

imagine.....

coming home from hospital

Executive Summary

Using Real Life Experiences to Improve Hospital Discharge at Watford General Hospital

A previous listening event with carers in Watford identified coming home from hospital as an area for improvement. This report describes a project undertaken in 2003/04, using an innovative process of community participation in a whole system approach.

The 'Imagine' process, developed by the New Economics Foundation (NEF), enabled genuine partnership, bringing together the skills, experiences and enthusiasm of people using services and those who provide services, including previously excluded groups.

It provided an opportunity for people to **tell their stories** and share their experiences, which generated possibilities for improving hospital discharge at Watford General Hospital.

In addition, it brought together people who wouldn't normally meet and established links for future work. It also demonstrated the important contribution that can be made by users, their carers, voluntary organisations and operational staff to statutory services.

With the focus on what works, participants were able to identify and appreciate existing success, which lead to a **shared vision and realistic outcomes** for 'coming home' from Watford General Hospital in the future.

These included:

- Ensuring patients receive appropriate transport and support on the journey home
- Identifying a named point of contact for the individual prior to discharge
- Discharge Checklist for staff patients and carers to be produced
- Improving information sharing between patient/staff/carers
- Rolling programme for professional advice/education/training for carers
- Improving night time support for those at risk, at home.
- Ensuring patients and carers can raise concerns about hospital discharge.
- Improving the management of medicines
- Ensuring individual needs are considered
- Providing regular feedback on progress with these actions

A local Steering Group comprising membership from statutory and voluntary organisations and members of the local Patient and Public Involvement Forums is taking these actions forward.

If you would like further information about the process or action plan, or you would like to get involved with the ongoing work of the project, please contact a member of the Steering Group below:

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Full copies of the report can be found on the following websites:

www.watford3r-pct.nhs.uk

www.westhertshospitals.nhs.uk

www.carersinherts.org.uk

www.hertsdirect.org



West Hertfordshire Hospitals NHS Trust, Watford and Three Rivers Primary Care Trust

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2003 – 2004



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In addition, it brought together people who wouldn't normally meet and established links for future work. It also demonstrated the important contribution that can be made by users, their carers, voluntary organisations and operational staff to statutory services.

With the focus on what works, participants were able to identify and appreciate existing success, which lead to a shared vision and realistic outcomes for 'coming home' from Watford General Hospital in the future.

These included:

- Improved multidisciplinary working
- Existing discharge roles clarified
- Ensure patients receive appropriate transport and support on the journey home
- Ensure that the quality of hospital discharge is part of performance management structures
- Ensure link person identified for the individual prior to discharge to ensure all links are there for continuation of care
- Feedback – maintaining links from the project
- Improve communications between clinical staff
- Carers/Discharge Checklist to be produced
- Improve the sharing of information between patient/staff/carers. Identify a mechanism to seek consent using appropriate clinical governance expertise
- Rolling programme for professional advice/education/training for carers
- Improve nighttime support for those at risk, at home.
- Ensure patients have access to mechanisms to raise concerns about hospital discharge.
- Improve medicines management
- Strategic Issues fed through PPI Forums
- Ensure needs of ethnic minority groups are considered

A local Steering Group comprising membership from statutory and voluntary organisations and members of the local Patient and Public Involvement Forum is taking these actions forward.

Full copies of the report can be found on the following websites: -

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INTRODUCTION

A project was established following a listening event with carers in Watford, which identified hospital discharge at Watford General Hospital an area for improvement. A Steering Group (pictured below and detailed in appendix 1) of local statutory and voluntary organisations was established and decided to use an innovative process of community participation to develop a shared vision for hospital discharge at Watford General Hospital.



From left to right, top to bottom (Heather Aylward, Diana Chatterton, Val Motyer, Dorothy Skidmore, Sue Reeve, Rachel Allen, Richard Murray, Ruth Connolly, Lesley Lopez, Elise Charles, Henry Goldberg)

Process

The Steering Group were trained to conduct the Imagine process, developed and facilitated by New Economics Foundation (NEF). Patients, carers and the whole system of professional staff across statutory, voluntary and private organisations were asked to tell stories about coming home from hospital and identify from that experience what worked well. The themes from these stories were used in a stakeholder conference to develop a local action plan.

