healthwatch

Healthwatch Hartlepool

Hospital Discharge Report

March 2024

Contents

Executive summary

Hartlepool is one of the most deprived areas in England, ranked 18th out of 326 local authority areas and with 7 of the 12 wards in Hartlepool amongst the 10% most deprived in the country.

Healthwatch Hartlepool recognises that many people in Hartlepool are significantly affected by health inequalities and high levels of ill-health. The delivery of supportive and appropriate hospital discharge services in the town are vital and play a major part in ensuring patients experience and subsequent recouperation are maximised.

On completion of our Hospital Discharge report in March 2023 various recommendations were made and Healthwatch Hartlepool undertook to re-visit the service early in 2024 to speak to patients and assess how the service has developed over the past year.

In order to achieve this, we re-launched our on-line patient survey which ran for six weeks during January and February. We also contacted care homes in Hartlepool and asked for an update on their experiences of resident being discharged home in the previous year. Four visits to the Discharge Lounge at North Tees Hospital were undertaken by Healthwatch Hartlepool staff and volunteers during the first two weeks of February with a view to speaking to patients and staff and observing the discharge process in action. Updates were also provided by North Tees and Hartlepool Hospital staff as to work that has been undertaken and changes that have been actioned since last March.

The summary below shows the recommendation which were made in the March 2023 report and an assessment of progress against each one based on findings from our recent survey work and patient engagement. Appendix 1 contains the Trust's Action Plan which was developed from the recommendations in last year's report and their own assessment of progress made. We have used the same Red-Amber-Green (RAG) rating to illustrate our assessment of progress and highlight any areas in which we feel further work is still required.

Recommendation	Findings	Progress
1. Communication and involvement of patients in planning their discharge and subsequent post discharge care arrangements happens consistently as per policy and national guidance.	1.Significant number of patients told us discussions about discharge are not happening until the morning of their discharge from hospital. Others said they had been well informed and involved from early stages of admission. 2. The Trust has generally been working well with Hartlepool Carers over the past year, and a representative from the organisation is regularly on-site. This has helped carers to access support and information on a variety of issues including discharge. 3. Need to ensure consistent approach to discharge discussions/planning across all wards.	Amber Green

2.Improved Information outlining the discharge process is produced and made available to all patients entering NTHFT,	1. Trust has produced an excellent patient information leaflet – Planning Together and Leaving Hospital – Discharge Advice which was released in November 2023. 2. Engagement with patients revealed that very few patients spoken to in the Discharge Lounge were aware or had seen the leaflet. 3. Need to promote consistent usage of leaflet across all wards.	Green Amber
3.Ensure patients are informed of the availability of post discharge support services	1.Several patients referred to discussion regarding ongoing support which had taken place before leaving the ward. However, some were unclear about arrangements for ongoing support post-discharge and greater consistency is still required. 2. The scope of this report does not cover the ongoing development of virtual wards and community based patient monitoring but progress in this area has been noted.	Amber Green
4. Alternative/easy read formats	1.The Planning Together and Leaving Hospital leaflet is available in a variety of formats which is advertised on the leaflet itself. 2. Several patients commented that they had not heard clearly information they were being given on wards about their discharge, and clear understanding of arrangements had not been checked.	Green Amber
5.Ensure principles of Johns Campaign are consistently integrated into discharge planning/arrangements	1.Discharge Lounge staff team actively supported patients who presented with memory issues or learning disabilities and whenever possible fast accelerated through the discharge process. 2. Two cases of patients arriving in Discharge Lounge unaware of where they were or what would happen next, and one person with a learning disability left alone and became very anxious waiting for transport. 3. Greater consistency of approach and, on occasions additional support for vulnerable people.	Green Amber/Red Amber
6. Wherever possible, patient transport and medication arrangements are finalised and in place prior to day of discharge.	1. Medication delays are still the main reason for extended stays in the Discharge Lounge. Progress was noted through the introduction of Pop-Up ward based pharmacies and arranging for patients to receive non-controlled medication later in the day via volunteer driver. Discharge Lounge staff were also seen spending significant amount of	Amber/Red

	time chasing up medication with pharmacy and wards and keeping patients updated as to progress. However, delays persist, particularly for patients who arrive in the Discharge Lounge around lunchtime when the hospital pharmacy closes between 1pm and 2pm. 2.Patients leaving the Lounge by ambulance also experienced long delays (in two cases 4+hours). Ambulance availability is limited for discharge and can be further reduced when service pressures are high. 3. Volunteer drivers are an excellent resource and patient feedback about previous experiences was very positive. 4. Family members were the most frequent provider of transport home. On several occasions this was complicated because of poor communication regarding likely time of discharge, which was particularly problematic when time out from work was required.	Red Green Amber
7 Pharmacy Issues	See comments in 6	
8. Discharge via the Discharge Lounge	1. We observed a significant increase in patient throughput at the Discharge Lounge which is clearly now being more extensively used than at the time of our previous visits in 2023. 2. The Transport Hub was never open during the time we spent conducting our visits. This was down to staffing issues and patients finding it cold in the winter months. Consideration should be given to its future viability, location and usage.	Green Red
9.Location of the Discharge Lounge	1. The location of the Discharge Lounge remains the same and the issues previously highlighted about its lack of suitability remain the same. Urgent consideration must be given to re-location in conjunction with issues regarding the usage of the Transport Hub highlighted above.	Red
10. Discharge Lounge Staffing Levels	1. Issues identified around staffing levels and the need for a dedicated staff team in the Discharge Lounge have been addressed and the improvements new arrangements have brought to patient experience noted.	Green
11.Communication with care homes and care providers.	1.Feedback from care homes suggests that whilst some progress has been made around communication, there is still work needed to improve the timely	Amber

	flow of information between wards and the hospital in order to ensure timely, safe and efficient discharge is the norm. Regular presence at the quarterly Care Home Manager Forum should be considered.	

We hope the table above provides a useful summary of the areas in which progress has undoubtedly been made but also highlights key areas in which further action is still required.

Background

Hospital Discharge Patient Experience 2024 Review

In 2023 Healthwatch Hartlepool conducted a major investigation of hospital discharge from North Tees and Hartlepool Hospitals following concerns received from patients, family members and carer providers with regards to experience of the discharge process and subsequent care provision. Following our investigation, a report was produced which made a series of recommendations around changes and developments we considered were needed in order to improve care provision and patient experience of the discharge process.

In response to our report, an action plan was put in place by the Hospital Trust to address issues raised and it was agreed that Healthwatch Hartlepool would conduct a short review of progress made against recommendations made during January and February 2024.

The review process included an on-line survey which gathered patient/carer feedback of experience of discharge from hospital in the previous year. This was followed by four visits to the Discharge Hub at North Tees Hospital and a re-run of our Care Home survey to ascertain care provider experience of discharge of residents back to their home.

The report combines survey findings and discussions and observations made during our visits to the Discharge Hub to assess and comment upon how far recommendations made in 2023 have been implemented and the subsequent impact on patient experience.

