



# Healthwatch Stockport Enter & View Report

## Safely Home after Discharge

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## 1. Introduction

### 1.1. General

In 2014 Healthwatch England began a Special Inquiry into the issues surrounding discharge from health and social care settings. 3,230 people shared their experiences through 101 local Healthwatch. In order to fully contribute to Healthwatch England's Special Inquiry, Healthwatch Stockport re-established its Discharge Subgroup to collect and evaluate information around local discharge procedures. Details of these experiences from Stockport residents including older people, homeless people, and people with mental health conditions were presented to Healthwatch England.

Healthwatch England reviewed all the data and classified it into various themes based on the concerns expressed by the individuals and this led them to build a clear understanding of the discharge process. Findings of the Healthwatch England report are presented on their website [http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715\\_healthwatch\\_special\\_inquiry\\_2015\\_1.pdf](http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf)

### 1.2. Methodology used by Healthwatch Stockport Discharge Subgroup

#### 1.2.1. Service Providers and patients

In order to fully engage with patients and staff and understand their views, Healthwatch Stockport carried out a number of Enter and View visits throughout Stockport. The primary purpose of the visits was to understand the views of patients about their discharge and also gather information about how health and social care professionals work together to enable a safe and timely discharge for patients in Stockport.

The following individuals and organisations were interviewed by Healthwatch Stockport members and staff between October 2015 and May 2016:

- Stockport NHS Foundation Trust Wards at Stepping Hill Hospital
- Discharge Co-ordinators - Stockport NHS Foundation Trust
- District Nurses - Stockport NHS Foundation Trust
- Chief Pharmacist at Stockport NHS Foundation Trust
- Social Workers, Stockport Metropolitan Borough Council, based at Stepping Hill Hospital



- **Marbury House - an Intermediate Care Home in Stockport**
- **Stockport GPs - Members of the Local Medical Council**

This report attempts to bring together the findings of those interviews and visits and sets out Healthwatch Stockport's recommendations to improve the process and the experience for patients. Once the report is completed and the service providers consulted, Healthwatch Stockport will be working with each of the services visited to put together an action plan to implement the recommendations. Services have a statutory duty to respond to local Healthwatch Enter and View reports, its findings and recommendations.

### **1.2.2. Stockport NHS Foundation Trust**

Stockport NHS Foundation Trust runs Stepping Hill Hospital, and other specialist centres, as well as community health services for Stockport. The hospital first opened in 1905 and now employs over 5,000 staff and treats over 750,000 hospital and community patients each year. It is a specialist hospital for emergency and abdominal surgery, one of only four in Greater Manchester, under the Healthier Together review and is a partner organisation within the Stockport Together programme to develop a single strategic plan to improve health and social care services.

Overall responsibility for delivering services rests with the Board of Directors but as a Foundation Trust they also have a Board of Governors who are the voice of the local community, the majority of whom are elected from its public membership.

### **1.2.3. Discharge Co-ordinators at Stepping Hill Hospital**

Stockport NHS Foundation Trust has four Discharge Co-ordinators based at Stepping Hill Hospital. Their role is to enable a safe and timely discharge for patients.

### **1.2.4. Stockport NHS Foundation Trust District Nurses**

Stockport NHS Foundation Trust provide nursing care in the local community and offers a 24 hours a day/365 days a year service for people either at home or community clinic settings. District Nurses provide nursing care in the home, in residential care homes and clinics. The work includes: dressing wounds, continence and bowel care, providing support and treatment for people suffering from acute illnesses or with complex needs, wishing to stay at home. The district nursing team works in partnership with specialist nursing teams and advanced practitioners, GPs (doctors) and multi-agency teams, providing treatments within health centres for patients who can attend clinics.

### **1.2.5. Chief Pharmacist at Stockport NHS Foundation Trust**

The Chief Pharmacist manages the pharmacy service at the hospital. Ward based pharmacists and pharmacy technicians provide advice and information to patients about their prescribed medicines throughout their hospital stay from admission through to discharge. The dispensary provides medication for both in and outpatients. There is also a small selection of products available to buy over the counter. A range of sterile medicines including antibiotics, chemotherapy and parenteral nutrition are prepared for patients.



#### **1.2.6. Social Workers based at Stepping Hill Hospital**

There is a social work team at Stepping Hill Hospital employed by Stockport Metropolitan Borough Council. If it's appropriate, they will assess the patient after they have been admitted onto a ward. The assessment includes a discussion with the patient (and any family members or carers that the patient would like to be involved), about the patient's wellbeing, and any care and support needs that they may have. Together the social worker and patient will consider whether any of the patient's needs could be reduced or prevented from worsening.

#### **1.2.7. Stockport GPs - Local Medical Committee (LMC)**

Stockport LMC are the local representative committees of NHS GPs, and represent the interests of all NHS GPs in Stockport to the NHS health authorities.

#### **1.2.8. Marbury House - Intermediate Care Home**

Marbury House is a two storey specialised Intermediate residential care home, situated on the Marbury Estate in Heaton Chapel, Stockport. The home provides accommodation and care for up to 41 people requiring varying degrees of rehabilitation support. Intermediate care is short-term care that's provided free of charge for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks. Intermediate Care at Marbury House is provided under contract with local health authority and social care commissioners. Admissions for Intermediate Care are arranged through the multi-disciplinary intermediate care teams.

### **1.3. Arranging the visits**

Healthwatch Stockport Discharge Subgroup worked with the Enter and View team to decide which services, wards, patients and staff to visit and interview. In some cases, health and social care professionals also advised of other potential interviewees eg. the discharge co-ordinators. As the Enter and View activity began it became obvious that in order to obtain a full overview of the experiences of patients and health and care social care professionals then the interviews and visits would have to be expanded beyond the wards at Stepping Hill hospital.

Healthwatch Stockport e-mailed the appropriate managers of each service and spoke to the relevant people in connection with the purpose of the visit, time required and what we expected to achieve. Healthwatch Stockport would like to thank all the people who facilitated the visits and co-operated with the Enter and View activity.

### **1.4. Report Format**

The following sections are divided into the services that were visited and illustrate

- An overview of the answers given to the questions and themes that were identified

- Quotes given to the interviewers by the patients and staff are in italics throughout the report. Every effort has been made not to alter the language used by the interviewees. However, in some cases it has been necessary to modify the answers in the interest of clarity.
- Recommendations from Healthwatch Stockport to improve the discharge of patients

As stated above, once the report is published, Healthwatch Stockport will meet with providers and commissioners to work with them in order to improve the discharge process for patients and staff.



## 2. Summary of Recommendations

It was clear to Healthwatch Stockport during the interviews that the discharge of patients from hospital was a very complicated process especially when a patient needs support after discharge. Multiple agencies are involved in the processes and it is obvious that good communication, in good time produced good discharges. Health and Social Care in Stockport is now provided under Stockport Together and Healthwatch Stockport hopes that this will improve the discharge of all patients but particularly those who need ongoing help and support.

Members of the Social Work Team at the hospital were candid in their answers around the delays within the discharge procedures and in their opinion about unnecessary re-admissions because of a lack of ongoing support in the community. Stockport's Urgent Care Delivery Group has recognised the importance of delayed transfers of care and the impact they have on admission to Emergency Department and other wards within the hospital.

As part of Stockport Together Health and Social Care provider organisations in Stockport have set out to become a 'multi-specialty community provider' (MCP) with shared clinical and social outcomes. The discharge from a hospital setting should be at the core of these shared services and clinical outcomes. GPs, Pennine Care staff, SMBC and NHS Stockport Foundation Trust Staff, as well as private sector organisations, can all be involved in a patient's discharge and therefore joint services and joint outcomes are welcomed by Healthwatch Stockport.

Healthwatch Stockport believes the following recommendations as the most prominent to have more timely safe discharges from Stepping Hill Hospital.

- Healthwatch Stockport recommends that the availability of places in Intermediate Care Homes be carefully monitored and that adequate funding is forthcoming from the public purse so that the Homes are sustainable businesses going forward. Although this will lead to an increased budget for Adult Social Care the overall cost to Stockport MPC will fall as Stockport NHS Foundation Trust will have patients in acute hospital care for a shorter period. This could be a joint initiative between SMBC and Stockport NHS Foundation Trust. **(Recommendation 3.4.2)**
- Healthwatch Stockport recommends that information given to vulnerable patients about their discharge should only be given when they have their family or carers with them. These patients seemed to us unclear about their date of discharge and the arrangements to be made for them. The patients seemed not to fully understand what care they would need going forward and what (if any) equipment they would need at home. **(Recommendation 3.4.6)**
- Healthwatch Stockport recommends that temporary outside of hospital placements are needed, especially for people who are waiting for a CHC assessment or waiting for their family members to decide which residential care home is suitable for them. **(Recommendation 3.4.12)**
- Healthwatch Stockport recommends that the Trust look at the way information is shared between Consultant, Ward Staff, Discharge Co-ordinators, Patient Trackers and Social Workers. Data should not be sent by fax but by electronic means with the sharing of data by using a common database format. **(Recommendation 4.3.6)**
- Healthwatch Stockport recommends that the discharge letter should be included in the referral to the District Nurse Team **(Recommendation 5.3.1)**



- A leaflet should be given to patients on admission to the ward that explains that the medication brought with them to hospital has been recorded and will be taken into account when new and ongoing medication is prescribed and/or administered. The leaflet should also include details and a contact number for the Pharmacy Department so that family and friends are aware that they can be with the patient when discussions take place about their discharge medication (**Recommendation 6.3.1**)
- Healthwatch Stockport also found out that the delays in discharge are primarily caused by lack of care beds in the community. It puts a lot of pressure on the Social Work Team (SWT) to find the right care home for a patient and as a matter of urgency we would recommend that SMBC Adult Social Care investigate with 'Stockport Together' a way to improve the availability of places which appears to be getting worse because of the financial restraints on public spending. (**Recommendation 7.5.6**)
- Healthwatch Stockport was disappointed to learn that re-admissions to hospital after a short stay *{5 days was quoted}* in an intermediate care home were not unusual. Medical staff were apparently declaring those patients as medically fit who had additional complicating health conditions that they did not go into hospital for. Healthwatch Stockport recommends this situation should be thoroughly investigated and an audit kept on this type of re-admission. (**Recommendation 7.5.12**)
- Healthwatch Stockport recommends that more resources should be made available in the community so that patients can be treated for conditions such as chronic obstructive pulmonary disease. We believe that this would relieve pressures on hospital beds and re-admissions. This is an important issue and is one that 'Stockport Together' should be working on. (**Recommendation 7.5.14**)
- The SWT considered that better use of everyone's time could be made for the meetings with the Medical Staff on the Patient Discharge List. Healthwatch Stockport understand the issues involved and feel it is worth investigating a more time efficient process. (**Recommendation 7.5.19**)
- Urgent emails to GPs should be used as standard to highlight any actions needed within the first week of discharge. (**Recommendation 8.3.5**)
- Healthwatch Stockport recommends a formal admission policy including a tool which the staff could complete to ensure all patients that are admitted to care homes arrive with everything they require for them to be safely cared for ie medication, discharge letter, walking aids, care plan. This would enable an audit which could be shared with the hospital to improve the discharge and admission process. (**Recommendation 9.4.2**)
- Healthwatch Stockport recommends an agreement with the hospital regarding a time after which patients cannot be admitted to Marbury House to ensure they receive the best quality care. This could be incorporated into the admission policy. (**Recommendation 9.4.3**)



### **3. Interviews with Staff and Patients on the Transfer Unit, Wards M4 and A11 at Stepping Hill Hospital**

#### **3.1. Introduction**

The interviews were carried out in October and December 2015.

#### **3.2.1 Staff on Wards Transfer Unit, A11 and M4**

A variety of clinical and non-clinical staff were interviewed on the three wards: Staff nurses, auxiliary nurses, ward sisters, ward manager, health care assistants, a consultant doctor and ward managers.

They described how their roles fit into the discharge process:

- Talk to Patient and help them pack belongings.
- Give the patient support and information.
- Co-ordinate with other staff
- Liaise with Doctor about the care Package and if there are any Physiotherapy requirements. Make sure the next of kin details are correct and that medication is in place
- Ensure that patients belongings are packed, they are dressed and ready to go.
- Ensure that discharge is safe and timely

The ward manager answered that she led on the discharge process although doctors decide when patients are medically ready to be discharged. There is input from the Occupational Therapist and Physiotherapists as well. It is a multi-disciplinary decision.

