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LOCAL INVOLVEMENT NETWORK
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NOTTINGHAM
CITY LINK

HOSPITAL DISCHARGE SOCIAL CARE PACKAGES INTERIM REPORT



Task and Finish Group Interim Report

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Executive Summary

Background to the Project

The local community raised a number of concerns relating to Hospital Discharge to the LINK. The issue under consideration for this report is social care packages following hospital discharge, and specifically the transition between healthcare services to social care services.

Focus

- The transition between health and social care services
- Partnership working between agencies
- Gaps in services
- Implications of delays in receiving services

Approach

The Task and Finish group was set up in September 2009 to take this work forward. The group decided to carry out a piece of primary research on patient experiences, over the last twelve months, of receiving social care services through a planned care package following hospital discharge. Due to time constraints, the group commissioned the research company Bright Sparks to carry out the fieldwork in collaboration with the Task and Finish group. The group designed a research focus, decided on an appropriate sample and designed a questionnaire in partnership with Bright Sparks. The fieldwork was then carried out, analysed and put into a report of key findings and recommendations.

Results

- 91% of people interviewed were happy with the social care and health services offered to them, in particular the following groups of people: those whose duration of stay in hospital was of one to two days, under the age of sixty-five and of white British ethnicity.
- Nonetheless, 9% of the respondents were unhappy with the service offered to them in particular females, those aged over sixty-five and Black and Minority Ethnic groups (BMEs). The main reason for dissatisfaction was that people wanted more support services than those offered.
- The following are the top five services the interviewees specified they wanted which were not offered to them: home care package (9%), day centre rehabilitation (8%), occupational therapy (5%), voluntary sector support (5%) and aids/adaptations (4%).
- Only 9% (7 respondents) of those interviewed stated they did not have services

set up in place ready for them when discharged from hospital; of these most stated that it took over two weeks for their services to be provided and others said it took between six and eight days.

- 20% of the respondents thought the transition from hospital to being at home could have been improved, in particular females, those aged over sixty-five and people from BME community.
- Respondents discussed how they thought the transition from hospital care to support at being at home could be improved and the key thoughts are summarised below:
 - Transfer medical notes more quickly
 - Provide contact details on people to go to for help e.g. nurse
 - Provide someone to talk to, do not isolate people
 - Provide support at home e.g. with food preparation, bathing etc
 - Provide more information on what is happening to the person and what their illness is
 - Provide support with claims
 - Ensure consistency of support/agency staff

Recommendations

- Ensure that the entire range of support services available to the patient are offered at the earliest opportunity, giving the patient information on the service, how to access it, and possible implications of using that service (including delays in receiving the services) and all alternatives.
- If health and social care services cannot be put into place immediately upon discharge, we recommend that patients are given all information including the reasons for this delay, when they can expect to receive the service, any alternative or interim services that are available, and who to contact for any additional information and updates.
- Provide relevant and up to date contact details for patients to gain further information on their condition, and any support services they are due to receive including voluntary services and self help groups.
- Where possible, try to ensure a consistency with agencies and the staff providing the services to discharged patients.

Monitoring

The Nottingham City LINK Task and Finish group will be monitoring the progress of each of the recommendations over the next twelve months.

Thank you

The Nottingham City LINK would like to thank the participants that completed questionnaires for their time and effort.

Jane Overton

Chair of Hospital Discharge Task and Finish Group

1. Origination of Issue

Three issues had been fed into the Nottingham City LINK concerning hospital discharge services. These issues were fed into the LINK as a result of planned engagement activity and highlighted concerns in the community relating to delayed and unsafe discharge, with particular reference to transitions between services following discharge from hospital, and waiting times for medication once discharged from hospital.

All issues raised to the Nottingham City LINK are analysed by the Issues Panel (a panel of LINK participants) using a set of questions which help to score and prioritise concerns without having bias. The same questions are used for every issue, as approved by the Nottingham City LINK Board of Directors in April 2009. The issues received by the Nottingham City LINK regarding Hospital Discharge were processed by the Issues Panel and forwarded to the Board of Directors to consider inclusion in the Work Plan for September 2009 to March 2010. The Board of Directors felt this issue deserved more in-depth research and should be processed as a Task and Finish Group of LINK members with specific expertise and interest in Hospital Discharge.

2. Participation including Partnership Working

Once this issue had been prioritised by the Issues Panel, the referrer was notified and invited to take part in the Task and Finish Group. Registered LINK participants and known stakeholders were also invited to form a Group that would select a process to make recommendations from a service user perspective. At the initial Task and Finish group meeting, participants identified any gaps to ensure there was a good balance of representatives from organisations or services and individual service users.

