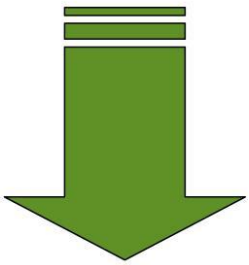
healthwatch
Cheshire West

Unsafe Discharge



Summary of information collected by Healthwatch Cheshire West in response to Healthwatch England's Special Inquiry into Unsafe Discharge.

September 2014

Acknowledgements

Healthwatch Cheshire West would like to thank all those who provided comments, completed questionnaires and contributed to the Special Inquiry workshops. Your contributions made the production of this report possible.

Contents

Abbreviations used in this document

A&E – Accident and Emergency
CBT – Cognitive Behavioural Therapy
CCG – Clinical Commissioning Group
COCH – Countess of Chester Hospital Foundation Trust
CMHT – Community Mental Health Team
CPA – Care Programme Approach
CPN – Community Psychiatric Nurse
CQC – Care Quality Commission
CWAC – Cheshire West and Chester
CWP – Cheshire and Wirral Partnership NHS Foundation Trust
GP – General Practitioner – *generally your own doctor*.
MCHFT – Mid Cheshire Hospitals Foundation Trust

1. Introduction

The purpose of this report is to share local intelligence and feedback collected by Healthwatch Cheshire West in response Healthwatch England's Special Inquiry into unsafe discharge.

The report presents views and experiences as shared by over 30 local people with Healthwatch Cheshire West during a period of engagement between June and July 2014.

The comments collected during the special inquiry that related to unsafe discharge have been shared with Healthwatch England. In addition to this all comments have been recorded on Healthwatch Cheshire West's information system in order that they can be shared with local organisations responsible for commissioning or providing local health and social care services.

Healthwatch England will publish its national report with recommendations on 18th November 2014.

2. About Healthwatch Cheshire West

As the new independent consumer champion for health and social care in Cheshire West, our role is to champion the needs of children, young people and adults and make things better for the most vulnerable in our area.

There are a number of key activities that Healthwatch Cheshire West carries out;

- Provides information and advice about local health and social care services
- Gathers local people's views and experiences about services
- Helps people to get their views, experiences and concerns heard
- Reports any issues and concerns to those who plan and provide services
- Involves local people in monitoring the quality of provision and experience of local services
- Challenges those who plan and provide services and makes recommendations
- Reports findings to regulators such as the Care Quality Commission (CQC)
- Shares local views and experiences with Healthwatch England.

3. Background to Special Inquiry 2014

The special inquiry came about following feedback from the local Healthwatch network to Healthwatch England. Concerns have been raised by local Healthwatch organisations across the country, that people are being discharged from hospitals, nursing or care homes and mental health settings unsafely, and without adequate assessment of their on-going needs or arrangement of sufficient support in their own home, temporary accommodation or in the community.

As a result Healthwatch England is running its first ever special inquiry, to find out what happens when people are discharged from a hospital, care home or secure mental health setting.

The focus of the special inquiry is to understand the experiences of homeless people, those with experience of a mental health condition and older people. Groups that intelligence from Local Healthwatch organisations, suggest are particularly affected by the issue of unsafe discharge.

The purpose of the special inquiry 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 local practice. Evidence shows 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. The evidence shows that an unsafe discharge can have the biggest impact on these groups, so the inquiry focuses specifically on their experiences.

When the inquiry reports in November 2014, Healthwatch England will use the evidence collected through the inquiry and its statutory powers, to advise the Secretary of State for Health and any relevant statutory bodies (like NHS England), about changes that should be made to policy and guidance or practice.

In support of Healthwatch England, Healthwatch Cheshire West chose to run focus groups looking into the experience of discharge for older people and people who use mental health services or have experience of a mental health condition. The rationale for focusing on these groups was underpinned local intelligence collected by Healthwatch Cheshire West through community engagement and the identification of local priorities.

In addition to attending focus groups, a number of local people also contributed by sharing comments via telephone, in writing or by completing questionnaires to capture their experiences of being discharged from health and social care settings.

4. Engagement Methodology

Healthwatch Cheshire West used a variety of methods to collect evidence for the special inquiry.

Four widely publicised workshop sessions were held to collect people's views on unsafe discharge:

- Two workshops to engage with people with an experience of a mental health condition took place on Monday 30th June in Chester and Tuesday 1st July in Northwich.
- Two workshops to engage with older people took place on Monday 30th June in Chester and Tuesday 1st July in Northwich.

The following questions were asked at the start of each of the workshops, however these were mainly used as prompts and participants were encouraged to share their own comments and stories.

1. What happened during your discharge?
2. What happened after your discharge?
3. What worked well, and didn't work well during the discharge process?
4. What could be improved?

Healthwatch Cheshire West also collected evidence for the special inquiry by producing two questionnaires for members of the public to complete. One questionnaire related to people's experience of discharge from mental health settings, and the second questionnaire focused on older people's experiences of discharge.

In addition to this Healthwatch took comments from participants who submitted intelligence online and via telephone.

The people attending the focus groups, those who we spoke to on the telephone and who contributed written evidence; formed a broad range of individuals including those in receipt of care, close family members and carers of people who've had the experience of using services. Also attending were some professionals involved in the care of people who use services.

5. Summary of Findings

This section provides a summary of the comments shared with Healthwatch Cheshire West during the special inquiry. Full lists of the comments (attributed to a particular provider/commissioner of care where possible) can be viewed in the appendices starting at page 28.

During our engagement Healthwatch Cheshire West received a number of comments directly relating to the special inquiry into unsafe discharge, but in addition to these, we also received a variety of general comments regarding health and social care provision in CWAC. Healthwatch Cheshire West has decided to add these comments to its existing commissioning intelligence but they are also included under section 7 of this report.

5.1 Mental Health

- A number of people shared the view that they didn't feel that sufficient planning took place when people were discharged from an acute mental health setting.
- Some people felt that whilst there was some support when people were discharged back to the community, this was often only for a short period and discontinued after a number of weeks.
- A number of people, caring for family members with mental health conditions were unaware that the people they were caring for had been given a care plan on leaving hospital.
- One of the participants told us that she only found her daughter's care plan whilst casually reviewing some of the information that had been provided to her daughter and left lying around at home. When reading her daughter's care plan, she found out that she was named party within it and that this was the first she had heard about it.
- There were difficulties when discharging people out of Community Mental Health Team support (CMHT) and back to their GP. Some participants said that they found it very difficult; once they had been discharged out of the CMHT; to receive help quickly in a crisis period. For some people this made them scared of being discharged out of secondary mental health services.
- There was concern about discharge planning. One of the participants said that her son was asked to attend a meeting with a psychiatrist, where his discharge from a psychiatric unit was to be discussed. The son expected to be discharged on a gradual discharge initially (spending a day a week whilst adjusting to life away from the psychiatric hospital) but was told by the psychiatrist that he was being discharged in two days time.
- Participants also felt a greater period of notification should be given when people are discharged from a long term admission.
- Participants also told us about the difficulties in accessing psychological therapies. In successful discharges the next steps for many people would be to access psychological therapies, however, there was often delay on people being referred to these services.
- Participants told us that they felt more should be done at discharge to have a holistic view of people's situations post discharge and that follow-on

support, housing support, benefits etc. should be in place when people are discharged to avoid future crisis.