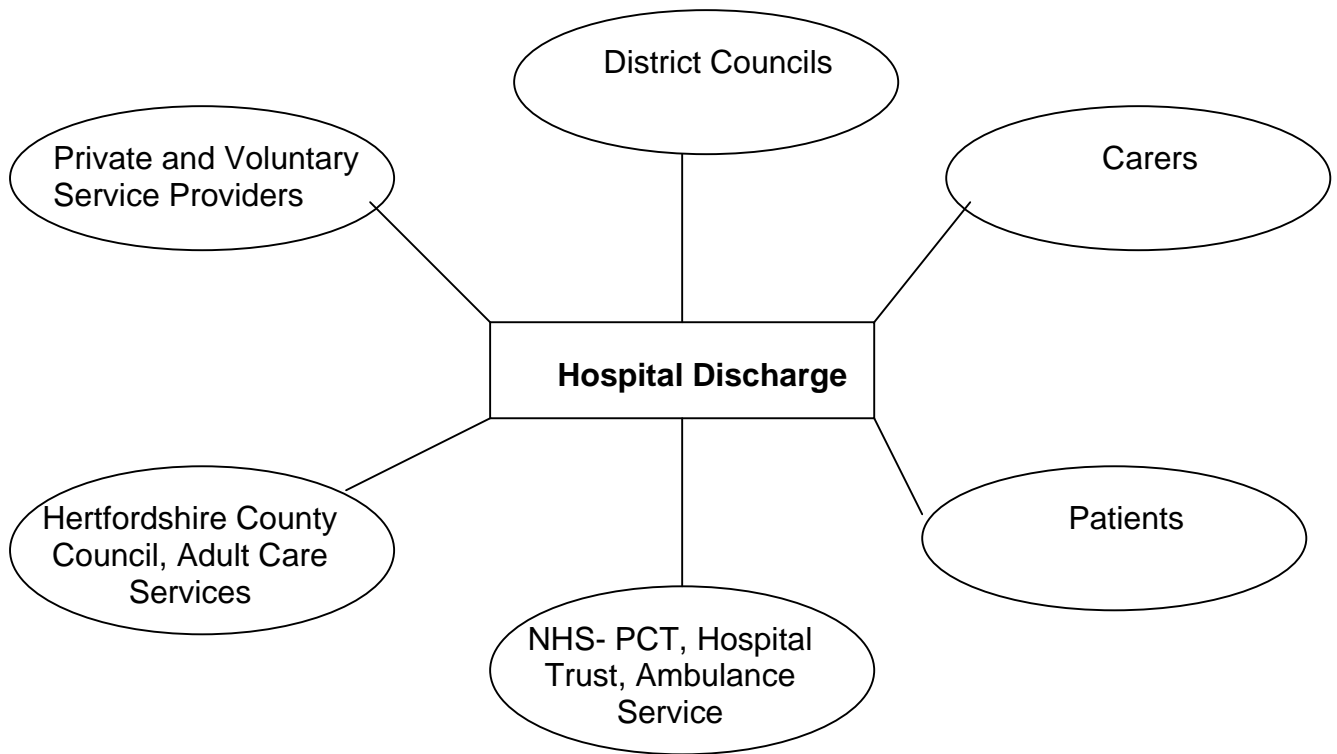
The six stages of the Imagine process are:-

1. Define the issue and develop a set of questions to explore it
2. Discover what is working by using the questions to draw out stories
3. Dream how the future could be building on existing success. Express people's ideas as 'provocative propositions'.
4. Co-create the dream by forming partnerships that in turn use the Imagine method
5. Celebrate the project and its achievements
6. Evaluate the approach and the achievements and use the evaluation to improve next time around

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STAKEHOLDERS

This chart illustrates the main stakeholders involved in hospital discharge who were included in the Imagine process.





Stage 1 – define the issue and develop questions

The first part of the project involved piloting questions to gather information through semi-structured interviews (– more like conversations) with individuals from the different stakeholders. These questions focused on the important elements of a good “coming home from hospital process” and explored how this could be improved.

The pilot questions asked were:-

1. Tell me about a time or occasion when you felt in control of decisions in your life? What made you feel in control?
2. What does this tell you about a patient’s experience of hospital?
3. Tell me about a time when coming home from hospital went well. What were the main reasons for this?
4. Thinking of your experience of coming home from hospital, what is important to make it work?
5. How can health, social and care services give patients the support and confidence to do the right things for themselves?
6. If you are thinking of making a significant change and it involves other people, what helps you to plan/make the change well?

The following groups of people were involved in the pilot:-

- Housing
- Nursing homes & Age Concern
- GPs
- Hospital staff/users
- District Nurses
- Carers & Powher
- Care Agencies
- Complainants
- Alzheimer’s Association
- Ethnic minority groups
- Councillors and MPs

After the pilot the questions were amended to produce a final set of questions to be used in stage 2.



Stage 2 – Discover

The stakeholders involved in stage 2 of the process (appendix 2) were asked to respond to the revised set of questions below:

1. Coming home from hospital can go well and it can also go wrong / be difficult. Tell me about your personal or professional experiences of this. / What has it been like for you?
2. Reflecting back on your experience, what is important to make it work well?
3. The things we're interested in that are important for making coming home from hospital a good experience are about people being able to make choices and decisions for themselves. Tell me about an occasion when you were confident enough to make your own choices and decisions. This can be in terms of your health and well-being or if you prefer, any situation in your life. What made you feel confident?
4. Thinking about the conversation we have had and the points you've made, how can health and social care services give patients the support and confidence to do the right things for themselves?
5. Imagine that at sometime in the future you intend to make a significant change that affects you and involves other people. What helps you to plan / make that change effectively?

The questions were used to draw out stories about people's experience of coming home from hospital and to understand what works well.

Quotes from these stories can be found throughout the report and in appendix 3.



Stage 3 – Dream how the future could be

Following stage 2, the Steering Group identified themes from the questioning process to form provocative propositions.

The themes were:-

Information
Communication and Empowerment
Network: Post Discharge
Involvement
Doing Things Differently
Assessment, Planning and Follow Through

Provocative propositions are statements about an achievable vision of good hospital discharge that is not currently happening but is just out of reach. The statements are ones that everyone can aspire to.

The provocative propositions developed by the Steering Group are listed below:

Involvement

It is recognised that care starts at home. When someone comes into hospital, patients, carers and professional staff contribute to decisions about and arrangements to support their care when they come home.

Network: Post Discharge

When a person leaves hospital, they are helped to adjust to the change. Their feeling of safety and security is maintained by continuity of care and professional support. Before they come home, they know what to expect, have a written plan of care and know who to contact if things go wrong.

Information

Appropriate and relevant information is always shared between professionals, patients, families and carers. This information is timely, understandable and enables them to make informed decisions.

Communication And Empowerment

Successful communication generates trust and understanding. Everyone responsible for providing care shares and communicates all the information and choices available in a way that is co-ordinated, understandable and reassuring. Opportunity is given to express views and concerns so that

patients feel confident and supported through the coming home process and professionals can provide a safe and seamless service.

