BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

THE LONDON BOROUGH
www.bromley.gov.uk

TELEPHONE: 020 8464 3333
CONTACT: Philippa Stone
philippa.stone@bromley.gov.uk

DIRECT LINE: 020 8313 4871
FAX: 020 8290 0608

DATE: 8 November 2011

To: Members of the
HEALTH SCRUTINY SUB-COMMITTEE

Councillor Judi Ellis (Chairman)
Councillor Roger Charsley (Vice-Chairman)
Councillors Ruth Bennett, Peter Fookes, Julian Grainger, William Huntington-Thresher, Tom Papworth, Catherine Rideout and Charles Rideout

Non-Voting Co-opted Members

Babul Ali, Bromley Federation of Housing Associations
Patricia Choppin, Bromley LINk
Angela Clayton-Turner, Bromley Mental Health Forum
Brian James, Learning Disability Representative
Leslie Marks, Bromley Council on Ageing
Keith Marshall, Disability Voice Bromley
Lynne Powrie, Carers Bromley

A meeting of the Health Scrutiny Sub-Committee will be held at Bromley Civic Centre on **TUESDAY 15 NOVEMBER 2011 AT 2.00 PM**

MARK BOWEN
Director of Resources

Copies of the documents referred to below can be obtained from www.bromley.gov.uk/meetings

A G E N D A

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF ALTERNATE MEMBERS

2 DECLARATIONS OF INTEREST

3 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Wednesday 9th November 2011.

4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 19 JULY 2011 (Pages 3 - 16)

5 MATTERS ARISING FROM PREVIOUS MEETINGS (Pages 17 - 20)

6 PROPOSED CHANGES AT ORPINGTON HOSPITAL

7 UPDATE FROM OXLEAS NHS FOUNDATION TRUST

Mr Iain Dimond and Ms Helen Smith to provide an update on recent changes implemented at Oxleas NHS Foundation Trust.

8 UPDATE FROM SOUTH LONDON HEALTHCARE NHS TRUST

Dr Chris Streather to provide an update on the CQC Action Plan.

9 MODEL OF CARE FOR CANCER SERVICES (Pages 21 - 28)

10 BROMLEY LINK: DISCHARGE ARRANGEMENTS AT THE PRINCESS ROYAL UNIVERSITY HOSPITAL (Pages 29 - 120)

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HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 10.00 am on 19 July 2011

Present:

Councillor Judi Ellis (Chairman)
Councillor Roger Charsley (Vice-Chairman)
Councillors Ruth Bennett, Peter Fookes and Charles Rideout

Patricia Choppin, Angela Clayton-Turner and Lynne Powrie

Also Present:

Councillor Graham Arthur, Councillor Robert Evans and Councillor Diane Smith

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF ALTERNATE MEMBERS

Apologies for absence had been received from Councillor Tom Papworth, Councillor William Huntington-Thresher, Councillor Julian Grainger, Councillor Catherine Rideout, Mr Keith Marshall and Mrs Leslie Marks.

The Chairman welcomed Councillor Diane Smith and Mrs Patricia Choppin to the meeting.

2 DECLARATIONS OF INTEREST

Councillor Diane Smith declared an interest as the LBB representative on the Bromley Healthcare Council of Governors.

3 TERMS OF REFERENCE

The Sub-Committee noted the draft term of reference that had been circulated. The Chairman stressed that it was not the role of the Sub-Committee to review the internal management of the Trust. The remit of the Sub-Committee extended to the provision of services – quality and capacity issues.

The Chairman expressed concern regarding the public questions that had been submitted as they related to the management of the Trust. In future questions that did not relate to service provision would not be forwarded to the Trust for response.

In reviewing the Terms of Reference the Sub-Committee noted that they may evolve overtime.

RESOLVED that the Terms of Reference of the Health Sub-Committee be approved.

4 WITNESS SESSION: SOUTH LONDON HEALTHCARE NHS TRUST

Dr Chris Streather, Chief Executive, South London Healthcare NHS Trust (SLHT), attended the meeting and provided the Sub-Committee with an update on the Trust following recent Care Quality Commission (CQC) inspections. Dr Streather highlighted that the Trust had undergone three CQC inspections in the past year; this had not been entirely unexpected as the Trust had not declared compliance on all the targets. The compliance review in September 2010 had identified some improvements to be made. The unannounced inspection had found staff to be open and honest about the challenges they faced. The CQC inspection in March 2011 found that the Trust met the basic standards for dignity and nutrition. Some issues were identified with the "red tray" system for nutrition and these issues had been taken on board and the Trust was working to address them. In April 2011, CQC identified that good progress had been made in improving maternity services. The need to increase the midwife to patient ratio was a long-term challenge and one that was being faced by acute trusts across London. Increasing early access to care was also an issue to be addressed and action needed to be taken to address this.

In terms of the issues already addressed since the September 2010 CQC inspection, following the implementation of the new on-line system for reporting incidents, the number of incidents recorded increased. This was not unexpected as the new on-line system meant that data was captured in a more accurate way.

Work was ongoing to improve the process of ensuring staff working in high risk areas had the necessary CRB checks as well as highlighting the importance of ensuring medicines were kept securely. In September 2010, the Inspectors had found that some medical notes had been kept in potentially publically assessable areas on wards, following the inspection there had been a Trust-wide awareness campaign to highlight the importance of ensuring confidentiality of patient records was maintained.

Dr Streather reported that over the past 12 months significant improvements in mortality rates had been made and it appeared that the figure was improving every three months. In terms of maternity services, the Trust now had high quality midwifery and medical leadership in place. The number of serious incidents had halved in the past 12 months and the number of caesarean sections preformed had also been reduced. Dr Streather reported that in its first three months of operation the hyper acute stroke unit had admitted 103 patients and the feedback received from a number of the patients and their families had been very positive.

In terms of the future, Dr Streather reported that the Trust would be required to save £50 million a year for the next three years and this was against a backdrop of the need to increase quality, innovation and productivity. Referring to waiting times, Dr Streather acknowledged that there were still significant problems with the waiting times for elective pathways. In order to address these, the Trust needed to reduce blockages in the system, this would also improve patient experience and save money. The Trust was also looking to move more elective surgery onto the Queen Mary Sidcup site and the Trust was currently waiting on commissioners in Bexley to develop their plans for the Sidcup site as this would help inform future decisions. There was also a need for the Trust to consider the financial viability of extending theatre times over and above the current 36 hours per week.

Dr Streather highlighted the need to provide as much radiotherapy treatment as possible locally. There was a national target of 45 minutes for the time taken by patients to travel to radiotherapy facilities. Dr Streather advised that around 90% of Bromley residents would not meet this target due to the lack of locally provided radiotherapy facilities. There was also a growing cancer network across London in which South London Healthcare had been heavily involved.

Responding to a question regarding the Trusts targets for waiting lists, Dr Streather stressed that there were three main elements to this: the Trust was required to improve the quality and safety of services and ensure that patients were treated within an appropriate time frame; all of which needed to be delivered within budget. Dr Streather reported that in the previous year the Trust had met the target for A&E waiting times. In the first three months of this financial year more patients had been treated than in the corresponding period last year. In terms of the waiting lists for elective surgery, an action plan had been developed and work was underway to reduce the backlog that had developed. Attention also had to be paid to speeding up the discharge process.

The Sub-Committee considered the Trust's financial position and as way of an update, Dr Streather explained that the Trust was facing a number of cost pressures but that savings of nearly 11% of the turnover of the Trust had been made last year. Whilst the cost pressures remained, the Trust had agreed to save 7% of its turnover in the current financial year. In order to address the financial deficit the Trust would need to consider ceasing use of estates that were surplus to requirements.

The Sub-Committee was reminded that the deadline for Trusts to convert to foundation status was April 2014 and in order to meet this deadline savings of £60 million would have to be found each year. Dr Streather reported that Trusts unable to convert to Foundation Status by the April 2014 deadline could be taken over by existing foundation trusts.

Mrs Angela Clayton-Turner questioned whether the reduction in the mortality statistics was in any way linked to the movement toward enabling people,

especially older people, to die at home. Dr Streather responded that the majority of people who died in hospital were elderly patients who were in the emergency care pathway and the reduction in the mortality rate suggested improvements in care resulting from the changes that had been made to the model of emergency care.

Turning to the issue of pressure ulcers, Dr Streather acknowledged that the Trust had higher instances of pressures ulcers than expected and whilst the position was generally improving this was not happening fast enough. Dr Streather regarded the instances of pressure ulcers as a marker of the quality of care and whilst a clear improvement on the numbers of grade three and grade four pressure ulcers had been recorded, in reality, there should be no instances of ulcers this severe. The Chairman requested that Members be provided with a breakdown of where pressure ulcers originated, for example whether patients had been admitted from residential homes, nursing homes or their own homes, as this would assist the Adult and Community PDS Committee with its wider scrutiny. Dr Streather agreed to provide this information and suggested that it would be helpful if the Interim Director of Nursing attended the next meeting of the Health Sub-Committee to answer Member's more detailed questions.

The Health Sub-Committee considered issues surrounding safeguarding adults training for staff. Dr Streather reported that this was a relatively new focus for the Trust and the 60% compliance figures reported since the September 2010 CQC inspection was continuously improving. Internal training was being provided by the Trust's Learning and Development Department and staff also participated in multi-agency training. The Director ACS highlighted that Bromley's Safeguarding Adults Board had a particular focus on providing support to SLHT.

A Member expressed concerns that, in terms of care for the elderly, when standards fell short, patients and their families did not complain to the Trust for a variety of reasons. Dr Streather acknowledged that the complaints actually received by the Trust were the "tip of the iceberg". There was currently a greater focus of outcomes and what was needed was a greater focus on patient experience.

A Co-opted Member queried the reporting around venous thromboembolism (VTE) and questioned whether more patients were now being assessed. In response, Dr Streather clarified that initially 25% of patients admitted had been assessed and this figure had increased to 67%, demonstrating that improvements had been made. Dr Streather stated that, in his opinion, no patient should be admitted to hospital without having undergone the necessary assessments.

In terms of infection control, Dr Streather reported that any instances of infections were followed-up with a serious incident investigation. The two cases of MRSA within the PRUH had been on different wards and were unrelated which demonstrated that there had been no cross infection.

Turning to the ratio of patients to midwives, Dr Streather reported that the biggest single reason for the closure of the maternity unit had been recruitment. The Trust had been unable to deliver the high quality of care required across the three sites due to problems with the recruitment and retention of staff. The new state-of-the-art unit at the PRUH was now delivering high quality care. Feedback had shown that patients were happy with the new unit and this had made it easier to recruit staff. Dr Streather highlighted that SLHT had not experienced problems that were any different to other hospitals and the recruitment of midwives was a national issue.

A Co-opted Member asked for an update on the Trust's Dementia Strategy and Dr Streather undertook to provide a written update to the Sub-Committee.

In responding to a question around pharmacy delays Dr Streather acknowledged that there were opportunities for the Trust to improve quality of care and make financial savings in the area of medicine management. The Trust was currently awaiting the implementation of a new IT system that would assist in ensuring that medicines were ready for discharge.

The Sub-Committee considered the issue of Urgent Care Centres (UCCs) and questioned whether enough was being done to direct patients to the services available at the Centres. The Chairman suggested that it maybe helpful if the Trust arranged for information about UCCs to be distributed in Local Authority publications such as council tax bills and information about waste collection. Patricia Choppin suggested that Bromley LINk could also help spread information regarding the services offered at UCCs. Another Member suggested that it would be useful to review the scripts used by NHS Direct and GP surgeries to ensure that they signposted patients to UCCs. Dr Streather acknowledged that more needed to be done to advertise the Centres. As a general rule, if a patient needed an ambulance they would be taken to A&E, if a patient could get themselves to hospital they could be treated in an urgent care centre. One of the main benefits of a UCC was that treatment times were much quicker.

In response to a question from the Portfolio Holder regarding discharge processes, Dr Streather reported that there were relatively few problems in Bromley. From the Trusts perspective, more work needed to be undertaken to agree on the best model of intermediate care. The Director ACS stressed that the longer patients remained in hospital, the more difficult it becomes for for them to regain their independence and this is not desirable for individuals or their families and is also much more costly for Health and the local authority. With this in mind it was in the interests of patients and the Council to ensure that stays in hospital were as short as possible. The Chairman also stressed the need to include families when discharge arrangements were being considered and that this should be done at an early stage following admission.

The Portfolio Holder highlighted that Bromley LINk had produced a very thorough report on discharge at the PRUH and the Chairman suggested that the Sub-Committee should review the report at its next meeting.

In considering the new Hyper Acute Stroke Unit at the PRUH, Dr Streather reported that there were currently 6 beds in the unit and this would rise to 14 in the autumn. The Unit was also staffed at the necessary levels and Dr Streather reported that he felt it would be easier to recruit staff to fill vacancies in a specialist unit.

Following a question regarding why the Trust was not implementing telemedicine, Dr Streather stressed that he felt that patients should be seen by consultants where possible. In Bromley there were no geographical reasons why consultations should not be able to undertake face-to-face consultations with patients and this would provide a better patient experience.

The Chairman thanked Dr Streather for attending the meeting and providing the Sub-Committee with an update. Members agreed that it would be helpful to have the next meeting in November 2011 at which Dr Streather and the Interim Director of Nursing could provide a further update to the Sub-Committee.

The Meeting ended at 11.55 am

Chairman

Minute Annex

Questions to Health Scrutiny Sub-Committee 19th July 2011 (Item 4. Witness Session: South London Healthcare NHS Trust)

From Mrs Susan Sulis, Secretary, Community Care Protection Group

SECRET PROPOSALS FOR CHANGES OF USE &/OR CLOSURE OF ORPINGTON HOSPITAL CANADA WING.

1. **The CCPG asked questions on this at 23.3.11 Trust Board. The answers given on 25.5.11 ignored parts (c), (d) and (e) of the question, concerning the appointment, brief and report of Management Consultants, and Public Consultation.**

(i) Will the Trust now answer these questions, and inform this Sub-Committee of its proposals?

There are no 'secret' plans regarding Orpington Hospital.

The current situation with regards to Orpington Hospital is unsatisfactory and needs to be resolved in a way which revitalises services for Orpington patients.

We are in the early stages of working with the local authority, Commissioners/GPs, the Friends of Orpington Hospital patient representatives from the Orpington community and staff representatives on deciding together the best future for these services.

The crucial starting point for these discussions is that the services currently provided at Orpington Hospital need to be available locally to Orpington patients in a way that is beneficial to patients and to the town of Orpington. There must also be continuity of service if any changes to services are recommended.

Only when these stakeholder discussions have concluded, can the Commissioners of the services decide the terms of the consultation process required.

We asked for external advice to review the Trust's clinical services and the estates that it will require to provide these services.

This review was publically announced at the time, and involved a series of stakeholder events to discuss some of the options. None of these options were decisions by the Trust. These decisions will be made carefully by the Trust's Board when Commissioning intentions for some services are clearer.

2. The answer included the statement "the trust will be meeting on 19th May to agree a joint position to avoid any potential for further confusion".

(i) Why hasn't the Trust publicised the results of this meeting?

There was nothing secretive about this meeting. From this we agreed to participate in joint work with stakeholders on ensuring the best services for Orpington patients.

(ii) What is the 'joint position' agreed?

see above (i)

RESPONSES BY THE CHAIRMAN AND TRUST BOARD WHICH DEMONSTRATE LACK OF HONESTY, EVASIVENESS, OBFUSCATION AND MISLEADING ANSWERS TO QUESTIONS FROM MEMBERS OF THE PUBLIC.

3. (i) Why does the Trust Board repeatedly fail to respond to proper questions from the public without integrity and transparency?

(ii) Why do they ignore the requirements of the Committee on Standards in Public Life?

(iii) Do they think they are exempt from these standards?

(iv) If so, can they explain why?

We reject this completely, and would suggest that there are a minority of people who attend the Board meeting that use the forum to ask questions which are not of clear relevance to the issues that are being discussed at the Board

However, we do acknowledge that engagement with the public at Board meetings can always be improved, and have introduced in consultation with local LINks and people who regularly attend Board meetings a new protocol, which aims to improve the quality of questions and answers at Board meetings.

Please find attached a copy of this protocol.

From Mrs Jean Stout, Chairman, Community Care Protection Group

4. DEEP VEIN THROMBOSIS RISK ASSESSMENTS

What percentage of patients are being assessed in accordance with NICE guidance CG92?

The answer is 67% currently - and we are working hard to improve this

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South London Healthcare NHS
NHS Trust

TRUST BOARD MEETING IN PUBLIC PROTOCOL

1.1 The Board of South London Healthcare NHS Trust will meet at least six times during the calendar year 2011. These meetings are held in public and the public are entitled to come along and listen to Board discussion.

1.2 Before each meeting commences, members of the public will be invited to ask questions on items for decision and discussion relevant to the Trust Board meeting agenda.

1.3 Members of the public are reminded that: -

- When asking a question, please introduce yourself;
- Questions relating to individual patient care or the performance of individual staff members will not be discussed at Board meetings;
- To enable as many attendees to ask a question or make a comment, each attendee is invited to make one comment or ask one question.
- There may be a need at times for responses to be provided outside the meeting. If answers cannot be provided at the meeting, a full response will be given in writing/telephone within 20 working days.
- The Chair reserves the right not to respond to comments or questions which relate to issues which are the subject of current confidential discussions or legal action or any other matter at his discretion. The Chairman will provide an explanation if such discussion cannot take place;
- The Chair reserves the right to decide that a comment or question requires a formal Trust response and in such cases the question will be acknowledged and responded to within the provisions of the Freedom of Information Act. Further details of may be found on the Trust Website at http://www.slh.nhs.uk/?section=aboutus&id=9
- The time available for comments or questions should not prejudice the proper and timely conduct of the Trust Board Meeting in Public;

1.4 Notice of the question and/or comment, can be submitted through completion of the Trust proforma. Please note that any written communication of verbal request may be treated as a request under the Freedom of Information Act Regulations and treated accordingly

1.5 A record of questions asked and answers given will be published on the Trust Website at www.slh.nhs.uk Questions and responses will be posted on the Trust's website within 20 working days. They will be placed in the Frequently Asked Questions

1.6 After Questions from the Floor, the Trust Board Meeting in Public will commence.

1.7 South London Healthcare NHS Trust is committed to openness and transparency in its decision making, and will continue to develop and invest in other methods of working with local people to fulfil its responsibilities.

QUESTIONS / COMMENTS FOR TRUST BOARD MEETING IN PUBLIC

2.1 Members of the public are invited to comment/submit questions on any subject pertaining to items for decision and discussion relevant to the Trust Board Agenda

2.2 Questions should be submitted through completion of the proforma, in advance of the meeting, to enable a full response at the meeting or within 20 working days of receipt.

2.3 Should members of the public require help or guidance to formulate a question or complete the pro-forma they may contact the Trust Board Secretary or their Local Involvement Network (LINks). Contact details are given below.

South London Healthcare NHS Trust
Trust Head Quarters
Queen Mary's Hospital
Frognal Avenue
Sidcup
DA14 6LT

Phone Number:

0208 302 2678 Extension 4000

Email address:

boardsecretary.slh@nhs.net

Bexley LINk
Suite 3, Leigh House
7 Station Approach
Bexleyheath, Kent
DA7 4QP

Phone Number

020 8303 1948

Email address:

bexleylink@shaw-trust.org.uk

Bromley LINk
Community House
South Street
Bromley
Kent
BR1 1RH

Phone number:

020 8315 1982

Email address:

bromleylink@shaw-trust.org.uk

Greenwich LINk
Greenwichwest Community
& Arts Centre
141 Greenwich High Road
London
SE10 8JA

Phone number:

0208 853 2857

Email address:

info@greenwichlink.org.uk

2.4 The completed proforma should to be delivered to the Trust Board Secretary, by email or at the address given above, no later than 12:00 noon 24 hours (excepting weekends and Bank holidays) before the date of the meeting of the Trust Board.

QUESTIONS / COMMENTS FOR TRUST BOARD MEETING IN PUBLIC

2.5 Please complete all sections of the proforma and return to the Trust Board Secretary, by email or at the address given above, no later than 12:00 noon 24 hours (excepting weekends and Bank holidays) before the date of the meeting of the Trust Board.

Name	
Address	
Telephone number	
Email Address:	
Issue/Subject	
Agenda Item	
Question / Comment:	

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Report No.
RES11131

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**Health Scrutiny Sub-Committee**
Date:	**15th November 2011**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**MATTERS ARISING FROM PREVIOUS MEETINGS**
Contact Officer:	Philippa Stone, Democratic Services and Scrutiny Officer Tel: 020 8313 4871 E-mail: philippa.stone@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Resources
Ward:	N/A

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1. Reason for report

1.1 This report updates Members on recommendations from previous meetings which continue to be "live".

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2. RECOMMENDATION(S)

2.1 The Committee is asked to note the progress on recommendations made at previous meetings.

Corporate Policy

1. Policy Status: Existing policy.
2. BBB Priority: Excellent Council.

Financial

1. Cost of proposal: No cost
2. Ongoing costs: N/A.
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £344,054
5. Source of funding: Existing 2011/2012 Budget

Staff

1. Number of staff (current and additional): There are 10 posts (9.22 fte) in the Democratic Services team.
2. If from existing staff resources, number of staff hours: Maintainig the matters arising report takes less than an hour per meeting.

Legal

1. Legal Requirement: No statutory requirement or Government guidance.
2. Call-in: Call-in is not applicable. This report does not involve an executive decision

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Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Current Membership of the A&C PDS Committee (16 Members including Co-opted Members)

Ward Councillor Views

1. Have Ward Councillors been asked for comments? N/A.
2. Summary of Ward Councillors comments: N/A

Appendix A

Minute Number/Title	Decision	Update	Action	Completion Date
19th July 2011				
4. South London Healthcare NHS Trust	That the Sub-Committee be provided with a breakdown of where pressure ulcers originated, for example whether patients had been admitted from residential homes, nursing homes or their own homes.	Dr Streather agreed to provide this information and suggested that it would be helpful for the Interim Director of Nursing to attend the next meeting of the Health Sub-Committee to answer more detailed questions.	SLHT	15 November 2011
4. South London Healthcare NHS Trust	That an update be provided on the Trust's Dementia Strategy.	Dr Streather undertook to provide a written update to the Sub-Committee.	SLHT	TBA
4. South London Healthcare NHS Trust	That Bromley LINk's report on discharge at the PRUH be added to the agenda for the next meeting.		Democratic Services Officer	15 November 2011

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London cancer services:
Implementing the model of care

London Borough of Bromley

Health Scrutiny Sub-Committee meeting

Tuesday, November 15, 2011

Developing the model of care

- 45 clinicians working over 12 months
- Three work areas: early diagnosis; common cancers and general care; rarer cancers and specialist care
- Patient panel to ensure strong patient voice
- Case for change: December 2009
- Model of care: August 2010
- Extensive 3-month engagement on proposals – over 85 per cent of survey respondents supportive
- London GP Council has endorsed the recommendations

LondonHealth PROGRAMMES

NHS London

The case for change

- Later diagnosis has been a major factor in causing poorer relative survival rates
- There are areas of excellence in London but inequalities in access and outcomes exist
- Treatment and care should be standardised
- Specialist surgery is taking place on too many sites: common treatments are available on too few
- Comprehensive pathways should be commissioned; organisational boundaries should not be a barrier

LondonHealth PROGRAMMES

NHS London

The model of care

- Improve early diagnosis by addressing public awareness, GP access to diagnostics, screening uptake rates and health inequalities
- Extended local provision of common cancer services, such as chemotherapy, non-complex surgery and acute oncology. Further consolidation of surgical services for rarer cancers into specialist centres
- Providers working together in a small number of integrated systems delivering standardised pathways

Early diagnosis

- Working group consisting of GPs, public health consultants, diagnostic experts and patient representatives
- Aim is to identify the most effective evidence based interventions to improve early diagnosis
- The shadow London Health Improvement Board has selected prevention and early diagnosis as a priority – reporting in October
- Health and Wellbeing boards will support this process locally, recognising local population issues and promoting positive messages

LondonHealth PROGRAMMES

NHS London

Integrated cancer systems

- Groups of hospitals working together to ensure that patients experience seamless cancer care
- Integrated cancer system specification developed in partnership with cancer community
- Two proposed systems submitted system and service plans on 30th June
- 'The Crescent' and London Cancer
- Assurance process completed involving GPs, nurses, Macmillan, external clinical experts and commissioners
- Recommendations to commissioners in September

LondonHealth PROGRAMMES

NHS London

Next steps

- Continue to support integrated systems in their service planning
- Share possible local implications with Health Overview and Scrutiny Committees in late autumn

- Any further queries can be directed to cancer@londonhp.nhs.uk

LondonHealth PROGRAMMES

NHS

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Bromley LINk
Local Involvement Network

Hospital Discharge at the Princess Royal University Hospital

A patient experience insight study

Experiences of patients from Jan – April 2011

Report authors: Colin Beesting & Nathalie Walsh

Introduction

In February 2011 Bromley Local Involvement Network (LINk) initiated a research programme to gain deeper insights into the experiences of patients being discharged from the Princess Royal University Hospital (PRUH).