5.2 Older People

- A number of the participants felt that not enough information was given out when people were being discharged. One of the participants, who cared for his wife, commented on that he was not provided with information that his wife would likely be sick after discharge due to the operation she had undergone. This had created a lot of anxiety which could have been resolved by providing better information at discharge.
- A number of other participants reported issues relating to dignity. One of the participants explained that when her father was discharged from A&E earlier in the year (after a brief stay) an A&E doctor asked if the father could be discharged to his care home in a taxi. When the daughter said this wasn't possible due to her father's health condition, the doctor contacted the care home directly and asked them if the gentleman could be discharged in a taxi. The care home endorsed the daughter's comment backing the family's view. The family believed that the care home was contacted to get the answer that the A&E doctor wanted; which was not the answer that the family were giving.
- Some participants felt that they had to wait for a long period in the discharge lounge. One of the participants who is disabled and unable to walk found this quite isolating. She shared that because there was less staff in the discharge lounge she felt that she couldn't access the same level of support as she would have done on the ward.
- A number of participants felt that their families and carers were not involved in the discharge process. One participant reported when their daughter asked for information, she was given the 'brush off' and made to feel like she was interrupting the work of the staff. Another participant felt that a request for her husband to be placed in Ellesmere Port Hospital for rehabilitation was refused and he was then placed in a care home where there was availability, rather than in the service the family wished to place him in.
- Many of the participants felt that they only received ongoing rehabilitation care because of the persistence of family members to request it.
- Many of the participants felt that ongoing support packages were not put in place prior to discharge and that this affected care. One client said that staff didn't speak to them about the support available post discharge and where they were expecting a district nurse to visit (post discharge) this did not happen. As a result most of the continued care was provided by neighbours and friends.
- Some of the participants felt that not enough or appropriate information was shared at discharge. One person felt that her GP would be informed about her admission but this didn't take place. Another participant's father who was discharged into a care home reported that the care home didn't receive a discharge letter from the hospital as expected.

- A number of participants felt that discharge was often delayed because of delays in putting community support equipment / housing modifications in place prior to discharge.
- Discharge could be delayed because appropriate transport is not in place and some participants felt that when transport is delayed patients are not given appropriate information about when transport will arrive.
- One of the participants, who spent six hours in a discharge lounge, felt that a meal pack should have been provided for her.
- Some of the participants shared positive experiences of discharge. One client spoke about how specialist equipment was put in place prior to discharge and how they were given a treatment plan which included rehabilitation carers visiting the house post discharge. One of the participants made the suggestion that if a patient required a GP appointment post discharge this could be arranged prior to discharge.
- One of the participants spoke about their experiences of their mother being discharge from Leighton hospital into a care home. The hospital arranged three meetings prior to discharge to discuss the discharge and ensure all the support was in place. Some of the participants at the focus group wondered why similar approaches were not used for other clients.

6. Themes emerging from the special inquiry

Healthwatch Cheshire West heard from over 30 people during the special inquiry and a number of common themes emerged. The issues that we received most comments about were;

- Negative experiences of hospital discharge lounges
- Delays in receiving aftercare support
- Lack of rehabilitation support for patients leaving care after a long stay
- Lack of consistency or a common approach to discharge
- Need for improved planning for discharge
- More information needed for family members / carers post discharge.

In addition to this, we received a number of comments relating to Mental Health 'Crisis Care' which didn't directly relate to unsafe discharge, but which we feel require attention.

6.1 Negative experiences of hospital discharge lounges

6.1.1 Comments from older people

We received a number of comments relating to this issue, in particular it was felt by some individuals that there is a need to improve facilities and care in the discharge lounge of both acute trusts that serve our area. Of particular concern were a number of comments made by older individuals.

Several people commented on having to wait long periods for suitable discharge transport and that during the waiting period that they were given misinformation on times of arrival etc.

One lady in particular said that she had to wait a long time for transport and was not helped to the toilet (she could not walk unaided) another lady reported that she was not spoken to, other than when the ambulance men arrived.

Other people commented on the need to maintain patients' wellbeing whilst waiting for transport, particularly when the frail and elderly may be in a confused state. Concern about how the wellbeing of elderly patients is monitored when being discharged from A&E was particularly prevalent.

Several people reported that they did not know what would happen post discharge and did not know what services that they could expect to receive. One felt; reporting on her experience in the discharge lounge; that because she was so old, people automatically thought that she had ***"lost her marbles,"*** and therefore, ignored her whilst she was there.

One service user commented that she had waited in the discharge lounge for six hours without food. Having been in hospital for a week she knew that there was no food at home.

One lady told us that she was upset that whilst awaiting transfer by ambulance to a separate care facility, she had to wait hours in the discharge lounge. Though quite capable, staff had not allowed her to change into her own clothes prior to being moved. She did not mind having to wait commenting, *"The waiting was OK but I hated not being able to dress properly. Sitting for hours in just a nightie and a dressing gown was not good!"*

One of the participants reported that a reason for her delayed discharge was, *"due to staff in the discharge lounge being off work with sickness, with sickness cover not arranged."*

6.1.2 Comments from people with experience of a mental health condition

One of the participants felt that during the discharge of her son; from a mental health unit (CWP); medical staff were careful not to ask any anything which could delay the discharge – almost as if they wanted him simply, *"off the books,"* as quickly as possible.

6.2 Delays in receiving aftercare support

6.2.1 Comments from older people

People commented that any GP appointment required should be arranged prior to discharge and this would help the patient; being one less thing for them to worry about. People commented that it was often difficult to get a GP home visit post discharge. A number of older people also commented on some difficulties getting an appointment for other services. One individual commented that often there were, *"too many different organisations to contact."*

From those that we spoke to it appears that there is often a delay in receiving the services they require and patients believe that this is a result of funding cuts.

One lady, who had been discharged following three days in intensive, care followed by seven days on a ward, expected to at least have had a visit at home from a district nurse or doctor, *"they might have come round just to check that I wasn't dead!"*

She told us that she lived alone and relied on friends to bring her out of the hospital; *"They only let me home because I told them that I had a stair lift but no one checked if it was working. I had no visit from a district nurse, thinking this would be organised for me. When I saw my doctor eight weeks later he did not know that I had been in hospital."*

She expressed deep concerns for those who were discharged under similar circumstances who did not have a close circle of friends to look after them or who did not understand the complications of prescribed medication.

She had been prescribed 22 tablets a day and she felt that someone who had *"a frail mind"* or who *"forgot things,"* would find this difficult without supervision. She was basically astonished that having been admitted for a life threatening condition, no health professional visited her at home post discharge, and that her own doctor knew nothing at all about what had happened until she went to see him eight weeks later over a separate issue.

Participants also told us that community physiotherapy services are significantly understaffed and that it is difficult to get an appointment.

