

Hospital Discharge

Experiences of Warrington & Halton Hospitals



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What is hospital discharge?

Hospital discharge is the process of leaving the hospital after treatment, either to the patient's home or to another health or care facility. It is a crucial stage in people's health and care journey.

Discharge rates and processes have implications for other services. For example, patients who leave the hospital free up beds so people who need care can be admitted more quickly from A&E to wards, reducing pressure on emergency departments and speeding up ambulance handovers.

However, when people are discharged too early or are not given the proper support or information, pressures on services can increase, with patients going back to the hospital or turning elsewhere such as to their GP. This is both frustrating for patients and adds to the workload of already stretched NHS staff.

NHS bodies and local authorities should work together to ensure people move safely out of the hospital to the right place at the right time, with the support they need.

In 2020 the '*Discharge to Assess*' model was introduced with an aim to ensure that people were discharged to the right place with the right support at the right time without unnecessary waits for care assessments whilst in hospital.

However, we know from feedback people have given us that this doesn't always happen. It is key that as we move forward, people's experiences both during discharge and after leaving hospital are at the centre of plans to get things right.

In December 2022, more than 13,000 beds – out of a total of around 100,000 hospital beds in England – were occupied by patients who were medically fit for discharge, an increase of 57% since December 2020.¹

¹ <https://www.health.org.uk/publications/long-reads/why-are-delayed-discharges-from-hospital-increasing-seeing-the-bigger>

Summary

This project was identified as a priority by both Healthwatch Halton and Healthwatch Warrington following local feedback and national reports on the subject indicating some of the current challenges faced by our local hospitals. It was also chosen because it has a strategic alignment with local system development. There is both national and local interest in improving the experience people have of discharges from hospital.

In addition to carrying out a survey to gather the views of those who had been discharged from Halton and Warrington Hospitals, we also carried out a series of joint visits to the two hospitals to speak with patients and their families / carers awaiting discharge.

Report – Key Findings

64

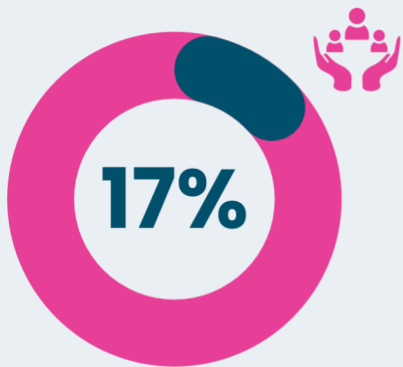
people discharged from hospital and their family members shared their experiences of being discharged from hospital.



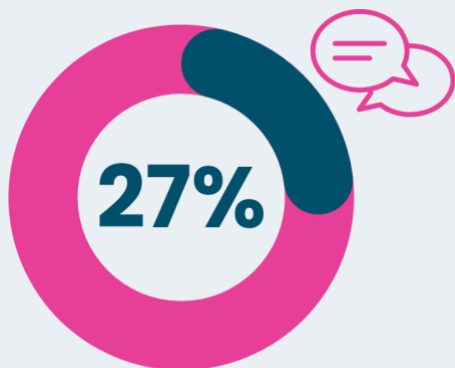
Where discharge had worked well, people highlighted good communication, feeling involved in the process, involvement of their family members where applicable, and good coordination and quality of aftercare.



of family members and patients (combined) said they didn't feel prepared for discharge
Dissatisfaction was higher amongst family members with 47% dissatisfied.

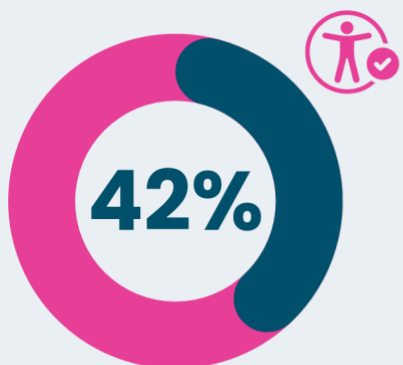


of family members of people discharged home said that they had been told about Carer's Assessments.



of patients said they were dissatisfied with how involved they'd been in conversations about their discharge whilst on the ward.

Dissatisfaction was higher amongst family members, with 37% dissatisfied.



of people discharged said they weren't asked about any communication needs when they were in hospital.

Background

Prolonged stays in hospital are bad for patients, especially for those who are frail or elderly. Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning. Despite this, nearly 350,000 patients spend more than three weeks in acute hospitals each year.

A lot of work in the planning of health and care services has focused on trying to make sure that people don't stay in hospital any longer than they need to.

This was partly initiated by the need to free up beds during the pandemic but also because it is recognised that prolonged hospital stays can cause loss of independence and deterioration in a person's health.

Throughout the report, we have included extracts from the current government guidance on hospital discharge and community support to give an indication of what is advised nationally.

Current government guidance

The Government guidance on safe hospital discharge states:

- Hospital discharge teams should ensure people have transport to return home or move to another facility. Staff should make arrangements to ensure there is transport for people to return home from the hospital, via family or carers where appropriate or suitable, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS).
- Health and social care professionals should give **'safety netting'** information on discharge, including the contact details of their discharge team for people leaving the hospital as well as their carers.

However, Healthwatch research² suggests that many people leave the hospital without the right support or information, or are not always asked if they need transport to get to the place they are discharged to.

Why we did it

We have been aware of issues surrounding discharge from hospitals for several years and it has been recognised within both the local and national health and care system as an area of concern. Healthwatch England, British Red Cross and Carers UK have independently produced reports following the introduction of the Discharge to Assess model outlining some of the issues from the perspective of both people using services and unpaid family carers. Key themes from these reports were people not feeling involved and informed in discharge planning and insufficient follow-up support and aftercare.

The aim of this piece of work was to hear about how changes in the discharge process have affected people's experiences of being discharged. It is also

² <https://www.healthwatch.co.uk/blog/2023-11-20/nhs-urged-do-more-help-patients-leave-hospital-safely>

about hearing about the experiences from the point of view of family and friends who are such an integral part of people's support networks.

It is key that these experiences are at the centre of planning as we move forward, as the priority must be to getting it right for people and their families and unpaid carers.

What we did

Virtual Voices report

At the start of the project, Healthwatch Warrington asked members of its 'Virtual Voices' panel for their experiences of hospital discharge following an in-patient stay or their experience of being a day patient.

Sixty-nine responses were received. Twenty-six people gave their experiences of discharge following an in-patient stay in hospital. Feedback from the Virtual Voices report highlighted good staff care on wards but a lack of communication with patients around their discharge.

