



WANDSWORTH LOCAL INVOLVEMENT NETWORK (LINK)

IMPROVING THE PROVISION OF HOSPITAL DISCHARGE AND AFTER CARE IN WANDSWORTH (Executive Summary)

"I know my way around the system – but I was shocked by the poor discharge arrangements made for my neighbour. I felt that my neighbour could have returned home with support from her GP... but she was inappropriately placed in a care home."

"When I was about to be discharged my husband and carer had not been informed - so I contacted them myself."

"I am satisfied with the discharge process. I knew well in advance when I would be going home."

December 2010

Summary

Why we looked at how people experience hospital discharges

The hospital discharge process can be a critical time for patients and their carers. After a period of illness they may be suffering from temporary or permanent impairment and may need assistance not previously required (including physical adaptations to their home and support services) in order to resume living at home. Alternatively, they may need to move to a care or nursing home. Discharge can thus be a point of 'life crisis' and so needs to be handled with the full involvement of patients and their carers.

We wanted to know how people in Wandsworth experience this important process.

What we did

Our study involved

- holding two fact finding days with health and social care staff involved in the hospital discharge process to understand current policy and practice
- the LINK Enter and View team undertaking two visits to St George's Hospital, talking to patients expecting to be discharged that day
- conducting 31 interviews with Wandsworth residents who had recently experienced the discharge process or were carers of such people
- talking to senior managers in health and adult social care to understand current issues and plans
- holding open meetings with LINK members and others to get their views

What we found

More than half the people we interviewed said that their experience of hospital discharge had been unsatisfactory. Despite noticeable efforts in some hospitals, there remain a number of recurring problems;

- delay
- lack of communication with the patient and their carer or between staff
- a lack of coordination between the hospital, community health services, and the providers of social care services whose services are critical for the patient's recovery in the post-discharge period

We found that the Wandsworth health and care system is working in a climate where all concerned are trying to improve their practice and do their best within tight resource constraints.

However, we also identified two dominant and rather separate cultures; the world within the hospital and the world of services provided to support people at home or living in a community setting.

What we think needs to be done to improve the hospital discharge process for patients and carers in Wandsworth

Our main recommendation is that there needs to be much more continuity throughout the whole patient experience - linking both the in-patient and community after-care phases.

We think all agencies have a responsibility to improve discharge practice and achieve a broader understanding of patients' needs;

- hospital discharge must be given greater attention as a priority in improving the work of hospitals and community services
- the role of the Discharge Coordinator must be extended to cover weekends and strengthened to include the task of ensuring that important after-care arrangements are in place
- there must be better communication between hospital and community services staff and the patient and their family and/or carer of the plan for the patient's discharge

- there needs to be greater coordination between hospitals, social care providers, and community health services
- GPs should take greater responsibility for patients of theirs who are discharged from hospital

We are of the view that the lack of coordination and ownership of the responsibility for the patient are the biggest challenges.

What next?

Wandsworth LINK intends to bring together key managers from all the health and care agencies in order to discuss the ownership of action on each of our recommendations.

We have specific recommendations for individual agencies in the process

For St George's / Queen Mary's / Kingston / Chelsea and Westminster Hospitals

- Wherever the patient's medical condition allows it, forward planning of discharge should take place to ensure that there are no delays in discharge, in providing medication, transport or writing discharge summaries
- Discharge should not be postponed overnight if everything is in place for discharge
- The patient, his family and/or carer should be informed about discharge plans well in advance to enable them to make preparations accordingly. The communication of the discharge plan to the patient and family or carer should be recorded
- Hospital staff should consider the patient's home situation and the housing situation when planning each hospital discharge
- At discharge, all patients should be given a discharge summary which is copied to their GP. The information given to the patient should include written guidance on how best to recover as quickly as possible, what to expect and whom to contact if the patient is in doubt about their recovery
- Discharge Co-ordinators should receive more training on the role of social care assessment staff (care managers) and community support services

- The Discharge Co-ordinator should routinely make telephone contact with the discharged patient 2-3 days after discharge to check if the discharge arrangements are working out well. The Discharge Coordinator must ensure that the patient's GP is informed
- It is imperative that the work of the Discharge Coordinator is extended to cover weekends as well as week days

For NHS Wandsworth and Wandsworth Council Social Care Commissioners

- GPs must take more responsibility for their registered patients post-discharge. Especially where the patient was hospitalised as a result of a referral by the GP, the GP should contact the patient within 2-3 days of discharge
- The focus given to hospital discharge at St George's is something we would like to see in all hospitals. Such focus should be given bearing in mind the need to work in conjunction with Community Services
- Processes should be put in place for periodic review and monitoring of hospital discharge processes and practice
- More attention needs to be given to communication between hospital staff and the co-ordination of services by all health and social care staff
- Community services, including physiotherapy, should respond quickly and within a week at most if needed by someone discharged from hospital

For South West London and St George's Mental Health Trust

- Inpatient mental health staff should ensure patients are introduced to staff from community mental health services to ensure a seamless hand over
- A record should be kept of any shortfall in resources (community support services) that delay discharge of mental health patients. This information should be used by all the agencies to make the case for resources and so ensure the availability of the full range of community support services