We were told that discharge is often delayed because people are waiting for community support, equipment and housing needs that are not in place. The feeling from one workshop in particular, was that it is important to have everything in place before someone is discharged into their own home. One example of poor service was provided by a participant who contacted us by telephone to say she had waited several days for equipment and by the time the equipment came her condition had improved to the point of not needing it.

6.2.2 Comments from people with experience of a mental health condition

Several people with experience of a mental health condition (and their relatives) commented that visits from CMHT representatives were limited and often too short. Reporting on this one commented, *"by the time they had sat down for a cuppa it was almost time to go."*

The feeling was that community based appointments should be longer. A mother of a mental health service user told us that post discharge; her son (who had been in a secure unit for twelve weeks prior to discharge), did not see a Community Psychiatric Nurse (CPN) for three months after he had been discharged from a secure unit.

One of the participants reported that her son was in a mental health unit longer than required due to family circumstances; her son not being discharged to home due to a relative being cared for in relation to a terminal disease. Her son had to wait some time until a unit became available at a hostel, which meant he stayed in hospital longer than he should have done and led to even more distress for the family.

Comments from participants were that they felt more resources and support are provided to people with conditions such as cancer and even common colds and influenza, than those with mental health conditions.

In addition people commented that the waiting times for some psychological therapies; Cognitive Behaviour Therapy (CBT); are far too long. *"more needs to be done to train more therapists."*

Participants told us that talking therapy sessions were, **"too limited,"** in that they only covered a short period post discharge. Several individuals commented that on completion of talking therapy sessions, all other treatment seemed to drop off.

One of the comments we received was from a mother whose son was only being allocated six weeks rehabilitation from a secondary mental health service. She questioned if this was enough?

Participants in the workshop felt that the aftercare given to patients often varied depending on who you see and where you live. One mother of a mental health service user commented that she felt her son had received a lower level of support as a result of him having a family home to come back to. She felt that those who had no family and nowhere to live, were given a lot more support in terms of intermediate hostel places, benefits and professional help. She did not see this as fair and equitable treatment.

6.3 Lack of rehabilitation support for patients leaving care after a long stay

6.3.1 Comments from older people

One lady, having had treatment on an acute ward following a fall was extremely upset that she was not able to continue her rehabilitation in her home. Having spent three months on a rehabilitation ward she felt that everything done for her there could have been done at her home (which was already converted for accessibility) and it was only when she eventually came home and started working with community physiotherapists that she felt that she started to make real progress with her rehabilitation. The lady had documented her three month stay in hospital in a diary (shared with Healthwatch Cheshire West) in this she outlines the considerable difficulties experienced in obtaining a care package that allowed her to go home. She expressed the view that services should be joined closer, to aid progress of rehabilitation and to avoid the patient having to make contact with numerous agencies, which can be stressful.

6.3.2 Comments from people with experience of a mental health condition

Some of the participants from the Northwich Mental Health workshop reported that there used to be rehabilitation facilities in the local community, for people to use as an alternative to staying in a mental health acute ward. These facilities supported people to develop skills on how to live at home. It was commented that these facilities have since closed down due to funding cuts.

6.4 Lack of consistency or a common approach to discharge

6.4.1 Comments from older people

One older person who had experienced discharge from two different hospitals could not believe the differences in the approach of each hospital. One lady commented that she had considerable praise for one hospital that had arranged three meetings prior to her mother's discharge – something that did not appear to be repeated at other hospitals in our area.

A number of older people could not understand why each hospital seemed to have a different approach. In addition, a number of patients commented that having been transferred to a care facility / rehabilitation hospital – it was obvious to them, that the staff at the new establishment were not in receipt of the patients details/needs.

6.5 Need for improved planning for discharge

6.5.1 Comments from people with experience of a mental health condition

An employee of a supported housing provider, who attended to represent those who work in his organisation, reported that his colleagues often feel that they are being used as a replacement for the work that should really be done by trained professional psychiatric staff.

They also commented on patients not being fully prepared for discharge in terms of welfare benefits and that the feeling was (as expressed by many members of his team) that some clients had been discharged too early.

Many participants felt that better planning for discharge is required in relation to the provision of information and advice, the involvement of support groups and ensuring welfare benefits are in place before people are discharged back into the community. Most participants felt that the planning that took place for discharge often has a very short-term focus and is not really aligned to an individual's long-term needs. Participants felt that better planning would support the individual to recover more quickly and manage their mental health condition more effectively.

One of the participants who attended was a support worker for a hostel. He reported that some of the people that he works with do not have access to a Community Psychiatric Nurse (CPN) six months after being discharged from a psychiatric ward. He believes that this is because they are being supported by support workers at the hostel and because some CPNs are at full capacity, often with a case load of over 200 patients.

A number of people commented that there were not enough joined up assessments at discharge and that some people are discharged with only minimum support and advice.

6.6 More information needed for family members / carers post discharge.

6.6.1 Comments received from older people

One Gentleman reported that his wife was very sick post discharge and he did not know what to do. *"Apparently it is quite normal; as I found out later; but I did not know this at the time – I felt very worried and incredibly anxious."*

He further reported that the district nurse had asked him to perform daily injections for is wife. The gentleman refused because he felt uneasy about it and felt that it was their job to do. He also felt that if he gave the injections, that the district nurses wouldn't visit daily and his wife wouldn't get the support needed.

The gentleman reported that he and his wife felt uneasy because the district nurse did not visit immediately after discharge (they started coming a few days later and were able to resolve the issue regarding the sickness). He felt that if they had come immediately they would have been able to reduce the couple's anxiety.

The gentleman commented that the possibility of his wife's sickness should have been mentioned to him pre discharge, as being his wife's principal carer he should be informed as to what might happen.

One lady contacted us with her view that she believes that patients and relatives are given too much written information and not enough face to face explanation;

"My husband suffered a heart attack resulting in heart failure in April 2013. He was treated excellently in Manchester but discharged to home care on the third day as Chester didn't want to know (our post code is WA), and Warrington had no beds. Home care was me (his wife) who has no medical interest let alone ability.

He has had his first decent GP/patient conversation this last week when he finally decided to ask questions. Issuing leaflets is all well and good, but of little practical use when in the midst of the situation!"

One participant commented that, *"things were difficult,"* in relation to the co-ordination of her mother's care. She felt that different agencies were not talking to each other.

Several participants felt that there was a need for improved communication:

- with patients/service user
- with families and carers
- between care providers and support organisations

6.6.1 Comments from people with experience of a mental health condition

One lady was shocked when she found out that her son was being discharged to home with only two days notice. She reported that her even her son was shocked himself, as prior to this he had only been allowed as far as the grounds of the hospital and this only with supervision. The son, when asked about discharge in his meeting with the psychiatrist, had asked initially to be discharged, maybe for a weekend at first, to get used to coming home and to be gradually re-integrated over a few weeks. However, during these discussions her son was told he was to be discharged in two days time. She commented that ***"If I had been on holiday, my son would have gone back to an empty house and who knows what might have happened?"***

Following discharge he received support from the CMHT. However, this support reduced after a few weeks. Her son was therefore, left in a situation where he was still socially isolated but receiving no support. His mother felt that support should have been provided to get her son into a volunteering role or undertaking regular activities weekly. As a result of no continued support being in place, the cycle started again, and her son has stopped taking medication again.