#### **3.2.2. Which other health and social care professionals do you work with in relation to discharge?**

The auxiliary nurses and health care assistants answered that they **only** worked with staff nurses and that staff nurses relay any information that they need to know to them.

The ward managers, sisters, doctors and staff nurses spoke about the number of other health and social care professionals they work with around the discharge process. A deputy ward sister did note however:

*“Under a new procedure I attend regular meetings between 9.30am and 1.30pm in Oak House with senior managers on discharges. This takes me away from vital work to make beds available early in the day. More senior meetings on the ward instead would be more effective.”*

It was also noted that although the health care assistants stated that they only worked with staff nurses the ward managers, sisters and deputy sisters answered that the people that they worked with included health care assistants and auxiliary nurses.

The nursing staff and doctors also work with:



Care home staff, district nurses, residential homes, social workers, the hospital pharmacy, social workers, physiotherapists, intermediate care, continuing healthcare team, patient journey manager, patient transport manager.

### 3.2.3. What works well with the discharge process your ward?

A ward manager replied

*“We are able to access intermediate care services well. Twice a week there are multi-disciplinary meetings when we are able to discuss patients who are ready to be discharged or will soon be ready to be discharged. The Occupational Therapist (1 Full Time Equivalent post - 2 people job share) and Physiotherapist are based on the ward. (M4)”*

Communication was seen as the key to the best discharges with almost all the staff mentioning this in their answers.

*“The best discharge processes work when doctors are available, medicines are ordered the day before and delivered on time, the Ambulance Service and District Nurses have been contacted and sufficient HCAs are on hand.”*

However, auxiliary nurses and health care assistants were less enthusiastic stating that discharges only work well when the ward clerk is present. One person responded

*“Nothing works well.”*

### 3.2.4. What are the challenges with discharge on your ward?

This question had a variety of answers with over ten members of staff giving a different challenge. Challenges that were listed included the patients’ families, and a lack of communication but some staff were willing to go into more detail with their answers about patients from outside Stockport and how their ongoing care and the processes associated with it differed from Stockport.

*“Patients from out of area. Their assessment criteria is different and it is obviously a different intermediate care team. There is less Community Care and intermediate care in Stockport though. We have to wait for the package of care to be agreed and then put in place. In East Cheshire patients who require any ongoing care have to go to an intermediate care home before going home. This does cause delays for discharge. Patients from East Cheshire can only go straight home if there is zero ongoing care.”*

A health care assistant did note that they were not invited to meetings about patients’ discharge

*“Even though we have lots of inside information to pass on about the patient.”*

Challenges centred around the communication and availability of other departments eg. Social work team and pharmacy. The availability of the Ward Clerk was mentioned again as being integral to the discharge process and their lack of involvement at times was an issue. It should be noted that this answer was given by a different member of staff on a different ward to the



previous respondent who talked about the Ward Clerk's involvement resulting in a discharge that works well.

Other issues were

- Waiting for medical test results.
- Unavoidable disruptions
- Staff shortages.
- Lack of information
- Short notice of discharges - 30 minutes

More than one member of staff raised the issue of patients' reactions to trauma. This was explained as patients who had been just about coping at home but during their stay in hospital additional problems were presented to the staff. This meant that more background information was needed as well as input from the social work team. This often resulted in ongoing care after the patient was discharged.

**3.2.5 Are there differences to the discharge process when a person is discharged to residential care, the person already has a social worker, now needs the support of a social worker or is going to intermediate care? If so, please explain the differences**

*"It can be more complicated for different scenarios. For example There are often Physio to Physio reports if a patient is from out of area. If somebody does require intermediate care then we are using Marbury House and Berrycroft at the moment. This does complicate the process too if people require intermediate care as we have to wait for beds to become available. We have 5 patients in that position at the moment (from 27 beds)*

*When a person is admitted then we tell the Social Work (SW) team. Where the person requires an assessment for ongoing care from the SW team then we notify the SW team. There is no difference if the patient does or doesn't have a social worker prior to their stay in hospital because it can be difficult to track down an existing social worker whereas if the person needs a new social worker we go to the team based at the hospital."*

There are sometimes problems if a patient is admitted from a residential care home and when the patient is ready to be discharged back to the care home the care home decides that the patients' needs have changed and will not accept the patient back as a resident.

It was also noted that

*"Discharge to Care Homes can be compromised due to time restrictions and where there is pre-social worker assignment early involvement is needed. Discharge to a patient's home needs a lot of background checking and care arrangements, especially with palliative care patients. Intermediate discharge usually works well - there are good procedures in place. If it's a residential home there is need of a continuing health care certificate.*

**3.2.6. How do you give information to the Transfer Unit if a patient goes there before discharge?**



There was a difference of opinion from the members of staff from the different wards. Some staff thought that a phone call to the Transfer Unit was sufficient whereas others spoke about the Transfer Referral Form.

One member of staff answered

*“The information to Transfer Unit needs to be done carefully, particularly with food and medicines, as these vary patient to patient, but a procedure is in place.”*

### **3.2.7. How do you inform the relevant health and social care professionals when there will be a need for ongoing care? For example GP, District Nurse, Social Worker?**

The healthcare assistants and auxiliary nurses are not involved in this process.

Once again the Ward Clerk was mentioned as integral to the information being passed on to the appropriate health and social care professional.

*“Relevant professionals are advised by the Ward Clerk prior to discharge, who checks information has been received.”*

A District Nurse referral is faxed when the patient is ready to go. It was stated that this was sometimes the day before depending on when the visit from the District Nurse was required. It is the nursing staff that do the District Nurse referral whereas the discharge is done by a doctor and is then accessed electronically by the GP surgery.

### **3.2.8. Is there anything you would like to see changed to make the procedures more practical, easier or more simple for the patient and/or you?**

There were a range of answers from the staff that included *“better communication”* and more healthcare assistants. However, the main theme was that the discharge process should not be fast tracked so that the patients were always safely discharged.

*“Not to be so rushed which would prevent re admittance. Measures should be taken when staff are not following procedures”*

The problem with out of area patients was brought up.

*“Each locality (Manchester, East Cheshire, Stockport etc) to have the same paperwork. Even a Southern Sector agreement would make a difference. At the moment it is still very fragmented.”*

Other suggestions were that all information should be sent by email rather than fax and that every ward should have a discharge co-ordinator working on the ward.

### **3.2.9. Are there any patients that are ready to be discharged but their ongoing care is not yet ready?**

It was recorded that of the 27 patients on Ward M4 five patients were in this position. An auxiliary nurse pointed out that their knowledge of a patient and the relationship they had developed was often ignored.



*“Many discharges are not prepared and all staff not consulted. If the patient is going straight home the nurses give them bread, milk and jam out of our own staff supplies. Senior Staff meet up to discuss a Patient’s discharge but do not include Nurses who have spent more time looking after Patient and know more details about them.”*

This issue was seen as a very common occurrence

*“There are always instances where on-going care is delaying discharge.”*

### **3.2.10. Is there anything else you would like to tell us?**

The auxiliary nurses spoke about their frustrations of being overlooked in the discharge process when they saw the patients so frequently and knew a lot of background information as the patient would share stories with them. They also thought that the main problems were lack of communication at all levels and rushed discharges.

There is an electronic display which shows the movements of the patients’ progress within the ward as regards their treatment which is updated by staff on computer system.

Again the issue of out of area patients came up but this time it was about the repatriation of patients to hospitals covered by the accompanying CCG.

The lack of appropriate community settings was brought up repeatedly and the time taken for these provisions to put in place due to a variety of factors:

*“It can be very frustrating that there are not enough EMI (Elderly and Mentally Ill) placements. There isn’t enough community support. Discharge process starts far too late. Social workers will only accept when “Fit to go”. There also needs to be better liaison needed with care homes, they demand that they come in to assess and this causes delays. Continuing Health Care - they can wait as long as 5 days for an assessment after they are declared fit for discharge*

The joint working between orthopaedics, older people’s medicine and medical doctors on the ward was mentioned as an example of positive joint care. This means that from Monday-to Friday there are no problems with prescriptions on the wards.

### **3.3. Patients on the Transfer Unit, Ward M4 and A11**

It is a relevant and revealing fact that despite visiting three wards that have a higher number of discharges, and were considered by the Foundation Trust to be most appropriate for the Enter and View team to visit, the E &V representatives were only able to interview seven patients who were waiting to be discharged and of those seven two were being discharged the next day. Therefore the representatives interviewed five patients from three wards who were being discharged that day.



### 3.3.1 When did you find out you were leaving the hospital?

The majority of patients had been told the day before that they would be discharged the following day.

There was some confusion with patients whether they would be going home that day or the next day. In some cases this was because of the patients' capacity and their inability to understand, in other cases it was because the message from staff had been vague. One patient was waiting for an intermediate care bed to become available and had been waiting for two days. The patient's daughter was interviewed by an Enter and View representative a week later.

### 3.3.2. Were you given enough notice about when you were going to be discharged?

One patient spoke of her anxiety that she didn't know she was going home.

*"I was a bit upset at the time, as the person who told me thought that I already knew {Social Worker}. I didn't know that I would be going home so soon."*

The daughter of the patient who had been discharged explained:

*"No, the ward rang at 11am on Thursday 10<sup>th</sup> December to tell me that a bed was now available at Berrycroft Care Home and she could leave within the hour. I was not able to get to the hospital until 3pm."*

However, the other patients were happy with the amount of notice they were given - the day before discharge.

### 3.3.3. What has happened between the time you were told that you would be discharged and now? For example, were you told if there was a delay and why? Have you had any drink or food?

The patients in the Transfer Unit had either eaten or had been offered food.

Apart from one other patient, who had eaten, all other patients were being discharged the next day.

### 3.3.4. Was it clearly explained to you what would happen? If no please explain

Again this question produced mixed answers. There was uncertainty from some patients including those on the Transfer Unit who had been waiting on average for 3-4 hours.

*"No, not yet. Nothing has been explained. I'm not sure where I am going."* And

*"My daughter will pick me up. I think I will go home. Someone in hospital suggested I should stay with my daughter instead."*

Other patients however felt the process had been clearly explained and they knew that they were waiting for medication, patient transport or a family member to pick them up.



**3.3.5. Were you told or given information about what you should or shouldn't do on leaving hospital?**

The majority of patients were unsure what they should be doing to keep well.

*"No. It's a bit confusing, not sure where I'm up to."*

The daughter of the patient Healthwatch spoke to after discharge answered:

*"No, she wasn't. Mum wears pads and Berrycroft don't do pads so I had to go to her house and get her pads. There was no choice with the care home. It was Berrycroft or Marbury House, whichever had a bed first."*

**3.3.6. Have the hospital staff discussed with you if any health and social care services were required to get you home and whilst living there?**

Those patients that required ongoing care were unable to explain the next steps for their care and support. One patient who was unsteady on her feet and had mobility issues still did not know what would happen on discharge.

*"Not really. Not told if I will have physio when I leave. I have a walking frame and three walking sticks at home (including one at the bottom of the stairs and one at the top)"*

**3.3.7 Questions were asked relating to medication - were potential side effects explained, how long had they been waiting for their medication and when and how continued medication would be given to them.**

The patients on the Transfer Unit had not had the potential side effects explained to them as none of them had had their medication prescribed to them at the time of the interview.

One patient had been fully briefed about potential side effects, while another explained that her family had been present at the "interview" and knew more about her medication than she did. A change in medication had been explained as well as the ongoing delivery method.

*"The Co-op will deliver to my home. One medication has stopped because of my blood pressure."*

**3.3.8. Were you told of any danger signals to watch out for when returning to and whilst at home?**

Patients had been told to be careful and to avoid falls but had not yet been given written information.



**3.3.9. Do you feel you have been well informed about your condition, its treatment, your progress, self-care, and prognosis or had your questions answered?**

All patients answered that they had all their questions answered and they had been kept informed about their progress.