Main survey

Following the Virtual Voices survey, a more in-depth survey was developed to look at the following:

- What involvement the patient / family members had in discharge planning.
- Where patients were going after being discharged from hospital.
- What was discussed with patients / carers prior to discharge.

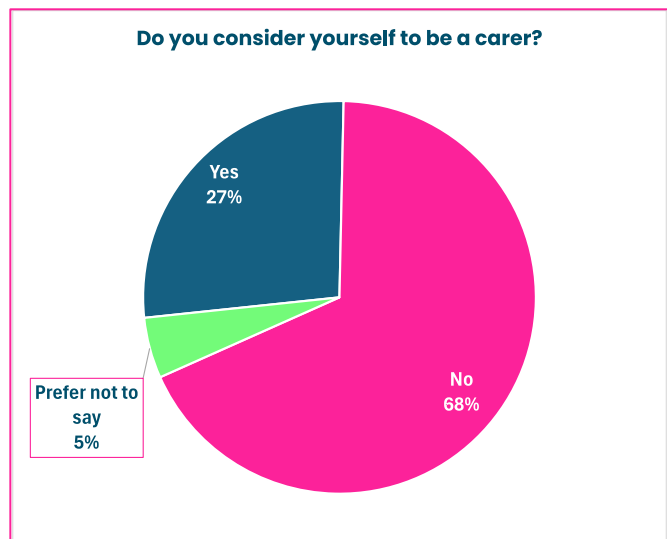
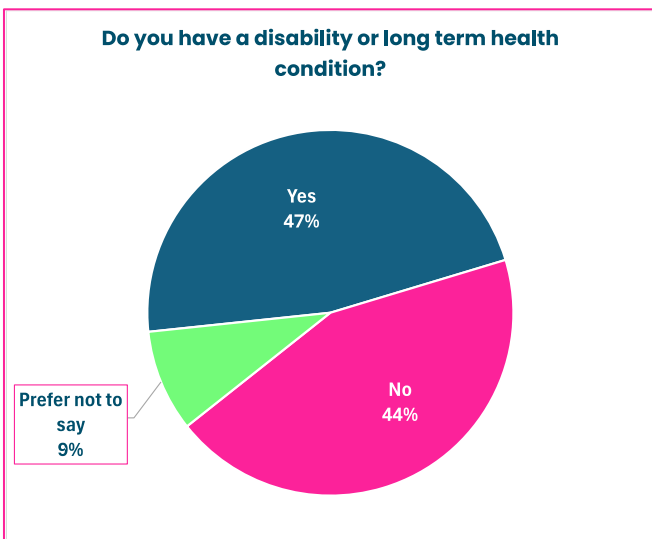
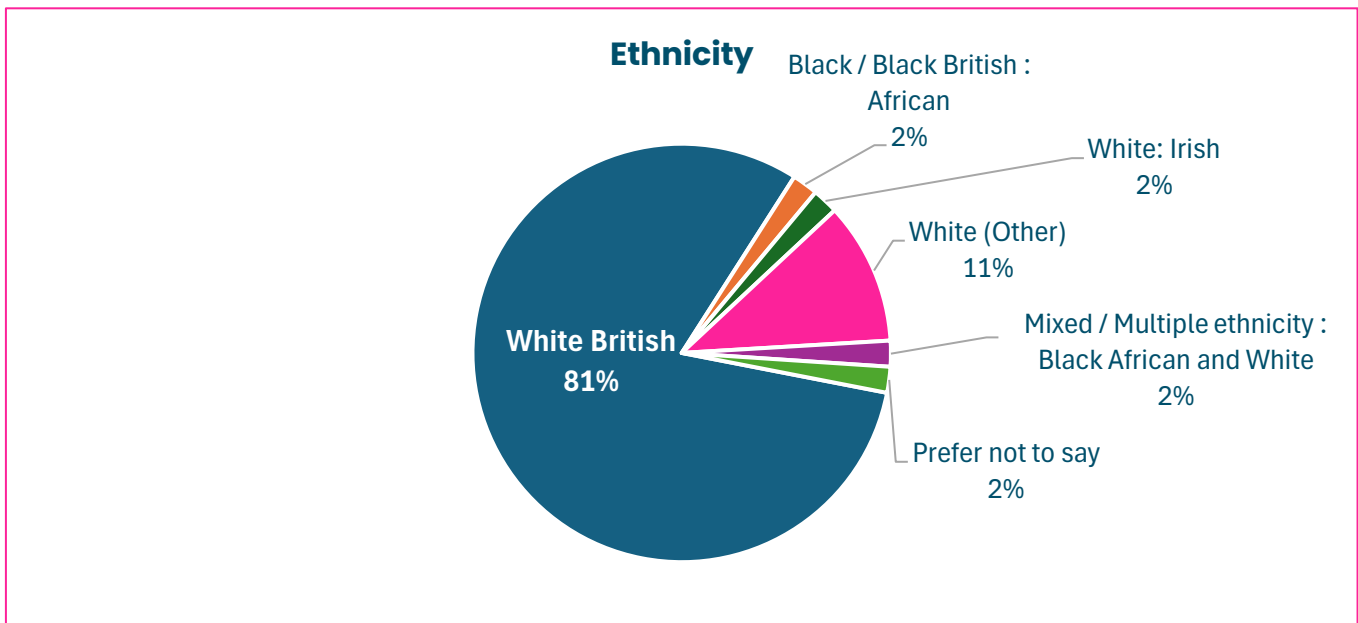
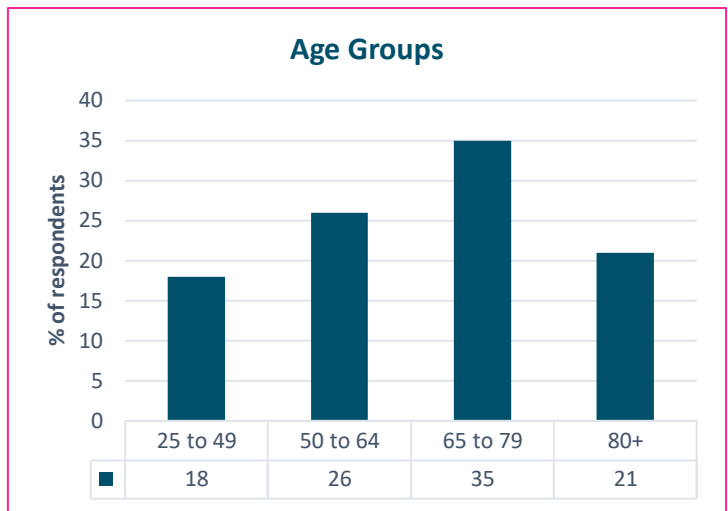
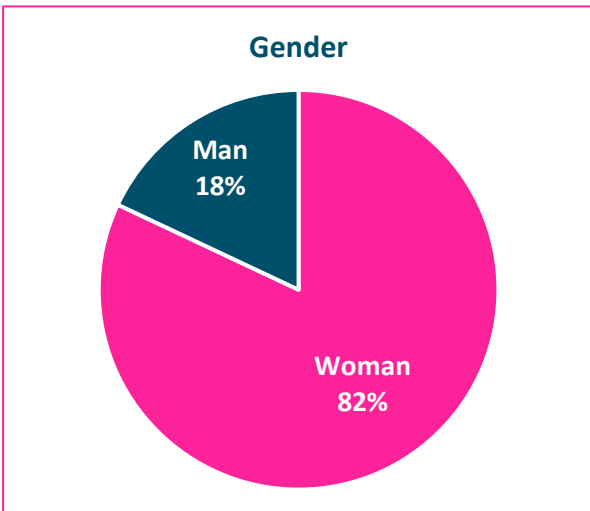
The survey was made available online and was promoted on social media by both Healthwatch and the hospital trust.

