

What happens when people leave hospital and other care settings?

Findings from the Healthwatch network

October 2017



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About us

Healthwatch is the independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care.

We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. We also help people find the information they need about services in their area.

We have the power to ensure that people's voices are heard by the government and those running services. As well as seeking the public's views ourselves, we also encourage services to involve people in decisions that affect them. Our sole purpose is to help make care better for people.

Role of local Healthwatch

There is a local Healthwatch in every area of England. They provide information and advice about publicly-funded health and care services. They also go out and speak to local people about what they think of local care, and share what people like and what could be improved with those running services. They share feedback with us at Healthwatch England so that we can spot patterns in people's experiences, and ensure that people's voices are heard on a national level.

Where our evidence comes from

The evidence in this briefing has come from a range of reports, surveys, forums, discussion groups and visits made by Healthwatch across the country over the last two years. As a result, some of the individual issues raised in specific reports may have been addressed at a local level, but they have been included here to illustrate the problems being experienced across the country.

The list of those who have shared their experiences with local Healthwatch includes people in the process of leaving hospital, their relatives and carers, as well as frontline NHS and social care staff and service managers.

Discharge from hospital is not just a single point in time, but an ongoing process that requires thought, planning and support before, during and after the event. Because of this, local Healthwatch often gather evidence about hospital discharge procedure during visits to other services, including GP surgeries and care homes.

Local Healthwatch have a legal power to carry out 'Enter and View' visits to health and social care providers - meaning that they can visit formally in order to see services in action and advise those in charge about how people's experiences could be improved.

Any visit conducted by a Healthwatch must not affect the care, privacy or dignity of the people for whom the service cares. Local Healthwatch only have the right to visit communal areas of a service. The 'Enter and View' power does not apply to places providing social care to people under the age of 18.

Executive summary

Thousands of people treated in hospital every year are kept in longer than medically necessary because of administrative delays or a lack of available care in the community.

This causes unnecessary distress for patients and places additional strain on the NHS.

Yet tackling the underlying reasons for the delays, whilst also ensuring every patient has a positive and safe experience of being transferred between services, is not straightforward.

To find out more, the Healthwatch network collected and reviewed 3,200 people's experiences of leaving hospitals and other health and care settings in 2015.

We focused specifically on people in vulnerable circumstances, including older people, patients with no home to go to, and those with mental health conditions. The stories shared with us highlighted both the human and financial impact when discharge goes wrong.

Although the evidence was hard to hear at times, our [Safely home](#) report played an important role in galvanising much needed system-wide leadership. Since publication we have seen encouraging changes at both a national and local level.

However, with a rising population of elderly people, and the cost of care going up it's not surprising that key indicators of poor patient experience such as the numbers of delayed transfers of care have hit record levels.

To help assess progress from the patient perspective two years on from *Safely home*, this briefing brings together what 46 local Healthwatch have heard from over 2,000 people about the discharge process since.

Whilst we have heard numerous positive stories about people's experiences transferring between hospitals and care in the community, it is clear that there is still significant work to be done to ensure discharge is a good experience for everyone. In particular:

- People still don't feel involved in decisions or that they have been given the information they need.
- People continue to experience delays and a lack of co-ordination between services, highlighting specific problems with being given medication and transport services.
- People feel left without the services and support they need after being discharged.

We explore these points further in this briefing and highlight where local Healthwatch have been working with partners across health and social care to make changes. If adopted more broadly, these examples have the potential to improve people's individual experiences and ease some of the broader pressures on the NHS.

We also explore the need to carefully evaluate the introduction of such initiatives, in particular the new target to reduce delayed discharges set out in the Mandate to NHS England, to ensure they are having the right impact.

Finally, this briefing seeks to outline how the move towards greater integration of services provides a perfect platform from which to fix the discharge problem once and for all.

Why this matters

Kate's story

Kate's mum was admitted to the local hospital with fluid on her lungs. She received what Kate described as "fantastic care and attention" from the staff.

However, after a previous experience where her mum was kept in the hospital for 10 days longer than needed whilst a care package was arranged, Kate was already anxious about the plans for her mum's discharge.

She tried to speak to a doctor about what support her mum would need after leaving hospital but despite repeated requests she was not able to speak to anyone.

Talking to [Healthwatch Hillingdon](#) about her mum's discharge Kate said:

"Mum was given the Friday as a discharge date. I arranged with the hospital that she would be brought home in the hospital transport ambulance at 4pm as I had arranged for two carers to receive her at her house. This was necessary as Mum cannot walk, is very deaf, diabetic and needs support.

"For some reason the hospital transport ignored this instruction and took her home at 2pm. They took the key out of her key safe and let themselves in, dumping my Mum on the bed. They left her alone without a drink or any support.

"She rang my aunt who lives far away. My aunt tried to get hold of the carers to go around straight away but they couldn't, so she was left disorientated and alone for two hours.

"I'm really not happy about this as my mum is 80 years old and it is disorientating enough coming out of hospital, but to be dumped on a bed and just left is not how an elderly person with multiple health conditions should be treated."