Doing Things Differently

In a patient-centred service, patients, families and carers are able to have a say about their experiences and are confident that this is listened to and acted upon so that this leads to a change for the better. Everyone is encouraged to think of flexible and creative solutions.

Assessment And Planning And Follow Through

When patient arrives in hospital, their needs and those of their carer/relative(s) are fully assessed by the appropriate professionals. Their views and concerns are listened to. This includes discussion of the support they need to come home. The patient and/or their carer/relative agree a plan for their care and treatment in hospital and for when they come home. All professionals involved in the patients care contribute to and agrees this plan. The patient has confidence that commitments made to them are followed through.

These propositions were discussed at a stakeholder conference, which was stage 4 of the process.



Stage 4 – Co-create the dream

A stakeholder conference was held at the Ramada Jarvis Hotel, Bushey, in November 2003. The event was hosted by Carers in Hertfordshire, Watford & Three Rivers Primary Care Trust, West Hertfordshire Hospitals NHS Trust and Hertfordshire County Council, and was facilitated by NEF.

53 people attended (excluding the Steering Group) and a full list can be found in appendix 4.

The purpose of the conference was to discuss and amend the provocative propositions to achieve a shared vision amongst patients, carers and professional staff of good hospital discharge and to create an action plan to achieve this.

The conference was jointly chaired by Rosie Sanderson, Chairperson of West Hertfordshire Hospitals NHS Trust and Gerald Bordell, Chair of West Hertfordshire Hospitals NHS Trust Patients' Panel.

Professionals, patients and carers were invited to ensure that all viewpoints were considered. During the day there was a lot of lively discussion and many practical suggestions of ways to improve the patients experience.

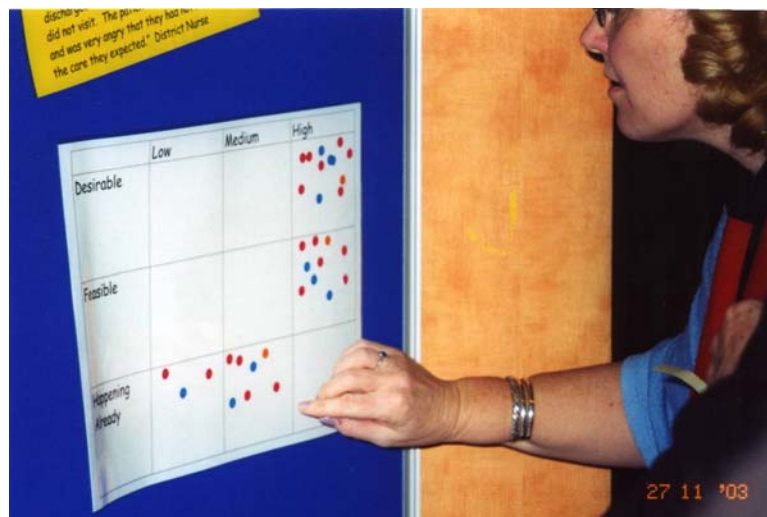
The day began with presentations from Ruth Eley from the Department of Health Change Agent Team and a patient Jessie Winyard. Ruth highlighted some of the problems with regard to coming home from hospital and how these were being addressed at a national level.

Jessie spoke about her own personal experience of coming home from hospital and helped set the scene for the conference.



Gerald Bordell and Jessie Winyard

Participants were then asked to review the provocative propositions and decide whether they were desirable, feasible or happening already by using the matrix shown below.



Participants also provided comments on what was missing or should be changed. In the afternoon, group discussion took place about what action was needed and in what timeframe to make the propositions happen.

Short: within 3 months

Medium: by December 2004

Long term: beyond December 2004

The following sections of the report outline the discussions and feedback that was received on the six provocative propositions.

FEEDBACK FROM THE CONFERENCE

Involvement

“For elective admissions, discharge options should be known before the patient is admitted and these should have been discussed jointly with health professionals and the family. For emergency admissions, where possible there should be a long term care plan, options should be discussed when the patient is not in pain or stressed and they should be involved at an early stage.” GP



One strong theme emerging from the short session that made up the morning workshop was the barriers to involvement, regardless of being a patient, carer or professional. This included:-

- Attitude towards age, ie. If you are old you do not have an opinion
- Lack of recognition of everyone's role
- Conflicting perspectives and expectations. For example, when there is a conflict between patient and carer or conflict of views between professionals in different parts of the discharge process. This was highlighted by an example of conflict between the ward and the ambulance service.
- Hiding behind confidentiality or status
- Communication problems, eg understanding or language
- Lack of information ie. not able to make an informed decision
- Information not being shared
- Patient being transferred between wards, no consistency
- Lack of knowledge of advocacy services
- Last minute discharges

Another theme concerned how to ensure the patient had the necessary medication on discharge and that they and their carer knew how to administer this medication.

The afternoon session also identified the need to establish clear values around hospital discharge and develop a shared culture in connection with these. Lots of ideas were given about what this culture should be, including:

- Empowered patients, carers and staff
- Communication not assumptions
- Informed choice
- Respect for privacy and dignity
- Training and learning is facilitated

The following actions were identified throughout the workshops and these are shown below:

Action	Responsibilities	Timescale
Producing a Discharge Directory	Steering Group	Medium
Wearing of identification	Facilities Division, West Herts Hospitals NHS Trust	Ongoing
More joined up services and better co-ordination between specialities	All	Ongoing
Better networking between ambulance service and the hospital trust	Lesley Lopez and Modern Matrons	Medium
A checklist for patients on discharge	Steering Group	Long
Regular drop-in sessions to talk to the Ward Sister	Steering Group	Medium
Ensuring links with existing patient groups to help influence and improve services	All	Ongoing

Network: Post Discharge

“A good experience of hospital discharge was when the Discharge Co-ordinator phoned and gave information about the patient prior to them being discharged.” District Nurse



The following five common themes emerged during the morning market stall workshops which can be divided under the following headings:-

Clarity of roles

There are very many staff and other people involved in the discharge of any patient, the role of each of these people is often far from clear. It was felt that information should be gathered in advance – before it was needed.

