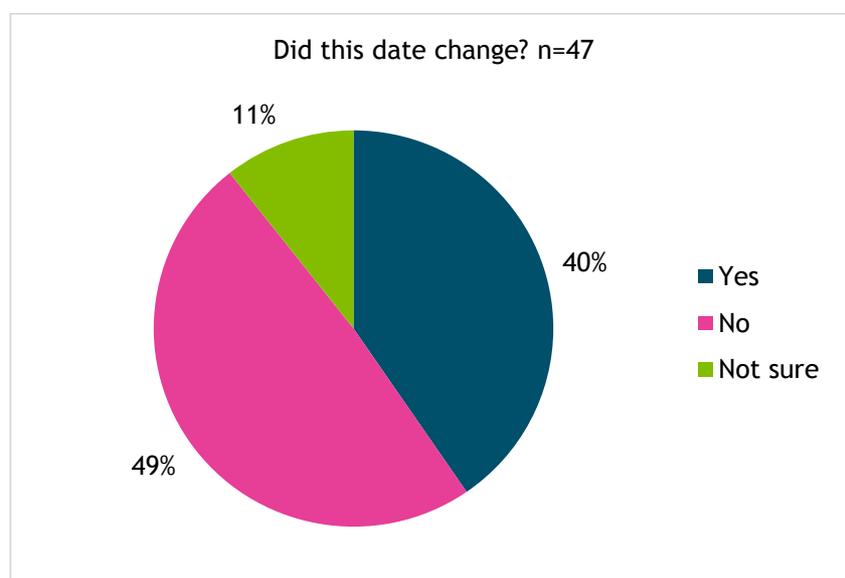
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Keep other clinicians up to date with my care. Communication between departments is important.

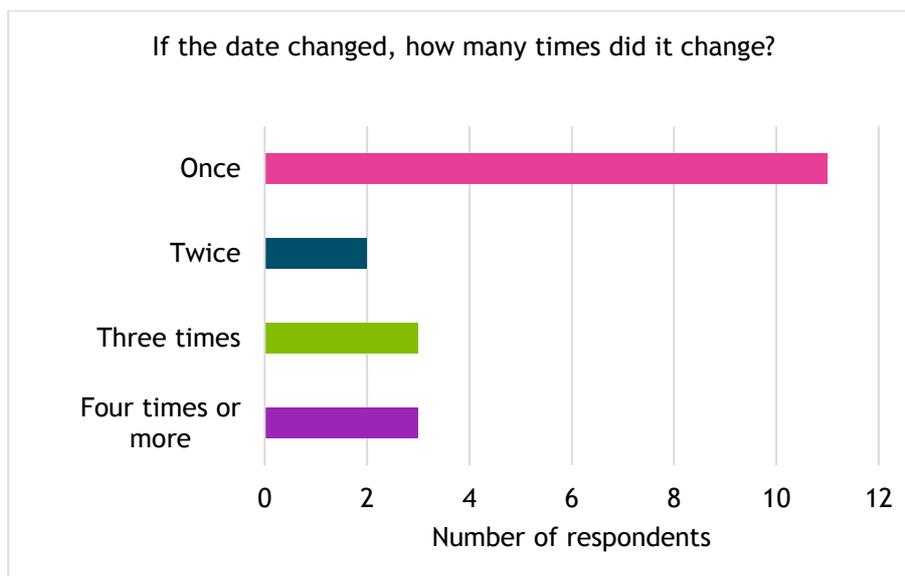
Less departments (more communication).

3.1.3.3 Changing plans

- 40% (19) of this cohort of patients said their Estimated Date of Discharge (EDD) changed during their stay.
- Half, 50% (11) of those answering this question had only 1 change, and 83% (19) of those whose EDD changed said they were told why the change was necessary.
- However, of those whose discharge was delayed beyond the point they were well enough to go home only 47% (15) had had the reason for the delay explained. 86% (12) patients whose discharge was delayed beyond the point they were well enough to go home experienced delays of more than 5 days.
- Only 8% (2) of respondents said they could have taken action to avoid being delayed themselves.



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



When we asked people whose discharge was delayed what they thought had caused their delay the answers we got included the following:

Not known

Nothing suitable to go too

Not explained - waiting for the care package to be put in. waiting 6 weeks. Told won't do shower until back home

Paperwork for the next stage of care package at home

Waiting for special hoist

Lack of availability of carers

Adaptations being done

Care plan was not in place - care providers have had to change

Hospital has been great - fit to leave a month ago - outside agencies dreadful

The problem was there weren't any carers available

Seems silly to offer home help if it cannot be pre-arranged to coincide with the date of discharge. Disjointed.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

This suggests that planned changes to discharge relating to changing medical needs are being relatively well managed, but that completing the discharge for a person medically fit to go home is still being held up whilst plans for ongoing care are finalised - and in particular that access to care packages remains a problem.

3.1.3.4 Last minute hitches with pharmacy

Many patients in this cohort reported problems with the preparation of the medication they needed to take out of hospital with them, and indicated that this held up going home on the day of discharge.

Indeed when we asked how the process could be improved, the area most frequently cited was the link with pharmacy at the end of the pathway, and typical comments included:

Pharmacy - pharmacy - pharmacy On ward is excellent. Doing their best. Change system/procedure - maybe start day before

Biggest problem is pharmacy. Always 6 hours delay. Also happened in Reading - waited until 11.30pm. No one to ask who knows. Otherwise all done in 1-2 hours except meds

Medication available and not delayed

Get medication quicker

If things could be sped up. Pharmacist provide medication. Junior Doctor to decide on medication.

Delays at pharmacy

Waiting for pharmacy and meds. Nowhere to wait if you vacate your bed.

Delay in pharmacy providing medicines for discharge.

Delay caused by late delivery of drugs.

Prompt delivery of drugs - improve process for supply of drugs at discharge

Having to wait for the Prescriptions was too long

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

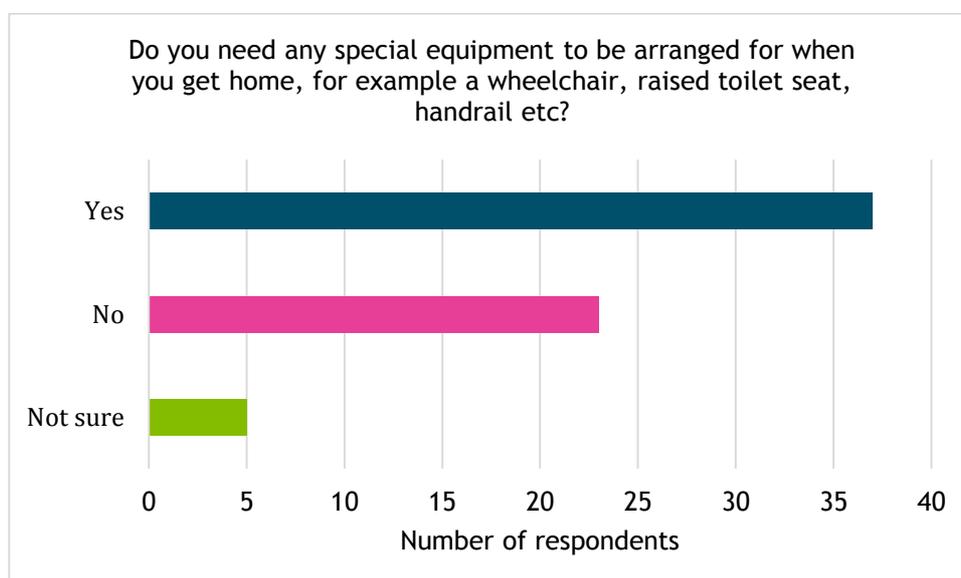
Medication could have been issued quickly or on the ward so as to avoid having to come into the discharge lounge at all

Previous discharge = bad - delayed pharmacy wrong meds

Medication for discharge delayed from pharmacy to ward

3.1.3.5 Access to equipment and support at home⁴

57% (37) of the patients in this cohort had been assessed as needing equipment at home when they were discharged. Most of these reported that their equipment needs had been assessed, and some said that the equipment they needed was already at home - with evidence of staff going the extra mile to make sure needs were met:



Things already sorted

Hoist - delivered 2-3 weeks ago - got other equipment

All geared up at home already. Hospital provided additional walking equipment, commode, raised seat

OT spending "own" time to find the most appropriate aids and equipment.

⁴ Note responsibility for provision of equipment and support at home is not the responsibility of OUHT or OHFT.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

However once again this is not a universally positive picture - either in terms of the equipment being available or the patient being confident about how to use it:

Has equipment which is not fit for purpose!

Partner made ramp otherwise discharge would have been delayed

OT has put a list in but waiting for the package to come through.

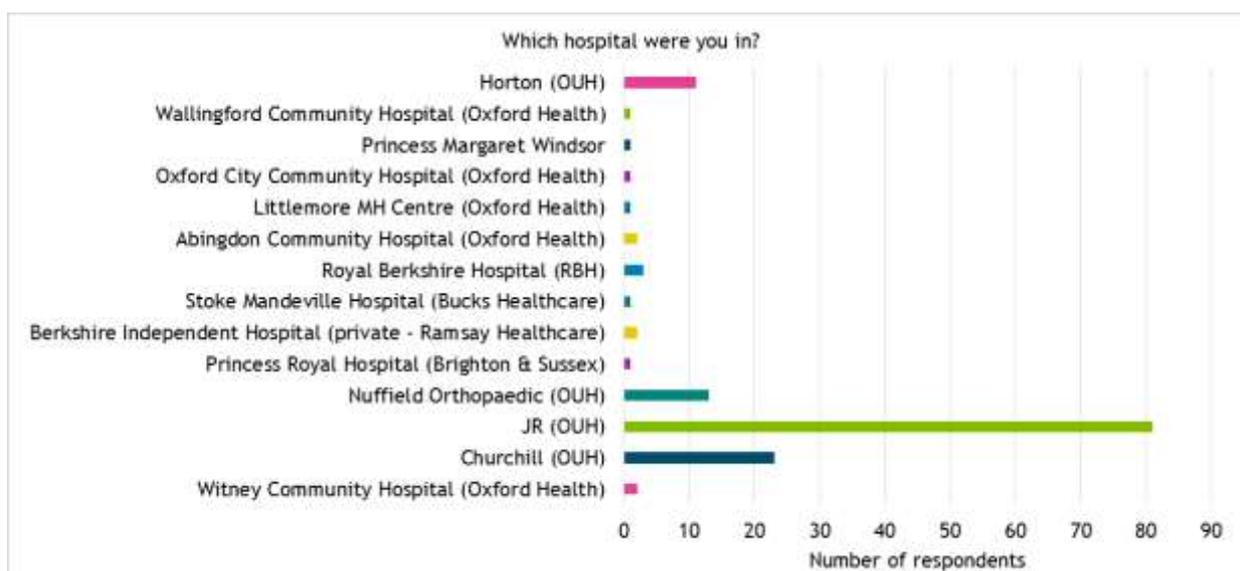
Discharge was agreed on Friday - on the Monday delivery truck arrived with all equipment including bed etc with no planning or communication. Didn't know what was coming and would have liked to see a list

I ONLY needed to be advised what to do and avoid when I got home with commode + zimmer after I had fallen and crushed my femur. But there was no advice

3.2 Patients: after discharge

3.2.1 About this cohort

144 patients completed our survey after their discharge had been completed.



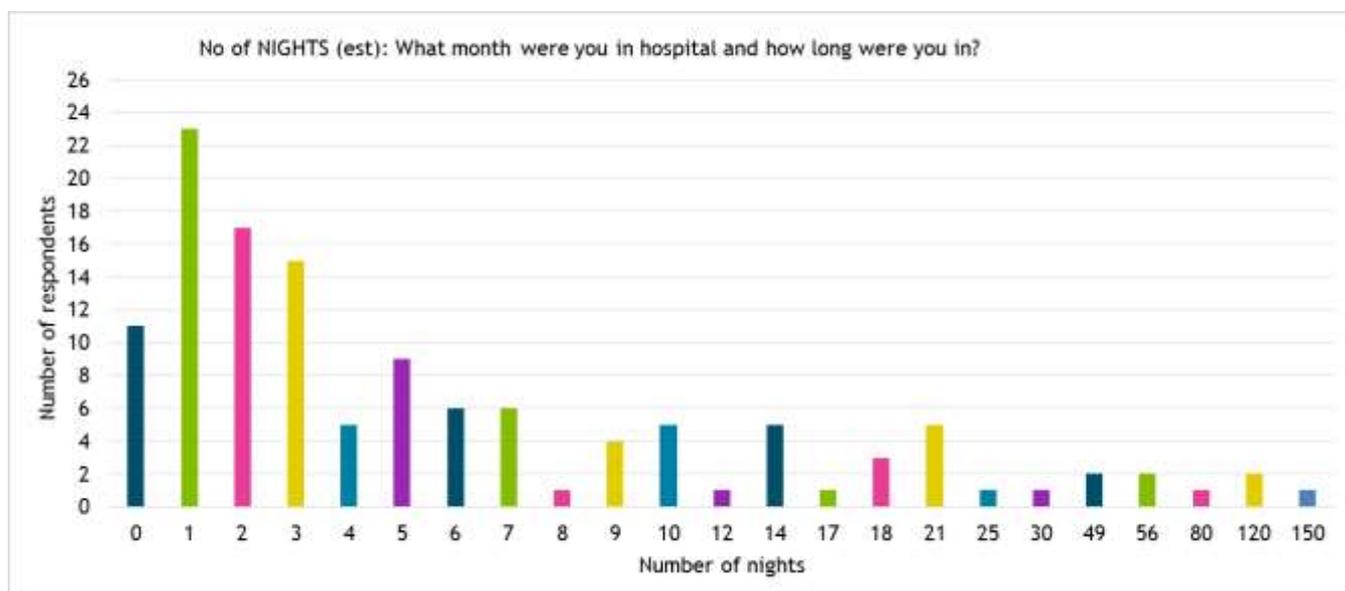
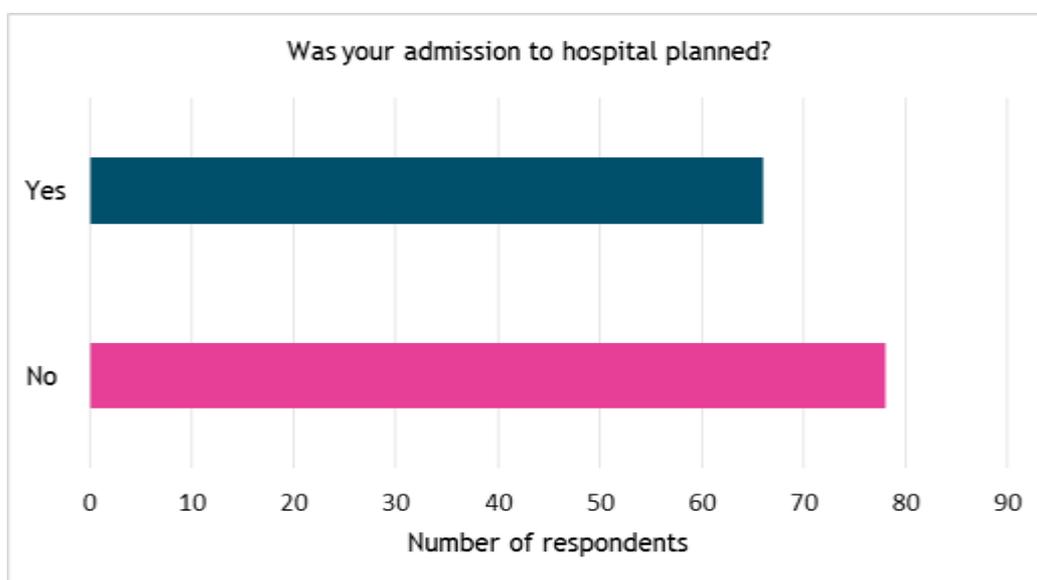
56% (81) had been discharged from the John Radcliffe, 33% (47) from other OUHT sites, 5% (7) from OHFT sites and 6% (9) reported discharge experiences from hospitals outside Oxfordshire. Again the small numbers of