The need for this work was prompted by anecdotal evidence and feedback from both members of the public contacting LINk and LINk members. Both groups reported varying levels of dissatisfaction with their experience and raised concerns with LINk.

In order to ascertain the degree to which the reported experiences were more widely shared, and arrive at a fuller understanding of the particular reasons that discharged patients were reporting dissatisfaction with their experience, both quantitative and qualitative programmes of investigation were embarked upon.

The overall objective and desired outcome of the research programme was:

- To improve patient experience, with particular reference to discharge

The research aims were:

- To gain a better understanding of patient experience through accepted research methodologies
- To gain insights into individual cases, to enrich that understanding and provide qualitative data
- To arrive at a number of recommendations as a result of the work that South London Healthcare Trust could consider implementing, to improve patient experience.

This report gives an overview of research findings and offers a number of practical recommendations.

With thanks to the Princess Royal University Hospital (PRUH) for their assistance in distributing questionnaires to patients.

1. Methodology

1.1 The research used both **quantitative and qualitative research methodology** in order to give a holistic picture of patient experience.

1.2 Bromley LINk developed **a questionnaire comprising 43 questions**, plus equalities monitoring information. Approximately 900 questionnaires were distributed in order to get a good sized sample, through a range of outlets.

- 400 were distributed by staff at the PRUH
    - *Within the PRUH the patient experience lead at the distributed to pharmacy, the day care unit and some wards*

- 500 were distributed to LINk members, through voluntary sector organisations and also residents associations
    - *A range of distribution methods were used including hard-copy and electronic copies*

Questionnaire distribution commenced on 22 February 2011 with final responses being received on 6 April 2011.

1.3 A total of **30 semi-structured interviews** were conducted. Participants were recruited from the Hospital Discharge Patient's Questionnaire if they had consented to being contacted for further feedback. They were initially written to by Bromley LINk and told to expect a telephone call from an independent researcher. Interviews commenced on 14 March 2011 and were completed on 20 April 2011

1.4 Participants were called at least four working days after the letter was sent. The interviewer introduced themselves and made arrangements for a telephone interview at a time convenient to the participant. Interviews were subsequently conducted, if still acceptable, digitally recorded and transcribed verbatim. Subsequently all participants became anonymous and identified by numbers.

2 Framework for research

2.1 In order to arrive at a series of conclusions and recommendations, the Department of Health guidance '*Ready to go? Planning the discharge and the transfer of patients form hospital and intermediate care.* (Department of Health, 2010.) was used as a framework for the structured interview part of the research.

2.2 The interview script was structured around the 10 key steps to achieving timely and safe discharge, as a way of ensuring that the questions asked uncovered relevant and useful data to enable a thorough investigation to be made. The 10 steps and 10 principles have been included in appendix 1 for reference.

3. Questionnaire surveys

3.1 Analysis

Results from the questionnaire surveys were entered into 'Survey Monkey' and from this, statistical data for each question is drawn. Full results for each question are shown in appendix two, with free-text answers converted to statistical information where possible. Where additional information is requested as free-text, the full written answer as submitted by the respondent has been included.

3.2 Responses are representative of the recalled experiences of patients' stays at the PRUH and their discharge process.

3.3 For the purposes of this analysis questions have been examined only where they offer useful insights and mapped against *'Ready to go?'* where it helps to identify useful recommendations.

4. The sample

4.1 In the region of 120 completed the survey, although it should be noted that not all respondents completed all questions – leading to a very minor variation in some questions. Statistically, this variation is not sufficient to affect the overall results.

4.2 Of the respondents 65% were female and 35% were male. 92.7% described themselves as White British, with other white backgrounds being next at 1.8% for both White Irish and any other White background. 98.2% said their first language was English. The survey captured the opinions of a wide range of age groups, with the majority falling into older age groups and 66% being over 65 years of age. 38.1% considered themselves to have a disability.

4.3 The residential status of respondents varied with three quarters (75.2% living in a house) and 66.4% having a downstairs toilet.

5. Questionnaire section two: Hospital details

5.1 106 respondents gave dates of their hospital admission and in the vast majority of cases, responses given referenced admissions from 23 January 2011 to 3 April 2011. This is helpful in that it gives a specific snapshot in a given defined time period.

5.2 In order to check that respondents were describing their experience of the PRUH, they were also asked which hospital and ward they stayed in. Almost all were PRUH patients, with respondents from other hospitals being so small that their statistical significance would not affect the overall results.

5.3 Respondents to the questionnaire represent a good spread from across many wards in the hospital. This means that the experiences we have captured are relatively representative of the whole hospital and do not pertain to specific wards

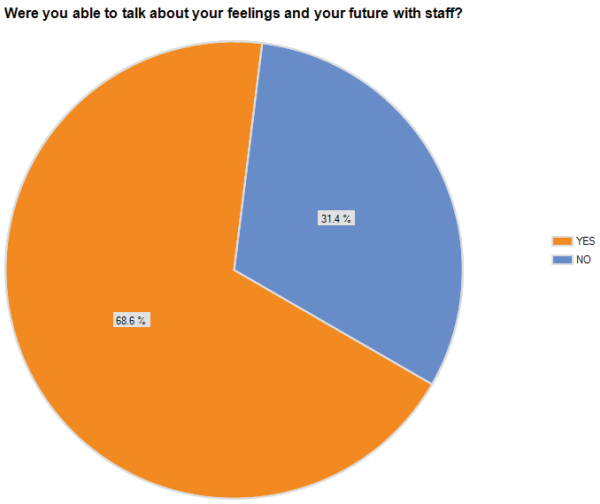
5.4 Of those who responded (98), 42.9% had been admitted for surgery, and 8.2% were day cases. 62% of these were admitted as a result of a visit to the Accident & Emergency department, 29.4% were planned admissions and 7.6% via an Urgent Care Centre. 66% were admitted with a new medical problem.

6. Questionnaire section three: Your care

6.1 The spread of respondents from across the hospital allows us to view the responses in the 'Your care' section as being relatively representative of the general hospital experience. When mapped against the 10 best practice steps in 'Ready to go', respondent's reported experiences fell short of the prescribed good practice.

6.2 Only just over a third (36.08%) of respondents reported that discharge was discussed with them within 48 hours of admission to the hospital – whilst good practice requires that an expected date of discharge or transfer is set within 24-48 hours of admission and discussed with the patient and carer. This increases to 69% at a week into the hospital stay. 5% of respondents reported that discharge was never discussed with them in advance.

6.3 Communication is highlighted as a key issue in question 13 of this section, where respondents were asked ‘Were you able to talk about your feelings and your future with staff’?



Almost a third (31.4%) responded that they were not able to discuss this with staff members – counter to the good practice guide which stresses the involvement of patients to deliver a personalised care pathway. It is inconclusive from survey results whether there is any correlation between this response and comments made in the free-text questions towards the end of the survey (Q42 & Q43) however, some patient’s articulated concerns about staff shortages may be a factor. (See 9.7 for patient comments).

6.4 A further 43.6% reported that other health needs were not taken into account by staff during their hospital stay, suggesting under-achievement within the operating principle ‘A person-centred approach treats individuals with dignity and respect, and meets their diverse or unique needs to secure the best outcomes possible.’

6.5 91.4% reported having some kind of long-term condition which may or may not have been the reason for their admission and 12.1% having some kind of sensory impairment.

7 Questionnaire section four: The day of leaving hospital

7.1 For the purposes of the questionnaire, to aid comprehension, the discharge day was referred to as ‘the day of leaving hospital’. For this section we specifically focused on

patients' experiences of the events on this day and also gathered some information on experiences of the discharge lounge, where this was relevant to patients.

7.2 Of the 110 people responding, 87.3% told us that they felt well enough to go home, with the remaining 12.7% reporting that they did not. 26.9% were being discharged for a recurring condition.

7.3 Slightly over half of respondents went home using their own car, 20.4% in an ambulance (patient transfer service). Just over three quarters (76%) had someone with them on discharge and 63.8% had someone at home when they arrived.

7.4 81 respondents reported having had some experience of the discharge lounge. Length of wait was a key concern, with over a third (36.85%) waiting in the lounge for an excessive amount of time - over two hours.

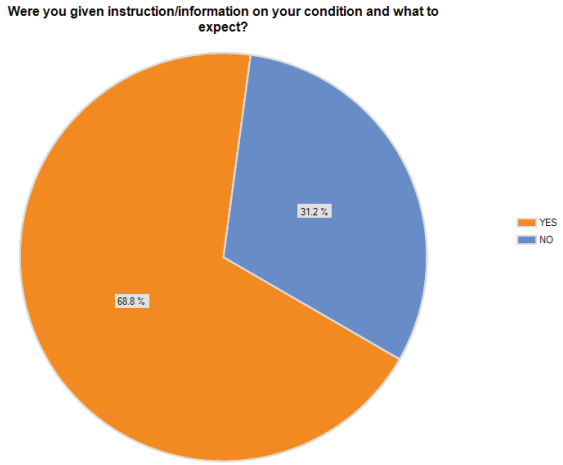
7.5 This is further underlined by the findings of our telephone interviews, where some respondents reported dissatisfaction with this element of their experience. Several respondents commented on the cold, unwelcoming and under-staffed environment. This was illustrated in some responses to open-ended questions on the survey, with one respondent reporting,

> *"The delay waiting for medication is ridiculous and seems universal. The departure lounge was most unwelcoming."*

7.6 It may be worth noting that 63.8% of respondents to the questions 'Did you have anyone waiting at home for you' answered 'No' to this question. Whilst for those being discharged for minor conditions this may be of no concern, for those who are older and more vulnerable this may be a factor in some of the negative feedback received regarding ongoing care once discharged (see 8.6 below).

8. Questionnaire section five: The discharge process

8.1 Approximately 41% of respondents reported on aftercare from another professional. Of these, 55.1% were told that they would have a visit from a District Nurse, 32.7% from a doctor and 20.4% from a care worker.



8.2 85.5% of those responding were given some kind of medication on discharge – however only 77.7% report being given instruction or information about how to use medication.

31.2% report being given no information on their condition or what to expect following discharge.

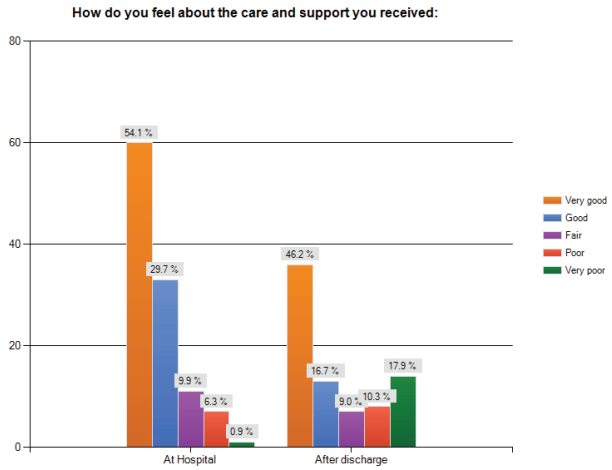
8.3 Over a third (36.1%) reported being given no instruction or information on how to look after themselves once discharged and a further 43.3% were given no information about who to call for advice.

8.4 Of the 97 respondents who responded to the question, “If you needed it, did you have a plan for your ongoing care prepared for you before discharge?” 53.6% reported that they had. When asked if they had been involved in those plans, slightly over half (51.7%) reported that they had been involved.

8.5 Operating principles state that ‘Patients and carers are involved at all stages of discharge planning, given good information and helped to make care-planning decisions and choices’. The experiences of respondent’s to the survey show that for a significant section of patients this practice is not standard and is impacting on their care.

8.6 In the open ended question responses, a number of respondents reported a lack of focus on this element of the discharge process, with one respondent stating,

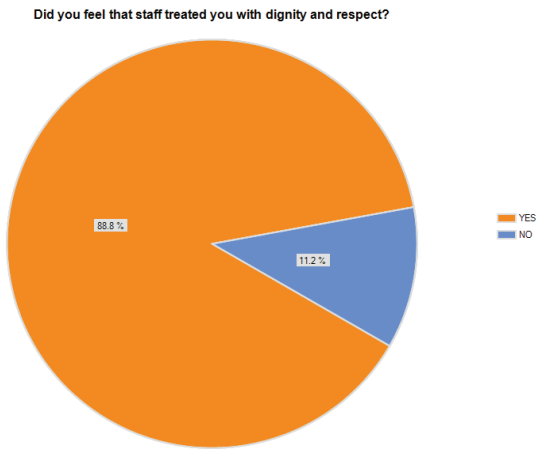
"On discharge I was rather abandoned. I was still unwell the day after discharge and I had no idea who to contact. No after care was even discussed."



8.7 We were also interested to find out if patient's experiences impacted on their overall impression of the care they received.

8.8 In the majority of cases, respondents reported being positive about the care and support they received in hospital, with 83.8% rating their care as good or very good.

8.9 However, this drops significantly when the same group were asked about their ongoing care following discharge, with 62.9% telling us that they felt it was good or very good – again, indicating some key issues to be tackled through the discharge planning process.



8.10 88.8% of the 107 respondents to the question 'Did you feel that staff treated you with dignity and respect' gave a positive response with the remaining 11.2% reporting a less favourable experience.

9 Free-text questions

9.1 The open-ended questions on the survey uncovered a number of key issues that were suggested in other questions and give insights into the reported experiences of our respondents. These fall into many of the same themes as discovered through the in-depth interviews, with communication, aftercare, and concerns about pharmacy being recurring themes.

9.2 Communication

"Liaison generally was poor - contradictory instruction from medics and physio."

"Very poor communication between hospital departments and with family."

"Some staff were very supportive and reassuring about first time surgery. I would have liked to have actually been told what was done after the op instead of waiting until the next afternoon to be told to put my mind at ease."

9.3 Aftercare

"No guidance given to my wife on which equipment hospital would provide and which she had to find. Promised help in moving equipment never turned up. Hospital didn't tell my GP I had been an in-patient I had to give GP details."

9.4 Pharmacy

"I feel the discharge system of waiting for drug/medication for up to 3-6 hours is a waste of time and can let down the overall service provided. Nowadays I often leave without my medication and arrange to collect it later."

"I was advised I could go home at approx midday. Told prescription available by 4pm - received at 6.30pm"

9.5 Other recurring concerns within the free-text responses highlighted a number of reported issues regarding the continuity of care over weekends and also an acute awareness

amongst patients of staffing pressures. Whilst the majority of respondents were sympathetic, the high levels of awareness suggest an impact on care.

9.6 Weekends

"Rushed final arrangements on Friday night - no arrangements over the weekend. Literally thrown in at the deep end. Very poor."

"Weekends were a nightmare, no-one seemed to know what to do - just general nursing care and washing happened."

9.7 Staffing pressures

"Very short staffed in hospital"

"…obvious shortage of nursing staff - less than used to be especially nights. Nurses sometimes under stress due to it - shortage of staff nurses at weekends, medical staff at night and weekends."

9.8 It is inevitable that questionnaires of this nature encourage feedback and focus on the more negative elements of patient experience. However, respondents also reported very positive experiences and gratitude for the care received.

"I was very satisfied with the care and attention I received from being admitted until discharge. We had the heavy snow at that time and I was very impressed how the staff coped. The staff remained helpful and cheerful under difficult conditions."

"Staff excellent, very friendly and made me feel I was in safe hands at all times - All my questions were answered at all times and I was made to feel that I was looked after."

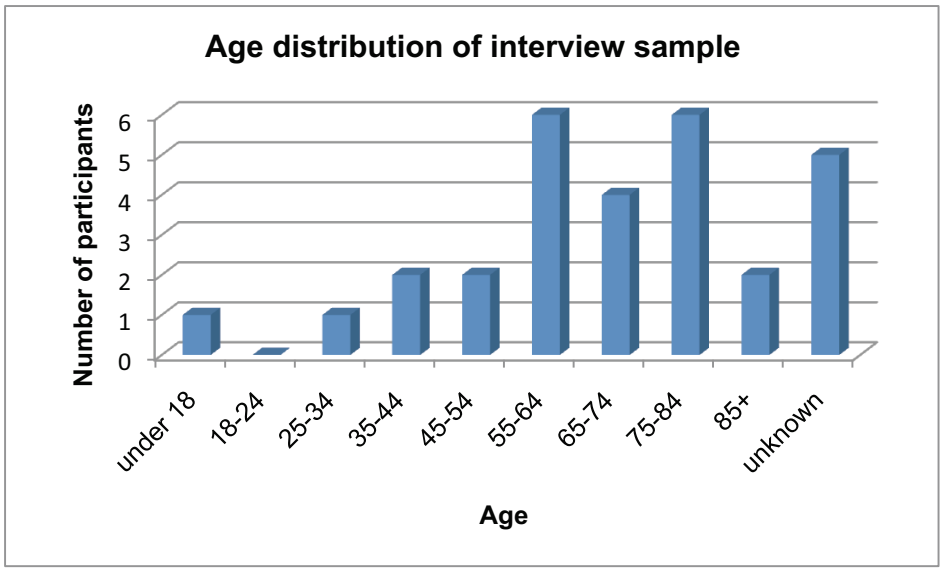
"All the staff, doctors and carers were kind and patient. They took the time to explain what was going to happen. I have been to other hospitals but have never experienced such kindness and care"

10. Telephone interviews

10.1 The interview transcripts were analysed using qualitative research techniques to extract themes. Where appropriate these themes are discussed in accordance with the Good Practice Guidelines[1]. Descriptive statistics were also extracted from the 30 interviews, to give quantifiable representation of sample obtained and a small amount of quantifiable information unattainable from the questionnaires alone.

11. Sample

11.1 The sample consisted of 9 males (30%) and 21 females (70%). They fit into the age groups as shown below. This sample broadly reflects a similar age and gender profile of the large sample in our questionnaire survey, with a bias towards female respondents and those at the upper end of the age range.



[1] *Ready to go? Planning the discharge and the transfer of patients form hospital and intermediate care.* Department of Health , 2010.

12 Results

12.1 Interviewees were almost universally (96%) very happy with the care they received at the Princess Royal Hospital. Their experiences of the discharge process were however mixed. Those that were disappointed with their discharge largely felt it let down an otherwise very good experience of the hospital. Interestingly, the same issues kept coming up in the interviews.

12.2 All of the negative experiences of discharge reported in the interviews were grouped into the below themes. These themes are not necessary mutually exclusive, however have been separated into four themes to aid clarity of discussion. These have been broadly listed ranging from the most to the least frequently reported.

a. **Communication** between hospital staff/wards
b. **Aftercare** – poor knowledge/advice/concern regarding post-discharge care
c. Delays concerning the **pharmacy** service
d. **Transport** – patient consideration

12.3 In many of these themes there were also reports of exceptionally good practice; these will be flagged up also.

13. Communication

13.1 This was the most commonly reported problem by patients, probably because it spans all aspects of the discharge process. Within this theme there were three levels of communication, each with their own issues:

a. Patient & medical professionals
b. Between medical professionals (within the ward)
c. Between hospital departments

13.2 *Patient & Medical professionals* – participants generally were fairly happy that they were told as much as possible throughout their treatment in hospital, but when it came to discharge information was often unclear or non-existent.

*13.*3 The issue of aftercare will be discussed later in this report, and therefore not here, however it was mentioned by a few respondents that communication regarding the

discharge process itself should be more explicit and clear. They talked about being told they could go home, and then being left without any guidance of what to do, where to go, what they need (i.e. medication & paperwork), what time to arrange transport for, or how their transport was being arranged for them etc.

13.4 One instance where the patient was particularly upset by poor communication was when they had specifically requested that a particular family member not be called to collect them and this was ignored to overcome a transportation problem as they were having problems finding an ambulance to take him home. This was perhaps a mistake but the patient's experience was one of disregard for their wishes and disrespect.

13.5 Another issue that arose was communicating with patients with dementia and staff's lack of training on this issue. In that instance the patient's partner was not kept informed of his wife's progress, nor any plans discussed with him. Although she had come from a care home and was being discharged to that care home again, he felt that he was left out of any decisions and information sharing. This clearly should not be the case.

13.6 One final example of poor communication and involvement of the patient was an elderly man who had been in hospital for approximately 14 days and the decision was made without discussions with him or his wife that he should be discharged to a nursing home for 2 weeks of convalescence. Although he was happy with that decision, and in hindsight he thought it was the right decision, he was very apprehensive of where he was going and what was ahead.

13.7 *Between medical professionals* – there were only a couple of reports of medical professional contradicting each other and these were usually inter-departmental issues e.g. ward and physiotherapy. Generally this level of communication seemed to be good and medical staff were unanimous on their communication with the patients regarding discharge.

13.8 *Between hospital departments* – This is where most of the issues arose. Patients often reported that discharge was delayed, sometimes by a day or two, because of delays getting tests or investigative procedures in different parts of the hospital. The Good Practice Guidelines suggest that *'all tests and treatments continue seven days a week' (Chapter 1: Key Practices and principles)*. Although this may be too difficult and costly to

implement immediately, perhaps the organisation of the working-week-only departments can be managed better to aid communication to patients.

13.9 Often the ward staff were unable to accurately advise on timescales because they simply did not know the availability of tests or procedures until offices opened again after the weekend. Terms like “farcical”, “uncoordinated” and “ridiculous” were used to describe the “chaos” between departments.

13.10 More minor examples of problems are patients waiting for crutches to be able to leave, or to see the physiotherapy team. However the majority of problems seemed to be regarding waiting for medication from pharmacy and transportation home which is discussed elsewhere.

13.11 The pharmacy issue will be discussed separately, but communication issues in relation to transport were a big issue within our sample. It should however be noted that many of the participants were referring to discharge during December 2010 to January 2011 where the Orpington area experienced very heavy snowfall and very bad transport conditions. Patients were understanding of this, but still the lack of communication regarding estimated times was felt unacceptable.

13.12 There was an instance were a patient required a specific wheelchair attachment and a double ambulance crew due to the patient’s size and home situation and despite this being requested at the beginning, it took three different ambulances and 5 and a half hours to do a two mile journey home. This is an example of poor communication being very costly in resources and in patient-time.

13.13 Good examples of communication usually involved patients developing a trusting relationship with a member of staff or team, some mentioned them by name, and said things like

“I knew if I need anything or had any questions I could ask so-and-so.”

13.14 Planned admissions generally were more happy with the discharge process because it was discussed previously or they had written information detailing what to expect. This shows the importance of planning ahead and managing patients’ expectations is something that can greatly improve the patient’s experience of discharge and although more difficult, should be adopted in unplanned admissions as much as possible.

13.15 The Good Practice guideline has several suggestions throughout but suggests setting an estimated date of Discharge (EDD) within 24-48 hours of admission which is subsequently adjusted through patient consultation and negotiation. Although there seems to be little evidence that EDD were set within 24-48 hours of admission, when questioned, patients were happy with that and understood that this was difficult to accurately set so early, and therefore would not have been very useful to them. What seemed more important to them was having warning, perhaps 24-48 hours prior to discharge. When they were suddenly sent home, although they were generally pleased to be going, they would have liked as much warning as possible.

14 Aftercare

14.1 There were several examples of excellent aftercare, the most prominent being from a patient on what she described as the 'Rapid Recovery Programme' (she may have been referring to PACE, provided by the community healthcare provider). It seems that this is a perfect example of how discharge can work effectively, efficiently and clinically. In that example, the home care team was introduced to the patient while in hospital where they negotiated her needs at home. When the patient was discharged, she had confidence in her care, knew what to expect and what was expected of her. She described it as "incredibly organised". The patient reported that she went home earlier than she would have felt confident to otherwise, received excellent home care and recovered quickly.

