Engagement report:

Public perceptions and experiences of being discharged from health and social care services in Suffolk
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1.0 INTRODUCTION

1.1 In May, Healthwatch England launched its first ever special inquiry to find out why things so often go wrong when people are discharged from health and social care institutions.

1.2 The Healthwatch network told Healthwatch England that people leaving hospital or care without the right support was a significant concern across England, and so it chose to investigate this on a national level.

1.3 The purpose of the enquiry is to establish a deeper understanding of people's experiences, with a view to using Healthwatch England's statutory powers to ensure improvement in national policy and our influence to improve local practice.

1.4 Locally, we have been hearing stories of poorly planned discharge. This includes cases where elderly patients have been sent home too early and without the equipment or the care packages needed to look after them. This can result in return visits to hospitals and distressing situations for them and their families.

1.5 We believe that there are many of these incidents and most could be avoided if more care and attention was paid to preparing the ground for people to return to their home and community from a hospital or social care service.

1.6 In conducting its inquiry, Healthwatch England asked 148 Local Healthwatch across the country to provide support by seeking the experiences of homeless people, those with mental health conditions and older people with regard to being discharged from health and social care services. It considered that evidence shows unsafe discharges can have the biggest impact on these groups.

1.7 Following this request, a local decision was taken to obtain experiences in Suffolk.

1.8 Members of the public were invited to share their experiences and views through surveys and drop-in sessions. This report is our summary of the experiences submitted.
1.9 As the independent champion for health and social care, Healthwatch Suffolk has independently collected and analysed people’s feedback and opinions on behalf of the local health and social system.

1.10 Healthwatch England has been gathering experiences from across the country. It will use this evidence to advise the Secretary of State for Health and organisations responsible for health and social care like NHS England and local authorities on changes that it thinks need to be made to improve people's experiences.

1.11 The raw commentary included within this report has been submitted to inform the national inquiry. It is our intention that this report should be used locally for the purposes of service improvement in Suffolk.

2.0 PUBLIC ENGAGEMENT

2.1 The methodology was developed by Healthwatch England and adapted for local use in Suffolk.

2.2 It consists of several components:

- Questionnaire survey
- Focus groups
- Healthwatch Suffolk Community Development Team drop-in sessions

2.3 The surveys were designed by Healthwatch Suffolk on the basis of questions set by Healthwatch England. They sought to obtain both qualitative (comments about the services) and quantitative data (numbered data).

2.4 Whilst predominantly similar, the surveys included questions that were specifically relevant to the target group. These groups were as follows:

- People who are or have been homeless
- People that have received treatment for a mental health condition
- Older people

2.5 The above groups were identified by Healthwatch England because it considers that people with mental health conditions, those who are or have been homeless and older people can end up in very difficult situations when they are discharged from a hospital or care home.
2.6 The surveys were created and uploaded to www.surveymonkey.com, which is an online survey creation service. It allows Healthwatch Suffolk to gather responses with one URL by including a link on emails, websites, Twitter and Facebook. Hard copies of the questionnaire were also made available on request from Healthwatch Suffolk.

2.7 100 copies of the survey were distributed by the Healthwatch Suffolk Community Development team to the following locations:

- Waveney Advice Service Project event
- Access Community Trust
- Heart Care Social Group
- Suffolk Family Carers Forum
- Mental Health Forum (Lowestoft)
- Stowmarket Library
- Over 60’s club
- Mental Health Focus Group (MHFG)
- Suffolk MIND - Bury and Hintlesham Office
- Ipswich Hospital Users Group
- BME Group
- Suffolk VASP

2.8 Focus groups were held jointly with:

- Salvation Army (July 2014)
- YMCA - engaging with young people (July 2014)

2.9 The engagement was supported by the Healthwatch Suffolk Information Team with website content and regular social media updates. The team also included information within Healthwatch Suffolk fortnightly electronic updates and created posters to support the publicity of focus group sessions.

3.0 RESPONDENTS

3.1 A total of 43 qualitative comments are logged that refer to experiences of being discharged from hospital, mental health settings or care homes. These comments were collected through surveys, focus groups and online engagement about the national inquiry to elicit local input.
3.2 A total of 14 people from all groups chose to complete a survey. They are broken down as follows:

- Respondents that are or have been homeless (57%)
- Respondents that have experienced a mental health condition (22%)
- Older people (21%)

3.3 In 2013/14 we began to set up monthly outreach points at locations across Suffolk. Relationships have been developed with groups and organisations to enable us to engage with communities at regular intervals where they meet and on their terms. These sessions have been very successful, enabling us to reach many individuals to obtain their views and talk to them about our work. An additional 12 comments to support this work were obtained from individuals that attended our drop in sessions.