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

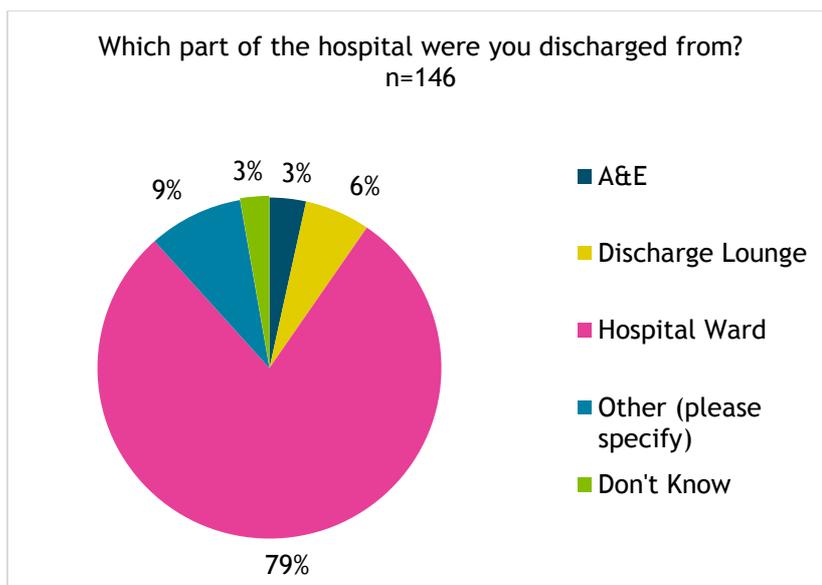
respondents who described a discharge from a provider other than OUHT made it invalid for us to undertake an analysis by provider.

For the patients in this cohort of the study:

- 54% (78) of them had an unplanned admission, and 45% (66) were on an elective pathway.
- 45% (66) had a stay of under 4 nights, 26% (36) of between 4 and 10 nights and 17% (25) more than 10.
- 79% (115) described a discharge direct from their hospital ward.
- 89% (131) were discharged home, 3% (5) were discharged to a community hospital and 3% (4) to a nursing or care home
- Of those respondents who reported a delay 17% (8) agreed that they could have done something to reduce their delay themselves



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



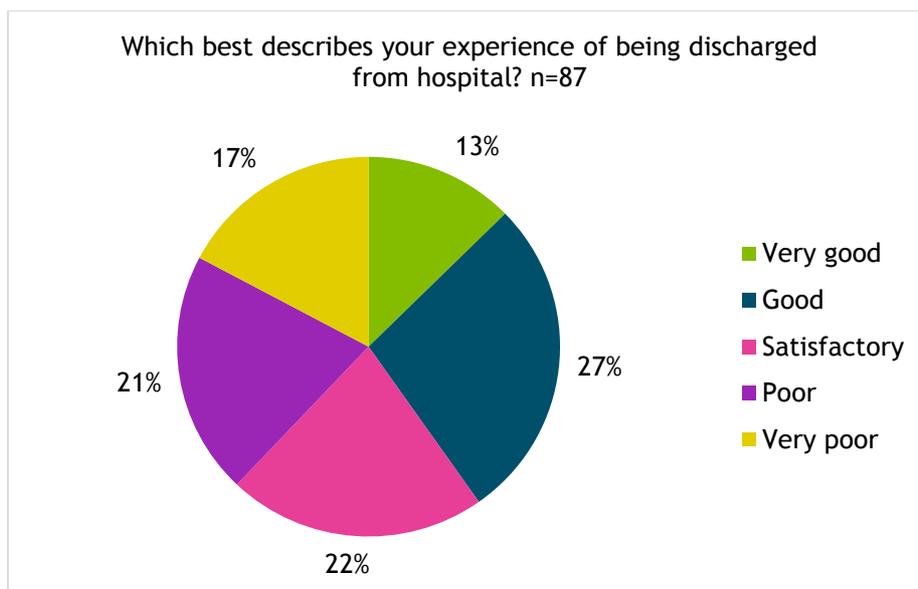
3.2.2 Overview

This group of patients, who had all completed the discharge pathway, described significantly lower levels of satisfaction than the group that were still in hospital when they completed the survey, but it was not all bad:

My experience of discharge from hospital was perfect. I was fully consulted and asked if I was ready to go home with the right amount of support.

Overall in-hospital care was excellent. After first night surgeon discussed with me the option of leaving that day or staying another night, leaving the decision to me and my carer (my wife, who is a nurse). Over course of the afternoon, with the support of the duty nurse, we decided that I was fit to be discharged and that was arranged promptly for late in the afternoon. The excellent aspect of this was that I and my wife were completely involved in the decision process, along with the very supportive duty nurse and the prior approval of the surgeon.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



But it was also not all good - with 38% (33) of the respondents describing their experience of being discharged from hospital as poor or very poor.

When we asked patients what was good or very good about their discharge, respondents praised staff saying:

Everyone was very helpful, no problems at all, my husband took me home

Ward nursing staff tried very hard to make stay and discharge as easy an experience as possible.

The care and attention the nurses gave me.

Everyone was very helpful, but everything very rushed. I was unable to get around without help (but my husband did everything) and I did not realise how difficult everything would be for the first 3 weeks.

The nurse and student were kind but so stretched they had little time to actually see to me. I was given paper work and left when my friend arrived. I could not find anyone to tell I was leaving until down the corridor when I spotted a carer who I spoke to and thanked for her care of me.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

However some had such a frustrating experience that in answer to this question which actively sought positive feedback, respondents said things like:

There was nothing good about it

Nothing, no one knew what was going on the bank staff did not know how to fill in the discharge form and we had to wait 3 hours for medicine. We finally got out at 9 p.m.

All appalling.... I'm disgusted at my treatment.

Never be admitted to the JR Die in the car park Find someone who can speak English

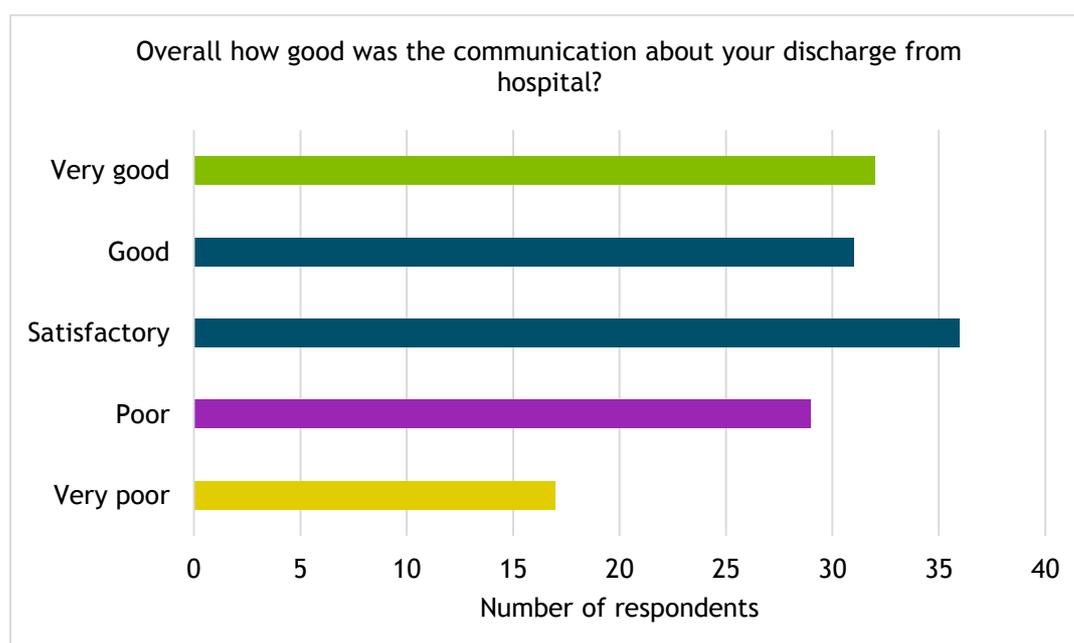
3.2.3 Communication

When we asked for suggestions on how the discharge experience could be improved, a common theme was the quality of communication. Trusts are getting it right sometimes:

I was consulted about every aspect of my discharge home from hospital after surgery.

I was kept informed and was involved in every aspect of my discharge. I felt very comfortable with the whole process.

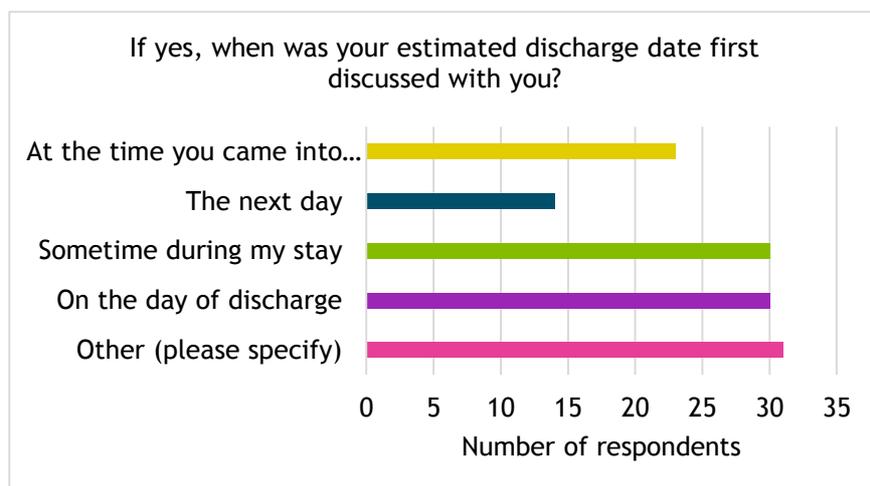
It was very thorough, apart from not being told to continue a certain medication. Otherwise cannot fault the discharge procedure.



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

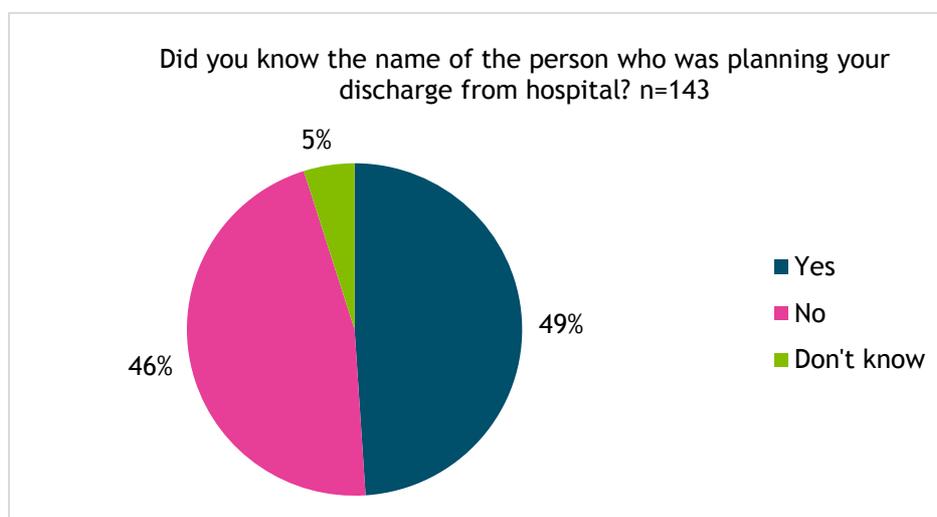
But a substantial minority - 32% (46) of respondents in this group said communication about their discharge was poor or very poor.

- Only 29% (37) reported having their EDD discussed with them for the first time on the day of admission or the next day, and the Trust's stated policy is to set EDD within 36 hours of admission (see Appendix 1).

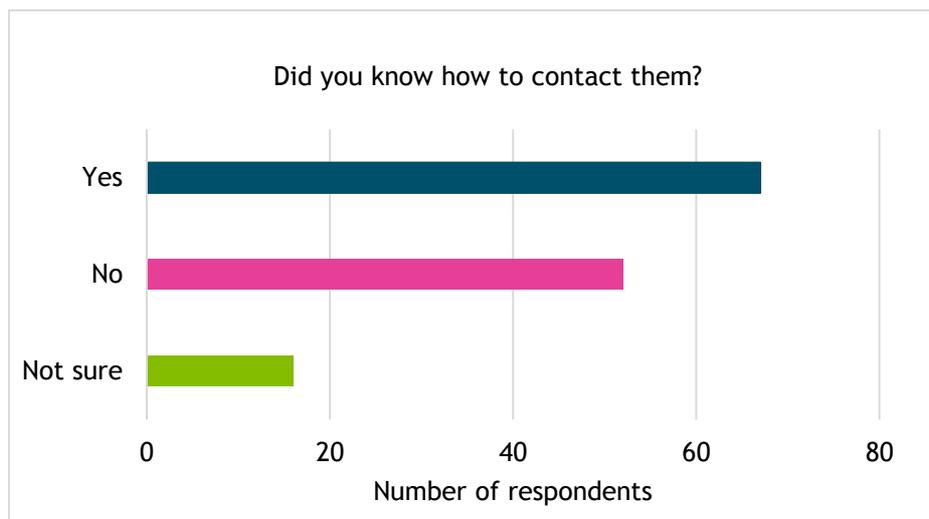


- 23% (30) said the first time their discharge date was discussed with them was on the day they went home.
- 55% (77) patients said they had a say in the care and support they needed so they could be discharged from hospital.
- 62% (88) said they had the opportunity to ask questions about their discharge, but some reported finding this difficult:

Make sure there are enough staff on duty to do a proper discharge and have time to answer your questions. I felt guilty taking the nurse away from care of the other patients



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



- 49% (70) knew who was responsible for planning their discharge, but only 50% (67) of them knew how to contact that person.
- 63% (92) fully understood what would take place on the day they were ready to be discharged but 28% (42) did not.
- 68% (96) of people knew how to contact the ward they were discharged from when they got home, and 28% (40) needed to do that.

When asked to sum up what could be done to improve the discharge process, the need to make improvements to communication was a common theme:

Communicate with the patient and their GP or whoever is taking over their care.... We are people not bed numbers.

Someone to have the time to discuss in full how you would manage

Wish that someone listened to my concerns instead of rushing me out the door- I might not have had to go back in 3 days later if they had.

Consistency and better communication from orthopaedic team...seen by different orthopaedic teams on different days...found it difficult to keep up with the changing plans, one day he was told he might need to return to surgery and the next day he was told he would be able to return home. He found the idea of an extended stay distressing.