14.2 There were, however, several reports of poor aftercare. These were mainly examples of patients who were told on discharge that they would be contacted regarding further outpatient tests or treatments and then did not hear from the hospital again.

14.3 Unfortunately the majority of the interviewees that were sent home expecting to be contacted had to chase follow-up appointments, and sometimes to no avail. Two participants had undergone operations and were told by their consultants they would have post-operative physiotherapy but it did not happen, despite both asking for it. Subsequently both were readmitted within 6 months and operated on again. Both people pushed for physiotherapy treatment the second time, and explained how critical it was to their recovery. It is impossible from this piece of work to explain what went wrong in these situations, but this should be investigated further and addressed. It was perceived by patients that there was no clear responsibility for setting up further appointments and was arranged in a haphazard manner.

14.4 Another aspect of aftercare is the aspect of involving the patient and their carers with the discharge process and ensuring their continued recovery after hospital. Many of the patients interviewed were elderly and several of the females especially, lived alone.

14.5 Although some reported good experiences of consideration for the support they had at home, many didn't. An example of this is a 75-84 year old lady with a long term condition who presented to A&E unwell and was discharged at 4am back to her home alone. She was so confused at the time that she couldn't even recall how she got home. A friend visited in the morning and called the doctor again and she was readmitted within hours.

14.6 Many elderly patients said that their home environment and support was not discussed, nor any support offered. Of those with live-in partners, some older than the patient themselves, only one patient reported that their wife was consulted in the process of discharge and her ability to care for her husband. The good practice guidelines suggest that carers are strongly involved with the discharge process, and therefore this is an area for recommended action.

14.7 When home care was set up, it seemed to work well and be very helpful to patients in bridging the gap between hospital care and becoming more independent at home. District nurses and other home care were reported as punctual, friendly, helpful and responsive to needs.

14.8 Occupational Therapists also were well reported and seemed to be available to those that needed it, and timely in their interventions. The only criticism was from one participant where the OT had been to the home and carried out an assessment, but the list of required equipment had not specified what would be provided from the OT team and what the patient had to source himself and therefore when he returned home he was a vital piece of equipment missing, to allow him to get out of bed.

15 Pharmacy

15.1 The most frequently reported reason for delay in discharge was waiting for medication from the Pharmacy. A wait of 4 to 5 hours was not uncommon. Several experienced patients had learnt to go home and come back later or the next day for medication, but noted that the elderly or people without their own transport may not have that option.

15.2 This is not a problem unique to Princess Royal University Hospital, many hospitals have reports of huge delays in pharmacy, but nonetheless it should be noted and anticipated where possible to limit the delay in discharge. If discharge is well planned, prescriptions could be processed within the 24-48 hours before discharge which would reduce delays, patient frustration and the amount of time patients are waiting on wards or in the discharge lounge.

16 Transport

16.1 Delays due to transport have already been discussed, but there were a few reports of problems with discharge transport. Several people mentioned themselves or other patients being transported in very cold, snowing weather in minimal clothing, often only a hospital gown. Blankets were requested, but were told there were not any available.

16.2 One reported a 90 year old man in a nightgown that was so short he was exposed. He was given a very thin blanket and taken out through the snow with inadequate covering. Another reported giving her own coat to an elderly lady who was told there were no blankets available. All of these instances were reported from patients that used the discharge lounge and therefore the following suggestion may be made:

16.3 The use of Age Concern for transport was highly appreciated and respected by the interviewees that use it, reporting the drivers as friendly, helpful and thoughtful. One elderly lady that lived alone was called two days after being dropped home to check she was okay; she and others were very pleased with their service.

17 Summary and recommendations

17.1 The following recommendations are based on the findings of this research programme and the gaps identified between actual patient experience and the good practice for discharge described in 'Ready to go.'

17.2 Recommendations are made with a view to improving patient experience of the discharge process and are not intended to impact on the clinical care being delivered.

17.3 RECOMMENDATION 1

Evidence from the survey and interviews suggests that some patients felt badly informed about their hospital stay and the discharge process. In some cases, dissatisfaction arose as a result of bad practice. In others, there was a mismatch of expectation and reality. Improved communication and information could help to improve this.

- **A short & simple leaflet should be made available to patients on admission outlining the 'housekeeping issues' on the wards e.g. times of meals, how to call for help, where to get towels for showering, discharge process, including information on the discharge lounge, potential wait for pharmacy, paperwork required, medical certificates required etc.** ***This is also suggested in the Good Practice Guidelines, Chapter 1: Key practices and principles.***

17.4 RECOMMENDATION 2

A significant number of respondents reported poor communication at the point of discharge, lack of information about medications and who to contact should they need additional information or ongoing support.

- **When suitable, patients be issued with personalised discharge summary for their information. Some suggested elements to include important test results, diagnosis/explanation of what happened, any outpatient appointments required, advice on self-care and/or prevention of reoccurrence, brief medication explanation and schedule, telephone number to call with questions or concerns.**

17.5 RECOMMENDATION 3

Respondents highlighted particular issues with the coordination of care at weekends and even extended hospital stay as a result of the lack of tests or clinical expertise. 'Ready to go' recommends, "Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient". Respondents to our research reported that this is currently not standard practice.

- **Investigate the possibility of extending some tests and procedures that are currently only available 5 days a week to 7 days a week. This could dramatically reduce the length of hospital stays over the weekend where well patients are simply waiting. To aid this issue, any tests and investigations that can be done in outpatients should be arranged so that patients can be discharged and return in the week.**

17.6 RECOMMENDATION 4

'Ready to go' recommends "Start planning for discharge or transfer before or on admission" and "Set an expected date of discharge or transfer within 24-48 hours of admission and discuss with the patient or carer." Repondents to the research reported that this is not currently the case in many patient's experience.

- **Staff to discuss Estimated Date of Discharge with patient as soon as reasonably possible, explaining that there may be changes and what those changes are dependent on. Discuss daily until actual date of discharge.**

17.7 RECOMMENDATION 5

Respondents reported a lack of care coordination at the point of discharge and poor communication between hospital and out-of-hospital care providers (such as district nurses, GPs and social care) and family members. 'Ready to go' recommends "Involve patients and carers so that they can make informed decisions and choices that deliver personalized care pathway and maximise their independence"

- **Improve communication between hospital staff and out-of-hospital services by appointing a lead nurse/carer for each patient who has specific responsibility for communications with the patient's GP and/or community services as appropriate. A standard template letter could be developed to aid the process.**
- **Ensure all information is shared with patients and carers at the point of discharge.**

- **Involve family/friends/carers in discharge planning to ensure they are able and equipped to care for the patient after discharge. Carer needs assessments may be required where long-term care is required.**

17.8 RECOMMENDATION 6

Some respondents reported a clear lack of communication between hospital services and those providing home-care or the patients and families themselves with regard to any additional equipment required.

- **Review Occupational Therapists assessment reports to ensure it is clear which equipment is provided and when and what needs to be sourced by the individual.**
- **Offer information on local providers so that patients and carers can source equipment as necessary - making it clear when and where additional professional assessment and support may be needed.**

17.9 RECOMMENDATION 7

Pharmacy delays at the point of discharge was a recurring theme and at present impact negatively. Positive steps in this area could help to dramatically improve patient experience.

- **Prescriptions should be thought about as early as possible in the discharge planning to limit delays and waiting time. Specific targets should be considered in this area.**

17.10 RECOMMENDATION 8

The hospital discharge lounge was reported as a key concern by many patients, who referenced environment, length of wait and provision of information as issues.

- **Make available a supply of hospital blankets in the discharge lounge for use when transported by hospital ambulance.**
- **Improve the visibility of staff in the discharge lounge and the flow of information to ensure that patients are kept informed throughout the process.**

Appendix one

About Bromley LINk

Bromley LINk is a network of individuals and organisations working together to improve health and social care in the London Borough of Bromley.

The LINk is open to all and anyone with an interest in health or social care services can get involved in the way that they want – whether it's receiving information, feeding issues into the LINk or actively attending meetings to help the LINk with its work.

LINks were set up by the Local Government and Public Involvement in Health Act 2007 with powers to:

- Ask for information and get answers in a specified period of time
- Carry out spot checks, when necessary, to see if services are working well
- Make recommendations about how services can be improved and get a response
- Refer issues further if it seems action is not being taken.

Principles of Bromley LINk

Bromley LINk has been established to give local people a voice in the commissioning and provision of health and social care in Bromley.

In order to do this effectively, the LINk aims to operate in a way that is:

- Inclusive and diverse – valuing, representing and involving the whole community
- Accessible, so that everyone has the opportunity to have their say
- Open, transparent and accountable to the people of Bromley
- Promoting equality, treating people fairly and with respect

The LINk will continue in its aim to represent the views of all sections of the community in Bromley in the coming year.

Appendix two

Key Practices & Principles

‘’*Ready to go? Planning the discharge and the transfer of patients form hospital and intermediate care.* (Department of Health , 2010.)’

10 steps

1. Start planning for discharge or transfer before or on admission.

2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.

3. Develop a clinical management plan for every patient within 24 hours of admission.

4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.

5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.

6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.

7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.

8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.

9. Use a discharge checklist 24–48 hours prior to transfer.

10. Make decisions to discharge and transfer patients each day.

Operating principles

1. Discharge and transfer planning starts early to anticipate problems, put appropriate support in place and agree an expected discharge date.

2. A person-centred approach treats individuals with dignity and respect, and meets their diverse or unique needs to secure the best outcomes possible.

3. The care planning process is co-ordinated effectively.

4. Communication creates strong and productive relationships between practitioners, patients and carers.

5. The MDT works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers.

6. Social care are involved, where appropriate, and the requirements for the assessment notification and discharge notification are met. NHS bodies are required to make two notifications to social care departments in order to trigger a claim for reimbursement. The first (assessment notification – Section 2) gives notice of the patient's possible need for services on discharge. Following this notification, social care departments have a minimum period of three days to carry out an assessment and arrange services. The second (discharge notification – Section 5) gives notice of the day on which it is proposed that the patient is discharged. Reimbursement liability commences on the day after the minimum three-day period (Section 2) or the day after the proposed discharge date (Section 5) – whichever is the later.

7. Patients and carers are involved at all stages of discharge planning, given good information and helped to make care planning decisions and choices.

8. Patients who do not have capacity to make decisions are given their rights and obligations under the Mental Capacity Act.4

9. Carers are offered an assessment to identify any services they may need to support them in their caring role, if appropriate.

10. A person's eligibility for NHS continuing healthcare is assessed where appropriate.

Appendix three

Questionnaire

Appendix four

Semi-structured interview script

Questions have been mapped against the ten 'good practice' steps in the Dept of Health guide 'Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care'.

Not every step is directly mapped against a question. To help the interview flow smoothly, some steps are covered as part of another question.

Question guide prompts are presented in **BOLD PURPLE.** This is what the interviewer will actually say to the participant to prompt the response.

The information that the questions aim to uncover is offered underneath. This is to help us with prompts if we're not quite covering the areas we were hoping to.

10 Principles of Good Practice	**Question to participant** and prompts
	▪ **Introduce yourself** ▪ **Say that the call will last about 20 to 25 minutes – is that okay?** ▪ **Undertaking a research project to get some feedback from patients about their experience of being discharged from hospital - when people go home.** ▪ **The research is being carried out by Bromley LINk – a local group who work with patients to improve health and social care locally** ▪ **We are talking to about 30 different patients to get a range of views** ▪ **The call is being recorded so that we can listen rather than writing things – it will be written up later.** ▪ **You will remain anonymous. Your name won't be used in any reports or feedback we do. It can't be linked back to you and won't affect any care you receive in future** ▪ **We will mention things like your age or condition so that people understand a bit more about the people we spoke to** ▪ **How many questions. Not comfortable. Stop interview.** ▪ ***(However, if you report any actual abuse we have a duty to follow up) – we are taking advice on this at the moment***
Understand patient	**Where do you live (by postcode) and how old are you?**
Understand condition	If you are comfortable telling us - **Can you tell me a bit about why you were admitted to hospital recently.**
Understand hospital stay	**How long were you in hospital?**

Start planning for discharge or transfer before or on admission.	**Tell us about your memory of when your doctor or nurse first mentioned the date on which you would go home.** **Who initiated the conversation?** **Was it regularly discussed during your stay in hospital?** **Were you updated on any changes to the date if they occurred?** (At what point did a member of staff first begin talking to you about when you might be discharged from hospital?)
Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.	**How involved did you feel in planning what would happen when you went home from hospital? Did you feel you should be involved?** (Was your discharge discussed with you in any detail? Were you aware of dates and reasons?)
Develop a clinical management plan for every patient within 24 hours of admission.	
Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.	**Thinking about any help or support you might have needed after hospital, tell us what you remember about any discussions you had about this?** (Did anyone talk to you about your needs when you got home? Did anyone talk to you about any ongoing care or support from other services (district nurses, physiotherapists etc) once you got home?)
Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.	

Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.	
Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.	**Tell us how you felt about the planning for when you went home from hospital – did you feel involved?** (Were you consulted on your discharge? Did you feel that your discharge was planned around your needs? Were your family, friends or carers involved?)
Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.	**Now, thinking about your actual day on which you went home, can you tell us a bit more about what happened. Who explained what was happening.** **Thinking back - did you end up going home when you were initially told you would be? How did you feel about that? If it changed, do you understand why?** (On what day of the week were you discharged? Were all the services you needed in place for you when you were discharged? Did you understand how to care for yourself, including things like taking medication or what to do if you needed more help at home? Were your family, friends or carers involved in this?)
Use a discharge checklist 24–48 hours prior to transfer.	

Make decisions to discharge and transfer patients each day.	**Tell us a bit more about leaving your hospital bed and the process from there to getting home….** (At the point at which you were discharged, did you understand what was happening to you? Were there any issues that affected your discharge (eg transport, medication, getting into your home, having adaptations made to your home))
General views	**Did you feel happy about the process of getting you home from from hospital – from beginning to end?** **Is there anything in particular you'd like to tell the hospital about how they handled the process of getting you home?**
Close interview	Thank patient for their views and spending time talking about them. Will send a copy of report if they want. (Take address to send to)

Appendix five - Additional information from other surveys and studies that readers may find informative.

Several other patient feedback mechanisms have been used during 2010 and 2011 which have been briefly reviewed in order to ascertain whether patient feedback in other studies highlights any recurring themes when cross-referenced with the results of this study.

It is noted that the studies referenced below were carried out using different methodologies and relate to the whole hospital experience, whilst our study focuses predominantly on the discharge element of the patient journey. As such, only limited information can be cross-referenced.

Only questions where there is a valid cross-reference are highlighted.

The information referenced is:

- SLHT Inpatient survey - February 2011
- SLHT Inpatient survey - November 2010
- CQC Inpatient survey – June – Aug 2010

Aftercare – poor knowledge/advice/concern regarding post-discharge care

Our study highlights several areas of concern with regard to information provided to patients at the point of discharge on self-care and after-care.

- The CQC Inpatient Survey results indicate that this was a concern for patients, with a score of 5.3 out of 10 for 'Advice after discharge', 3.9 out of 10 for 'Side effects' (being told what to look for) and 4.2 for 'Danger signals'.
- In the February 2011 SLHT Inpatient survey responses to the question 'Were you told about medication side effects to watch out for when you went home?' were very mixed, with 5 red indicators on the survey RAG rating.

Delays at discharge

Our study indicates that some patients experienced delay at discharge due to issues with transport, pharmacy and the working patterns of some internal hospital services.

- The CQC Inpatient Survey results indicate that this was a concern for some patients, with a score of 7 out of 10 for NOT being delayed on the day of discharge.

Perceptions of under-staffing

Free text fields on the survey highlighted a perceived shortage of staff in some areas of the hospital.

- The February 2011 SLHT Inpatient survey had 13 red RAG ratings for patients responding to the question, ‘In your opinion, were there enough nurses on duty to care for you in hospital?’

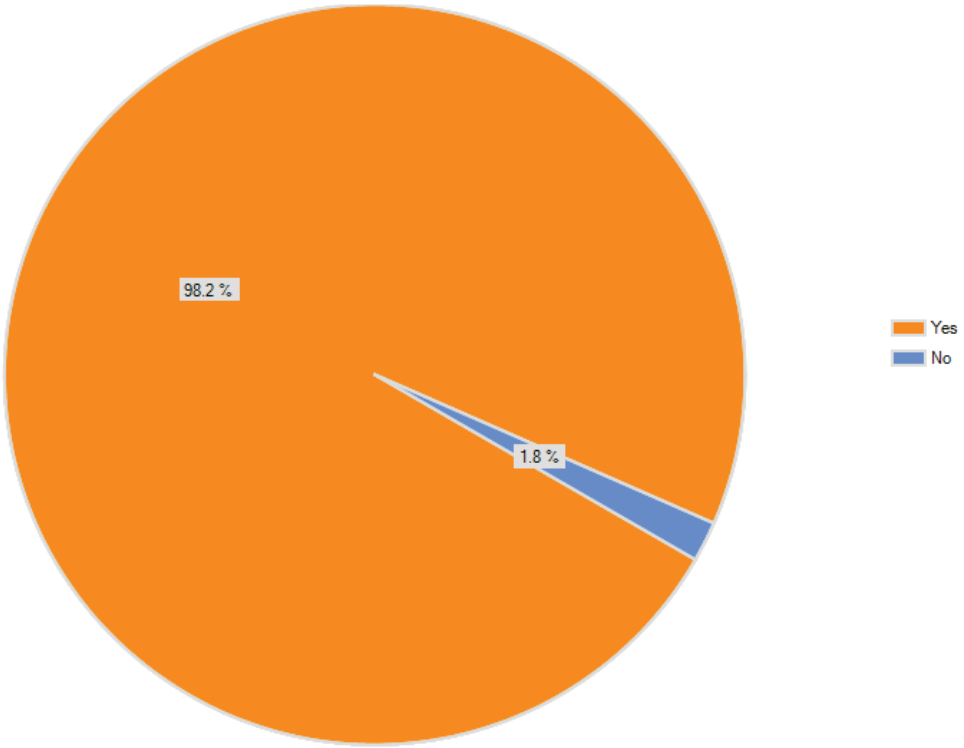
Appendix six

Questionnaire data

Section one: About you

Q1
114 respondents

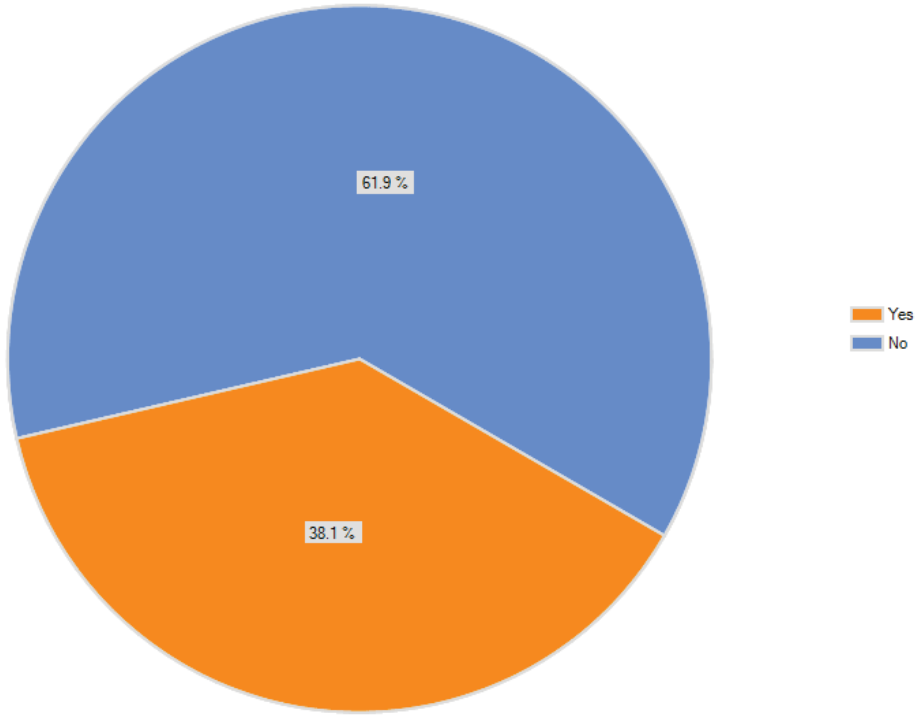
Is English your first language?



Section one: About you

Q2
113 respondents

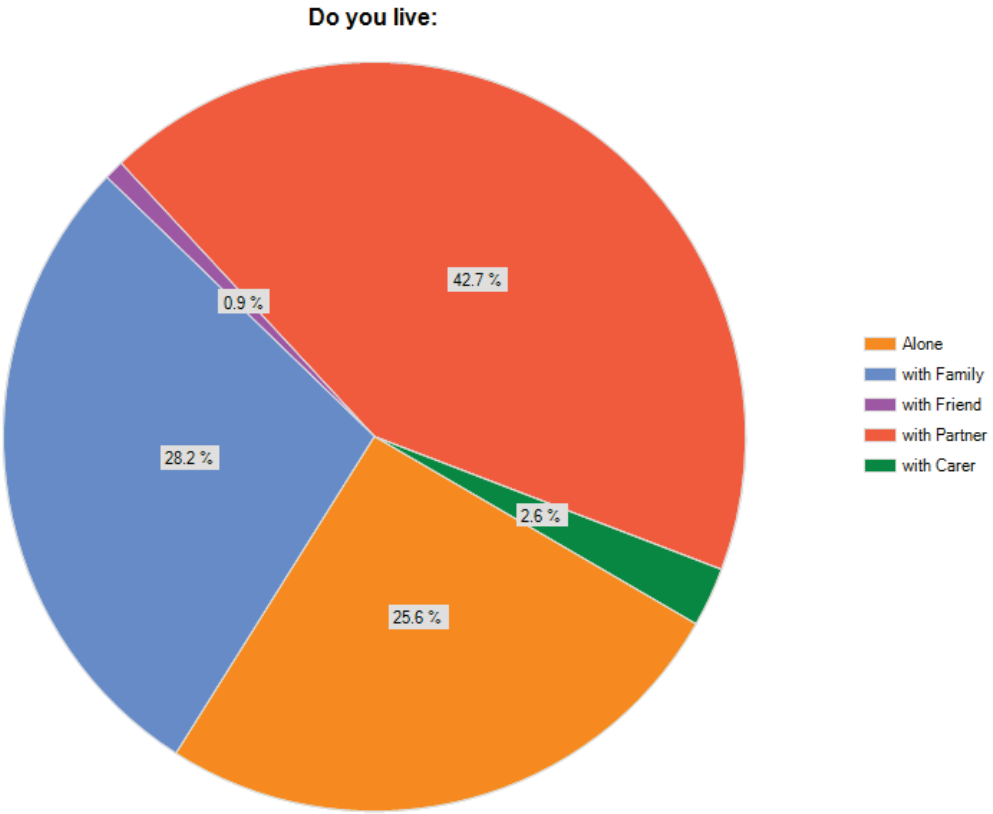
Do you consider yourself to have a disability?



