healthwatch Stockport

‘Hospital to Home’ Research Report

July 2024

Contents

1 EXECUTIVE SUMMARY

We conducted our Healthwatch Stockport 'Hospital to Home' research project, between April and June 2024, to gain a deeper understanding of the experiences of individuals being discharged from Stepping Hill Hospital and requiring social care and support services back home.

This project seeks to influence local health and care service commissioning and provision to improve the quality, support, and overall experience of local people using health and care services.

The research encompasses several key areas including the engagement and feedback of 35 individuals and carers who have been in hospital and discharged back home/or another place of care., who also required additional social care and support needs. It also looked at how individuals understand and access the information and support provided to them at the point of discharge and when they were back home.

Key findings from the data we collected reveals a mixed bag of people's lived experience and whilst there were positive highlights there were several areas of concern and opportunities for improvement.

Many patients and their families reported **insufficient involvement in discharge preparations** and a **lack of clear communication** regarding discharge plans. **Delays and last-minute changes** to discharge timing, as well as **inconsistent coordination of transportation**, further compounded the stress and confusion experienced by patients.
Additionally, the **quality of discharge assessments and care plans** varied significantly, leaving some patients uncertain about their next steps once they were back home.

Despite these challenges, there were several positive aspects noted in the feedback.
Staff were frequently praised for their care and support, with many patients expressing gratitude for the attentiveness and **professionalism of the REaCH (Reablement and Community Home Support) Team**.

Effective discharge planning was highlighted in some cases, particularly **in departments like urology**, where patients felt **well-informed and supported** and most patients regardless of the department where they were being discharged from **recognised the work force challenges** and how busy staff were.

Through the feedback we gathered, we were able to identify several areas that with small changes could enhance discharge processes, strengthen support systems, and improve communication between patient, family and carers and health and care staff. These include establishing better communication methods for patients and their families.

Patients themselves made several suggestions such as:

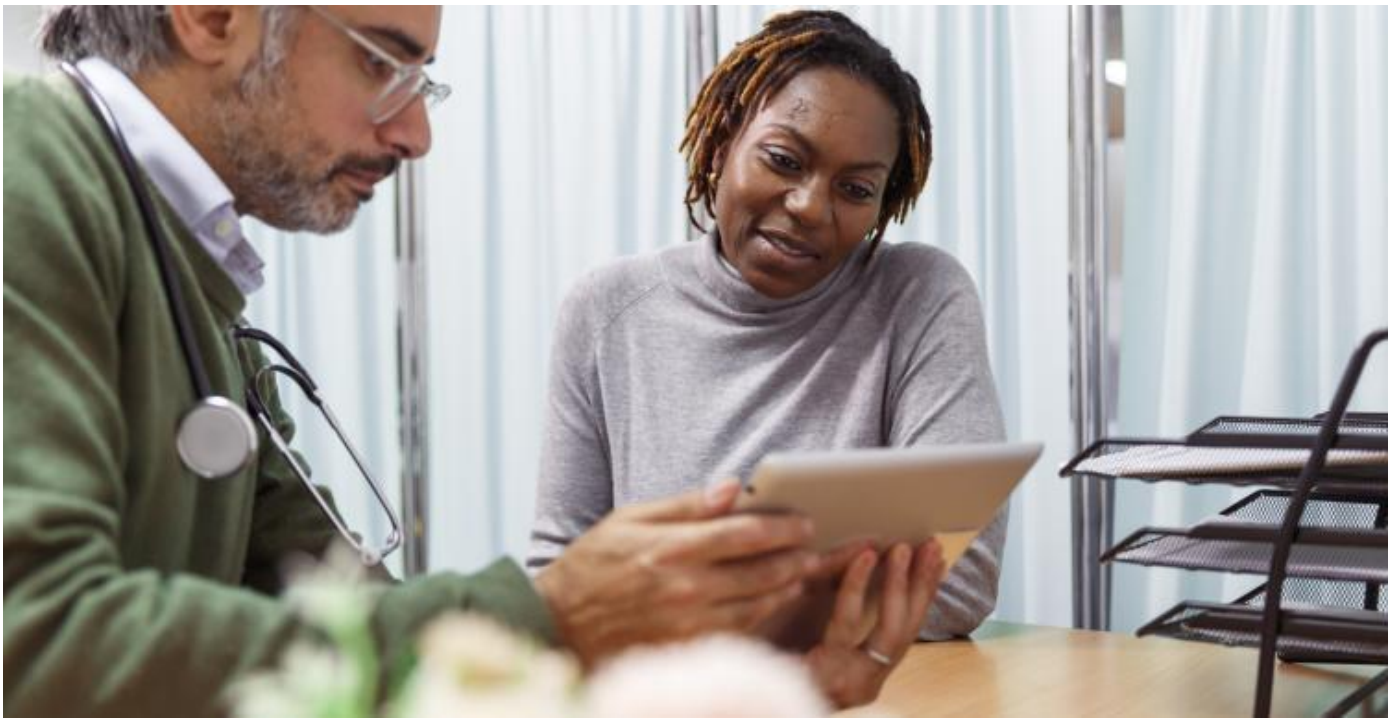
- Having discharge champions
- Volunteers in the transfer lounge
- Providing more advance notice of discharge dates
- Ensuring detailed care plans are communicated clearly
- Improving coordination between hospital and social care services.

Healthwatch Stockport recognises it needs to do more to reach people from more diverse backgrounds as our demographic data indicates, people we engaged with through the discharge lounge and feeding back to us were a predominantly older population, (expected in pathways 1 and 2) with a majority being female and identifying as White British.

A significant proportion of participants reported having a disability or long-term condition, highlighting the main cohort of people requiring extra support and the need for tailored support and resources.

We have, through being part of integrated health and care system meetings been aware of the continuous hard work being carried out to improve discharge from hospital such as tighter monitoring of 'No Criteria to Reside' and 'Discharge to Assess' beds. Thus, encouraging the Home First ethos to improve the discharge flow of patients out of the hospital back home receiving the right care.

Whilst things are moving in the right direction, we must not forget the person is at the heart of all this and when trying to ensure the speediness in which patients need to be transferred out of hospital we don't compromise their overall patient experience. It is all too easy to say people are usually forgiving of staff as they know how busy they are, but are we willing to accept this as normal practice as patients report feeling isolated whilst in hospital and becoming unsure when it is ok to interrupt a busy nurse?



In conclusion, our Hospital to Home Research Project provides valuable insights into the current discharge processes and experiences of social care and support services users in Stockport.

By offering suggestions for addressing the identified issues and implementing them, working collaboratively we can enhance the quality of care, provision of information and ensure appropriate community discharges, ultimately improving the overall patient experience and their outcomes.