Talk with me please - COMMUNICATION!! At one point an SHO came over and told me he was taking blood, even though I already had a line in. He didn't gain consent, didn't look at me at all.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

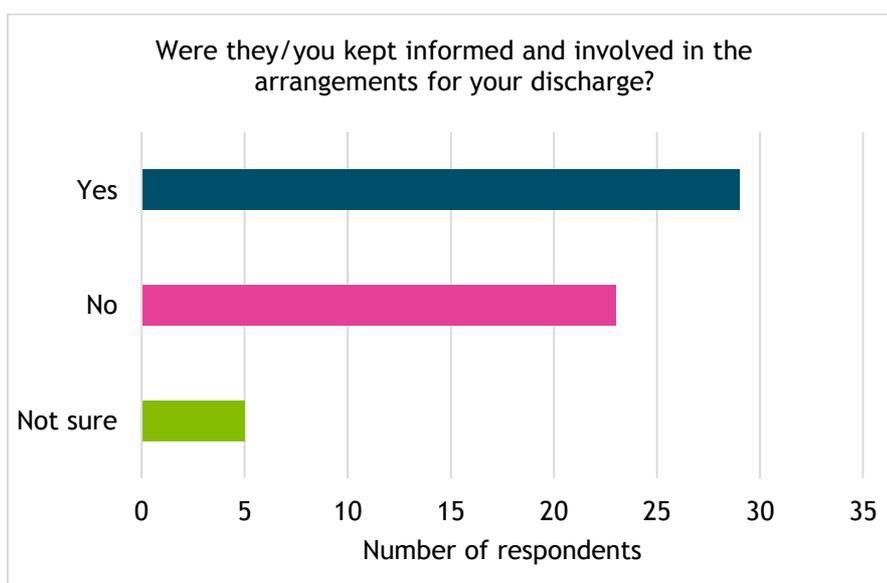
increase ability of staff to communicate effectively and to keep me and my husband appropriately informed. SHO lacked any form of bedside manner. I would go as far to say that he was socially inept

More training of staff in how to approach and manage patient care

Improve communication and dialogue between each link in the process e.g. information provided over the phone prior to a person attending surgery, communication and dialogue on the day, both for the patient and the person accompanying them

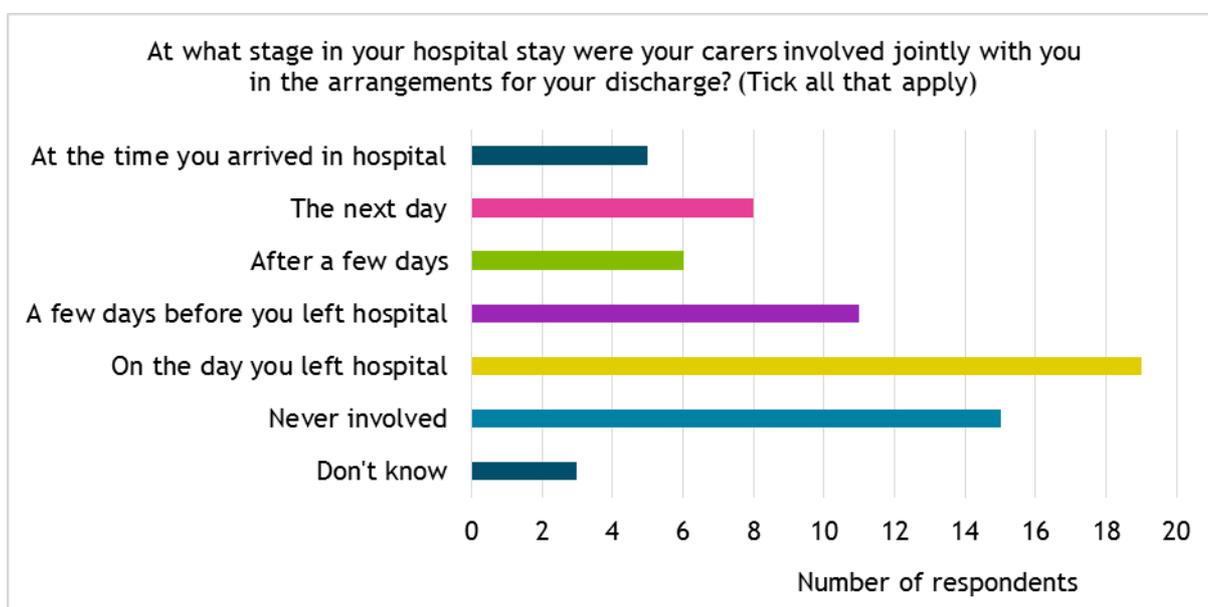
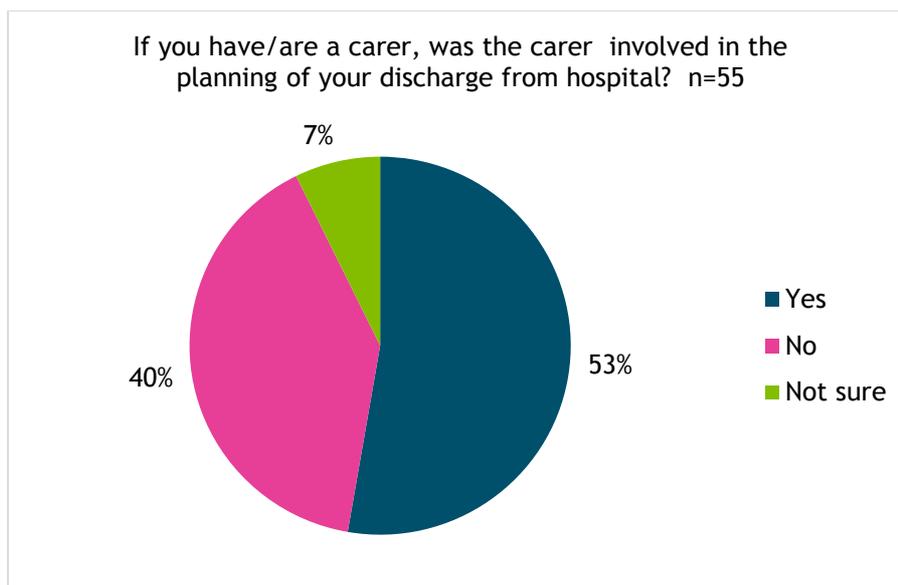
3.2.4 Involving family or carers

Concerns about communication often extended to include concern about failure to include family members properly in care planning.



- 68% (98) of respondents in this cohort said someone had talked to them or their family or carer about the arrangements for their discharge.
- However when asked later in the survey if they or their family or carers were involved in planning their discharge, only 53% (79) said yes.
- And only 50% (29) said they or their carer was kept informed and involved in the arrangements for their discharge

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



Even when carers were reported as being involved, the involvement was often very late on in the process. 16% (11) were only involved in discharge arrangements a few days before discharge, and a worrying 28% (19) on the day the patient left hospital (19). Only 19% (13) of carers were involved on the day of admission or the next day.

The orthopaedic team visited him at different times, usually very early morning or after 8pm so family could not be present. On the day before discharge he had been told the orthopaedic team would review, hopefully to agree discharge, at 8am, so family got to ward by then, but although the named nurse tried to contact the orthopaedic team, no one came to see him until 1pm.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

A long time passed from when the doctor said my son was to be discharged and when it actually occurred. We sat and waited for hours, expecting someone to come, and no one did. Finally, I went to find out what was going on, only to be told my nurse was on a break, and couldn't come now. More waiting ensued. Communication was very bad. Long wait was unnecessary.

This set of responses suggests that family and carers are being *told* about plans far more frequently than they are being *involved* in discharge planning decisions throughout a hospital stay, and that their involvement is seldom from the outset of care.

It also seems that when someone who is themselves a carer is admitted, the system does not communicate well or plan appropriately:

I am a carer for my husband and only finally managed to hear that his care was arranged the day before I went into hospital. I had to arrange everything. When I asked about care for me and my husband when I got home I was told this would be arranged at the hospital. I did mention this when I came for my assessment before op. But no help offered with, out staying in hospital longer but could not do this as my husband's care finished after the 9 days. I felt let down as I had explained the situation but no one seemed to be listening. Hence I have found it very difficult since I got home and become very depressed at times.

I asked if I could get help when I got home as husbands care finished on the day I got home. He has memory problems I was told it could take up to 2 weeks so just had to go home and cope by myself

In answer to the question asking respondents to sum up what could be improved about the discharge process, improving communication with family was a common theme. Typical of the comments and suggestions made were these:

Improve communication with immediate family. Involve immediate family in decision making.

Discussion with family before discharge

Communication with family

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Lack of explanation to carer of what care was going to be needed. No regular input from nursing service after discharge from hospital. More co-ordination of the discharge & more information to be given to patient & carer about discharge process.

3.2.5 Information

Problems with communication were also reflected in the comments people made about information.

- When information was given 88% (91) thought it was satisfactory or better and 88% (88) could understand it, but information appears not to be given as often as patients would like.
- 58% (85) received information about their expected recovery, but 32% (61) either did not or were not sure.
- 37% (53) of respondents did not fully understand or were unsure what would happen to them on the day they were ready to be discharged

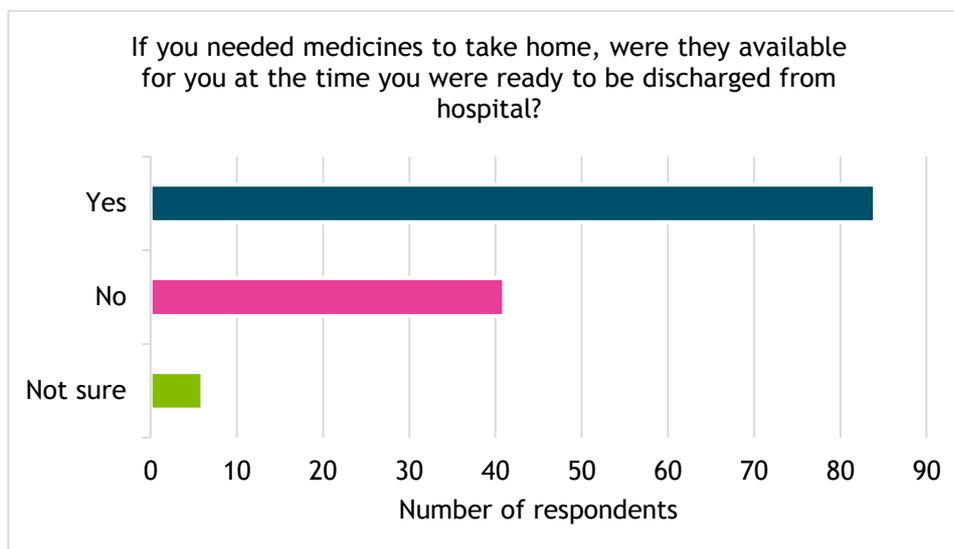
I would appreciate it if someone could tell me what was the outcome of my surgery (as, prior to surgery, the consultant was not sure which treatment option he would use to treat me until he was in surgery) and why I wanted the support of my husband by my side, because at that time, no one had told me what had happened to me and I was being prepared for discharge from the hospital without knowing

More information should have been given to me to tell me what to expect in the days after surgery. I needed to be told what I should feel like and what to do if this did not happen.

Need greater understanding about how patients might be feeling immediately after surgery, what might be distressing them, why this might be and how they can be supported.

3.2.6 Medication

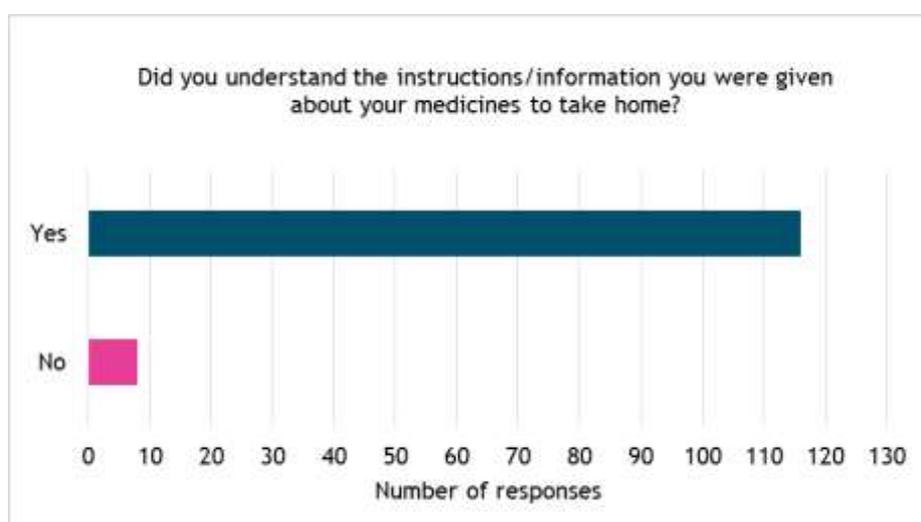
As with the patients surveyed before discharge, this group cited problems with the pharmacy part of the pathway more often than any other aspect of discharge.



- 94% (116) understood the instructions/information they were given about their medication to take home, but only 64% (84) patients said their medication was available for them at the time they were ready to be discharged.

We found one positive comment about the pharmacy part of the pathway:

The ward round to determine discharge was early and take home drugs decided on that round. The pharmacist came immediately afterwards and the drugs were available for me to go home in a timely manner so that I didn't have to go to the discharge lounge.



However this experience seems to be far from typical, and responses from respondents included:

Worst hospital experience ever! Shocking waiting time for a simple prescription.

I had to wait for 1.5 days for my take home medicine. This was known weeks in advance so why order it from pharmacy at the 11th hour?

Prescription waiting time was appalling!

We never bother with hospital pharmacy as it takes so very long. On previous occasions it has necessitated a trip back to the JR the next day to collect medications.

Waiting hours for medication to take home

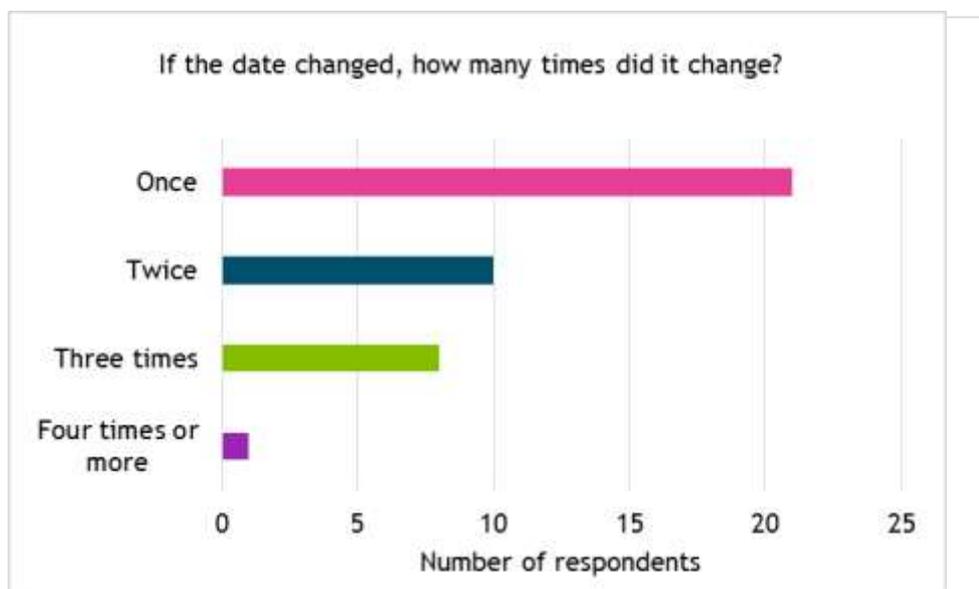
All the staff, doctors and nurses were outstanding in the way they looked after me. It is the system where take home medication is only ordered from pharmacy at the 11th hour that causes bed blocking, extra NHS costs, extra work for nurses and frustration for patients Ensuring the time waiting for medication is greatly reduced.

