Exploring Hospital Discharge at Princess Alexandra Hospital

December 2023

Renée Robey
Engagement Officer

healthwatch Essex

healthwatch Essex

Princess Alexandra Hospital: Exploring Hospital Discharge

Engagement Project
December 2023

Produced by Renée Robey//Engagement Officer

Contents

1.0 Introduction

1.1 Healthwatch Essex

Healthwatch Essex is an independent charity which gathers and represents views about health and social care services in Essex. Our aim is to influence decision makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience. We also provide an information service to help people access, understand, and navigate the health and social care system.

1.2 Background

The Healthwatch Essex Information & Guidance Team receive many calls and feedback from the public regarding their experiences of hospital discharge. This rise in calls has made hospital discharge one of the most common call topics that the service deals with regularly. It has been reported within local media sources of issues that Mid and South Essex hospitals have faced encountering difficulty discharging patients and 'freeing up beds.' Princess Alexandra Hospital is currently undergoing improvement and development and therefore West Essex has been chosen as an appropriate area for Healthwatch Essex to explore during this project.

1.3 Acknowledgements

Healthwatch Essex would like to thank Princess Alexandra Hospital, East of England Ambulance Service, St Clare Hospice, De Vere Care Partnership and Hertfordshire and West Essex Integrated Care Board who participated in this engagement project. This extends to the patients and family members for their time given and the feedback received.

1.4 Terminology

PAH- Princess Alexandra Hospital
DNR- Do Not Resuscitate
CNS- Clinical Nursing Specialist

1.5 Disclaimer

Please note that this report relates to findings and observations carried out on specific dates and times, representing the views of those who contributed anonymously during the engagement visits. This report summarises themes from the responses collected and puts forward recommendations based on the experiences shared with Healthwatch Essex during this time.

2.0 Purpose

The purpose of this project was to engage with individuals from a variety of professions, capture patient voice and provide a series of different vantage points of those who have experience of hospital discharge within Princess Alexandra Hospital. This involved examining areas of good practice and shedding light on potential areas of improvement, whilst understanding the current challenges being faced by the hospital.

A focus of the project was to explore the collaboration between PAH, healthcare staff, patients, and external organisations and identifying where there may be communication gaps. The exploration of the hospital discharge process was to include barriers to discharging patients and delve into potential solutions. The results of this project will help Princess Alexandra Hospital review their current hospital discharge process and highlight what is working well and what could be improved.

2.1 Engagement methods

Participants were contacted either via Princess Alexandra Hospital or through direct contact from Healthwatch Essex. There was a common consensus recognising that by sharing their views, they can support potential change, or positive continuation of the process, within PAH based on their reflections on the hospital discharge process.

To gain a more in-depth understanding of hospital discharge, 15 participants were interviewed on virtual platforms either individually or in small groups to capture their views. The interviews were recorded for transcription purposes however, all participants have been kept anonymous.

3.0 Key Findings and Recommendations

Based on the interviews with the 15 participants, several key findings emerged highlighting areas for improvement, challenges faced by both patients, PAH staff and external stakeholders and opportunities to improve the hospital discharge process. The following sections present the key findings and provide an overview of the dynamics surrounding hospital discharge at the Princess Alexandra Hospital.

3.1 Communication within Princess Alexandra Hospital

There were clear examples of positive communication, such as daily calls which take place with system partners to understand capacity for patients, where capacity gaps are and what can be done to move patients through the system partners pathways quickly and efficiently. By trying to move patients through the pathways as quickly and safely as possible, they are ensuring that patients are not being delayed unnecessarily which was seen to be a positive quality for PAH.

> *"I think the real bonus for West Essex is that, because of the relationships, we have an integrated pathway out for patients who are going home with care. So, we don't at that point have to argue whether it's social care or healthcare. Everybody goes out on a reablement pathway and is enabled to get home."*
>
> - PAH participant

Care plans are made easily accessible for patients with complex needs who may be regular attendees. These may range from loneliness and isolation of an older person or more extreme cases such as drug or alcohol abuse. The care plans and community partnerships are utilised to ensure that patients are only admitted if hospital care is necessary, and they are supported at home if hospital admittance is not required, subsequently helping ease up hospital bed pressures.