2 THE PROJECT

Project Overview:

- **Title:** Hospital to Home Research Project
- **Timeline:** April – June 2024

Project Goals:

1. Understand the experiences of individuals discharged from hospital who require social care and/or additional support.
2. Influence local health and care service commissioning and provision to improve the quality, support, and experience of people needing social care and support following a stay in hospital.

Project Scope:

- Enter and View visits took place at Stepping Hill Hospital at different times over the course of a week.
- Hosted an Afternoon Tea inviting people and their family/carers who have been discharged from hospital with support from the Reach Team.
- Included feedback from people contacting the Healthwatch Stockport Information and Advice Service.
- Attended community engagement events – E.g. attending Signpost for Carers event.
- Attended the Home Care/Care Home Forums
- Engaged the Adult Social Care Team – seeking feedback via social work teams
- Engaged with people following discharge from hospital.
- Included carers' experiences.
- Included people access to information and support.

Project Stakeholders:

- **Task Group:** Healthwatch Stockport Volunteer Members, Trained Volunteer Enter and View Team, staff, and community sector colleagues.
- **Target Population:** Individuals discharged from hospital, using social care services, including older people, disabled people, learning disabilities, mental ill health, other complex health and care needs and people from minority backgrounds.
- **Health and Care System:** Adult Social Care, NHS Integrated Care Board (Stockport), Stockport NHS Foundation Trust.

- **Forums & Networks:** Care Home Providers; Home Care Providers, Signpost for Carers, Age Friendly Network, Community Voice Partnership, Healthwatch Stockport.

Project Priorities:

1. Overall experience of the health and care journey from hospital to home.
2. Quality of health and care provision following discharge from hospital.
3. Sources of information and advice about discharge, social care and support needs.
4. Carers' perspectives.
5. Emphasis on equality considerations.

Defined Outcomes:

- Improve patient experience.
- Ensure appropriate community discharges.
- Increase knowledge about care access rights.
- Influence local policies and service provisions.

Background:

Overall, we have included the following in our data analysis:

- Observations and Feedback from people who we spoke to in the Transfer Lounge at Stepping Hill Hospital [patients and staff]
- Observations from our visit to the Transfer Hub at Stepping Hill and discussions with staff.
- Feedback from people, families/carers who attended our afternoon tea event.
- Case studies from 1-1 conversations we had with people who could not attend the tea event
- Data from our Feedback Centre database
- Gaps: Engaging people with mental health however we have feedback from our One Size Does Not Fit all Report on Mental Health Report which can be referenced.
- Gaps: Engaging with learning disabled people, we did not see anyone with a learning disability during our visits to the Transfer Lounge. However, we did speak to families of people with a learning disability appear to be discharged more often directly from the ward with family/carers.

- Gaps: People from minority backgrounds - although we invited feedback, we received little and most people who we saw in the lounge were older white females, indicating that a further piece of work to do here.

Criteria for discharge for all patients is as follows:
Pathway 0 – Simple discharges with no input from health / social care.
Pathway 1 – Support to recover at home, with input from health and / or social care.
Pathway 2 – Rehabilitation in a bedded setting.
Pathway 3 – Following a life changing event; home is not an option at point of discharge.

The Transfer Lounge accepts patients from wards across the hospital on pathway 1 and 2.

A note on our data

the main section of this report is based on qualitative analysis of a sample of self-reported experiences of health and care services shared with Healthwatch.

This data is qualitative, and we cannot quantify themes with exact numbers. However, all issues highlighted were consistent themes in the data, gathered from local people in Stockport.

Aspects of our findings support data from Healthwatch England representative polling carried out nationally, this data represents a reliable snapshot of patient experience.

3 KEY FINDINGS FROM THE DATA

How we collected the feedback:

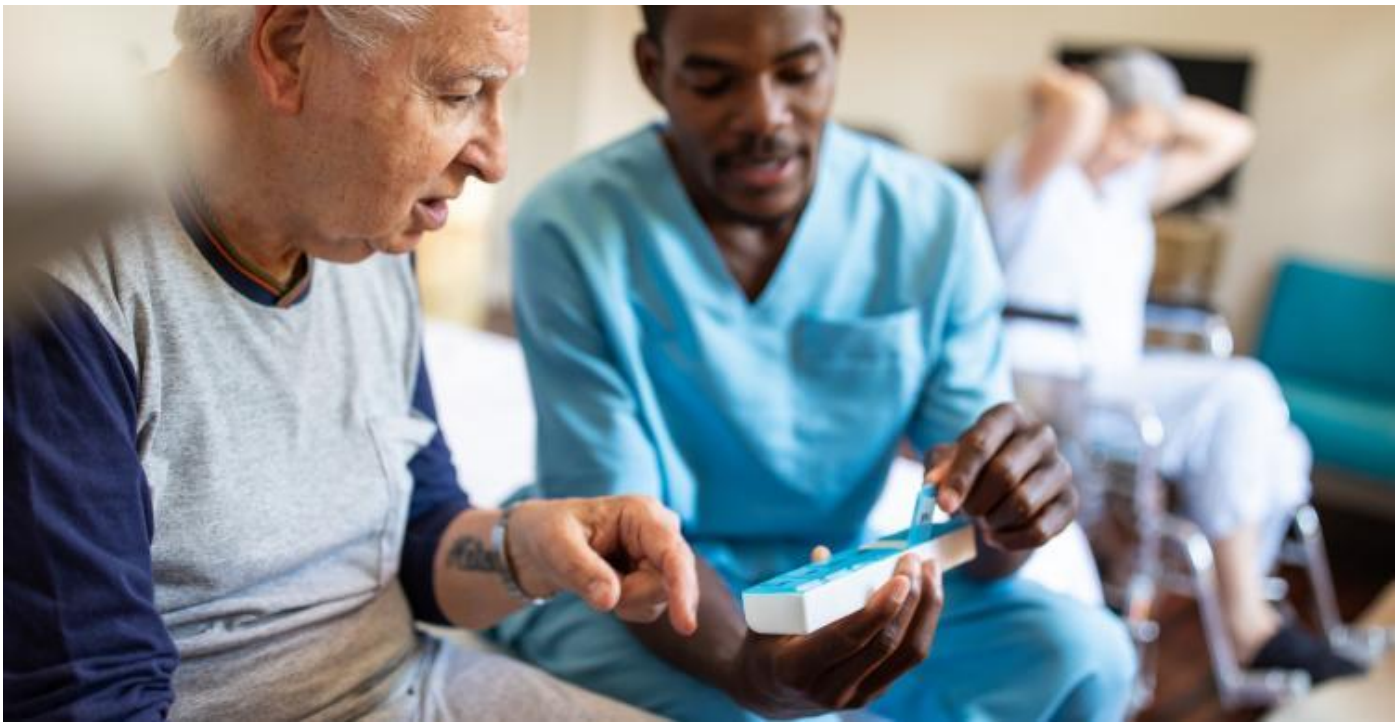
A series of questions were developed with our volunteer Social Care Task Group and Enter and View Members, based on examining the issues we received through our feedback centre which triggered us to research this issue further. These were used as prompts and triggers to facilitate discussion with participants. Copies of these can be found in the appendix.