My medication was still not available after 4 hours wait and had to be sent to me by courier - which is a waste of NHS funds.

3.2.7 Changes of plan

A number of patients experienced changes to their Estimated Discharge Date:

- 31% (40) reported that their EDD changed
- 47% (19) experienced more than one change.



- Of those who experienced a delay, 40% (19) went home one day after their original EDD and 30% (14) stayed four or more days longer than they expected to.
- Of those who experienced a delay, only 57% (28) knew why they were delayed and 51% (21) said staff checked to see if they knew the reason for their delay.

3.2.8 Services after discharge⁵

Most of this cohort needed some sort of support post discharge, with only 35% (52) reporting that they did not need any support after leaving hospital. 19% (28) reported not being offered any support.

Of those who did get support the majority, 32% (47) said they got support from a source other than home care 3% (4), reablement 5% (7) or supported hospital discharge 6% (9).

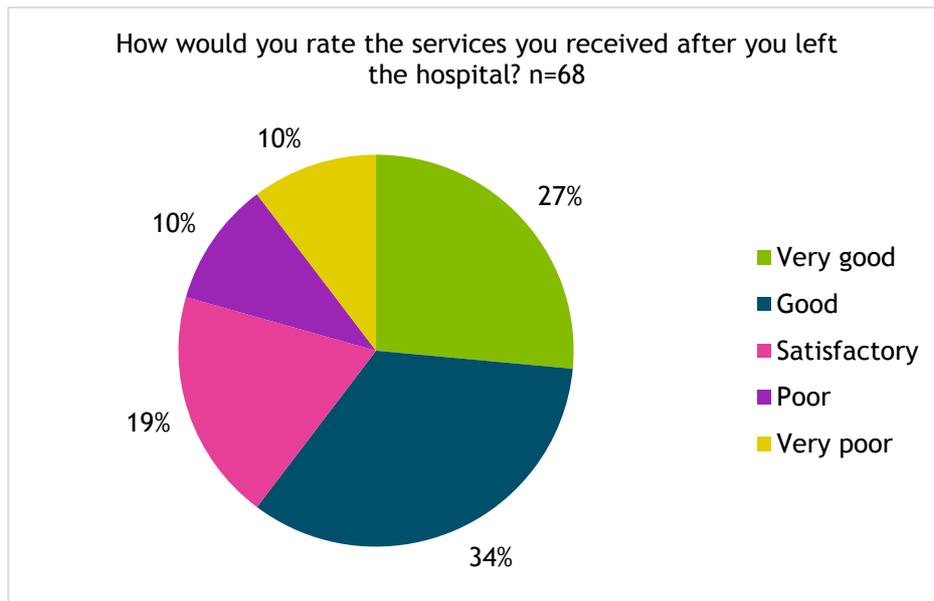
⁵ Note that post discharge support services are not always the responsibility of OUHT

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

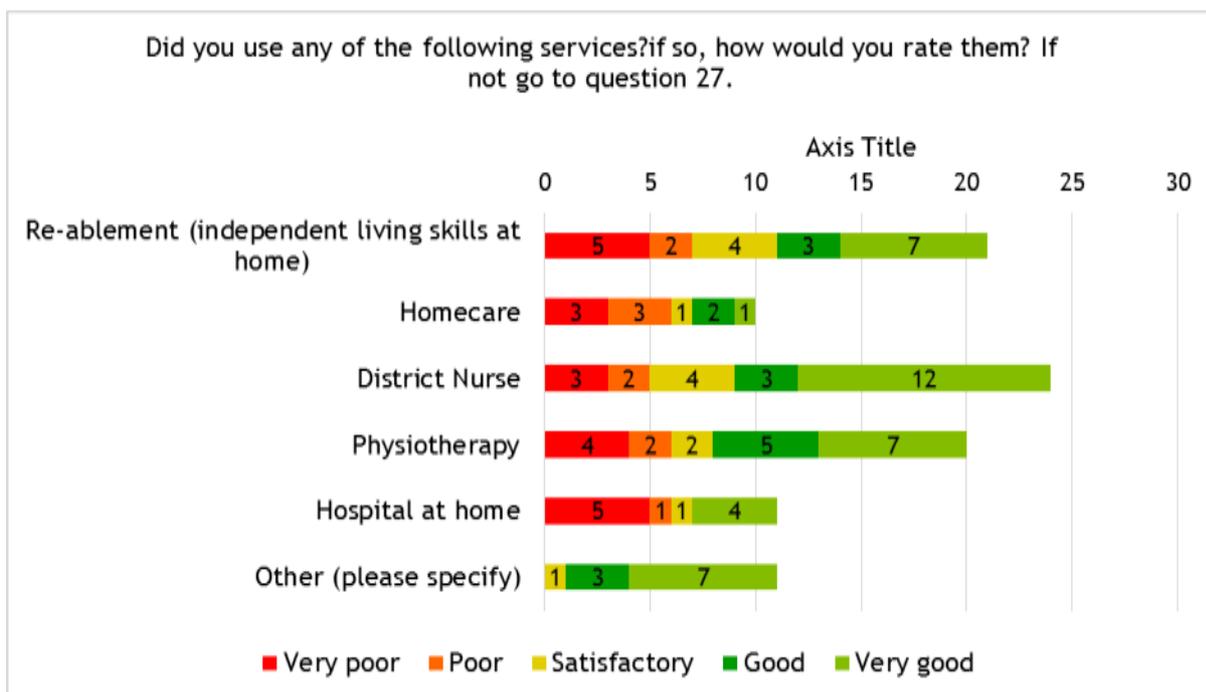
The other forms of support accessed included advice, physiotherapy, phone number for a nurse or consultant, support from the cardiac rehab team, equipment, district nursing, hospital at home or support from family and friends.

80% (54) reported the services they received after discharge as satisfactory or better, with 20% (14) rating them poor or very poor.

Discharged twice without support. Revolving door. Discharge not sustainable without assistance and support. Hospital acquired infection. Neglect of care elements including teeth, toenails and eventual UTI. Three additional A&E admissions by ambulance requested by neighbours who responded when condition deteriorated at home.



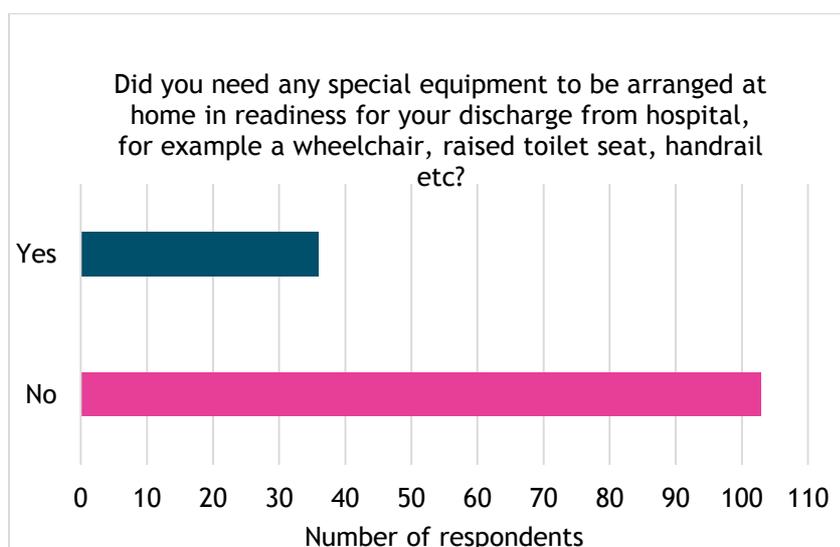
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



3.2.9 Equipment⁶

As reported by patients before discharge, 29% (36) of patients required some equipment to facilitate their return home.

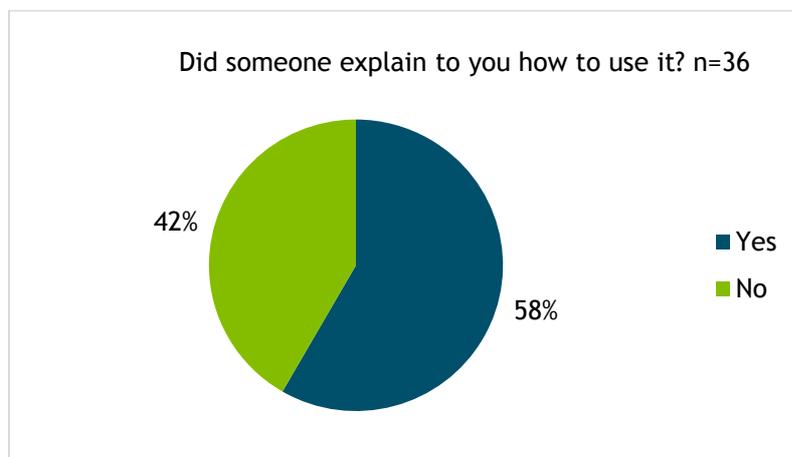
- 25% (36) needed equipment to be arranged in readiness for their discharge.
- 58% (21) said someone explained how to use it
- 79% (31) said it was available when they needed it.



⁶ Note that provision of equipment for use after discharge is not the responsibility of OUHT

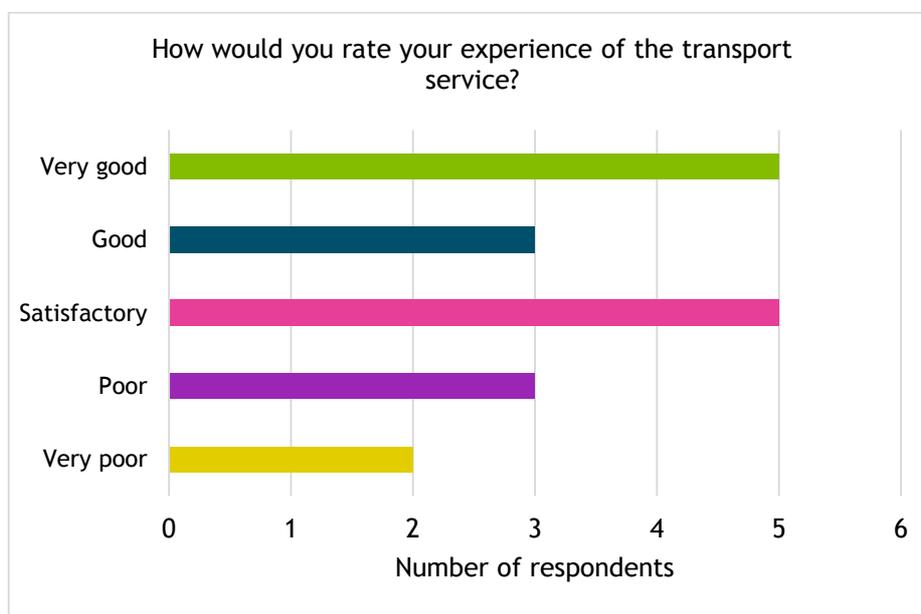
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

However, with 42% (15) of patients unsure how to use their equipment when returning home, there remains room for improvement.



3.2.10 Transport

Of the patients who told us they were entitled to transport to help them get home, 55% (10) said the time it took to get home was reasonable, and 72% (13) rated their experience of the service as satisfactory or better. 52% (14) reached their destination at approximately the time they expected to - but 48% (13) either did not or were not sure.



my uncle was left waiting most of the day and then told it was too late, his nurse was too busy to chase the ambulance!

Having been discharged at 7:30pm we had to wait 5 hours for the patient transport service to arrive

Driver and companion very good and helpful.

It took a long time from leaving the hospital ward to arriving home. (approx 2 hrs 15 mins.) This was because there were other people to be picked up/dropped off.. It felt a long time as the seat was not very comfortable.

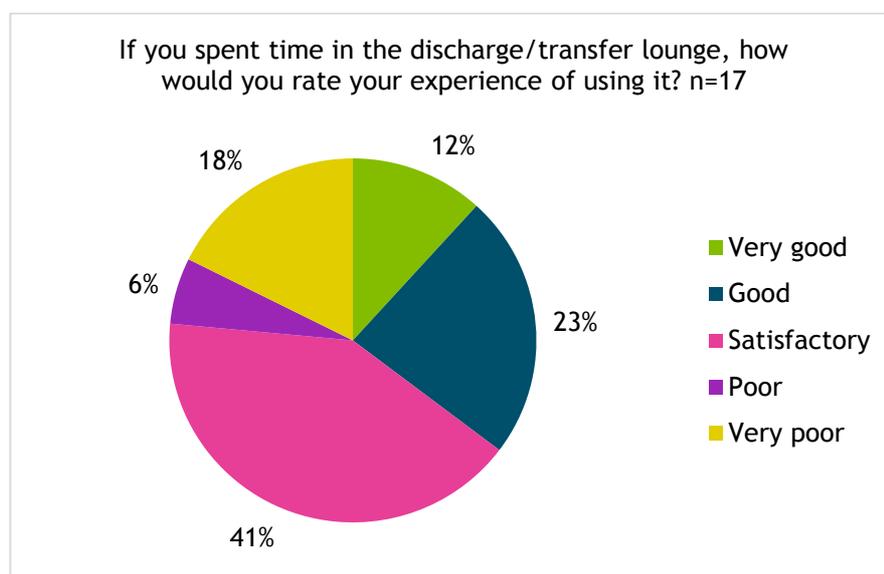
I have to award 5 to the service of the ambulance service. The staff are always so kind, considerate and sympathetic.*

OK. They left me earlier than expected in an empty house in a wheelchair with no food or drink accessible. Fortunately my daughter arrived half an hour later, then the carers

3.2.11 Discharge lounge

Experiences of the discharge lounge seemed varied, with the largest proportion of patients, 41% (7), rating their experience as 'satisfactory'.

- 16% (24) of this cohort had used the discharge lounge.
- 76% (13) of them rated the experience as satisfactory or better but 24% (8) rated it as poor or very poor.



When individual comments about the discharge lounge are taken into account, a more negative perception of the discharge lounge surfaces:

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

It was awful. Understaffed and too many confused elderly people in there. One lady fell whilst I was there and had to be taken into A and E. I had surgery the day before was in a lot of pain and left sitting in a chair. I felt like I was rushed out with no info and little support.

Busy, lack of privacy. The discharge nurse was excellent

I understand that the bed was needed at 10am the day after my minor surgery but since I did not come up to the ward till 6.30pm I was still feeling effects of the anaesthetic and found sitting in the specialist surgery discharge lounge a little uncomfortable as I was sleepy. I had to wait for paperwork, medication and my sick note. I also had to ask for some ice cream because I was completely forgotten and because I was starved for over 18 hours the previous day was feeling a little weak. I got all my paperwork etc by about 3pm after vacating my bed at 10 am!