Paper copies of the survey were made available, and our staff teams carried out six visits to the discharge lounges at Halton and Warrington Hospitals.

The report statistics are based on the responses of the 64 people who completed this survey.

The report also includes some additional patient and carer experiences related to hospital discharge received by both Healthwatch during the past 12 months.

Demographics



What we found

We received a total of 64 responses to the main survey. 70% were from people who had recently been discharged or were awaiting discharge from hospital and 30% were from a family member. 75% of responses were from people who had been, or were being, discharged home or to stay with family / friends.

Involvement of people in discharge planning

An update to the statutory 'Hospital discharge and community support guidance'³ in January 2024 states:

'Involving families and carers - the guidance now specifies that NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions. This reflects the amendment to section 74(1) of the 2014 Care Act made by the Health and Care Act 2022.'

'Where relevant, the decision about when to discharge a person, and any support they might need before an assessment of their long-term needs, should take into account the views and circumstances of any unpaid carers as well as those of the individual.'

'Planning for discharge from hospital should begin on admission. Where people are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family or carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs.'

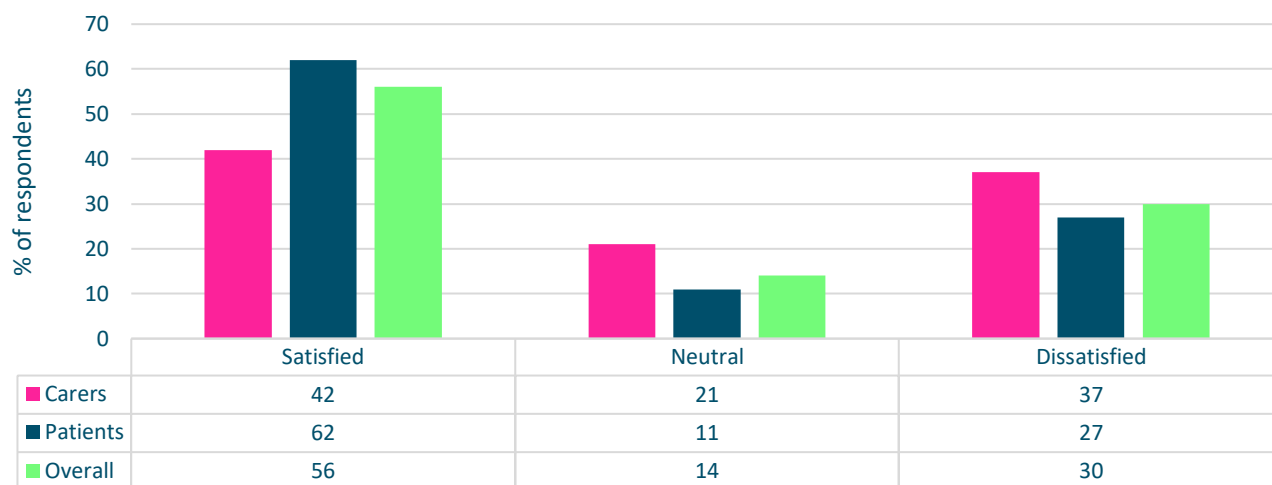
'From the outset people should be asked who they wish to be involved and/or informed in discussions and decisions about their hospital discharge, and appropriate consent received. This may include a person's family members (including their next of kin), friends or neighbours.'

'Paid care workers and personal assistants should also be involved, to ensure that any changes that may be needed to someone's support plan can be reflected in a timely manner to best support their recovery or end of life care.'

'A person who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an independent advocate.'

³ <https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance>

How satisfied were you with the way staff kept you involved in conversations about your / your relative's discharge and care and support needs when you/they were on the ward?



We've heard about the impact of poor communication, both with patients and their loved ones. This includes family members and carers not getting prior notice of discharge, nor being involved in conversations about the support available at home.

Overall, 30% of people told us they were dissatisfied with how they'd been kept involved in conversations around discharge. There was however a significant difference between the responses from people discharged and family members, with 37% of family members dissatisfied with how they'd been kept involved in conversations as opposed to only 27% of patients.

Other research has also highlighted this issue. In the latest Adult Inpatient Survey⁴, 25% of people said they had little to no involvement in decisions about their discharge.

People also told us about being discharged without adequate support or a discharge assessment, which can result in emergency readmissions. Some felt their discharge was rushed.

Other people shared stories about being discharged without appropriate transport and in the middle of the night.



'At 1.30 in the morning my wife was discharged and told she could go home. There was no patient transport, and we couldn't get a taxi... It was a total stranger who overheard our conversations who was at the hospital who volunteered to give us a lift home. **Feedback to Healthwatch Halton**

⁴ <https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey>

It is worth remembering that family and friends are often the ones looking after patients who are discharged to home. As such, they should be recognised as an important part of people's support during discharge, and these comparatively high levels of dissatisfaction should be considered as a key indicator that more needs to be done to recognise them as a key partner.