Kate was just one of 172 patients and family members Healthwatch Hillingdon spoke to, as well as staff from 20 local organisations, to inform their 2017 report.¹

Patricia's story

75-year-old Patricia's experience was very typical of what [Healthwatch Leicestershire](#), and many other local Healthwatch, have heard about coordination and communication problems during the discharge process.²

"I was asked to vacate my bed space by 11am for a new admission, so I stayed in a day room for six hours only to be told that my medication and discharge letter was not complete.

"I had to prompt the staff to give me antibiotics whilst waiting in a day room so that no doses of medication were missed but they had nothing for me.

"I felt very unwell in the day room on a chair for six hours and by the time I got home I felt more poorly than before I was admitted.

¹ Healthwatch Hillingdon, [Safely "home" to the right care](#), February 2017. Where requested case studies have been anonymised.

² Healthwatch Leicestershire, [The lived experience of hospital discharge](#), March 2017.

“My son took me home and had to pick up my medication at 6am the next morning from the hospital.”

Margaret's story

As part of an independent two year study tracking the experiences of patients in the first few months after being discharged, [Healthwatch Lambeth](#) and [Healthwatch Southwark](#) documented 92-year-old Margaret's story of her journey from a fall to recovery.³

“After four weeks in hospital I'm glad to be home. But things aren't easy, just going home from the hospital was exhausting, physically and emotionally.

“There was so much that needed to be sorted out at home, and at the hospital. A new bed in my lounge, carers, hospital transport, then there was a delay with the nurse getting my medicines so the hospital transport driver had to hang around and the carer had a wasted first visit.”

Week 1 - “This week has been really difficult with people visiting all the time. Carers, physiotherapists, district nurses, people coming to talk to us about how to make things easier. It was so frustrating when a different carer visited and we had to explain everything all over again.”

Week 2 - “Two weeks after leaving hospital and we are still having trouble getting hold of incontinence pads. My daughter's exhausted from chasing everyone, the blood tests, the foot clinic, sorting out a replacement mattress. Nothing seems organised or easy. Looking after me isn't easy, she's having to sleep on the floor beside my bed.”

Week 3 - “I'm in hospital again, a problem with fluid coming from my legs. They've given us a leaflet with information about keeping my legs raised. Maybe if they'd done this when I left hospital I wouldn't have had to come back. Still no incontinence pads.”

Week 4 - “Hospital again! When will this end. I feel so unwell. Am I dying? They've given me an appointment with the stroke clinic, but no one's told me I've had a stroke. Maybe I have cancer and they're hiding it from me.”

Week 5 - “We are still having problems with appointments, making them and people turning up. Why is it so difficult to get to see people. Even the GP doesn't seem to care. Although my daughter is speaking to him every couple of weeks now.”

Week 6 - “I'm starting to feel better. The pharmacist said the tablets I'm taking for the pain might be making me feel ill. Why didn't one of the doctors or nurses tell me? Changing my tablets has made such a difference.”

Week 7 - “The social worker suggested respite care so my daughter gets a rest. We don't want that.”

Week 8 - “Finally we have an appointment at the foot clinic.”

Week 9 - “Two and half hours messing around with hospital transport services for a 5 minute appointment. Is it worth it?”

³ Healthwatch Lambeth and Healthwatch Southwark, [Going Home](#)

Week 10 - "I'm feeling better. But the system seems to work against us. It's all chasing and waiting. People we've seen have been lovely but we just haven't been given enough info or told how to get things sorted."

Following the research project, Healthwatch Lambeth and Healthwatch Southwark worked with their local Clinical Commissioning Group (CCG), to share their findings with over 150 staff, including local health and care leaders, GPs, pharmacies and the community and voluntary sectors. This is helping to reinforce why getting discharge right is so important.

The national picture

In the last two years the number of bed days lost because the NHS can't discharge patients who are ready to leave has risen by over a fifth.

Every part of the health and care system must now focus on working together to reverse this trend.

Our 2015 *Safely home* report helped to galvanize system-wide leadership on tackling the underlying problems, but it is clear that the challenge is growing.

As a result the issue has come under increasing scrutiny, both by the media and by Government.

Discharge in numbers

- In July 2017, the latest month for which data is available, an average of 5,861 NHS beds a day were occupied by patients who didn't need them.
- This is up 23.4% compared with July 2015 when we published our original report.
- Last winter the delayed transfer of care figures hit an all-time high with an estimated 5.6% of the 131,000 NHS beds occupied by people who no longer needed them.
- The majority of delays are still caused by the NHS (55.9%).
- There has been a significant increase in the number of delays attributed to social care services, which now represents 37.4% compared with 30.4% two years ago.

A new target

In March 2017 the Government introduced a new target in its Mandate to NHS England, calling on them to lead the way in reducing the level of bed days lost to 3.5% by September 2017.⁴ Whilst the Mandate only legally applies to NHS England, the government has made clear that it expects local authorities and other NHS partners to play an equal part in meeting this target.

We will not know until November 2017, when the official figures are released, whether or not this target has been met, but based on current progress key commentators, such as NHS Providers and the King's Fund, have already said they don't think it is likely.

It was always going to be a tough ask. After all, the last time delayed transfers were at 3.5% was the first quarter of 2014/15. The important thing is that the ambition is in the right direction, with

⁴ Department of Health. [The Government's Mandate to NHS England 2017-18](#), March 2017, p20.

Government sending a strong message to the NHS about the need to focus on this particular challenge.