Section one: About you

Q3
117 respondents

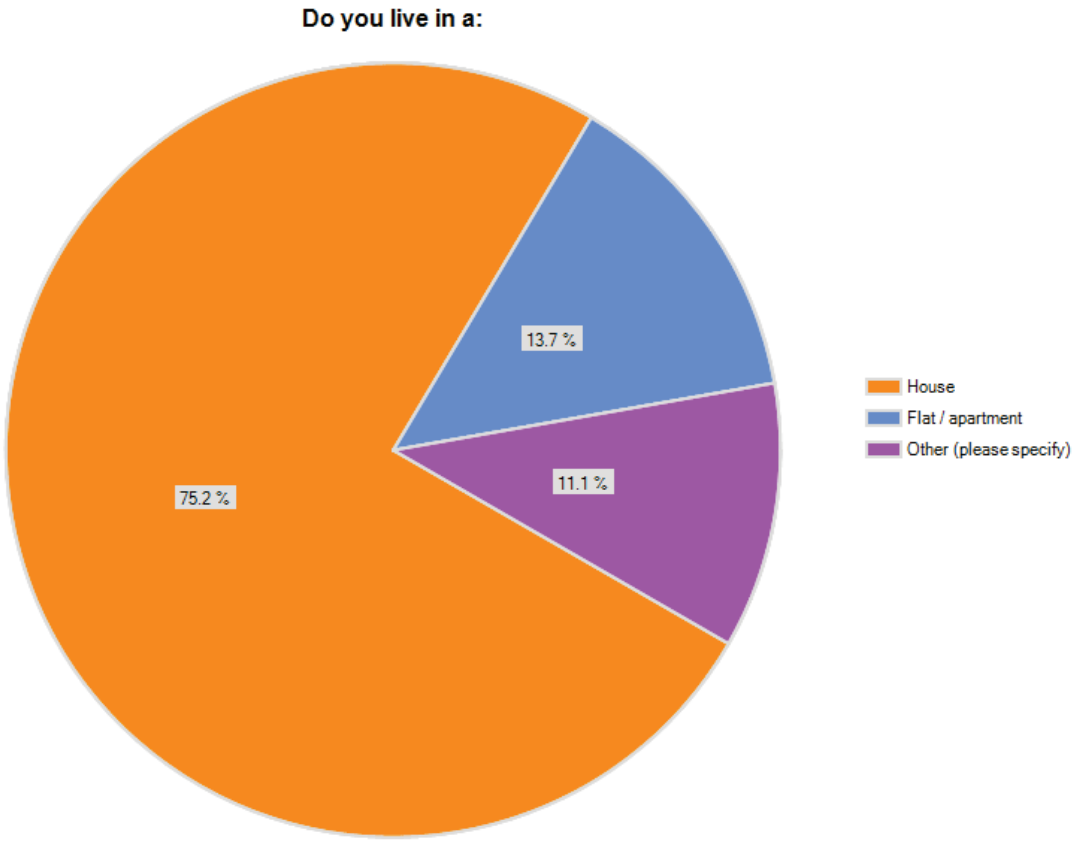
Who respondents live with



Section one: About you

Q4
117 respondents

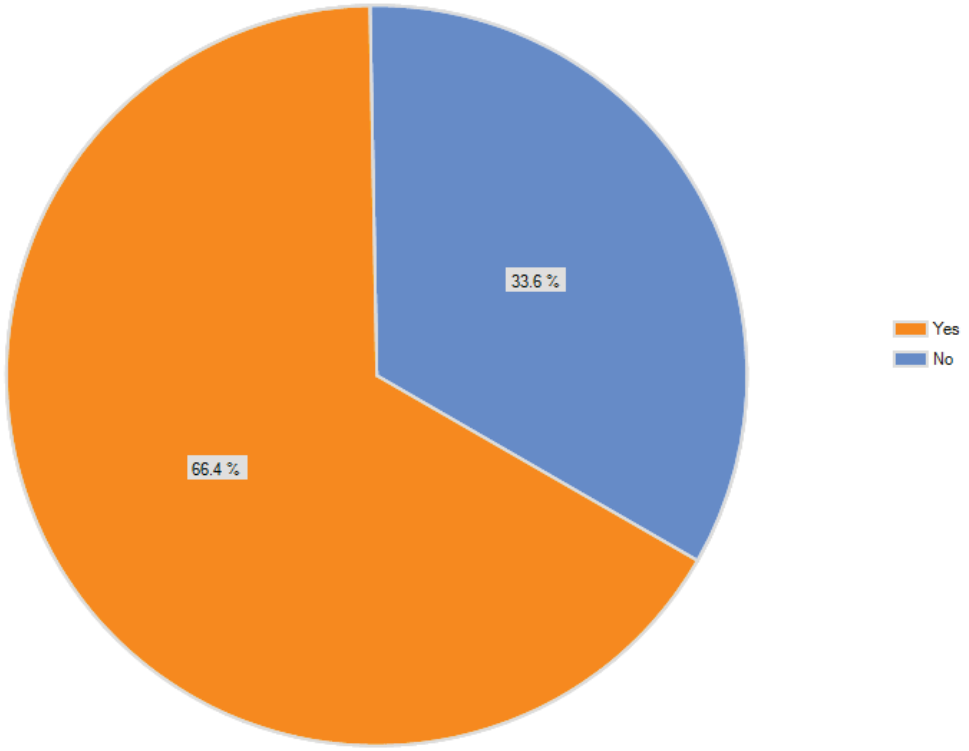
Where respondents live



Section one: About you

Q5
113 respondents

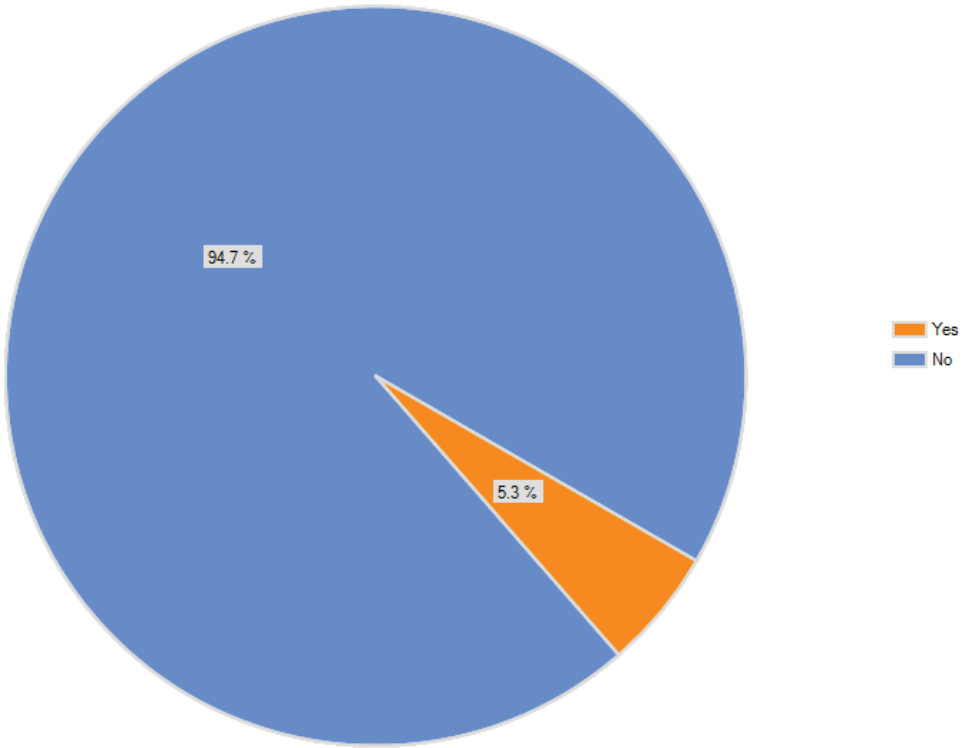
Do you have a downstairs toilet?



Section one: About you

Q6
114 respondents

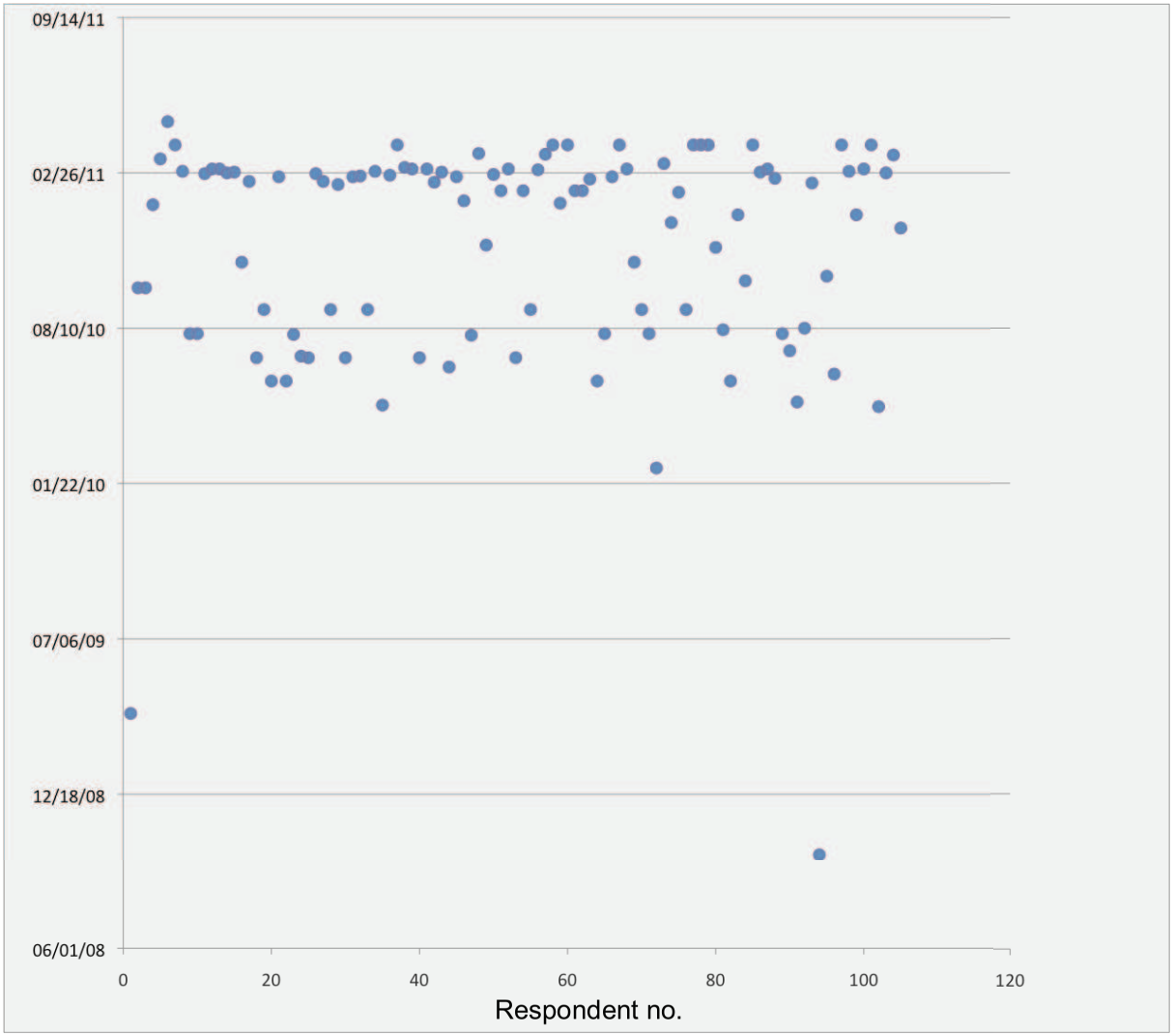
Do you have a lift?



Section two: Hospital details

Q7
105 respondents

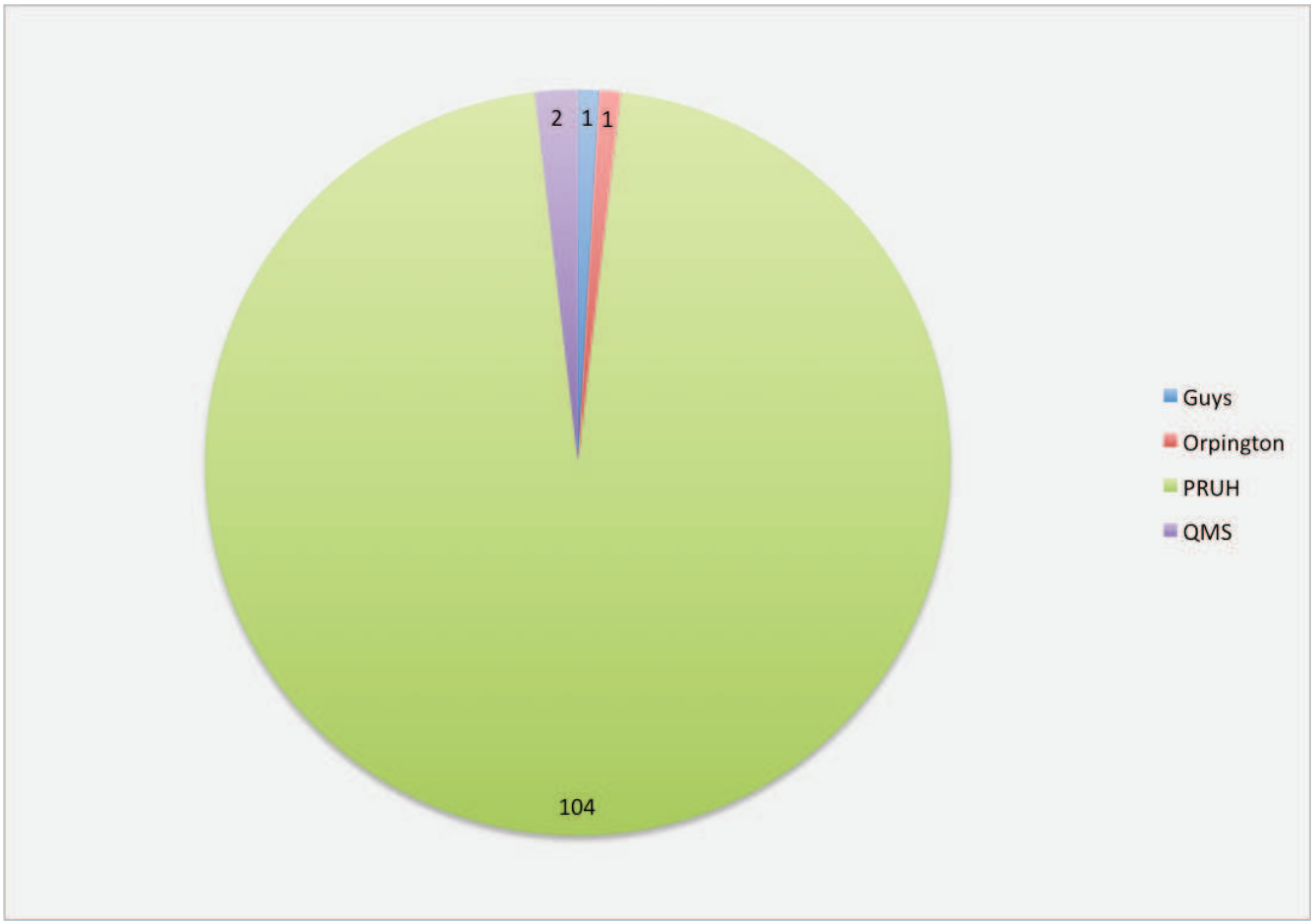
When were you admitted to hospital?



Section two: Hospital details

Q7b
108 respondents

Which hospital were you in?



Section two: Hospital details

Q7c
100 respondents

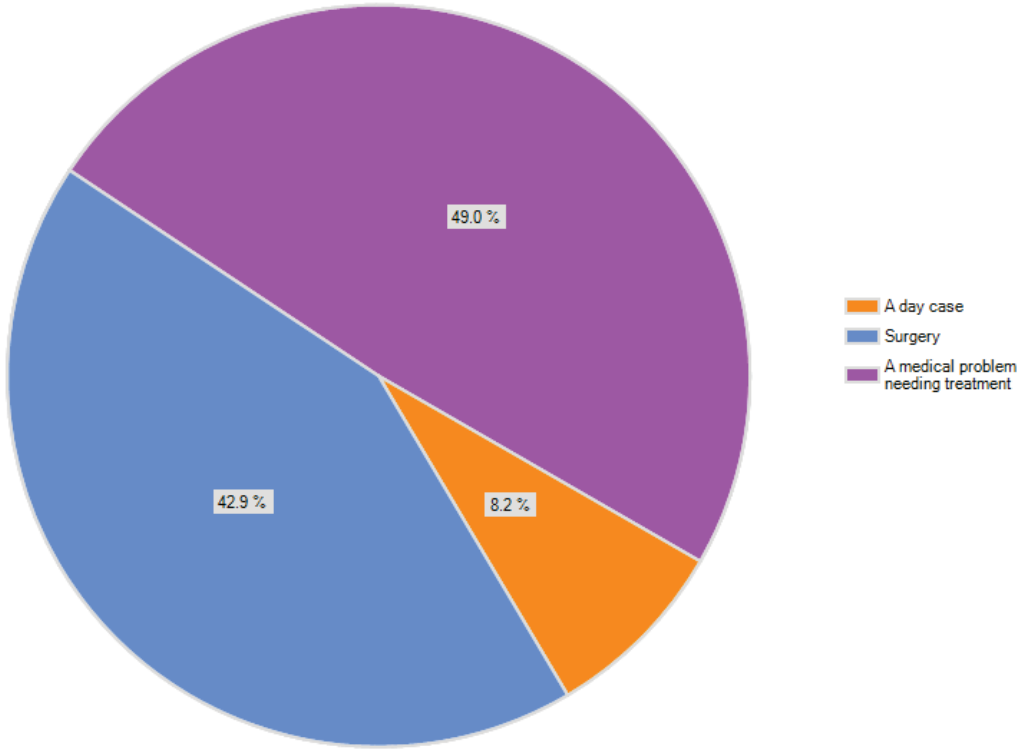
Which ward were in you in
(Ward names as reported by respondent)

Ward	% of respondents	Actual no.
A&E	2.27	2
Alan Cumming	7.95	7
Aston Keys	1.14	1
Betts	1.14	1
Chartwell	1.14	1
Childrens	2.27	2
CCU	3.41	3
Day	1.14	1
EAU	9.09	8
Farnborough	7.95	7
Hazelbrook	1.14	1
ICU	2.27	2
Maternity	3.41	3
Medical 2	2.27	2
Medical 3	1.14	1
Medical 4	1.14	1
Medical 6	3.41	3
Medical 7	4.55	4
Medical 8	4.55	4
Medical 12	2.27	2
Ward 17 North Wing	1.14	1
PIU	1.14	1
Ruxley	1.14	1
Stroke	3.41	3
Surgical 1	1.14	1
Surgical 3	1.14	1
Surgical 4	1.14	1
Surgical 5	9.09	8
Sugical 6	4.55	4
Surgical 7	4.55	4
Surgical 8	7.95	7
	100	88

Section two: Hospital details

Q8
98 respondents

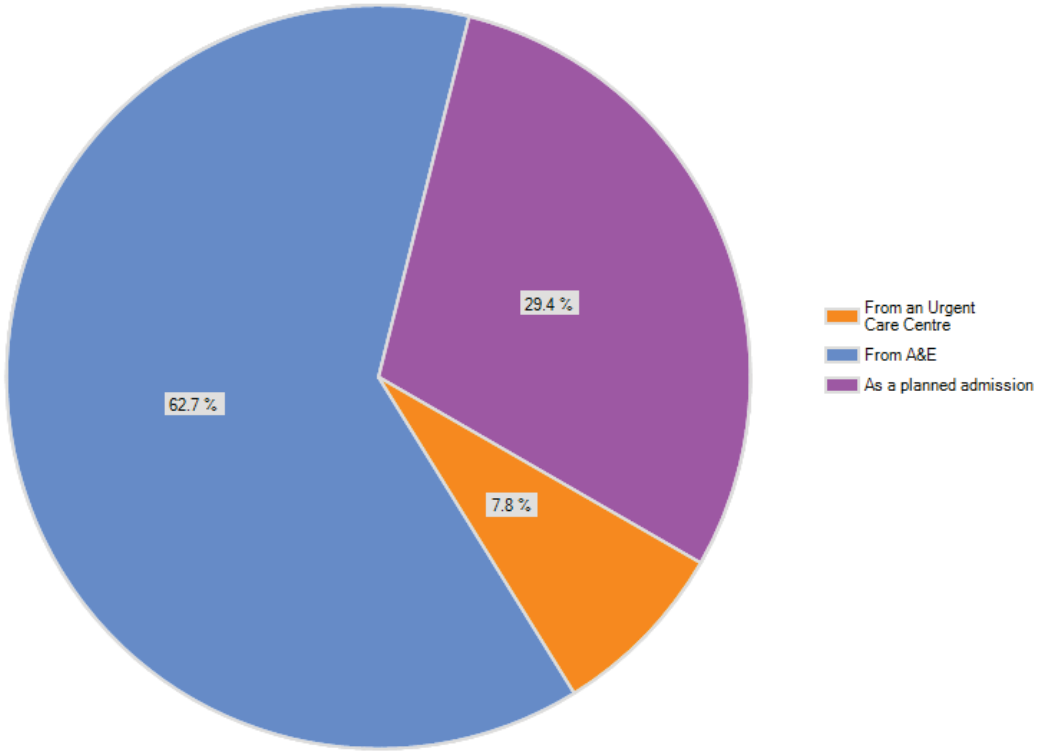
What were you admitted for?



Section two: Hospital details

Q9
102 respondents

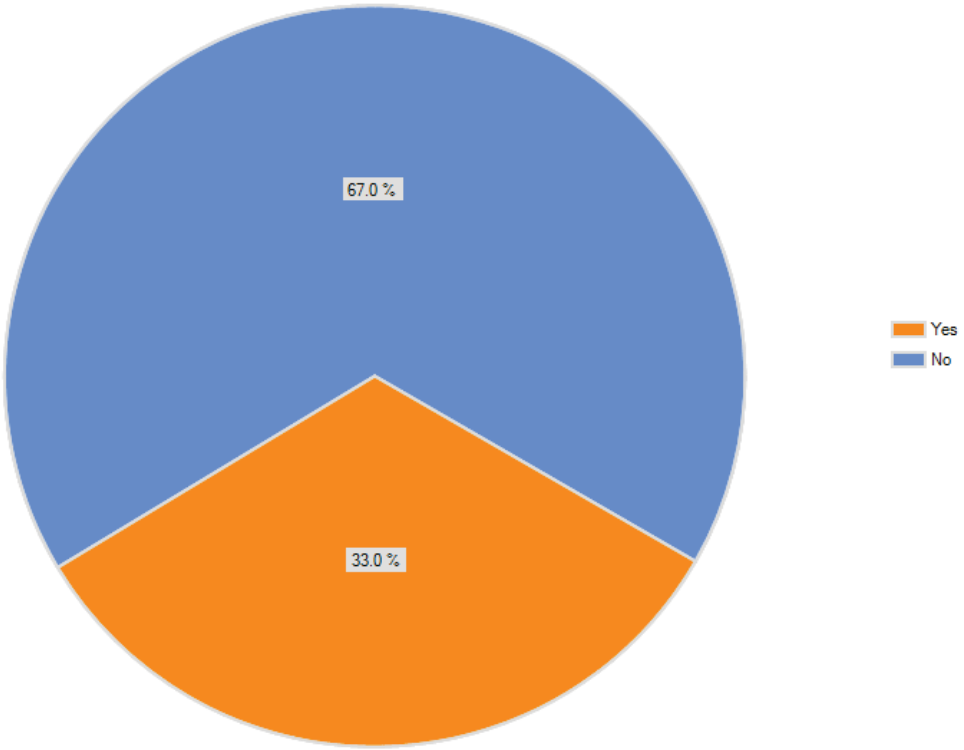
How were you admitted?



Section two: Hospital details

Q10
109 respondents

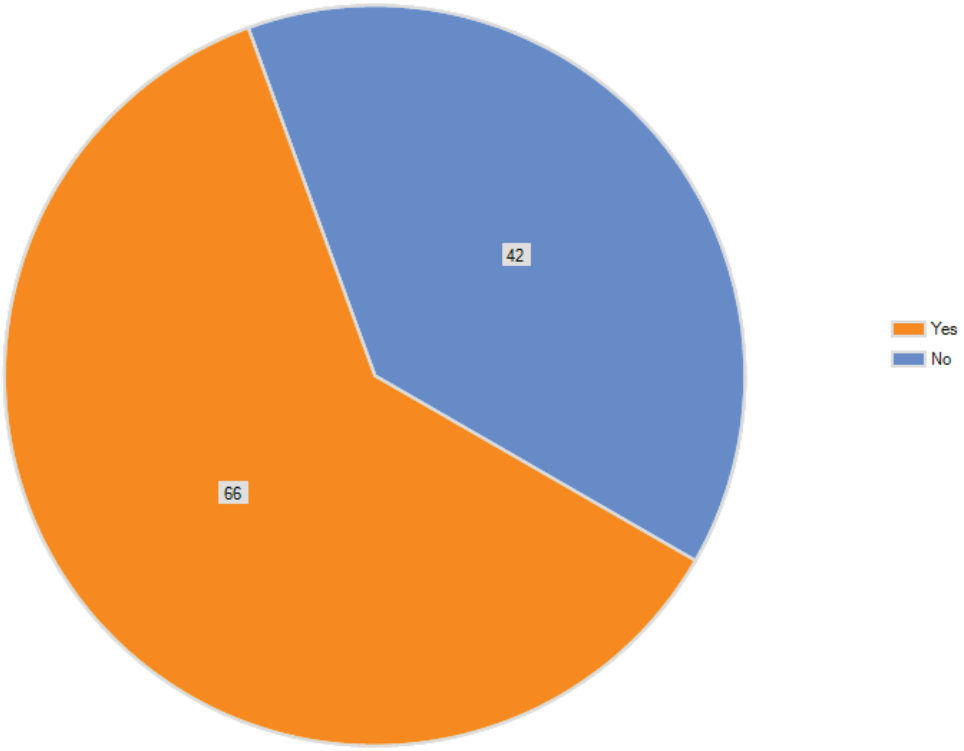
Were you on your own when you were admitted?



