

Effective discharge from hospital: multi agency discharge seminar - the patient journey

November 2017



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1. Introduction

Healthwatch Coventry is the independent champion for health and social care in Coventry, providing information and advocacy services and arguing for the interests of local people in how services are run and planned.

Healthwatch Coventry sets an annual programme of work.

As a result of intelligence gathered through outreach and links with local voluntary sector organisations the Healthwatch Coventry Steering Group added a piece of work related to hospital discharge to the 2016-17 work programme. This looked at effective hospital discharge and the impact of communication of home circumstances. The Steering Group then agreed that follow up work should be carried out in 2017-18.

Healthwatch Coventry has also conducted ward visits looking at person-centred communication in general, including that relating to discharge¹. This found that patients and relatives were not very aware of estimated dates of discharge. We expected more involvement of relative and communication around discharge than patients and relatives described.

Healthwatch is also regularly asked by the Care Quality Commission (CQC) to feed in local intelligence and has been asked to do this as part of the CQC inspection of the Coventry Health and Care system in December 2017 -January 2018. This inspection will include Delayed Transfers of Care.

2. Context - Healthwatch work in 2016

Effective hospital discharge has been a topic of concern locally for some time in order to ensure a better flow of patients into and out of University Hospital Coventry. New initiatives have been used including 'perfect weeks' amended processes, development of interagency working and discharge to assess pathways.

In May 2016, Healthwatch Coventry held a focus group of front-line voluntary sector workers to understand the role of communication of home circumstances for successful discharge. This was followed by further one to one discussions.

Healthwatch Coventry published a report of the findings in February 2017 (including content from University Hospitals Coventry and Warwickshire (UHCW) on initiatives introduced since the focus group²).

¹ Patient centred communication on hospital wards Full Report (October 2017) www.healthwatchcoventry.co.uk/hospital-services-0

² Effective discharge from hospital: the role of communication of home circumstances (February 2017); www.healthwatchcoventry.co.uk/hospital-services-0

This report was discussed at UHCW's Strategic Patient Experience and Engagement Committee (PEEC) meeting in April 2017, with UHCW's formal response following shortly after.

One of the recommendations was that *“Through Healthwatch Coventry, front-line workers from Age UK Coventry, Carers Trust, Citizens Advice Coventry and the Law Centre meet with the Discharge and Therapy Leads from UHCW later in 2017 to review the direction of travel and provide constructive feedback on the patient experience and how this can be improved.”* Therefore, this seminar was organised in October 2017.

New discharge to assess pathways have been introduced in Coventry (see appendix 4), the aim being to assess patients' ongoing needs for care once they are either back within their home environment or within a short-term residential placement.

University Hospital Coventry and Warwickshire discharges between approximately 1200 and 1350 people per week.³

3. Aims of this piece of work

This seminar aimed to:

1. Better understand recent initiatives to improve communication within discharge processes in terms of specific pathways
2. Gather insights into how these initiatives are reflected within patient experiences
3. Identify the learning and how this can be applied to further improve discharge processes

The session plan can be found at appendix 1.

4. Method

4.1 Participants

There was a good attendance at the seminar on 17 October 2017:

- the hospital - University Hospitals Coventry and Warwickshire (UHCW) - and NHS community services provider - Coventry and Warwickshire Partnership Trust (CWPT)
- the NHS commissioner - Coventry and Rugby CCG - and the social care commissioner - Coventry City Council

³ Excludes day case, people who do not stay 24 hours, and deaths

- key local voluntary sector organisations with roles of either supporting people (Carers Trust and Age UK Coventry) or supporting people if discharge has not worked well (CAB and Coventry Law Centre)

West Midlands Fire Service also attended because they had recently started a pilot service taking people home after discharge from A&E

A full list of attendees can be found at appendix 2.

4.2 Questions we asked

The focus was on following the patient's journey from admission to discharge, including considering those who will need some support after discharge (approximately 20% of patients), and using post-it notes to record comments relating to four key questions:

1. risk of discharge falling down?
2. involvement of patients and carers?
3. evaluation - how do we know the discharge process is working?
4. being clear where is it funded from?

A summary of the wallchart including the post-it notes is at appendix 3, with questions (3) and (4) merged.

5. Findings

5.1 Overall interagency approach to discharge

A) Joined up processes

Attendees showed a clear understanding of how processes should be working, but it is less clear how agencies know it is working as described.