A mother spoke about her daughter's first contact with mental health services; during a crisis admission to a psychiatric unit six months ago. The only information she felt she was given post discharge was the telephone number of a carer's service and was told to ring them to get support. She has since been able to find out information through research carried out independently and speaking to people providing support services. She felt she would like to have been given an information pack to explain what was going on at the time and what to expect in the coming weeks and months.

It was suggested by the group that more information should be given to people using services for the first time and also to families involved with an individual's care; so they understand what is going on and know what to expect. Some of the participants said if you go onto a cancer ward you are provided with all the information required yet this did not appear to be the case within mental health services.

A mother, who was caring for her daughter, told us that when her daughter was discharged from the psychiatric unit at Macclesfield Hospital, she had been provided with a care plan for her continued treatment. Despite being a named party on the care plan the mother was not notified that her daughter was discharged with a care plan and therefore, had no knowledge of what was contained in it. Because this was her daughter's first admission to a mental health unit, she had no experience of what would normally be provided at discharge.

It was only a few weeks later; when she was receiving carer's support from a local mental health charity that she was informed that her daughter probably left hospital with a care plan, which prompted her to look through at daughter's notes and find the care plan on which was a named party.

A large independent mental health charity in the Cheshire area; Mid Cheshire Mind; expressed the view that people who would benefit from their support, are not provided with enough information about how to find their service. This was endorsed by one of the people attending the workshop (who could have benefited from the support of Mid Cheshire Mind). They were unaware of the service stating that they were not informed that the service was available – ironically, based in their own town (Winsford).

A number of carers also expressed opinions on the support they were given following the discharge of a person they cared for. People told us that carer's respite provision across Cheshire West varies depending on where you live. People feel that individuals get a different level of support in the Vale Royal than that they would get in West Cheshire.

6.7 Mental health Crisis Care

Although not directly relating to unsafe discharge, many of the comments we received during the mental health workshop related to mental health crisis care.

One of the difficulties many people face is that there is no 'fast-track' back into secondary mental health care services during crisis and after they have been discharged. Despite being known to services, people have to go through the process of being re-referred into secondary mental health care services. This can be both time-consuming and adds to people's stress (at a time of crisis).

Participants at one workshop also identified that a potential impact for some people, is that they try to avoid being discharged from secondary mental health services because they don't want to go through the process of being re-referred, if they then require secondary mental health services at a later date when in crisis.

A number of participants told us of difficulties with the crisis team. These participants felt that it was difficult to access this service during a crisis period and that for many was not helping the avoidance of a psychiatric admission.

We were told that people believe that they can't get referred to or receive support from crisis teams at the initial stages of crisis. People commented that the system should provide support to people prior to (and therefore potentially avoiding) admission to a psychiatric hospital.

One lady spoke about her son presenting at A&E and requesting an urgent psychiatric appointment; due to him having to stop taking this medication. This request was refused. He was asked to wait for his next 6 monthly psychiatric appointment (due six weeks later), by which point his health had deteriorated to such an extent that he was sectioned under the Mental Health Act.

Participants felt that access to psychiatric appointments post discharge needs to be more flexible and responsive to needs. ***"It should not be steadfastly set at six months! If somebody has a need for an appointment there should be a way of getting an appointment sooner."***

A Support Worker from a local shelter attended the workshop and said that some of the people that they supported who had presented at A&E in crisis, were also sent away with no support. They said, ***"it felt like they were being punished for doing the right thing."***

In general discussions, the view was that more support and early intervention needs to put in place for people who recognise that they are heading towards crisis and that this would avoid crisis and costly admissions.

Participants also commented that recovery courses run by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Recovery College were often oversubscribed and very difficult to get on. Most of the participants that we engaged with had not been successful in accessing any courses, which they described as being oversubscribed.

Some of the participants within a group discussion; shared experiences of people that they knew who were not able to get a mental health bed during a period of crisis at a local hospital and who were sent to hospitals such as Warrington, where there were beds available.

7. Other comments

During the workshops participants shared with us a number of other comments relating to service provision in Cheshire West and Chester that were welcomed and are noted below;

In relation to Mental Health Services

- One participant who worked for a local shelter reported that they felt that their clients didn't receive the same level of support from CMHT that they would if they lived outside the shelter. They believe that this is because there are people employed in the shelter, who are expected to provide an unrealistic level of support to patients. They felt that this was placing a big burden on support workers who do not receive the same level of training as professionals such as community psychiatric nurses (CPN).
- A number of participants commented on the lack of information that's available to somebody when they are first referred to a psychiatric unit (or come into contact with mental health services). One of the participants, whose daughter came into contact with mental health services for the first time within the previous six months, felt that it would have been really helpful if she had been given some information about what to expect and who to contact for support. We were told in one workshop that local Charity Mid-Cheshire Mind had offered to prepare this information for providers but had been turned down.
- We received comments about the existence of a 'post code lottery' and a lack of rehabilitation and carers support services in the Vale Royal area, following service closures in previous years.
- Some participants reported that there were issues with mental health patients being placed in a psychiatric unit out of area or at distance from family and friends, when no bed is available at their local psychiatric unit.
- A number of participants told us how important peer support was. Two participants attend a local carers group and said that the support that people with experience of a mental health condition provide to each other is invaluable. Another identified that peer support would be of benefit to their son who would be able to speak to other people going through a similar situation.

In relation to other services:

- One participant shared an anecdote about a friend being left on a trolley bed overnight in the corridor of a local hospital.
- Several participants shared the view that there needs to be improved communication between care providers to achieve a seamless service for recipients of care.
- Many participants also felt that the way services communicate with patients and the public needs to be improved.
- More effort needs to be made to ensure that patients, family members and carers are aware of the care pathways that they/their loved ones are on.

- Many participants commented that they didn't understand what care pathway they were on following discharge.
- Many participants feel that there is not enough provision of community physiotherapy appointments; leading to long waiting times.
- Many participants felt that social workers working in teams to support patients do not communicate effectively. The involvement of different social workers visiting patients on different days often causes problems.
- One participant commented that discharge from A&E should put more focus on potential safeguarding issues. Participants who were discharged from maternity wards are routinely asked about any potential domestic abuse issues, however, these questions are not asked in A&E.
- Availability of advocacy services. Many the participants felt that should be greater availability) of advocacy services (and publicity of existing advocacy services) for patients.
- One participant made a comment that he did not believe that the NHS was good at problem solving. The participant believed techniques he used during his career as an engineer could be used to resolve many issues that prevail in the NHS today.
- Many participants commented that service provision changes depending on where you live and that there is a postcode lottery in place determining what services you receive. An example was given around a carer's lunch club. Vale Royal CCG used to pay for two carers lunches per week, one in Winsford and one in Northwich. The funding for the luncheon club in Northwich has been cut and no longer operates.
- One participant commented about their experience of using the 'Out of Hours service' at Leighton hospital with her daughter. They had to wait for over an hour to see a Doctor (despite calling ahead) after which they were discharged with no treatment. The mother felt treatment should have been offered at this time so wanted to pursue a complaint. However, because her daughter was over the age of 18, the Patient Advice and Liaison Service (PALS) told her that her daughter had to consent to a complaint being made (which she didn't do). As a result the mother's complaint about the provider was neither heard nor resolved. As her daughter's principal carer, she feels that she should have been able to make complaint regarding the service.
- A number of participants commented that they felt hospital food was often of poor quality and needed to be improved. They pointed out an initiative being run at Southern hospitals by a TV chef to improve hospital food.