Assumptions should not be made about a patient or their family for example about family availability to assist post discharge. This information could form the basis of a discharge ‘check-list’ which could assist the discharge co-ordinator, who should be involved. Discharge experiences should be shared appropriately so lessons can be learnt and improvements made for the benefit of the client.

Emotional Aspects

There was a strong theme supporting a move to ensure the patient was at the centre of all aspects of the care and discharge plan. Patients should be treated with dignity through the discharge process which is their ‘journey’.

Single Assessment was seen as a positive way to improve the patient journey and hopefully, being patient centred, be a means to breakdown some rigid professional mindsets and introduce flexibility to service provision. There was a support for one key-worker or contact to assist with the discharge process for a patient as this was seen as more effective and less tiring.

Carers Assessments

From the outset there should be a clear understanding of the role of a carer in a particular situation, and whether or not one has been identified. The carer should then be actively involved in the discharge process, be given information and notice of the discharge date. The carer may benefit from information on outside resources and services and these should be readily available. If this involvement does not take place there can quickly be a

breakdown in the carer network. As in Section 2 one key-worker with a single telephone contact point was favoured.

Access To Services

Patients felt the criteria was sometimes too strict inaccessible or impossible to understand. Some felt that the criteria made it feel that it was a battle to obtain what a patient actually needed which was draining for the carer who needed considerable support through the process. To assist the following were suggested, use of the discharge co-ordinators, PALS service, introduction of an equipment 'supremo' and to abolish the answerphone – unless calls are returned without fail in a reasonable time.

Post Discharge Network

Discharge will be most successful if there is careful, co-ordinated planning before, during and post discharge. Active participation from the patient will lead to a more successful discharge and a 'Patients Rights Charter' should be considered .

. In addition to the themes and specific points outlined above the following points were raised. There should be simple written instructions to include information such as re- admission procedure. Promises should be kept, eg the provision of services, and provider agencies should be informed of discharges as soon as possible. In general there should be better communication between agencies.

Quick reference guide to key points ensure a successful discharge network

Actions to be clear – by whom/when

Assessments and re-assessments – by any appropriate

Communication

Contact point post discharge

Discharge card with information

Discharge planning to be improved

Equipment provision – promptly

Flexibility in service delivery

Hospital at home – to be used to the full

Information – if you receive it you are responsible for it and any required action

'Meet and Greet' person

One Access point to staff

Pathway defined for patient and carer

Planning – crucial in all circumstances

Resources – more – better – accessible

Responsibility – take it and own it

Share knowledge and information for benefit of patient

Social workers – to be used to the full

Timely provision of services eg shopping

Training for all staff as required.

ACTION	RESPONSIBILITIES	TIMESCALES
Patient pack		Short
Discharge Card with essential information		Short
Focus and discharge goal set at time of admission		Short
'Meet and Greet' Service		Medium
Plan essential staff training		Medium
Training for particular, possibly new, staff roles		Medium
Resource facilitator/match		Long
To 'get it right in the future'		Long

Information

"I was given a leaflet with information on what procedures I had undergone with 'what to watch out for' information and special instructions...another leaflet of what to do if I had any problems or concerns...I had at my fingertips telephone numbers and who to contact if I had concerns...everything was clear and I had no doubt as to what to do." Patient



Participants stated that there was an issue around 'information overload' – but identified that it needed to be timely, understandable and include all aspects of hospital discharge. This should be available in different formats and take into consideration patients whose first language is not English or those who are not literate. It would need to link in with external service providers : raising awareness within health of community groups . It was felt that there was sometimes a lack of respect for other service providers. Information should also include 'what to expect' – for example future caring tasks or side effects.

Participants thought that there were too many links in the chain: too many people involved in the information giving process. A Key Person was required to take responsibility for the whole 'going home ' process. This would aid professionals to work together and would provide a contact post discharge. It was felt that GP's had a key role to play in the process: they should be aware when a patient is admitted from hospital, when they have been discharged and what information had been provided. There should be a sharing of information between all 'users' of the service as well as professionals. Professionals should actively seek out information and provision of this should not be dependent on who you speak to.

Patients should be treated as key partners in the process and as such given more information on procedures and on what to expect. It was suggested that staff training on communication would be advantageous to ensure that

assumptions are not made and that they are not scared to give information out.

Participants in the afternoon session looked at ‘what needs to change’

They identified that everyone should be treated professionally and sent information prior to admittance. If there was a pattern/structure to disseminating information everyone would be on board, not reliant on individuals. NHS Direct could be more widely accessed for information provisions. Participants agreed that discharge should be Patient rather than Professional led, for example several appointments could be done during one assessment.

Actions

Action	Responsibilities	Timescale
A Patients Aide (possibly a volunteer) overseeing patients and on duty in corridors – could informally check that patients had been seen , transport arranged and troubleshoot by instant problem solving – possibly linking into PALS	Could link in with existing Volunteer network, be administered by PALS	Short Term
Information required prior to admittance and discharge. An individual KEY WORKER to co-ordinate ALL aspects of a successful hospital discharge.	Linking into Discharge Lounge	Short/Medium
Checklist for Carers/Patients and Staff to ensure correct information is provided.	Key Worker	Medium Term

Participants praised the theme: acknowledging that information was the key to a successful ‘coming home’ experience. A Key worker was seen as important to achieve the proposal.