“People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes.”

Hospital Discharge and Community Support Guidance (DHSC – March 2022).

Aim of review

- To provide constructive patient, family member and carer feedback of recent experiences of hospital discharge, and the extent to which this has changed over the last twelve months. The study focused on those patients whose experience of discharge falls into pathways 0, 1 and 2 in the diagram below as no patients on pathway 3 were identified during our investigations. Pathways 1, 2 and 3 are

usually referred to as complex discharge procedures as patients leave hospital with some level of ongoing health or social care need.

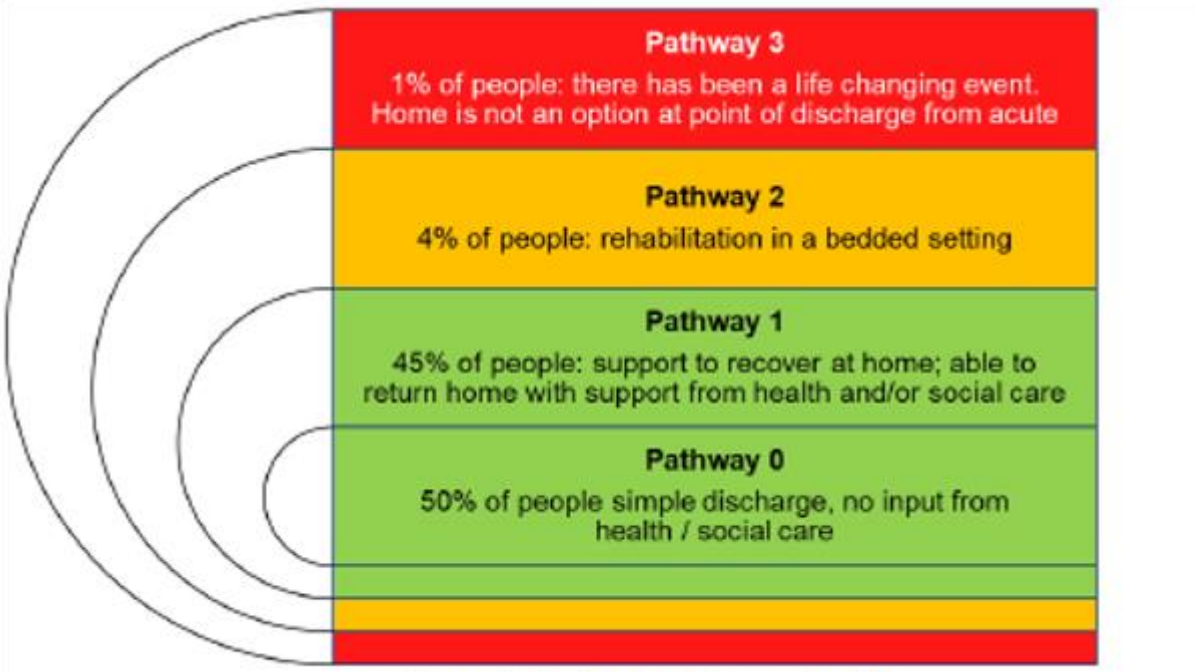


Figure 1: Discharge to Assess model

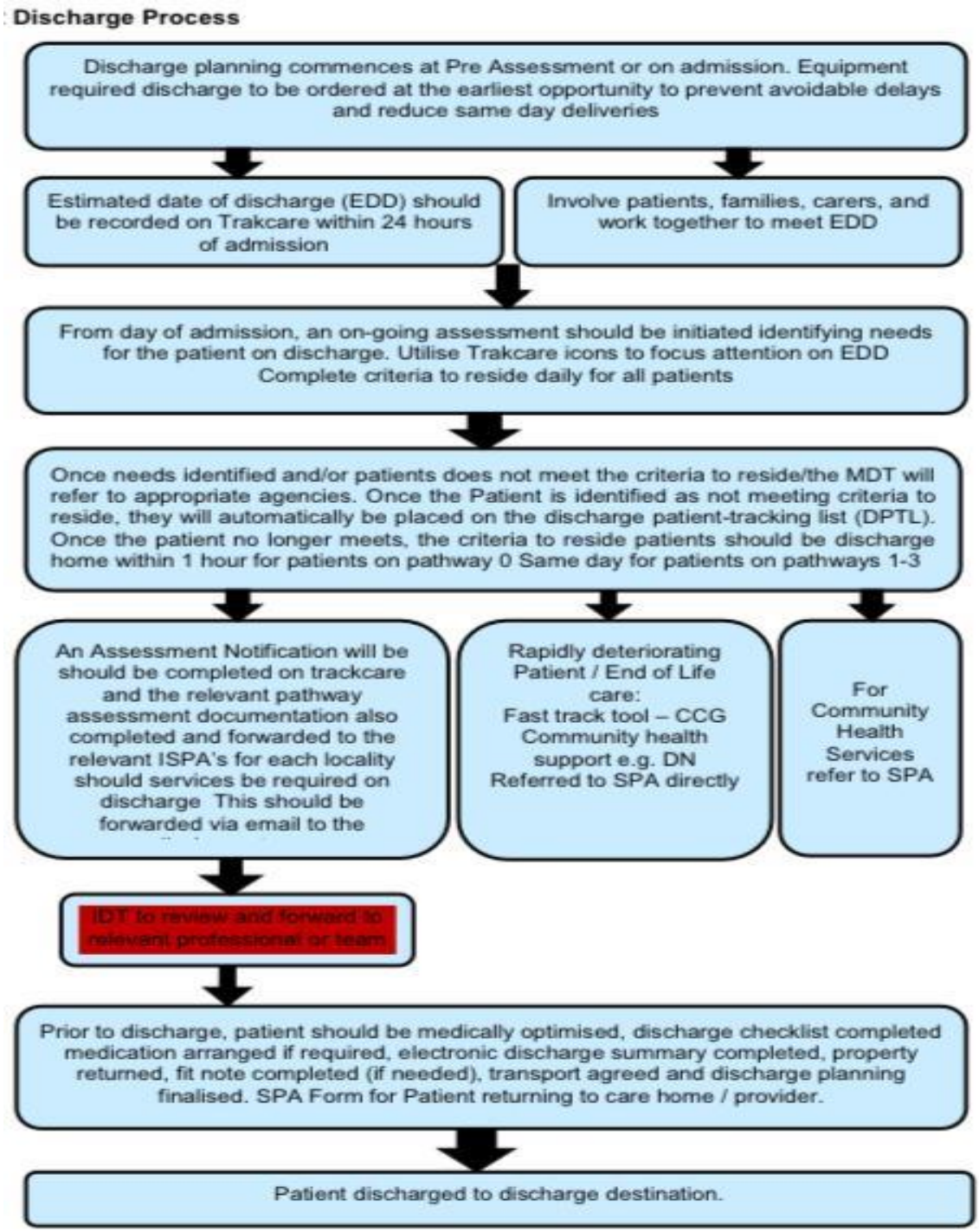
- To provide feedback from local care providers of their experiences of resident discharge from hospital back to the home in the previous year and the effectiveness of the process from their perspective.
- To develop an informed understanding of developments to discharge practice at North Tees and Hartlepool NHS FT in the past year and their impact on patient experience.
- To review progress towards recommendations made in the March 2023 Hospital Discharge Report.