*"I have been in hospital coming up to 2 weeks now. I have had physio, seen a Social Worker, the Doctors and a Specialist for my hip operation. I have been given exercises to do. My husband is told information too."*

**3.3.10. Was any information given to family and friends about how to care for you at home?**

There was uncertainty about how much family members knew and unfortunately in many cases the patients were reliant on family members knowing more than them.

*"I think I will be at the care home over Christmas. My husband is physically frail but very supportive."*

*"I hope so, I hope she knows more than I do."*

*"Yes, my family have been told about my diet and exercise once I leave here."*

In some cases it was true and the family member did know more than the patient.

*"There will be a review every 2 weeks. Physio has said that when she leaves Berrycroft she will continue with the physio."*

**3.3.11. Were you involved with the staff and/or doctors about your ongoing healthcare or social care once you are back at home?**

Again there were mixed answers from this question with some patients feeling that their views and experiences were included in their ongoing healthcare.

*"Yes, happy to agree and accept anything they tell me. I will comply with their suggestions."*

Others were less enthusiastic.

*"Not really. I don't know what's really happening. Bit worrying as you don't know if I'll lose my own home."*

**3.3.12. Do you have anything else you want to tell us about discharge?**

As the patients on wards A11 and M4 were going home the next day they did not have their discharge notes. Some of the patients in the Transfer Unit did have their discharge notes but were also given an information leaflet that had out of date telephone numbers and outdated information.



One patient spoke about an outpatient appointment that had been arranged for him at Christies and the daughter of one patient, who Healthwatch spoke to after discharge, stated

*“The discharge to Berrycroft went smoothly. The Occupational Therapist went to Berrycroft. The Occupational Therapist has been given the house measurements too.”*

### **3.4 Healthwatch Stockport Recommendations**

**3.4.1** Ward staff indicated that Multi-Disciplinary Team meetings for patients discharge worked well and Healthwatch Stockport recommend that these be improved with the attendance of staff more intimately involved with the patient’s day to day care, including Health Care Assistants.

**3.4.2.** Healthwatch Stockport recommends that the availability of places in Intermediate Care Homes be carefully monitored and that adequate funding is forthcoming from the public purse so that the Homes are sustainable businesses going forward. Although this will lead to an increased budget for Adult Social Care the overall cost to Stockport MPC will fall as Stockport NHS Foundation Trust will have patients in acute hospital care for a shorter period. This could be a joint initiative between SMBC and Stockport NHS Foundation Trust.

**3.4.3** Healthwatch Stockport would recommend that discharge paperwork be consistent across the geographical locations close to Stockport so that ‘out of borough’ patient’s discharge was not delayed. Problems highlighted were mismatch of data, different criteria in care package assessments, different care teams make up etc.

**3.4.4** Healthwatch Stockport understands that the Transfer Unit is an underutilised resource in the discharge process. We would recommend that its use be re-appraised and resources made available to improve its use so that ward beds become available for new patients sooner. The main problems identified were the accurate transfer of patient information from the Ward to the Unit and the unfriendly atmosphere for patients in the Unit.

**3.4.5** The non-availability of places at Elderly Mentally Ill (EMI) Care Homes was highlighted and we would recommend that this issue be taken up by Stockport Together - a patient’s wellbeing is rarely confined to a purely health care or social care issue - it is usually a combination of *the* two.

**3.4.6** Healthwatch Stockport recommends that information given to vulnerable patients about their discharge should only be given when they have their family or carers with them. These patients seemed to us unclear about their date of discharge and the arrangements to be made for them. The patients seemed not to fully understand what care they would need going forward and the equipment they would need at home.

**3.4.7** Healthwatch Stockport recommends that discharge dates should be given as far in advance as possible and be made with the full knowledge of the care package that a patient will require after discharge. We also believe that all patients should have a copy of their Discharge Notes given to them on discharge.

**3.4.8** Healthwatch Stockport recommends that for vulnerable patients the side effects and taking of any medication should be fully explained to the patient when their family or carers are with them. It was very evident to us that these patients relied heavily on family or carers to ‘get



things right' for them. Early ordering of medication from the Pharmacy Department is highly recommended so that patients can take it with them. See also **Pharmacy Recommendations 6.3**

**3.4.9** We recommend that more Health Care Assistants on the wards would help to improve the discharge process for patients - particularly those who are old, infirmed, confused and very vulnerable.

**3.4.10** We feel that patients, family and carers should not feel that the discharge process is being rushed. Information should be given by Ward staff to patients, family and carers without them having to ask about it. One family member felt like they were intruding and had to ask for every detail. This was particularly evident when asked about information on the danger signals a patient should look for when back home - they answered they were not informed.

**3.4.11.** Healthwatch Stockport recommends that all Ward staff work to the Stepping Hill Hospital procedures for discharge of patients. We learnt from the interviews that this was not always the case as some members of staff reverted to the practices that they had used in previous roles. Training should be improved to eliminate this problem.

**3.4.12.** Healthwatch Stockport recommends that temporary outside of hospital placements are needed, especially for people who are waiting for a CHC assessment or waiting for their family members to decide which residential care home is suitable for them.



## 4 Discharge Co-ordinators at Stepping Hill Hospital

### 4.1 Introduction

The interviews were carried out on the 23<sup>rd</sup> May 2016. The Enter and View representatives spoke to all four discharge co-ordinators and one patient tracker at Stepping Hill hospital.

### 4.2 Interview Questions and Responses

#### 4.2.1 What is the role of the discharge co-ordinators?

We all have our own areas of responsibility. There are four discharge co-ordinators and four patient trackers. We go to wards assigned to us and see if we can move discharges forward. We check all the notes, listen to the whiteboard round and then try to pre-empt anything that might become complex. We try to get as involved as possible to try and stop any delay in discharge for the patient.

Facilitating the discharge, especially the complex ones but even the day to day simple ones. That is the role of the trackers too. We enable for quicker and safer discharges.

#### 4.2.2 How does your role fit into the discharge process?

We generally are involved in the complex discharges. There are very many discharges on a given day so we only focus on the ones that need our support. We have the meetings, '*the health and social care meeting*' we call it, every day with the social workers, Funded Nursing Care, Continuing Health Care, Age UK Stockport and try and iron out any problems. We also liaise with the out of area services which the wards find more difficult as it's more complex. Each local area has their own way of doing it.

#### 4.2.3 Which other health and social care professionals do you come in to contact with?

Physios, OTs, Moving and Handling co-ordinators, dieticians, mental health professionals, learning disabilities team. Each patient is an individual so it's a broad scope.

#### 4.2.4 Can you talk us through the daily Delayed Transfer of Care (DToC) meetings and how effective they are?

At the moment quite a few patients are on the DToC list. Some are on the list but have not reached the delayed point yet. So we only deal with those that are considered complex cases at those meetings. These meetings can be very useful as you have everyone round the table together. Sometimes other people come up with an idea that you haven't thought of and vice versa.

#### 4.2.5 Is there a role for Social Work Assistants?

Yes. They already exist in Cheshire East and Derbyshire and are called Social Work Assessors

#### 4.2.6 Do you think the whiteboard rounds could be more efficient?

There is work going on at the moment with Chris Gidley and the whiteboard rounds - SAFER. She is leading on it.



**4.2.7 Do you have any of the Stockport Care homes refusing to re-admit their residents after they have been in hospital?**

Yes, a lot. They say that they can't meet the needs now. We then have to go through the Continuing Health Care process which is very lengthy. Difficult for the patient as they come from their care home into hospital and then they are told that they can't go back. The problem is that in some cases some of the issues may have started before they came into hospital so should have been sorted out without having to bring them into hospital. In other cases the patients' needs may have changed.

The CHC team then have a meeting with the family and the patient to decide what level of funding is available. Sometimes they ask for our input but it would be the nurse on the ward that does the assessment, who knows the patient best.

**4.2.8 What works well with the current discharge process?**

The Trackers is a new role. The Trackers go to the whiteboard in the morning, we will see the patients that could be going home but are waiting for a scan so we chase that up and hopefully get that done that day so the patient can go home. We help the wards with the discharge to progress the discharge while they deal with the other patients. We try and fill the gaps, run down to pharmacy, help the person book transport, take the patient to transfusion.

Each patient Tracker has a discharge co-ordinator to link with. If the Tracker picks up something complicated it will be discussed with the discharge co-ordinator. There are four Trackers and four Co-ordinators. First Tracker started in September 2015.

**4.2.9 Do you have measurements or outcomes to show the value of the Trackers?**

Well, the posts have been extended for a year and they have a new contract. So there must have been positive feedback from the wards.

**4.2.10 A Consultant on ward M4 said that discharge forms were different on each ward - do you agree?**

No. The discharge co-ordinators said that they were the same.

**4.2.11 Can you show that discharge planning does start when the patient is admitted?**

The CARE team has been in at the front end in Emergency Department so they start the initial assessment. Then the doctor is expected to put the estimated discharge date. The CARE team are having more staff at the front end so the planning can start there.

**4.2.12 What are the challenges you face with the discharge process?**

The availability of packages of care.

The availability of homes.

Care homes are asking for top ups, which the families can't afford so that narrows down which care homes the families can choose. Then they are on a waiting list.



## Out of area placements

Continuing Health Care meetings for out of area patients can take up to 28 days to take place. The national framework allows that to happen. So that causes a delay to discharge, whereas in Stockport it will be earlier - better processes.

### **4.2.13 If you could make any changes to the discharge process what would they be?**

Increase the packages of care that are available, that's what holds people up

More therapy available - 7 days a week therapy definitely. It comes to a halt on a Friday and restarts on a Monday and that can hold somebody up. Physio and OT. We work 7 days a week since just after Christmas.

### **4.2.14 A Consultant was frustrated that information is still sent by fax rather than email. Do you agree?**

We have been trying to set up a .net group/account. The ward would need to set that up. Shared care records should be accessible between the hospital and GPs. Social workers have a different database and we can't access that. Joint records?

### **4.2.15 Apart from Intermediate Care are there other temporary arrangements that you use?**

Newlands have SMBC and CHC beds. Saffron is MH assessment. Bluebell has CHC beds too. Meadows and Medway Court. Step down and intermediate beds tend to be residential. A lot of our problems with discharge are due to lack of nursing and EMI (Dementia) places. We need more nursing placements or a place for people to stay while they are waiting for their assessments (CHC).

### **4.2.16 Are there occasions when 2 people on different wards are waiting for the same intermediate care bed? How is the choice made?**

The intermediate care and INREACH nurses make the decision.

### **4.2.17 Do you feel empowered to be able to influence change?**

Yes, our ideas are always listened to. We escalate if there are any problems. Sometimes though the delays are out of the Trust's hands when it is the delay to care packages that we don't have control over.

### **4.2.18 How effective are the 3 letters that the Trust sends to patients and their families?**

Letter 1 is just a general generic thing really

Letter 2 is 'You've chosen to do X, Y or Z so off you go.'

Letter 3 is that the Trust will find a bed

Letter 4 - We have a meeting before the letter is sent and then tell patient which care home they will go to. But the 4<sup>th</sup> letter has never really been given out 'cos it's not really effective is it? Because you have to have a home for them to go and then you'd have to ask the home to come in to do an assessment and how can you do that without asking their permission.



But sometimes the earlier letters do prompt the families. The 3<sup>rd</sup> one is often given in the meeting with the family and Age UK Stockport. If you just sent it then it would cause upset so it's better when you are there to offer support too.

**4.2.19 How are family carers involved in the discharge process?**

From the beginning all the way through they are very much involved.

**4.2.20 Does the Trust follow John's campaign?**

Yes - there are carers' passports. It's helpful to the staff to have the families there and have the wards let families in when they want to come.

**4.2.21 Healthwatch is interviewing the Chief Pharmacist - Is there anything you would want us to ask him?**

Could there be longer pharmacy cover. My daughter could have been discharged earlier from the unit. I could have come into work the next day but in the end I ended up trawling round pharmacies late at night to try and get the medication. It wasn't very late about 8pm.

At weekends they finish at 4pm and once the discharge doctor has been round then it can be that period in the afternoon when they are inundated with a lot of medication requests. We try and manage that but sometimes it can result in delayed discharge until the next day. The discharge doctor finishes at 12pm so you only have till 4pm. So longer opening times really.