To help, in the 2017 Spring Budget the Government announced an extra £2 billion of funding for social care services to be spread over the next three years. Although this money was not solely invested to help the NHS, it was in part provided to increase capacity in social care and enable local authorities to do their bit. The government set a clear expectation that both sectors would free up 1,250 beds each through reducing delayed discharges. In August government ministers wrote to every local authority area, CCG and NHS trust with an individual target for each of them in order to achieve this expectation. Health and Wellbeing Boards have a key coordinating role in achieving this target.

In July 2017 the Department of Health also asked the Care Quality Commission (CQC) to conduct a series of local system reviews to assess how well people are moving between health and social care services. Whilst one of the key areas the reviews are looking at is how people are discharged from hospital, it is also encouraging to see the CQC looking at the wider context, including how preventative measures are being used to keep people out of hospital in the first place and how local services are working to reduce costly and avoidable readmissions.

What are delayed discharges?

According to NHS England, a delayed discharge (also called a delayed transfer of care) occurs when a patient is ready to depart from care and is still occupying a bed.⁵ A patient is ready for transfer when:

- A clinical decision has been made that a patient is ready for transfer **AND**
 - A multi-disciplinary team decision has been made that a patient is ready for transfer **AND**
 - The patient is safe to discharge/transfer.
-

Integration of services

Discharging patients effectively is not just about freeing up beds and getting people home safely. It is about getting people in the right care setting as quickly as possible to aid recuperation and recovery following treatment.

It is well recognised that keeping patients in acute care settings for long periods of time increases their potential exposure to infections and, particularly for older patients, can result in significant muscle wastage.

Many of the Sustainability and Transformation Partnerships (STPs) are therefore looking to reduce the number of acute beds in favour of providing more community-based services.

For example, the STP for Staffordshire and Stoke-on-Trent is looking to review the number of hospitals needed across the area and to develop a series of highly efficient seven-day elective centres to separate urgent and planned care. To make this work they have set an ambitious target of reducing delayed transfers of care to just 25% of capacity by 2020/21.

⁵ NHS England, [Monthly delayed transfers of care situation reports: definitions and guidance](#), October 2015

With fewer beds potentially available in the future, it will become increasingly important that local areas are able to manage the flow of patients around the local system effectively. There will be no room for services to consider their responsibilities for a patient's recovery in isolation or for protracted disagreements over who picks up the bill.

From an individual's perspective this should result in better communication between services and a more joined up approach focusing on what is right for the patient.

As a result, we have long argued for discharge, and particularly people's experiences of the process, to be introduced as a metric for tracking how well services are integrating with each other. We will be looking to encourage take-up of this approach as part of our work supporting the 'Accountable Care Systems'.

The Healthwatch network's contribution

To develop *Safely home*, the Healthwatch network spoke to over 3,200 people about their experiences of being discharged, including 300 with mental health conditions, over 200 people who had experienced homelessness, and 1,000 older people.

Making the case for change

In preparation for the launch of the report we hosted a joint event with the Department of Health, bringing together key leaders from the NHS, social care, the voluntary sector and other areas that have an integral role to play, such as housing.

Armed with the often heart-breaking stories people had shared with us, as well as the solid financial case for change, we used *Safely home* to galvanise a system-wide commitment to address this problem, which had previously been lacking. This saw the creation of a Department of Health led cross-system programme board to keep the conversations going at a national level.

As the issue has grown we have seen a whole range of organisations, including NHS Providers, the Parliamentary and Health Services Ombudsman (PHSO), and the National Audit Office (NAO), draw on our initial findings as they have made their own case for change.⁶

Ultimately the weight of evidence, instigated by *Safely home*, has led to scrutiny by both the Public Accounts Committee and the Public Administration and Constitutional Affairs Committee.⁷

This work culminated last autumn as we made our recommendations for what should be included in the Mandate to NHS England for 2017/18. Using our status as a statutory consultee on the Mandate, we argued for the inclusion of a strong commitment to addressing the problem of delayed and unsafe discharges.

We were therefore encouraged to see the 3.5% target introduced, but this is only the start. We will now monitor the situation to ensure this renewed focus has a positive outcome for patients.

⁶ NHS Providers, [Right place, right time, better transfers of care](#) December 2015; PHSO, [A report of investigations into unsafe discharge from hospital](#), May 2016; NAO, [Discharging older patients from hospital](#), May 2016.

⁷ Public Administration and Constitutional Affairs Committee, [Follow up to PHSO report on unsafe discharge from hospital](#), September 2016; Public Accounts Committee, [Discharging older people from acute hospitals](#), November 2016.

What is an unsafe discharge?

An unsafe discharge is when a patient is transferred before it is clinically safe, or without appropriate support in place to allow them to cope at home or in another care setting.⁸

Although there are national statistics that tell us how many delayed discharges occur, there are currently no statistics that look at the number of unsafe discharges.

One way to start to quantify the number of unsafe discharges would be to conduct further analysis of the data available regarding emergency readmissions (when a patient is subject to an unplanned admittance to hospital within 30 days of having been discharged).

Whilst we acknowledge that not every emergency readmission is the result of a poor decision to discharge, understanding the reasons behind readmissions could provide useful insight.

Practical support

Since the launch of *Safely home* we have supported the introduction of a number of discharge focused initiatives led by our national partners.