That was just dead time. Once you are out of the bed, then it seems not to matter when you leave, but I could have been out of the bed sooner, if discharge was effected more efficiently. You are always waiting for nobody in particular.

Do not "dump" people in the transfer lounge to wait for medication.

3.2.12 Patient Advice Liaison Service (PALS) & Complaints service

Though we didn't specifically ask any questions about the PALS or complaints service, a number of patients commented on this service anyway:

I complained to the PALS woman. e.g. Prior to that I complained to the Sister/nurse that the shower drain was blocked. Nothing was done about it. I eventually got the right man to fix it after 3 My experience of the complaints system is that that the hospital staff 'close ranks' and deny there is a problem...

There is no point in complaining the Horton will not do anything about it anyway

Poor experience of complaining to Oxford Health NHS Foundation Trust despite going through their own channels (i.e. PALS).

I complained to PALS but they did not reply

Overall, patients reported that they didn't feel listened to, or that they complained and never heard back from the PALS/complaints team at the hospital.

3.3 Recommendations arising from the patients who contributed to this study:

- Take swift action to improve start of discharge planning.
- Provide a dedicated person for each patient to talk to about their discharge; make this person responsible for that patient's discharge; ensure the patient and his/her carers knows who this is and how to contact them.
- Require the responsible person to record each occasion when they involved the patient or family in planning the discharge and make the outcome of that discussion available to them, in writing, in language they can understand.
- Review the process for prescribing medicines at the point of discharge, starting the process earlier.
- Ensure patients know what equipment they are getting, when they are getting it and how to use it.

3.4 Professionals: care providers

Healthwatch Oxfordshire liaised with the Oxford Association of Care Providers (OACP) to author the questionnaire for care providers on their experience of discharges from hospital in Oxfordshire, and to encourage OACP members to complete it.

3.4.1 About the respondents

29 questionnaires were started, of which 14 were sufficiently complete for analysis and inclusion in this report.

Of those who completed the questionnaires:

- 28% (4) were Care Home Managers
- 44% (6) were Domiciliary Care Managers
- 28% (4) were 'Other' (Sheltered Housing, Voluntary sector, Housing Association and Supported Housing for Learning Disabilities).

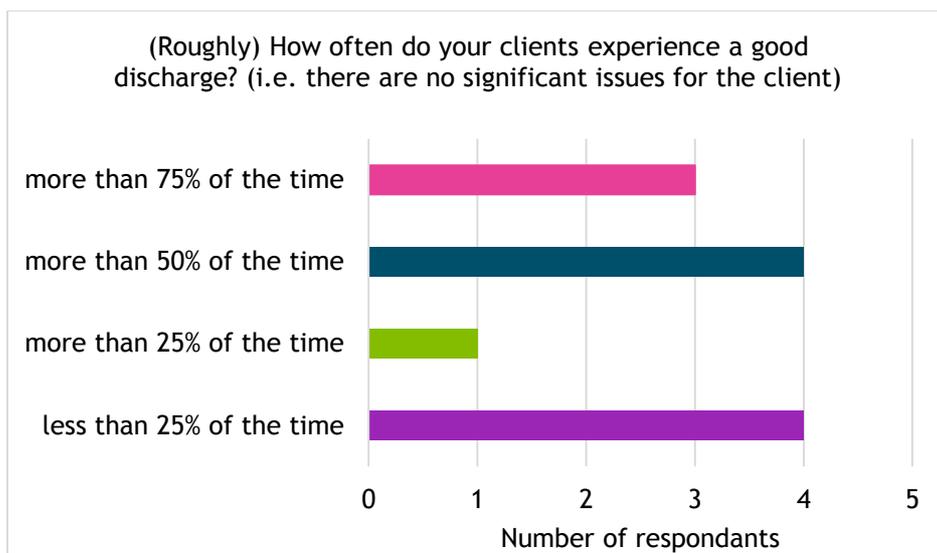
78% (11) of the questionnaires marked the views expressed as being those of "both themselves and of their colleagues". This would seem to indicate that the views expressed would be seen as largely 'consensual' by those completing them.

3.4.2 Quality of discharges

Responses indicated that 'good discharges' (ie there were no significant issues for the client) were not perceived as the norm:

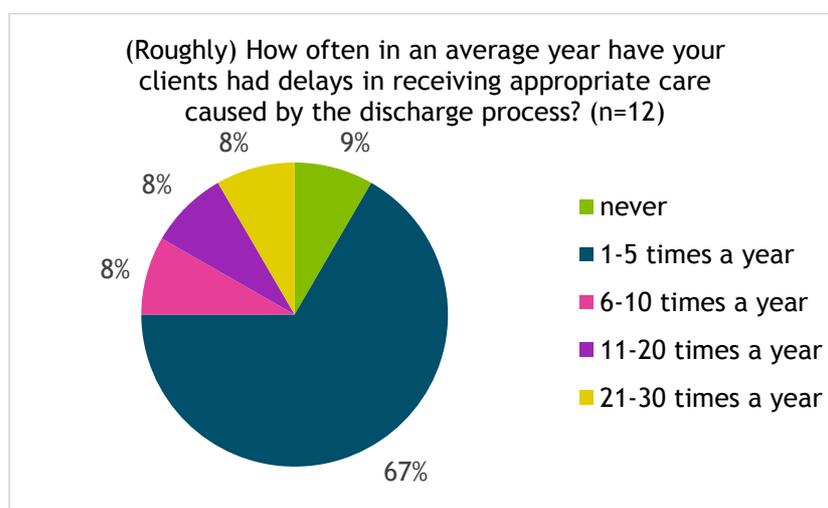
- 25% (3) of respondents said that their clients experienced 'good discharges' more than 75% of the time
- 33% (4) of respondents said that their clients experienced 'good discharges' between 50% and 75% of the time
- 8% (1) of respondents said that their clients experienced 'good discharges' between 25% and 50% of the time
- 33% (4) of respondents said that their clients experienced 'good discharges' less than 25% of the time.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



The overwhelming majority of respondents had seen their clients experiencing delays in receiving appropriate care caused by the discharge process:

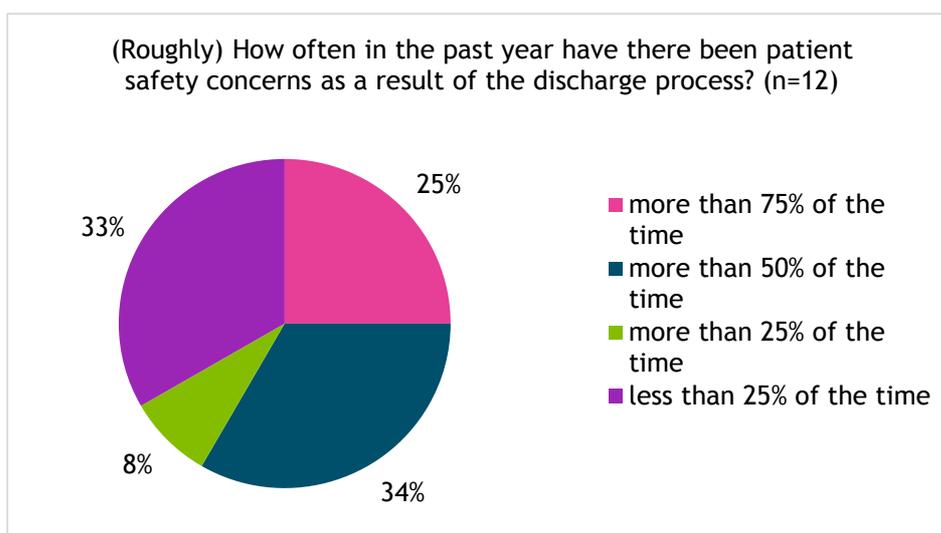
- Only one respondent said that their clients never experienced delays in receiving appropriate care
- all the other respondents said that their clients had experienced delays in receiving appropriate care
- 67% (n=8) of all respondents said that their clients had experienced delays between 1 and 5 times a year
- 24% (n=3) of respondents said that their clients had experienced delays between 6 and 30 times a year.



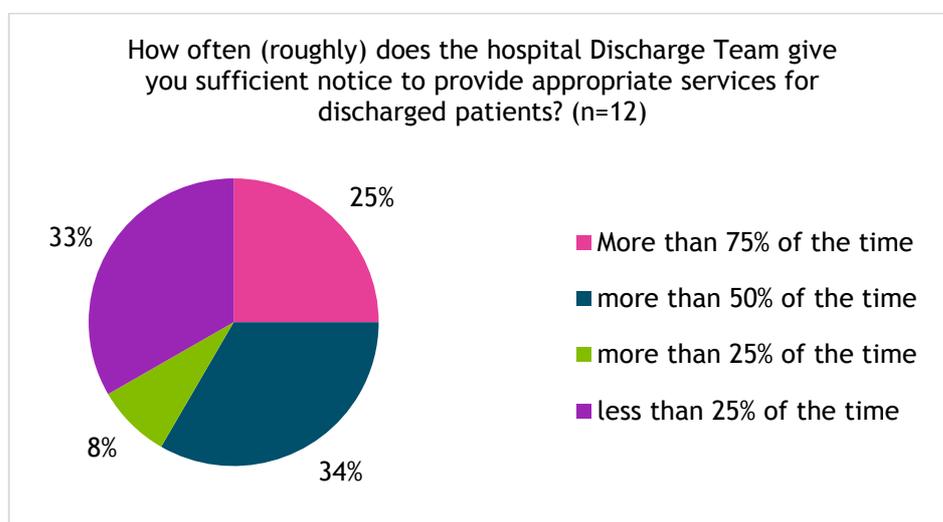
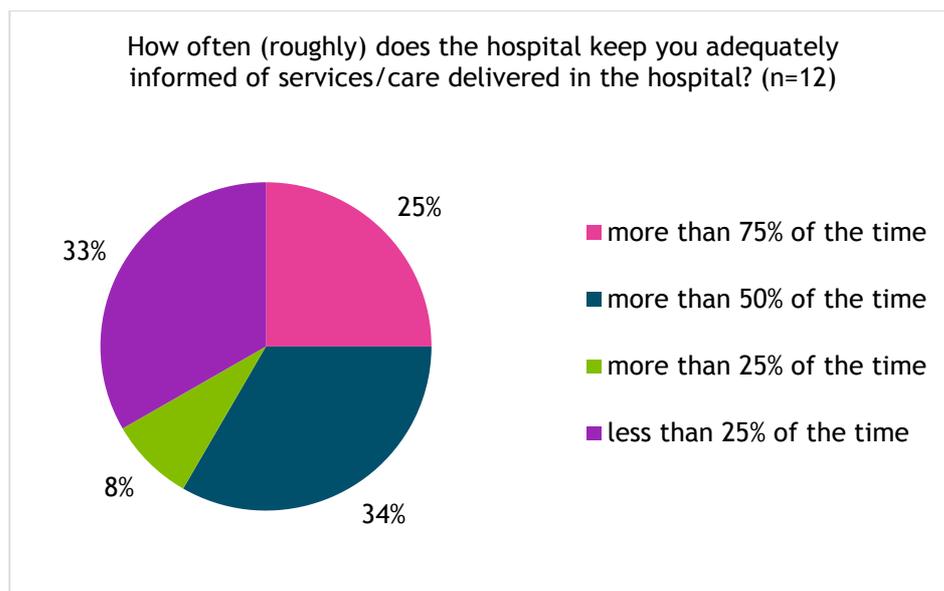
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

There was clear evidence of concerns on the quality of discharges over the previous months:

- 66% (8) of care providers said that there had been patient safety concerns more than 25% of the time in the previous year.
- 45% (3) of providers said that their clients had been upset or distressed by the discharge process more than 5 times in the previous year.
- 25% (3) of providers felt that they were kept adequately informed of services/care delivered in the hospital more than 75% of the time.
- 25% (3) of providers felt that they were given sufficient notice to provide appropriate services for their clients more than 75% of the time.



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



3.4.3 Key issues

When asked for the top three issues that they encountered with discharges, clear patterns emerged. More than 50% of the issues mentioned first were communication-related.

Typical comments relating to communication included:

Poor communication...[twice]

Person not knowing what is happening unable to make choices

Releasing patient without knowing that they are home

Lack of communication

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Mixed messages

Transparency of health professionals within the hospital

Lack of information

Paperwork not completed

A significant number of respondents mentioned patients being discharged too early and/or insufficient time to prepare for their discharge as being one of the top three issues

Comments/issues on the timing of patient discharges included:

pushed to take them back at short notice

no clear time for the client to be discharged

Cancelling at the last minute when rosters have been scheduled.

Person still very ill on discharge additional risk to health and wellbeing

inappropriate discharge

Readmission due to inappropriate discharge" "sent home before they are fully fit

33% (4) of respondents mentioned additional problems with medication. Medication-related issues included:

No medication sent

Medication not ready

No correct medication

Discharging with not enough medication and a perscription (sic) which is required asap.

Issues related to support in the community were also raised and these included:

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Clients being sent home with little or no care/support

No support or care

Carer and cared for unable to cope independently

Trying to get support back in when client has been discharged (sic)

3.4.4 Perceptions of good and poor practice

In terms of their impact on care provision, the following specific named items were ranked as having the greatest impact by the care providers (in relative order):

- patient discharged with no risk assessment in place
- patient discharged with no updated care package in place
- patient discharged with no discharge notes in place
- patient discharged with inadequate information about medication.

Perhaps unsurprisingly, these themes were also reflected in answers to the question "What characterises a 'good discharge' from *your clients'* perspective?"

Good communication Is discharged before 3pm Has all medication Has all documents.

"Communication from all parties involved in the care and support.

medications all present. all paperwork sent from the home is returned ie DNAR [do not attempt resuscitation forms]. Being discharged at a reasonable time of day. concise discharge

Timely communication prior to and in readiness for discharge so all appropriate care/support is in place upon discharge.

The same themes emerged in answer to the question, "what characterises a 'good discharge' from *your* perspective?"

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Good communication between all parties, specific dates and times to enable provider to plan in advance instead of it being left to the last minute. To ensure that client is discharged with all correct medication/prescriptions.

correct discharge paperwork communication from hospital prior to discharge residents brought back before 17.00 at night all meds present all personal items returned all paperwork returned correct information from hospital

Good communication between hospital/GP/care and support services and family. Appropriate treatment medication and aftercare. TTO's [medication to take out] ready at time of discharge. GP receiving discharge notes in a timely fashion

and perhaps most succinctly, from one respondent:

Good communication

Poor discharges were seen as having a severe impact on care providers' clients.

Issues raised included confusion, frustration, anxiety, loss of confidence, stress, and reluctance to use health services again, lack of trust in the NHS, low mood and anger.

Poor discharges were cited by care providers as resulting in medication being stopped inappropriately, worsening of their medical condition, refusal to have treatment and in safety concerns.

A number of care providers cited readmission as being an outcome of poor discharges:

*Re-admission to hospital. Worsening of physical and mental health
Previous hospital treatment then serves no purpose Engenders lack of trust in NHS and has resulted in refusal for further essential treatment*

One respondent succinctly identified the 'vicious circle' that arises:

they have to be sent back to hospital due to being sent out too early because of bed blocking

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Poor discharges had a considerable impact on care providers' own workloads. Most cited additional work, additional time, and additional stress. In some cases the Safeguarding team had to be involved.