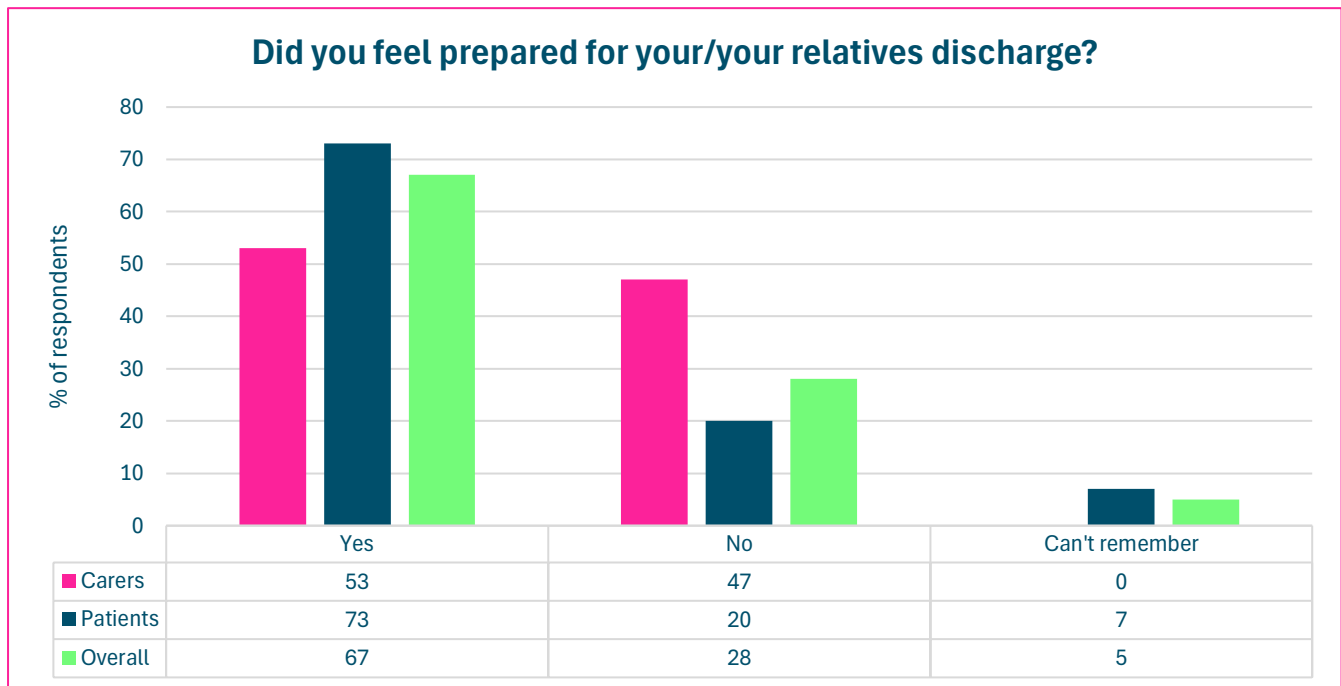
It shouldn't only be seen as good practice to involve people and their carers in discharge planning, but also be recognised as a legal duty. Since 1st July 2022 when it came into force, Section 91 of the Health and Care Act states that, *'Where a relevant trust is responsible for an adult hospital patient and considers that the patient is likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after it begins making any plans relating to the discharge, take any steps that it considers appropriate to involve (a)the patient, and (b)any carer of the patient.'*



'My husband had been in hospital for two weeks and I was sat holding his hand as he was unresponsive and I got a call from the discharge team stating they were sending my husband home, I asked when this decision had been made and they stated two weeks ago. This is when my husband had been admitted. He was unresponsive and hadn't eaten or drunk since the 7th June, I was out of my mind... Even though my husband was none responsive I asked to speak to staff by the desk as they would come and talk in front of him, I knew he could hear them, and this upset him and caused distress. One day when my daughter was visiting the consultant female and a doctor said to her, "we want you to convey this information to your mum", the information they were conveying was very distressing and they had no right talking to my daughter about this. She wasn't his next of kin, they should have waited for me to attend. She was so distressed she told them she wasn't going to do this and left the hospital in tears, luckily I was on my way in and caught her on her way out. These are conversations I didn't want my daughter to hear she travelled an hour and half every day to sit with her father. Disgraceful.' **Family member**

'Just advised on the day that I was being discharged and at 9.00pm at night an ambulance came to take me home. Apparently, I should have gone home at 6.27pm.' **Patient**

Feeling prepared for discharge



Most patients were eager to be discharged, with one person who was being discharged to a care home setting telling us:

6 'I'm over the moon that I'm being discharged eventually today, can't wait to get out even though I'm not going home.' **Patient**

Relatives and Carers responses were more evenly split, with 53% saying they were prepared, against 47% who weren't prepared for their relative's discharge.

While 77% of patients also felt they were given enough notice of discharge, this was a marked contrast with the responses from family members with 42% saying they'd not received enough notice of discharge.

A number of people said they had only been told at the point of discharge or just a few hours earlier.

6 'Discharge was very quick, with very little notice to tell the family. The ambulance arrived halfway through the patient's lunch and took her from the ward. Carers were arranged for at home, but they were not there when the patient was left at home by the ambulance. They could only get in and out of bed with the help of a friend who needed to stay with them for five days.' **Feedback to Healthwatch Halton**

'I got told to sit in waiting room as they needed my bed. So I had to sit there waiting until I got told to go home.' **Patient**

'We had to ask all the time about what was going on, he felt ready to leave for ages but had to get a doctor to look over his notes to sort the discharge out after asking for 2 days.' **Family member**

'My sister was sent from Warrington Hospital to Halton Hospital ward B3, with very little notice. I just happened to be visiting her at the time and helped with the packing. I had been assured by the hospital OT that she would be staying on Ward C21 over the weekend, being discharged on the Monday and going straight home. That did not happen, and she was sent to Halton Hospital at a moment's notice. I did not want that to happen due to her fragile state of mind at that time. As it was, she was kept in the discharge lounge from 2.30pm until transfer to Halton at 6.00pm. She arrived at Halton having had no food and the kitchen were closed at Halton by then. I find this unacceptable and would recommend a rethink on patients waiting in the lounge in these uncertain times for ambulance transport availability.' **Family member**

'I was asleep and didn't think I would be leaving. The ambulance lady woke me up. I'm housebound so can't walk or anything.' **Patient**

There were also examples of good practice with both patients' and families feeling well informed and prepared for discharge:

6 'Staff spoke to us in depth about how to support our daughter at home bathing/toileting/painkillers/sling etc., and when to expect letters for her follow up appointments/outpatients.' **Family member**

'Everything was in place before I came in. Three weeks' notice to get the house ready.' **Patient**

For some people though, being kept out of the loop meant that they were not able to support their loved ones as effectively as they wanted, as highlighted in the Carers UK report on hospital discharge:

'A very clear thread from carers' experiences shows that carers have not been involved, consulted, or given the right information in order to care safely and well. If carers are considered to be partners in care, then, like health and care professionals, they need access to relevant information to help them support a person needing care safely.'