A key question was raised early in the discussion about the involvement of GPs in the process - and the information they get is mainly clinical and at the point of discharge (a discharge summary). The GP is then however in the position where care may be handed over to them in the community once the patient is discharged.

A lot of the work, as described by seminar participants, sits with the Integrated Discharge Team at UHCW. It is therefore really important that this team is able to make the right links with other organisations to facilitate effective discharge and that the communication flows are good. They need to be supported to be able to take a

Questions for discussion and Issues raised

More consideration needed of gathering and hearing evidence of the reality (from partner orgs and patients)

Within the multi-disciplinary team how could there be GP input earlier

How is this working and how will it be reviewed?

How does it support the work of the Integrated Discharge Team?

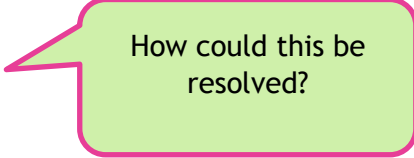
wider view - beyond the hospital and the immediate task of the hospital discharge process.

There is a new initiative: the Discharge Hub - this is an inter-agency forum for discussing individual patients e.g. 160 patients on progress chase at any one time and 40 daily Delayed Transfers of Care (DTC).

B) Communication challenges

The speed with which patients now go into and out of hospital has increased as new approaches are used. As patients are in hospital for shorter periods of time (perhaps 24 hours) it is challenging for hospital staff to complete all the necessary steps for discharge and communicate effectively.

There can also be communication issues if patients' circumstances have changed.



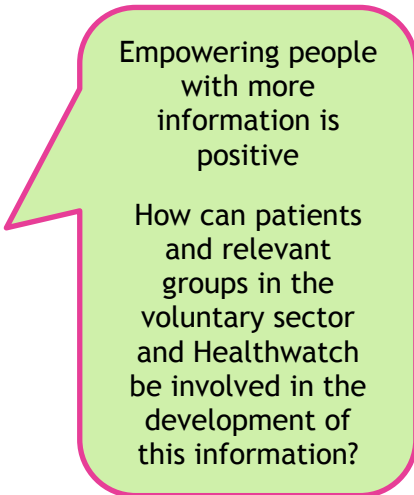
How could this be resolved?

5.2 Communication with patients and relatives

A) Patients

UHCW said that a number of ideas were being developed to support communication with patients regarding discharge:

- Patient discharge leaflet - following discussion about the roles of other organisations including voluntary sector work it was suggested that this could reference useful organisations
- A summary sheet to be given to the patient
- Patient booklet on the patient journey



Empowering people with more information is positive

How can patients and relevant groups in the voluntary sector and Healthwatch be involved in the development of this information?

B) Relatives

During the discussions, the importance of patient consent to pass on information (for those patients with capacity) was flagged a number of times by the hospital.

Voluntary sector organisations and Healthwatch stressed how vital family carers/relatives could be for successful discharge and the important part they should play in the process.

Healthwatch understands the importance of consent but wonders if this might be being over referenced and acting as a barrier to communicating with relatives. It may also be the case that patients temporarily do not have capacity or understanding due to their illness.

It was noted that relatives and family carers do not know whom they should speak to on hospital wards to get information and that as relatives usually visit in the evenings they rely on nursing staff to have information or to broker contact with others such as doctors. This does not always work well.

Healthwatch Coventry found some frustration and confusion from relatives when asked about communications during Enter and View visits carried out in March and August 2017.

There is a need for more work here to ensure that barriers and practicalities are addressed

The new written information resources may help

5.3 Continuing Healthcare (CHC)

This is NHS funding for those who are assessed as having an ongoing health care need. A process involving a checklist on wards for initial assessment was described by UHCW whilst commissioners said that CHC assessment is not done in acute trusts now due to patient circumstances being likely to change after discharge.

Healthwatch raised concerns from a recent case whereby a person at the end of their life had experienced delays in assessment meaning their CHC package started only three days before they died. This assessment was not done in line with the timeframes described by seminar participants.

Healthwatch is looking at communication with patients regarding CHC as a separate piece of work (working with CRCCG).

More work needed to ensure consistent and timely CHC assessments

Clarity needed about patients at end of life and an effective fast track process for them

Monitoring of timeframes for assessment is important

5.4 Dementia patients

Some issues were highlighted regarding the discharge to assess process for people with dementia with a recent instance of support not being in place straight away after discharge.