Communication and Empowerment

"My hospitalisation went well because I was totally consulted and felt safe. Prior to discharge...my family and I were able to ask questions and amend the (discharge) package where necessary." Patient



There were many suggestions made about the elements needed for successful communication. This included:-

- Not making assumptions
- Ensure it is understood – repeat if necessary
- Plan communications to ensure they are structured
- Be honest
- Listen – value people, absorb information and use to good effect
- Ensure information given is accurate
- Good communication is everyone's responsibility
- Being proactive through better planning

Other special areas for consideration included:-

- Children
- Language
- Providing leaflets

There was a strong agreement that communication between professionals was very important and needed improvement and the following suggestions on this subject were made:-

- Medical team in the hospital liaising better with multi-disciplinary teams in the community
- Better communications between GPs and hospitals
- Doctors training needs to include communication skills
- Ambulance drivers need comprehensive information eg on patients home situation and patients condition.
- Need to communicate to patients/relatives that the ambulance service can't transport excessive personal belongings. Will reduce claims!
- Better information to GPs regarding the medication prescribed in hospital to ensure they do not run out

- Better communication of medical conditions between medical staff – what do they need to know?
- Better liaison between the hospital and sheltered housing wardens

Participants were disappointed that there were no GPs present at the conference as it was felt they were the key person for the patient to get information

Another key point was the involvement and empowerment of patients, relatives and their carers. Participants felt strongly that patients, relatives and their carers should be involved at an early stage to help professionals make decisions. This in turn would help them feel empowered to make their own decisions and ask questions. The following points were raised for consideration:-

- Giving greater consideration to outcome expected by the patient
- Professionals need to actively seek patient feedback on the ward
- Form for patients to ask questions and have doctors supply written answers
- Ward environment does not empower people to be independent.
- Important for the patient to have a friend, relative or advocate with you when care is being discussed with professionals
- Professionals available out of hours to talk to

In relation to involvement, other issues were raised about confidentiality, particularly the conflict between relatives and carers needing to be involved whilst maintaining the confidentiality rights of the individual. The following points were raised in relation to this:-

- Check if the patient is happy to have someone else listening to confidential matters
- Need to ensure confidentiality is respected – opportunity to have conversations in private not on the ward
- Sharing information with other professionals important but patients need to know who it will be shared with
- Data protection/confidentiality don't let this dominate

In the afternoon, a group workshop was held to identify the actions required to ensure that the vision for communication and empowerment could be achieved.

The following actions were identified:-

Action	Responsibilities	Timescale
Multi-disciplinary meetings regularly	Dee Ramtej, Watford General Hospital	Short
Promote DISH co-ordinator role – admissions pack, leaflets, posters	3 Discharge Co-ordinators (Nicky Perkins)	Short
Promote and feedback this role to 3 Rivers Council Sheltered Housing Officer	Jenny Jones (Sheltered Housing, Watford Council)	Short
Maintain links from today	Everyone	On-going
Ward clerk records improved to contain more detailed information necessary for patient discharge (consider use of BHAPS good practice form)	Gary Ethridge and Modern Matrons, Watford General Hospital	Short
Incorporate hospital discharge issues in the Performance management system via Trust Board	Ailsa Bernard and HR	On-going
Discharge Co-ordinators to ensure that the necessary links are made between all the relevant people involved in the continuing care of the patient when they are discharged.	Discharge Co-ordinator posts	Medium

In summary, the comments received from participants regarding this theme supported the provocative proposition, which was thought to be achievable.

Doing Things Differently

“Try to be creative, look beyond your current resources and what is done now. It doesn’t have to be the same all the time.” Patient



The comments from this workshop can be grouped into 3 types demonstrating that action is necessary on a number of fronts to really make a difference

- Change of Attitudes
- Use of existing resources in different and improved ways
- Strategic messages

Change of Attitudes

People were very clear and united in their identification of the attitudes that are important –person centred; empowering of users and carers by involving them, share information and knowledge. It is interesting that many participants needed to restate these principles in the conference. This suggests that whilst these attitudes are sometimes shown, we still have to make them a reality every time for every patient leaving hospital.

These values are enshrined in many of the current strategies and frameworks governing practice, so there are many drivers to facilitate some work in this area. Perhaps a start would be to simply make them more explicit in the environment of the hospital: in the literature given to patients and carers, as well as in training of staff, so that literally people do not lose sight of them under the daily pressures experienced by people in our hospital.

Use of existing resources in different and improved ways

People could see some simple ways of using how existing resources or processes in a better way, some with little or no significant resource implications. It is important to note that patients and carers showed the same

realism about constraints on resources, particularly money, and confounded the stereotype that, if asked, patients and carers will produce an unachievable wish list.

Strategic messages

There were good examples in suggestions for action for not creating new services and thereby m re gaps, but creating packages that people need. It will be possible to point to the tie up between the suggestions made in the conference and the overall strategic direction in Hertfordshire for work to improve health and social care services and make better use of resources. The conference emphasised the importance of checking back and finding out whether the change is creating the desired impact or something different! We will need to do the same in implementing actions from the conference

Action	Responsibilities	Timescale
Build on the sisters clinic by giving other professionals access to it and information about it to patients /carers and include it on the carers checklist.		Short
Carers checklist (already started?)	Gerda, Ruth, Adrian, Ansuya, Louise Coleman, Sarah Brown and carers /CinH	Medium
Written information for carers	Gerda CinH Rachel	Medium
Ask for written patient consent to share information with carer	Ward	Short
General education /advise for carers, moving and lifting, managing medication etc open to all (not necessarily just on discharge), in a programme linked to the	Girda/CinH/Rachel Allen	Medium

day centre and written information for carers		
Night time support for the most at risk who prefer to be at home	Intermediate care team, particularly MH	Long

Assessment, Planning and Follow Through

“To make coming home from hospital work, it is essential to have all the necessary help in place prior to discharge. A promise to do this is simply not enough – it must be a written statement of what is going to be in place, which is signed by both the patient and the professionals prior to leaving hospital.”