Below is a list of participants and partners involved in the group:

David Turner	LINK Board Director Lead
Jane Overton (Chair)	LINK Participant
Anthony Oliver	LINK Participant
Catherine Jameson	LINK Participant, HLG
Jennifer Golding	LINK Participant, NHS Intermediate Care Service
Marian Tudball	LINK Participant
Pat Nicholson	LINK Participant

Mavis Harrison	LiNk Participant
Alicia Rowley	LiNk Participant, NHS Nottingham City Commissioning Officer, Mental Health, Learning Disabilities & Marginalised Groups
Laura Thomas	LiNk Support Team
Laura Marano	LiNk Support Team

3. Background to the Project

The Nottingham City LiNk Board of Directors decided to include two distinct work streams under the heading hospital discharge, onto the work plan spanning from September 2009 to March 2011. The work stream under consideration for this report is social care packages following hospital discharge, and specifically, the transition between receiving healthcare services, to social care services.

Through planned and continuous engagement with the community of Nottingham City, hospital discharge themes transpired to be a wide cause concern, covering many different strands under the umbrella heading of hospital discharge. The Nottingham City LiNk soon became aware that Nottingham University Hospitals NHS Trust (NUH) already had in place many on-going projects to improve the discharge experience, and felt that the work of the LiNk could support and contribute to the good practices and changing procedures already emerging.

Referrers made the LiNk aware of the key focus of the transition between health and social care packages under a care plan following hospital discharge. Referrers felt that there were delays between services, and that this had a knock on effect to receiving further services on time, and often interrupt the patients' on-going care. The LiNk decided to carry out their own piece of primary research to identify if this is an experience shared by others within the community.

A Task and Finish group was then put together to focus on both themes of Hospital Discharge. Due to extremely tight deadlines, and the need to carry out high quality research which reaches a larger number of the community the Task and Finish group decided to commission a research company named Bright Sparks to work closely with the Task and Finish group on research design and results, and to carry out the fieldwork. This included working in collaboration to design a questionnaire, decide who the sample for this questionnaire should be, and work to tight deadlines to ensure that each stage of the research process was completed on time, and with the best outcomes.

The Task and Finish group anticipated that the research would identify possible delays in receiving services, and this would then have a knock on effect to the patients after care and treatment. This may also have a negative impact on friends, family and carers, and may also lead to the patient being readmitted to hospital.

The expected outcome from this piece of work was to ensure that patients receive all aspects of their care package in a timely manner and that all treatment can be carried out when scheduled and effectively.

4. Research and Collating Information

The following policies have been identified by the group as relevant to the study:

- Achieving timely simple discharge from hospital: A toolkit for the multi-disciplinary team (DoH, 2004)
- Nottingham University Hospital Trust Operational Policy and Procedures for the Discharge of Patients from Hospital

5. Results

The overall objective of the research is to:

“To determine Nottingham hospital discharged patients’ opinions on and satisfaction with the social care package they have received.”

Methodology:

The remit for the research was to gather the opinions from a representative sample of Nottingham citizens’ by conducting face to face interviews using a structured questionnaire (quantitative methodology).

The recruitment criteria were defined as: any one aged eighteen or above who had been discharged from a hospital and been in receipt of a social care package. Carers, day patients and people discharged without a social care package were excluded from participating in the research.

The survey was conducted at different times of the day with different groups of people to ensure a variety of citizens’ were interviewed. The participants were sourced through various avenues including support groups, charities and day care centres. We would like to thank all the organisations/charities involved in the research for their support with arranging the interviews.

The fieldwork was undertaken during January through to March 2010 and each

questionnaire took approximately five minutes to complete. An explanation on what a care package is was explained to the potential participants, by the Interviewer, before the research was conducted. The definition provided was “support the hospital, health or Social Care Services should have arranged for you when you went home e.g. aids, social worker, occupational therapy classes”.

The aim of the research was to complete 100 interviews, a total of 77 questionnaires have been completed, processed and analysed.

We were unable to complete the necessary quota because of problems with accessing people who could remember being provided with a care package; plus, some members of the public were confused about what happened to them in hospital and what services were provided to them on discharge.