A potential topic for future discussion

5.5 Holistic Assessment

There were indications from the hospital Social Work Team that they look holistically to include a person's partner, husband or wife who acts as their family carer as part of the assessment process.

It is unclear how this sort of approach might work for other assessment processes related to discharge.

Finding more ways to understand home circumstances and the interdependences of couples who both have long-term health issue will support discharge that is more effective

5.6 Support post discharge

Within the seminar, less time was spent discussing the part of the patient journey once they have left hospital.

The recently introduced pathways, which aim to discharge and then assess ongoing care or healthcare needs, were seen as a crucial step for efficient discharge from hospital and reducing discharge delays (see appendix 4).

More consideration of how to evaluate these from a patient's point of view and patient outcomes is needed

These were described as having benefits for patients in terms of assessments taking place once patients had potentially recovered further and reducing time spent in hospital, which for frail patients could adversely affect their overall strength and mobility.

Some concerns were raised regarding patient/relatives' expectations around length of hospital stay and understanding of what the discharge to assess pathways are working to achieve.

Need for work on how to communicate these sorts of messages to patients/relatives well

There was no clear answer to the question of who co-ordinated someone's care once they return home. Voluntary sector participants and Healthwatch highlighted how confusing it could be for individuals and family carers to understand who to contact and which organisation was doing what. Often communication was not at the right level as it presumed a level of understanding of 'the system' which individuals are unlikely to have.

Should be a key consideration for the new Out of Hospital contract (led by CWPT/SWFT) which begins from 1/4/18

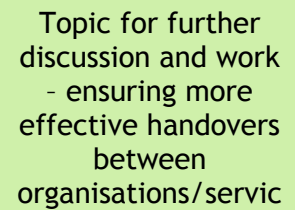
A social worker follow up call was mentioned but it was also stated that the social work team at the council is supporting 4000-5000 people at any one time.

What information should be produced to help patients/ family carers navigate and know who has been to see them, and why, and who to contact if there is a problem?

It was acknowledged that handovers/handoffs between NHS and social care organisations were points when care could fall down.

The strengths of voluntary sector organisations in looking at the whole individual and the different issues they face were recognised. VCS organisations often work to help individuals navigate and receive joined up care.

The active referral systems used by many voluntary sector organisations were contrasted with signposting. Active referral makes sure the information is received and acted upon by the recipient organisation, whereas signposting relies on the patient or family carer making the connection.



Topic for further discussion and work
- ensuring more effective handovers between organisations/service

6. Conclusions

The feedback from participants about the usefulness of the seminar was very positive and this session could be the springboard for further interagency discussion of a similar format.

Organisations were keen to demonstrate they are working together. The value of the multi-disciplinary team was acknowledged along with the value of voluntary sector involvement such as Age UK Coventry. However, it was also recognised that not all voluntary sector organisations could take part within the multi-disciplinary Team (MDT) and therefore consideration of communication channels and opportunities for problem solving are important.

However, sometimes leaders from different organisations may be describing how *it should work* rather than the actual reality for patients. Voluntary sector participants brought some case examples highlighting real experience of how the processes actually worked for some individuals. Within the seminar we collected relatively few examples of how the various organisations involved within discharge process check that it is working from the patient's point of view or from the perspective of other organisations. The focusing on '*this is how it works*' could be a barrier to more open conversations, problem solving and acknowledging that processes do not always work in the way intended or may have unintended consequences.

There should be further discussion regarding seeming gaps around care co-ordination once a patient is back within the community. This is important as the new models of service delivery are developed by CWPT and SWFT as they begin and implement the contract for Out of Hospital Services starting in April 2018. This contract focused on patient outcomes provides excellent opportunities to do things differently, ensuring a more joined up approach. Patient, carer and voluntary sector input to this design is very important at all stages.

The voluntary sector's holistic person-centred way of working is a strength - voluntary organisations are used to working in a way, which seeks to resolve a range of issues for individuals and connect them with other support as needed. The NHS acute model of care is more linear: see patient, treat, and discharge. VAC co-facilitated with UHCW a workshop in November 2016 - *Better Outcomes In and Out*

of Hospital - which showcased joint working between clinicians and voluntary organisations on frailty, alcohol abuse and respiratory disease, with a 'speed dating' format and quick-win actions to enable new connections to be made.