One answer summarised the wide-ranging nature of the impact of a poor discharge on their care provision:

Reassuring clients and getting the right care/support team in place as soon as possible. District nurse/hospital at home care /support agencies in place. Visiting clients more often where there are concerns. Trips to chemist to get emergency prescriptions/medication. This takes a lot of time up and thus impacts on daily workload.

Care providers provided a number of examples of good practice on discharges. These included the following specific process:

When a client is admitted to hospital we add their name to our 'Hospital' board and ring the ward regularly for updates. From the start we tell the ward who we are and what care we provide and ask them to note our number. We explain that we plan our schedules one week in advance so ask them to bear this in mind. For the first week we cancel care on a day by day basis so that it can be restarted immediately if necessary. This generally works well.

Other specific examples of good practice included:

- one respondent who cited the John Radcliffe Hospital as keeping both the care provider and the clients families well-informed
- Hospital at Home was cited by more than one respondent as giving good planned treatment and facilitating good communication
- good service from a Learning Disability liaison service
- after packages being put in for elderly patients needing rehabilitation
- having a dedicated discharge co-ordinator available.

One care provider cited the story of a particularly good discharge where services appeared to be well co-ordinated:

A resident with Parkinson's was going to be discharged and staff contacted hospital as they had not got the full history of client. By

all working together a full package and with care and support was set up and also a move to alternative accommodation was authorised so client able to live independently with wife at home.

3.5 Recommendations arising from the care providers who contributed to this study:

- Agree a protocol for communication with care providers where a patient has been admitted from a care home or with an existing package of care that starts from the point of admission.
- Overhaul the process for prescribing medicines at the point of discharge, starting the process earlier and ensure patients are discharged with the medication they need.
- Ensure patients are discharged with full discharge information including risk assessment, details of medication and details of medical and/or social care packages that have been set up.

3.6 Professionals: GPs

Healthwatch Oxfordshire liaised with the Local Medical Council (LMC) to author the questionnaire for GPs on their experience of discharges from hospital in Oxfordshire - and to encourage Oxfordshire's GPs to complete it.

3.6.1 About the respondents

61 questionnaires were started, of which 33 were sufficiently complete for analysis and inclusion in this report.

All those who completed the questionnaire stated their role as GP.

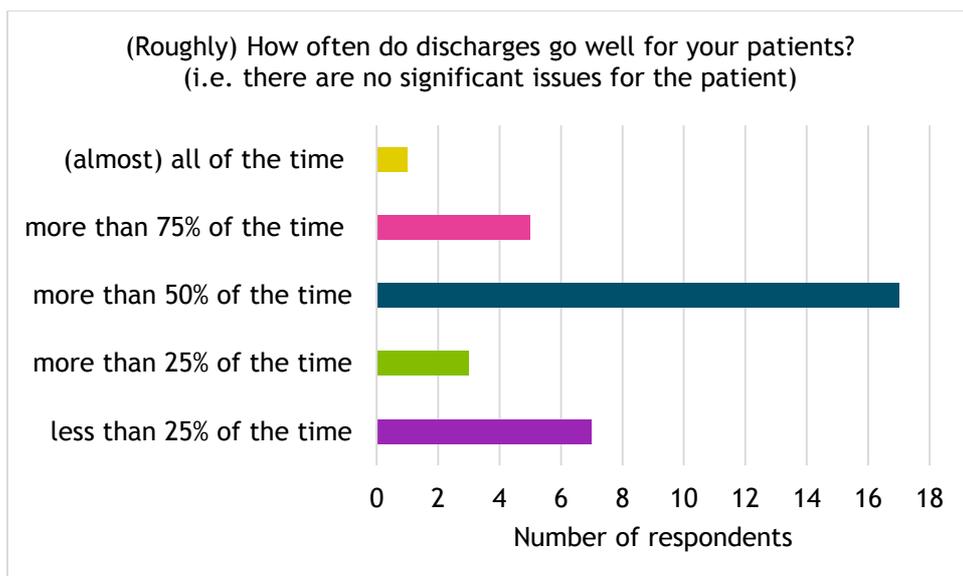
- 25% (8) of those who completed the questionnaire stated the views as being those of “both themselves and of their colleagues”.
- 75% (24) of those who completed the questionnaires stated the views as being those of themselves.

3.6.2 Quality of discharges

Responses indicated that ‘good discharges’ (ie there were no significant issues for the client) were not perceived as ‘the norm’ by this group of Oxfordshire GPs:

- Only 3% (1) of respondents said that patients experienced ‘good discharges’ almost all the time
- Only 15% (5) of respondents said that their clients experienced ‘good discharges’ more than 75% of the time
- 52% (17) of respondents said that their clients experienced ‘good discharges’ between 50% and 75% of the time
- 9% (3) of respondents said that their clients experienced ‘good discharges’ between 25% and 50% of the time
- 21% (7) of respondents said that their clients experienced ‘good discharges’ less than 25% of the time.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

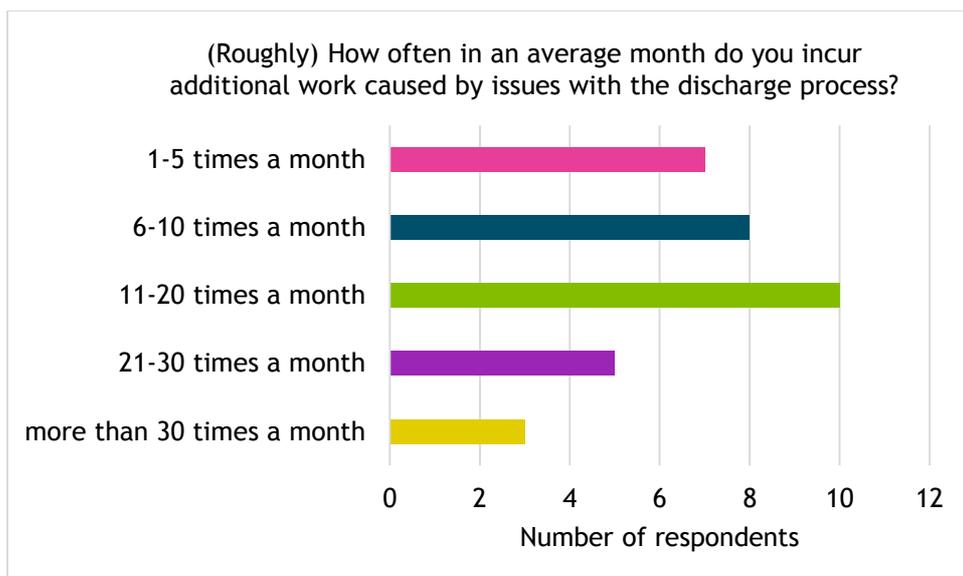


Almost all GP respondents had seen patient safety concerns in the previous 3 months caused by the discharge process. Comments on how frequently this had occurred varied from '25% of cases' and 'Several times a week' to 'I'm not sure, but we spend a lot of time trying to prevent problems'.

There was clear evidence of the impact of discharge issues on GP workloads. Estimates of the frequency of additional work caused by issues with the discharge process were as follows:

- 21% (5) of respondents said that they had additional work 1-5 times a month
- 24% (8) respondents said that they had additional work 6-10 times a month
- 30% (10) respondents said that they had additional work 11-20 times a month
- 15% (5) respondents said that they had additional work 21-30 times a month
- 9% (3) respondents said that they had additional work more than 30 times a month.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE



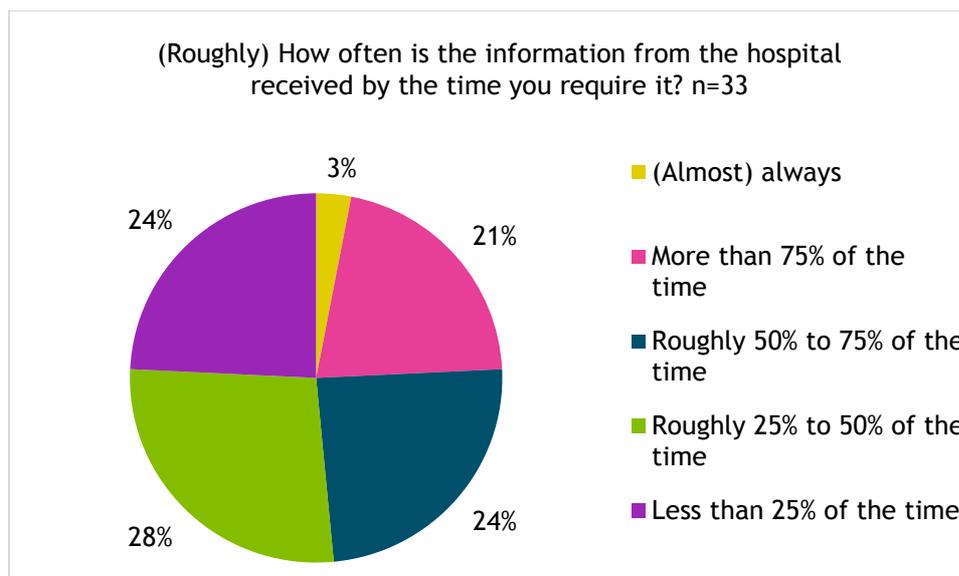
The majority 69% (22) of respondents estimated the additional working time caused by each issue to be between 11 and 31 mins:

- 41% (13) of respondents estimated the extra working time per issue to be 11 and 20 mins
- 28% (9) of respondents estimated the extra working time per issue to be 21 and 31 mins

Using these figures, one might calculate that the additional work caused by discharge issues to the average GP responding to this survey would be in the region of four to six hours per month.

In terms of the timeliness of the information received, there were strong indicators that the respondent GPs felt that the information was often received too late, although there was considerable variance in their perceptions of how often this happened:

- 1 GP indicated that the information was almost always received by the time that they required it
- 21% (7) of GPs felt that they received the information by the time required more than 75% of the time
- 24% (8) of GPs felt that they received the information by the time required between 50% and 75% of the time
- 27% (9) of GPs felt that they received the information by the time required between 25% and 50% of the time
- 21% (7) of GPs felt that they received the information by the time required less than 25% of the time.



3.6.3 Key issues

When asked what were the top three issues that they encountered with discharges, clear patterns emerged:

- more than 50% of respondents cited discharge summaries/letters and/or other communication issues as their ‘top issue’
- 33% of respondents mentioned medication-related issues second
- in total more than 50% of all issues listed could be seen to be communication or discharge summary related
- other frequently cited issues related to:
 - care co-ordination
 - care planning
- together, 75% of issues listed as GPs ‘top three’ could be seen to relate to these five areas (communications, discharge summaries, medication, care co-ordination and care planning).

Specific issues raised most often with discharge summaries were: timeliness; too much information/no clear synopsis (eg information appropriate to community nurses sent to GPs); lack of diagnoses; inaccurate medication information; lack of information about reasons for medication changes; handwritten discharge summaries; lack of clear information for GPs to act on/unclear follow-up plans; asking GP to chase on actions that hospital has initiated.

Wider communication-related issues included: lack of information provided to patients and/or their families; inappropriate assumptions about patient’s home situation; patients being confused or unclear about future plans; lack of information about the Estimated Date of Discharge; not knowing that patient has been discharged.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

More than one GP mentioned the value of a phone call directly to the practice prior to discharge, particularly for complex patients.

Issues related to medications included: wrong medications stated/medication errors (mentioned by 4 respondents); insufficient meds on discharge (e.g. after eye surgery); unclear why medication changes made; inappropriate medications used (e.g. Warfarin rather than more appropriate anticoagulants).

Issues related to care co-ordination included: hospital failing to follow-up on promised actions (e.g. contacting District Nurses - mentioned by a number of GPs); GP being asked to follow up investigations or arrange onward referrals; GP needing to chase outpatient appointments and arrange tests.

Test results was a frequently cited area of contention.

Dumping of test results follow up on us. This is endemic, particularly with CT scans.

With regard to care planning, GPs mentioned the lack of information/clarity on follow up plans, the frequent changes to follow up plans, care not set up when required and lack of awareness of social needs of patients.

GPs were asked to rank a list of specific issues in terms of their impact on the GPs practice. This indicated the impact of issues around discharge summaries, readmissions and medications:

- 49% (16) of GPs listed 'patient discharged but no Discharge Summary/letter received' as having the greatest impact on their practice
- 67% (22) of GPs ranked 'patient discharged but Discharge Summary/letter arrives late' either first, second or third in terms of impact on their practice
- 55% (18) of GPs ranked 'patient readmitted within 48 hrs following inappropriate discharge' either first, second or third, in terms of impact on their practice
- 54% (18) of GPs ranked medication issues ('inadequate medication' or 'inadequate information') either first, second or third in terms of impact on their practice

3.6.4 Perceptions of good and poor practice

Perceptions of what characterises a good discharge from a patient perspective were clear and aligned closely to the quality-related topics above.

Key elements included:

- patient well enough to be discharged
- clear & concise communication, particularly to patient & family, GPs, community services and social services
- clear diagnosis & treatment summary
- clear information on medication changes (including meds stopped & started & why)
- sufficient medications for a number of weeks after discharge
- sufficient notice for all parties to prepare for discharge - plan & services in place
- well-structured, electronic discharge summary.

There was remarkable consistency in the answers from GPs. One answer summed up what was, by and large, consensus:

Clear plan for discharge agreed with the patient and their family/carers, with time for family/friends to prepare for this; appropriate agencies informed with enough time to start involvement with the patient as soon as they are discharged; clear concise communication with primary care so they know why the patient was admitted; what the diagnosis is; any plans for follow up; what drugs they have been discharged on and how long they should continue on them; also that the patient should go home with at least two weeks medicine to give the GP time to take over the prescription in an orderly way

Perceptions of what constituted a good discharge from a GP perspective were, unsurprisingly, similar - if more succinct:

Good clear diagnosis correct meds info re investigations A GP plan A Hosp plan What I told the patient re plan

Many GPs mentioned the importance of a concise, well-structured, accurate Discharge Summary, in addition to what a patient requires.

A number of GPs gave very specific advice on appropriate layout and/or format of Discharge Summaries, including the importance of having key

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

information at the top - and not burying important information in the middle of the text.

One respondent gave an example of quite how critical a Discharge Summary can be:

A Discharge Summary is precisely that - a Summary, not the clinical narrative that lead to the test request e.g. obs, symptoms, signs etc I currently am a clinician involved in a case where a patient was admitted and discharged three times in a row with no discharge correspondence at all - she died in the back of an ambulance on the way back to the hospital... This is an extreme example of where failure to provide discharge correspondence might have improved her assessment and prevented her death...

Specific examples of good practice on discharge included examples of junior doctors ringing the GP to explain the discharge plans (phone calls seemed to be particularly appreciated by a number of GPs), Emergency Multidisciplinary Unit (EMU) monitoring patients until they were seen as fit and stable, patients having a copy of their Discharge Summary, as well as their GP, and discharges from the Cardiology Department in Reading, who:

never slip up. Patients know who their consultants are. Letters are sent very swiftly. Plans are very obvious for the patients. Follow up is always organized.