Where and When:

All the feedback involved people's stay at Stepping Hill Hospital.

In patient stay was between 3 and 90 days all occurring between October 2023 and May 2024. One person reported spending 2 days in the emergency department before spending a further 7 days on a ward (fractured hip).

The Enter and View Team visited Stepping Hill during the week of 6th May 2024. One of the days was following a Bank Holiday. Activity in the Transfer Lounge was remarkably quiet.



1. Preparing for Discharge:

Feedback was asked in relation to discharge planning starting from the ward, how much they were involved and kept informed. Note: some people were not discharged from a ward to the Transfer Lounge but from the Emergency Department.

Positive Aspects:

- **Informed and Involved**: Many patients felt informed and involved in discharge plans and patients generally understood them.

Areas for Improvement:

- **Notice Timing**: Some patients got very short notice about their discharge, causing stress.
- **Communication Gaps**: Some patients did not receive enough information about discharge plans, not knowing what to expect post-discharge back at home.

Examples

- A patient informed two days before discharge said he felt prepared.
- Another patient reported they got only five minutes' notice, which they report caused stress and anxiety.

2. Waiting to go Home:

The feedback provided here was mainly to do with the experience in the Transfer Lounge, where people were brought to wait for medication or transport home either by ambulance, or family member or carer.

We asked about discharge time notification, food and drink provision, and their self-assessment about being ready for discharge.

Positive Aspects:

- **Provision of Food and Drink**: Most patients were offered food and drinks before leaving.
- **Comfort:** The reclining seating was comfortable, however were bulky and no room between each to crouch and have a conversation with people (hard to hear with background noise)
- **Timely Transport/Meds Coordination**: When transport/medication was well-coordinated and came when expected patients were satisfied.
- **Support**: it was reassuring to see a formal carer from a care home waiting with a care home resident and who had stayed with him whilst he came into A&E. This, we believe is not usual practice by a care home. The Transfer Lounge staff were considerate and kind.

Areas for Improvement:

- **Provision of Food and Drink:** Some felt the quality of the [hospital] food was not good enough. On one of the days when we were at Stepping Hill, the lunch didn't arrive until quite late, the porters citing they had forgotten about the Transfer Lounge!
- **Delays in Transport/Medications**: Coordination of transport and medication was inconsistent, resulting in extended waiting times for patients. People did comment often about the long waits in the discharge lounge, people talked about being confused by it all, especially when they didn't understand why some people were leaving before them when they had been waiting longer. On one of the days when we were there, ambulance staff called in sick therefore there was no morning transport.
- **Transfer Lounge Experience**: Some patients found the transfer lounge experience frustrating, clock watching made time go slow and it felt like it was a 'holding pen'.

Examples

- A patient waited several hours for an ambulance, causing frustration for the patient but also logistical challenges for the staff.
- Another patient appreciated the drinks and comfort of the transfer lounge.
- The side room was used for a patient with stomach bug whilst we were there, we were made aware that there was potential for spread of infection and to take precaution.

3. Quality of Assessments:

We asked people about whether they understood the assessment at discharge process, if they received a care plan, medication plan, and how it was explained to them or their family/carers.

Positive Aspects:

- **Clear Assessments**: Some patients felt assessments were thorough and well-explained and when assessments were communicated effectively, patients felt more confident and prepared.

Areas for Improvement:

- **Awareness of Assessments**: Some patients were unaware of assessments and their purpose. Many patients and families did not understand the assessments conducted at discharge or were unaware that assessments had taken place either before discharge or once back home.
- **Care Plans:** Some patients did not receive clear or detailed care plans, leading to uncertainty about the next steps in their care.

Examples

- "The discharge assessment was explained to me thoroughly, and I felt involved in the decision-making process," reported one patient.
- Taken from an assisted survey - The carer didn't seem aware of the process and was worried about respite care at night, when their loved one left hospital.

4. Information, Communication, Advice, Dignity and Respect:

We asked people about the information, communication and advice given around discharge e.g. leaflets about medications, specific conditions, discharge letters, who was involved in their discharge, transport information and whether they felt they were treated with dignity and respect during their hospital stay.

All patients had some home care services arranged.

Positive Aspects:

- **Supportive Home Care:** When communication was clear, patients felt well-informed and supported.
- **Detailed Information**: Some patients and carers received detailed information about their discharge.
- **Helpful Staff**: Staff generally explained medications and discharge instructions well.
- **Support Information:** Age UK Stockport citied as being friendly and helpful, having had a call or visit from them once they were back home and some people had received information about them that was given to them on the ward.

Areas for Improvement:

- **Incomplete Information**: However, some information provided at discharge was often insufficient, with patients lacking necessary details about medications, care plans, and follow-up care.
- **Use of available Information Resources:** Patients often arrived from the ward with a porter in a wheelchair completely missing the well-resourced information stand which is hidden from main view in the discharge lounge.
- **Lack of Written and Verbal Communication**: Patients were often left to rely on written instructions without verbal explanations or vice versa.
- **Treatment of Patients**: Many patients felt the staff treated them well but also recognised how busy they were, no time to chat, having to alert staff if another patient needed assistance, quoting it was a shame they were too busy or the demanding conditions they were under.

Examples

- A patient appreciated the detailed explanation of medications that was provided.
- Another patient felt hurried out with their discharge and felt left without enough information.
- One lady was sent down to the transfer lounge from a ward in a hospital gown, tied at the back with only underwear on underneath. She said she felt undignified, we helped her with getting back into her day clothes.
- One lady was visibly upset that she did not have her own glasses and was given any spare pair and one of our Enter and View Team (retired nurse) helped to explain a patient's new medication schedule.
- One patient quoted that were "Very impressed by all the staff"
- One patient was still waiting 2 weeks for a care plan to come through.

5. Post Discharge – Back at Home Experience

We asked people about their experience of support once they were back home after hospital. We asked if they needed to stay in a residential care facility, needed extra care at home, whether they saw another professional such as social worker and were they happy with the extra care or support they received and if they were involved in the planning of that support.