3.4 The relatively low number of responses and the self-selected nature of our sampling method limits the external validity of our data. This means that we cannot state with any significant certainty that our results are representative of the population that we have engaged.

3.5 Whilst this is the case, we believe that the views expressed are indeed indicative of wider problems within the health and care system regarding the process of being discharged from services and should be treated as such. We expect the results of the national inquiry to confirm this assumption.

4.0 SURVEY FINDINGS

4.1 The surveys were completed by a variety of respondents. In total, 14 people responded from the following demographics:

- Respondents that are or have been homeless
- Respondents that have experienced a mental health condition
- Older people

4.2 The majority of respondents had been discharged from a health or social care premises within the last 18 months.

4.3 Other than one respondent, all participants had been discharged from a hospital setting.
4.4 Most respondents were satisfied or very satisfied with their treatment.

4.5 With regard to those respondents who were or had been homeless, we asked if a member of staff had asked about the individuals housing situation. A majority of participants told us that they had and several stated that this had been completed in detail.

4.6 There was a relatively even split in respondents with regard to their experience of being involved in the decision to leave the hospital or care environment. Some were involved and others were not.

4.7 There is a concerning trend amongst our sample that a clear majority of respondents told us they were not ready or only partly ready to leave the care of the hospital. Whilst we do not claim our results to be representative of all hospital users, we do expect that the national inquiry will confirm this finding and highlight it as a problem in the system.

4.8 Just over half of our respondents told us that they were given clear instructions regarding their medication either in detail or briefly.

![Time of Discharge](image)

Figure 1: Time of discharge

4.9 As figure one above shows, discharges occurred at all times throughout the day.

4.10 For the most part, respondents had no transport arranged for them post discharge.
4.11 When asked about treatment plans, few respondents had been offered support or treatment following discharge and half of our sample received no further contact to find out how they were getting on.

4.12 Most respondents were readmitted into care within three months for the same or a related problem.

5.0 QUALITATIVE ANALYSIS (ALL FEEDBACK)

5.1 A total of 43 comments are recorded about being discharged from a range of health and social care institutions.

5.2 Comments were obtained using the following methods:

- Healthwatch Suffolk Information Team engagement about the special inquiry to encourage feedback from people living in Suffolk (e.g. social media updates, website content and fortnightly update emails issued to all members (over 3000 individuals) and features online.
- Healthwatch Suffolk Community Development Team Drop-in Sessions.
- Focus groups held in partnership with the YMCA and the Salvation Army.

5.3 As figure 2 shows below, a majority of the comments were negative in sentiment, with only six comments expressing positivity about the discharge process.

![Comments by Sentiment](image)

Figure 2: Comment sentiment.
5.4 Figure 3 shows the number and sentiment of comments that were received about specific providers of health and social care in Suffolk.

![Comments by Sentiment and Provider](image)

Figure 3: Comment sentiment and provider.

5.5 Analysis of the commentary has identified a number of themes. These are highlighted in Figure 4 and explained below.

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Figure 4: Comment themes.
Theme 1: Information and Advice

5.6 This first theme is comprised of comments that directly refer to information that the patient, carer or relative has received about the discharge process or about how to self-manage the cared for persons condition outside of professional/clinical assistance.

5.7 Comments attributed to this theme may be broken down as follows:

- Poor quality information
- Positivity about information

Poor quality information and advice

5.8 A number of comments made reference to issues pertaining to information and advice that:

- Is absent or insufficient to adequately inform the person being discharged of their options or how to self-manage their condition
- Conflicting with other advice offered
- Confusing to the patient

5.9 Examples of such comments include:

Absent or insufficient information

Example: “Often each professional in the pathway will just give a leaflet to explain what will happen and as time is short no further advice is given.”

Example: “…When you are given diagnosis there should be some information given to you for you to go away and read, then go back at a later date (1-2 weeks) to ask questions. We had no questions at the time as we were shell-shocked but we do now and feel we can’t. Navigation the system is a nightmare…”

Example: “They didn’t tell me how to change the dressing but sent me home with 2 new dressings.”
**Example:** “…Not enough information was provided regarding the patients’ needs on discharge.”