It can take a few hours to prepare and administer the medication for the patient to take home which I think is a long time really.

**4.2.22 Is there anything else you would like to tell us?**

No, I think we've moaned enough!

*{There was a quick discussion about re-admissions because of social care packages not working and the co-ordinators thought that the doctors may code wrongly for admissions when it is a medical reason but doctors would code for a re-admission because of social care needs.}*

**4.3 Healthwatch Stockport Recommendations**

**4.3.1.** Healthwatch Stockport acknowledges the roles of the Discharge Co-coordinators and the Patient Trackers in the discharge process for patients needing care after they leave hospital. We recommend that the Trust improves and expands this process and that all staff involved in the discharge of patients receive adequate training and regular updated information.

**4.3.2** Healthwatch Stockport believes that the funding of equipment needed for a patient in their Care Home or the patients own home after discharge needs to be clarified and made a much easier system for the patient their family or carers to engage with.



**4.3.3.** Healthwatch Stockport would like to see the existing '*WhiteBoard*' system improved so that it works more efficiently.

**4.3.4.** Healthwatch Stockport learnt during the interview that funding and availability of Care Homes beds delays discharge from hospital. Continuing Health Care assessments could also take too long. We would recommend that the reasons for this be identified and steps taken to improve the situation.

**4.3.5.** Healthwatch Stockport recommends that increasing packages of care and increasing availability of therapies in the community would help to speed-up the discharge process.

**4.3.6.** Healthwatch Stockport recommends that the Trust look at the way information is shared between Consultant, Ward Staff, Discharge Co-ordinators, Patient Trackers and Social Workers. Data should not be sent by fax but by electronic means with the sharing of data by using a common database format.

**4.3.7.** Healthwatch Stockport recommends that there is more provision for nursing placements and suitable places for patients awaiting their assessments. **See recommendation 3.4.2 Page 17**

**4.3.8.** Healthwatch Stockport believes that the existing four letter system the Trust sends to patients (and family or carers) in the discharge process is unwieldy and contributes very little to a good discharge. We recommend that the Trust reviews this way of working to be more efficient, streamlined and effective.



## 5. District Nurses Interviews

### 5.1. Introduction

The interviews were carried out on Wednesday 1<sup>st</sup> June 2016 at Hazel Grove clinic. 10 District nurses took part in the interviews.

### 5.2 The Interviews

#### 5.2.1. How are you informed of a referral to the District Nurse Team (DNT) when a patient has been discharged?

A fax comes through and sometimes it's followed up by a phone call but this is quite rare. Sometimes the fax system works but quite often the DNT receives the fax late afternoon and needs to respond quickly e.g. go out the following day which is hard when the work schedule is already complete for the day.

*"We're not an emergency service but we are sometimes treated like we are".*

Sometimes the DNT receives a request on a Friday and the patient cannot be seen until the following week and that causes a problem. Poor referrals e.g. late in the day or without enough information like telephone numbers also causes complaints.

#### 5.2.2. How much notice do you receive of patients being discharged?

The DNT do not get notice of a discharge and usually receive a fax late afternoon to respond to patients ASAP. The discharge often happens without a referral to the DNT and thus results in irate family members. The DNT needs medical referrals but this is a "tough process".

The discharge letter is only given to the patient and therefore the DNT only become aware of the contents of this letter for the first time at the patient's house.

#### 5.2.3. Are discharged patients able to access their prescriptions and medical requirements at discharge or within 48 hours?

The DNT had no idea and considered this to be a matter between the hospital and the GP.

*"We don't have any record as it's on the GP (computer) system. It's a different system to ours".*

The DNT would benefit from generally being on the same computer system like they are at Heald Green.

#### 5.2.4. Are discharged patients able to access visits from GPs within 48 hours?

*"No idea - that depends on the GP. Some people say they can't get an appointment and some can".*

#### 5.2.5. Which other health and social care professionals do you work with in relation to discharge?



Macmillan Nurses, OTs, Intermediate Care, Social Workers, Reach Team.

The DNT have a good relationship with all these professionals.

#### **5.2.6. What works well in the discharge process?**

A clear fax with all the correct telephone numbers on it and at least two days in advance.

A system that lets the DNT know what is expected of them so that they can prepare for the discharge in advance.

*“The rapid discharge process can be wonderful but we do get a lot of poor discharges”.*

#### **5.2.7. What are the challenges in the discharge procedures?**

There is often a misunderstanding around the DNT’s remit as people think they are an emergency service. There is so much paperwork.

The DNT receives discharge faxes around 3pm to 4pm. It is sometimes urgent and this needs to be backed up by a phone call but the DNT often do not get one.

Whoever writes the discharge fax should be aware of the remit of the DNT e.g. if a patient is not housebound and can get to a treatment room then there is no need for the DNT to be involved.

#### **5.2.8. Are there differences in the discharge process when a person is discharged to residential care or is going to intermediate care? If so, please explain the differences**

The DNT was not aware of any differences. The DNT go in without any knowledge to these situations as they do not have a discharge letter and often the GP will not have received the discharge letter either.

#### **5.2.9. Is there anything you would like to see changed to make the procedures more practical, easier or more simple for the patient and/or you?**

Better communication e.g. a phone call to accompany faxes, especially urgent faxes.

Everything flows better with communication.

It would be helpful if they could also fax care plans.

It would be helpful if patients could be discharged with enough medicines, dressings etc for a few days to see the patient through the weekend as often the DNT do not have supplies e.g. some patients are discharged with burns and no bandages.

#### **5.2.10. Is there anything else you would like to tell us or any real life examples you would like to tell us about?**

The DNT are integrating with Social Services at the moment and Social Services work in a paperless environment - *“That’ll be interesting!”*



*"I had an unstable diabetic when I first started. That was a nightmare. He came out on Friday night and he was unstable. That needed intermediate care and rapid response".*

*"We need to redefine our role as we're not an emergency service."*

*"It's all...can you pop in.... there's no limit to our caseload".*

*"We're not allowed lieu time."*

*"It's the referrals that don't come that's the problem - sometimes patients wait 3 days and need anticoagulant injections etc - this becomes 'an incident' then."*

*"We are now broken down into localities and work to the postcode. We do cross over into Poynton but we're only allowed so many miles in petrol a year. If we go over 300 miles per month our mileage goes down to 7p a mile from 55p per mile."*

#### **5.2.11. Are patients in receipt of a discharge letter?**

The DNT answered yes but the DNT do not get a copy

#### **5.2.12. What sort of problems do you have with regards to discharge paperwork?**

The procedures used for the authorisation of medicines are not accurate. The DNT does not use the same medicine authorisation sheets and procedures as Stepping Hill Hospital and therefore the DNT needs to go through the process of getting them changed. Some authorisations and procedures are different and are time consuming.

*"They won't let us use emails at all - absolute joke".*

#### **5.2.13. Do you have any problems with SMBC and hiring specialist equipment?**

The DNT have a good relationship with SMBC and the providers of any specialist equipment needed for a patient.

### **5.3. Healthwatch Stockport Recommendations**

**5.3.1.** Healthwatch Stockport recommends that the discharge letter should be included in the referral to the DNT

**5.3.2.** Healthwatch Stockport recommends that the faxed referral should be followed by a telephone call from the ward to the DNT

**5.3.3.** Healthwatch Stockport recommends that a working protocol is drawn up and followed between the wards and the DNT. This would include agreed appropriate and timely notice of referrals

**5.3.4.** Healthwatch Stockport recommends that the DNT is able to access patients' electronic records in the same way GPs can

**5.3.5.** Healthwatch Stockport recommends an increase in the capacity of the DNT, this would include changes in the structure and roles within the DNT as this does not necessarily mean an increase in the number of specialised nursing staff. The increase in cost is a preventative



measure for the ongoing healthcare of discharged patients from a readmission to hospital and to keep residents well within the community

**5.3.6.** The faxed referral process changed to email referral



## **6. Chief Pharmacist at Stepping Hill Hospital**

### **6.1. Introduction**

The interview with Dr Paul Buckley - Chief Pharmacist at Stepping Hill Hospital was carried out on 24 May 2016 at Stepping Hill Hospital.

### **6.2. The Interview**

#### **6.2.1. How many staff does the Pharmacy have and what are their roles?**

- 27 Fully qualified Pharmacists who check prescriptions, dispense medicines and consult with patients on the wards
- 23 Technician Pharmacists who dispense medicines, consult with patients on the wards and check medications in ward lockers.
- 12 Support Worker Pharmacists who dispense 'simple' medicines, deliver medications to wards, engage with patients on the wards and make sure correct medications are on wards
- Admin support staff

Other Foundation Trusts of similar size to Stepping Hill Hospital have a larger number of staff in their Pharmacy Department.

The Pharmacy Department is fully staffed from 8.45am to 5.15pm every day with only a skeleton number of staff in attendance from 5pm to 7pm.

#### **6.2.2. How does the Pharmacy Department's role fit into the Discharge process for a patient?**

On admission to hospital any medication brought in with the patients is checked and recorded by a member of the Pharmacy Team and locked in the patient's bedside locker. On receipt of a patient's Discharge Prescription from his/her Consultant/Doctor the Pharmacy Department dispenses the medicines and delivers them to the patient on the Ward or Transfer Lounge.

The Pharmacy Department monitors the time taken for this process using the following Key Performance Indicators (KPI's):

- Key Performance Indicator 1. 95% delivery of medications with 3 hours of receiving Discharge Prescription
- Key Performance Indicator 2. 80% delivery of medications within 2 hours of receiving Discharge Prescription

Latest figures for the Pharmacy Department are 91% for Key Performance Indicator 1 and 79% for Key Performance Indicator 2.

#### **6.2.3. Can you describe the process for dispensing Discharge Medication to a patient who is ready to leave hospital?**

Pharmacy Ward Teams have been set up with each team covering 2 to 3 wards.



The patient's Consultant/Doctor writes the Discharge Prescription after his/her ward visit and signs the patient off as fit for leaving hospital.

The Discharge Prescription is sent electronically or as a paper copy to the Pharmacy Department.

A qualified Pharmacist checks the Discharge Prescriptions and any errors or anomalies are checked with the Consultant/Doctor.

An appropriate member of staff dispenses the medicines in the Pharmacy and medicines are then taken to the Ward or Transfer Lounge by a Pharmacy Team Member who endeavours to engage with the patient.

From receipt of the Discharge Prescription to Medication Delivery the Pharmacy Department is meeting its time limits given in Section 6.2.2. above. If the Discharge Prescription is not received by the Pharmacy Department before 5pm it may lead to the patient going home without their medication. Ideally Discharge Prescriptions should be received no later than 2pm so that all patients can go home with their medication in a timely manner.

A pilot has been carried out where fully qualified Pharmacists write the Discharge Prescriptions themselves on the Ward from the Doctor/Consultant's patient notes/discussions. This proved to be quicker and more accurate and also patient engagement was improved.

#### **6.2.4. When and how are patients advised of any side effects from the medication?**

On delivery of the Discharge Medication to the Ward or Transfer Lounge a Pharmacy Team member will tell the patient about their medication using the Pharmaceutical Company's Information Leaflets that come with it. The reasons for using the medication and the main side effects are discussed with the patient. Patient queries and concerns are answered.

The Pharmacy Department has its own leaflets on items like inhaler use and these are discussed and given to the patient where appropriate.

#### **6.2.5. Are Carers/Family Members/Friends given information or involved in the patient engagement process of handover of Discharge Medication?**

There is no formal dialogue with Carers/Family Members/Friends in the Medication handover process.

There is a need to consider raising awareness that Carers/Family Members/Friends can ask to see a member of the Pharmacy Department to discuss the patient's Discharge Medication with them.

When a patient is being discharged to an Intermediate Care Home or directly to their permanent Care Home the Pharmacy Department will ring the home and tell the Care Worker on duty about the patient's Discharge Medication.

#### **6.2.6. How is information about Discharge Prescriptions shared with Community Pharmacies and the patient's GP?**

The Discharge Prescriptions are sent electronically to the patient's GP.



There is another KPI in audit use where this must be done within 48 hours of a patient's discharge.

Discharge Prescriptions were in the past faxed to a patient's Community Pharmacy but this was stopped because of Data Protection rules. Any information needed by Community Pharmacies would now have to be managed by the patient's GP.