Appendix I - Mental health questionnaire

Special Inquiry Questionnaire
All RESPONSES WILL BE TREATED IN CONFIDENCE
Please write N/A in sections that do not apply.

Have you been discharged from a health or care setting in the past 18 months? **If yes – please complete below.**	**Yes**	**No**
How many times have you been discharged in the past 18 months?		
What type of health or care facilities? What type of ward were you staying on?		
What were you admitted for?		
Did you have any additional health needs at the time? *(i.e. in addition to your primary reason for seeking treatment*)		
How long did your admission last?		

Please tell us what happened when you were being discharged?		
How were you treated by healthcare staff?		
Did you feel stigmatised or discriminated against in any way?	**Yes**	**No**
If you had more than one condition at the time. Do you think they were all considered in the discharge planning?	Please explain…	
Did staff ask you about support available to you from your family or in your community when discussing discharge?	**Yes**	**No**
Did you feel well /ready to be discharged?	**Yes**	**No**
If Yes - Did you feel your discharge had been delayed?		
If No - What would you have liked to have happened and what additional care or time did you need?		

If you feel you were discharged too early, then what do you think were the reasons you were discharged?		
Did you feel involved in the decision to be discharged?	**Yes**	**No**
Were you given a care plan?	**Yes**	**No**
Were you offered any follow up support e.g. benefits or housing?	**Yes**	**No**
If Yes – Please detail		
Do you remember what time you were discharged?	**Yes**	**No**
If Yes - What time?		
Was transport arranged for you?	**Yes**	**No**

Please tell us what happened after you were discharged from the hospital or care facility?		
If you required support for alcohol or drug dependency, were you offered support or treatment following discharge?	**Yes**	**No**
Were you readmitted within 28 days		
For the same reason as your initial stay	**Yes**	**No**
For a different reason	**Yes**	**No**
If Yes - Were you previous reasons for being admitted discussed with you.	**Yes**	**No**
If No - Did you seek healthcare within three months after being discharged for the same or a related problem?	**Yes**	**No**

Please tell us what happened after you were discharged from the hospital or care facility?

-

The following questions may help you plan your account – **not all may apply**.

- Where were you discharged to? (*e.g. home, home with support from crisis team, to somewhere else - where*)
- If you required support for alcohol or drug dependency, were you offered support or treatment following discharge?
- Were you readmitted within 28 days of discharge?
    - For the same reason
    - For a different reason
    - Were your previous reasons for being admitted discussed with you.
- Did you use other health or social care services within three months after being discharged? For example, did you visit your GP?

• How easy was it to access support after your discharge? • How did the care and support you actually received, compare with what you were offered or expected when being discharge from hospital • Were you contacted to find out how you were getting on following your discharge?
Please tell us you personal story in the space below.

What do you think could be improved for people during discharge	
What do you think could be improved for people in your position when being discharged	
What didn't happen when you were discharged that you would have wanted to happen?	
Do you have any examples when you had a better discharge process	

Thank you for taking the time to complete this questionnaire.

Appendix II - Older People's questionnaire

Special Inquiry Questionnaire

All RESPONSES WILL BE TREATED IN CONFIDECE

Please write N/A in sections that do not apply.

Have you been discharged from a health or care setting in the past 18 months?	**Yes**	**No**
How many times have you been discharged in the past 18 months?		
What type of health or care facilities or what type of ward were you staying on?		
What were you admitted for?		
Did you have any additional health conditions at the time (*in addition to your primary reason for seeking treatment*)	**Yes**	**No**
How long did you stay in hospital / care home?		

Please tell us what happened when you were being discharged from the hospital		
How were you treated by health care staff?		
If you had **more than one** condition at the time, do you think they were **all** considered in the discharge planning?	**Yes**	**No**
If Yes, Please explain		
Did staff ask you about support available to you; from your family or in your community when discussing your discharge?	**Yes**	**No**
Did you feel as if you were well enough / ready to leave the hospital at the time you were discharged?	**Yes**	**No**
If Yes - Did you feel your discharge **had been delayed**?	**Yes**	**No**
If No - What would you have liked to have happened?		
What additional care or time did you need?		

If you feel you were discharged **too** early, then **what do you think** were the reasons for you being discharged?		
Did you feel involved in the decision-making process to leave the hospital?	**Yes**	**No**
Were you given a treatment plan?	**Yes**	**No**
Were you offered any rehabilitation or therapy services?	**Yes**	**No**
If Yes, Please detail		
Do you remember what time you were discharged from care?	**Time -**	
Was transport arranged for you?	**Yes**	**No**
Were you given clear instructions regarding your medication?	**Yes**	**No**
Did staff check your understanding regarding the medication?	**Yes**	**No**

Please tell us what happened after you were discharged from the hospital?			
Where were you discharged to? *e.g. Own home, relative, care home etc.*			
If you were discharged to your own home. Did anyone make a home visit prior to your discharge?	**Yes**	**No**	
Did you need any specialist equipment on discharge? *(e.g. chair, raised toilet seat, trolley, crutches etc.)*	**Yes**	**No**	
If Yes - What equipment?			
If Yes - Was this provided?	**At time of discharge**	**Shortly after discharge**	**Days after discharge**
Were you readmitted within 28 days for the same or a related health concern?	**Yes**		**No**
If No - Did you seek healthcare within three months after being discharged for the same or a related health concern?	**Yes**		**No**

Were you readmitted within 28 days for a different health concern?			**Yes**		**No**
If Yes - Were your previous admissions discussed / recent medical history discussed?			**Yes**		**No**
What (if any) intermediate healthcare services did you access after being discharged from hospital? (*e.g. district Nurse, physiotherapy, health visitor)*					
How easy was it to obtain support following discharge?	**Very Easy**	**Easy**	**Not Sure**	**Difficult**	**Very Difficult**
How did the care and support **you actually received** compare with **what you were offered** when you were being discharged from hospital?					
If you were discharged to a care home. Did you feel the home was well equipped to deal with your health and care needs?			**Yes**	**No**	**N/A**
Were any other agencies or organizations involved with your discharge? (*e.g. home care provider, district nurse, British Red Cross, 3rd sector organisation)*			**Yes**	**No**	**N/A**
If Yes – Who was involved?					
Did you visit or were you visited by your GP?			**Yes**		**No**
Did anyone else from a service contact you to find out how you were getting on following your discharge?			**Yes**		**No**

General questions	
What do you think could be improved for people in your position when being discharged from a hospital?	
Do you have any examples when you received a better transfer of care from a hospital or care?	
What would you have wanted to happen when you were discharged, what support would you have liked?	