One GP had this comment on Discharge Letters:

A good discharge letter saves a lot of time. It avoids our staff having to bother hospital staff to get information that we should have been sent. It saves wasted appointments by patients coming to discuss the contents of a discharge letter.

And one GP had this advice on good discharge practice:

Clarity Clarity Clarity What has been the thinking? What is the plan?

GPs were very clear about the benefits of good discharge processes on their own practice and workload. Comments included:

Huge reduction in workload

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Streamlines care, prevents me having to recontact hospital, wasting their time and mine, to seek clarification

Helps enormously - not having to chase summaries or ring hosp doctors or to liaise with pharmacies. An enormously positive impact.

We asked GPs what single change/improvement they thought would make the greatest positive impact on discharges for patients.

The greatest number of answers focussed on the Discharge Summary, particularly on ensuring electronic delivery, its timeliness, quality and structure, reflecting the points mentioned above. Answers also mentioned the importance of ensuring that consultants take responsibility for the Discharge Summary, for the discharge itself and are named. GPs also emphasised the importance of in person communication for complex cases.

Other answers included:

A unified patient record with relevant parts accessible by patients

Assume absolute responsibility for the actions you have taken in the hospital. After all they have a medicolegal responsibility for doing so.

More "step-down" services e.g intermediate care beds where patients can go from acute setting to rehab/community care rather than from hospital to home alone only to bounce back in again.

Patient being fully fit and able to cope, for the discharge setting.

Thinking about information you would like to receive if taking over care.

Finally, we asked GPs if they had any additional points about discharges in Oxfordshire. Their answers reflected the 'case for action':

They (discharge summaries) could and should be so much better. Once completed the clinician concerned should read through and ask themselves : 'can the person receiving this safely pick up the clinical management of this patient'

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Please ask clinicians to take responsibility for what they are doing, think about the effect this has on the patient and do what they would wish a professional to do for their family member - communicate clearly with patient and primary care.

I would really value hospitals being utterly responsible for their actions. Dumping patients on the community is bad form and very bad for patients. Telling patients they will contact them with OP appts or with results and this never materialises is bad form and bad for patients. It is also not defensible. I have dealt with two cases of this this morning alone in my am surgery - so 2 x 10min appts.

They do need to improve Please use casenotes at the least please start to understand the impact on GPs if we have no information or incorrect information

There is a lot of room for improvement. Computer systems need standardising so that a standard discharge form is used.

Please can someone do some work on improving this.

3.7 Recommendations arising from the GPs who contributed to this study:

- The electronic discharge summary should be redesigned with input from GPs.
- Standards for use of these electronic Discharge Summaries and Discharge Letters, including timeframes for delivery should be agreed across the system and enforced through training, education, audit and other appropriate mechanisms.
- Standards for supply of medications on discharge should be agreed across the system. These standards should include minimum periods for supply of ongoing medications, a requirement to explain reasons for medication changes, clear, printed, advice for patients on medications on discharge and processes to ensure alignment on use of medications across primary and secondary care.
- Wherever possible, discharging clinicians should phone and speak to the GP - particularly when discharging patients with complex care needs.

- Vulnerable patients requiring additional support should not be discharged at 5pm on a Friday.
- Hospital doctors should take responsibility for chasing results of tests they order and communicating the results to GPs and patients.

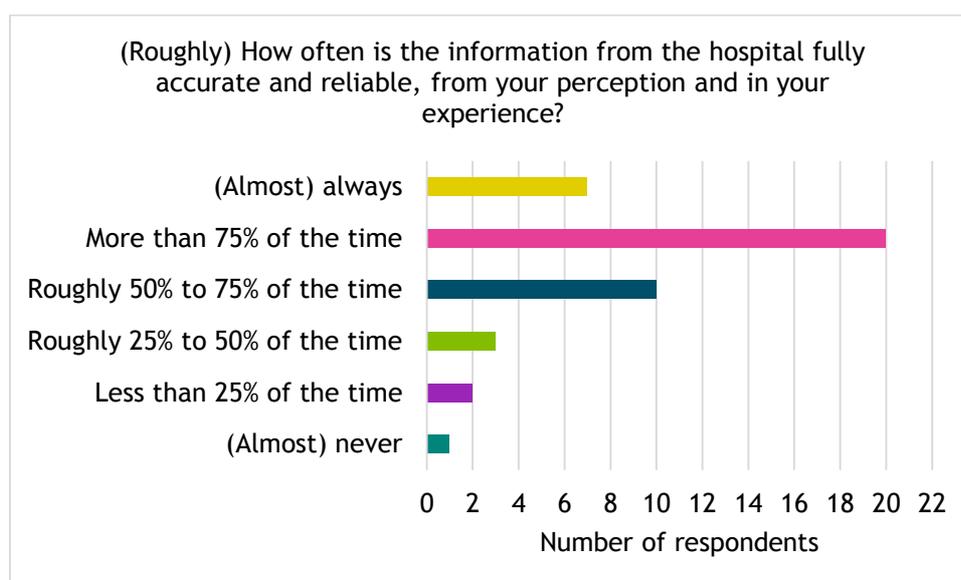
3.8 Professionals: pharmacies

The findings in this cohort are similar to those of the GPs. They focus significantly on communication, the benefits when communication is done well, and the stress to patients and additional workload for pharmacies when it isn't done well. Overall, the comments seem to suggest that when the information is received, it is usually accurate, with some suggestions for improvement. However, pharmacists are not routinely receiving information in a timely way.

There were 44 respondents to the 'pharmacies' questionnaire, 20 of which categorised themselves as pharmacy manager, 20 as Pharmacist and 4 as 'other'.

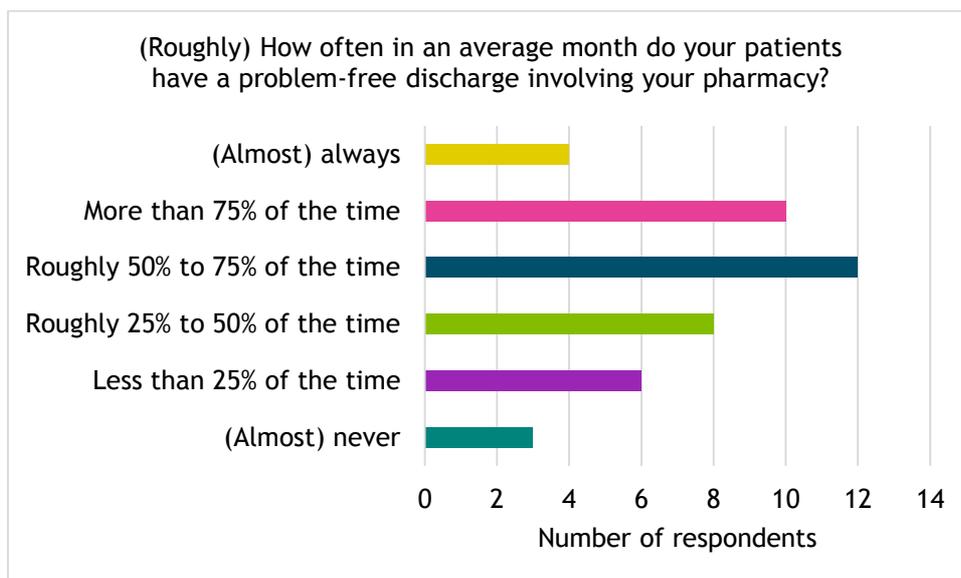
3.8.1 Quality of discharges

- 62% (27) of participants report that information received from hospitals is fully accurate and reliable (almost) always or more than 75% of the time



IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

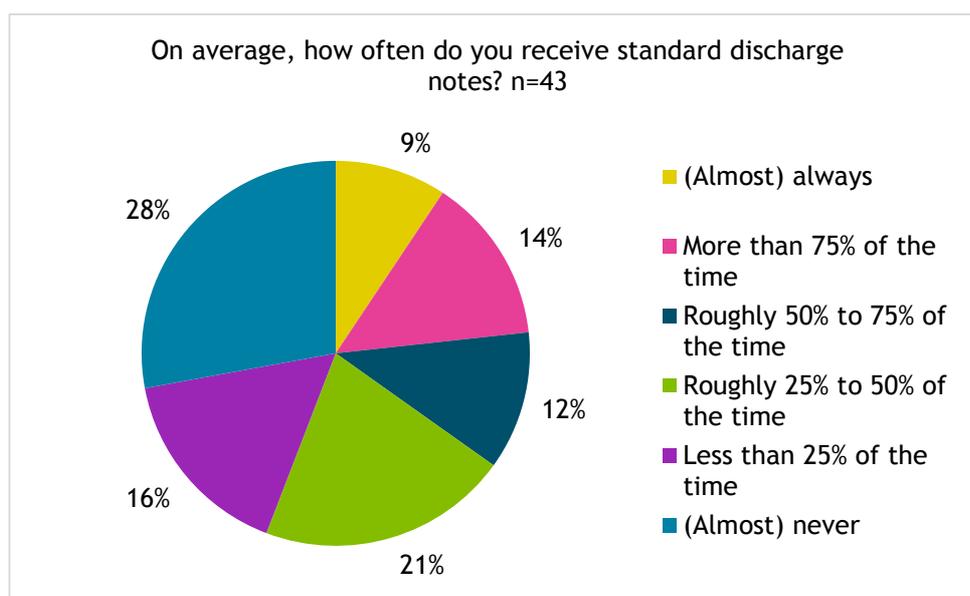
- 60% (26) of participants state that discharges are 'problem-free' 50% of the time or more.



- 60% (26) of participants report their workload is impacted by issues of the discharge only 1-5 times per month
- 53% (21) report that dosette boxes are being recommended appropriately by hospital more than 75% of the time or (almost) always

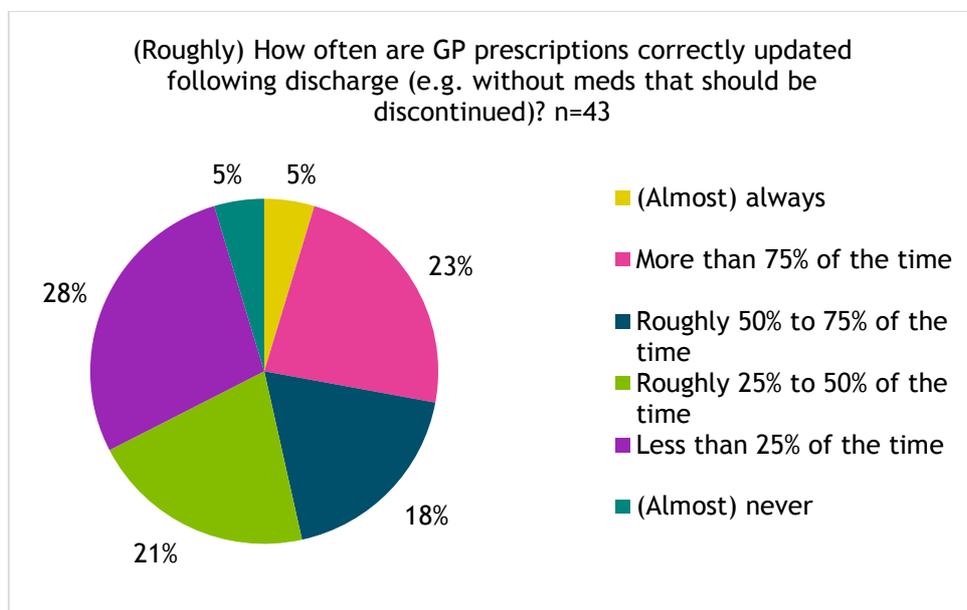
3.8.2 What could be improved?

- 65% (28) of respondents are receiving standard discharge notes 50% of the time or less.

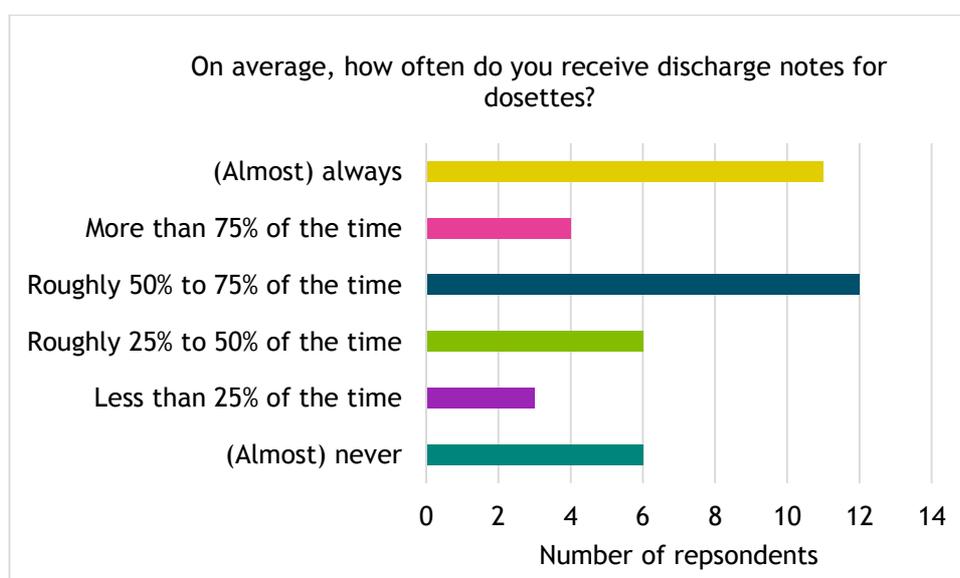


IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

- Only 38% (16) of respondents said they are (almost always) or more than 75% of the time receiving the information they need on time.
- 53% (23) of respondents report that GP prescriptions are updated correctly less than 50% of the time.



- 16% (7) reported an uninterrupted continuation of medication prescribed in secondary care as occurring (almost) always
- 44% (15) of respondents report receiving information on dosette boxes before patients run out of medication 50% of the time or less



The respondents to the pharmacies questionnaire were very clear about both the impact of poor communication on patients and their workload, and on what could be improved.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

Typical comments on the impact, include:

V stressful [for patients]

The patient doesn't get their medication on time

Delays in meds, distress & loss of confidence in service

We try to minimize impact, but they will be anxious about receiving their meds

Sometimes we don't get discharges and we have to ring round trying to get someone to copy us into the discharge

GPs may not always do prescriptions for changes until they get the discharge note - which is sometimes quite delayed. Patients not always told of changes as they query it with me and it takes time to chase up

There was a particular concern on the impact of delays on safety:

Sudden demand of urgent DDS boxes which do not hav resource to dispense and check safely

Pharmacies had a few concrete recommendations on how discharge summaries, and communications on discharge, in general, could be improved:

Discharge summaries on time, GP record updated on time

Two weeks worth of discharge meds from hospital and all notes given to us and GP at the same time, i.e. day of discharge. This give plenty of times for all concerned to organise meds.

Patients leave hospital with a clear idea / written plan of their new medication/treatment. The GP and pharmacy are notified (either by hospital or patient) and are able to organise continuing supply in plenty of time. Good communication is key.

Nominated Pharmacy to be emailed when patients admitted and discharged. This will avoid dossette boxes being prepared when

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

pharmacy unaware of admissions and allow warning of when they may be resumed.