**6.2.7. For how long does the Medication given to a patient by the Pharmacy Department last?**

A minimum of seven days is the normal period at Stockport NHS Foundation Trust. However, some other Foundation Trusts give Discharge Medication that will last for fourteen days.

**6.2.8. Are patients given 'pill dispensers' etc?**

If patients come into hospital with 'pill dispensers' etc as part of their medication then they will be discharged with their medication likewise. Otherwise 'pill dispensers' etc will only be provided if during the Pharmacy Team's engagement with the patient such equipment is considered to be in the patient's interest.

In general the Pharmacy Department would prefer the patient to be knowledgeable about their medication and when to take it so that 'pill dispensers' are only used for patients who cannot remember how to take their medicines.

Patients with severe lack of mental capacity usually are cared for by a Carer/Family Member and under these circumstances 'pill dispensers' should not be necessary.

**6.2.9. Can the Discharge Medication be sent to a patient's Home/Care Home after they leave hospital?**

A taxi service is available but there are risks involved in its use. For example, medicine may be delivered to the wrong place/person

**6.2.10. What are the challenges facing the Pharmacy Department?**

Discharge Prescriptions from a patient's Consultant/Doctor not being sent early enough in the day.

Discharge Prescriptions containing errors, anomalies etc

Patient's not fully aware what the Pharmacy Team Member tells them either due to lack of mental capacity or fear (white coat syndrome)

Pharmacy Team not engaging with a patient's Carers/Family Members/Friends as appropriate.

**6.2.11. Are there any changes you would like to make?**

Discharge Prescriptions to be written on the Ward by one of the Pharmacy Department's fully qualified Pharmacists in consultation with the patient's Consultant/Doctor.

The Information Leaflet given to a patient on admission to hospital to include details and a contact number for the Pharmacy Department so that Carers/Family Members/Friends are



aware that they can be with the patient when discussions take place about their Discharge Medication.

NHS IT system to be developed so that Community Pharmacists can have details of a patient's Discharge Medication and in the same timeframe as the patient's GP.

#### **6.2.12. What works well?**

Pharmacy Ward Teams.

Pharmacy Department's turnaround period from receipt of Discharge Prescriptions.  
Audit system using the KPI's outlined above.

#### **6.2.13. What does not work so well?**

For patients waiting a long time for Discharge Medication or not getting it before going home blame is usually attributed to the Pharmacy Department but in reality is due to the late arrival of Discharge Prescriptions.

Turnaround times can be poor if dispensing and delivery is done between the hours of 5pm and 7pm.

The Discharge Medication requirements could be discussed with the Pharmacy Ward Team sooner than the current timeline which is usually on the day of discharge.

Anticipated date of a patient's discharge from hospital could be improved by the Trust generally.

Engagement with patients and their Carers/Family Members/Friends could be better organised, more inclusive and made aware of all the help and advice that is available.

Community Pharmacies not receiving a patient's Discharge Medication details.

**6.2.14. For vulnerable patients (for example people with dementia or learning disabilities) a Discharge Co-Ordinator is appointed with a Multi Disciplinary Team as appropriate. Does the Pharmacy Department have a role in this process?**

No.

#### **6.2.15. Is there anything else that you would like to tell us?**

The Transfer Lounge is not working as well as intended :

- Not liked by Ward staff
- Patients need information about the purpose and function of the Transfer Lounge

### **6.3 Recommendations**

**6.3.1.** A leaflet should be given to patients on admission to the ward that explains that the medication that they have brought with them to hospital has been recorded and will be taken



into account when new and ongoing medication is administered. The leaflet should also include details and a contact number for the Pharmacy Department so that family and friends are aware that they can be with the patient when discussions take place about their discharge medication.

**6.3.2.** The discharge prescription should be written on the ward by one of the Pharmacy Department's Pharmacists in consultation with the patient's Consultant/doctor

**6.3.3.** The electronic patient record should include the facility for Community Pharmacists to have details of a patient's discharge medication, not just the patient's GP.

**6.3.4.** The discharge medication should be discussed with the Pharmacy Ward team as early as possible rather than on the day of discharge

**6.3.5.** A working protocol should be drawn up, agreed and followed between ward staff and the Pharmacy Department. This would ensure that discharge prescriptions are sent early enough so that a patient's discharge is not delayed.

**6.3.6** The Pharmacy should be open the same times seven days a week rather than reduced hours at weekends.



## 7. Social Workers at Stepping Hill Hospital

### 7.1. Introduction

The Enter and View visits took place on Thursday 11<sup>th</sup> February 2016 and Tuesday 16<sup>th</sup> February 2016. Enter and View representatives interviewed patients, with the patients' permission, who were being assessed by social workers for any ongoing social care needs after discharge. Interviews with the Assistant Social Work Managers took place on Tuesday 3<sup>rd</sup> May 2016.

### 7.2. Patients Interview on Discharge from Stepping Hill Hospital

When asked about being kept up to date with the discharge process, including information regarding their medication, there was a mixed response from the patients. They also stated that the assessment process had not been explained to them but that they now knew their expected discharge date.

*"Yes, I have been kept up to date with how and when I will be discharged."*

*"Today's assessment has been mostly explained."*

*"I have one new tablet and I will be told about potential side effects when it arrives"*

*"I was told 2 days ago that I would be going home today"*

*"I am going to Reinbeck whilst I wait for a new prosthetic"*

### 7.3. Social Workers at Stepping Hill Hospital Interview

#### 7.3.1. The role of the social work team at Stepping Hill Hospital

Social workers, assistant managers of the social work team and the social work team manager were interviewed. Social workers considered their roles to ensure patients were engaged with services and the discharge process and that their needs were identified so that they could obtain the social care they require after discharge from hospital. They stated that they enjoyed their job, albeit pressured a lot of the time, they complemented the work of the AGE UK Stockport, who support where appropriate in the discharge process.

The social work manager liaises with hospital managers to try to develop good practice, manage safeguarding, deal with complaints and supervise absence.

#### 7.3.2. How does your role fit into the discharge process?

The social work team considered their role as an integral part of the discharge process in a variety of ways:

- Assess patient needs
- Advocacy for needs
- Co-ordinate the appropriate staff
- Ensure safe discharge
- Find any other gaps in needs e.g. carer's needs at home
- Liaise with social work locality team



- Any other liaisons eg with the community social workers or staff in the residential care home

*“My role is to see that patients obtain the social care they require after discharge and is vital to the proper functioning of the wards.”*

The social work manager’s role included being responsible for allocating the work, putting systems in place, ensuring that social workers fulfil their responsibilities.

### **7.3.3. Referral to the Social Work Team**

The Foundation Trust staff prepare the health and social care notification when patients will be fit for discharge within 24 hours. Referral to the social work team can come from either the family or the hospital staff within wards. Then the administration team put the patient information on to the social work system. There is a health and social care list every morning that is then allocated to the individual social workers and an update is given on each patient at the daily bed management meeting.

However, all members of the social work team that were interviewed did indicate that the wards differ very much in timing of referral to the social work team. Early identification is the rule in some wards but not in others.

### **7.3.4. Working well with other health and social care professionals in relation to discharge**

The social workers felt that therapists [including occupational therapists and physiotherapists], the moving and handling assessors, discharge co-ordinators, intermediate care nurses and mental health workers were a vital part of the team in order to provide a joined up service to meet the needs of patients.

When all partners from various teams participate in the discharge process and communication is good between all the team, the discharge process runs more smoothly.

### **7.3.5. What works well with the discharge process?**

Social workers and managers agreed that the discharge process works well when there is good communication between clinicians and the social work team. Each social worker aims to work on allocated wards so that they develop familiarity with the ward and staff, and this builds up a mutual trust.

### **7.3.6. Challenges with the discharge process**

The social workers cited that pressure for beds was a major challenge when trying to sort out discharge. Even when patients were medically fit to be discharged there were cases where social care needs were not being met or were not likely to be met for a variety of reasons. Lack of appropriate places in care homes is another challenging issue due to the availability of residential beds across the sector, family objections or top ups, which need to be found when patients are not eligible for free care.

When asked about how they follow up and ensure the packages which are put in place are implemented, the social workers felt that this was an area of concern as external care partners



take over from the point where the patient leaves hospital. Social care teams only become aware of any problems when informed by the patient or their family. Sometimes a discharge needs to be delayed until the team are satisfied that the correct set up is in place. Sometimes four calls a day from a carer must be in place but pressure for beds means a rushed necessary assessment has to be made.

Although the social work team cited communication as “what works well in the discharge process” they added that it can also be a barrier to discharge:

*“Communication is the biggest challenge: getting good information at the right time. Some people on the ward are at different stages. Everyone knows where the patient is up to, it’s just the whole co-ordination of it.”*

Another issue was assessing patients’ capacity under a duty of the Mental Capacity Act. It was said that it was a difficult process and very time consuming.

*“Social workers cannot just spend 10 minutes with the patient, they will have to go back and see the patient, as well as assess them 3 or 4 times as well as speaking to the families to obtain that background information. Again communication is at the centre.”*

The Enter and View representatives were also told that there are sometimes safeguarding issues that arise because of self-neglect.

*“Some people come in with bruises so the background has to be investigated and unpicked, this scenario doesn’t fit well with the Foundation Trust’s policy agenda of moving patients through the beds. There can sometimes be tension between Foundation Trust managers and the perspective of clinicians and working to different priorities. Risk is another challenge - infection in hospital or other risk at home - the person will have to have a certain level of understanding and the capacity to understand the risks when they are discharged and are back at home. We are discussing people who have impaired mobility and capacity, and it can be that it is in their best interests for them to go into residential care.”*

There is always pressure for community bed places: both intermediate care and residential care. The social work team repeatedly said that the placement after discharge was a major challenge. This was largely due to a lack of suitable placements in residential care as well as family objections to a proposed placement.

One social worker said:

*“There are very many (challenges) but the two most important are communication and waiting for essential equipment whilst “arguments” occur as to who is responsible for the provision.”*

The daily meeting to discuss delayed discharges was cited as a challenge. The reason given was that it took two members of the social work team. The team felt that the list was often inflated due to the fact that the Trust would not take patients off the list when they are not medically fit.

*“They put people on as delayed transfers of care when they are waiting for mental health assessments on the wards. Or they are waiting for the family to find a home funded by themselves or they (the family) are in dispute about whether the patient is medically fit. I accept they are all delay reasons but they won’t disaggregate these patients from the ones*



*that are ours. So they expect us to be involved in answering for all of the patients and it's very frustrating because if the family are saying 'We don't care, we want to meet with the consultant, we don't believe that dad is well enough to be discharged' then it is beyond our control.*

*Then we can't progress anything yet every single day it's -*

*'Where is Fred Smith up to'*

*Well, he's still waiting for his family to meet with the consultant. I have asked them (Trust staff) to disaggregate this list and they won't do it. I think it's all about trying to present a really black picture of how bad things are "40 delays transfers of care, 36 delays transfers of care." When we drill down for the Thursday conference where a social care manager sits in on a conference call with them, we generally get that 30 odd down to two or three."*

On numerous occasions the hospital social work management team referred to the amount of time spent at this meeting to be disproportionate and that they were not achieving as a service as they were not pro-active enough in managing, along with the social workers, their caseload and making sure that the actions that needed to be progressed did progress.

*"This over focus on the delayed transfer list is skewed because we do as many discharges off the list as we do on it. In fact the patients that the social workers can identify from their own local knowledge of the wards would be far more productive to focus on those patients. I am hoping the whiteboard will be more realistic. It's only going to happen if the hospital let's go of this safety blanket of assessment notice of discharge, as it's flawed and out of date. The list was done on Friday and it's Tuesday now so it's out of date already."*

The social work team also spoke about their frustration around referrals for patients who have come from a care home.