**Awareness of support choices post discharge**

**Example:** “…My mother has not been told of any services she may be eligible for, to help my father. She is relying on word of mouth from other people…”

**Example:** “When people are discharged from hospital and care is being arranged patients if told they are eligible for the first 6 weeks care free do not have future expectations and costs explained so that they can plan. They are told it will be discussed at a later point but this never happens so people become nervous about the costs they would be expected to incur. As a result people have been known to stop care early rather than risk large bills.”

**Conflicting advice and confused messages**

**Example:** “Communication between departments or services can lack at times with professionals not knowing what the others have already said. This can lead to contradictions and confused messages.”

**Positivity about information and advice**

5.10 A number of comments praised the discussions and information received from the discharging organisation.

5.11 Examples of such comments include:

**Example:** “Once in the last 10 months, my husband was in Addenbrookes for an operation. After a fairly major operation he was discharged after 24 hours…Staff discussed everything with my husband and he was shown and told how to do the follow up injections on his release. He was happy with all of this but I felt it was a little soon and a lot to do…Discharge went well from my husband’s perspective.”
Theme 2: Quality of Assessment

5.12 Various comments make direct reference to the extent to which the cared for person received an assessment prior to being discharged.

5.13 For the purposes of this report, assessment is defined as encompassing physical assessment, wellness or readiness to return to a domestic environment, mental state and whether or not the individual has somewhere to which they can be discharged safely and that is appropriate for their needs at the point of discharge.

5.14 The commentary is broken down as follows:
- Lack or poor quality assessment
- Positivity about being assessed prior to discharge

Lack of or poor quality assessment

5.15 Roughly half of the comments attributed to this theme were negative about assessment prior to discharge. Examples include:

Example: “My father has been discharged from hospital (Addenbrookes). At no time has he been assessed as to whether he can climb stairs, get into a shower or bath. My mother is of poor health herself and is struggling to cope…”

Example: “...I could not believe the doctors decision as I had already had great difficulty moving him or even taking him to the toilet. The nurse told me to be firm and insist that I could not take him home. The doctor came to the bed and took off the oxygen roughly saying my husband didn’t need that. He then told us that they would help put him in a wheelchair and put him in the car for me. It took 5 nurses to get him in a wheelchair then three nurses took him to my car and put him in. For them job done. I called my son and when I got home we had to push my husband up the stairs. My husband was obviously feeling very unwell. He was sick and coughing and stayed in the chair all night. He was sick during the night and coughed badly.”

Example: “Wanted to send mum home, she couldn’t even stand up no one to look after her. I told them no way. They sent her to Bluebird Lodge who were very good.”
Example: “Our elderly friend was admitted to hospital with confusion + when investigated it was a water infection. She stayed in for 1 or 2 days as still confused but received treatment. After this she was discharged home but no carers of family were available (family holiday. She returned home very confused + didn’t recognise the house. Hospital transport dropped her off but they were going to have to lock her in as she was saying she had to go home. I don’t know how this was resolved on the day but she is now in a care home as her mental health has deteriorated and she is unable to stay in her own home.”

Example: “Discharged from Norfolk & Norwich hospital. Arrived home at 9pm due to delays with medication and found there was no power on. Ambulance staff left while wife was lighting candles. No help was given to get patient in to bed and as wife was elderly too she was unable to lift on her own. The patient died 1 week later. Patients should not be discharged unless care is arranged and in place at home…”

Example: “…He was diagnosed with Pneumonia. The hospital decided that the man was fit to go home after just six days on the ward… On the following day after discharge from the hospital, the gentleman was found collapsed on the floor still holding his bag from the hospital. He was admitted straight back into hospital and diagnosed with TB… PALS who have provided assurance that the gentleman was assessed by a Physiologist who had noted that he could act independently and wanted to go home. The hospital claim that the gentleman had told them that everything in his home was on one level when in fact the toilet is upstairs. The hospital was satisfied that he was fit for discharge based on the assessment made by staff and information provided by the patient…”

Positivity about being assessed prior to discharge

A number of people were positive about being assessed prior to discharge. Examples include:

Example: “…They assessed whether I could get around the hospital on my own + care for myself, using a zimmer frame to get around. They discussed everything with my husband + made sure that I had support at home…”
**Example:** “...I cannot fault the staff they discussed releasing me from hospital with my family and checked that my carers were in place for me to go home. Following the first fall I did not need further medication but after the second I needed pain killers and this was all discussed before I left hospital...”