Thank you for taking the time to complete this questionnaire

Appendix III - Comments received relating to mental health services

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
1	Several participants commented that visits from Community Mental Health Team representatives were limited and often too short. Reporting on this one commented, *"By the time they had sat down for a cuppa it was almost time to go."* The feeling was that community based appointments should be longer. One mother of a service user told us that post discharge her son (who had been in a secure unit for 12 weeks prior to discharge) did not see a CPN for three months after he had been discharged from a secure unit.	CWP Vale Royal CCG West Cheshire CCG
2	One lady was shocked when she found out that her son was being discharged to home with only two days notice. She reported that her son was even shocked himself, as prior to this he had only been allowed as far as the grounds of the hospital and this only with supervision. The son, when asked about discharge in his meeting with the psychiatrist, had asked initially to be discharged, maybe for a weekend at first, to get used to coming home, to be gradually re-integrated over a few weeks. However, during these discussions her son was told he was to be discharged in two days time. She commented that, *"If I had been on holiday, my son would have gone back to an empty house and who knows what might have happened?"* Following discharge he received support from a Community Mental Health Team. However, this support reduced after a few weeks. Following this the son was left in a situation where he was still socially isolated but receiving no support. The mother felt that support should have been provided to get the son into a volunteering role or undertaking regular activities weekly. As a result of no continued support being in place, the cycle started again, and the son has stopped taking medication again.	CWP Vale Royal CCG West Cheshire CCG
3	One participant felt that during the discharge of her son from a secure mental health unit; the medical staff were careful not to ask any anything which could delay the discharge – almost as if they wanted him simply off the books as quickly as possible.	CWP Vale Royal CCG West Cheshire CCG

4	Aftercare given to patients often varies depending on who you see and where you live. One mother said that she felt her son had received a lower level of support as a result of him having a family home to come back to. She felt that those who had no family and nowhere to live, were given a lot more support in terms of intermediate hostel places, benefits and professional help.	CWP CWAC Vale Royal CCG West Cheshire CCG
5	One of the participants reported that her son was in a mental health unit longer than required due to family circumstances - her son not being discharged home due to the presence of a relative receiving care for a terminal disease. He had to wait some time until a bed became available at a hostel, which meant he stayed in hospital longer than he should have done - which led to even more family stress.	CWP Vale Royal CCG West Cheshire CCG
6	A mother who was caring for her daughter told us that when her daughter was discharged from the psychiatric unit at Macclesfield Hospital; she had been provided with a care plan for her continued treatment. Despite being a named party on the care plan the mother was not notified that her daughter was being discharged with a care plan and therefore, had no knowledge of what was contained in it. Because this was her daughter's first admission to a mental health unit, she had no experience of what would be normally provided at discharge. It was only a few weeks later, when she was receiving carer's support from a local mental health charity, that she was informed that her daughter probably left hospital with a care plan, which prompted her to look through at daughter's notes and find the care plan on which was a named party.	Millbrook Unit – CWP Vale Royal CCG
7	We were informed of a problem involving discharge from secondary mental health services, back to primary care mental health services (care of a GP) and that one of the difficulties is that there is no fast track back into secondary mental health care services if people again reach crisis. Despite being known to services, people have to go through the process of being completely re-referred into secondary health care services. This can be time-consuming and adds to people's stress at a time of crisis. Participants also identified that a potential impact, for some people, is that they try to avoid being discharged from sectioned mental health services because they don't want to go through the process of being re-referred if they then require secondary mental health services again when crisis.	CWP NHS England Vale Royal CCG West Cheshire CCG

8	A number of participants told us of difficulties with the crisis team. The participants felt that it was difficult to access this service during a crisis period and that for many was not helping the avoidance of a psychiatric admission. We were told that people believe that they can't get referred to or receive support from crisis teams at the initial stages of crisis. People commented that the system should provide support to people prior to (and therefore potentially avoiding) admission to a psychiatric hospital.	CWP Vale Royal CCG West Cheshire CCG
9	One of the issues that came up during the workshop was that of people not being able to receive support until they reach crisis point, with too much emphasis placed on crisis and not enough resource aimed at prevention of admission. One lady spoke about her son presenting at A&E, and requesting an urgent psychiatric appointment; due to him having to stop taking this medication. This request was refused. He was asked to wait for his six monthly psychiatric appointment (due six weeks later), at which point his health deteriorated to such an extent that he was sectioned under the Mental Health Act. A Support worker, from a local shelter attended the workshop and said that, *"Some of their clients who had presented at A&E in crisis were also sent away with no support."* They said, *"It felt like they were being punished for doing the right thing."* People felt that more support and early interventions need to put in place for people who recognise that they are heading towards crisis and that this would avoid the crisis and later (costly) admissions.	CWP Vale Royal CCG West Cheshire CCG
10	One of the comments we received was from a mother whose son was only being allocated six weeks of rehabilitation from a secondary mental health service. She asked if this is enough?	CWP Vale Royal CCG West Cheshire CCG
11	Many participants felt that better planning for discharge is required in relation to the provision of information and advice, the involvement of support groups and ensuring welfare benefits are in place before people are discharged back into the community. Most participants felt that the planning that took place for discharge often has a very short-term focus and is not really aligned to an individual's long-term needs. Participants felt that better planning would support the individual to recover more quickly and manage their mental health condition more effectively. A number of participants commented that there are not enough joined up assessments at discharge and that some people are discharged with minimal support and advice.	CWP CWAC Vale Royal CCG West Cheshire CCG

Other comments relating to mental health services

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
12	One of the main comments received from the public was about the lack of information provided to people when they are first referred to mental health service. A mother spoke about daughter's first contact with mental health services; during a crisis admission to a psychiatric unit six months ago. The only information she felt she was given was the telephone number of the carer's service and was told to ring them to get support. She has since been able to find out of information through research carried out independently and speaking to people providing support services. She felt she would like to have been given an information pack to explain what was going on at the time and what to expect in the coming weeks and months. One of the managers for a local mental health charity attending the meeting said they offered to partially prepare this information; however, this offer wasn't taken up. It was suggested by the group that more information should be given to people using services for the first time and also to families involved with an individual's care; so they understand what's going on and know what to expect. Some participants said that if you go onto a cancer ward you are provided with all the information required yet this did not appear to be the case within mental health services.	CWP CWAC Vale Royal CCG West Cheshire CCG NHS England
13	One participant felt that access to psychiatric appointments post discharge needs to be more flexible and responsive to needs. *"It should not be steadfast set at six months! If somebody has a need for an appointment there should be a way of getting an appointment sooner."*	CWP Vale Royal CCG West Cheshire CCG NHS England
14	One participant who attended was a support worker for a hostel. He reported that some of the clients that he works with do not have CPN six months after being discharged from a psychiatric ward. He believes this is because the clients are being supported by the support workers at the hostel and is aware that some CPNs have over 200 clients. He further reported that some of his clients who go to A&E with mental health issues are sent away because they are resident in the hostel (and can receive support from the support workers). He said, *"At times it feels like people are punished for doing the right thing!"*	CWP Vale Royal CCG West Cheshire CCG NHS England