Section two: Hospital details

Q11
108 respondents

Were you admitted with a new medical problem?



Section three: Your care

Q12
99 respondents

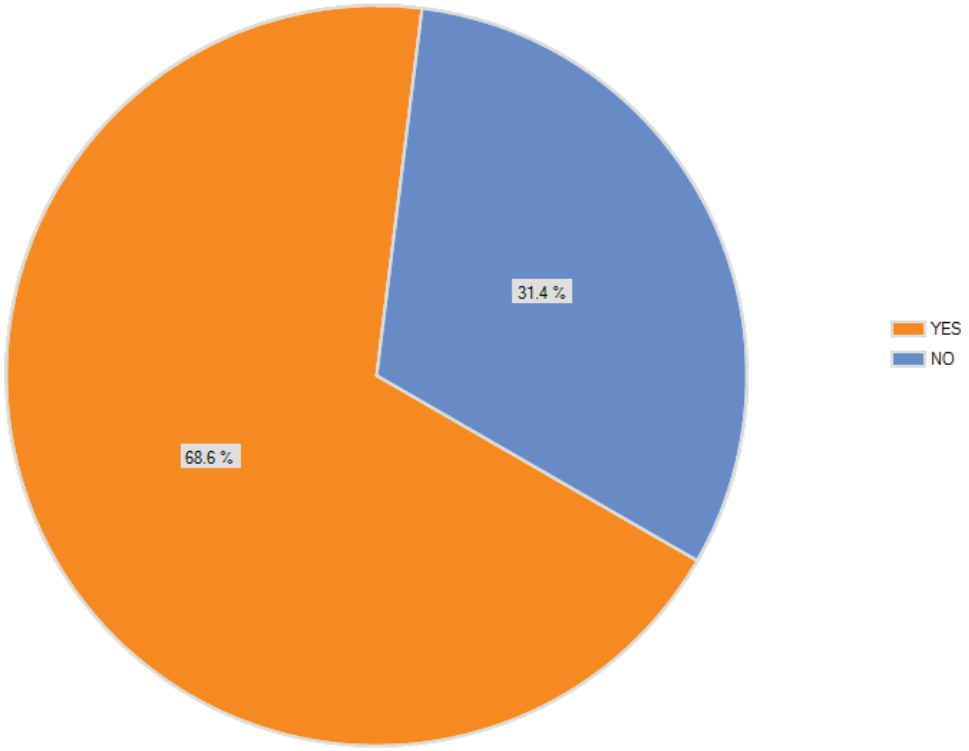
How long were you in hospital before your discharge was discussed?

Response	%	Actual no
On day of admission	15.46	15
UNDER 2 WEEKS		
Within 1 day	13.40	13
Within 2 days	7.22	7
Within 3 days	8.25	8
Within 4 days	6.19	6
Within 5 days	9.28	9
Within 6 days	2.06	2
Within 7 days	9.28	9
Within 8 days	1.03	1
Within 9 days	2.06	2
Within 10 days	1.03	1
Within 11 days	2.06	2
Within 12 days	3.09	3
OVER 2 WEEKS		
14 days	1.03	1
15 days	1.03	1
17 days	1.03	1
21 days	1.03	1
28 days	3.09	3
35 days	2.06	2
49 days	1.03	1
Never discussed	5.15	5
On the day	2.06	2
Inconclusive	2.06	2
TOTALS	100	97

Section three: Your care

Q13
102 respondents

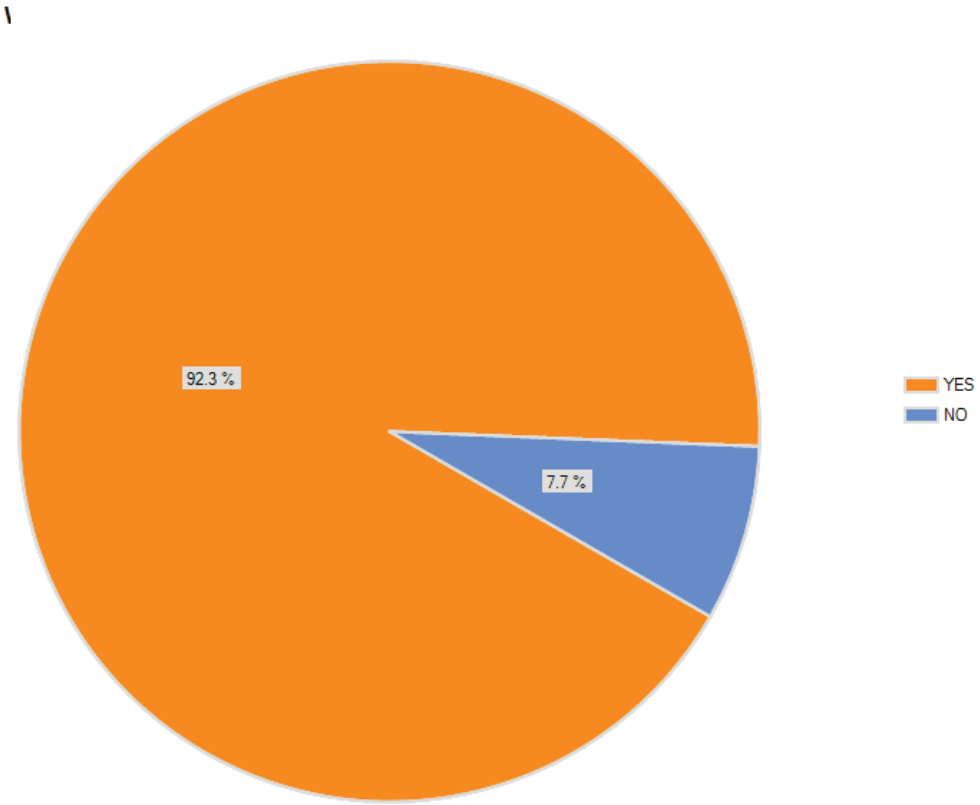
Were you able to talk about your feelings and your future with staff?



Section three: Your care

Q15
104 respondents

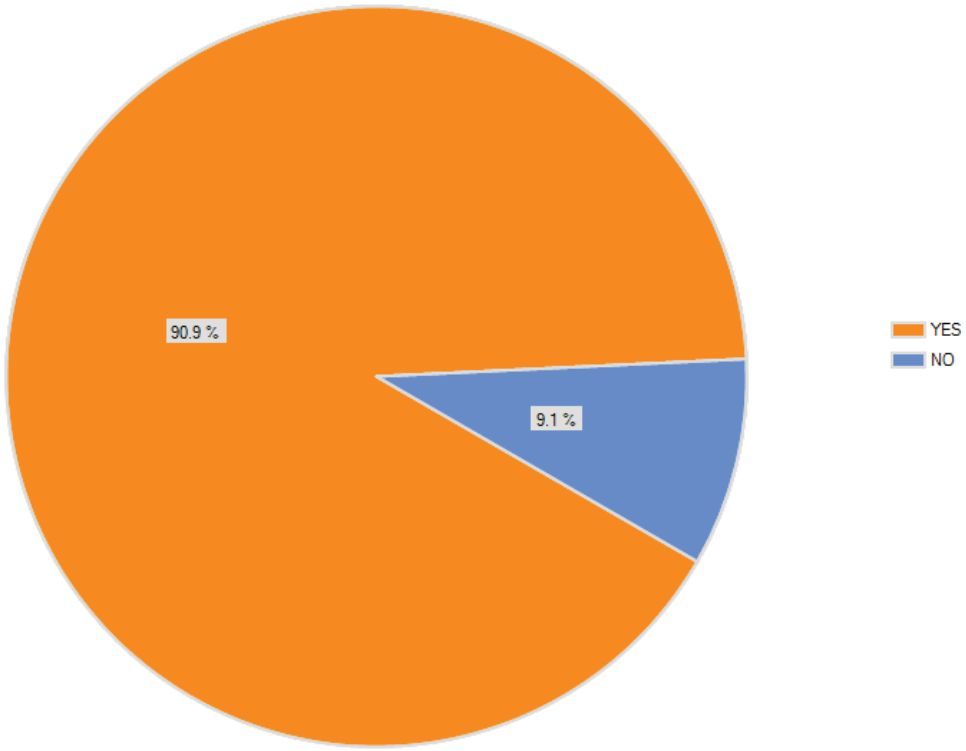
Were family and friends present at any time during your hospital stay?



Section three: Your care

Q14
100 respondents

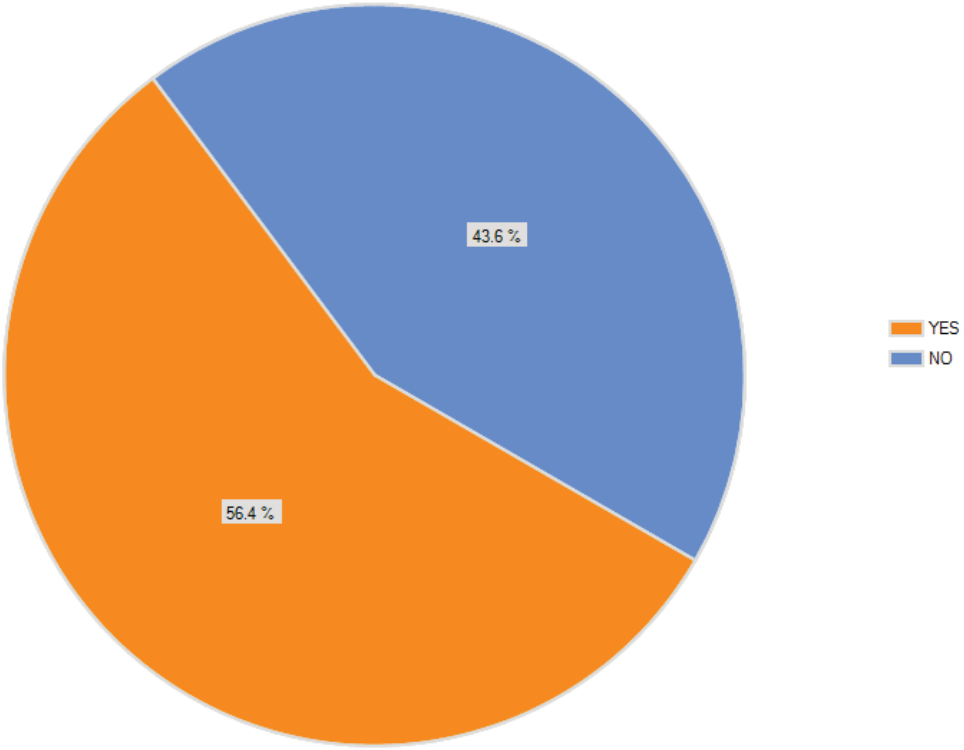
Did you have the support of your family and friends at the time of your admission?



Section three: Your care

Q16
101 respondents

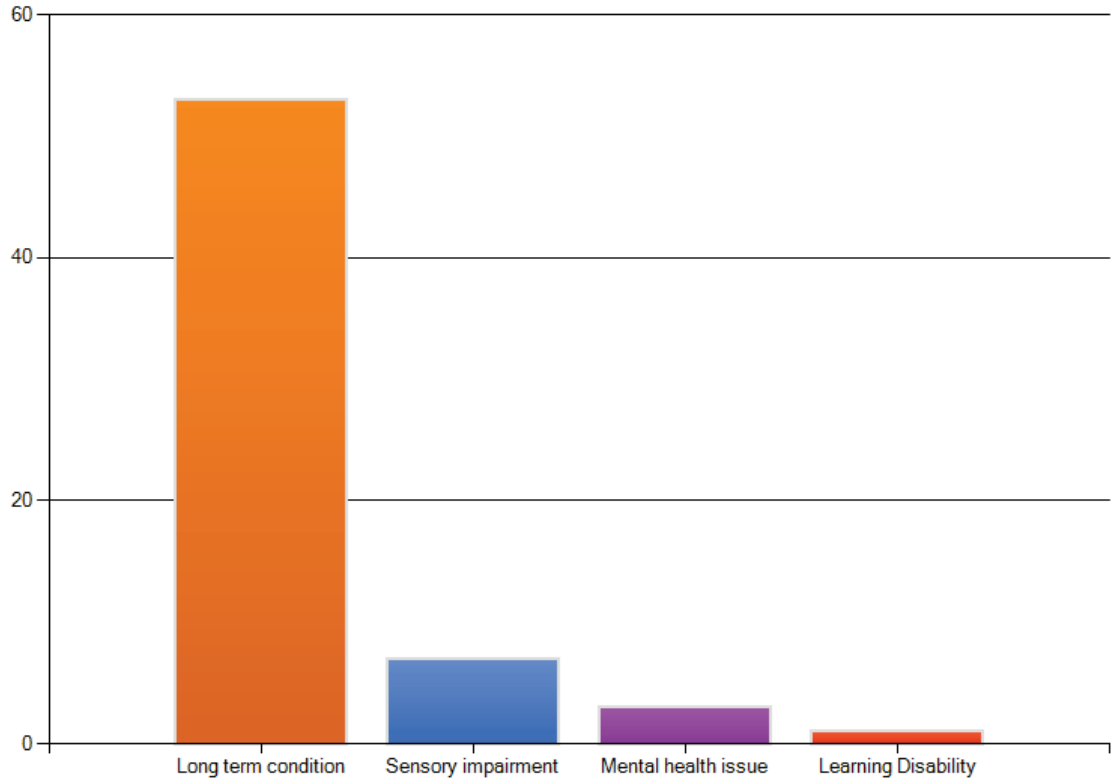
Were any other health needs taken into account by staff?



Section three: Your care

Q17
58 respondents

If ‘yes’ – what are your health needs?

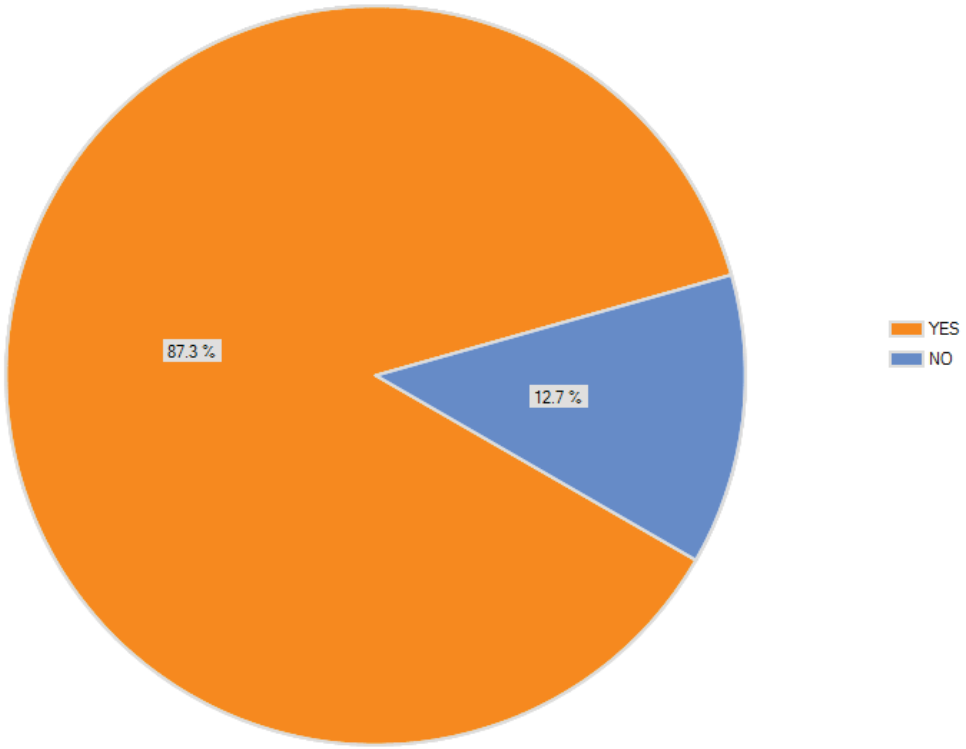


NB: Some respondents have more than one condition, so total responses add up to more than 58.

Section four: The day you went home

Q19
110 respondents

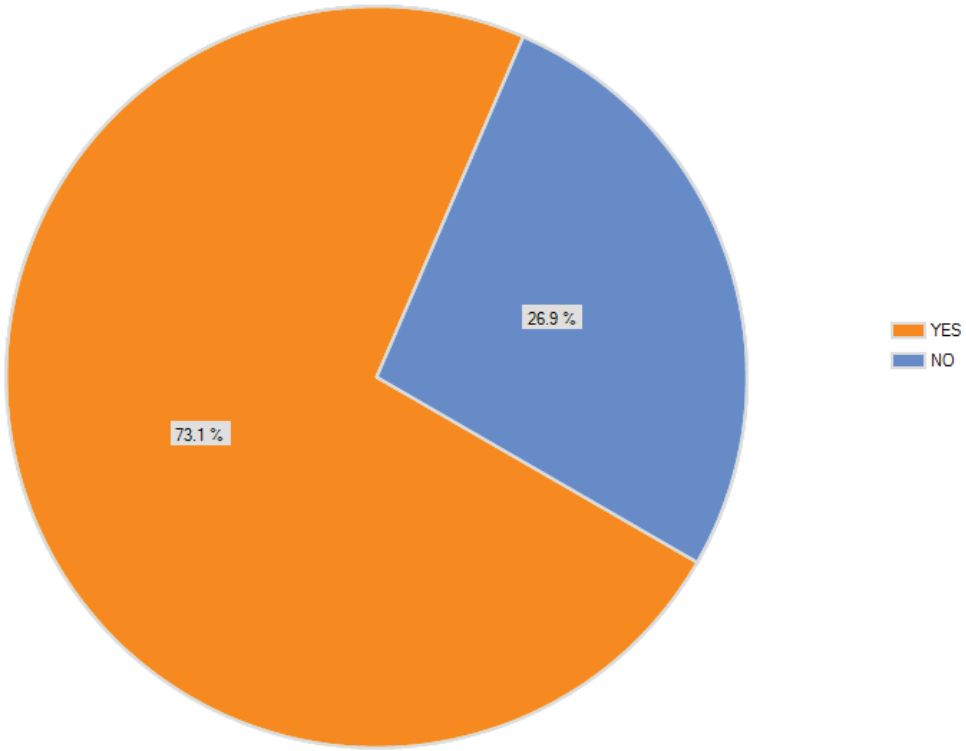
Did you feel well enough to go home?



Section four: The day you went home

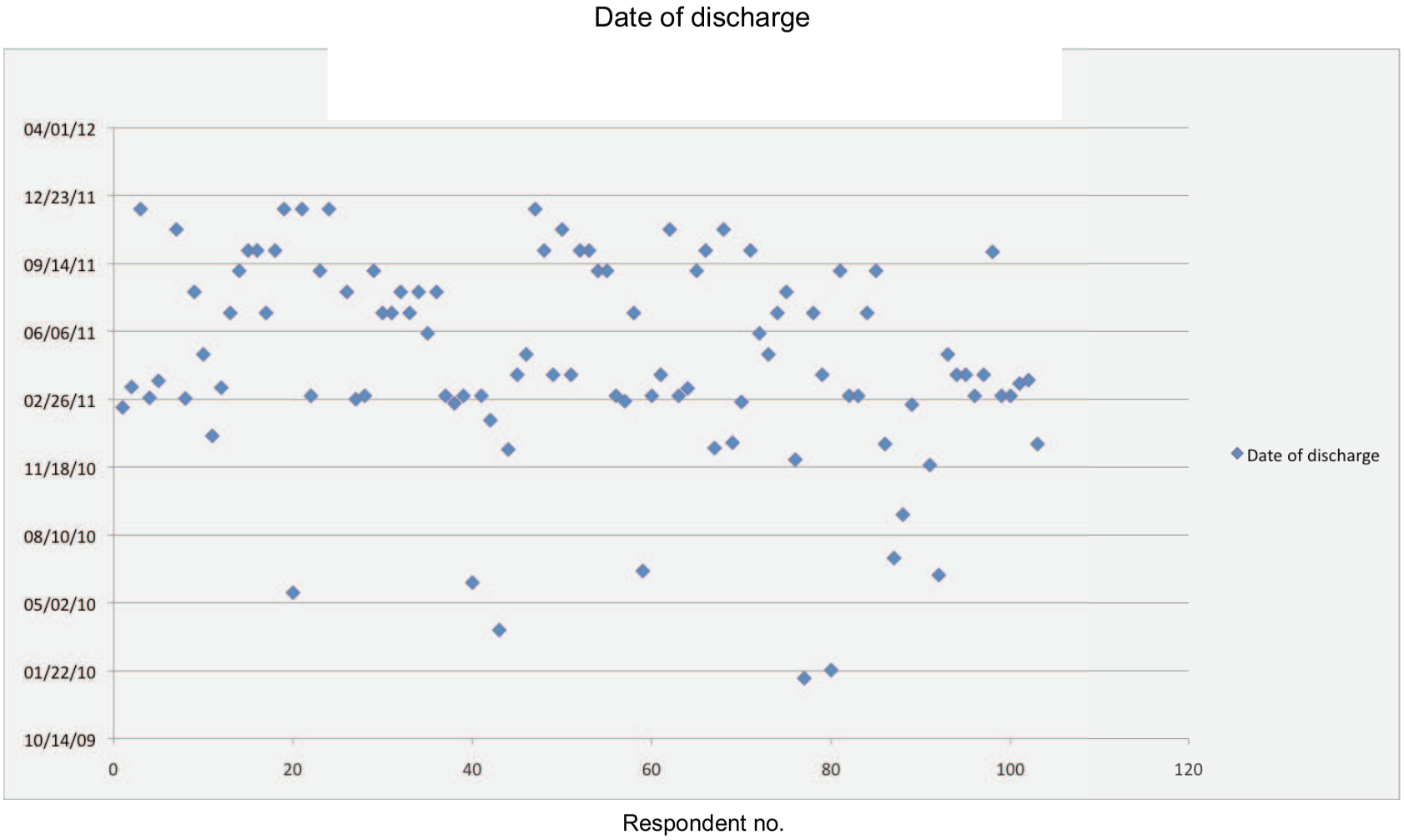
Q20
108 respondents

Is this your first discharge because of this medical condition?