Methodology

Stage 1 – Preliminary Research

Updates were received from North Tees and Hartlepool staff which outlined discharge processes and steps taken to action recommendations made in the march 2023 Hospital Discharge Report.

The process diagram below is taken from the Trust's Inter-Agency Discharge Policy and summarises the approach which is taken to planning and co-ordinating discharge arrangements.



Stage 2 – Survey Design/Data Collection

The patients and family members survey which was used last year to gather recent experience of patient discharge from hospital was re-launched. The survey could be accessed via the Healthwatch Hartlepool website, and the link to the survey was kindly shared by several community sector partners via their websites. The survey ran for a four-week period during January and February and 14 responses were received.

A second survey aimed at care homes was also produced. This enabled Homes to give feedback on their experiences of discharge in the previous year and to identify any changes in performance during this period.

Stage 3 – Discharge Hub Visit

Finally, four visits were made to the Discharge Hub at North Tees Hospital at which visitors were able to observe the discharge process first hand and have discussions with patients and family members/carers. The visits covered both mornings and afternoons and were undertaken between 5th and 15th February 2024.

In total, 32 patients were spoken to over the course of the four visits.

Key findings from patient/family on-line survey

A total of (14) questionnaires were completed and returned.

- Most patients (9) said that they were discharged from the ward on which they were staying rather than the Discharge Hub or Transport Hub. As with previous findings, it was again reported that some wards were reluctant to send patients to the Discharge Hub due to the possibility they may face a long wait there before going home.
- (8) patients reported that their discharge arrangements had not been discussed with them or family members until their actual day of discharge. (6) patients reported that discussions about their discharge had started either before their stay in hospital commenced or during their stay.
- (6) patients said that they had not been given any information about what would happen when they were discharged.
- (4) patients reported that they had waited less than 2 hours in the Discharge Hub before being able to return home, and (1) said they had waited over 4 hours.
- The main reasons given for Discharge delays were waiting for medication (6) waiting for transport (3) and waiting to see a doctor or consultant (1).
- (4) patients reported that they had found their stay in the Discharge Hub to be uncomfortable, and (3) said that it lacked privacy as confidential discussions could be overheard.
- (12) patients reported that a family member or friend took them home, and (2) by ambulance.
- (6) patients described their overall discharge experience as excellent or good, and (6) as poor or very poor.
- (9) patients said they received an adequate supply of medication to take home and (5) said they felt the supply to be inadequate.
- (5) patients described their care arrangements after discharge as excellent or good, and (3) as poor or very poor.
- Overall, patient rating of their discharge experience varied considerably, with (15) patients rating the experience as excellent or good, and (15) patients reporting their experience as being poor or very poor.

Comments from on-line questionnaire

1) Were you provided with any information about what would happen when you were discharged from hospital?

Comments

- "Advice on medication and future pathway for further tests and subsequent cardio rehabilitation."
- "No information whatsoever, except if we had any questions to ring the Surgical Discharge Team."
- "Information given on post-surgery rehabilitation."
- I received a leaflet with all the information I needed.
- We felt that despite asking for guidance on diet, exercise, driving, wound care amongst other things, we were given either very limited or factually incorrect information.

2) If your discharge was delayed, what was the reason(s)?

Comments

- "No idea why the discharge took so long as no contact made with family."
- "The only delay was due to transfer of care from North Tees to South Tees, six days. A bed was available a day earlier, but no ambulance was available for safe transfer."
- Long wait in the lounge for my medication to arrive."

3) Was your stay in the Discharge hub comfortable?

Comments

- Uncomfortable chairs and a lot of people crammed in a small space, and I suffer from social anxiety, and this did not help."

4) Did you receive an adequate supply of medication to take home?

Comments

- "Contacted hospital to ask where medication was and what some of it was for as he did not take some of the prescribed medication before going into hospital."
- "I had to wait for nephrostomy bags to be delivered to house."
- "My husband was initially given another patients medication. It was only when I questioned the nurse about the medication that they then went and got the correct bag. In fact, they had already used one of the injections on my husband when showing how to self-administer. Fortunately, it was the correct injection, and they then replaced the one from the original bag with one from my husband's."
- My daughter contacted them and got things sorted."

5) Did you get a follow up visit or call, and if so by whom?

Comments

"I had to call the hospital and was told to go back to see my doctor, who further prescribed more medication for recovery."

"Heart nurse visited me at home."

"No follow up." (x 3)

Visit from District Nurse (this was not related to initial reason why admitted, but for something found whilst in hospital)."

Numerous social workers supposed to do assessments but didn't. Poor communication from professionals. My daughter who is already a carer for her disabled children had to step in to support me, putting further pressure on an already stressed family.

6) Is there anything else you would like to tell us about the care and support you received after discharge from hospital?

Comments

- "There was little contact with family made by any health professionals and the family felt totally let down by the discharge process."
- "Everything required was in place."
- On completion of cardio rehabilitation there were no facilities available that would cater for people that work or able to return to work. No option for continuing help other than ran services."
- "No concern that I had recovered and no suggestion what I should do if no improvement in condition."
- "I had been assured I would be given a rehabilitation place, but this was not arranged, and I was sent back to my own flat. Carers arranged but this was not really suitable due to my condition."
- "My father was discharged to X care home. The family had expressed their wish that he was not to be discharged into the care of this facility due to previous family members lack of care and subsequent death at this home – the families wishes and concerns were totally ignored and no consultation as to where and when he was being discharged was received. No prior warning of date/time of discharge was given or discussed".
- "Discharged without any further investigation and asked to go back to doctors for further referrals."

7) Respondent Profiles

Age	Number
Under 18	0
18-24	0
25-34	1
35-44	3
45-54	0
55-64	2
65-74	2
75 +	3
Total	11

Gender	Number
Male	4
Female	7
Prefer not to say	0
Total	11

Postcode	Number
TS24	1
TS25	6
TS26	3
TS27	1
Total	11

Ethnic origin	Number
White UK	11
Total	11

Key findings from care home questionnaire

- Care Homes were advised that Healthwatch Hartlepool was revisiting the work it had carried out in 2023 around the patient experience of hospital discharge. We told them that we were particularly interested in hearing about their experiences during the previous 12 months and if any changes had been noticed.
- 4 completed questionnaires were returned.
- Three homes reported that the discharge process had stayed the same and one that it had become slightly worse.
  "Not always safe discharge, for example, missing medication, residents not fit for discharge, incorrect paperwork."
  "The wards don't always follow protocol and frequently try to discharge residents without going through the discharge process."
  "Some wards try to discharge without going through the discharge team."
- All four of the homes reported that communication from wards about the progress residents were making and discharge arrangements had not improved.
  "We are not kept informed of their progress, will ring when they want to discharge."
  There is a lack of communication from the hospital."