For example, we worked with NHS England to develop guidance for hospital staff, including new quick guides - one on helping patients to understand their choices when being discharged to a care home, and the other on implementing 'Discharge to Assess'.⁹

These have been incredibly well received by staff, giving them the confidence to work with patients when developing discharge plans and inspiring the creation of multi-disciplinary teams to speed up the process of both assessing patients and getting their place of residence ready for them to return home as soon as possible.

We have promoted the roll-out of best practice initiatives like 'Red2Green', where hospitals aim to reduce the number of 'red bed days' - days which don't contribute to a patient leaving hospital - by encouraging staff to constantly challenge inefficient processes and break down barriers between departments.

We have also provided practical support for local Healthwatch to help them work with health and care providers looking to improve the way they transfer patients.

In total 46 local Healthwatch have continued to pursue this issue, sharing 2,083 people's experiences with local services about how they could make things better.

From this insight it is clear that three of the five key themes from our original report continue to come through strongly:

- Information and involvement;
- Coordination between services;
- Support after discharge.

⁸ <https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/97/97.pdf>, September 2016.

⁹ NHS England [Improving Hospital Discharge into the Care Sector](#), November 2015; [Discharge to Assess](#), October 2016.

However, this does not suggest the other two original themes, regarding stigma and the requirement for every one of a person's needs to be considered, have gone away. Drawing evidence from more than just the three groups looked at in *Safely home* - older people, people with mental health conditions, and people without homes - means these issues have just come through less strongly.

Where evidence has been shared by people in more vulnerable and complex situations, these themes do still come through and we would be keen to hear from these individuals, as well as those organisations who represent them, on what they feel may or may not have changed over the last two years.

What people said

In this section, we share what local Healthwatch have heard from their communities since our 2015 report and outline how people want to see departures from care improve.

Information and involvement

Individual patients, their families and carers should all have an opportunity, where appropriate, to be involved in decisions about the discharge process. It is also vital that all those involved are provided with clear and consistent information.

[Healthwatch Suffolk](#) raised concerns with their local hospital in 2016 after they heard that poor discharge planning processes, and particularly a lack of patient involvement, were having a negative impact on continuity of care and the level of support for carers.¹⁰ They also found that information that should have been given to families about managing symptoms, possible side effects of new medications or who to call for advice out of hours, had not been made routinely available.

Since Healthwatch Suffolk shared its insight, a daily teleconference has been established between the hospital's discharge planning team and the area's CCG. This group has a specific remit to discuss all cases awarded NHS continuing healthcare funding that are either waiting for care packages to be started or care placements to be found. This will help to improve communication between the discharge planning team, patients and their families and carers.

Throughout early 2017, [Healthwatch East Riding of Yorkshire](#), [Healthwatch North Lincolnshire](#) and [Healthwatch Kingston-upon-Hull](#) worked together to develop a regional understanding of patients' experiences of being discharged from hospital.¹¹ They heard from 98 people and 26 care providers. Whilst eight out of ten respondents felt that the discharge process was 'OK', 'Good' or 'Very good', a fifth had a 'Poor' or 'Very poor' experience.

One of the key things patients told them could be improved was the clarity about when they would be discharged and information about the ongoing support available. Respondents to the

¹⁰ <http://www.healthwatchesuffolk.co.uk/news/carers-of-patients-within-west-suffolk-hospital-will-receive-more-support-after-we-raised-concerns/> April 2016.

¹¹ Healthwatch East Riding of Yorkshire, Healthwatch Kingston-upon-Hull and Healthwatch North Lincolnshire, [Discharge from hospital](#), March 2017.

survey said they wanted to be “told exactly when I would be leaving” and to be provided with “more paperwork explaining what to do in the future”. They also said they wanted planning for discharge to start early.

These findings were echoed in the responses from service providers, with half of the care homes and home care professionals contacted providing examples of how failing to involve them in the planning process had led to a negative experience for one of their users.

One care home manager said: “There have been times when hospital staff have argued over the phone regarding capacity assessments and family involvement. There have been approximately six negative transfers over the last 12 months that could have been detrimental to the patient.”

A number of others said that poor planning had resulted in patients being discharged **“late at night”** and **“dressed only in hospital garments”**

However, they also talked about what happened when things went well, including:

- Occasions when care homes were told when residents would go home so that staff could make necessary plans.
- When family members and care homes were involved in discussions about discharge arrangements, particularly when patients couldn’t make decisions themselves.

To encourage this collaborative approach and ensure both hospitals and care services properly understand people’s needs, the local Healthwatch involved in the review recommended the introduction of a Patient Passport. East Riding of Yorkshire Council subsequently invited Hull and East Yorkshire Hospital Trust to their Care Sector Forum so that the hospital could explain the challenges they face when discharging a patient, and care homes could explain the issues they face when patients are discharged.

A third of patients (30%) [Healthwatch Kent](#) (2017) spoke to said they didn’t feel involved or listened to during their transfer.¹² Almost half (44%) said that the date and time of their discharge was not discussed with them. Almost two-thirds (62%) of people said that their discharge plan was not discussed or agreed with family or carers.

Thanks to Healthwatch Kent’s findings, the local hospital trust has introduced a series of measures to ensure staff are better equipped to provide support, and patients are more empowered to ask questions about their discharge plan.