There were 3 patients who reported that they went to either Bramhall Manor or Abney Court. The latter being more positive.

- **Care at Home:** Quality of care at home varied, with some patients receiving excellent support while others faced issues with care coordination and consistency.

Positive Aspects:

- **Quality Care:** Some patients reported receiving high-quality care and support at home.
- **Professionalism:** Patients appreciated the dedication and professionalism of many healthcare workers, particularly the Reablement and Community Home Support (REaCH) Team.

Areas for Improvement:

- **Inconsistent Care**: Some patients faced challenges with coordination and communication in home care arrangements.
- **Equipment and Medication:** Delays and miscommunications regarding equipment and medication were common, causing stress for patients and families.
- **Need for More Support**: Patients highlighted the need for better follow-up from support services once home and coordination of services.

Examples

- "The carers who visited me at home were professional and attentive, making my transition from hospital much smoother," shared one patient.
- "I received all the information I needed about my medications and follow-up appointments," said one patient.
- A patient had carers visiting 2-3 times a day, it was arranged quickly.
- There were a lot of praise for the REaCH Team who were often quoted as supportive and informative.
- Another patient felt there was a lack of follow-up and clear communication.
- “I have 4 calls a day for my husband, the last one is too early for him to go to bed [7.30pm] so I have to lift him to help him to the toilet later anyway.”

Additional Feedback

- **Staff Interaction:** Generally, staff were praised for their care and support, although some instances of perceived neglect or insensitivity were reported.
- **System Navigation:** Patients and families often struggled to navigate the complex healthcare and social care systems, indicating a need for better guidance and support.
- **Example:** "The staff were incredibly caring and made sure I was comfortable during my hospital stay,"

Personal stories:

"There were many things I was unhappy with especially when I was put in a home after discharge, I felt there was no choice, and I was deeply unhappy there I felt I was there against my will and the home would not supply me with incontinence knickers and I had to wash my wet knickers out myself at the sink. There were lots of very distressing things happen and I will tell you another time."

Patient Discharged to a care home

Personal stories:

"Hospital Sent me home with an infection and covid and without appropriate care. When I was sent home, I wasn't fit and therefore was so poorly I ended back in Stepping Hill Hospital within 3 days. Although I was under the D2A team, when I had severe sickness and diarrhoea, they did nothing to help me. In fact, they left me, and my house covered in sick and diarrhoea. I was so poorly after 3 days they couldn't take blood out of my arms because I was so severely dehydrated. I had to go into the acute medical ward."

Healthwatch Stockport Feedback Centre

6. Observations about the Transfer Lounge

Transfer Lounge:

- The Healthwatch Stockport Enter & View Team visited the lounge the day after a bank holiday. It was very quiet, with approximately 8 people discharged that day, compared to the usual 30 people (approx.).
- The lounge can become cramped when busy. While the reclining chairs are comfortable, they make it difficult to move around and hear conversations when extended.
- Staff were attentive but they could spend more time explaining procedures and hat to expect when they got home to patients during quieter periods.
- Patients felt like the lounge was a holding place to get them off the ward. Regardless of whether they waited 30 minutes or a whole day, it didn't feel person centred.
- Laminated cards with key information were suggested to improve communication.
- The loud 80s music on the TV channel was noted as a distraction.
- There was a need for more senior staff, particularly to assist patients with dementia who were often on their own.
- Staff demonstrated impressive knowledge of policy and procedures, particularly regarding safe numbers.

Transfer Hub:

Observations of the transfer hub (located next door to the lounge) there was Buzz of activity could see immediately how many people waiting to go home on the board, huddles of social workers, health care professionals and coordinators, Age UK Stockport all collaborating to facilitate transfer home. Impressive.

4 RECOMMENDATIONS / SUGGESTIONS FOR IMPROVEMENT

Supporting Improvements in the Discharge Planning

1. **Build on Good Practice:** Aim for ALL patients and family/carers reporting they feel informed and involved in their discharge planning.

   Of the people we spoke to or heard from, who were brought to the transfer lounge and needed additional support back at home after being in hospital, most needed to have continual reassurance whilst in the lounge about what was happening that day and when they got back home.

   Here are suggestions to think about for improvements to people's care and support:

   Person-Centred Approaches:

   - Tailor discharge information to individual needs, recognising that not everyone can take in the same amount of information or in the same format.

   Distinctive Discharge Information:

   - Print discharge information on different coloured paper to make it easily identifiable and easy to find in a bag for example.

   Accessible Information:

   - Provide accessible information, such as large print and black ink on yellow paper. Ensure there is an Accessibility Champion on all wards and Transfer Lounge to comply with accessible information standards.

   Durable Information Cards:

   - Use laminated cards with general details about what will happen at discharge and at home to avoid damage. Include easy-read and pictorial formats.

   Updated Discharge Leaflet and Checklist:

   - Ensure there is an updated discharge leaflet and checklist that stays with the patient. Consider involving patient groups to improve these materials.

   Written Details:

   - Provide written details about the care agency, services to be received (e.g., REaCH as part of Adult Social Care at the Council), and information about supportive organisations like Age UK Stockport, Signpost, and Healthwatch Stockport. Include a contact name for further assistance.

Explanation of Discharge to Assess (D2A):

- Include an explanation card or leaflet about what Discharge to Assess (D2A) is, clarifying what an assessment is, who conducts it, and when it happens.

Clear Language Use:

- Use and explain terms like Assessment, D2A and REaCH clearly to avoid confusion.

2. Advance Notice

Advance Notice and Discharge Readiness:

- Where possible, provide more advance notice of discharge dates and times to allow for better planning and support.
- When advance notice is not possible, establish a process to ensure patients are discharge-ready, even at short notice. This includes:
  - Providing thorough and timely information about the discharge process.
  - Ensuring patients understand and feel comfortable with the plan.
  - Supporting patients to allay fear and anxiety through reassurance and clear communication.

3. Transfer Lounge Experience

Enhanced Patient Engagement:

- During quieter periods, suggest staff sit with patients to explain more about what to expect when they go home, answer queries, and possibly provide information packs.

Person-Centred Care:

- Improve person-centred care by ensuring patients understand the discharge process and feel involved.

Comfort and Space:

- Make the discharge lounge more comfortable and spacious. Consider moving the lounge to a larger space as most days it is full and busy, and can be difficult to connect with people.

Volunteer Support:

- Train and use volunteers/champions in the lounge to sit and speak to people while they wait for discharge, reassuring them about what is happening and filling gaps in information and communication.

Dementia-Friendly Areas:

- Consider for people with dementia, utilise the serenity lounge more often.