Patient



Several key points emerged from the morning market stalls workshops

Key Points:

- Starting the assessment process as early as possible and ensuring that assessment information is shared throughout the patient's journey both with the patient and with other professional staff involved in the patient's care. This would prevent crucial information about the patient's home circumstances being missed out altogether
- Cultural shift to patient being at the centre of the process and their views taken more fully into account in future plans. The importance of patients' having an opportunity to talk in private and for relatives to have easy access to doctors were raised repeatedly throughout the morning session.
- Communication between acute and community staff to include to include other professionals who know the patient well (e.g. wardens in sheltered accommodation. This will not only allow a more rounded picture of how the patient was managing prior to admission but would also give a greater understanding of the what services are available to support the patient at home.
- Important role for carers and/or advocates. Carers, friends and relatives are able to contribute to the patients' assessment with their knowledge of how they were managing prior to admission. They can offer support in meetings with staff in the hospital to ensure that information and choices are fully understood. They may themselves be feeling under stress and it

is important that they have an opportunity to share their concerns as early as possible during the patient's stay in hospital. They may need an assessment in their own right as a carer to enable them to carry on their caring role.

- **Co-ordination:** Again a common theme running through the morning session was the need for an identified person to be in overall charge of the process. And for there to be written information that will help the patient and carer know what the assessment entails and what has been agreed.
- **Medicines management:** recognising the importance for patients to be clear about their drugs particularly where these have changed and highlighting the fact that confusion leads to re- admissions. Several suggestions were made about how the role of pharmacists in both the hospital and community could be strengthened.

Conclusion from the morning session

There was a strong sense that small steps with an emphasis on better communication would make a difference to a patient's experience of coming home. A practical suggestion included a follow –up telephone call a day or two after discharge to ensure that services are in place and the patient is coping.

Afternoon workshop

Discussion focussed on key themes raised during the morning session and some of the constraints to making this proposition a reality for all patients. There was a general recognition that time is the biggest constraint in Watford General. There is always a relentless pressure on beds which means that patients who are less acutely ill may be rushed through their hospital stay. This tension is also felt in the community with District Nurses caring for people who are very frail. Some of these themes link to work already in progress across the Trust. The introduction of the single assessment process from April 2004 and the review of the Discharge Planning will begin to address many of the points that were raised.

Action	Responsibilities	Timescales
Feedback from Questionnaires with patients having planned admissions	Lesley Lopez	Short
Follow up on simple steps identified – e.g. not cancelling care until admission agreed	Link to A& E/ESC work in progress (Suzanne Colbert?)	Short
Check correct booking of ambulances	D/Cs & Amb service	Short
Medicines' management to include review of practices across the Trust and completion of TTAs	Joan Ashby	Medium
Understanding roles & responsibilities of all staff involved both in Acute & community	Link to Single Assessment process & d/c planning (key staff are Ruth Connolly, Sue Cooper, & other d/c posts)	Ongoing – with implementation of SAP from April 2004
Raising Awareness of needs of patients from ethnic minority communities	Link to PALs and Patient Panel members (? Others to help with this)	Medium



Stage 5 – celebrate the project and its achievements

Through the Imagine process, the Coming Home Project enabled genuine partnership, bringing together the skills, experience and enthusiasm of people using services and those who provide services, including previously excluded groups.

It provided an opportunity for people to tell their stories and share their experiences, which generated possibilities for improving hospital discharge at Watford General Hospital.

In addition, it brought together people who wouldn't normally meet and established links for future work. It also demonstrated the important contribution that can be made by users, their carers, voluntary organisations and operational staff to statutory services.

With the focus on what works, participants were able to identify and appreciate existing success, which lead to a shared vision and realistic outcomes for 'coming home' from Watford General Hospital in the future.

SHARED VISION AND REALISITIC OUTCOMES – ACTION PLAN

The following action plan has been put together to take forward the issues raised during the Coming Home Project.

Outcome	Action Required	Responsibility	Timescale	Progress
Improved multidisciplinary working	Find out the outcome of a recent review and feedback to conference participants	Ruth Connolly		
Existing discharge roles clarified	Job descriptions and job titles to be obtained	Steering Group	1 st Quarter	
Ensure patients receive appropriate transport and support on the journey home	Check use of BHAPS booking form and link with Essence of Care	Lesley Lopez		
Ensure that the quality of hospital discharge is part of performance management structures	Communicate with NEDs to identify responsibility	Lesley Lopez Diana Chatterton Rachel Allen	1 st Quarter	
Ensure link person identified for the individual prior to discharge to ensure all links are there for continuation of care	Identify mechanisms. Link with Single Assessment process	Ruth Connolly Dorothy Skidmore	1 st Quarter	
Feedback – maintaining links from the project	Use existing newsletters to feedback progress with the project	All	Quarterly	
Improve communications between clinical staff	Build on Sister clinics on each ward – increase access – promote	Ruth Connolly		
Carers/Discharge Checklist to be produced	Convene a task group to take forward	Sue Reeve		
Improve the sharing of information between	Convene a task group to take	Sue Reeve		

patient/staff/carer. Identify a mechanism to seek consent using appropriate clinical governance expertise	forward	Ruth Connolly		
Rolling programme for professional advice/education/training for carers	Convene a task group to take forward	Sue Reeve Ruth Connolly		
Improve night time support for those at risk, at home.	Feedback to Elderly Medically Ill (EMI) group to include in current work	Sue Reeve		
Ensure patients have access to mechanisms to raise concerns about hospital discharge.	Raise with PALS	Lesley Lopez Rachel Allen		
Improve medicines management	Find out what work is currently being undertaken	Lesley Lopez Rachel Allen		
Strategic Issues fed through PPI Forums			9 – 12 months	
Ensure needs of ethnic minority groups are considered				