*"We do get referrals for patients from care homes but wards are told to send an assessment notification which takes our referral workers time to load it onto the system, passes to the social worker and then the social worker checks on the ward and they might be ready to go back to the care home and then the social worker checks a day later and the person has already gone back. Then the social worker has to ring the family and ask whether the patient has been OK since the discharge, then we have to ask for that to be followed up by the community SW team. We get referrals from the wards but they won't let us do a reassessment of need. Or they don't make the referral as they've already made the decision that the person will be going back to the care home and they put a lot of pressure on the care home take the person back. We do see that though the patient can be in and out from the same home. How often do we wait until we properly review? We can miss that person a few times."*

**7.3.7. The differences to the discharge process when a person is discharged to residential care, the person already has a social worker, now needs the support of a social worker or is going to intermediate care?**

The data programme system that SMBC use, Care First, shows what type of support the patient has had before admission to hospital. The process and assessment are the same but the care planning is different dependent on the care package. Every day a REaCH nurse will go to the ward and will then agree/verify the social worker's assessment. Then intermediate care in



their own home or residential care can be arranged. Placement in a residential care setting can take a number of weeks

Residential care is governed by the local community social work team and it can take up to 6 weeks to do a follow up after discharge.

If nursing care is needed then an FNC (Funded Nursing Care) screening (a contribution to the funding if someone is eligible for nursing care) assessment will take place. Some of the patients may qualify for all of their care to be paid for by Continuing Health Care. Then the social work team refer to Age UK Stockport who will start to assist the family, if they want it. Some families choose not to use Age UK, they want to go their own way and do it themselves.

*“Then the whole thing progresses from there as we know what level of care we are looking for, we explain to families about the local authority rate. We explain the implications of choosing a home with a 3<sup>rd</sup> party top up and we send them off with Age UK’s support.”*

One social worker said:

*“Since ‘person centred care’ should be designed then the destination should make no difference”*

### **7.3.8 How do you inform the relevant health and social care professionals eg. GP, District Nurse, community social worker, when there will be ongoing care?**

The Foundation Trust provides this information to the GP and district nurses. Care First alerts the community social work team and the patient will be assigned to the relevant Social Work team depending on location, ideally within the six week period.

If the patients are self-funded (private care) or informal care there is no follow-up from the community social work team. The team is trying to streamline its own internal processes including the number of documents required to be completed for various reasons.

The team spoke about patients they believed would be re-admitted:

*“Unfortunately sometimes you can see when someone is going home that it’s going to fail and that person will be back in 2 weeks. But the patient has the capacity to choose to stay at home. We flag it up to the community team to do a review and the patient does end back in hospital but the community team haven’t had the capacity to the review. Quite a lot of missed opportunities to divert people from hospital.”*

The CARE team have 3 full time equivalent social workers who try and reduce the admissions to hospital. They are based at Willow House and they are part of a multi-disciplinary team including nurses, physiotherapists and occupational therapists. They work with the Emergency Department from 8am to 8pm 7 days a week.

### **7.3.9. What would make discharge procedures more practical, easier and simpler for the staff and patients?**

It is a common occurrence that there are patients ready to be discharged but their care is not ready. This is not generally the case when patients are funded privately and things move more easily.



It currently appears that there is not adequate resource and capacity to carry out a high quality and satisfactory discharge for patients. There appears to be tension between social work teams and hospital admin and lack of accessible training and role clarification within the hospital. Patients seem to get confused by the number of people giving them conflicting information and this may be a cause for concern.

Discharge paperwork and processes take up a lot of time, therefore more time is needed to put together proper appropriate care packages tailored to patient need, particularly being able to access other services earlier so that discharge packages can be put in place.

It was suggested that community matrons would be a good role for the monitoring of complex patients. An active case manager with a health background could take more of a pro-active approach to monitor patients' wellbeing after discharge. Other boroughs and areas have outreach community matrons or advanced practitioners who have a defined case load. They are able to visit and check people, can issue prescriptions, can decide on treatment changes and keep them out of hospital. It was said that the equivalent was not available in Stockport. It was felt that on the chest wards the same people were being admitted time after time.

The Enter and View representative asked whether the REaCH (REablement and Community Home Support) team already deal with some of the issues raised in that answer. It was explained that REaCH covers short term re-ablement and this is long-term case management.

*"Somebody may not be managing their medication very well. Or I can give the example of the man who has been re-admitted and he was missing last week and he was found in the pub and not managing his medication, an active case manager could have picked up on that a bit sooner to try and address those problems."*

*"I have just been arguing the case for someone who has compromised swallow. He is going to silently aspirate at which point he will get a chest infection, lung abscess, he's got dementia so he won't comply very readily with a stage 2 diet. He won't comply with staying safe and in bed, so he will have a bad fall. His family struggle with the concept that he's so impaired that they keep returning to the theme that we promised dad that we'd never put him in a nursing home. If ever anyone needed a nursing home it's this guy. We've gone along through Best Interests, we've reluctantly agreed with the family that we'll trial him at home with every expectation that it will fail. We can't get a single care agency in this authority to take that responsibility on because it's not really a social issue, it's got a strong medical element."*

It was felt that if a patient needed to manage an ongoing condition a health and social care component was needed. A person may then be able to live at home if there is a specialist able to check on the person regularly.

The team also spoke about having a therapist involved in their assessments for intermediate care particularly on an orthopedic ward and the current frustrations with the process.

*"Once the notification of assessment is referred the OT closes their case. We think the person needs a home assessment. They used to have a manager and now they don't, so we could go to the manager but now we don't know the process. The manager has gone to the CARE team. The CARE team have been successful but I think it's because they have the therapy input. What it has highlighted to me is how important the therapy input is across the general wards. Here it is a real battle to get the therapists to do home visits. We have social workers at weekends but not the therapy cover at the weekends."*



A shared database would make administration easier as a lot of time is spent transferring information. The team repeatedly spoke of the time and effort of the Delayed Transfer of Care meetings that they thought did not particularly speed up a discharge. It was felt that the communication should be on the ward round not micro-managed in a meeting.

*“The vast majority of discharges go through unruffled. When there is a challenging situation then somebody on the ward should take responsibility for that particular person. Rather than a different nurse every day. There needs to be better communication between the nurse, patient and their families. Despite the white boards the social workers become very frustrated when they are not kept up to date if the person does become unwell again.”*

### **7.3.10 Where do the district nurses fit into the discharge process?**

The social work team had the opinion that the District Nurses were already overstretched and did not have the time to build up the relationships with their existing patients.

*“They are going from house to house. They might be going in and then they are rota’d on to go to a different area for staffing issues. So they aren’t having time to build up those relationships. The days when you had someone on your visiting list and you got to know them are just not there now.”*

However, the team spoke positively about the benefit of the Targeted Preventative Alliance (TPA) workers in the lower level cases, especially where a person is socially isolated.

*“Having a dedicated TPA worker helps. For example the environment is a bit cluttered and they are trying to sort out making it a better environment. That’s worked but again on that lower level. We have seen that the TPA workers are doing a good job in hospital. They are working beyond their remit on things that are more complex than initially envisaged. And you are going to see some knock on effect from that eventually in terms of preventing a return to hospital or preventing someone’s deterioration in certain conditions but that is going to take a long time to filter through. In the meantime what’s missing is the higher level stuff where they are already at that level. The hospital are saying that we are treating them as well as we can and they are as stable as they are going to be. How do we get them out and keep them out, that’s the question. It really is the case, because then this place wouldn’t have the pressures on the beds.”*

### **7.3.11. Are there any patients that are ready to be discharged but their ongoing care is not yet ready?**

The social work team agreed that this did happen regularly:

*“Unfortunately this is a common occurrence. If they are privately funded or the family will care things move more easily. Resource availability issues, demand for beds outweighs the supply.”*

It was stated that at any time there may be three to five patients waiting for a bed at a care home commissioned by the Local Authority. Around ten patients may be waiting for a care home of their own choice. Both these issues are a matter of capacity and are of concern.

Other reasons for the delay might be

- Waiting for Continuing Health Care meeting with multi-disciplinary team



- Around five patients waiting for the mental health liaison nurse to be involved for an assessment
- Some going through the intermediate care assessment process
- Some might be medically unwell and not ready for discharge
- Some might have been discharged that day or going the day after so they have care plans
- Some are going through the Best Interests process
- Care providers are not willing to provide care for a variety of reasons. One such example could be change in care need of the patient.

*{HW Stockport was given an email as an example of one day's breakdown of the numbers and how they are categorized}*

Members of the social work team worked through the list:

On that day the Health and Social Care list report for Stockport had 63 patients. Of those 63 patients 30 were classed as Delayed Transfer of Care (DToC), the number of patients from outside out of Stockport was 27 and 14 of those were DToC. Members of the team worked through the list with the Enter and View representative.

*"POC stands for Package of Care. So, out of those four (who were classed as waiting for a package of care) two were waiting for care that we couldn't provide. The other 2 were waiting for care but they also had equipment needs. So a pressure relief mattress that hadn't been delivered yet. So as we work through the list of 30 patients classed at DToC we actually have two patients who can genuinely be classed as DToC becomes two. That is similar week in and week out. But the overall figure shows that we have over 30 waiting and that's never really the case."*

Another member added

*"We are not moaning about it because it's onerous to do, it's just not productive. It doesn't help the Trust. The electric whiteboards were re-introduced for a simple point of truth, they weren't implemented properly. They became clinical management meetings, they became long instead of quick 10 minute meetings, consultants used it as a ward round and we couldn't supply social workers for them all at 9am. We only had half that that number. The whiteboard rounds just fell by the wayside. We would welcome the re-introduction of the whiteboard rounds but we would argue if we are doing that then we don't need the daily meeting as well."*

*"I don't know. They get an update from us, but we could do that throughout the day rather than at a set time of 11am every day. If we weren't at the meeting we would have more time to actively manage cases especially when social workers are off on annual leave or ill. It used to be just Tuesdays and Thursdays but they (the Trust) have changed the rules on this and unless the patients are on amber or green 48 hours prior to the meeting they insist that we are present and that we answer the list and as you can see it's 10 pages long today."*

*It takes us about an hour to go through it all and then we spend an hour in the meeting. Then you get to the meeting and they have different views to what's going on. But then you have tasks from the meeting and that takes another hour.*



*The good thing about the meeting is that they let Age UK Stockport have a copy of the list. AGE UK Stockport have their own list and they were finding their list was not in the same order or format.*

*For us the actions are the same if we do or don't have the meeting."*

### **7.3.12. How do you ensure that the ongoing care needed, and described in your assessment, is followed and implemented?**

This was seen as a difficult area for the social work assessors as the community social work team only take responsibility once the patient leaves hospital - this is arranged through the Care First system and a review is expected to take place within six weeks of discharge. The hospital social workers only become aware of any issues if informed by the patient, the patient's family phoning the hospital team or if the patient is re-admitted. The discharge has to be delayed until satisfied that the correct set up is in place.

Another way to check progress was through SMBC's Home Care and Choosing and Purchasing team. The social work team fax agencies who then decide whether they will provide the ongoing care needed and then that information is passed on to the social work team.

One social worker stated that sometimes they checked personally if the patient was a complex case

*"Patients with complex needs are challenging from the point of admission. I check sometimes if they are worrying me."*

### **7.3.13 What difference is made by the letters that are sent by the Trust to families explaining that the patient is "bed-blocking"?**

The social work team described how the process was not being consistently applied, as some wards do not want to do it and there was reluctance from those wards to send the letters as it would upset or antagonize families. Sometimes it is the bed managers or discharge coordinators that then have to send the letters. The social work team were unsure whether the letters made any difference to the families.

*"Even then it doesn't really have that much of a result. In reality what can they do? They (the Trust) issue the letter, the family say 'No, we are still disputing that my father is well.' Or in the case where we can't find a provider, the family say 'Look there is nowhere'"*

The different processes at other hospitals were described:

- Every patient has an assessment notice as soon as the social work team decide that they need to be assessed
- Every patient gets a discharge notice 3 days later
- That is the absolute minimum timescale

*"In other hospitals I have worked in it has been much more flexible and the multi-disciplinary teams have a realistic estimated date of discharge for this person and they have included social care in that discussion."*



An example was given of a patient who has had a stroke and therefore has had a substantial change in function. The family needed time to come to terms with it and the patient needed time to be psychologically well enough to go home and be able to make a success of it. The patient may also need specialist equipment, and the package of care needs to be planned and booked. In some hospitals this would be discussed at a multi-disciplinary team meeting and the number of days agreed how long that process would take. However at Stepping Hill Hospital it is calculated as an average of what the presenting condition has as a length of stay in the last 12 months without any room for negotiation.