- Three homes reported that they had been asked to accept late discharges, beyond their normal cut off time from North Tees Hospital in the previous year and one home told us that they had not been asked to do so.
  "We have received emergency admissions up until 11pm."
  "Our cut off time is 6pm, however, they will ask if they can extend this to a later time or they will send them out after cut off and can arrive back at 9.30pm.
  "Our cut off time is 4pm, however, residents often arrive back after this. We have this cut off time to allow the senior ample time to book in medications and check any queries with the ward."
- Two homes told us that there had been occasions in the previous year when they had concerns about the fitness of a resident to be discharged home, and two homes said that they had no concerns over fitness to be discharged in the previous year.
  "I had to ring the ambulance back out and they were re-admitted within a couple of hours."
  "A resident kept being re-admitted back into hospital and we were having to send them back within one hour of coming home due to the same issue they were originally admitted with."
- Two homes informed us that in the last year they had not always been informed of changes to medication, new therapy requirements or new equipment needs when a patient is discharged.
  "Occasionally incorrect paperwork."
  "Only find out changes from discharge letter, often says no discontinued medications, but some medications have stopped."
- Other comments included –
  "The nurses are often rude when we remind them, they must follow discharge process and not just send residents home."
  "Better communication from wards is needed as we have to ask for information at handover about residents."

Key findings from Discharge Hub visits

During the review period four visits were conducted to the Discharge Hub at North Tees Hospital. These visits took place between 10am and 1pm on Monday 5th February and Wednesday 7th February, and between 1pm and 4pm on Tuesday 13th February and Thursday 15th February. The visits gave us the opportunity to speak directly to patients about their time in hospital and their discharge arrangements.

We were made aware that due to staffing pressures the Transport Hub, located at close to Costa Coffee at the main entrance to North Tees Hospital would not be operational. Staff also informed us that patients had found the Transport Hub to be cold during the winter months. The Transport Hub is specifically for patients who are just waiting for transport and already have medication and their discharge letter.

Observation of Discharge Lounge

The Discharge Lounge is still located in the former gymnasium and is a shared facility with cardiac patients. The toilet is accessed via the cardiac section of the facility. When entering the lounge, there is a fridge with sandwiches and snacks for patients and a hot drink facility.

In the centre of the room was the nurse station, behind which it was partitioned off for patients who required cardiac medical input.

The seating area for patients awaiting discharge was initially laid out in the same way as it had been the previous year and at the far end of the lounge beds were still present. However, by the second week of visits the beds had been removed and chairs placed in a horseshoe arrangement facing the nurse station.

On the wall was a TV and noticeboard with useful discharge related information, including contact numbers for support services out outside agencies.

On arrival, patients were greeted by staff from the lounge, shown to a seat and offered refreshments.

Conversations could be heard from the nursing/clinical staff when discussing patients discharge arrangements. Also, conversations could be heard from patients speaking to family members etc and no private facilities are available in which discussions of a sensitive nature can take place. On a couple of occasions, patients were quite loud causing some of the other patients in the room to feel uncomfortable.

When patients were brought to the lounge most wore pyjamas and dressing gowns, and some wore daytime clothing. On one occasion an elderly lady was brought to the Lounge wearing a night dress and was covering herself with a blanket which kept falling to the floor. The lady was clearly uncomfortable, and in this instance, more could have been done to protect her dignity.

Staffing levels had noticeably improved since our previous visits in 2023 and all times there were at least three nurse/health care assistants present. We were told that the Lounge now has a dedicated staff team, which is a significant improvement on the ad-hoc arrangements which were in place last year. Staff were courteous, respectful, and tried hard to ensure that patients were discharged as quickly as possible, following up medication delays, contacting family members and chasing up outstanding issues with the wards.

Since our previous visits we noted that discharge letter can now be printed off in the discharge, which saves time and reduces unnecessary waits for patients.

We were also told that "pop-up pharmacies" have now been introduced on some wards. They can despatch non-controlled drugs to patients prior to discharge, thus reducing patient waits for some medication in the Discharge Lounge. However, all controlled prescriptions must come from the main pharmacy. We also learnt that the hospital pharmacy closes between 1pm and 2pm, so if a patient arrives at the Lounge around lunchtime, their length of stay is likely to be extended if they are waiting for medication.

Staff informed us that wards have requested that they do not contact them until at least ninety minutes after a patient has been taken to the Discharge Lounge. This may reduce the number of calls they have to take at busy times but frustrates patients and can result in a minor issue which could be quickly resolved causing delays to patients getting home.

During all of our visits the Lounge was much busier than it had been the previous year, and in total we spoke to 32 patients over the course of our 4 visits.

We noted a significant increase in the number of patients awaiting discharge who had initially been admitted to hospital because of a drug or alcohol related issue (approximately 15% of the patients we spoke to)

We noted several occasions in which staff made considered and appropriate decisions regarding the discharge arrangements for individual patients. In one instance an ambulance was prioritised for a patient with a learning disability who was becoming distressed. On another occasion the nurse contacted the ward from which the patient had come as she had concerns about the patient's condition and care arrangements. Finally, staff ensured that a homeless gentleman was discharged quickly in order to get to an appointment with his local council at which his housing situation was being discussed.

What Patients Told Us – Key Points

- Without exception, all of the patients we spoke to in the Discharge Lounge were positive about their overall experience of care whilst in North Tees Hospital.
  "I can't fault the way I have been treated, the staff on Ward 33 really looked after me."
  "The Discharge Lounge has been pleasant and stress free, a big improvement on when I was last here 2 years ago."
  "I stayed for a week on Ward 33, care was first class."
  "I have been treated really well, the staff on ward 36 and in the Discharge Lounge have been excellent."
  "Excellent treatment – top marks to EAU."
- One person said that a staff member in the Discharge Lounge had been abrupt when asked a question.
  "I only asked if they knew when I would be leaving soon, and they told me to sit down!"
- The most frequent causes of delay were waiting for medication to arrive or waiting for transport. Patients who were being picked up by family members or friends commented that not having a time when they would be discharged made this difficult to co-ordinate. Patients experiencing the longest delays were often waiting to be taken home by ambulance.

"I was told I was being discharged on the ward at 8.30am. I have been here since 9.30am, its now 12.15pm, I am waiting for an ambulance to take me home because I need oxygen. I am really fed up!"