15	Service users and relatives of service users commented that they felt those CPN sessions were, *"too limited,"* in that they only covered a short period post discharge. Several individuals commented that on completion of talking therapy sessions, all other treatment seemed to drop off.	CWP Vale Royal CCG West Cheshire CCG NHS England
16	Comment that courses aimed at recovery organised by a local provider are over subscribed and that *"you can never get on one!"* The perception is that places are booked by those who are already on a course, therefore blocking access to those not yet in the system.	CWP Vale Royal CCG West Cheshire CCG
17	The waiting time for some psychological therapies; like CBT (Cognitive Behaviour Therapy); are far too long. Participants feel more needs to be done to train more therapists.	CWP Vale Royal CCG West Cheshire CCG NHS England
18	A large independent mental health charity in the Cheshire area; Mid Cheshire Mind, feels that people who would benefit from their support, are not provided with enough information about how to find their service. This was endorsed by one of the people attending the workshop (who could have benefited from support of Mid Cheshire Mind). They were unaware of the service stating that they were not informed that the service was available - ironically in their own town (Winsford).	CWP Vale Royal CCG West Cheshire CCG NHS England
19	One issue relating to access to mental health services is when people are placed on wards either out of area or far from home; which makes it difficult for family members to visit. An example was shared, where a lady was due to be placed at an outreach unit in Macclesfield which makes it difficult for her husband in Cheshire West to visit without a car. The husband and wife both don't want to be separated and have made requests for this treatment to be done at home.	CWP Vale Royal CCG West Cheshire CCG
20	One participant reported that he had to wait eight weeks for an assessment to receive a diagnosis of Asperger's Syndrome. He had only been provided with brief counselling interventions (time limited) which hadn't helped him to resolve his issues.	NHS England Vale Royal CCG West Cheshire CCG
21	Some participants during group discussion; shared experiences of people that they knew who were not able to get a mental health bed during a period of crisis at a local hospital and were being sent to hospitals such as Warrington where there were beds available during crisis.	CWP Vale Royal CCG West Cheshire CCG NHS England

22	A participant spoke about an historical issue when they called a mental health team run by CWP to cancel an appointment post discharge. They reported that during this call they heard details of another patient's case whilst on the telephone. Another participant shared similar experiences, when somebody they supported phoned the team to cancel an appointment; they overheard the staff team making negative comments about them.	CWP Vale Royal CCG West Cheshire CCG
23	Some participants from the Vale Royal mental health workshop; reported that there used to be rehabilitation facilities in the community locally based, for people to use (as an alternative to staying in a mental health acute ward). These facilities supported people to develop skills on how to live at home. These facilities have since closed down due to funding cuts.	CWP Vale Royal CCG CWAC
24	A number of people told us that provision of carer's respite varies across Cheshire West and depending on which Clinical Commissioning Group (CCG) people receive support from. People feel that individuals get a different level of support in Vale Royal than that they would get in West Cheshire. An example was quoted that there used to be respite lunches provided for carers in Northwich - which have stopped due to the funding now ending.	Vale Royal CCG West Cheshire CCG CWAC
25	Two participants; who attended the workshop, both of whom cared for individuals with a mental health condition and attended a carers support group run by Making Space; felt that the peer support that they provided for each other was very important and *"Is the kind of support that is essential."* Both participants felt it would have been useful for their sons to be offered the opportunity to speak to people in a similar situation to themselves; to be able to see that they are not alone and to be able to witness that recovery is a possibility - to learn from others in a similar situation to themselves.	CWP CWAC Vale Royal CCG West Cheshire CCG NHS England

General comments relating to mental health

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
26	Participants felt that greater resources and support seemed to be offered to people with cancer and flu conditions than those with Mental Health problems.	CWAC Vale Royal CCG West Cheshire CCG NHS England
27	One of the participants are workshop felt that the support she and her husband; who had terminal cancer; received was far better than support her son had received for his mental health condition. The mother felt it was clear that there was more funding in the cancer support services and as a result the support provided was of a far better quality.	CWAC Vale Royal CCG West Cheshire CCG NHS England

Appendix IV - Comments received relating to older people's services

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
28	One lady, who had been discharged following three days in intensive care followed by seven days on a ward, expected at least to have had a visit at home from a district nurse or doctor. *"They might have come round just to check that I wasn't dead!"* She lived alone and relied on friends to bring her out of the hospital. *"They only let me home because I told them that I had a stair lift but no one checked if it was working. I had no visit from a district nurse, thinking this would be organised for me. When I saw my doctor eight weeks later he did not know that I had been in hospital."* The lady expressed deep concerns for those who were discharged under similar circumstances who did not have a close circle of friends to look after them or who did not understand the complications of prescribed medication. The lady had been prescribed 22 tablets a day she felt that someone who had, *"a frail mind"* or who, *"forgot things,"* would find this difficult without supervision. She was basically astonished that having been admitted for a life threatening condition, no health professional visited her at home post discharge	COCH CWAC Vale Royal CCG West Cheshire CCG NHS England
29	A service user, whose husband had been discharged from a Manchester hospital commented, *"My husband suffered a heart attack resulting in heart failure in April 2013. He was treated excellently in Manchester but discharged to home care on the third day as Chester didn't want to know (post code is WA), and Warrington had no beds. Home care was me (his wife) who has no medical interest let alone ability. He has had his first decent GP/Patient conversation this last week when he finally decided to ask questions. Issuing leaflets is all well and good, but of little practical use when in the midst of the situation."*	CWAC West Cheshire CCG NHS England
30	One of the participants shared the experience of when her dad was sent to A&E following a fall in a care home. The father at dementia and was unable to walk. The A&E department had decided to discharge him following a check-up (the nurse wanted to admit, however the on duty doctor felt that this wasn't required). He then waited in an A&E cubical for five hours without been offered any food or drink. A nurse approached his daughter and asked whether their father could be taken home in a taxi. The daughter informed that this was impossible because he couldn't walk and had severe dementia. The daughter later learned from the care home that following this conversation	CWAC COCH West Cheshire CCG

	the doctor called the care home and asked the same question. The care home made it clear this wasn't an option. The family later learned that their father / husband had been experiencing kidney failure since 2007, and that at the time of his admission to A&E, he was entering the final stages of his life. The family wish that they'd been informed at this stage that the father was close to the end of his life so they could start preparing to say goodbye.	
31	On 14th March 2013, whilst on ward 48 at the Countess of Chester Hospital, a family was told that their father was to be discharged to a care home. They were told that even if they objected and tried to take him home they would be overruled. The following Tuesday, their father fell out of his seat at the hospital and fractured is hip during a ward hand over procedure. He required an operation which then delayed his discharge. At this stage his dementia was getting worse. The family asked he if could be discharged to Ellesmere Port Cottage Hospital for respite, before being moved to a care home. This request was refused. In the end he was discharged to a care home on Friday 5th April which was to be his final residence (the family had wanted to place him in another care home, however there were no places available at the time of his discharge and they decided not to relocate him when a place became available). He was not discharged with a discharge letter which should have detailed the support was required by the care home. During discussions to enquire why the hospital didn't send a discharge letter, the hospital said that a letter was not required as they had had a number of conversations with the care home in preparation for the discharge. However, the care home felt a discharge letter should have been provided. The family were caught in the middle of this dispute. The ward that their father was located on was a general older people's ward and the initial reason that he had been admitted was in relation to his diabetes. The family felt that the ward was not suitable to provide support to people with diabetes.	COCH CWAC West Cheshire CCG