Diverse Communication Needs:

- Ensure staff training in communication needs of diverse groups, including people with hearing and visual impairments, and provide interpreters as needed.

Hearing Aid Support:

- Have spare batteries for hearing aids available in the lounge to significantly improve patient experience.

Information Accessibility:

- Relocate the information stand to a more visible and prominent place in the lounge.
- Proactively provide information resources by putting together a tailored information pack for every patient at discharge.

Communication Toolbox:

- Ensure there is a communication toolbox in place and visible for use when required, which may necessitate staff training.

Calming Environment:

- Consider the volume and content of the TV channel to create a more calming environment. Utilise the TV to provide information outlining what to expect, similar to GP surgeries, and consider quieter, calming music or picture slideshows.

4. Enhancing Patient Experience, Dignity, Care and Respect

Ensure Dignity:

- Ensure patients are fully dressed before coming to the lounge.

Belongings Check:

- Check that patients have all their belongings and that they are their own.

Continuous Feedback:

- Regularly engage with patients, family, and carers to collect and act on their feedback (in addition to the Friends and Family Test) to continually improve discharge processes and care quality.

Periodic Independent Feedback Collection:

- Consider commissioning Healthwatch periodically to independently collect and analyse feedback.

5. Strengthening Support and Improving Information, Communication and Advice

Follow-Up Calls:

- Arrange follow-up calls to check on all patients' experiences back home.

Staff Training:

- Provide additional training for health and care staff on the importance of clear communication and patient involvement in discharge planning.

Detailed Care Plans:

- Ensure all patients receive a detailed care plan with clear instructions and contact information for follow-up support.

Explanation of Assessments:

- Provide better explanations of assessments and care plans, ensuring patients are aware of their outcomes.

Continuity in Home Care:

- Ensure continuity and clarity in home care services.

Improved Coordination:

- Improve coordination between hospital, social care, and support services to provide seamless care transitions.

5 CONCLUSIONS

Our Healthwatch Stockport 'Hospital to Home' research project, conducted between April and June 2024, has provided valuable insights from 35 individuals into the experiences of individuals requiring social care and support following hospital discharge. The findings highlight a mix of positive experiences and areas for improvement, particularly in discharge planning, communication, and coordination of care.

Positive Aspects:

- Many patients praised the professionalism and attentiveness of the staff.
- Effective discharge planning was noted in some departments, with clear communication and support.
- Some patients received timely and well-coordinated care, both during and after discharge.

Areas for Improvement:

- **Discharge Planning:** Many patients reported insufficient involvement and short notice in discharge preparations.
- **Communication:** There were gaps in communication about discharge plans, medications, and follow-up care.
- **Coordination of Care:** Delays and inconsistencies in transportation and home care arrangements were common issues.
- **Quality of Assessments:** The clarity and thoroughness of discharge assessments varied significantly.

Gaps in Engagement:

- **Diverse Populations:** The project lacked engagement with individuals from diverse ethnic backgrounds.
- **Mental Health:** More comprehensive feedback from individuals with mental health issues (other than dementia) was needed.
- **Younger Adults:** Limited engagement with younger adults who may also require social care support.
- **Learning Disabilities:** Some feedback received from families.

Recommendation Summary:

- Enhance communication by building on established best practice and the positive experience of patients which lead to more patients having better discharge experiences, focussing on providing more advance notice of discharge dates, and discharge readiness.
- Strengthen support systems through detailed care plans and improved coordination and involvement between patient/families, hospital and social care services.
- Provide an improved experience within the discharge lounge space by taking on some of the suggestions identified, for example; providing consistent levels of care and information for patients and families and involving them to better understand discharge processes, the available support or support which has been put in place back home.
- Healthwatch Stockport task group willing to support this piece of work.

Hospital to Home Research Report

Appendix

- Case Studies
- Demographics
- Questions We Used

Appendix i
Case Studies – Positive Experience

Patient: Case Study 1

Hospital: Stepping Hill – Unsure which ward
Discharge Date: April 2024
Discharge Location: Home

Experience:

- **Preparing for Discharge:** The patient was spoken to a couple of days prior to discharge and all their dressings were changed before they left the hospital.
- **Journey of Leaving Hospital:** The patient was given 2-3 days notice and felt ready to go home by the end of the week. A family member did the shopping to ensure they had everything needed.
- **Quality of Assessments:** The patient felt ready to be discharged and understood the process. They did not require a care plan as they had a cleaner once a week and help from family.
- **Information, Communication, and Advice:** The patient was kept informed about their discharge and found the hospital staff to be very helpful. They had no complaints about their stay.
- **Home Care Experience:** The patient did not require any additional help at home and managed well with the support of family.

Case Studies – Mixed Experience

Patient: Case Study 2

Hospital: Stepping Hill – Possibly A1 then discharged to Abney Court
Discharge Dates: November 2023
Discharge Locations: First to Abney Court, then back to home

Experience:

- **Preparing for Discharge:** The patient was told the day before that they might be going home but had to wait until their medications were ready. This caused some confusion.
- **Journey of Leaving Hospital:** The patient experienced delays in the discharge process and found it difficult to get consistent information from hospital staff.
- **Quality of Assessments:** The patient did not feel fully prepared for discharge. There were issues with the equipment provided and the lack of clear instructions.
- **Information, Communication, and Advice:** The patient received some information, but not enough to feel fully informed. There were delays in receiving medication and essential equipment.
- **Home Care Experience:** The patient's experience at home was mixed. They had carers coming in but faced issues with changing carers frequently and a lack of clear communication.

Case Studies – Negative Experience

Patient: Case Study 3

Hospital: Stepping Hill - Stroke Ward
Discharge Date: May 2024
Discharge Location: Home

Experience:

- **Preparing for Discharge:** The patient and family were informed about the discharge only two days before it happened. The patient felt that there was insufficient notice. The family was not adequately involved in the planning.

- **Journey of Leaving Hospital:** On the day of discharge, the patient experienced significant delays. They were kept in the discharge lounge for several hours, waiting for an ambulance. The patient reported feeling very frustrated due to the long wait and lack of communication about when transport would arrive.

- **Quality of Assessments:** The patient felt that the discharge assessment was not explained thoroughly. They were not sure what the assessment entailed and did not feel prepared for the transition back home. No clear care plan communicated, and the patient was left uncertain about next steps.

- **Information, Communication, and Advice:** The patient received their medication while in the lounge but reported that there was minimal explanation about the medication plan. They felt that the information provided was insufficient and lacked detail. Additionally, the patient and their family did not receive clear communication regarding who was involved in the discharge process.