- (16) patients said that their discharge arrangements had not been discussed with them until that day. Some had only had relatively short stays (1 or 2 days), but others had been in hospital for a week or more.
- Several patients were unclear as to why they had come to the Lounge and what would happen next.
  "I don't know what I am waiting for, I thought I was going home."
  "I can't remember what they said on the ward."
  "I didn't realise this was the Discharge Lounge, I have been in 12 days and haven't been told much."
  "I am hard of hearing and didn't get a lot of what the nurse told me."
- (20) patients said that they had not received any information about what would happen in the Discharge Lounge or when they returned home. Very few had seen or were aware of the leaflet "Planning Together and Leaving Hospital – Discharge Advice," which has recently been produced by the Trust. The leaflet gives a full, clear description of the discharge process and what the patient can expect on their return home if ongoing treatment, rehabilitation, or social care is required. A copy of the leaflet can be found at Appendix (2).
- On several occasions patients told us that the ward from which they had come had not said that they may be in the Discharge Lounge for several hours before going home which led to some patients becoming quite frustrated and voicing their frustration with staff in the lounge. Several patients had also contacted family members when they were told they were leaving the ward, expecting that they would be able to be picked up from the Lounge immediately. This caused considerable inconvenience for relatives who had left work expecting their relative to be ready to go home.
  "I thought I would be home by now, no one told me I would have to wait this long, I am going to miss my fish and chips!"
  "My partner works, and I don't have a key, so even though everything is ready I have no option but to wait!"
- Patient waiting times in the lounge varied, although most were discharged within two hours. However, two patients said they had been waiting over 4 hours and others said that there had been a delay between being told they were being discharged on the ward and actually arriving at the Discharge Lounge.
  "They told me (ward staff) I was being discharged at 8.30am and to get ready, but I didn't get here till 10.15am!"
  "I didn't expect to have to wait when they told me on the ward that an ambulance would be taking me home!"
- When asked what they were waiting for, (21) patients said medication and (19) transport. A large number of patients were waiting for both medication and transport arrangements to be finalised. Patients experiencing the longest delays were invariably those waiting to be taken home by ambulance.
  "Everything is ready, I am just waiting for the ambulance to take me home."
  Despite the introduction of pop-up pharmacies on some wards, some patients told us they were waiting for quite routine medication such as water tablets. On several occasions nurses asked the patient if they would like to go home and have

the medication delivered by volunteer driver. This was only possible when the medication in question was not a controlled drug.
"I am waiting for water tablets; I was told I have to take them after the surgery I have had."

- Several patients told us that they found the seating to be uncomfortable, particularly if they were waiting for a long time or if they had arthritis or a back condition.
"I have been waiting for nearly 2 hours and the chairs aren't that comfortable.
Finally, when asked how they would rate their discharge experience in the Lounge, (20) patients said excellent or good, (7) ok and (5) poor or very poor.
"I have been well looked after here; the staff have been very helpful."
- One patient told us that their discharge had been delayed by 2 days due to delays in getting their care package in place.
- Several patients told us that the toilets were too far away. Toilets are accessed by going through the Cardio Unit and into a side room, which is around 20 metres from the Discharge Lounge. Staff said they would take patients who were unable to walk that far by wheelchair, but some commented they felt uncomfortable asking.
"The toilets should be nearer; it's putting me off having a drink!"

Patient Case Studies from Discharge Hub Visits

Three more detailed examples of typical patient discussions are shown below –

University Hospital of North Tees

Hospital Discharge Lounge

General Observation -Increase in staff levels: staff very professional showed empathy and supported patients with their discharge.

Patient 1: Female (White)-age 65-74 (Retired)

Consent gained, introduced self and role.

Admitted to A&E Tuesday Jan 30th then w/d 30 then w/d 28. Discharged back to their own home. Post Code TS26 then EAU. Discharged back to their own home.

Previous 2 hip replacements and Lung Cancer.

Discharge was discussed while in hospital. Informed was going to discharge lounge (discharge delayed) await medication and discharge letter. Unable to give time to her son to collect her (son was at work).

Snacks/drinks provided:

No privacy: was handed the phone by the nurse (pharmacy rang twice to discuss client's meds).

Discharge Hub was comfortable, informed would be contacted for further investigation.

Was asked what support was in place on discharge.

Comments: Would like Hartlepool hospital reopened 4 patients on the ward all from Hartlepool.

Would have liked Discharge letter and meds from the ward and go straight home.

Patient 2: Female (white 65-74) retired Postcode TS24

Consent gained, introduced self and role.

Admitted to EAU five days ago and then onto ward 28? Told at 8.30am was being discharged today and would be taken home by ambulance. The patient then waited in ward until 10am before being taken to the Discharge Lounge. Experience of care was particularly good.

Discharged first discussed with doctor this morning and was being discharged back to her home where she lives with her sister.

Snacks and drinks offered on arrival and again during course of stay. Comfortable and warm. Medication and discharge letter all ready but waiting for ambulance to take her home as travelling with oxygen due to condition (COPD).

Discharge delayed due to ambulance pressures, kept informed by staff who regularly updated patient. Further delay as first available ambulance prioritised for a patient with a learning disability who was becoming upset.

A nurse brought two bags down to the patient that had been left on the ward. The patient said that one belonged to her, but the other did not. It had been near to her bed when she arrived on the ward and had syringes in it. The nurse apologized and said she would investigate whom it belonged to.

Finally, the patient said staff had been caring and supportive in the Discharge Lounge but was very frustrated by the delay. She was still waiting for an ambulance when we left at 12.45pm.

Patient 3: Male (White) aged 45-54 unemployed unavailable for work. Postcode TS24

Consent gained, introduced self and role.

Admitted to A&E Saturday Feb 3rd. Discharged back to their own home.

Discharge was discussed. Taxi arranged to take home. (Has no immediate family).

No care package or medication required.

Was only in the Discharge Lounge 10 mins then staff member took patient for their taxi. Drinks/snacks available. Overall happy with EAU and discharge lounge. Although no privacy.

Patient suggests that staff were terribly busy and had no time to change bandages on ulcerated leg. Therefore, suggests that he would smell the taxi out. Informed by EAU that District Nurse would follow up.

Patient 4: Male (White) aged 65-74 Retired.

Consent gained, introduced self and role.

Admitted the previous day at 6pm. Suspected Stroke, TIA, Taken straight to the ward 42. CT scan taken all clear.

Health conditions: Arthritis, hips, shoulders, neck Diabetes, AF.

Discharge discussed on day of discharge. Discharged back to own home. Wife to collect.

No care package required.

Awaiting Discharge Letter (no meds required). Waited about 1hr then Wife came to collect.

Discharge Hub comfortable, however could overhear staff, patient conversations.

Offered drinks/snacks.

Suggests, everything was rushed once told was getting discharged. Lots of information given. Would have liked a follow up courtesy call to see how managing.

Patient 5: Female (white 55-64) permanently sick or disabled postcode TS24

Consent gained, introduced self and role.

Admitted to Ward 33 one week ago. Discharged back to their own home. Experience of care is exceptionally good. Discharge has been discussed during stay and aware it was happening today. Arrangements made for physio support on return home.