Section four: The day you went home

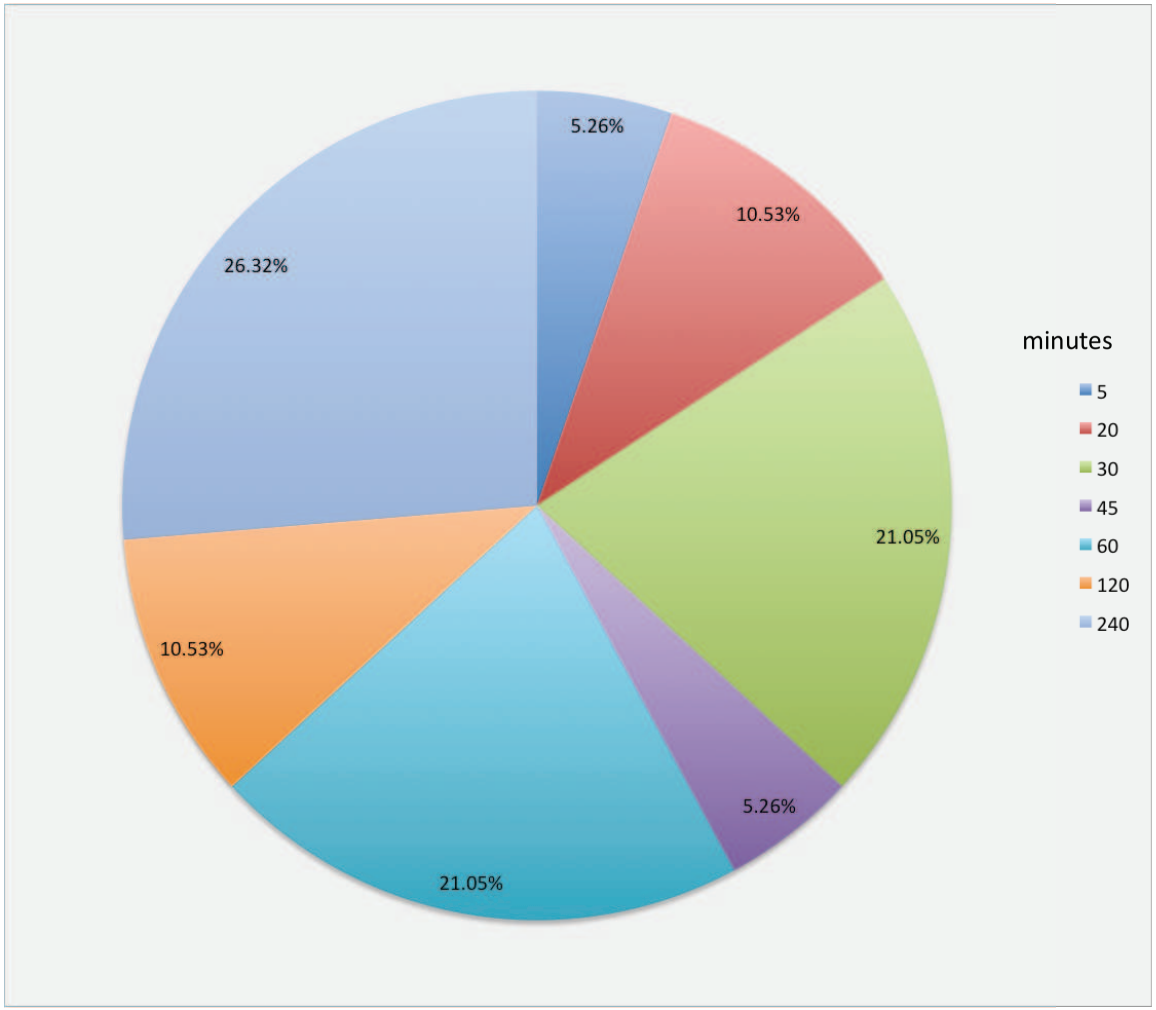
Q21
106 respondents



Section four: The day you went home

Q23
81 respondents

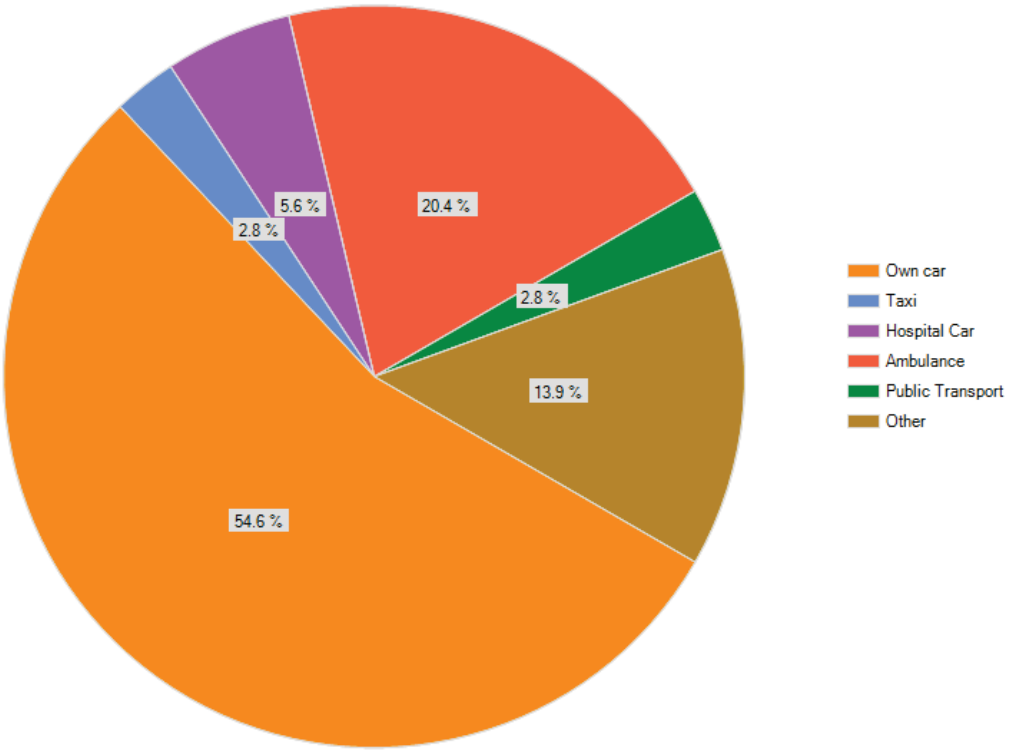
How long did you wait in the discharge lounge?



Section four: The day you went home

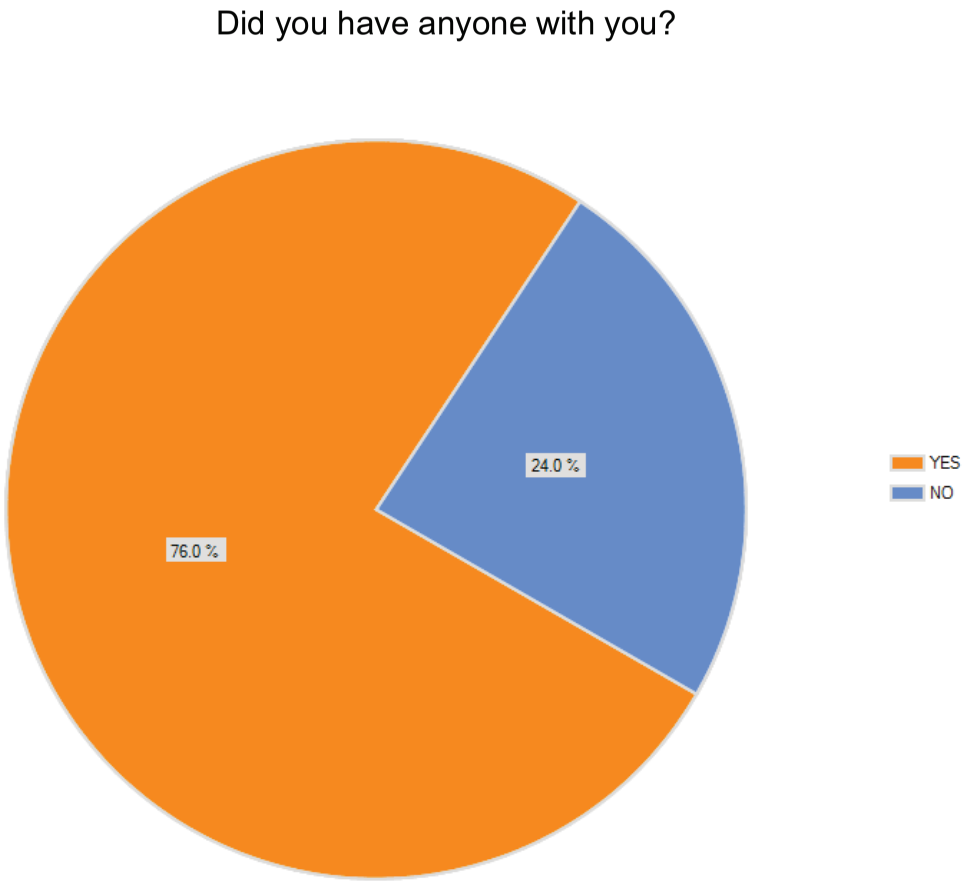
Q 26
108 respondents

What form of transport did you use to get home?



Section four: The day you went home

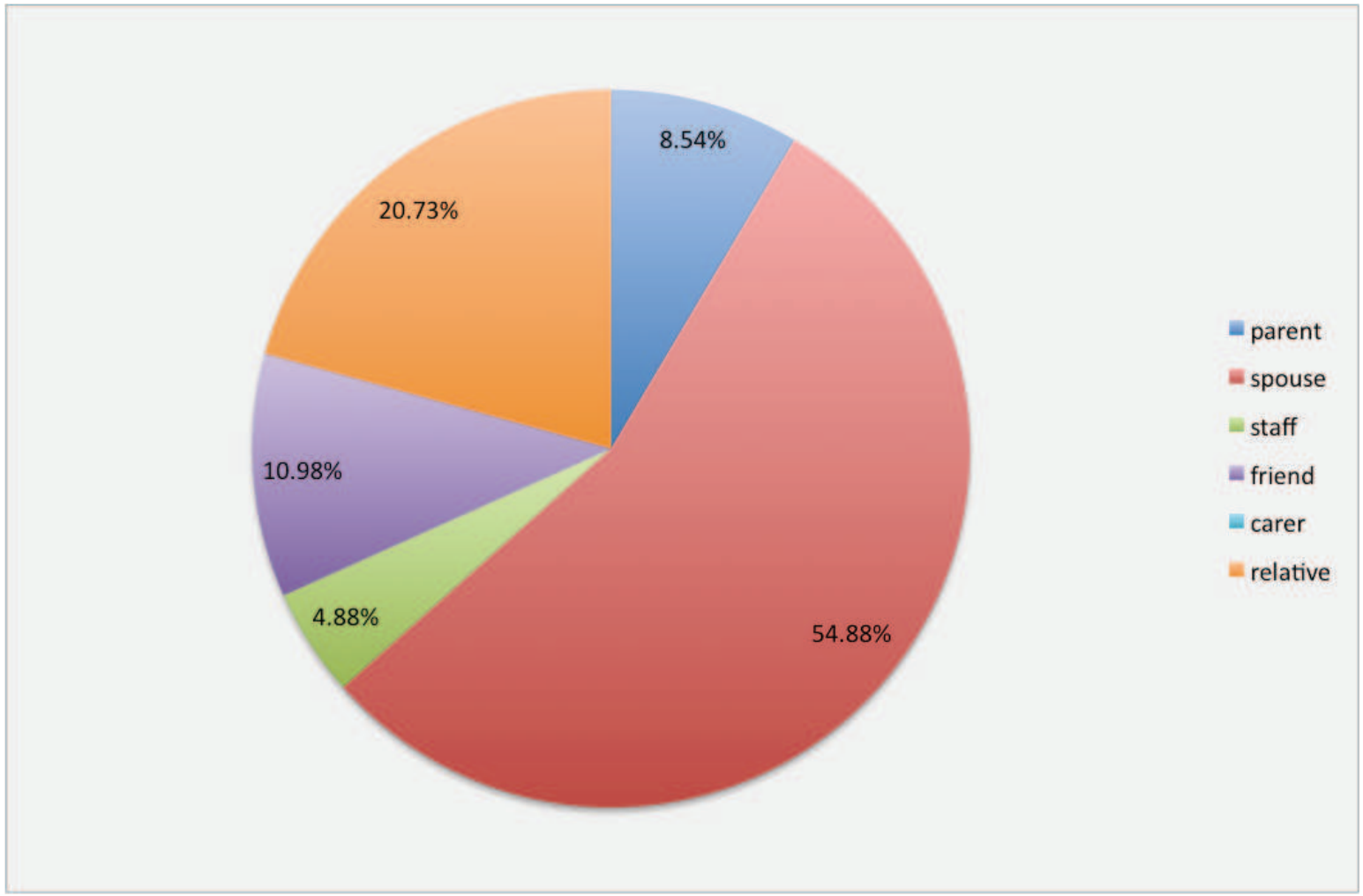
Q 27
104 respondents



Section four: The day you went home

Q 28
83 respondents

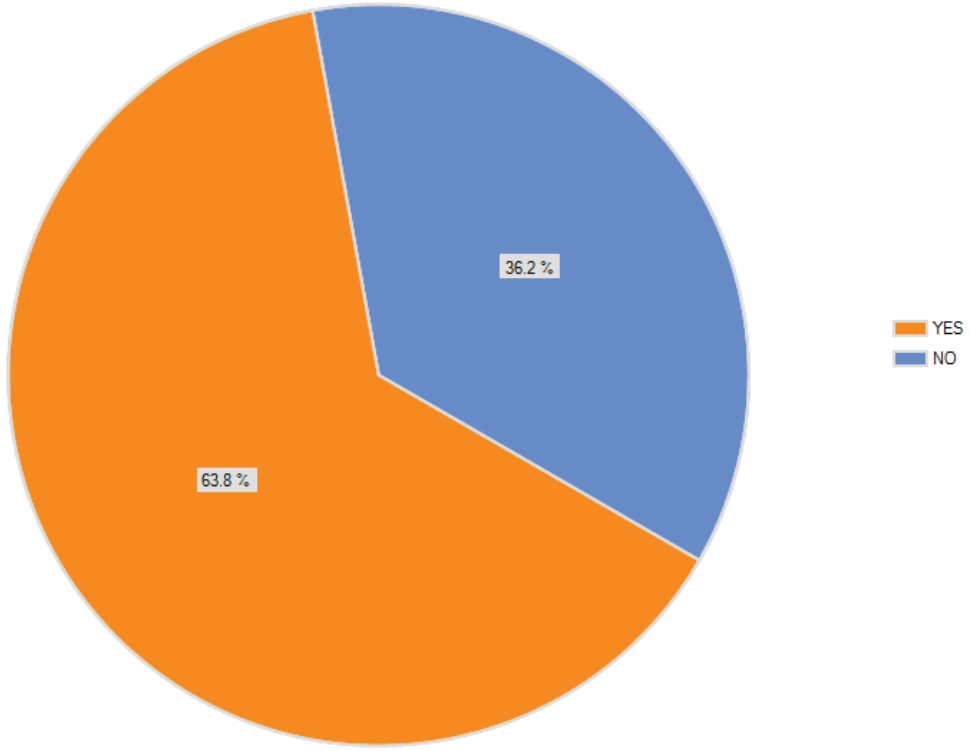
Who did you have with you on discharge?



Section four: The day you went home

Q 29
105 respondents

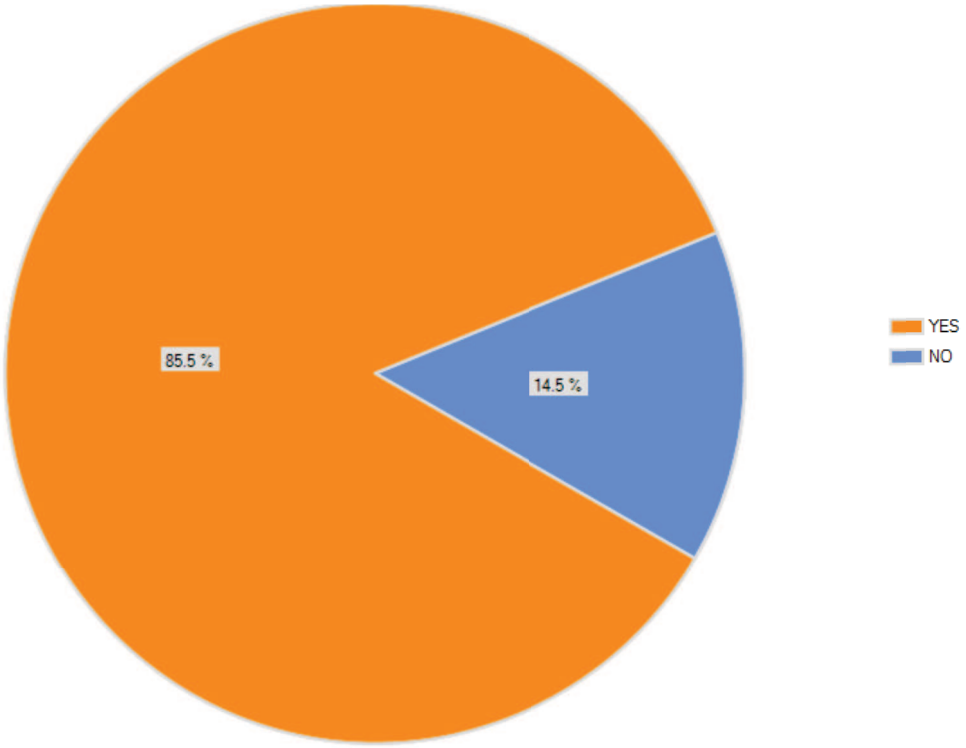
Did you have anyone at home waiting for you?



Section five: The discharge process

Q 30
110 respondents

Were you given medication to take after you left hospital?

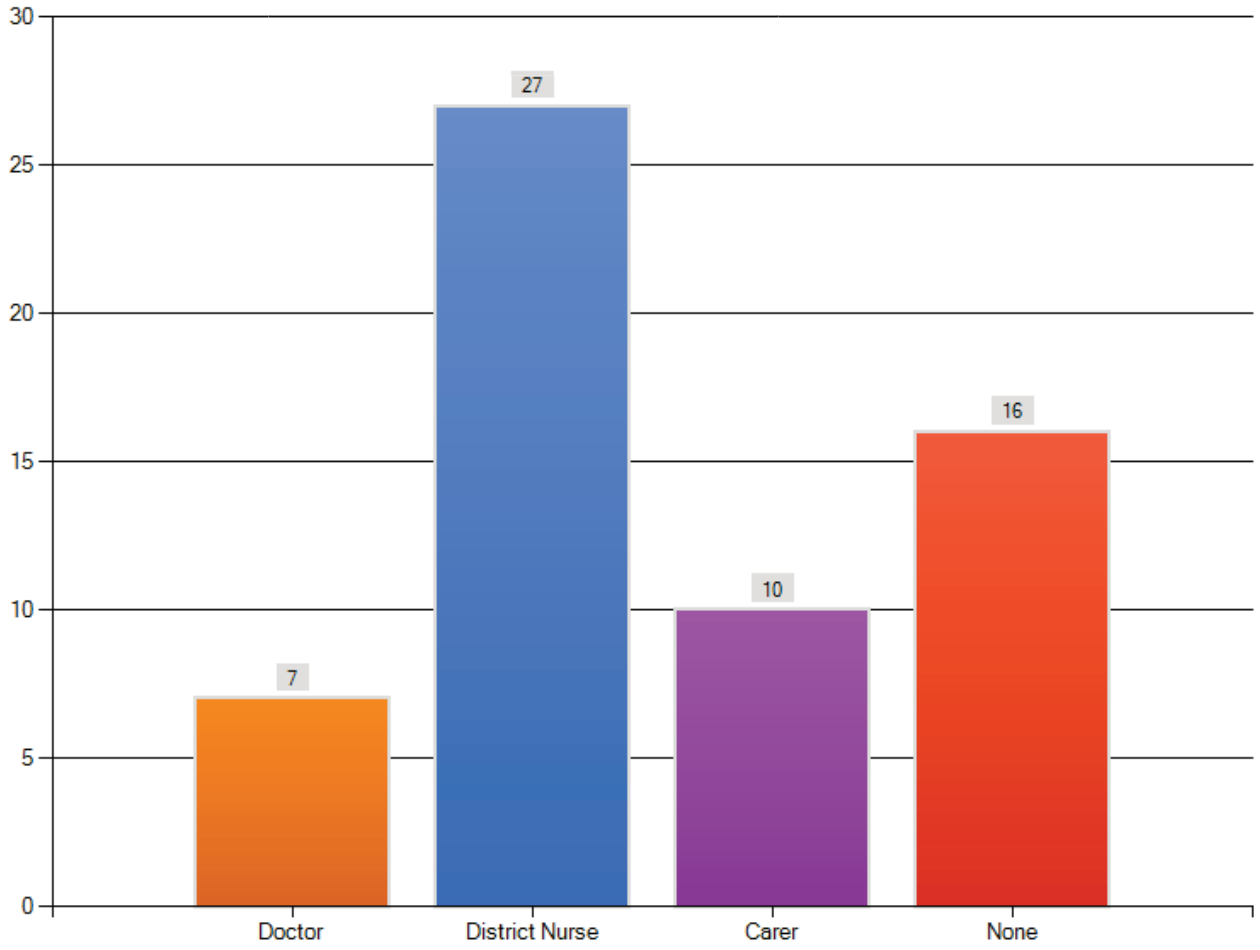


Section five: The discharge process

Q31
49 respondents

Were you told you would have a home visit from anyone?

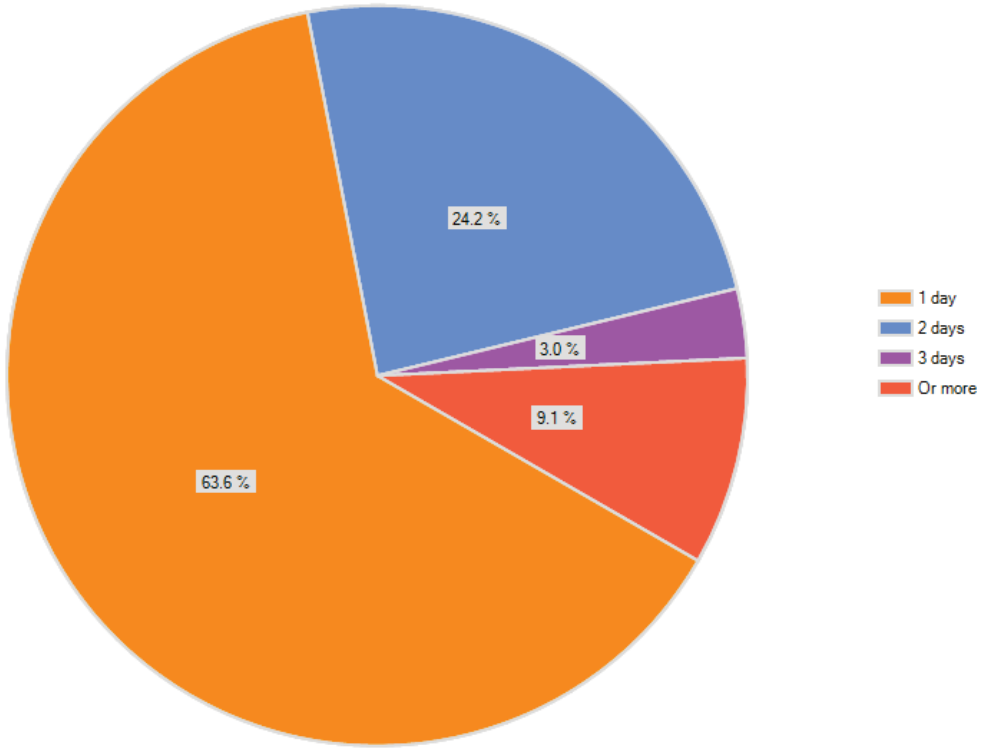
(totals add up to more than 49 as some respondents were told they would have more than one visitor)



Section five: The discharge process

Q 32
33 respondents

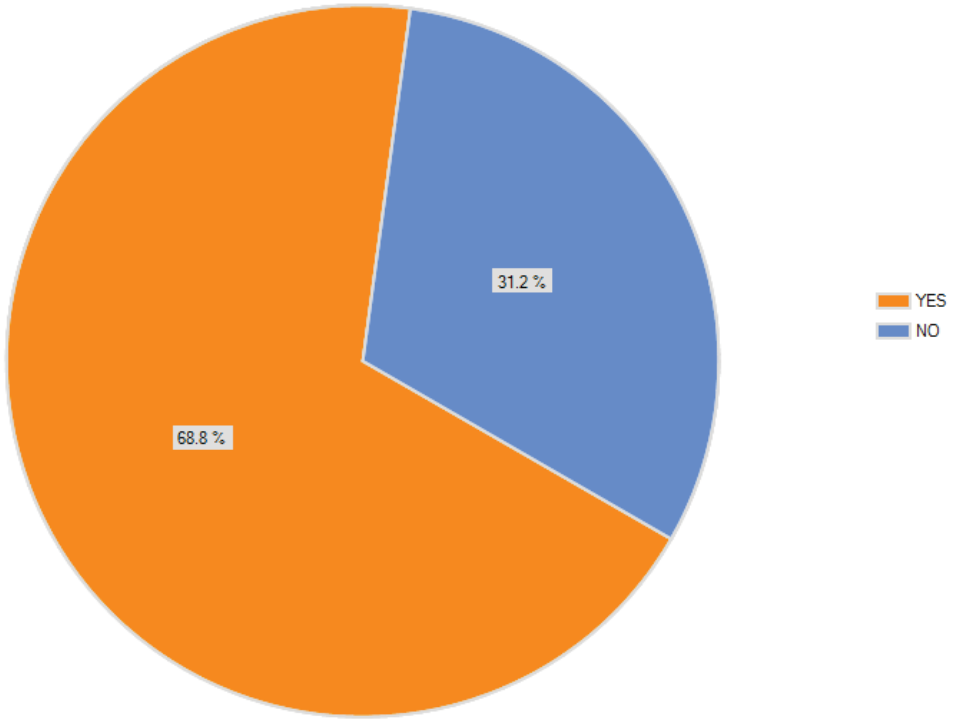
If ‘yes’ – how long after arriving home?