Carers Experiences of hospital discharge report (Carers UK).⁵

Another common reason given by people for not feeling prepared for their discharge was a lack of practical information such as discharge letters, instructions for after-care, and relevant contact details.

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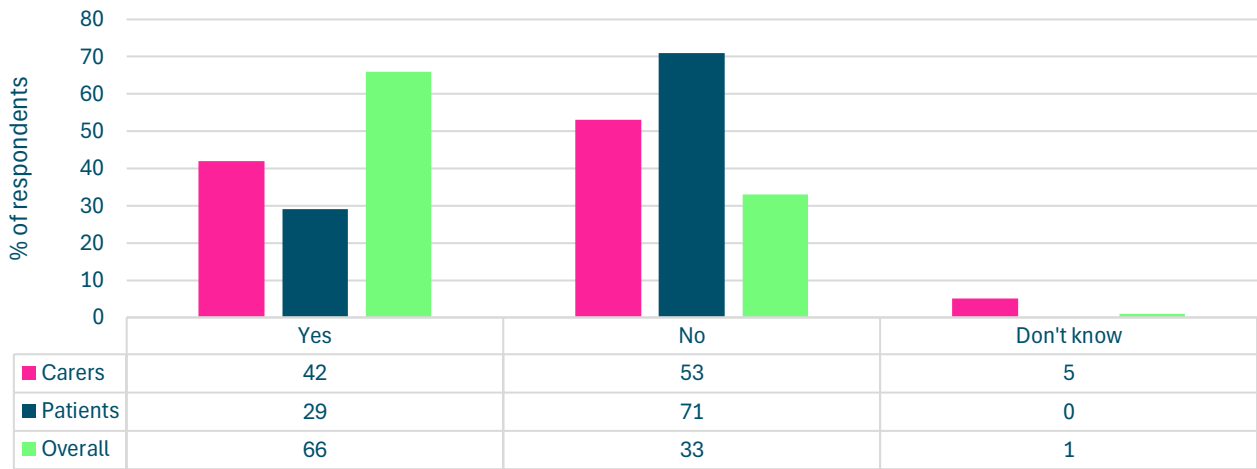
'It was unclear who was providing the wheelchair but definitely needs one and walking aids.' **Family member**

'We were told the dressings would be delivered for his nephrostomy bag but had a nightmare for weeks later trying to get hold of them, we had to go back the ward in the end for help!' **Family member**

'I was not given in writing any information about my follow up appointment. Only found out about because I returned to hospital on another matter and decided to ask them. That's when I received my discharge form with the details on. If I hadn't returned, I would never have known.' **Patient**

⁵ <https://www.carersuk.org/reports/carers-experiences-of-hospital-discharge-discharge-to-assess-model/>

Did you feel you/your relative stayed on the hospital ward longer than was needed?



Overall, family members / carers were more likely than people discharged to feel their relative had stayed on the hospital ward longer than needed,

Both relatives and people discharged gave similar reasons as to why their stay had been extended further than necessary. They were as follows:

- Waiting for equipment or adaptations at home
- Waiting for medication
- Waiting for care packages
- Waiting for a care home place

Some people mentioned that staying in hospital for a long period had impacted their health.



'I've been in hospital so long I need new glasses. I can't see with current ones and can't hear properly. I need a hearing test, my daughter is going to sort appointments for these when I'm discharged.' **Patient**

What the 'Hospital discharge and community support' guidance says:

'Health and social care professionals should support and involve the patient to be discharged in a safe and timely way to ensure they do not spend longer than necessary in an acute or community hospital, or local authority run community setting. People should be discharged once they no longer need care in that setting. Timely discharge from acute settings improves a person's outcomes and reduces the risk of medical complications...'

Communication preferences and needs

The Accessible Information Standard (AIS) places a duty on all service providers across the NHS and adult social care system to identify, record, flag, share and meet individuals' information and communication support needs.

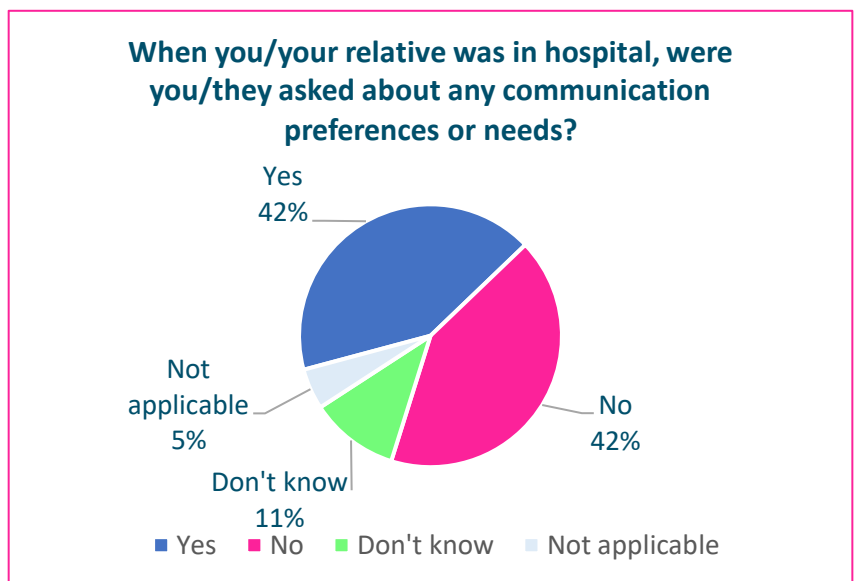
Patients and service users (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss should receive:

- 'Accessible information' ('information which is able to be read or received and understood by the individual or group for which it is intended'); and
- 'Communication support' ('support which is needed to enable effective, accurate dialogue between a professional and a service user to take place');

Such that they are not put '*at a substantial disadvantage...in comparison with persons who are not disabled*'⁶ when accessing NHS or adult social services.

Overall, responses to this were split equally between those who felt prepared for discharge and those who didn't at 42% saying 'Yes' and 42% saying 'No'.

When we looked at the data for groups of people who are more likely to have some communication needs, 60% said they were not asked about them.



'I'm registered blind, and no one asked about my preferences for communication and not a lot of people have communicated anything with me.' **Patient**

⁶ <https://www.legislation.gov.uk/ukpga/2010/15/section/20>

People discharged home

The following questions were asked of those people who were discharged to their own home rather than a community care or step-down setting.

Were any of the following discussed prior to discharge?

How you were and if you had any general concerns.