Waiting for medication and transport provided by volunteer driver. Had Discharge Letter with them on arrival at the Lounge.

Snacks and drinks offered on arrival, comfortable, kept informed of progress and staff particularly good. Could overhear conversations but not concerned. Arrived in Lounge at 12.00pm and left with Volunteer Driver at 1.50pm

Patient Profiles

Age	Number
Under 18	0
18-24	0
25-34	1
35-44	0
45-54	4
55-64	2
65-74	16
75 +	9
Total	32

Gender	Number
Male	13
Female	19
Prefer not to say	0
Total	32

Postcode	Number
TS24	6
TS25	3
TS26	3
TS27	1
Other	19
Total	32

Ethnic origin	Number
White UK	31
Indian	1
Total	32

Recommendations

1) That the progress made by the Trust against the recommendations in the previous report is noted and the positive impact this has had on many aspects of the patient discharge experience and subsequent care and support.
2) That consideration is given to addressing ongoing concerns identified in the recommendation review table contained within the Executive Summary of this report.

Acknowledgements

- Thank you to everyone who has helped us with our consultation including:
- Members of the public who completed our survey and shared their views and experiences with us.
- People who attended and contributed at our various consultation events.
- Staff from North Tees and Hartlepool Foundation Trust and in particular the Discharge Lounge team who made us very welcome during visits.
- Healthwatch Hartlepool volunteers who took part in our visits to the Discharge Lounge.

References

1) Hospital Discharge and Community support Guidance
   DHSC – March 2022
   NHS England Publication – Gateway Reference 05871
2) Nice Guidance ng74 – Intermediate Care Including Reablement – September 2017
   www.nice.org.uk/guidance/ng74
3) North Tees and Hartlepool NHSFT
   Integrated Discharge Policy
4) Healthwatch Hartlepool
   Hospital Discharge Report – 2014
   www.healthwatchhartlepool.co.uk
5) Healthwatch Hartlepool
   Hospital Discharge Report – 2023
   www.healthwatchhartlepool.co.uk
6) John's Campaign
   https://johnscampaign.org.uk
   Local Government Association 2021
7) Planning Together and Leaving Hospital – Discharge Advice Leaflet
   North Tees and Hartlepool NHSFT

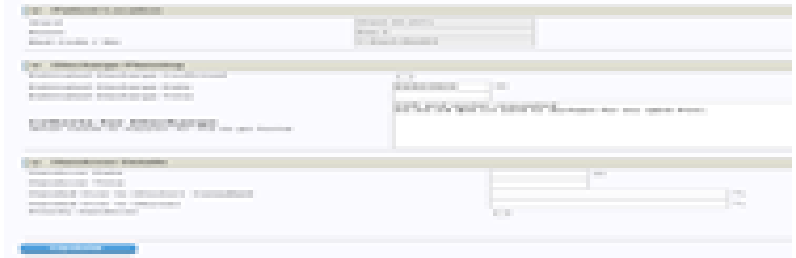
Appendix 1

Trust action plan

HEALTHWATCH HARTLEPOOL HOSPITAL DISCHARGE REPORT 2023-ACTION PLAN

Recommendation	Action/Response	Lead Organisations	Progress	Completed
1. Communication and involvement of patients in planning their discharge and subsequent post discharge care arrangements happens consistently as per the requirements of the North Tees and Hartlepool Discharge Policy Framework and guidelines contained within the Hospital Discharge and Community Support Guidance (DHSC-March 2022).	• The trust and Hartlepool borough council will continue to work collaboratively when coordinating discharge from acute care through the Integrated Discharge Team and the Integrated Single Point of Access as per the Hospital Guidance. • Ensure involvement and family is completed for complex discharges P1/P2/P3	**NTHFT** **HBC**	**25/07/23** Terms of reference for the Transfers of care group involving all partners has been updated. Draft TOR and meeting schedule attached. **01/12/23** meetings ongoing **01/02/24** Updated SBARD introduced November 2023. SBARD Has section to document family /patient's views and care won't be arranged until this is complete.	**Complete**

	• The Trust and HBC have also worked together with Hartlepool Carers to ensure there is a representative on site at North Tees Hospital, working alongside the IDT to ensure non-paid carers are communicated with and are receiving the support from their service on discharge.	**NTHFT** **HBC**	**09/05/23** Service in place at North Tees. To be reviewed August 2023 **26/07/23** Meeting in place 28/07/23 **01/12/23** Staff continue to work with the Discharge Lounge and Discharge Team. Literature available throughout trust.	**On going**
	• The trust will complete a follow up audit of the 2064 NICE Guidance: Transition Between Inpatient Hospital Settings and Community for Adults with • Social Care Needs. This audit will involve a review of the healthcare records to review if there is documented evidence of patients and carers are being communicated with on their discharge. Results of this audit will be shared across the organisations.	**NTHFT**	**9.05.23** Plan for audit in place  2064 NICE NG 27 and QS 136 Transitic **25/07/23** Audit of records has started. Will be ready for presentation October/Nov 2023 with a further action plan. **01/12/23** Delayed Completion date now March 2023	**Delayed**

	The “4 Patient Questionnaire” project the trust is working collaboratively with ECIST is due to roll out onto further pilot wards in the trust with the ambition this is implemented in all areas. 	**NTHFT**	**25/07/23 ECIST pilot** x2 wards involved- Piloting on 24/40 Due for roll out to do 2 further ward areas wards. **01/10/23** rolled to 2 further wards. **01/12/23** Documentation on EPR rolled out to all wards.	**Complete**
2. Improved information outlining the discharge process is produced and made available to all patients entering North Tees and Hartlepool Hospitals for non-elective procedures. We recommend that’s the Wirral NHS Leaflet – Your Discharge Explained as an	The trust is currently using the Hospital Discharge Leaflet as recommended by the Department of Health and Social Care “You are leaving Hospital: returning Home”. However, this will be reviewed using the best practice from other areas including The Wirral. Once approved through the Patient Experience groups, this leaflet will be given to patients on discharge and will be available in the discharge and transport Hubs.	**NTHFT HBC**	**19/05/23** Draft leaflet produced to be final comments requested by end July then to go through Trust leaflet approval process. (see attached draft) **13/12/23** Agreed by patient information group in the process of being ordered and circulated.	**Complete**