We did not have a GP within the discharge seminar and this would be useful within any future discussions as a lot of the conversation within the seminar focused on processes within UHCW in preparation for discharge - starting at the point of admission. Decision-making on who funds packages was only touched on briefly.

7. Recommendations

Healthwatch Coventry makes the following recommendations to the local system of providers and commissioners. Coventry and Rugby CCG should take the lead on ensuring these recommendations are addressed in their role as commissioner.

This report and recommendations is also very relevant for the Coventry and Warwickshire Better Health, Better Care Better Value (STP) Board and STP work themes especially out of hospital services.

1. Further work is undertaken to link the local voluntary and community sector providers to the Out of Hospital programme of work for the benefit of patients, including a follow-up VAC voluntary sector seminar to consider some of the points raised regarding better joined up working and communication with the voluntary sector.
2. Patients and family carers to be involved in the design and content of new information aimed at patients and relatives/careers to provide useful information and a guide to discharge before and during the hospital discharge process.

In addition, there must be consideration of how to empower service users and their family carers with information once people are within their home or community setting. There should be a focus on helping people to know who to contact and the steps in their plan of care.

3. There is work to follow up on the issues highlighted in the discussion (see the speech bubbles in the report and further discussion takes place between agencies as needed.

There is potential for more Healthwatch work regarding patient experience and communication and this will be considered by the Healthwatch Steering Group once the results of the CQC's System Review are known in 2018).

8. Acknowledgements

Thank you to Voluntary Action Coventry for organising and facilitating this seminar for Healthwatch Coventry and to all the organisations, which provided input and gave time to take part.

Appendix 1: session plan

Format

Walkthrough of discharge pathways, with partners sharing learning. The room will be arranged as a horseshoe of 15-20 chairs, facing one wall which will be covered in sticky brown paper - we'll use marker pens and cards to draw out on the wall the patient journey along the pathways and who talks to who. Our emphasis as Healthwatch is on the patient experience and perspective.

Observations from delegates will be added as we go along using coloured post-it notes to pick out key points for:

- risk of discharge falling down
- involvement of patients and carers
- evaluation - how do we know the discharge process is working?
- being clear where is it funded from?

10.00	<p>Welcome & introductions & brief recap:</p> <ul style="list-style-type: none"> • the research process & broad findings • recent ward-based work on person-centred communication by Healthwatch
10.10	<p><i>Session 1: An older person with a long-term condition and living in their own home <u>without</u> a care package in place is admitted into hospital. They will be in need of some support in order to return to their own home.</i></p> <ul style="list-style-type: none"> • How are the patient pathways meant to work - who communicates with whom, starting from the conversations with the patient? • What insights do we each have on patient experiences of these pathways?
11.00	<p>Quick review: Have we identified all the key points on the patient journey for:</p> <ul style="list-style-type: none"> • risk of discharge falling down? • involvement of patients and carers? • evaluation - how do we know the discharge process is working? • being clear where is it funded from?
11.10	Refreshment break

11.20	<p><u>Session 2</u>: How would the patient journey along these pathways differ for the following:</p> <p><i>a) An older person with a long-term condition and living in their own home <u>with</u> a care package in place is admitted into hospital, but there is a question over whether this package is suitable for their return to their own home?</i></p> <p><i>b) An older person with a long-term condition and living in a residential care home?</i></p> <ul style="list-style-type: none"> • What insights do we each have on patient experiences of these pathways?
12.20	Reflections from each attendee on usefulness of today's exercise and what learning has been achieved
12.30	Closing comments and thanks