57% said they were asked how they were and whether they had any general concerns about discharge. 39% said this wasn't discussed with them.

If you needed help organising transport home.

46% said they were asked whether they needed any help with organising transport home. 48% said this wasn't discussed with them.

Whether there were people to support you when you got home.

74% said they were asked whether there were people to support them when they got home, 24% said this wasn't discussed with them.

Whether anything needed doing before you got home (getting food in, turning on heating etc).

32% said they were asked whether anything needed to be done before they got home. 58% said this wasn't discussed with them.

Whether you needed any support for tasks (eg washing, cooking, taking medication etc).

38% said they were asked whether they needed any support for tasks. 54% said this wasn't discussed with them.

If you were concerned about finances.

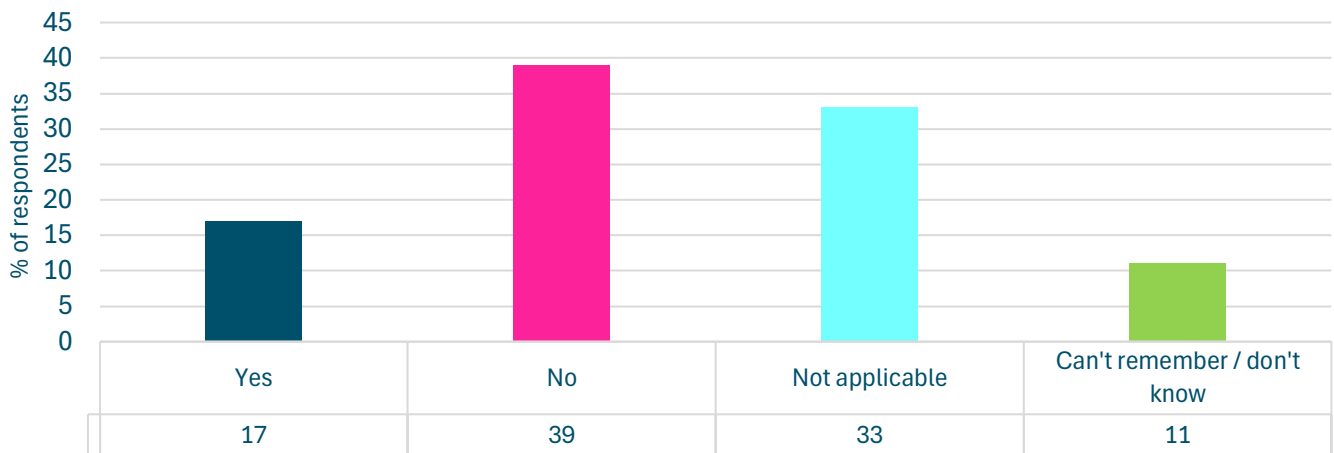
79% said this wasn't discussed with them. Just 11% said they were asked if they had any concerns around finances.



'I was discharged in a bouncy, uncomfortable ambulance, not good for orthopaedic issues. Carers meant to be at home, but no one was there when I arrived home. Friends had to arrange food, this was not checked at discharge. Medication given just with leaflets in box. I had a discussion with GP and pharmacist myself when home.' **Patient**

'No paperwork was given on discharge, so I'm not sure what happened whilst I was in, if they found anything or what they gave me and don't know if I was referred for any other outpatient appointments.' **Feedback to Healthwatch Halton**

If you are helping to look after your relative, were you told that you are entitled to a Carers Assessment to help determine any help and support you might need as an unpaid carer?



Of the 19 family members of people who had been discharged home, only three (17%) said that they had been told about Carer’s Assessments. Six family members didn’t see themselves as carers.

What the ‘Hospital discharge and community support guidance’ says:

‘The relevant NHS trust should make a determination as early as possible in discharge planning – or as early as possible during a period of recovery – about the status and views of any unpaid carers who provide care, including that they are willing and able to provide support and care after discharge.’

‘Unpaid carers, including family members, providing care for the individual, should be offered support when they are identified. For example, all unpaid carers may benefit from signposting to local carers’ support services or voluntary services⁷ or referred to their local authority for a Carer’s Assessment.’

‘The relevant local authority should undertake a carer’s assessment before caring responsibilities begin if this is a new caring duty, or, if there are increased care needs, a review of the previous carer assessment and support plan.’

⁷ In NICE guideline Supporting adult carers, section 1.2.7 states that practitioners involved in transferring people to and from hospital should seek to identify carers and refer them to appropriate services.



What the ‘Hospital discharge and community support’ guidance says:

‘Discharge planning should include information about post-discharge care, such as advice and information about voluntary and community sector organisations, housing options (such as home adaptations, the Disabled Facilities Grant (DFG) and possible alternative housing) and NHS and/or social care crisis response teams that can be contacted if needed.’

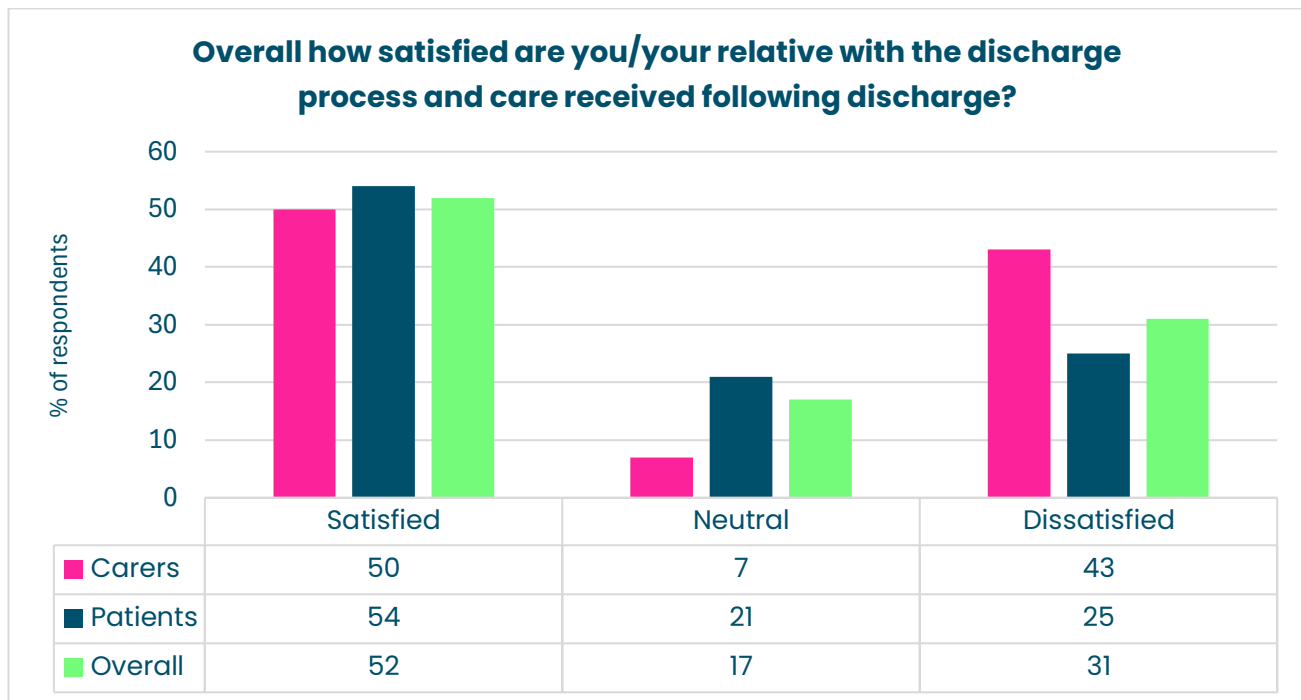
Exactly half of people who were discharged home (50%) said that they were given written contact details of who to contact if they needed any further advice following discharge.