- **Home Care Experience:** Once back at home, the patient required carers 2-3 times a day. Although the care was arranged quickly, the patient felt that the communication and coordination of this care were poor. They were not fully aware of what to expect and felt that the overall process was disorganised and stressful.

Case Studies – Positive Experience

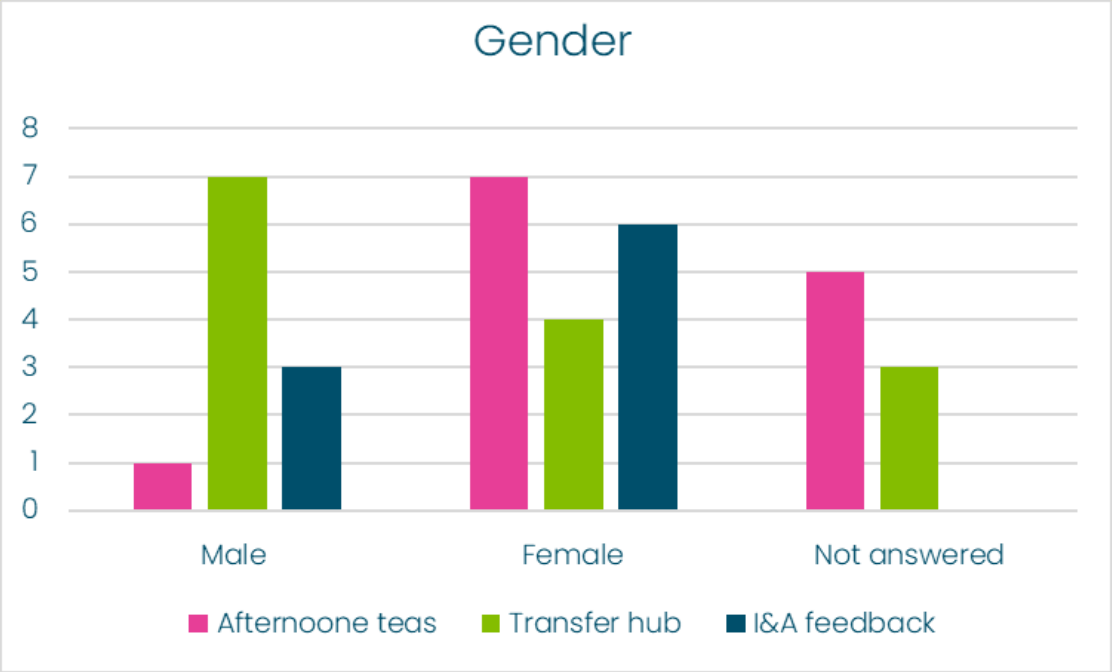
Patient: Case Study 4

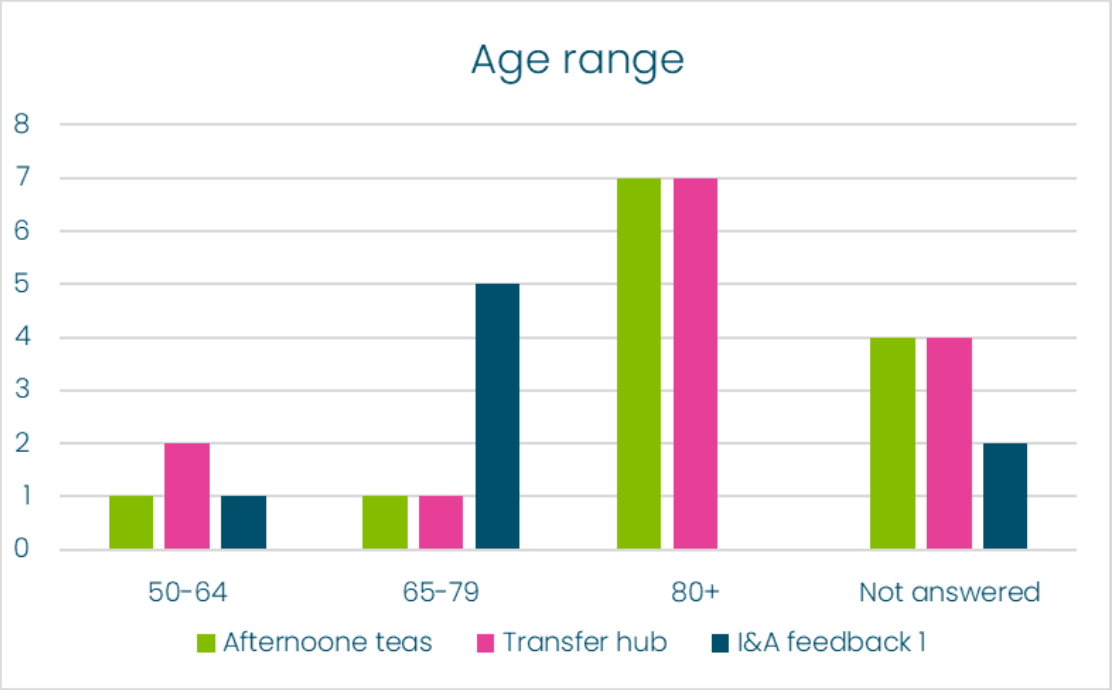
Hospital: Stepping Hill Ward A10
Discharge Date: March 2024
Discharge Location: Home

Experience:

- **Preparing for Discharge:** The patient was kept informed and engaged in the preparation conversations. Family members had a few days' notice before the patient was discharged.
- **Journey of Leaving Hospital:** The patient was given a rough timeline for their discharge, and although there was a slight delay, it was not significant.
- **Quality of Assessments:** The patient understood the discharge assessment and was fully involved in the process. A care plan was put in place for their return home.
- **Information, Communication, and Advice:** The patient was well-informed about their discharge and ongoing medication plans. They appreciated the detailed communication from hospital staff.
- **Home Care Experience:** The patient received four weeks of daily visits to assist with showering and dressing. They praised the care received as professional and supportive, although noted the need for continuous monitoring and adjustment of care plans.