Appendix 2: attendees

Balwant Nahal	Head of Casework Services	Citizens Advice Coventry
Diane Eltringham	Associate Director of Nursing for Professional Standards	University Hospital Coventry and Warwickshire (UHCW)
Diane Hawtin	Head of Service, Therapy	University Hospital Coventry and Warwickshire (UHCW)
Fiona Rickards	Clinical Commissioning Manager	Coventry and Rugby Clinical Commissioning Group (CRCCG)
Ian Bowering	Head of Social Work (Prevention and Health)	Coventry City Council
Ian Smith	Station Commander, Binley	West Midlands Fire Service
Jim McCabe	Director of Services	Age UK Coventry
Jo Morris	General Manager (Integrated Community Services)	Coventry And Warwickshire Partnership Trust (CWPT)
Joanne Adams	Head of Core Services	Citizens Advice Coventry
Kerrie Manning	Integrated Discharge Team Leader	University Hospital Coventry and Warwickshire (UHCW)
Laura Duffy	Occupational Therapist	Carers Trust Heart of England
Natasha Ramrous	Healthwatch ICAS Caseworker	Coventry Law Centre
Rae Bottrill	General Manager, Hospital Social Work Service	City Council
Rajo Saira	Services Manager Helping Hand at Home and Hospital Services	Age UK Coventry
Rob Allison	Director of Policy & Partnership (<i>Seminar Co-Facilitator</i>)	Voluntary Action Coventry (VAC)
Ross Palmer	Associate Director of Nursing, Operational Projects & Discharge (<i>Seminar Co-Facilitator</i>)	University Hospital Coventry and Warwickshire (UHCW)
Ruth Light	Healthwatch Chief Officer	Healthwatch Coventry
Sarah Roscoe	Care Manager	Carers Trust Heart of England
Vicky Hackett	Head of Urgent Care	Coventry And Warwickshire Partnership Trust (CWPT)

Appendix 3 - Healthwatch Discharge Seminar 17 October 2017 - the wall chart

	Entry to UHCW via ED	Initial / further assessment	Working up discharge routes	Getting discharge completed	Support at home being implemented	Keeping the support at home working
Cards describing the process	<p>REACT team assesses</p> <p>GP screens for frailty</p> <p>MDT on ED assess home circumstances</p>	<p>Physio & Occupational Therapists and IDT screen</p> <p>Continue REACT assessment</p> <p>Integrated Assessment Form with progress chasing through IT system</p>	<p>MDT ward rounds; Nugensis Wardview IT system; strategies include Red 2 Green, Pyjama Paralysis and SAFER</p> <p>Referrals to IDT, Social Care, Age UK, CHC, District Nurse</p>	<p>Discharge Hub</p> <p>Date for discharge confirmed</p> <p>Getting equipment in place and transport and TTOs</p>	<p>Electronic handover of information to GP re: what has been done and what the care plan is</p>	
Risk of discharge falling down	<p>If we have concerns about the patient's mental capacity we will provide signposting information for carers for Age UK, Carers Trust, Alzheimer's Soc, etc</p>		<p>Caseworker is key to preventing communication breakdowns; Questions raised about info. flow to GPs who may not be involved until after discharge - Electronic Patient Records will make this easier in future.</p>	<p>Carers Trust - it can be a big risk to bring someone home too soon, before the support is properly in place</p> <p>CAB - Social Care assessments not always timely - some people discharged without support</p>	<p>Healthwatch client at end of life had waited over 5 weeks for CHC assessment. Discharge 2 Assess (D2A) should do this within 2 weeks away from the acute setting through Intermediate Care Team - every patient on Pathway 3 is allocated a case manager and tracking info. is shared with Social Care.</p>	<p>Question of who coordinates care once patient is in the community - can be a gap</p> <p>How CWPT is commissioned does not always help this - new Out Of Hospital (OOH) contract from April should help by being more flexible including Single Point of Access for triage, reducing referral paperwork and speeding up support.</p> <p>Shortage of Band 5 nurses so skilling up Band 2-4.</p>