‘I struggle to hear as I’m partially deaf and I don’t always remember what I’ve been told or get chance to ask the questions that I later think of... Being given an email address to ask further questions or a patient forum would really help.’ **Virtual Voices survey response**

‘Care on the ward was good. Communication with families was poor. Discharged without assessing needs, even when raised a safeguarding. Now at home and waiting to be assessed by an OT and assisted living whilst at risk!’ **Virtual Voices survey response**

Overall satisfaction



The above chart shows the overall satisfaction rates for the discharge process and the care and support received following discharge.

While overall 52% felt positively about the discharge process, one in four patients were dissatisfied with the experience.

Carers and Family members were generally more dissatisfied than the people who had been discharged.

There were some people who had been discharged home who talked about positive experiences of support they'd received from staff at the Trust and follow up services.



'Staff were very kind and kept me and my daughter informed all the time.'

Patient

'There was a lot of encouragement to speak to the bereavement midwife and counselling for both me and my partner on discharge and look after my emotional health as much as my physical health, which I think is really important.'

Patient

'They went to great pains to coordinate my discharge in a timely way.'

Virtual Voices response

‘Warrington Voluntary Action Discharge team helped me enormously. They also referred me to CAB who sorted all my money and housing issues out.’ **Virtual**

Voices response

‘Nurses are amazing I feel well cared for. Being discharged to B3.’ **Patient**

‘There were brilliant nurses on ward A6 who very caring and knowledgeable.’

Feedback to Healthwatch Halton

Some people had mixed experiences of discharge:



‘Getting into the system should be easier but as soon as she was there the care was great.’ **Family member**

‘Family had to find care home as it's determined on postcode and I'm out of the area.’ **Patient**

‘Ambulance men put me into bed at home. They were excellent. I saw four doctors, all had different ideas of what was wrong with me lots of tests. Couldn't have had better treatment. Food was rubbish. On the day I was admitted I couldn't get to see my GP they sent the frailty team they were brilliant got me into hospital and came to visit me when I was discharged, they are fantastic.’ **Patient**

‘Discharge discussion complicated. Offered to send to Halton hospital but not appropriate due to personal reasons so kept in Warrington hospital for longer. Social services came to discuss home equipment and delivered this home before discharge. OT assessment not done whilst at home, months wait. Physio present when tried to get off bed and set up equipment to support with this, but I didn't get any further support after that. Community physio gave an exercise, but this caused pain and wasn't appropriate. My consultant later said this exercise was not appropriate.’ **Patient**

We received some comments about a lack of support for people at end of life, with one person saying:

G 'My relative has now passed away. We were given very little support when he was sent home, which resulted in him having to return to hospital. He died 5 days after return to hospital but with support he could have died at home.' **Family member**

Another family member told us about their experiences at the hospital, saying:

G 'I asked to speak to the palliative care nurse because the hospital discharge team were saying he didn't meet the criteria for hospice care. I knew when he was first admitted he was dying and near the end no one seemed to care.'

There wasn't even anywhere to have a private conversation on this ward no privacy rooms or an office it was disgraceful. His care and support wasn't good he should have been turned every two hours this didn't happen only as and when they remembered, they never came and moistened his lips with water, I had to keep requesting pain relief, I knew he was in pain, I had been with my husband for 60 years and his carer for the last 3 so I knew when he was in pain.

When he first went in, I asked the staff to make sure he was comfortable and not in pain I had to constantly ask them to give him pain relief as he had no voice. One sister said she couldn't give him anything unless he's in really bad pain I told her he didn't have a voice and he was in pain the sister on the ward stated it would be inhumane to give him pain relief if he didn't need it. He was crunched up, holding his stomach, I knew he was in pain. In the first instance on the ward they gave him a saline drip one bag with anti-biotics in because they thought he had an infection I advised them he didn't as he'd already been tested multiple times over last weeks and days and he didn't have an infection, no one listened when I told them he wasn't eating or drinking they never put him on any fluids or feeding tubes they just used to bring a drink or a meal leave it on his tray and walk away.

He went onto food monitoring and one morning I asked had he eaten, and the staff said 'yes' and when I asked what a teaspoon, tablespoon or whole bowl they said a teaspoon, I told them that wasn't eating. It took two weeks for the doctors and consultants to actually say he wasn't eating or drinking but he had been left all this time. I asked a doctor to give him pain relief, he said he couldn't, he could only prescribe, but not administer as it wasn't his job. My husband was left with no pain

relief for an hour and half before anyone came. My husband had a DNR in place, but I feel he was pushed aside, maybe because of this, as no one cared on this ward, not an ounce of compassion, care or respect. In the end the palliative care nurse stated he did meet the criteria and he was then moved to the forget me not ward for two nights. They were amazing with him and then he was moved to Halton Hospice and he died Friday 9 July in the morning.' **Family member**

Others expressed their views about having a rushed discharge:

G 'I was rushed to get dressed, forgetting my lower denture in a plastic cup on the side cabinet, I rang the hospital next day, but it wasn't found and probably binned by a cleaner. Before an ambulance was available to take me home, I sat in the discharge lounge for 3½ hours feeling cold, hungry, and still feeling ill from pneumonia. My wife is in St Luke's care home suffering from dementia, and it took me several weeks to regain strength enough to visit her.' **Patient**

'Whilst in Warrington Hospital I was advised that they needed my bed for someone with a water infection and I would be moved to another bed. I was happy to do this within the ward, I was put on a corridor for an hour and half and then told there was no beds, and I was being moved here to Halton. I wasn't happy at all how they had gone about dealing with this situation...They obviously knew they were moving us so why not be transparent and open about it instead of lying, I wasn't happy at all.'