For example, hospital staff have visited local care homes and other community-based services to help them understand the full range of options available to help people recuperate.

A new patient leaflet has also been introduced explaining the discharge process and where to go for support and information. The leaflet is currently being piloted with 20,000 patients and is supported by a poster campaign designed to empower people and their families to ask four simple questions that will give them the information they need. This initiative has been shared with other Kent hospital trusts, who are also considering developing their own versions.

In addition, the ‘trusted assessor’ model has been introduced, which ensures all relevant staff have access to patient records, meaning that patients no longer have to repeat their story to each individual they meet.

¹² Healthwatch Kent, [Discharge from hospital in North Kent](#), May 2017.

[Healthwatch Coventry](#) (2017) heard that discussing home circumstances prior to discharge helped to prevent unnecessary readmissions.¹³

They spoke to a number of professionals - senior caseworkers, occupational therapists, care navigators (who help to advise and guide people to other services they can use) and care home managers - to find out how they felt things could be improved. They told Healthwatch Coventry that potential problem areas for frail people include: access to a toilet, long flights of stairs, buildings without lifts, rooms with inadequate heating, beds upstairs that could have been brought downstairs prior to discharge, and a lack of key safes to allow different carers to gain entry to their homes.

They said that information gained on a person's home environment is critical for an accurate assessment of their care needs, so that the right package of support can be put in place. Speaking to the patient, their family or someone familiar with their circumstances about what they need is vital to their safe departure from hospital.

Coordination

People told local Healthwatch that their departure from hospital was sometimes delayed as a result of poor coordination between services. Some people had to wait longer than they expected for medication to be delivered, while others faced delays to transport services to get them home safely.

Transport

People said they often experienced delays with patient transport services, leaving them distressed, confused and having to stay in hospital longer than necessary.

[Healthwatch Richmond upon Thames](#) (2016) heard that non-emergency patient transport was not always available from their local hospitals when needed.¹⁴ One person said: **"I was discharged in a dressing gown and had to get my own taxi home, as transport was not available,"** while another said that they had to wait six hours to be taken home.

One family member told Healthwatch Richmond upon Thames that they went to collect a relative who was booked for hospital transport, they waited hours, and then when the patient was finally able to go home, they were told they couldn't travel with them, despite there being plenty of room. The patient finally arrived home, became unwell, and was readmitted within a few days.

In response to the findings, one hospital committed to involving family members and carers in supporting people's transport home, while another looked into finding a new transport supplier following a review of the contract.

[Healthwatch Middlesbrough](#) (2016) also heard how people were dissatisfied with the hospital transport system.¹⁵ Two of the 99 patients they spoke to said they'd been told they were fit to go home but had been forced to spend an extra night in hospital because of a lack of transport.

¹³ Healthwatch Coventry, [Effective discharge from hospital: the role of communication of home circumstances](#), February 2017.

¹⁴ Healthwatch Richmond upon Thames, [Discharge from hospital](#), April 2016.

¹⁵ Healthwatch Middlesbrough, [Discharge and medication supply at the James Cook University Hospital](#), February 2016.

Another patient was very disappointed because she'd been told by the driver who brought her into hospital that there would definitely be transport available in the evening to take her home again. However, when the evening came around, she was told that she wouldn't be able to go home until the next morning because it was too late to arrange transport. Not only was this a waste of hospital resources, but because the patient hadn't been told to pack an overnight bag, she had not come prepared to stay, which caused her unnecessary distress.

In response to the issues raised by Healthwatch Middlesbrough, the hospital trust committed to monitoring the effectiveness of their transport service, and explained that, as part of a retendering process, they are exploring having a member of the company's staff on site to improve the service.

Medication

In almost all of the reports published by local Healthwatch since 2015, patients commented on hospital pharmacies and the amount of time they had to wait for medication before being discharged.

Healthwatch Leicestershire (2017) spoke to 216 people who were leaving hospital between September and December 2016.¹⁶ Of those who experienced a delay being discharged, 41% said it was as a result of waiting for medication.

In response, the local hospital trust has adopted the Red2Green programme in order to reduce the number of delays caused to patients in one of its hospitals, and that this would soon be applied in others. They also said they have started to prepare prescriptions for patients the day before discharge, and reintroduced discharge medication checking stations in wards to ensure that the correct medication is given to people when they leave.

What is Red2Green?

Red2Green is an initiative that aims to reduce the number of 'red days', when patients spend days in hospital that do not directly contribute towards their leaving care.

Every day starts off as red, and it's up to the staff team to turn the day green by helping move a patient's care along. This can be something as simple as chasing up the results of a scan or test that is holding up a patient leaving hospital. Where a hospital's systems and processes get in the way of getting people home quickly, members of staff are encouraged to challenge them, and they're regularly reviewed by middle and senior management to see how policies can be updated.

Red2Green aims to ensure that everyone, especially the person receiving care, understands the next steps towards their departure from hospital. The programme also aims to empower patients to ask questions about their care and what the NHS and local care services are doing to get them home as soon as possible.

Of the 99 people Healthwatch Middlesbrough spoke to about their experiences of being discharged, 51 reported delays getting their medication. Of these, 13 said they waited so long they

¹⁶ Healthwatch Leicestershire, [The lived experience of hospital discharge](#), March 2017

went home without their medication and then either had to go back to hospital themselves to get it or to ask a family member or friend to go for them.