	Entry to UHCW via ED	Initial / further assessment	Working up discharge routes	Getting discharge completed	Support at home being implemented	Keeping the support at home working
Involvement of patients and carers	<p>Family and carers involved in this discussion - in person or by phone</p> <p>Healthwatch ward visits showed low level of involvement and awareness around discharge planning</p> <p>Hospital staff said it is about patient capacity to give the answers and not all patients want you to speak to their family carers - we cannot override the wishes of the patient if they have capacity</p>	<p>Integrated Assessment Form is completed with patient or next of kin if the patient cannot answer and covers home circumstances including family carers, steps, toileting, etc.</p> <p>Needs of family carers form part of the initial discussion</p>	<p>Work planned and ongoing to develop information resources</p> <p>The patient receives within their Discharge Care Plan contact details of the organisations the patient has been referred to, and Patient Booklet idea to guide people through the patient journey.</p> <p>Discharge team flag up which patients will need a lot of family involvement.</p> <p>Hospital Social Worker will start the conversation if they know the family.</p>	<p>Healthwatch ward visits did not find many patients and relatives who understood who to speak to and families needed to be proactive?</p> <p>That is because the nurses are the first point of contact for families for identifying whom the right person to speak to, as this will depend on what the family need to know.</p> <p>Some family members will have information, some will not - cannot speak to everybody.</p>	<p>Age UK - things fall down when the patient has mental capacity but not the physical capacity and does not give a realistic assessment of what support they will actually have and does not want to be a nuisance.</p> <p>Carers Trust had a situation where self-discharged person had been at home 4 or 5 days without any support, complete breakdown of communication between hospital and community services.</p>	<p>If the discharge is very quick, the full Carers Assessment will follow later.</p> <p>Difficult to have a named Care Coordinator once the person is at home but do have this within the IDT and looking at this as part of OOH work.</p> <p>CAB - offers support with financial aspects such as maximising the patient's income to maximise their care options and ability to stay in their own home for longer</p>
How do we know the discharge process is working?	<p>Within hours of admission, we are planning discharge. If alarm bells ring about how the patient will cope at home, we start to have those conversations. Having different voices involved is important but these are dependent on having working relationships in place.</p>		<p>The Estimated Discharge Date (EDD) should be communicated throughout the process. The patient journey should be recorded in the patient notes. Daily ward rounds and electronic systems are used to track when the patient is ready for discharge.</p>		<p>Social Worker will put in a follow-up call the day after discharge and will notify Community Social Work Teams and CWPT if not going well and additional support needed. Brokerage team work with Social Care and have good knowledge of providers.</p> <p>Opportunity to use more non-medical solutions from the voluntary sector such as social prescribing</p>	

NOTES				
CHC - Continuing Healthcare	EDD - Estimated Date of Discharge	MDT - Multi-Disciplinary Team	REACT - intermediate care team	SAFER - see below
ED - Emergency Department (A&E)	IDT - Integrated Discharge Team	OOH - (care) Out Of Hospital	Red2Green - getting patients up & moving	TTO - Tablets to take away
<p>It was pointed out that:</p> <p>80% of patients do not need support to be set up in order to be discharged. Where patients do need support, sometimes relatives expect the patient to be in hospital for much longer but the discharge may be completed in 24 hours. Public perception may reflect NHS discharging people too soon to free up the bed, rather than better patient outcomes from earlier discharge (e.g. less muscle wastage).</p> <p>Volume of work and fast pace can make clinicians' time with patients more limited but Age UK can feed in information gained from informal conversations with the patient, bringing a non-clinical perspective on that person's home circumstances but this is only achievable by being part of the MDT.</p> <p>City Council social work team supporting 4000-5000 people at any one time.</p> <p>Hospital social work team - focus is on those who already have a social care package, do not get involved in assessment of new service users.</p>		<p>S - Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.</p> <p>A - All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.</p> <p>F - Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.</p> <p>E - Early discharge. 33% of patients will be discharged from base inpatient wards before midday.</p> <p>R - Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days - 'stranded patients') with a clear 'home first' mindset.</p>		

Appendix 4: Discharge pathways

(Information supplied by Coventry and Rugby CCG)

Pathway 1	Pathway 2	Pathway 3
Home with short term package of Care: With or without Therapy	Therapy based bedded units in care homes and HWC with the aim to return home.	Period of Assessment to determine long term needs
<p>Home based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation.</p> <p>In addition, therapy based support to improve mobility and transfers to regain independence.</p> <p>Telecare: Std packages</p> <p><i>Social Care gate keep access to provision</i></p>	<p>Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. This pathway is also for patients where safety between calls and overnight needs to be considered.</p> <p>In addition, therapy based support to improve mobility and transfers to regain independence.</p> <p><i>Social Care gate keep access to provision</i></p>	<p>Patients that require a period of assessment outside of an acute setting to determine their long term care and support needs. Options are;</p> <ul style="list-style-type: none"> • Home (POC) • Residential Home • Nursing home • Unstable Fractures • Non Weight Bearing (NOF) • CNRT <p><i>Provider access and management by CCG</i></p>
Case Manager: IDT / React / Social Care	Case Manager: IDT/REACT/ Social Care	Case Manager: IDT / Social Care with CCG

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