Communication that the patient meds have changed, if they are on a dossett box and when they will need their new set of dossett boxes.

Recently received report from a patient that clearly listed stopped medication/continuing medication/new medication and a temporary medication which was useful

It seemed that two weeks' worth of medication upon being discharged from hospital was the ideal window for pharmacist and GPs to have received all of the relevant information required to ensure continuity in medications after discharge. A number of comments specifically mentioned how helpful it was to include the medications that had stopped during a hospital admission as being as important as those that had started in the same period.

3.9 Recommendations arising from the pharmacists who contributed to this study:

- Ensure patients leave hospital with two weeks worth of medications.
- Ensure pharmacists are notified when patients are admitted and that they receive copies of discharge summaries on the day of discharge.
- Ensure discharge summaries include information on all changes to prescriptions (what has been started, stopped, changed - and why).

4 The gap between information given to patients and their experience.

According to its website, OUHT produces several leaflets for patients to help inform their discharge from hospital, and has a ward poster called Planning for Discharge.⁷ The Planning for Discharge poster helpfully summarises for patients, in a flow chart format, 15 steps in the discharge process. Using the data reported in Chapter 3 Healthwatch Oxfordshire has identified 10 points in the process, as described to patients in this poster, where experiences of discharge do not appear to be matching the information given to patients about what to expect.

Your hospital stay – planning for discharge



⁷ See Appendix 1 Planwell, Planning for Discharge; Planning to Leave.

The Planning for Discharge Poster says:

1. *Planning for your discharge will start on or before admission where possible. We will discuss your estimated date of discharge and together agree a plan.*

Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.

2. *We will discuss your needs and agree the help you need at home with the involvement of your family and/or carer.*
3. *We will expect you to be fully involved in planning your own discharge, together with a relative, carer or friend as appropriate.*

Only 54% (79) of the patients who completed the survey on line said they or their family or carers were involved in planning their discharge.

Only 50% (29) said they or their carer were kept informed and involved in the arrangements for their discharge.

Even when carers were reported as being involved, the involvement was reported as often being very late on in the process. 44% (30) of carers were only involved in discharge arrangements a few days before discharge (11), or on the day the patient left hospital (19). 19% (13) of carers were involved on the day of admission or the next day.

4. *If you have started new medication, you will be given a supply to take home. Your GP will then prescribe more if required.*
5. *We will explain your medication. There are also written instructions on the packaging and an information sheet will be provided.*

Whilst 94 % (116) of the patients who completed the survey after discharge understood the instructions/information they were given about their medication to take home, only 64% (84) patients said their medication was available for them at the time they were ready to be discharged and issues with medication were cited more frequently than any other issue.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

- 6. We will aim to get you ‘Home for Lunch’ on your day of discharge wherever possible. We may ask you to move to a transfer area/lounge or day room; here you can wait in comfort for your relative/carer/transport and medication. This will enable us to start treating another patient.*

We did not ask a specific question about what time people got home, but anecdotal evidence gathered by volunteers in the course of undertaking interviews with patients for this project suggests that “home for lunch” is not always achieved. 24% (8) of those who used it, rated their experience of the lounge as poor or very poor.

- 7. You will be given, and we will send, a letter to your GP explaining the reason for your hospital stay and giving details of your medication.*
- 8. If you and your team agree you need help at home, a discharge letter detailing support services will be sent to your GP.*

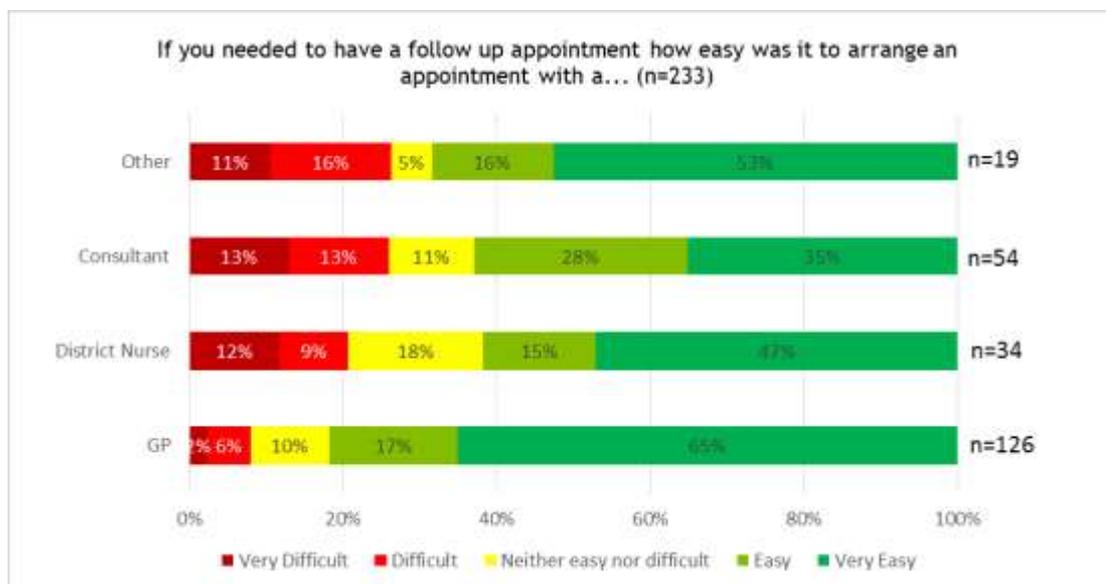
GP’s clearly told us that there are a number of problems with discharge summaries. The most frequently cited issues were timeliness; too much information/no clear synopsis (e.g. information appropriate to community nurses sent to GPs); lack of diagnoses; inaccurate medication information; lack of information about reasons for medication changes; handwritten discharge summaries; lack of clear information for GPs to act on/unclear follow-up plans. Lack of information provided to patients and/or their families and patients being confused or unclear about future plans were also cited by GPs as a problem.

- 9. If you need a follow-up appointment or further investigations, we will arrange this before you leave.*

We asked patients how easy they found it to make the follow up appointments that they needed. Most people found it was very easy or easy to arrange follow up appointments, particularly with GPs. However, 26% (14) found it difficult or very difficult to arrange a follow up with a consultant, 27% (5) with ‘other’ and 21% (7) with a district nurse.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

One of the top problems raised by GPs was the frequency with which they are asked to follow up investigations, arrange onward referrals, chase outpatient appointments and chase test results.



10. If you need equipment at home, we will agree arrangements with you. We will show you and your carer how to use any equipment provided before you leave hospital.

79% (31) of the patients who needed equipment said it was available when they needed it, but 42% were unsure how to use it when they got home.

4.1 Recommendations relating to the gap between patient information and patient experience.

- OUHT, OHFT and OCC should pay particular attention to improving performance in the 10 areas where the process as laid out in the “Planning for Discharge” poster is not being delivered.
- The poster should be redesigned as a leaflet that is given to all patients and discussed with them, and their carers/family members by the person responsible for planning their discharge. The Trust should routinely monitor that this is happening to ensure it becomes standard practice.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

- That leaflet should include a space in which the name and contact details of the patient's discharge co-ordinator can be written and it should include information on who the patient should contact if they are unhappy about their discharge plan.

5 Recommendations

Across all cohorts of participants to this study there were remarkably similar, and in many cases, simple recommendations. We would recommend that commissioners, providers, patients and professional bodies work together to enact the following recommendations:

The 14 main recommendations arising from our study are that:

1. Hospital trusts should take immediate action to increase the percentage of patients whose Estimated Date of Discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway⁸. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.
2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.
3. The “Planning for Discharge” ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.
4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place.
5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about ‘involving’ others and not just about ‘informing’ them.

⁸ See Appendix 1 for the summary pathway

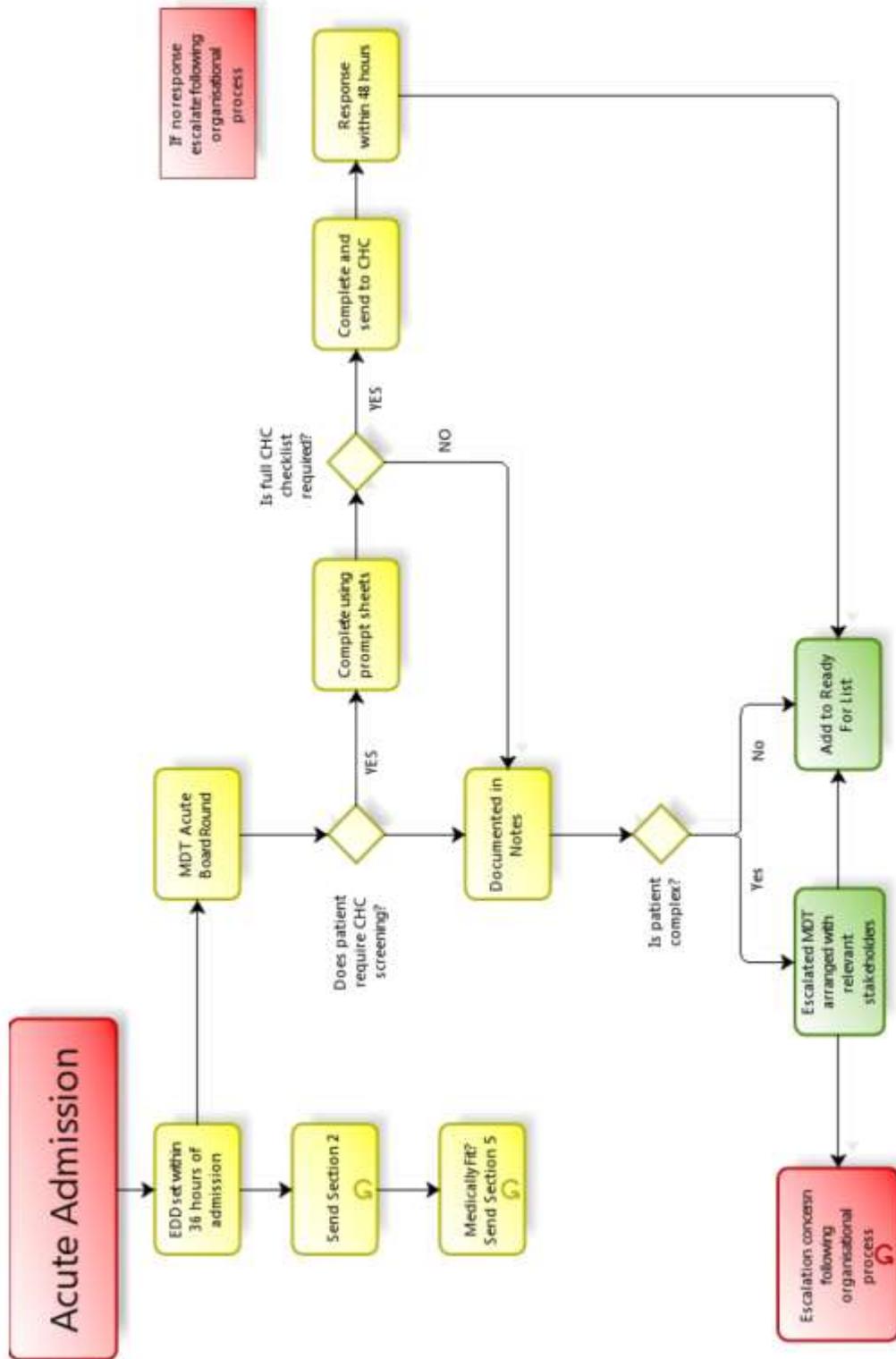
IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed.
7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services.
8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically:
 - Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.
 - Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.
 - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary.
 - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.
9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.
10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.
11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.

IMPROVING DISCHARGES FROM HOSPITAL IN OXFORDSHIRE

12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.
13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.
14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.

Appendix 1: Discharge pathway flowcharts



Your hospital stay – planning for discharge



What we will do

Planning for your discharge will start on or before admission where possible. We will discuss your estimated date of discharge and together agree a plan.

We will discuss your needs and agree the help you need at home with the involvement of your family and/or carer.

If you need to be transferred to a community hospital, we will send you to the first available bed. This may not be the one closest to where you live. The priority is to start your rehabilitation as soon as possible.

What we expect from you

We will expect you to be fully involved in planning your own discharge, together with a relative, carer or friend as appropriate.

We expect you to arrange your own transport home. Hospital transport is for people who meet strict medical criteria only.

You need to arrange outdoor clothes, your house keys, ensure heating is on and that you have enough food at home.

Please let us know if you require a medical (sick) certificate.

Medication

Medication which you brought into hospital, and still need, will be returned to you.

If you have started new medication, you will be given a supply to take home. Your GP will then prescribe more if required.

We will explain your medication. There are also written instructions on the packaging and an information sheet will be provided.

Day of discharge and follow-up

We will aim to get you 'Home for Lunch' on your day of discharge wherever possible. We may ask you to move to a transfer area/ lounge or day room; here you can wait in comfort for your relative/carer/transport and medication.

This will enable us to start treating another patient.

You will be given, and we will send, a letter to your GP explaining the reason for your hospital stay and giving details of your medication.

If you need a follow-up appointment or further investigations, we will arrange this before you leave.

Help at home and equipment

If you and your team agree you need help at home, a discharge letter detailing support services will be sent to your GP. The support services will be arranged before your discharge.

If you need equipment at home, we will agree arrangements with you. We will show you and your carer how to use any equipment provided before you leave hospital.

For more information, visit:
www.ouh.nhs.uk/leavinghospital

THE FIRST WITH BEST CARE

Appendix 2 & 3: Data tables & Questionnaires

Due to their length, the 5 questionnaires used in this study and the data tables are available in separate appendices. Appendix 2 & 3 will be available at www.healthwatchoxfordshire.co.uk or you can contact the office on 01865 520520 or on hello@healthwatchoxfordshire.co.uk to request a copy.

About Healthwatch Oxfordshire

Healthwatch Oxfordshire is an independent organisation that listens to your views and experiences of health and social care in Oxfordshire. We work to help you get the best out of these services, whether it is improving them today or helping to shape them for tomorrow. We have the ability to hold health and social care providers to account.

Authors

Mark Stone, Rachel Coney, Carol Moore and Emma Sutton

Acknowledgements

Healthwatch Oxfordshire would like to thank all of the patients and service users that contributed to this project through interviews and online. We would like to thank Patient Voice for identifying and alerting us to the need for this study. We would also like to thank our local providers including Oxford University Hospitals Trust, Oxford Health NHS Foundation Trust, the Local Medical Committee, the Local Pharmaceutical Committee and the Oxfordshire Association of Care Providers who co-operated with us in this project. In particular, we would like to thank our project steering group and patient reference group for their help in designing the questionnaires, and our Enter and View volunteers who interviewed over 60 patients and service users for this project.

Disclaimer

This report relates to findings from online questionnaires as well as interviews conducted with Enter and View volunteers which took place in the Spring of 2015. The sample sizes from some respondent groups are small and need to be interpreted with caution. Participants were encouraged to give their personal perspective on the discharge process. Recommendations are based on the overall feedback received.



Suite 2
Whichford House
1400 John Smith Drive
Oxford Business Park South
Oxford, OX4 2JY
01865 520520
Healthwatch Oxfordshire CIC Registered in
England and Wales as a Community Interest
Company, No: 8758793