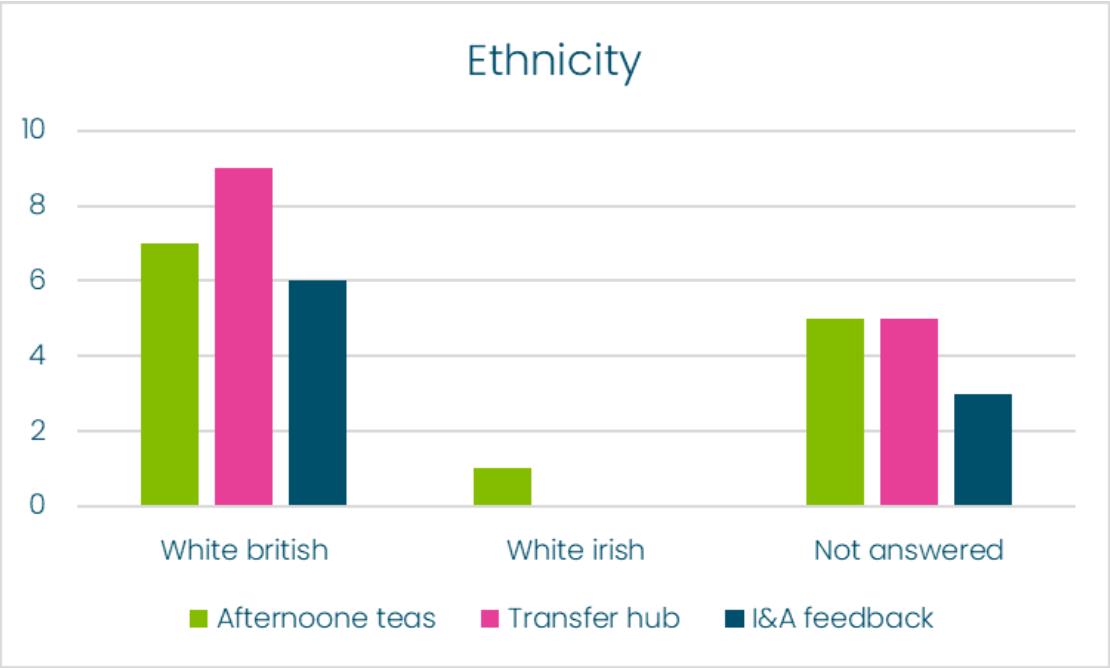
Appendix ii.
Demographics

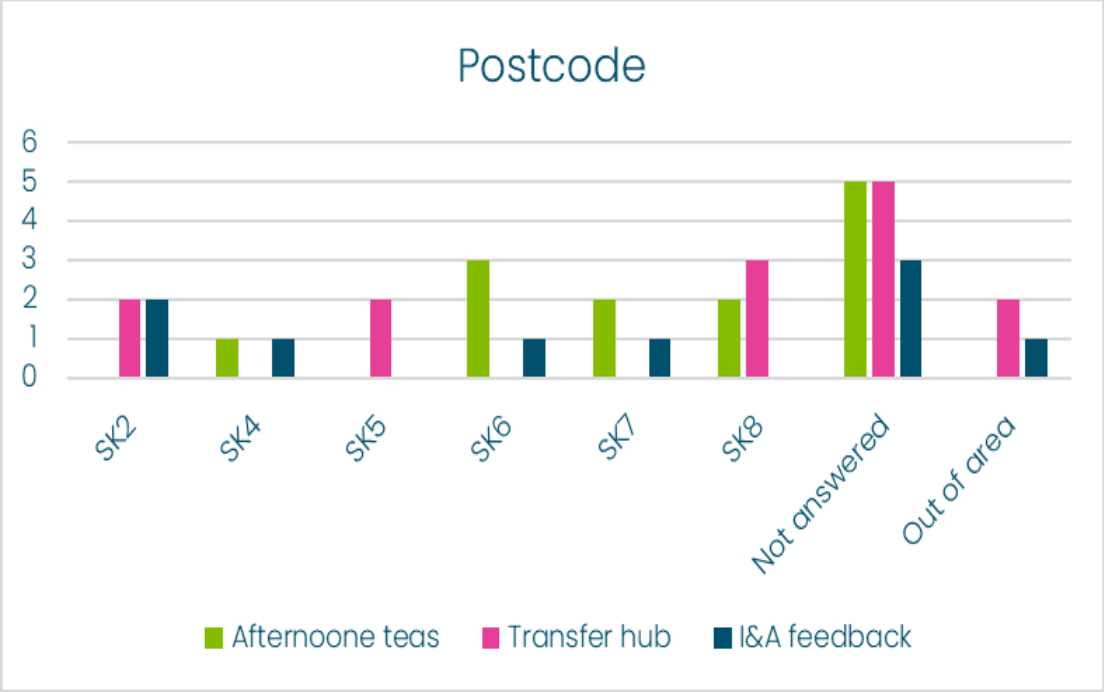




The demographic data indicates a predominantly elderly population, with a majority being female and most identifying as White British.