Key Findings:

- A variety of social care and health services were provided, the three most frequently issued were: Outpatients, 29%, Physiotherapy, 29% and Day Care Rehabilitation, 25%.
- 91% of people interviewed were happy with the social care and health services offered to them, in particular the following groups of people: those whose duration of stay in hospital was one to two days, under the age of sixty-five and of white ethnicity.
- 9% of the respondents were unhappy with the service offered to them in particular females, those aged over sixty-five and Black and Minority ethnics, (BMEs).
- The main reasons for dissatisfaction with the social care and health service offered were that people wanted more support/services than offered, 67% (4).
- The following is a list of the top five services the interviewees specified they wanted which were not offered to them: home care package (9%), day centre rehabilitation (8%), occupational therapy (5%), voluntary sector support (5%) and aids/adaptations (4%).
- 65% of the interviewees stated there was no social care and health services which they wanted that was not offered to them.
- Over two thirds of the respondents, 68% believe their social care and health services were set up and in place ready for them on discharge from hospital.
- 9% (7) of those interviewed stated they did not have services set up in place ready for them when discharged from hospital; of these 57% (4) said it took over two weeks for their services to be provided and 29% (2) said between six and eight days.
- 57% of people, who were not provided with a service on departure of hospital, were satisfied with the length of time it took for their service to be set-up.
- 43% of respondents, who were not provided with a service on departure of hospital, stated the length of time it took for their social care and health service to be provided was not acceptable and reasons why are quoted below:

“Thought I needed to see someone quickly because I was upset about the

treatment I had been given.

“Because I needed help straight away”

“Again, criticism that was discharged from hospital before grab rails in place and assistance from social services”

- 84% of discharged patients were satisfied, overall, with the social care and health services provided to them after leaving hospital and 74% thought that the transition from being in hospital to being at home could not be improved.
- 20% of people thought the transition from hospital to being at home could have been improved, in particular females, those aged over sixty-five and BME's.
- Respondents discussed how they thought the transition from hospital care to support at being at home could be improved and the key thoughts are summarised/quoted below:
 - Transfer medical notes more quickly
 - Provide contact details on people to go to for help e.g. nurse
 - Provide someone to talk to, do not isolate people
 - Provide support at home e.g. with food preparation, bathing etc
 - Provide more information on what is happening to the person and what their illness is
 - Provide support with claims
 - Ensure consistency of support/agency staff

“A contact number, nursing help”

“A nurse calling to check for infections; someone to talk to.”

“More help with food prep when at home, daughter had to do it.”

“Liked to have known what was happening to me rather than people just shunting me around. I would like to have been more aware of what my illness was, people didn't talk to me enough. I wasn't treated as a person.”

“If I had been offered better care. I had a stroke and wasn't offered any help at home, which I needed because it was only a small stroke. However, I later had a larger one because I wasn't given any help. I am so angry about the treatment I was given....”

“Could have been given more information and support, didn't really know what was happening.”

“If the same agencies were used all the time because I never knew who was coming to me.”

- 58% of people who completed the survey were female.
- The majority of respondents were aged sixty-five or above, 62%.
- Nearly three in every ten people interviewed had stayed in hospital for over fifteen days, 29%.
- The majority of people interviewed were retired, 47%.

- 61% of people interviewed specified they have a long term illness.
- 74% of interviewees were of white ethnicity and 26% were BME's.
- The majority of people interviewed were discharged on a Friday, 13% but a lot could not remember stated don't know, 53%

6. Recommendations

Following the findings and results listed above, the Nottingham City LINK would like to make the following recommendations. These recommendations will also be included in the full report, and may contain some additions.

➤ Ensure that the entire range of support services available to the patient are offered at the earliest opportunity, giving the patient information on the service, how to access it, and possible implications of using that service (including delays in receiving the services) and all alternatives.

➤ If health and social care services cannot be put into place immediately upon discharge, we recommend that patients are given all information including the reasons for this delay, when they can expect to receive the service, any alternative or interim services that are available, and who to contact for any additional information and updates.

➤ Provide relevant and up to date contact details for patients to gain further information on their condition, and any support services they are due to receive including voluntary services and self help groups.

➤ Where possible, try to ensure a consistency with agencies and the staff providing the services to discharged patients.

Although the recommendations above are a result of some negative opinions from patients, we would also like to emphasize the number of positive responses, and the acknowledgement from patients that the services received are positive, are appropriate to the needs of the patients, and the majority of patients feel that the waiting time to receive these services is acceptable.

7. Monitoring of Recommendation Uptakes

Feedback from this project will be provided initially through a report and recommendations, which will be distributed, to all stakeholders, providers and commissioners. In addition to this, a special edition of the newsletter outlining the findings of all Task and Finish Groups will be distributed to all LINK participants and partners.

It is also anticipated that a feedback session with stakeholders, providers and commissioners will take place during the Annual General Meeting in May 2010.

The Task and Finish Group will monitor uptake of recommendations and continue feedback when necessary.