*“A few years ago we did some work on Estimated Discharge Date and if a social worker challenged the timescale they didn’t like that. In other authorities the intermediate care is more health lead with a health assessment. Here SWs are expected to do a full assessment, so it’s another task that SWs are taking on. Intermediate care is jointly funded.”*

#### **7.3.14. Has the number of available beds decreased because of the Local Authority’s set rate for beds?**

The team spoke at length about their experience of the number of beds decreasing. They also explained that increasingly care home were asking the local authority to provide top up fees.

*“The number of beds at the approved LA rate has diminished. Problems have progressively been added. Started at some homes as £30 top up then £100 top up. Some can be £200 to £300 per week top up. There is a lot less choice for people in general even looking slightly out of the area in Tameside or Derbyshire. But still limited to what homes you can choose without a top up fee.”*

They also gave specific examples of care homes being able to turn down patients with equipment needs. As homes are feeling very financially pressured the social work team had experienced a couple of homes who did not want to take a bariatric patient with equipment needs. When they were challenged one home explained that the manager had been in discussion with the company’s accountant about the cost of the equipment. The accountant stated that the patient would have to survive for a minimum of 2 years before the home “broke even” so would not take the patient unless the Local Authority (LA) paid for the equipment. This was the first time the Local Authority had paid for equipment for nursing homes. The LA already pays for equipment in residential homes, if required, but usually a nursing home is expected to have a good range of equipment available. The Local Authority and Stockport CCG discussed who should pay for the equipment for the home and the CCG did pay for the cost.

Other examples were given of the CCG funding equipment of funding for care home placements if Continuing Health Care is needed. However, there was a downside to this:

*“You can imagine if you are a home that charges £100 top up and then the CCG pay that top up for 2 patients then that home will harden its resolve. We have lost that ability to bring the marketplace back down. It’s going to rise and rise.”*

The complexity of needs was also raised as a theme as care homes need the correct staff levels with the appropriately trained and knowledgeable staff. In fact some homes will decline to take a person because they know that the person’s needs will require 2 or 3 staff in the night and they do not have that level of staffing at night.



The staff from homes also visit the wards to do their own assessment and then the social work team contacts the Continuing Health Care team if the Care home are asking for a top up fee. Homes can refuse admission to someone if it can cause a detrimental effect to existing residents.

The social work team spoke about the work with some care homes to try and stop admission to the Emergency Department and the main wards which was seen as positive and had worked. However the team also spoke about some admissions that they deemed unnecessary:

*“We still see safeguarding issues where the GP is notified by the care home that the person is unwell and requests a visit. The GP sends some antibiotics, 2 days later not getting any better, and GP comes out and changes antibiotics, 2 days later still getting worse and GP sends person to hospital. That process should stop.”*

### 7.3.15 Is there anything else you would like to tell us?

The social work team all replied that although the work was pressurised they did enjoy the work that they did.

Twice the Age UK Stockport Placement team was praised for the work they do with families helping to find residential care for the patient.

The social work team stated that they increasingly had to consider the care homes that charge top-ups and negotiate on an individual basis. The number of care homes that accept people at the SMBC commissioned weekly rate are reducing steadily.

As the demand for some residential care homes is high within Stockport, including privately paying clients, care homes can afford to be choosy with the people that they provide care for. One example was given that all Elderly and Mentally Ill nursing homes had refused to take one patient.

*“Every single EMI nursing home in the area has refused a place because of how extreme his behavior is. We are absolutely stuck and we’ve now lost Marple Dale.”*

There is also an issue with provision for patients with poor mental health

*“The big impact is the MH resource, we are being asked to provide 24hr care in the community when a MH ward is more appropriate for the patient but people are waiting a long time to go to the MH ward. For example, at the Meadows.*

*Scarcity of resources at Pennine Care means that the gate criteria for access to service has risen. So that means that we now have a group of people that we didn’t deal with who have a fair degree of Mental Health problems and need quite specialist support and it is very difficult to achieve that.”*

As resources have become more stretched the social workers believed that the treatment criteria from Pennine Care had been raised

*“What they’re arguing in Pennine Care is that it isn’t severe enough to be admitted to Pennine’s service. So it’s more of a mixed picture than just being about dementia. A lot of its behavioural - the guy that I mentioned earlier, who we can’t find a nursing home for, it’s about his behaviour. Interventions haven’t been able to manage his behaviour. So he is still*



*in hospital. Care homes think 'I have 8 people on my waiting list why should I take this person with extreme behaviour when he could be such a problem to us when these other 7 will just sit in their beds.' So we are having to go out of area and that's a problem as well because we feel that families are being given Hobson's choice in terms of where their relative goes. Increasingly using Tameside based homes and Manchester. We would use Derbyshire as well but they are always full."*

There are two intermediate care pathways. The bed based service and the home based service. The social work team stated that they were increasingly receiving referrals for patients who weren't medically fit and there were still issues with the patients' general health that needed to be resolved on the ward.

*"We are being pushed that the person is ready for discharge and intermediate care have seen a slight increase in numbers of patients who are then re-admitted to hospital after a short period of intermediate care. The Trust have expressed great anger at the number of people who are being sent back within a few days, rather than reflecting on the fact that they've got some role to play in that in terms of sending people away when they are stable and when they are well, they choose instead to say 'This person has been sent back in by Marbury and Marbury won't have them back now, so that's the fault of social care.' Intermediate care is a joint service anyway. It shouldn't be contentious but they (the Trust) make it contentious."*

The social work team felt that readmissions were an issue because patients were not ready to be discharged in the first place.

*"I think if the Trust discharged patients when they are medically fit to be discharged they wouldn't have the pressures that they feel at the front door. A substantial number of people are coming back within 5 days. That really shouldn't be happening if the discharge has been managed properly - I'm not saying that it's purely the hospital and the medical side of things. There may very well be social and home support factors as well. But we need to get an understanding of those. We do keep a log of discharge issues we are aware of. That is more, for example, ambulance takes a person and because of the surroundings some slight problem with the environment they bring the person straight back to hospital which can be an issue in lots of ways."*

*"Sometimes the ambulance crew have made the decision that the person is not well enough to be returned home and the person has been brought back to hospital. We do keep a log of these. It's just that you see the same name come up again and you think 'We've just discharged them.'"*

The social work team discussed that sometimes blame for readmissions was attached to the social care team when it could have been that the patient was not medically ready for discharge. Examples were given when social workers had disagreed with clinicians.

*"If a doctor says they are medically fit then they're medically fit. That only stands on the day that the doctor says that. He can still be saying it 2 or 3 days later when the social worker replies 'Clearly he's not, I've seen this man several times. Today he's not talking to me, he's not looking at me, he's not eaten, something has changed'."*

The social work team felt that once a person was discharged they are away from the Trust's responsibility.



*“We have had quite a few people who have been referred to us after they have been discharged or they have gone to the Transfer Lounge without services being involved or in place. That is going to contribute to the re-admission rate as well because people aren’t being given the opportunity to have the support they need to keep them at home. And again the Trust will just state, “Well we’re full we need the beds.” That to me is a difficult thing really because it’s always going to come back to impact on the hospital and on the turn over and on the beds available but they’re not interested in looking at that, they’re only interested in getting people out. They are not focusing on how do we keep these people out of hospital once they are out? How do we make sure that their chances of success are at the maximum because it is so narrow the way they look at it.”*

The team also spoke about the increasing numbers of patients that needed support for their mental health needs. It was thought that there were a number of patients on the wards that had undiagnosed dementia and were therefore referred to the mental health liaison nurse and were waiting for an assessment from a doctor.

*“We are not delaying but because the person has a complex need some consultants have made comments recently that they feel that the social workers here, even though we are advocating for the person, are delaying the process and it’s up to the doctors to decide if mental health services need to be involved. So we are getting into a conflict ‘cos of the pressures on the wards. But we are doing what should have been done in the community.*

Some of the social work team had the opinion that GPs send patients into hospital in order to get quicker access to a diagnosis of dementia and this then adds to the length of stay in hospital as they are doing background work to see which health and social care professionals are already involved.

*“We are investigating if someone from CMHT (Community Mental Health Teams) is involved. Again if there was a better link and someone was in the community to follow the person through the outcome would be better. We are starting from the beginning and getting all this background information and that is the weakness for us. The strength in the community is that there is a named co-ordinator for someone who has that level of presentation, they know that patient. So when they apply the Mental Capacity Act and Best Interests they are doing it from a much better solid base than we can. I wouldn’t say we take longer to do it but we have to be more assiduous because we have no idea what the person was like before they came into hospital.”*

They also spoke about the impact of DOLS (Deprivation of Liberty Service).

*“The specialist team and the Safeguarding team do the DOLS Assessments. Sometimes that might conflict with what a social worker assessment is indicating up to that point so we might be organising a placement and then the DOLS assessor comes along and says ‘Actually Mental Health need to be involved.’ Again it’s the Mental Health part but the Mental Health doctor needs to decide if the person needs to be on a section. We’ve had the case where the DOLS assessor disagrees with the psychiatrist.”*

The social work team spoke about the reasons for the assessment notices and stated that they thought that it was a mechanical process:

*“The nurses on the ward, the ward managers and the sisters know that they are going to be questioned by bed managers ‘Have you done an assessment notice for everyone who is ready.’ There is an anxiety about not having done one, so you ring up to ask why the notice has been*



*sent for Fred Smith when he is still unconscious. 'We get in trouble if we don't.' Sometimes there are no reasons for referral just because 'We are safe now as we've referred.' Since the Care Act 2014 the form has reduced the amount of information required.*

They went on to explain about a recent referral where a reason for referral was not given. The social worker typed it all up as per procedure and then the family told the social worker they didn't want any support and it had been a wasted effort from the social worker when the ward staff could have asked the family before the referral.

**7.4.16. A referral form was shown and the only reason for referral was "Likely diagnosis of dementia".**

The social workers explained their frustration about this referral and explained that they shouldn't have had the referral until after the diagnosis. This meant that the team had to initiate the diagnostic pathway, and meanwhile the delay is attributed to the social work team.

## **7.5. Healthwatch Stockport Recommendations**

**7.5.1.** Healthwatch Stockport recommends that the system to inform patients about their assessments with a Social Worker should be improved to make the communication with patients, family and carers clearer and simple to understand.

**7.5.2** Healthwatch Stockport recommends that the Social Worker for a patient should engage with them and/or their families about their medication and explain the role of the Pharmacy Department.

**7.5.3.** Healthwatch Stockport recommends that a patient's Social Worker should be involved in obtaining as accurate a date as possible for discharge for them which gives everyone (Health and Social Care Professionals, patient, family and carers) time to organise their discharge from hospital.

**7.5.4.** The good work in ensuring communication between all parties involved in a patient's discharge should be strengthened by the involvement of the patient, family and carers from the **start** of the process.

**7.5.5.** Healthwatch Stockport were disappointed to learn that all too often the discharge process is rushed and we would therefore recommend that the current system be reviewed in order to improve this situation.

**7.5.6.** Healthwatch Stockport also found out that delays in discharge are primarily caused by lack of care beds in the community. It puts a lot of pressure on the SWT to find the right care home for a patient and as a matter of urgency we would recommend that SMBC Adult Social Care investigate with 'Stockport Together' a way to improve the availability of places which appears to be getting worse because of the financial restraints on public spending. **See Recommendation 3.4.2 Page 17**

**7.5.7.** Healthwatch Stockport recommends that additional staff and resources should be deployed to facilitate the assessment and discharge processes.



**7.5.8.** Healthwatch Stockport recommends that the medical staff at Stepping Hill Hospital take into consideration the time and effort taken to arrange community care for a patient and that this should be taken into account when deciding discharge dates.

**7.5.9.** Healthwatch Stockport recommends that the training of SWT staff should be reviewed for the discharge process and that this training should be accessible to all SWT staff.

**7.5.10.** Healthwatch Stockport recommends that more funding should be available so that patients are discharged to a care home that is suitable for them and not merely be offered the cheapest home.

**7.5.11.** We recommend that the availability of Elderly Mentally Ill nursing homes be investigated so that patients with challenging behaviours are not kept unnecessarily in Pennine Mental Wards at Stepping Hill Hospital.