example of good practice.				
3. Ensure patients are informed of the availability of post discharge support services such as the Community Respiratory Service that is available specifically for those with breathing difficulties and COPD. This will help to reduce patient readmissions to hospital and facilitate effective recuperation.	Community services that support patients post discharge such as the Community Respiratory Services (Known as Hospital @Home) have well established pathways with the acute teams and primary care to ensure patients are being discharged onto their services to continue with their care at home and prevent avoidable admissions. Patients who are referred to the Community Respiratory Service (Hospital @Home) are able to self-refer onto this service through the Single Point of Access. Information on how to access the SPA is provided on the discharge leaflet. The trust together with the Tees Valley Collaboration Group has produced a communication strategy to patients, primary care, care homes and all services involved in post discharge care on the Urgent 2hour response and how community service and support people at home and prevent avoidable admissions. The trust is also developing a directory of services for community services on the internal intranet page to promote their use and support hospital discharge.	**NTHFT** **HBC** **Tees Valley ICB**	**25/07/23** Progress update required re directory of services. **01/02/24** ISPA co-located with community services. All ongoing community support is managed through the ISPA and improved communication and coordination seen to support people to live well in their own homes. The introduction of virtual wards and patient monitoring systems have been introduced within community setting to support people to receive treatment within the community.	**On-going**
4. Alternative/easy read formats should be produced of all discharge related materials and support such as interpreters booked to ensure Deaf patients and patients with other languages	The trust will ensure that any patient leaflets given to patients is developed in an easy read format and available in other languages. The trust will work together with 'Everyday Solutions' to ensure that patients with sensory impairment are not excluded from being communicated to or involved in their care and discharge.	**NHTFT** **HBC**	**19/05/23 Draft leaflet** produced to be trialled and completion planned July 2023 **25/07/23** Final comments re leaflet due by end of July (see action 2) will be	Completed

and support needs are not excluded.			produced in various formats Interpreters available to patients. Posters to be displayed on all the wards for language solutions. **13/12/23** Leaflet produced and can be available in different formats	
5. Ensure that the principles of John's Campaign are consistently integrated into discharge arrangements in order to maximise support for patients who are living with dementia and similar conditions.	The enhanced care team, a team which can provided one to one support for patients with dementia and similar conditions will incorporate the principles for John's Campaign throughout the hospital stay and when making discharge arrangements. The trust will work with all the care groups to ensure that John's Campaign is used when making discharge arrangements, including encouragement of using it in the Discharge Hub.	**NTHFT**	**25/07/23** Principles of Johns Campaign used across the Trust. Enhanced care team asked to support all about me document with the patients on their caseload if not already done.	**Completed**
6. Wherever possible, patient transport and medication requirements should be finalised and in place in advance of the day the patient is due to be discharged.	The trust and HBC work closely together to ensure that the average length of stay for 22/23 was 3.7 days, which is currently below the national average. Whilst we aspire to ensure that patient transport and medication requirements is finalised well in advance of discharge, we are focused to ensure that any changes that may be made by other teams including the medical teams up to the point of discharge is reflected and patients are discharged with the right support.	**NTHFT** **HBC**	**25/07/23** Complete	
7. Current operational practices relating to the Discharge Hub and	The standard operational procedure for the discharge hub is to be reviewed to include a process for the use of hospital	**NTHFT**	**19/05/23** SOP Discharge hub completed.	**Complete**

Pharmacy should be reviewed, and the potential to use Hospital Volunteers to collect medication maximised in order to reduce medication related discharge delays	volunteers to support the collection and delivery of medication when it is appropriate to do so. However, there are medications including the prescription of controlled drugs, which are required from the hospital pharmacy to be collected by a health care professional.		**19/05/23** We continue to recruit volunteers for the discharge hub there are now 2 with the aim of having daily support/ Volunteer responders also can support medication collection. Information circulated to the current discharge hub team	
8. Unless there is a justifiable reason not to do so, patients discharge should be via the Discharge Hub or Transport Hub in line with national guidance.	We are working with across all our acute wards to improve the use of the Discharge Hub and Transport Hub when it is appropriate to do. We will continue to encourage the use of the discharge and transport hub as part of the pathway for leaving the hospital.	**NTHFT**	**19/05/23 Update** Funding for staffing agreed for the discharge hub moving forward (HCA and RN) recruitment progressing. **25/05/23** Recruitment ongoing **13/12/23** Recruitment completed. Cover available for Discharge Lounge and Transport Hub. Numbers using the hub have risen (data available if required)	**Complete**
9. Consideration should be given to the suitability of the current location of the Discharge Hub and efforts made to find a more appropriate bespoke location which gives patients a more	We are fully aware that the current location of the discharge hub requires improvement or possible relocation to improve patient experience. That is why we have submitted a business case to the trust board requesting long term improvements to the current area. The trust is limited with its current estate to identify a new bespoke location for the discharge hub.	**NTHFT**	**25/07/23** No further update re Discharge hub improvements Transport Hub due to re-open at end of August in preparation for winter. **13/12/23** Venue decided shared with cardiology	**Delayed**

comfortable and dignified experience.	The trust has introduced the transport Hub which is located at the front of the building near the main entrance utilising previous space which was occupied by the flower shop.		QIA being completed for both services in readiness for a business case to adapt the venue	
10. Staffing levels should be reviewed together with the wider review of the Discharge Hub arrangements recommended above. **Levels of Occupational therapy and physiotherapy support should also be at a level which ensures equipment required by patients to assist their recuperation is in place and available when discharged home in order to minimise the possibility of re-admissions.**	The current staffing arrangements for the discharge hub have been reviewed and will require additional investment in order to support a surge in activity. Levels of occupational and physiotherapy are being reviewed in order to ensure that patients discharged are receiving rehabilitation in the community with a focus of 'Home First'. This is including but not exclusive to the provision of equipment. The integrated single point of access works together between health and social care to ensure that the most appropriate team, are assessing patients who require on-going equipment. We review the incidents within our patient safety teams linked to issues with equipment or access to therapy teams as part of this action plan.	**NTHFT HBC**	**19/05/23 Update** Funding for staffing agreed for the discharge hub moving forward (HCA and RN) recruitment progressing. **13/12/23** Recruitment completed. Cover available for Discharge Lounge and Transport Hub. **01.02.24** There has been an investment of additional therapy support to Community therapy teams to ensure patients within the intermediate care bed based or home based are receiving the correct level of input to stay within their own home	**Complete**
11. Consideration should be given to improving communication with care homes and care providers to ensure the best possible transfer of care arrangements are always in place. We	North Tees and Hartlepool community services have conducted visits to every care home provider for older people within Hartlepool to build relationships and discuss improvements and support the trust can give to our patients in their homes. This has been received positively by the care home providers and is an exercise which we will continue to do.	**NTHFT HBC**	**25/07/23** This is on-going reps also attend Community forums	**Complete**

suggest that a workshop should be considered, at a future Care Mangers Forum which is facilitated by Hartlepool Borough Council, focusing on how future communication process between the Trust and care sector can be developed and improved in relation to discharge and other shared arrangements. Healthwatch Hartlepool are willing to be involved in the design and facilitation of the even it required.	The trust and HBC are committed to continue to work closely together including weekly meetings with the commissioning teams to discuss how we can improve the process of the transfer of care and will continue to collaborate on any event including a care home managers forum. From May 1st 2023, all email communication from HBC to Care Home providers will be through NHS.net email. This is an exciting opportunity to ensure communication is shared through a single format. Once this is established with all the care home providers, NTHFT will look towards the sharing of discharge information through nhs.net.			
12. That Healthwatch Hartlepool and health and social care colleagues involved in the delivery of the patient discharge pathway meet in six months to review progress	NTHFT and HBC would welcome review of the actions and any progress.	**NTHFT HBC**	**Revisit scheduled 05/02/24**	**On-going**