Stage 6 – evaluate the approach and its achievements

Evaluation forms were received from 37 of the 53 attendees following the conference

These evaluation forms were from the following groups of people:-

- 16 from Health Professionals
 - 5 from Patients
 - 6 from Carers
 - 3 from Social Care
- 7 from Voluntary Organisation Representatives

Rating the day overall

14 people rated the day as great value, 21 people rated the day as good value, 2 people rated the day as average.

Opportunity to voice views

21 people felt they had lots of opportunity to voice their views, 13 people felt they had good opportunity to voice their views and 3 people opportunity to voice their views was average.

What did you like best about the day?

Lots of comments were received about what people liked best about the day. These included reference to

Receiving information

Networking and interacting with a wide range of people

Working together towards a common cause

Opportunity to voice opinions and views and hear other peoples

What did you least like about the day?

Attendees were also asked about what they liked least about the day.

Negative feedback related to the venue and refreshments and also not having enough time on the programme.

How might the event have been improved?

When asked how the event might have been improved the main suggestion related to having more time on the programme.

Do you want to get involved further?

A number of people were keen to get involved further and plans are being made to accommodate this so that work can be taken forward.

Appendix 1 – Steering Group Profiles

Sue Reeve	Sue Reeve, Chief Executive of Carers in Hertfordshire, a countywide carers organisation, providing information, advice and support and enabling carers to have a voice in the county.
Val Motyer	Team Manager, Hospital Social Work Team, Watford General.
Dorothy Skidmore	Development Manager, ACS now with a lead for supporting the implementation of Single Assessment across the Hospitals in Herts and on the borders. (Formerly, Team Manager for the Social Work Team at Watford General Hospital.)
Diana Chatterton	Team Manager (Elderly, and Physical Disability), Adult Care Services.
Rachel Allen	Business Manager (Corporate Affairs) at Watford and Three Rivers Primary Care Trust with the management lead for Carers and Patient and Public Involvement. This role involves ensuring that patient and carer issues are addressed in primary and community care and that they are supported and involved in service planning and development.
Angela Cannon	Project Officer-Carers for Adult Care Services. Oversee spend of the Carers Grant for Hertfordshire (Dept. of Health funding) and work with staff on practice issues relating to carers assessments and supporting carers from all adult care groups on a county wide basis.
Heather Aylward	Team Leader for West Team, Carers in Hertfordshire a county wide Carers led organisation, which ensures all carers have access to information, advice and support, involves carers in the planning of and consultation on services and is a platform for the voice of carers about issues which affect their lives.
Lesley Lopez	Patient and Public Involvement Manager at West Hertfordshire Hospitals Trust, which covers Watford General Hospital, Hemel Hempstead Hospital, St. Albans City Hospital and some of the services provided at Mount Vernon Hospital.
Ruth Connolly	Senior Services Manager, Older Peoples Services at West Hertfordshire Hospitals Trust.
Elise Charles	Member of the Patient and Public Involvement Forum. Former Deputy Chief Officer, S.W. Herts Community Health Council – set up by the Government in 1974 to represent the interests of patients and the public in the NHS. For many years, was also the Senior Complaints Adviser for patients, providing independent

	help, support and advice about NHS complaints. Accompanied and supported carers and complainants at Formal Hearings , resulting in many recommendations to improve the quality of local healthcare services.
Henry Goldberg	Member of the Patient and Public Involvement Forum. Former long standing member of the S.W. Herts Community Health Council. He has been a member of the Herts CHD Implementation Group, the Herts Children's Services Review Steering Group and the Herts Information for Health Programme Board. Henry is a member of the Watford & Three Rivers Health Partnership Board, is Vice Chair of Relate, Watford and Three Rivers and Joint Chair of Chorleywood & District Residents Association.

National Economics Foundation Profile

NEF is an independent think-tank that works to promote a more sustainable and socially just economy, including how to create vibrant and sustainable communities.

Appendix 2 – People Involved in the Questioning Process

The following groups of people were involved in the questioning process, which was conducted by the members of the Steering Group:-

Community Health Council
Carers
Home Care Agencies
Residential Homes (Homefinder)
Patients/Users
Community Rehab Team
Local Authority – Housing, Meals
on Wheels
GPs
District Nurses
Therapists
Pharmacy
Transport
Modern Matrons
Social Workers
Health & Social Care Co-ordinators
Nursing Homes
Hospital at Home
Emergency Duty Team
Community Equipment
Voluntary Organisations
Bed Managers
Discharge Lounge staff
Cancer Network

Appendix 3 – Quotes from the conversations

Some of the quotes from the conversations are provided below:-

“ My wife (who was my carer) and I had easy and direct access to speak with my consultant...this made my wife and I feel more in control of the situation and avoided unnecessary trauma.” Patient

“A patient was discharged from hospital and was told to expect a visit from a District Nurse. I wasn’t informed that the patient had been discharged and needed my care and therefore did not visit. The patient had to chase this up and was very angry that they had not received the care they expected.”