**7.5.12.** Healthwatch Stockport was disappointed to learn that re-admissions to hospital after a short stay *{5 days was quoted}* in an intermediate care home were not unusual. Medical staff were apparently declaring those patients as medically fit who had additional complicating health conditions that they did not go into hospital for. Healthwatch Stockport recommends this situation should be thoroughly investigated and an audit kept on this type of re-admission.

**7.5.13.** It was also very disappointing to learn that the ambulance service have returned patients back to hospital because their destination environment was not suitable or that the patient was visibly not well enough to leave hospital. This situation should be picked up by the Ward Teams when deciding a patient's discharge. A thorough investigation of these cases is needed with an audit kept.

**7.5.14.** Healthwatch Stockport recommends that more resources should be made available in the community so that patients can be treated for conditions such as chronic obstructive pulmonary disease. We believe that this would relieve pressures on hospital beds and re-admissions. This is an important issue and is one that 'Stockport Together' should be working on.

**7.5.15.** Healthwatch Stockport recommends that the District Nurse Team should be properly resourced to cope with the high demand for medical care in the community. **See also Recommendation 5.3.5 Page 26**

**7.5.16.** After interviewing the SWT Healthwatch Stockport understood some blame was attached to them for most of the delayed discharges. For example, the Trust works to the average length of stay for a medical condition and does not necessarily take into account additional needs. Healthwatch Stockport recommends there should be a more collaborative effort of all concerned in the discharge process and we feel that this should be another initiative that 'Stockport Together' should pick up.

**7.5.17.** Healthwatch Stockport recommends that GPs should consider community based health care services before re-admitting a patient to hospital. This is important for patients who are old and have mental health issues.

**7.5.18.** Healthwatch Stockport recommends a stronger working relationship between the Community Mental Health Teams and the SWT. This would also be an opportunity for the recent Pennine Care Older People Mental Health Liaison posts that will be attached to the Community Hubs.



**7.5.19.** The SWT considered that better use of everyone’s time could be made for the meetings with the Medical Staff on the Patient Discharge List. Healthwatch Stockport understand the issues involved and feel it is worth investigating a more time efficient process.

**7.5.20.** Healthwatch Stockport would recommend that NHS Stockport Foundation Trust audits the admission rate in the Emergency Department and its wards to ascertain if certain care homes have higher admission rates.

**7.5.21**Healthwatch Stockport recommends that SMBC includes a “timely assessment for a person in hospital” performance indicator with contracted residential care homes so that patients awaiting discharge are seen in a timely manner by the potential provider.



## 8. General Practitioners

### 8.1. Introduction

The GP's were visited at one of their Local Medical Committee meetings on Tuesday 17<sup>th</sup> November 2015. The Enter and View representatives gave a short presentation about Healthwatch Stockport, its Enter and View activity around the Discharge process and obtained verbal feedback from the 15 GPs who attended. The GPs then also completed questionnaires which were returned to the Healthwatch Office via the Chair of Stockport LMC.

### 8.2. Questionnaire Findings

There appears to be a wide variation as to how GPs are informed of a patient's discharge from hospital. Some are informed electronically via Docman, some by letter and many by the patients themselves when they phone or bring in their Discharge Summary documents.

More than 50% of the GPs who responded said they were unaware of the prescribed period for receiving the patient's Discharge Summary. Most do not feel they receive the information in a timely manner. 50% reported not receiving a Discharge Summary until a week or more after the discharge date and sometimes they have to chase the hospital for documents. The Discharge Letter is not always accompanied with copies of the medical report giving details of a patient's treatment and medication.

GPs feel that due to the delay in receiving the Discharge Summary it can often be difficult to ensure that patients are able to access prescriptions outlined by the hospital. Most feel that patients should be discharged with 7 days' supply of medication to ensure that there is time to make changes to the patients' records. Sometimes community pharmacists receive a copy of the discharge medication before the GPs receive the hospital Discharge Summary.

GPs work with many other health and social care professionals in relation to patients' discharge from hospital - district nurses, pharmacists, occupational therapists, patients, carers, health visitors, social services, care/nursing homes. It was unclear in the feedback as to how the Discharge Summaries linked these services. However, a delay in receiving Discharge Summaries could compromise the patient's overall care.

The discharge process only works well if the Discharge Summary and any medication changes are received in good time and GP action is outlined clearly. If urgent action is needed by the GP a fax is sometimes sent through to the surgery for urgent action. However frequently letters arrive 2 weeks after discharge asking to repeat blood tests 1 week after discharge - this is given by GPs as an example of when an urgent fax should have been sent on the day of discharge.

Where patients are discharged to a care setting the outpatient follow up appointment is often missed as the letter is sent to the patient's home address. When patients do attend outpatients their prescriptions are being directed to the GP instead of being dispensed at the hospital pharmacy.

An example of good discharge practice is highlighted by the GPs as Salford Royal Hospital Discharge Summaries. One GP did comment that the re-designed form from Stepping Hill Hospital is now better. Several GPs did however comment that many of the negative points have been put to the Trust before with a very poor response.

GPs feel that complex and multiple medication changes, particularly for older people and those with dosette medication, should be discussed with the patient's community pharmacist so that



they can prepare the dosette box in advance to avoid any last minute *“I’ve ran out of my tablets given to me in hospital”*. These patients are sometimes sent home with multiple boxes of tablets without any discussion with their pharmacist. This can take up a lot of practice time particularly if GPs have not received the discharge summary.

Delays by the secretarial services in sending out dictated letters especially following outpatient appointments are an issue. Actions included in these letters are often not initiated until the letter is typed out and sent. This leads to lots of wasted time for GPs, their staff and patients chasing up letters. It sometimes wastes the next outpatient appointment, the consultant and patients’ time due to further investigations and changes needed not having taken place.

### **8.3. Healthwatch Stockport Recommendations**

**8.3.1.** The Trust needs to ensure that a process is in place to ensure that all discharge summaries are sent to GPs in an agreed timeframe to ensure safe continuity of care

**8.3.2.** An electronic system linked to GP practices would ensure information is received quickly rather than relying on typed information which are subject to delays within the postal service

**8.3.3.** Patients should be issued with one week of any medication prescribed on discharge

**8.3.4.** Complex medication should be distributed from medicine dispensers and the hospital pharmacist should discuss this with the patient’s community pharmacist

**8.3.5.** Urgent emails to GPs should be used as standard to highlight any actions needed within one week of discharge

**8.3.6** When patients are discharged to a care setting the patient’s notes should clearly indicate this so that any follow up appointments are sent to the correct address

**8.3.7.** Examples of good practice at other Trusts should be sought and shared to improve the process



## 9. Marbury House - Intermediate Care Home

### 9.1 Introduction

The interviews were carried out on Friday 23<sup>rd</sup> October 2015. The Enter and View Team spoke to 9 residents and 7 members of staff.

### 9.2 Residents Interviews

Marbury House is registered to provide intermediate care and accommodation for up to 41 people who require care, support and rehabilitation following hospital treatment before they either return to their own homes or transfer to a long-term care setting.

The majority of the residents spoken to were transferred from Stepping Hill Hospital following either orthopedic operations or falls. One did however live in their own home and came for day care 7am to 4pm. The person is a relative of a member of staff and came for social interaction.

Most residents did not know how long they would be at Marbury House. When having physiotherapy many assumed that they would be assessed in their own homes to make sure they would be safe once they left Marbury House and returned home.

It was unclear from the residents' responses whether they were given a choice of care home. It appears that social workers at Stepping Hill hospital discuss the issues with the patients and their relatives when they are ready for discharge and advise them of their options.

All the residents stated that they were transferred to Marbury House by ambulance, with some arriving as late as 7pm. Not all resident were given notice of being transferred.

On arrival at Marbury House the residents felt that the staff were expecting them and knew about their hospital treatment.

The staff highlighted issues around patients not being discharged from hospital with the walking aids they had been using. Also they are sometimes advised that a patient only needs one carer when in fact they need two. This puts a strain on staff resources.

One resident was unhappy to find that the staff could not change his spinal brace. There had been incorrect information given to Marbury House that the man had a neck brace which would not have been an issue.

Healthwatch Stockport has been told that Marbury House does not have a formal admissions policy so it has been difficult to assess the process against criteria.

None of the residents remembered personally being given a written discharge letter detailing their care and medication when they left the hospital. Some said that relatives were given one or the ambulance staff were given one to give to the staff at Marbury House.

The majority of residents thought their medication was the same as when they were in hospital and that they received it as prescribed.

Most of the residents were seen by the home's GP within 48 hours of being admitted. They felt that the care they were receiving was the same as in hospital and was relevant to their medical condition.



The majority of residents were happy with the care and treatment they were receiving, especially from the physiotherapist. They liked the home and cheerful staff.

### **9.3. Staff Interviews**

Residents who need to attend hospital appointments are not accompanied by the care home staff but the staff do arrange appropriate transport for them. Sometimes the residents have long waits at the hospital and the staff say that can prove very distressing for the residents.

The staff described having detailed discharge information available to them when they receive the patients. This is usually faxed in advance by a social worker but sometimes not in a timely manner. All staff who were interviewed felt it was easy to implement the residents' care plan and to ensure all the dietary requirements were met.

The staff described some minor issues around medication on discharge from hospital. These included medication not sent with patients and being unsure when the last doses were administered. A call to the hospital usually easily rectified these issues. They describe being very vigilant on checking medication because in the past they have been handed someone else's details.

### **9.4. Healthwatch Stockport Recommendations**

**9.4.1** Healthwatch Stockport recommends clarity on the funding and insurance for Marbury House to cover day care as well as intermediate care

**9.4.2** Healthwatch Stockport recommends a formal admission policy including a tool which the staff could complete to ensure all patients that are admitted arrive with everything they require for them to be safely cared for ie medication, discharge letter, walking aids, care plan. This would enable an audit which could be shared with the hospital to improve the discharge and admission process

**9.4.3** Healthwatch Stockport recommends an agreement with the hospital regarding a time after which patients cannot be admitted to Marbury House to ensure they receive the best quality care. This could be incorporated into the admission policy.

**9.4.4.** Healthwatch Stockport recommends that a copy of the discharge letter being given to the patient personally unless they are deemed not to have capacity

**9.4.5.** Healthwatch Stockport recommends clarification with the hospital whether patients should be discharged with the appropriate walking aids. Does the funding for these tie in with NHS Stockport Foundation Trust, Stockport Metropolitan Borough Council or Marbury House?

**9.4.6.** Healthwatch Stockport recommends a policy for when residents are required to attend hospital appointments. Family or friends may be asked to accompany them to avoid any distress.



## Distribution

This report will be distributed to the following:

- Local Authority Quality Team
- Health and Wellbeing Board
- Health & Wellbeing Scrutiny Committee
- Adults and Housing Scrutiny Committee
- LA contracting department
- Safeguarding Board
- Clinical Commissioning Group commissioning Body
- Care Quality Commission
- Healthwatch England
- Voluntary Organisations [state which ones]
- Other
- Healthwatch Stockport website [www.healthwatchstockport.co.uk](http://www.healthwatchstockport.co.uk)
- Council's My Care, My Choice website



## About Healthwatch Stockport

Healthwatch is an independent consumer champion created to gather and represent the views of the public. Healthwatch will play a role at both national and local level and will make sure that the views of the public and people who use services are taken into account.

Healthwatch Stockport is a membership organisation run by volunteers with an interest in health & social care.

They are supported by a team of staff to offer help to members carrying out activity on behalf of the organisation. Healthwatch Stockport is part of a network of other local Healthwatch organisations and is supported by Healthwatch England, a national body.

**Healthwatch Stockport has been given powers in legislation to help them carry out their role. These include being able to:**

- Enter & View places where publicly funded health and social care takes place;
- Promote and support local people to be involved in monitoring, commissioning and provision of local care services;
- Obtain local people's views about their needs for and experience of local care services;
- Tell agencies involved in the commissioning, provision and scrutiny of care services about these views;
- Produce reports and make recommendations about how local health and care services could or should be improved;
- Have a seat on the local authority statutory Health & Wellbeing Board where they are an important contributor to the local work on reducing health inequalities;
- Help Healthwatch England carry out its role as national champion by telling it about the views and experiences of local people;