Appendix 2

Planning Together and Leaving Hospital – Discharge Advice leaflet

Please click on link to see leaflet.

leaving hospital doc Discharge Leaflet.pdf

leaving hospital doc.pdf

Appendix 3

Response from the Trust

NHS
North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
Stockton on Tees
TS19 8PE

Telephone: 01642 617617
www.nth.nhs.uk

27TH March 2024

Mr Christopher Akers-Belcher
Chief Executive HealthWatch Hartlepool
Greenbank
Waldon Street
Hartlepool TS247QS

Dear Mr Christopher Akers-Belcher

Re: Healthwatch Hartlepool draft Report – Hospital Discharge March 2024

Thank you for giving us the opportunity to comment on the discharge report findings. North Tees and Hartlepool NHS Foundation Trust strives to provide excellent care and services to patients. We recognise that supportive and appropriate hospital discharge services are vital and we are committed to ensuring that patients' experiences and subsequent recuperation opportunities are maximised.

We are very pleased that you have observed the progress made by the Trust against the recommendations in the 2023 report and that this has had a positive impact on many aspects of the patient discharge experience and subsequent care and support.

We are committed to progressing/building on the recommendations from March 2023 report and this current report and will ensure that an agreed action plan is formulated/shared widely across the Trust. Progress against it will be monitored through the appropriate governance structures and system forums.

We would like HealthWatch to consider the enclosed response on behalf of the Trust. A more detailed action plan will follow once shared and discussed more widely with internal staff and as appropriate with external stakeholders within Hartlepool Borough Council

On behalf of myself and the clinical teams can I thank you for bringing forward the patients voice and supporting the developments of services to patients through their discharge process. We look forward to continuing to work closely with you in the future.

Yours sincerely

Mr N Atkinson
Managing Director

Enc Response to rec

Recommendations from the HealthWatch report and Trust comments

27/03/24

The Trust will build on the information gathered with this 2024 report. Gathering as much feedback as possible from various sources will enable us to further identify areas that require development and also identify areas of good practice within the Trust to build on. Whilst the sample of feedback from family /patients and carers and care providers is small it does reflect other sources of information and none of the recommendations came as a surprise. What can be seen is that the work commenced from the March 2023 has been recognised and we wish to continue to build on this positively.

We have taken the opportunity to provide feedback against the recommendations highlighting work done/ongoing work and possible areas of further development The Trust will share the recommendations more widely internally and with partners from Hartlepool Council to ensure where appropriate any local actions can be taken in collaboration. An action plan will follow with more details of the actions to be taken forward against the recommendation.

HealthWatch recommendations		Trust comments in relation to the recommendation
1	Communication and involvement of patients in planning their discharge and subsequent post discharge care arrangements happens consistently as per policy and national guidance	The Trust has been working well with Hartlepool Carers over the past year, and a representative from the organisation is regularly on-site. This has helped carers to access support and information on a variety of issues including discharge. Whilst every effort is made to ensure that discharge discussions start from early in the Journey it is acknowledged that further work is required, particularly with those patients with complex discharges where patient, family /carer engagement is vital. There is a larger piece of work across the trust regarding discharge information and HealthWatch have been invited to support.
2	Improved Information outlining the discharge process is produced and made available to all patients entering NTHFT	Positive feedback from HealthWatch regarding the production of an excellent patient information leaflet – Planning Together and Leaving Hospital – Discharge Advice which was ratified in November 2023. The Trust acknowledge distribution of the leaflet is required across all ward areas and to ensure that it is accessible to all patients.
3	Ensure patients are informed of the availability of post discharge support services	The support required for patients on discharge varies greatly depending on the patients' needs. This may require further discussion and investigation to identify areas of good practice and areas requiring further improvement. The discharge leaflet roll out aims to give more information about access to community services if required on discharge.
4	Ensure principles of Johns Campaign are	We have Johns Campaign embedded across the Trust. Feedback from HealthWatch during the visits to Discharge

	consistently integrated into discharge planning/arrangements	Lounge was positive in that staff were applying this in the lounge and making adjustments, supporting patients who are more anxious/vulnerable. Relatives /carers are welcome in the lounge at all times and we will continue to encourage this. The wards also apply the Johns Campaign. Volunteers in the lounge are a good source of support for more anxious / vulnerable patients who are there without carers or family. The volunteers are not present every day but we will continue to recruit volunteers for the lounge when possible.
5	Wherever possible, patient transport and medication arrangements are finalised and in place prior to day of discharge. Reduce avoidable delay in the lounge	For most patients, if their scripts and letters are ready they will be discharged that day. However, it is acknowledged that there are some patients who are waiting for care packages to start and that preparation for discharge could be progressed the day before. Where care packages start the next day we will explore with clinical teams further opportunities to make improvements. Producing a discharge letter and writing a script followed by the dispensing of medication are tasks that take time hence the role of the discharge lounge to release capacity on the ward. We aim to have a patient in the lounge for a maximum of 3 hours. Unfortunately, there are times where this has been longer. We will continue to review the processes to ensure that people are not in hospital, inclusive of the discharge lounge, for any longer than they need to be. We will also review escalation processes in place, if required. We need to communicate clearly to patients about the role of the lounge and manage patient's expectations. This will include development of a leaflet explaining the role and function of the discharge lounge. We recognise that bottlenecks in ambulance transport does occur at peak times and we will continue to work closely with our ambulance provider to support this. We strive to ensure that the full range of transport options are explored before an ambulance for a patient is requested.
6	Discharge via the Discharge Lounge	We are pleased that HealthWatch have observed a significant increase in patient throughput. There has been a drive across the Trust ensuring that more acute beds are available as early as possible supporting timely patient flow. We will continue to embed the Discharge Lounge as an important element of patient flow and also review the use of the Transport Lounge.
7	Location of the Discharge Lounge	We acknowledge that the Discharge Lounge needs to be adapted to ensure that the location and premises are optimal. This is a priority for the Trust to identify a solution. It is acknowledged that this will not only enhance patient flow but will have an impact on positive patient and staff experience.

8	Discharge Lounge Staffing Levels	The staffing levels have been enhanced since the last visit and we are very pleased that the introduction of a dedicated team and its impact on flow and patient experience was noted by HealthWatch during their visits.
9	Communication with care homes and care providers.	Feedback from care home survey was limited due to the numbers of survey returns and lacked context in order to identify improvements required. Feedback from care homes suggests that whilst some progress has been made around communication, there is still work needed to improve the timely flow of information between wards and themselves. Whilst there has been recent and ongoing engagement with care home providers forums by community services it is acknowledges that a regular presence should be prioritised from a discharge perspective to understand better how we can work together to improve services.