Many people were frustrated at having to do this, as they had to arrange transport, pay parking charges etc. But discharging patients without their medication isn't just inconvenient, it can be dangerous and costly. People can end up without the support they need or being readmitted to hospital unnecessarily.

Following Healthwatch Middlesbrough's report, the hospital has started to introduce dispensing carts on a number of wards to help take pressure off of the pharmacy department and ensure that people are able to be discharged more quickly.

Communication between services

Local Healthwatch often heard about communication issues, for example between hospitals and social care workers, or even between different parts of the same hospital.

Between July 2015 and January 2016 Healthwatch Richmond upon Thames spoke to 120 people through outreach sessions with community organisations, visits to inpatient units at local hospitals, and an online and paper survey. They heard that a significant challenge to effective and safe discharge was coordination of services. This was predominantly down to a lack of communication within and between services, especially between hospitals and care provided in the community (nurses, GPs and occasionally care homes).

The nursing teams spoke about not having enough detail about people's treatments, and finding that a patient has either been kept in hospital after their expected discharge date, or been discharged without their knowledge.

Patients said that poor communication between services led to problems, such as care plans not being in place in time for their discharge, community care staff not turning up, and GPs not having information about changes to prescription medications following a stay in hospital.

In response, one hospital told them that their Discharge Governance Group, made up of hospital staff, social services and voluntary sector representatives, had helped to improve communication between providers, and was going to be extended across their other sites. The group had already worked to create a new discharge checklist and a variety of actions, from improving communication between ward staff and families, to boosting connections between the wards and district nurses, were ongoing.

Since publication of the checklist, the trust has also introduced an initiative called '2B412' with the aim of discharging at least two patients from each ward before midday. By discharging patients earlier in the day they can relieve some of the pressure on beds and improve patients' experiences.

Another local hospital referred Healthwatch Richmond upon Thames to their "Faster Flow, Safer Care" programme as their process for improving communication. Although this was recognised as a positive step, the programme actually predated much of the intelligence gathered by Healthwatch Richmond upon Thames about people's experiences. This example highlights the importance of trusts evaluating the initiatives they introduce to ensure they are achieving their objective.

[Healthwatch Gloucestershire](#) first looked at people's experiences of discharge in 2015. In its report it recommended that local hospitals improved their communication with care homes and social care providers. To find out how things progressed, in 2017 Healthwatch Gloucestershire carried out a follow-up investigation.¹⁷ The team found that one trust had set up regular meetings with their local care homes and attends a meeting of care stakeholders. They also have an 'Integrated Discharge Team', which is involved in all discharges that involve care homes. Individual ward areas also communicate more often with care homes regarding individual patient needs.

This autumn, the Head of the Integrated Discharge team will be leading further work to review the current discharge processes and communication systems and will involve care home partners in this work. This review will include a review of the current information available to patients and carers via leaflets or the trust's website.

Sometimes the poor communication between services was down to a lack of trust. For example, [Healthwatch Essex](#) heard how a culture of health and social care colleagues blaming each other for problems with the discharge process was exacerbating the problem.

One social care worker they spoke to said that **"The discharge team will try and blame us, and in turn, we'll try and blame other things."** They heard that this could lead to even further delays to care assessments, contributing to a negative experience for patients.

Case study - Healthwatch Oxfordshire

In 2015 [Healthwatch Oxfordshire](#) reviewed the way Oxfordshire hospitals handle the discharge process, speaking to 212 patients, 14 care providers, 33 GPs and 44 pharmacists.¹⁸ They undertook the study after GPs in their area had raised concerns with the local CCG about hospital discharge, as Oxfordshire was one of the worst performing counties in the country when it came to discharging people from hospital in a timely and effective way.

Following their report, the local trust set out a number of improvements to the way they handle discharge, including:

- Reviewing the way in which the current discharge liaison team functions to provide greater support across the trust and for very complex discharges.
- Identifying a named nurse to patients as a point of contact for discharge queries.
- A re-designed patient discharge summary with input from clinical staff, including GPs and pharmacists.
- Reviewing all current discharge posters and leaflets for patients, with the aim of producing a comprehensive leaflet. This will include standard useful information, and a section with personalised discharge information for the patient. Healthwatch Oxfordshire approved the wording on the current poster and the same language will be adopted on the leaflet.
- Adopting a discharge plan for each patient, including the named nurse and contact numbers to use in the event of queries.

As a result of these improvements, Healthwatch Oxfordshire noted that the length of delayed discharges came down, and that fewer people experienced a delayed discharge in the following

¹⁷ Healthwatch Gloucestershire, [Hospital discharge task group report review of progress](#), March 2017.

¹⁸ Healthwatch Oxfordshire, [Improving discharges from Oxfordshire's hospitals](#), 2015.

year. Additionally, patients were now more likely to be in receipt of care and medical attention outside of a hospital setting, and were either nearer to home or at home during their recovery time rather than in an acute hospital bed. Healthwatch Oxfordshire also recorded a number of additional outcomes, including that patients who were expected to end their days in a care home were able to die at home instead.

Case study - Healthwatch Essex

In 2016 Healthwatch Essex undertook an independent study of the way in which three hospitals in the county dealt with hospital discharge processes.¹⁹ This involved almost 200 hours of observation and over 200 interviews with patients, staff, and family carers.