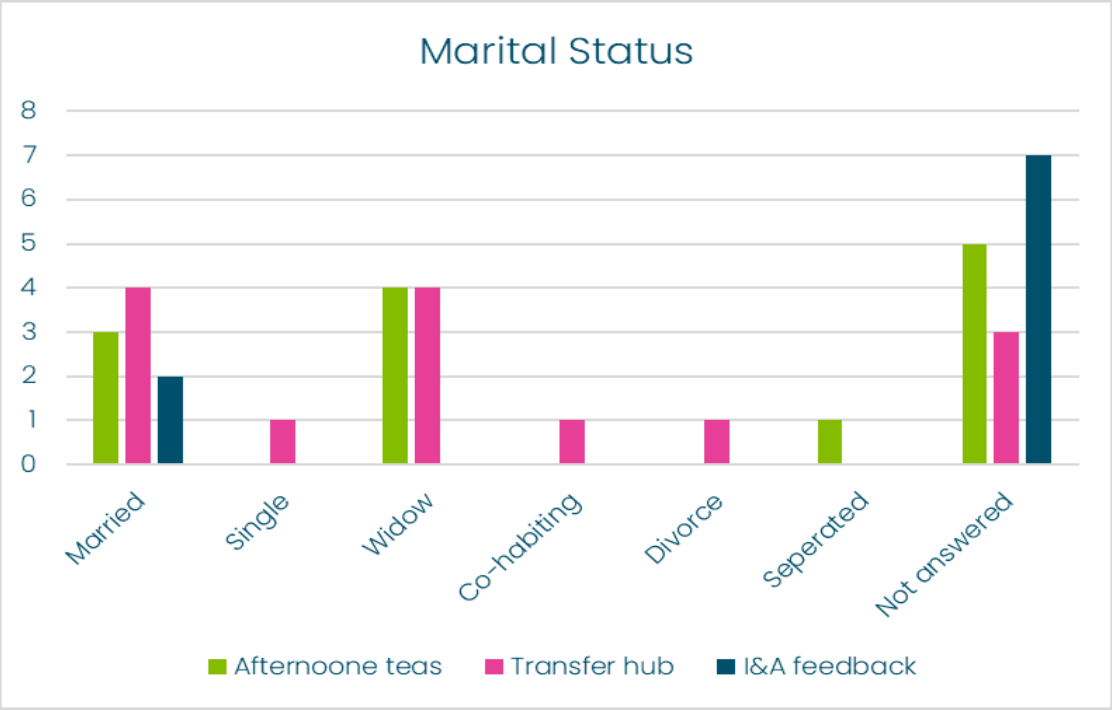
Demographics

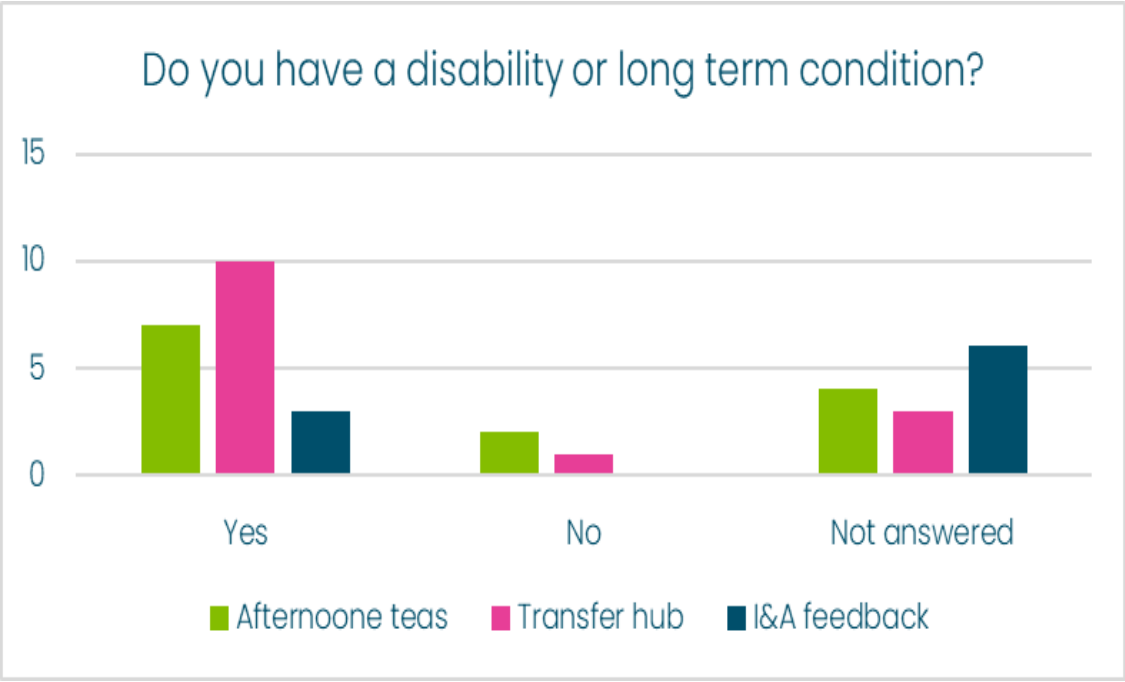




The geographic distribution shows a diverse representation across different areas within Stockport. This demographic insight helps to understand the varied backgrounds and needs of the individuals involved in the study, ensuring that the findings and recommendations are inclusive, and representative of the community served. However, there was little feedback from people from minority backgrounds and something Healthwatch Stockport wishes to explore further.

Demographics





A significant proportion of the participants are married or widowed, with a high percentage reporting having a disability or long-term condition.

Appendix iii

Patient/family/carer Feedback Questions

Healthwatch Stockport is undertaking a piece of work to understand people's experiences of support when being discharged from hospital, this includes Stepping Hill as well as other hospitals across Greater Manchester and Cheshire. We would like to capture the experiences of local patients, residents, families, and carers, so if you would like to share your experience, please complete any sections that are relevant to you below:

Questions
• Who is completing the survey (Patient/ Family/ Carer) • Hospital and ward discharged from • Approx date of discharge (month/year) • Location discharged to (home, care home, other) • Approx Length of stay on hospital
1. Preparing for discharge Were you: • Kept informed? • Involved in preparing for your discharge? • How much notice was given to you about your discharge date? • Were any concerns raised by you as the patient/ family/carer or the Discharge Team? If so, were these addressed? • What could be improved?
2. Journey of leaving hospital On the day of Discharge were you: • notified of your discharge time, if so, how much notice were you given? • was it delayed? • Was the discharge lounge used before discharge, if so how was your experience? • Did you receive adequate food and drink before discharge? • Was any medication you needed ready at the point of discharge? • Did you feel ready to be discharged? • What could be improved?
Quality of Assessments • Did you: • understand the assessment at discharge and what it entailed? Did you know you were having an assessment? • Receive a care plan? • Was there a medication plan, and was it explained to you or your family/carers? • Did they contain all the information you needed? • What could be improved?

4. Information, communication & advice given

Were you:

- Kept informed of expected discharge details?
- Given the information you needed for this discharge e.g. leaflets about medications, specific conditions, discharge letters?
- Did you know who was involved in your discharge – prompts An Assessor, Nurses, Physios, Occupational Therapists, Physician Associates, Pharmacists, Social workers?
- If you needed transportation – was it coordinated with the time of discharge?
- Do you feel you were treated with dignity and respect during your hospital stay?
- What could be improved?

5. Back Home

When you were back home:

- Did you need to stay in a care home before coming home? (describe the experience)
- Did you need extra care at home? What did this look like (new or more carers coming in, extra family support, more assessments from other services) did you see a social worker? Are you happy with the extra care you did or are receiving?
- If you did need extra care, were you aware of everything that was happening and felt involved?
- What could be improved?

6. Any other feedback

Is there anything else you would like to share with us today that we haven't covered?

Demographics

It would really help to know a little more about you so that we can better understand how people's experiences may differ. These questions are completely voluntary.

- Year of birth or age group
- Gender
- Describe your ethnicity
- Marital status
- Do you have a disability or long-term condition?

1st 3 letters of Postcode

NAME OF Healthwatch Rep completing this form if applicable

If you as the patient/ family/ carer, would like to be more involved in Healthwatch or receive the findings of our work please provide your details below.

Name Telephone Address Email

Your personal details will not be shared with anyone outside of Healthwatch Stockport and is protected in accordance with our privacy policy.

Please return the completed form via email to: info@healthwatchstockport.co.uk

THANK YOU FOR SHARING YOUR FEEDBACK WITH US TODAY.

YOUR VIEWS ARE IMPORTANT AND WILL HELP SHAPE FUTURE SERVICES FOR THE BETTER.

Healthwatch Stockport
Land O Cakes
48 Middle Hillgate
Stockport
SK1 3DG

www.healthwatchstockport.co.uk
t: 0161 974 0753
e: info@healthwatchstockport.co.uk