**Example:** “Discharge from hospital. I was admitted to hospital with a suspected heart attack but it ended up being something else. I only stayed in overnight but they spoke with my neighbours /friends about me coming home before I was released as I don’t have any close family. This was great.”

### Theme 3: Support after discharge

5.17 The theme of “Support after discharge” consists of 25 comments and can be broken down into three separate sub-themes (ST) as follows:

- The importance of support networks
- Absent or insufficient support/follow-up post discharge
- Lack of integrated care and poor communication between health and care professionals

### The importance of support networks

5.18 Comments attributed to this sub-theme indicated that people can be disadvantaged at discharge through having a limited friend/family support network or indeed somebody that is able to advocate on their behalf.

5.19 This might mean that a person does not receive sufficient information about how to self-manage their condition or that they are discharged before they feel ready to return home.

5.20 Examples of comments attributed to this sub-theme include:

**Example:** “There was concern that to get appropriate care in place families had to initiate case reviews and encourage forward progression for the patient. If someone is unable to do this for themselves or does not have family or friends able to advocate for them then it was felt that they would be in a worse position.”
Example: “...PALS who have provided assurance that the gentleman was assessed by a Physiologist who had noted that he could act independently and wanted to go home. The hospital claim that the gentleman had told them that everything in his home was on one level when in fact the toilet is upstairs. The hospital was satisfied that he was fit for discharge based on the assessment made by staff and information provided by the patient. VoiceAbility are involved with the gentleman’s case. The commentator noted that he has no family and nobody to fight his corner…”

Absent or insufficient support/follow-up post discharge

5.21 Several individuals provided comment about the extent of their support and follow-up post discharge, which they considered to be lacking.

5.22 Comments attributed to this theme include:

Example: “I will also be having to represent my daughter xxxx who is unable to attend the meeting due to suffering in severe pain from her chronic diseases. xxxx is waiting to go into hospital in Bath Somerset. Both myself and xxxx are too traumatised to attend Ipswich hospital for her treatment there because of the way she was treated by the staff and in the way she had been sent home and just left... It is appalling in the way xxxx was left and the damage that has been done.”

Example: “My father had a pretty bad experience having a very routine cataract op. He was referred to The Nuffield by his optician under the NHS funded contract for cataract removal. It was done OK but he was not given a follow up appointment, he was just told to go back to the optician in a month. He then had problems with a bleeding eye a few days later and he could not get any advice from the number they had given him, he rung them twice and left messages but they did not ring back. He went to his GP and then was sent straight to the Eye Clinic at Ipswich Hospital, who originally diagnosed an ulcerated cornea, now they have told him it is a substantial torn cornea and today he has had it glued. If this does not work he’ll need a corneal graft. I do feel there is an issue here with purchasing block operations- are the CCG (or is it NHS England?) also purchasing the follow up? If they are, it is not being delivered. I would like to tell them this.”
**Example:** “I had a hip replacement and although successful I thought the follow up was not as good as Ipswich hospital. I only had one check up after 6 weeks and felt that I was just left to get on with it. I wasn’t sure when to go from zimmer frame to walking sticks to one stick to none. I had to have physio which was very successful in the end.”

**Lack of integrated care and poor communication between health and care professionals**

5.23 This sub-theme consists of commentary that reports issues related to discharge that are compounded by poor communication between professionals and an apparent lack of joined-up services.

5.24 Example comments attributed to this theme include:

**Example:** “Communication between departments or services can lack at times with professionals not knowing what the others have already said. This can lead to contradictions and confused messages.”

**Example:** “It was felt by the group that not having a “key worker” dedicated to the patient who knows everything that should be happening at discharge means that there is no overall picture which is compounded when services do not communicate well.”

**Example:** “…Also, I wonder about the availability of notes across different providers/commissioners. He has a dry eye that possibility contributed to the complications and I wonder if this was adequately recognised.”