The findings revealed that in all too many cases neither patients nor family carers were involved in the planning of discharge and follow-up support. This contributed to a lack of continuity of care and sometimes saw patients readmitted.

Being discharged too soon was another key finding. Some patients – particularly older patients and those who had care responsibilities – said they felt under pressure to leave hospital before they felt ready to be discharged.

Delays on the day of discharge were also commonplace due to hold-ups in the delivery of take-home medication, hospital transportation and information, such as letters for GPs and discharge or care plans.

Where assessments for care packages were required, delays could be exacerbated by a lack of coordination between health and social care and the shortage of care places in the community, care homes, nursing homes and reablement services.

One of the core issues that affected the discharge process again and again was poor communication. Often the problem was about poor internal methods of communication, which often resulted in staff being without the right information about a patient's readiness and needs for discharge.

Patients said they were often told different things by different members of staff about the timing of their discharge, which led to further delays, confusion and frustration for them and their family care givers. By managing people's expectations and improving consistency of communication, people's experiences overall can be improved.

¹⁹ Healthwatch Essex, [Hospital discharge in Essex](#), 2016

Support after discharge

The support that people receive after they leave care is crucial to ensuring that they are able to recover properly. According to NICE guidelines a patient leaving hospital in need of ongoing care should have a fully documented plan. However, it is clear from what local Healthwatch have heard that this doesn't always happen.²⁰ Even those who have plans are not always made aware of it or of the support they should be getting.

In 2017 [Healthwatch Windsor, Ascot and Maidenhead](#), working with [Healthwatch Bucks, Slough, Wokingham, Bracknell Forest, Hampshire](#) and [Surrey](#), spoke to 114 people about their experiences of discharge.²¹ While many of the comments, especially about staff, were positive, the results highlight some clear issues with the process of leaving care. For example, although the majority of respondents said that they felt involved in decisions about their discharge from hospital and that a discharge plan was made with them and/or their family, over a quarter said this did not take place.

One in six of those who responded said they did not know what would happen next with their care after leaving hospital, whilst a fifth said that they did not get the planned services after discharge that had been discussed. Of the respondents who did receive planned follow-up support, only half reported they were satisfactory.

"I was discharged without a plan or discussion with my wife or myself. I am disabled and the need for home care, rehabilitation or physiotherapy was not discussed."

"Discharged without support, with low blood pressure, very weak and unsteady on my feet and diarrhoea, told to take a walking frame to get around, no question of an assessment regarding the layout of my home and how I was going to be able to get upstairs...which I can't so have to sleep on the sofa...very angry"

Respondents to Healthwatch Windsor, Ascot and Maidenhead's survey

Healthwatch Hillingdon highlighted in their 2017 report the lack of access to advice and advocacy as a particular area for improvement.²² At the point of discharge patients and their families/carers often have to make life-changing decisions in a short timeframe, with potentially significant financial implications. For those individuals who may have lost trust in the NHS or local care services during the discharge planning process, access to independent support to help them make the right decisions is vital.

Even when care was arranged, some people had to wait for the necessary support to actually be put in place. Healthwatch Kent heard of one person waiting 20 days for an appropriate care package to give them the support they needed at home, whilst others heard that people were readmitted because of the lack of proper support, equipment or planning.

²⁰ NICE, [Transition between inpatient hospital settings and community or care home settings for adults with social care needs \(NG27\)](#), 1.5.14-1.5.19

²¹ Healthwatch Windsor, Ascot and Maidenhead, [The hospital discharge survey - patient experiences of hospital discharge](#), June 2017

²² Healthwatch Hillingdon, [Safely "home" to the right care](#), February 2017.

Are people waiting too long to be assessed for social care support?

Under the Care Act, once a local council has been informed that a patient is ready to be discharged and that they will need care support, they have 48 hours to conduct an assessment. If the patient is not discharged within this timeframe then the delayed transfer is attributed to social care.

Over the last three years the number of delayed transfers attributed to social care has increased by 130%. This compares with a 25% increase in the number of delays caused by the NHS.

As a result pressure is being placed on councils to do more to increase capacity in social care and help get patients out of hospital.

However, too much focus on completing assessments for those awaiting discharge could see people in need of care still living in the community deprioritised.

This would be a short-sighted measure as ultimately the best way to reduce the number of delayed transfers of care is to reduce the number of admissions in the first place. It is vital that people get the care and support they need to live safely in the community.

In January 2017, research conducted by 18 local Healthwatch found that the data held on social care waiting times is inconsistent. Local authorities were often unable to provide any data or they can only tell how many people were currently on their lists rather than how long people had been waiting.

When local authorities did hold data, the average waits reported for an assessment ranged from 2.75 days to 52 days. Once a care package has been agreed there is often a further wait for packages to be implemented, with average waits reported ranging between 7.8 days and 54 days. In some extreme cases Healthwatch heard about local residents waiting well over a year to actually start receiving care support.

Without knowing how many people need social care support - whether they are living in the community or waiting to be discharged from hospital - local authorities can find themselves unable to meet people's needs, potentially causing people to be admitted, or readmitted, to hospital.

To ensure the system as a whole invests in social care in the right way, it is vital that councils develop a better understanding of local demand.