District Nurse

“My hospitalisation went well because I was totally consulted and felt safe. Prior to discharge...my family and I were able to ask questions and amend the (discharge) package where necessary.” Patient

“ From a professional point of view, the discharges that go wrong tend to be the ones where the person is still unwell or equipment is not in place. If I have to set up a care package too quickly this can be difficult.” Adult Care Services

“To have made my discharge work would have required all of the network of care to be in place. When even one link is broken the effect is traumatic. In my case, most of the links were broken and very little care, either physically or mentally was provided. I believe that this lack of aftercare added, not only to my acute discomfort, but also delayed my recovery. My wife was so traumatised she became hospitalised herself.” Patient

“No one came to see how we were going to cope once Mum returned home.” Carer

“Current services have not been able to meet short term needs for cleaning, shopping and furniture removal. These may not seem critical to the patients care but goes a long way towards normalising their experience and to promote a return to independent living.”

“I had been given extensive advice on rehabilitation after a heart attack...I therefore knew what I needed to do to get fully fit again.” Patient

“ I was given a leaflet with information on what procedures I had undergone with ‘what to watch out for’ information and special instructions...another leaflet of what to do if I had any problems or concerns...I had at my fingertips telephone numbers and who to contact if I had concerns...everything was clear and I had no doubt as to what to do.” Patient

"Information from the hospital to GPs is inadequate. Sometimes I don't know when a patient has been discharged, or the letter that is sent is incomplete. It is sometimes not clear what is expected." GP

"A patient was discharged into our care without a letter providing medical information and without tablets or a medicines list. It is difficult to provide continuity of care without this important information." Residential Home Manager

"Communication with the carer was non-existent. Nobody told the carer that the patient was being transferred to a nursing home even though they had plenty of opportunity to say as the carer was attending to the patient all day." Carer

"I would not necessarily have the same confidence...or the knowledge that the services communicate between each other well." Patient

"Make sure the patient knows what help is available even if they feel they don't need it when they are discharged. Make sure the patient has a contact name if they feel they need extra help or support." Voluntary organisation

"A good experience of hospital discharge was when the Discharge Co-ordinator phoned and gave information about the patient prior to them being discharged." District Nurse

"Everyone should be involved in things like case conferences, eg. health and social care professionals, carers, patients and their families." District Nurse

"For elective admissions, discharge options should be known before the patient is admitted and these should have been discussed jointly with health professionals and the family. For emergency admissions, where possible there should be a long term care plan, options should be discussed when the patient is not in pain or stressed and they should be involved at an early stage." GP

"Try to be creative, look beyond your current resources and what is done now. It doesn't have to be the same all the time." Patient

"To know that the people who I am dealing with are themselves able to deliver on their promises – just thinking they can is not acceptable...Only this way, could I be confident of making a significant change without taking one chance too many." Patient

"To make coming home from hospital work, it is essential to have all the necessary help in place prior to discharge. A promise to do this is simply not good enough – it must be a written statement of what is going to be in place, which is signed by both the patient and the professionals prior to leaving hospital." Patient

"I felt that for me it was a case of "you've have your operation – now get on with it". More help and support would have made my life much easier."

Patient

"It is important that a full assessment of the home is completed before discharge to ensure that the patient can function OK once they return home."

Community Physiotherapist

Hospital discharge can be "like a relay race – the Trust discharging her husband had tried to pass the baton to the GP, but dropped it...the GP then passed the baton back to the Trust who dropped it...by the time the baton was picked up...and some action was taken, the race was lost." Community Health Council

Appendix 4 – List of attendees at the Conference

Don	Alvarez	Carer
E	Ashley	Patient
Ruth	Atkin	Patient
P G	Batute	Carer
Ailsa	Bernard	West Herts Hospital Trust
Linda	Bonnick	Age Concern
Steve	Bromby	Watford General Hospital
Helen	Browne	Voluntary Organisation Representative
Janet	Bunce	Voluntary Organisation Representative
Ellie	Burtenshaw	Councillor
Fiona	Clark	PoWHER
Suzanne	Colbert	Watford General Hospital
Louise	Colman	Watford Gen Hospital
Felicity	Cox	Watford and Three Rivers PCT
Francis	Durham	Patient
Peter	Durrance	Beds & Herts Ambulance
Claire	Fenlon	
Frances	Flynn	Hemel Hempstead General Hospital
Jenny	Foulger	Watford BC Housing Dept
Michelle	Gallacher	Adult Care Services
Kusum	Gheewala	Sessional Interpreter
Seona	Gordon	Adult Care Services
Winston	Gosine	Voluntary Organisation Representative

Christine	Gregg	BHAP
Jacqueline	Hale	Voluntary Organisation Representative
Keeley	Hall	Age Concern
Brenda	Hall	Hospital at Home
Peter	Harper	BHAPS
Amanda	Horlor	Community Support Worker,
Jenny	Janes	Watford BC Housing Dept
Peter	Jenkins	Voluntary Organisation Representative
Robyn	Johnson	Watford General Hospital
Janet	Lewis	West Herts Rehab Service
Guna	Mahadevan	
Joan	Moult	Carer
Liz	Mowbray	
Shirley	N'Jie	West Herts Hospital Trust
Linda	North	
Nerisa	Petrie	Carer
Girda	Plummeridge	Saracen Ward
G	Poole	
Dee	Ramtej	Watford General Hospital
Ansuya	Raval	
Peter	Roach	SWH Community Health Council
Alfa	Saadu	West Herts Hospital Trust
Gill	Salen	Patient
Jo	Shipley	Carer

Joyce	Stratford	Carer
Marion	Sycamore	Community Wheelchairs
Adrian	Vyse	Watford General Hospital
Roger	Walker	Carer
Jessie	Winyard	Patient