**Example:** “I had kidney stones (7) and they tried to discharge me same day. I had only just woken up and it has the doctor who tried to discharge me. The motion matron would not release me as she said I needed to have my urine measured over a 24 hr period. So why has the doctor trying to discharge me.”
Theme 4: Transport

5.25 Comments attributed to this theme reflect on issues related to transport from the care premises to home post discharge.

5.26 A few of the comments relate to instances where the hospital have been inflexible in allowing patients to remain on premises until suitable transport becomes available. Both of these experiences were attributed to the Ipswich Hospital NHS Trust.

Example: “I went with my friend who has a thrombosis to her leg in an ambulance to Ipswich A&E. when we had been treated we were asked to leave. It was the middle of the night, there were no buses. We are both on benefits and have no money. We managed to find enough change to get a taxi to the nearest cash point. We withdrew everything we had. This was enough to get us to the Trimley roundabout and we then had to walk to the other side of Walton to get home. My friend is not meant to walk more than half a mile with her thrombosis. I have complained to Ipswich hospital who wouldn’t let us stay in A&E till the buses started running in the morning. I have heard nothing from them not even an acknowledgement. Disgusting.”

Example: “Went to A&E by ambulance very early in the morning, staff on reception were very rude. When I was released from A&E I was told to leave straight away. It was bank holiday Monday and the buses weren’t running very often. It was freezing cold and I asked if I could just sit in A&E in the warm until the buses started running. It took a police officer who was in A&E to persuade the reception staff to let me stay.”

Example: “1) I went in for a vaginal hysterectomy - I was discharged on a Sunday - feeling awful - the hospital would not provide transport - I had to wait till 9pm for my great nephew (who was rotten drunk after a day out) to pick me up. 2) xxxx 2012 - broke tibia - again no transport - changed to Bury.”

Example: “The staff and care is good when there. After a fall, my neighbour had to go to hospital by ambulance. It took over 1 hour to get to her in Lowestoft. They checked her over and discharged her at noon. She said how can she get home? They said ‘you will have to get a taxi’ She had no money on her and at 92 yrs d/d is very frail. The
attitude of ‘you will have to get a taxi’ is wrong. No question asked if any family can help we even a follow at doctors.”

Theme 5: The discharge process

5.27 Comments attributed to this particular theme can be broken down into two sub-themes as follows:

- Discharged too early
- Discharge was not dignified

Discharged too early

5.28 A number of people told us that they felt they had been discharged from the care environment too soon. Examples include:

Example: “Staff discussed everything with my husband and he was shown and told how to do the follow up injections on his release. He was happy with all of this but I felt it was a little soon and a lot to do…”

Example: “The doctor told me that I would have to be in the day room by 7am the next morning if I was going to stay overnight. I was happy to go home once the pain was under control but I felt that three days was very quick to go home.”

Example: “After a major operation for my ovarian cancer I was sent home after just 2 days from the operation. In total I was in hospital for 3 1/2 days. I went in on a Thursday, had the operation on Friday. Sunday morning my specialist came to see me and I said to him you are not discharging me yet are you? He said no we don’t just shove people onto the streets you know (Joking manner). However, Monday morning I was told I was being discharged. It took ages to get my prescription sorted and I refused to get off the bed until I could actually leave as it was agony to sit in a chair. I knew they needed the bed but just could not bear to sit...The journey home from there to xxxx was so painful. I had a stapled stomach about 10 inches long and they kept catching. We then had to go over the railway crossing, and you can imagine how that hurt juddering across. I felt it was far too early to come home... as I live on my own I had to do everything myself and it was so hard...”
Example: “After being admitted following a suicide attempt discharge was arranged but support workers were trying to prevent the person from being discharged as they didn’t feel the person was ready to go home. They were not listened to and the person involved was sent home. As expected the person involved tried to commit suicide again and had to be readmitted…”

Example: “I could not believe the doctors decision as I had already had great difficulty moving him or even taking him to the toilet... My husband was obviously feeling very unwell. He was sick and coughing and stayed in the chair all night. He was sick during the night and coughed badly.”

Undignified discharge

5.29 There were some reported incidents of discharge that appeared undignified.

Example: “A gentleman who is 91 lives across my street. He was brought home by ambulance in a nappy and hospital gown. That is just so undignified - how can they release someone in that way!”

Theme 6: Gaps in Services

5.30 Feedback attributed to this theme, includes comments that appear to be indicative of apparent gaps in services (mainly mental health services) or problems that occur because of a lack of capacity within the system at alternative services.