Patient

Conclusions

The patient and carer experiences we've collected during this project show that there is room for improvements to be made for patients being discharged from hospital.

- While overall 52% felt positively about the discharge process, one in four patients were dissatisfied with the experience.
- 43% of carers were unhappy with the discharge and follow-up care of their loved ones.
- Not all patients were aware if they had a care plan or not. If they had a care plan, they were often unaware of what was included.
- There is a lack of consistency in conversations around any support needed upon discharge. One in four patients said they were discharged without being asked if there were people to support them when they got home.

Recommendations and / or next steps

We're calling for more consistent implementation of the latest hospital discharge guidance⁸, including:

- 1. Patients and families need to be involved in conversations about their care** and to be informed as early as possible in the process about what the possibilities are.
- 2. All patients should be involved in the formulation of their care plan**, and staff should discuss with patients and family members what is included.
- 3. Improve involvement of people in conversations about their discharge at all stages of their hospital journey.** A key aspect of this is making sure people have as much advance notice of their discharge as possible. Under Section 91 of the Health and Care Act⁹ which came into force on

⁸ <https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance>

⁹ <https://www.legislation.gov.uk/ukpga/2022/31/section/91>

1st July 2022, NHS Trusts now have a legal duty to involve all patients likely to need further care and support in discharge planning.

4. Greater involvement of family and carers in decisions about discharge.

Family members should be considered an integral part of the discharge journey and, where appropriate, should be involved in discharge conversations from the point of admission until the person gets discharged home. Families often provide vital support with everything from arranging transport home, hands-on care and emotional support, as well as taking on a co-ordination role. Section 91 of the Health and Care Act also extends to involving unpaid carers in discharge planning.

5. Communication:

- a. **Routinely ask people receiving hospital treatment or care and their family members whether they have any communication needs** and act on these in line with duties outlined in the Accessible Information Standard. Communication needs aren't always visible!
- b. **Communication needs to improve between the hospital and other health and care professionals to ensure continuity of care.**

6. Carers Assessments:

- a. **Improve identification of family carers and refer to our local Carers Centres for information and support as required.**
- b. **Work from the assumption that all family members might have a caring role.** Carers should be clearly identified and flagged on the patient's record, with permissions actively sought prior to or during admission. Even if someone leaving hospital doesn't need a formal

assessment for a care and support package, they should be signposted to informal community support.

7. Discharge conversations:

Patients, families, and carers said that they were not always sure who to contact if they had concerns.

- a. **There needs to be a consistent approach to conversations around any support needed upon discharge.**
- b. **Support to help people make informed choices**, by providing contact information and advice, and asking about transport home.
- c. **There needs to be clear responsibility for who will arrange people's transport home**, with dedicated staff to make travel arrangements.

8. Patient Feedback

- a. **Monitor the quality of hospital discharge.** Upon discharge, patients and family members / carers should be given opportunities to feedback on how they felt the service worked for them. What was good and what could be improved.

9. **All partners involved in the hospital discharge process should review their discharge information**, policies and procedures to check that they involve both people staying in hospital and their family carers, where appropriate, at key points.

Warrington & Halton Hospitals response

Warrington and Halton Hospitals welcomed the opportunity to comment on the Healthwatch Discharge Report. The Discharge Report is very comprehensive and thorough document that assists WHH identify key areas of focus to improve the experience of our patients and families throughout the discharge process. WHH remains committed to the supporting improvements ensuring patients, carers and families have a positive experience. To ensure we can achieve these improvements it is vital we are able to hear from those we serve, therefore we welcome this report and its recommendations.

In response to the findings the Patient Experience Team are undertaking a full review of the report and recommendations and will map these against existing workstreams. For any gaps identified they will develop any further actions required. Any new areas identified will be featured as a priority workstream when revising our Patient Experience Strategy in 2024, of which Healthwatch is a key stakeholder. The Patient Experience Team will provide quarterly updates of associated actions at the Patient Experience Sub Committee from June 2024 onwards, where Healthwatch' continual feedback will be welcomed as an integral member of that committee.

Warrington and Halton Hospitals is happy this report provides information that is meaningful, understandable, and clear. We would encourage all Trust members, members of the public and others who are interested in our hospitals to read this report and note the positive improvements that will result from the findings.

Ali Kennah

Chief Nurse, Warrington & Halton Teaching Hospitals NHS Foundation Trust

NHS Cheshire & Merseyside Halton Place and Warrington Place response

I am writing in response to your email, dated 9th May 2024, in which you provided me with the Healthwatch Halton and Healthwatch Warrington report into the experiences of patients and carers during their discharge from Warrington and Halton Teaching Hospitals NHS Trust.

I would like to thank you and your teams for your continued support in achieving the residents voice and experience with all age services across the health and care system. It is such a valuable resource on which we can improve services and respond to need.

The Hospital Discharge report has provided us with some clear insight into our system response and impact of our discharge process especially in these challenging times. I feel the eight recommendations you make are key to change and quality improvement. As you are aware I have shared the report across the system, for example, both Place Quality and Performance Groups; both borough Directors of Adult Social Care; Trust colleagues and Senior Leadership Teams. All colleagues agree that we need to implement the recommendations and will action them. I understand the Hospital Trust has already provided you with a response.

I have shared the report with Sarah Haworth and Stephanie Haddock who are the Senior Responsible Officers for leading the 'No Criteria to Reside' workstream under the Urgent Care Review priority. They will ensure there is a joined-up approach to implement change and they will link in with the Patient Experience Team who are mapping the recommendations in the report to existing workstreams within the Trust. Once this work is completed any gaps identified that need to be addressed will be developed into an action plan. I think its key that we ensure we all work together to address this as a system.

I have asked for the action plan to report into both Place Quality and Performance Groups (QPG) for oversight and also to support as required. It is helpful that you are both members of the respective QPG's and will be able to gain assurance from this but also to provide any additional insight that you may have from your continued discussions with residents. I will also ensure

you have a copy of the initial action plan as well as updates so that you can see the progress being made.

I hope that the above will provide you with some initial assurance that the report is being valued and responded to. I am happy to discuss further should you wish to.

I would like to thank you once again for your continued support.

Denise Roberts

Associate Director of Quality and Safety Improvement

NHS Cheshire & Merseyside Halton Place and Warrington Place



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