32	Gentleman reported that his wife was very sick post discharge and he did not know what to do. *"Apparently it is quite normal; as I found out later; but I did not know this at the time – I felt very worried and incredibly anxious."* Gentleman further reported that the district nurse had asked him to do the daily injections for is wife. The gentleman refused because he felt uneasy about it and felt that it was their job to do. He also felt that if he gave the jabs, that the district nurses wouldn't visit daily. Gentleman and his wife felt uneasy because the district nurses did not visit immediately after discharge (they started coming a few days later and were able to resolve the issue regarding the sickness). Gentleman felt that if they had come immediately they would have been able to reduce the couple's anxiety. Gentleman commented that he felt the issue over possible sickness should have been mentioned to him pre discharge as he would become his wife's principal carer so that he had some knowledge of what could take place.	Wythenshawe Hospital East Cheshire NHS Trust Vale Royal CCG
33	One service user who had experienced discharge from two different hospitals could not believe the differences in approach of each. One lady commented that she had considerable praise for one hospital that had arranged three meetings prior to her mother's discharge – something that did not appear to be repeated at other hospitals in our area. A number of service users could not understand why each hospital seemed to have a different approach.	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG
34	Several service users reported that they did not know would happen post discharge and did not know what they would get in relation to service. One felt that because she was so old, people automatically thought that she had *"Lost her marbles,"* and therefore, ignored her.	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG
35	Families comment that they have little awareness of the discharge process and their options particularly when nursing/care homes have to be considered. Individuals commented that this was particularly relevant, *"As circumstances change."*	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG

36	One of the participants reported that one of the reasons for delays in discharge was *"Due to staff in the discharge lounge being off work with sickness with sickness cover not arranged."*	COCH MCHFT Vale Royal CCG West Cheshire CCG
37	One lady said she had to wait a long time for transport and was not helped to the toilet (she could not walk unaided) another lady reported that she was not spoken to other than when the ambulance men arrived. Other service users commented on the need to maintain a patients wellbeing during the pre-transport period post discharge where, particularly the frail and elderly, may be in a confused state.	COCH West Cheshire CCG
38	Several service users commented on having to wait long periods for suitable discharge transport and that during the waiting period that they were given misinformation on times of arrival etc.	COCH MCHFT Vale Royal CCG West Cheshire CCG
39	Discharge often delayed because people are waiting for community support / equipment/ housing, needs that are not in place.	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG NHS England
40	One service user commented that she had waited in the discharge lounge for six hours without food. Having been in hospital for a week she knew that there was no food at home	MCHFT Vale Royal CCG
41	Patents told us there is often a delay in receiving aftercare, and that they don't receive the services they need quickly enough.	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG NHS England

42	A number of patients commented that having been transferred to a care facility / rehabilitation hospital – it was obvious to them, that the staff at the new establishment were not in receipt of the patients details/needs.	COCH MCHFT Vale Royal CCG West Cheshire CCG
43	People felt that in an electronic age, any GP appointment should be arranged prior to discharge and this would help the patient; being one less thing for them to worry about. People commented that it was often difficult to get a GP appointment at your own home post discharge.	NHS England Vale Royal CCG West Cheshire CCG

Other comments relating to Older People Service Provision in Cheshire West

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
44	Service user commented, *"Things were difficult,"* in relation to co-ordination of her mothers care. She felt that different agencies were not talking to each other. - Greater joined up care is needed	COCH MCHFT CWAC Vale Royal CCG West Cheshire CCG NHS England
45	There are limited appointments for the community physiotherapy service. Some people felt that this is because the service is understaffed.	Vale Royal CCG West Cheshire CCG
46	People felt that occupational therapy appointments were arranged at a time when the family could have little involvement. People felt that it was essential that the family were involved to obtain an optimum recovery pathway.	COCH MCHFT
47	One of the comments made by a participant was that she'd heard from a patent; who did not want to be identified or complain; that her husband had been admitted to A&E and kept in hospital overnight. *"Prior to discharge family members found out that the gentleman had spent the whole night kept on a trolley in a corridor."*	COCH West Cheshire CCG

Appendix V – Other comments received

No	Comments from Particpants	Service Provider / Commissioner (where provided or required)
48	We had a comment about the Out of Hours service at Leighton Hospital. One of the participants accompanied her daughter to Leighton hospital on a Friday evening; when her daughter was heading towards a mental health crisis. After arriving at Leighton hospital they had to wait for an hour to see a doctor. The doctor felt that there was no problem with the daughter and she was sent home without any treatment. Over the weekend, the daughter's condition worsened. The mother told us that her daughter had barricaded the family into the house during the night. On Monday morning the mother and the daughter saw their GP who arranged for the daughter to be sectioned under the Mental Health Act immediately. The mother tried to put in a complaint against the Out of Hours Service. The PALS team told the mother that the complaint needed to come from the daughter who was in no condition to do this and didn't wish to pursue the complaint. So no complaint was made.	CWP MCHFT Vale Royal CCG
49	Opinion of participants that people are often *"Sent on their way,"* (from A&E) – No one seemed to quiz you on home circumstances, possible domestic abuse issues or carers. A professional commented that, *"Maternity issues had to now involve discussion on possible domestic abuse."* It was her opinion that this should be included in all discharges that were relevant.	CWP MCHFT COCH Vale Royal CCG West Cheshire CCG
50	Several participants felt that there was a need for improved communication: • with patients/service user • with families and carers • between care providers and support organisations	All agencies
51	One of the participants felt that hospital food was of poor quality and needed to be improved. He pointed to a new initiative being run at a southern hospital by a TV Chef.	MCHFT
52	Participants told us that they often ended up working with a number of social workers on their case and that this often makes communication difficult and disjointed.	CWAC

53	A family had problems getting a care package from the council to pay for the care of their father, as they had been turned down as being ineligible for support in an initial assessment. The family ended up spending their own money to pay for the care. A final assessment was due to take place as the father was dying. When the council phoned the family to let them know they were coming to assess the family informed him he was dying, they were told she would be entitled to immediate support now.	CWAC
54	We received comments that people need access to advocacy services when they are using health and social care services after discharge	CWAC
55	Participants in the group commented that more people are becoming homeless due to less support being available in areas such as tenancy support.	CWAC
56	A general comment made by one participant at a workshop, was that the health service do not understand problem solving expressing the view that many of the problems encountered post discharge could be resolved with the implementation of problem solving techniques.	NHS England Vale Royal CCG West Cheshire CCG
57	A number of service users also commented on some difficulties getting an appointment for other services.	Vale Royal CCG West Cheshire CCG