5.31 Examples of comments attributed to this theme include:

Example: “Arranging care at home and within care homes etc is delaying discharge from hospital. One family experienced delays with their fathers discharge as a result of no places being available for appropriate care.”

Example: “Having a local service such as a rehab type ward as previously operated from Hartismere hospital would enable discharge from hospitals more quickly as currently some families are undertaking 2 hour round trips to where patients are recovering in Aldeburgh. Care home places are limited and patients are expected to recover a long way from home making visiting by family and friends very difficult and costly.”
Example: “People being discharged from Ipswich Hospital with no care package, arriving home on a Friday, no community nurse or social services visit until the following Monday! Then readmitted to Ipswich Hospital.”

Example: “After ¾ days I was released from the ward, there was no discussion and although I was told the Wellbeing Service would support me it never happened as they said I was too bad but AAT said I wasn’t bad enough so I got not help at all... Because I was not getting any support or help from wellbeing or other mental health services I went to A&E for help but didn’t really get any. I have visited my GP Practice but because you see a different doctor each time you go there is no continuity of care and nothing happens...”

Example: “I was sectioned in xxxxx but when I was discharged I was told that I would get support from wellbeing but they said I was too bad for their services and then AAT told me that I was not bad enough for them. This means that I am not getting any support at all from mental health services + have fallen between the two.”

6.0 SUMMARY AND RECOMMENDATIONS

6.1 Generally, the experience reported in surveys is mixed with some individuals finding it difficult and others finding it easy to obtain support post discharge.

6.2 There is a concerning trend amongst our sample that a majority told us they were not ready or only partly ready to leave the care of the hospital. We expect that the national inquiry will confirm this finding and highlight it as a problem in the system.

6.3 People shared positive and negative feedback with us about the following themes:

- Information and Advice
- The quality of assessment
- Support for the patient post discharge
- Transport upon discharge
- The discharge process itself
- Gaps in services (particularly for mental health service users)

6.4 Similarly to our survey results, we cannot claim these themes to be representative of all users of health and social care services in Suffolk. We do however consider that they are indicative of wider trends in our local systems and should be considered on that basis.

6.5 For the most part, comments were negative in sentiment.

Information and Advice

6.6 We consider there to be a legitimate argument that patients are not receiving sufficient information upon discharge to enable them to self-care or understand their support choices. Information is not always presented to patients at the right time; it can also be too confusing for patients. Often patients receive several leaflets from different professionals along the care pathway.

Experience of Assessment

6.7 Respondents told us that their experience of assessment prior to being discharged varied. Some people commented about a lack of or poor quality assessment and others were positive that the appropriate steps had been taken to ensure that they were being discharged, safely and to an appropriate environment with the right support.

6.8 It is clear that, where the assessment prior to discharge has been insufficient, this has impacted negatively on the individuals return to the home environment.

The importance of support

6.9 The importance of support after discharge was also highlighted as a theme. This varied with a number of individuals reporting issues associated with insufficient support or poor communication between health and social care professionals. There are several examples of comments that report a highly negative impact on the condition of the patient where little or no support is offered after the person has left the care of the service.
Transport

6.10 There are a few comments that report issues related to transport. There is a need for hospitals to take a flexible approach to allowing some patients who rely on public transport to remain on the care premises until a suitable transport option becomes available. This is particularly relevant during periods of harsh weather.

6.11 Whilst this is the case, we understand that under some circumstances this is not always possible. We would however encourage leniency in this area provided that the patient has a clear understanding as to when appropriate transportation will become available and they are not being disruptive or detrimental to the care of others.

The discharge process

6.12 A group of comments provide an indication that the person receiving care was discharged from the care setting too early and, in some cases, in a less than dignified manner.

Gaps in services

6.13 Mental health patients make reference to an apparent gap in service provision whereby their care needs are greater than offered by the Norfolk and Suffolk Foundation Trust Wellbeing Service but do not warrant a referral to the Trusts Access and Assessment Team.

6.14 It is recommended that all local providers and commissioners of health and social care in Suffolk use the findings in this report for the purpose of service improvement activities.

6.15 The raw commentary included within this report has been submitted to inform the national inquiry into unsafe discharge being conducted by Healthwatch England. It is our intention that this report should be used locally to support its recommendations for improvements to national health and care systems but also for the purposes of service improvement in Suffolk.