Section five: The discharge process

Q 33
109 respondents

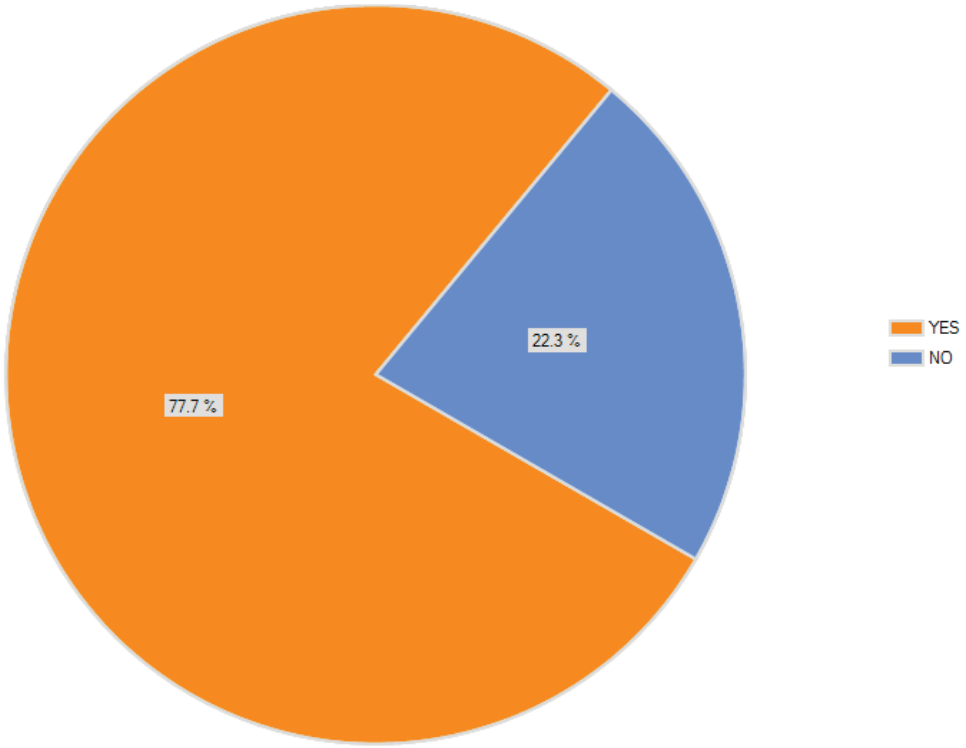
Were you given instruction/information on your condition and what to expect?



Section five: The discharge process

Q 34
103 respondents

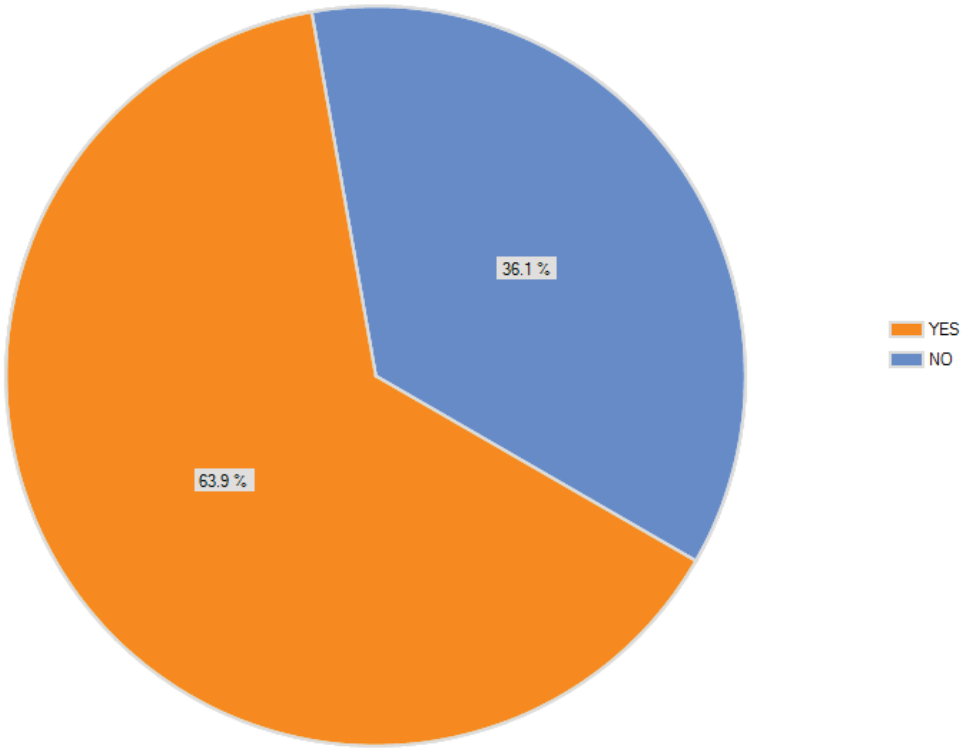
Were you given instruction/information on how to use your medication?



Section five: The discharge process

Q 35
108 respondents

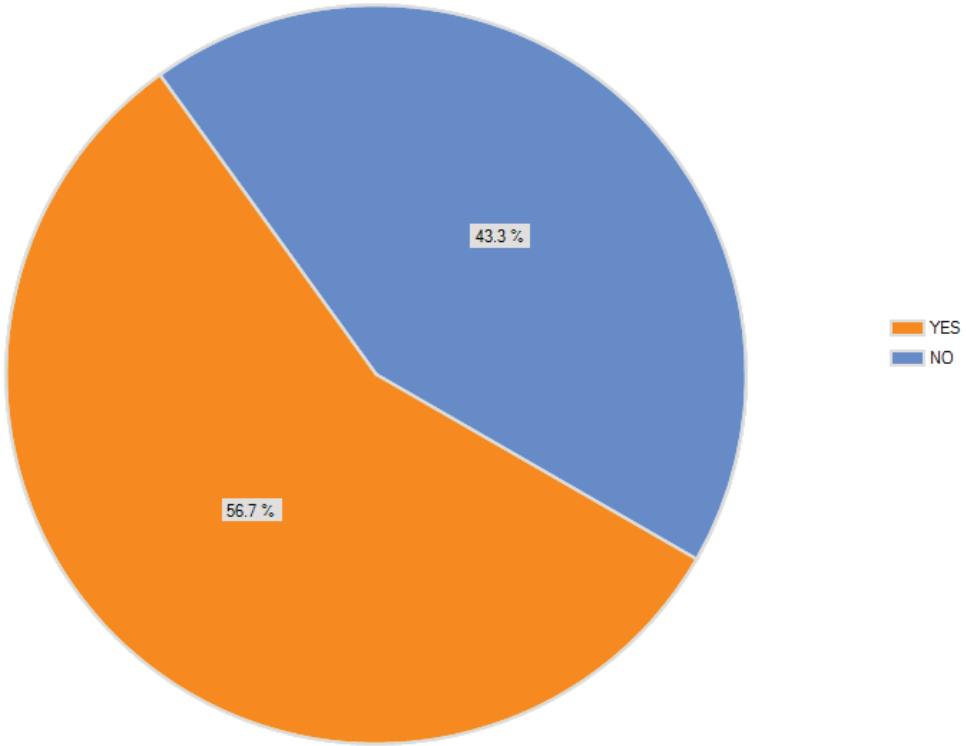
Were you given instruction/information on how to look after yourself?



Section five: The discharge process

Q 36
104 respondents

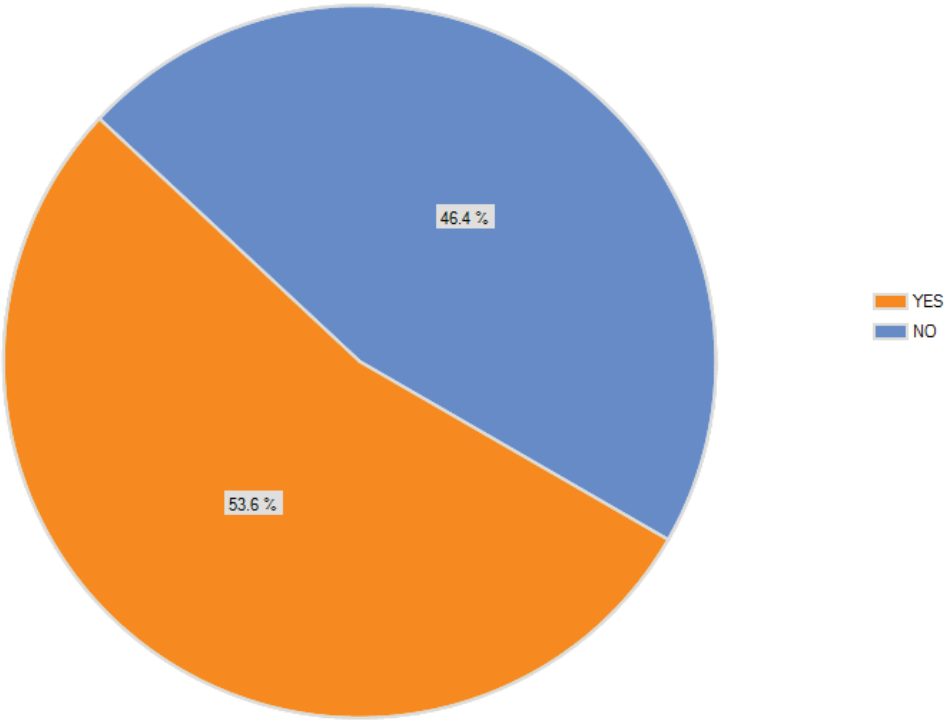
Were you given instruction/information on who to call for advice?



Section five: The discharge process

Q 37
97 respondents

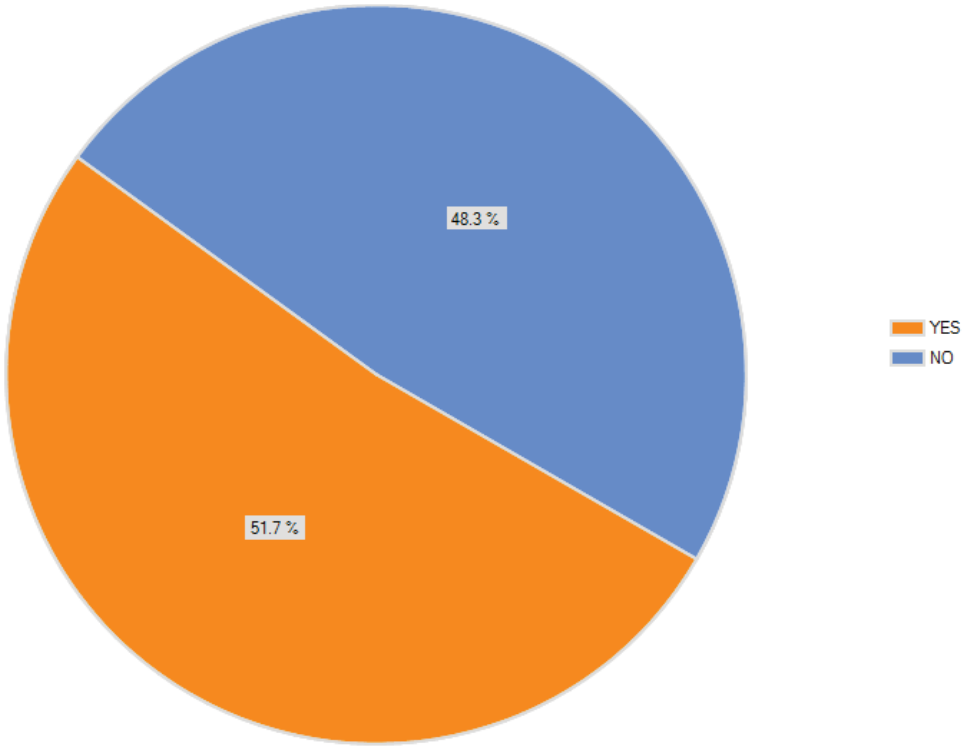
If you needed it, did you have a plan for your ongoing care prepared for you before discharge?



Section five: The discharge process

Q 38
89 respondents

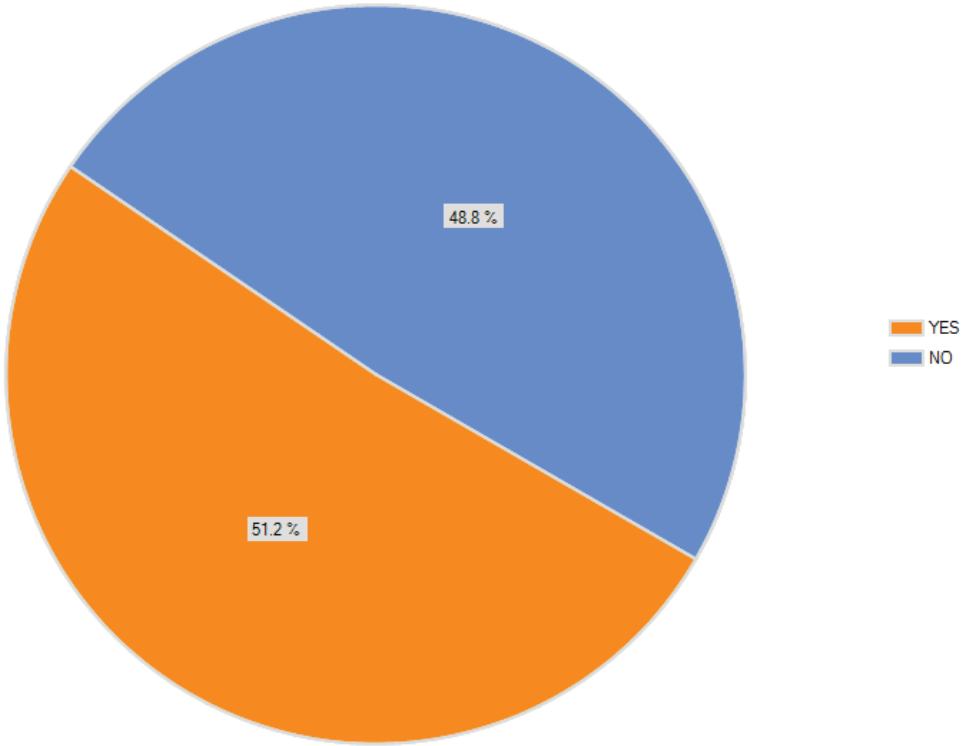
Were you involved with the plans?



Section five: The discharge process

Q 39
84 respondents

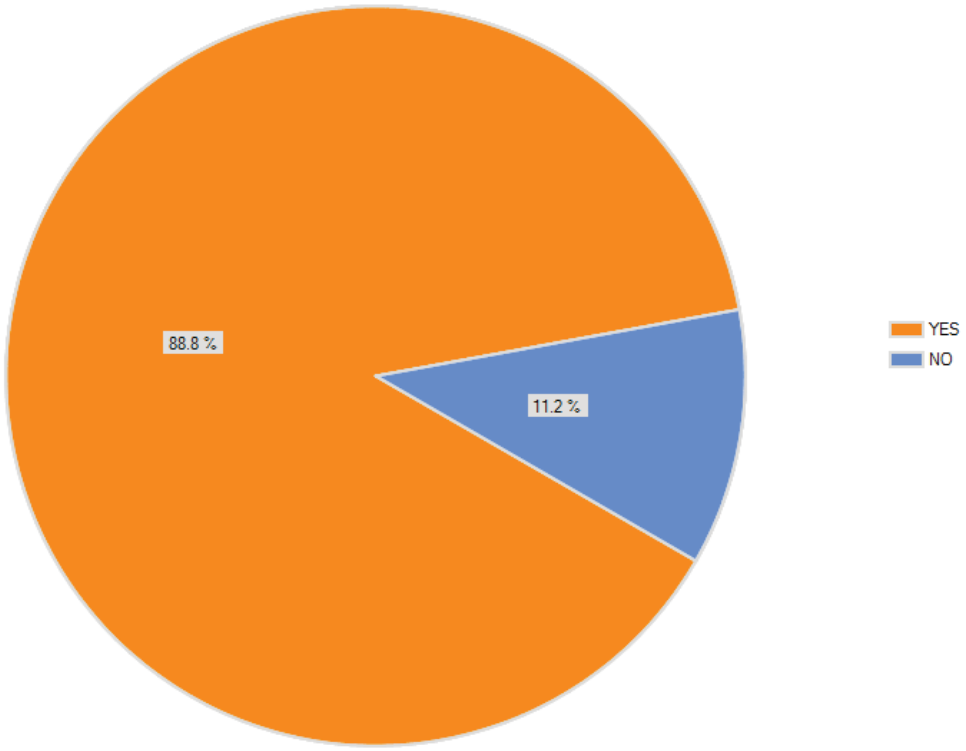
Were your family/friends/carer involved?



Section five: The discharge process

Q40
107 respondents

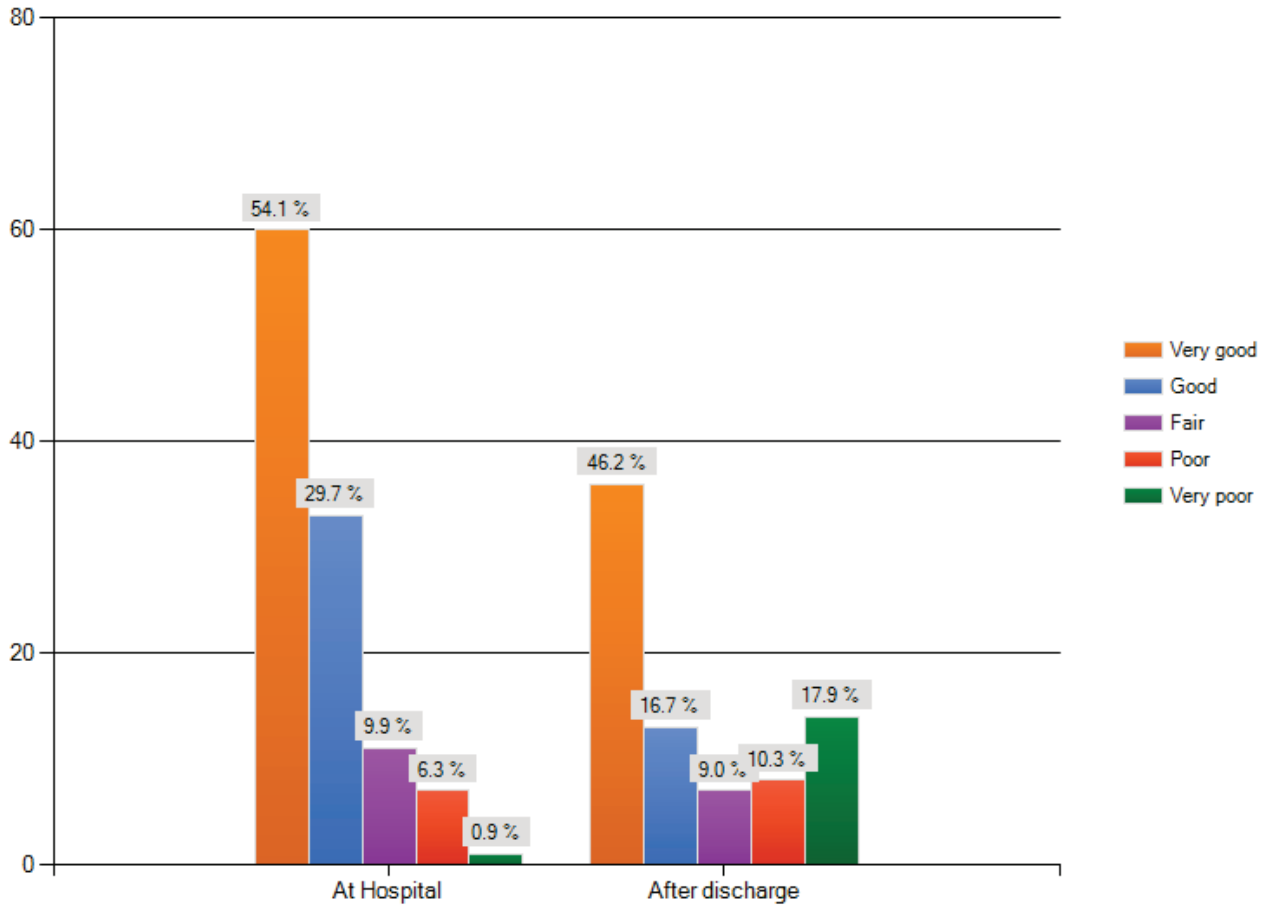
Did you feel the staff treated you with dignity and respect?



Section five: The discharge process

Q41
111 respondents

How do you feel about the care and support you received?



Section five: The discharge process

Q 42
88 respondents

What was good about your care? What would you have changed?

Please see responses in the appendix

Section five: The discharge process

Q 43
61 respondents

Please use the space to tell us anything else (good or bad) about your recent discharge from hospital and your home care after it. Do you think there is anything we should know?