How Healthwatch is helping to evaluate progress

Since *Safely home* was published, some Healthwatch have also been involved in helping to evaluate the procedures their local hospitals have put in place to improve people's departures from care.

For example Healthwatch Suffolk was asked to evaluate the 'Discharge 2 Assess' pilot programmes in the West and East of Suffolk.²³ 'Discharge 2 Assess' is a term used to describe a variety of different programmes to speed up the discharge process, but the basic premise is that patients no longer have to wait in hospital for an assessment of their ongoing care needs. Multi-disciplinary teams, including nurses, occupational therapists, physiotherapists and rehab assistants, work together to assess an individual's immediate and long term support requirements in the context of where they usually live.

Healthwatch Suffolk spoke to ten people about their experiences of being discharged from hospital to a separate reablement ward, as well as the professionals who cared for them while they were there. By evaluating the scheme at this early stage, Healthwatch Suffolk has been able to ensure that people's experiences shape similar care provided in Suffolk in the future.

The 'Red2Green' programme is now being used by a significant number of hospital trusts across the country and is helping to overcome many of the barriers that were previously preventing patients being discharged. However, much of the evaluation work to date has focused on how the initiative is working for trusts and staff.

In March 2017, [Healthwatch Staffordshire](#) was commissioned by NHS Improvement's Emergency Care Improvement Programme to conduct an evaluation of how well 'Red2Green' is working for patients.²⁴ In particular they were tasked with exploring how it is helping to inform patients about their recovery journey and empowering them to challenge staff to ensure red days are turned green.

²³ Healthwatch Suffolk, [A qualitative evaluation of the discharge to assess pilot in East of Suffolk](#), February 2017.

²⁴ Healthwatch Staffordshire, [Annual report 2016/17](#), pp30-31.

Where next?

Two years on from *Safely home*, improving the effectiveness of discharge processes is now firmly at the top of the health and care agenda.

This is clear from all the work going on at a national and local level to get people home from hospital faster and to make sure they have the support they need to recuperate.

Yet it is also clear that the challenge is growing, with the number of delayed transfers increasing and patient experience still highlighting problems with communication, coordination and the support available.

The Department of Health has sent a strong signal that it wants to see the number of delayed transfers significantly reduced, and quickly. Looking longer-term, the need to limit the amount of time people spend in hospital and to focus on providing better community-based care goes to the very heart of the NHS Five Year Forward View. To get to this point local areas need to focus on the following:

Build a better understanding of the problem

It is vital that local services look to develop a full comprehension of what's happening in their area.

It is encouraging that the Department of Health has produced an 'NHS-social care interface dashboard' to pull together data which indicates how well health and care services are working together in each local authority area.²⁵

As part of its 12 local system reviews, the CQC has followed a small number of patients from treatment to recovery. These case studies, part of larger 'data profiles', provide unique insight into experiences that statistics alone might overlook.²⁶

These steps are positive, but more remains to be done to fully understand people's experiences of leaving hospital.

One way to do this would be to build a better picture of emergency readmissions data to identify any potential trends and the fix the underlying reasons why things go wrong.

Likewise, a better understanding of social care waiting times can help commissioners, providers and front line staff manage demand more effectively and reduce the risk of people being admitted in the first place.

Make the most of technology

As set out in the National Information Board's 'Patient, Carers and Service User Vision', which has been developed with our support, technology offers a range of opportunities to tackle the problems people say cause them the most frustration.

Better information sharing can ensure patients don't have to repeat their story over and over again and that all those involved in an individual's care can be kept informed about the patient's progress. For example, GPs being automatically notified when a patient has been discharged from hospital could help to prevent mix-ups around medication.

²⁵ <https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions>

²⁶ http://www.cqc.org.uk/sites/default/files/CM071706_Item6_localsystemsreview_appendix1.pdf

Health and social care staff also need to be made more aware of the rules around data protection, to ensure that they know how to share information appropriately across organisations. Data protection should not be used as an excuse to withhold information that could save someone from harm.

Steal ideas

Local areas need to use their improved understanding to identify areas facing similar challenges and learn from one another.

Whether increasing the number of discharges completed before lunchtime or establishing integrated discharge teams, if the basic idea works in one place then the chances are that a similar approach will work in another. Local leaders need to demonstrate flexibility and encourage their staff to copy and adapt ideas, including those in this report.

The Better Care Fund's eight High Impact Changes also provide examples for areas to adapt to help meet local need, and forthcoming quarterly reports are set to indicate how best practice is spreading.²⁷

Prioritise evaluation

Just introducing new ideas and initiatives is not enough. Local services need to prioritise the evaluation of programmes like 'Discharge to Assess' and 'Red2Green' to ensure they are having the impact they set out to achieve. This is where local Healthwatch can help, supporting services to understand not just whether they are reducing delays and readmissions but if they are genuinely improving the experience for people.

We will use our overview of the Healthwatch network to identify trends in patient feedback and see how national policy changes, such as the new 3.5% delayed transfers of care target, are working in practice.

We will also continue to make the case for a new metric to track the integration of services based on patients' experiences of transfers between different parts of the system.

²⁷ Local Government Association, *High Impact Change model: Managing transfers of care between hospital and home*; <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

Thank you

Thank you to everyone who has shared their experiences.

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