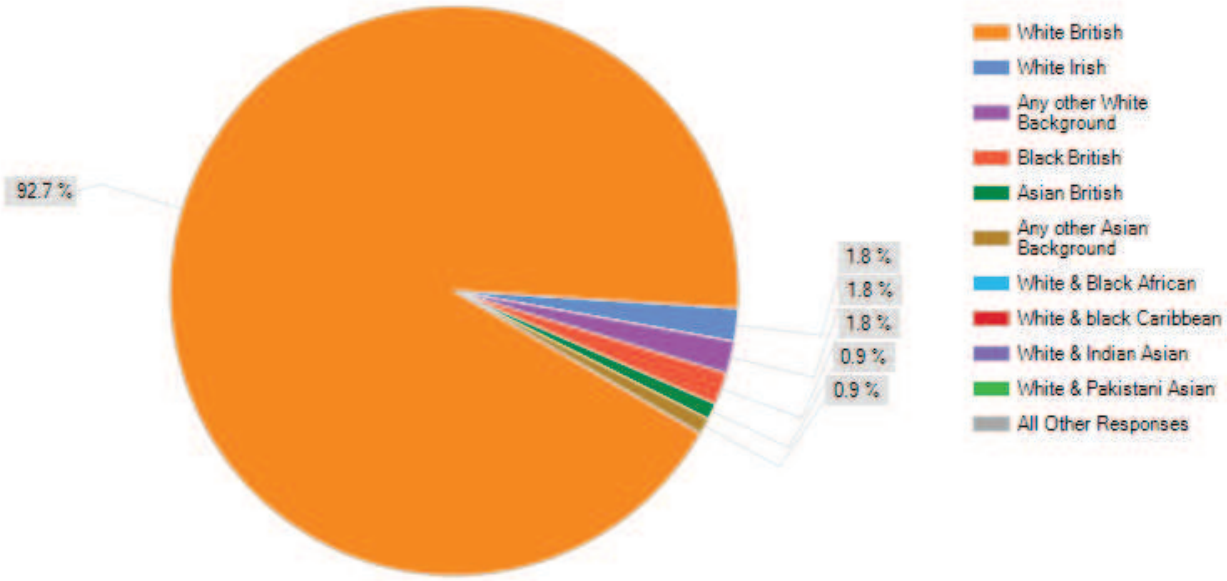
Please see responses in the appendix

Section six: Monitoring information

A
109 respondents

To help us make sure that all sections of our community receive good care, we'd be grateful if you could provide some information about yourself

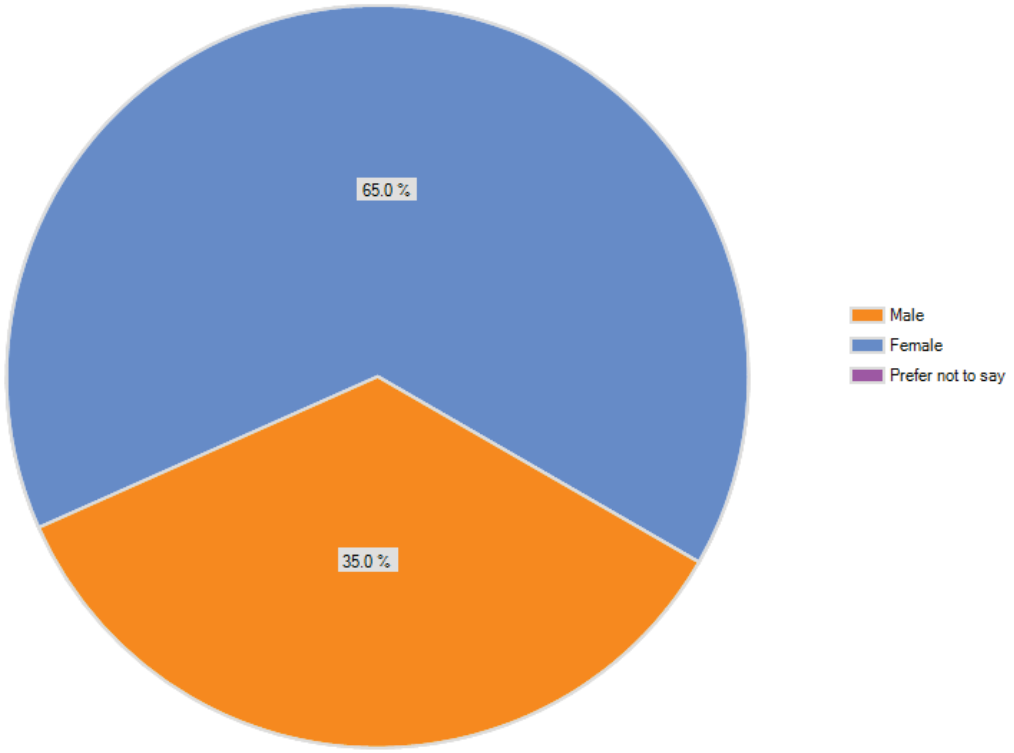
Ethnicity



Section six: Monitoring information

B
100 respondents

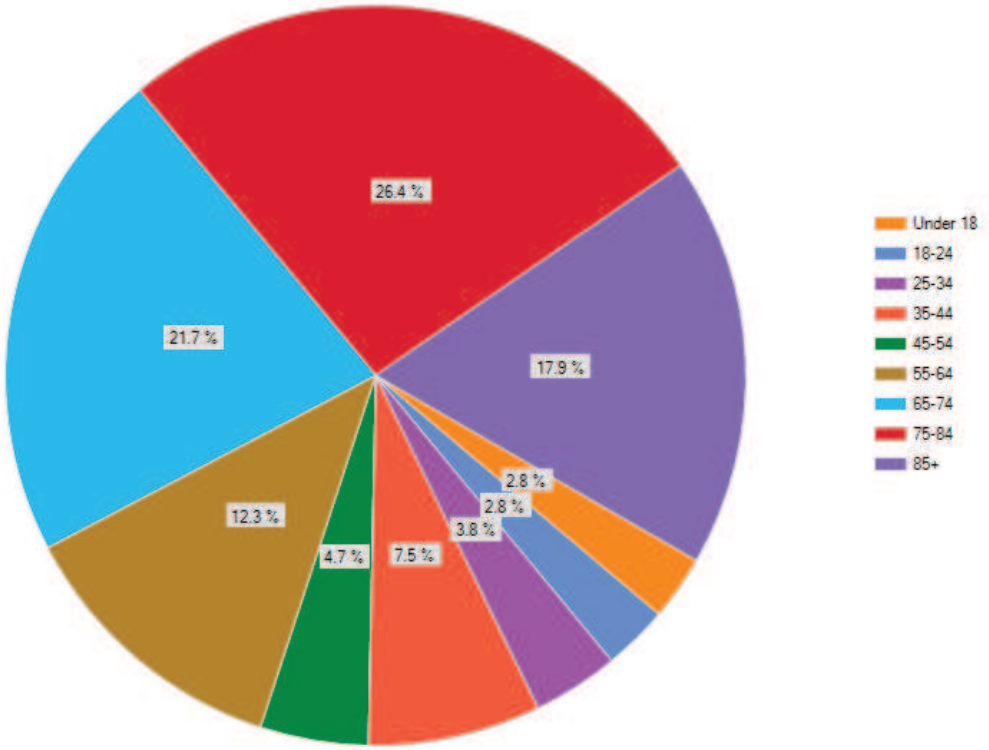
Gender



Section six: Monitoring information

C
106 respondents

Age



Section five: The discharge process

Q42
88 respondents

(All comments are presented verbatim).

What was good about your care and what would you have changed?

Kept clean. Staff had no apparent training in dealing with advanced dementia
Some individual nurses were good - but care generally very varied
Had a urine infection which made me very confused. I didn't have blisters on my heels when I entered hospital. I found A&E very thorough and I ws tested adequately for other conditions besides urine infection ef chest infection which was negative. i didn't eat very much or drink enough as I ws very confused. My daughter wan't allowed to feed me by coming in during meal times. Less nurses at the station, more working with the patients.
Staff explained information and procedures clearly. very personable manner that was respectful
Care was fine - discussion on medication very sparse. Rushed final arrangements on Friday night - no arrangements over the weekend. Literally thrown in at the deep end. Very poor
Doctors, nurses etc all very caring and attended all my needs
Everything was good. Only been discharge today
Many test were done but ther was conflict of opinion between doctors as to diagnosis. This wasted about 48 hours before final diagnosis. Nursing staff were wonderful and although extremely busy, spent time explaining all they could
All staff were considerate to all of my conditions and spoke to me clearly about problems and condition

When I was at hospital they did a lot of investigation after two days ago they've done CT scan also. Unfortunately I could not find out any results yet. They did not give any medication for my medical problem. Then I fed up and scared with this situation. I don't know what is going on
Carer very kind and respectful offered help. No change needed
Care of staff – nothing
Needed more physiotherapy
Some staff were very supportive and reassuring about first time surgery. I would have like to have actually been told what was done after the op instead of waiting until the next afternoon to be told to put my mind at ease.
Assessment carried out for the condition / complaint in admission.
Doctors and nurses and all staff were excellent
Everyone ws kind and they cared
Was satisfied (except see below)
Medical care - Kindness consideration and understanding, procedures explained.
Very poor communication between hospital departments and with family. concern about the necessity for 3 operation to repair a fractured hip. Concern about the impact of codeine given for pain relief and the lack of anyone noticing the amount of vomiting and water retention causing swelling
everything good
Training of nurses in paying patient attention to the needs of the patient, especially when communciationi s problem. Familiarity and endearment are unwelcome especially when that person then walks away. Patients need respect
Food and drink . Would have chance of getting gastroenteritis in hospital and coming home with it. Very short staffed in hospital

Satisfied
The care given by doctors and nurses
OK
Nursing
Doctors and other staff were good
All the staff, doctors and carers were kind and patient. They took the time to explain what was going to happen. I have been to other hospitals but have never experienced such kindness and care
I could not fault staff at all. Very kind and caring. Enjoyed my stay.
very friendly staff
The staff and the atmosphere was nice. I think they deserve a medal. On my last 2 days I watched one nurse work her socks off, she was fantastic.
Good nursing care, however my wife was not given the same info by different staff. There seemed not to be a strong link person to refer to. Staff always seemed to be 'buck-passing' as they went off duty. Weekends were a nightmare, no-one seemed to know what to do - just general nursing care and washing happened.
Nursing and doctor excellent generally. Food left a lot to be desired. Perhaps smaller helpings with improved quality. Lacked nutritional content, few vegetables which were over cooked.
satisfactory

My daughter was very well looked after, she was in isolation due to a chest infection + tonsilitis and they didn't want her catching anything else. I would have changed the fact I had to ask for her reflux meds as they were never on time and need to be.
Good after the operation
I was very satistified with the care and attention I received from being admitted until discharge. we had the heavy snow at that time and I was very impressed how the staff coped. The staff remained helpful and cheerful under difficult conditions. I am not so impressed with the admin side, at the moment I have three letters all for one appt in April. In the past there have been several similar incidents.
Clear information on what was going to happen. Focused kind and caring nursing staff and doctors Thoughtful nursing staff who often didn't miss a trick - noticed everything. Nurses paid attention to patient personal care ie organising wshing everyday. Small ward - only 4 of us and not overly noisy. cleanliness overall.
Good medical and nursing. It is obvious shortage of nursing staff not less than used to be especially nights. Nurses sometimes under stress due to it can be upsetting to have women patients opposite one toilet female opposite one toilet mle. shortage of staff nurses weekends , medical at night and weekends
1) A&E very good except the junior doctor lacked expertise and confidence 2) Good care on ward except for one day when staff seemed to be in short supply
It was excellent, I wouldn't of changed anything as my surgical early discharge team were caring and efficient.
Staff excellent, very friendly and made me feel I was in safe hands at all times - All my questions were ansered at all times and i was made to feel that I was looked after

The nurses themselves were (except for one or two) very helpful, emphatic and caring
Care I received at the A&E and AEU ws fantastic. doctors and nurses spoke to me about what was going on and what to expect.
Excellent care from paramedics in ambulance according to my husband. also excellent care in AEU. I was unaware of what was happening to me. Ward staff on Med 7 kind and caring and very efficient
The midwife I had during my delivery - Margaret Jones - ws brilliant. I will never forget how nice she was.
The staff (HCAS, doctors, nurses) on the EAU are fantastic. Difference roles apply on an emergency ward to those on othe wards (life and death); Depsite this the staff gave all of us respect, care, sympathy for our concerns. The thing that would be good is a leaflet explaining pratical things (dinner time, how to get showered etc) for new patients
The care I received was excellent
Med 7 - the ward staff did not come when i pressed my button even when I was in great pain. No one treated me well and I felt depressed. My legs were smelling and weeping but no one change the dressing.
All staff knew their areas of nursing and used that knowledge to my advantage
The nurses were very good and helpful
Standards were so variable - The doctors in A&E were excellent, reasuring and I felt they knew exactly what they were doing and why. The nursing staff in A&E hardly came near me I wasn't cleaned having had a nose bleed, a clean gown was put beside me nobody made any attempt to help me change it - the radiographers did - used hoist wipes and bagged the bloody nightie
The staff were polite professional and friendly. i could not see where you could improve except I was last on the list, which meant I waited from 7.45 till 11 o'clock to have my operation but it was worth the wait.
Caring nurses and surgeons, attentive to my daughters needs. I did however feelthat she should have had her appendix out in January, when she was last in hospital with the same problem. Nurses were a bit noisy at night.
Car excellent first class. Would not have changed anything

One thing alarmed me.. I'm allergic to peppers - this ent on my medical form as I mentioned it when ordering meals. Luckily the ingredients were still listed on my lunch & included peppers. Good nursing staff and well staffed. the degree of noise on the ward was dreadful and continued throughout the night. Obviously hawking, coughing and vomitting are unavloidable, but it would've been nice if night staff/porters or whoever could've tried to keep their voices down. Individual rooms would've been bliss or earplugs
On arrival, various people came to see me to tell me what would be happening and if necessary a different operations would be done depending on condition of my knee
I was due a visit by the midwife the following day after we were discharged. i phoned the community midwife office 3 times and got no response. I finally received a call at 4.30pm tosay my details had been sent to the wrong hospital and therefore wouldn't see a midwife that day. Had to wait until following day. disgusting aftercare.
Prompt examination and tests no ned fro change for initial stages. However, very little information given re: discharge - was informed that I would be written to regarding an appointment for assessment unit. No contact since and no letter yet. (14.3.11)
Staff were extremely reassuring, kind and helpful they told me on all occasions what was happening and answered all my questions. From the domestics to the drs/consultants they were excellent in all aspects. I would change the uncertainty and then all of a sudden you are going to be discharged within the next hour or so but if realise that this is a difficult thing to predict.
Everything - hospital gowns front fastening
Admitted promptly following out-patient appointment. Test comprehensive or done without delay. Positive resut of one test not acted up on and appropriate treatment not given until seen by consultant at follow-up appointment on 10.01.11
Both hospitals QMS . I had no complaints, care was very good lso at the PRUH
Fast arrival by paramedics. Seen by consultant in A&E. Nursing care was excellent and attentive. I was given a lot of tests, relevant to my condition.
Attention to medical matters good, bu day to day details on non-medical rountines had a few gaps - overlooking small patient needs to the point of annoyance - medical matters beyond criticism however
Intensive care saved my life. subsequent care in a medical ward varied from adequate to excellent

Nurses and care assistants
Fantastic treatment and care - which made a stressful, anzious situation bearable - also reassuring that holistic approach taken to both patients / relatives
Nurse Susan Walters was helpful and kind I couldn't ask for more or fault her. I would look into the admin side, it was noted I was away on holiday until 25th Feb. Ask to attend for MRSA swab 18 Feb. Luckily my mail was redirected and date altered to 23rd. At appt handed in completed form etc waited 30 mins and when I asked was there a delay informed "you have a green mark by your name which meant you had been seen. I ws seen straight away by an ex Farnborough person made redundant Dec but back as temp doing same job. the nurse was really good and king. On surgery day, the form I filled in was not added to my file by staff at the reception area. the admin staff must cause cancellation of operations due to carelessness.
Everything
Many of the hospital staff were very caring individuals but seemed to have little understanding of the restrictions that a full leg plaster impose. Liaison generally was poor - contradictory instruction from medics and physio. No guidnace given to my wife on which equipment hospital would provide and which she had to find. Prmised help in moving equipment never turned up. Hospital didn't tell my GP I had been an in-patient I had to give GP details.
This was the second time for the same surgery. The first time having failed. although physio was prescribed by surgeon no physiotherapist saw me either time. I had to badger physion dept by phone to get an appointment. this wasn't until a further 2 weeks
Very little. Would have changed 85% of it. the nurse in charge of me in recovery , despite neither bizarre English ws excellent, after that all downhill. In the 1st 2 hours 5 difference people were wearing latex gloves despite a notice on the door, handwritten and not obvious when door open. the PRUH has a latex policy pity the staff don't read or arent aware of it. No epipens around.
The nursing care was wonderful. Medication was a little hit and miss. as I self medicate at home - why can't I in hospital. I took my med rountine better than anyone.
Surgeon

The cleanliness of the ward. I had all the help I needed to walk both with the plaster and then when plaster removede . I was due to go and have screws removed on the 17th January 2011
Ambulance service treated me and took me to A&E - had to wait for Xray but made comfortable.
All excellent
Very Good. When you are old it is very difficult to walk to consultation in top level urology.
Patient aged 6 - nurses in cue dy surgery unit were very good with patient and whole environment was great for children. Everything was explained in a way child could understand. Very please that consultant made time to come to see patient before and twice after operation and explained details of operation. Aftercare to parents
I ws treated with utmost dignity and respect. All the staff were thoughtful. They were aware of the pain I was in and my limited mobility. theward ws clean compared to a 2008 admission
I was treated very well, my doctor and nurses made me feel very relaxed helping myslef and my partner cope
The cleanliness was faultless, felt very clean, fresh and hygenic all day long
General care in hospital. More involvement by my family with home care arrangements was needed.
Couldn't have wished for better care - outstanding. the staff on surgical ward 6 deserve recognition.
Guys hospital was excellent. full information supplied including a 2 hour seminar prior to admission. All medication provided prior to discharge.
No change

Section five: The discharge process

Q43
61 respondents

(All comments are presented verbatim).

Please use the space below to tell us anything else (good or bad) about your recent discharge from hospital and your home care after it. Is there anything you think we should know?

This form is being completed by my husband. I returned to my Care Home after assessment by them that they could meet my needs.
I think they had washed their hands of me - thought I was being over anxious
Discharge from hospital with weeling blisters and diarrhoea. Good district murses but wouldn't be needed if more care in hospital. @Pace@ people to help me get my mobility back but because of my heel I couldn't do much. Before my illness I was gardening, cooking, sleeping upstairs. It has taken me 5-6 months for my heel (MRSA) to heal. My life is only just beginning again.
Final arrangments should be talked through and any prognosis all together. No arrangements for physiotherapy after 4 weeks total spent in bed
Wait of approximately 1 1/2 hours for porter with wheelchair as wife considered walk from stroke unit to front extrance too far
Sent home alone too soon - needed at least another 24hrs hospital care considering I was at home alone
No advise at all about after care exercises. How much should I do
Wasn't really told anything other than the questions I had to ask before being discharged.
I was not given wound care information or info on how to remove dressings when to remove them etc.
The disturbance in EAU for 4 nights/days was unbearable. The hospital could have arranged for the gastroentologist team to review whilst in hospital. Despite advising the doctors for the diagnosis and treatment of hernia by Mr J Ellul at PRUH they failed to consider whether this

problem could be associated with chest pain or review it.
As above
PACE have done a wonderful job. Hospital staff coukld not have been better
Was told by unfamiliar worker that I could go home, which turned out to be untrue, hoever one of the doctors who lives close to my home was kind enough to deliver some necessary antibiotic tablets
other services – On one occassion I was asleep when lunch was delivered, Lunch left on trolley at end of bed, only knew it was there when the dinner lady roused me with "couldn't I eat it" - it was now cold. I was advised I could gohome at approx midday. Told prescription available by 4pm - received at 6.30pm
This is the sort of care that hospital should have provided. Time and patience in trying to explain and understand and respectful clear communications
I think staff at hospital have too much to cope with
Good attention by staff. Generally caring looked after in a clean environment. I would like to have had a chat with someone about looking yourself. and more time with physiotherapist
Breakfast and main meals time not so good
As I live in the Croydon area I would have gone to another hospital which is more convenient for family and friends to visit but as I was in the Bromley area I was taken to the PRUH. I am glad it was the case as I've had the problem before and it wasn't dealt with. Staff at the PRUH were very thorough and I am now getting treatment.
The way that Savoy Ambulances spoke about the London Ambulance Service was very rude
My discharge was ok and everything was fine for my homecoming.
Visited by PACE team after discharge, good care.

The PACE team were excellent, very thorough and seemed to care. It seems that when certain staff consider you a 'self-funder' they lose interest and help is reduced. It is wrong to be 'discarded' just because one has worked hard and acquired some savings.
No care after discharge was required.
I was last on the list for operation but we all had to be at day surgery at 12.30. Having starved and no drink since 7.30am, by 4pm I was really stressed and uncomfortable and on the point of walking out. they should have staggered the fasting and arrival times,
Towards the end of my stay, the norovirus bug arrived and I was shocked that visitors were still allowed in especially when they had to walk trough medical 8 to get to the other ward. The staff were very conscientous with hygiene but the visitors I saw were not!!!. Not my visitors - I asked people not to come in so as not to spread it.
If it hadn't been for the care and dedication of the surgical discharge team the infection I got after surgery would not of been picked up so quick which would have led to antibiotics and then back into hopistal
The only thing if I had to say was bad is that I had to leave hospital and go back to get medication - this didn't matter as was given the option to wait but said it could take all day and I wanted to get home.
I was brought home at approx 4.10am the person who bought me home asked if I had a key
No one explained about leaving/ what would happen next, I wasn't sure if I needed to speak to anyone / have a final check. No one explained follow on consultant appointments etc with me, advised me what to avoid etc (eg driving, exercise etc).
Care received on medical 6 ws okay. The consultat andhis team visited regularly to keep me updated with test results. However, the HCA (just one) was quite rude and made me feel I ws in a boot camp where is "do as I say"
Very good liaison skills between staff and the PRUH and staff at St Thomas's regarding scans and my new and ongoing treatment for Lymphoma
I would like written instructions to take home and a copy of the letter sent to my GP

I received excellent care and respect
IN EAU - Treated much better although not much information given. I did feel safer there. Visiting times were too inflexible and not good. No doctor or nurse have visited my home
Real problem when it came to going home. Not wel organised and I waited for 2 days on third day i arranged my own transport
The delay waiting for medication is ridiculous and seems universal. the departure lounge was most unwelcoming including the person on duty. I was not asked what I would like to ba called, my first name was used the whole time. the charm and friendliness of the domestic staff was very good and in marked contrast to some of the nurses. The food was excellent and nicely served. I would have liked more room to comment the variation in standards appalled. the manner of the discharge letter needs attention.
Overall pretty good. Most nurses really caring
I don't know who to tke this up with, but am concerned that NHS Direct weren't aware that my symptoms could have been a lupmonary embolism and not muscular/skeletal.
I had to wait a long time for someone to come and show me how to use my crutches. It was Christmas, and I found out later after contacting the hospital that I hadnt been given the exercises I needed to do. I phoned the hospital again to remind them that I didnt have an appointment after being told verbally that I needed to go back after 6 weeks. The next time I phoned was to ask if I needed physio - I was told that I did. Finally last week (March 2011) I received a letter to make an appointment. I did and will be going to physio next week - this will be almost 3 months since my operation. I went back to the clinic yesterday and was told that it would take 12 months for my knee to fully recover - when I left hospital I was told I would be on crutches for 6 weeks, which turned out to be much longer and no mention of how long this would take.
My hospital notes and newborn sons hospital notes were lost during the 48 hours I was staying in the hspital. My notes were not receivered before i was discharged and have still not been found to date.
As above
I have had 6.5 months in hospital. the only thing was transport.
I an unsure how long I should take the medicine for. There was no conclusion as o the cause of my chest pain.

It has felt a little remote in the immediate following days to be on your own without any obvious follow up enquiry from a hospital or doctors interest of ones health or well being status.
My last few days in the PRUH before transfer to Elmwood Nursing Home were in a transit ward and were fraught and unpleasant
I feel the discharge system of waiting for drug/medication for up to 3-6 hours is a waste of time and can let down the overall service provided. Nowadays i often leave without my medication and arrange to collect it later. Unfortunately I am a frequesnt user of my local A&E, hospital, critical care, ITU services - and have always received good treatment and care - but would like to be involved in evalutation or assessing the service from my experience and maybe sharing this with others.
Nobody should have been discharged on 22.12.10 - conditons were simply too dangerous. the OT had asked my wife to clear sloping driveway - ambulance crew refused to take me up it and a newighbour had to clear an alternative pathway. OT said she would check to see I was ok at home - she never did.
I was given a cery poor meal in discharge lounge. Other patients in lounge - very frail lady who lived alone with nobody to receive her - was not allowed to eat her meal as transport had arrived - so ws desolate. told me she had noteaten as they didn't give me my teeth on the ward.
Told i'd be in for 3 days in pre-assessment, send out next dayas it wasdeemed safer for an allergy point of view - I was made to feel having an allergy a nuisance.
On discharge I was rather abandoned. I was still unwell the day after discharge and i had no idea who to contact. No after care was even discussed. I really can't discuss food - suffice to say if I had been in hospital much longer I would have been malnourished
Head nurse appalling
Regretably Mrs Bell died on the 16th January 2011 due to heart attack.
I had a back injury but could walk slowly with assistance, was not told how I should treat myself at home, if i should go back any aftercare or physio.
All positive

Follow-up appointments was made at time of discharge and tofit in with childs school outing for which we were very grateful.
Having been in hospital before (2008) I was impressed at how things had improved.
Carers were due on evening of discharge and following am and then twice daily ther on. On both occasions carers failed to turn up. I was left stranded and immobile until relatives and a friend helped me to bed
Long wait for medication from the pharmacy on discharge
District nurse at Beckenham Beacon was chaotic. I went to the nurse rather that want for a home visit. Had to wait 1 hour 45 minutes for the nurse to arrive only to find out they had identified the wrong nurse and the one I wanted was there all the time. Nurse refused medical supplies Guys said I should definitely had been given by the nurse.
Explanation of medication - dosage and interaction between tablets and liquid eg morphine