> *"I think that's where hospital discharge and front door services come together well is understanding when it's the right time for someone to come in because they genuinely really need it and when is the right time for them to be supported at home. That doesn't mean that they don't need any support. It just means what does that support package look like and might be different and I think that's an area that we're growing into and starting to explore a bit more."*
>
> - PAH participant

The discharge referral process itself was at times perceived as difficult by some PAH participants. This was especially the case in relation to the description of the patient's needs. The referral document to the Transfer of Care Team is filled out electronically, however depending on the input from the medical professionals, the document is not always seen to be accurate which can lead to complications and delays with the discharge process. Emphasis was placed on the importance of discharge documents being fully informative and explaining clearly what the patient should be expecting from their healthcare providers after they have been discharged.

> *"The nurses may send the transfer of care team a referral and then call back and say that they can't go home with that. And then we're like, but that's the description you gave us, so something doesn't quite add up. We have done training with the wards around that, but it needs to be an ongoing thing just to get that flow improved."*
>
> - PAH participant

It was disclosed that the participants believed this issue could be reduced by ongoing training with all members of staff that complete the referral form, including ward managers and matrons. They were also keen on ensuring that new nurses at the hospital understand, from the very start of their career at PAH, the referral system and the importance of accurate form filling. PAH colleagues discussed that emphasis needed to be placed on 'looking at the bigger picture' and the patient's needs once they have been discharged. Examples given were checking if there is a key safe at the house, if they have mobility issues or identifying who may be at their place of care to support them, if required.

For external partners, like St Clare Hospice, the referral process was deemed to be simple and easy to access. As the Hospice has a two-hour response time, the patient can be released into their care quickly and seamlessly from PAH.

> *"If it's a CNS referral from the Princess Alexandra Hospital, it's quite a quick process. With the CNS team, it's easy and streamlined."*
>
> - St Clare Hospice participant

It was revealed that failed discharges were relatively common with reasons including medication not being ready, transport not being there, the discharge summary not being signed and families being unaware that their relative was due to be discharged. Furthermore, PAH colleagues shared their frustrations of referrals being sent to the Transfer of Care Team when the patient is optimised, and care being continued in a non-acute setting, but the discharge itself failing for any of the various reasons above. It was revealed that this could be highly disruptive as the site team rely on confirmed discharges, so any which do not take place can have an impact on the patient flow.

"We get told the next of kin didn't know about the discharge, but you sent us the referral, so why doesn't the next of kin then know? Why haven't you spoke with them when you actually sent the referral which is frustrating?"

- PAH participant

PAH participants were keen for there to be more honest and transparent communication from all parties involved. Experiences were shared of patients being referred for hospital discharge however, they potentially were too unwell to go home. Some of these patients may have appeared well during the morning ward rounds and deteriorated during the day. Instead of reviewing the patient again, it was recalled that some patients' referral forms had still been processed and then the patient was too unwell to leave by the time of the discharge. Participants shared the frustrations from all perspectives, as the patient would believe that they were going home, and PAH colleagues would be planning for that bed to be spare for a new patient. If using non-emergency transport when a patient is taken ill on their way home, this can result in the vehicle being out of service and unable to transport patients later in the day.

"Let's say the ward tells us the medication didn't come up in time. We then think, what time did the doctors actually write medications? What time did it go to the pharmacy? What time did it come back from pharmacy? There's a number of steps involved, so it's not as easy as to say when the medication was back. If you only send the medication out at 4:00, but doctors only do the medications at 4:00, then they're not going to be back by 5:00 so the patient can go home for their care call at six. Ideally what we would like for them is to get everything ready once they send the Transfer of Care Team the referral."

- PAH participant

Participants shared problems with the timings of the hospital discharge itself. It was revealed that returning patients to their home or place of care could be disorientating if it was late at night, especially if the patient is elderly. If it is deemed that discharging a patient late in the day may be harmful to them, it is understandably postponed until the next day. However, this does mean that the patient is occupying a hospital bed when they were well enough to go home earlier in the day. PAH colleagues shared that to help tackle the risk of a late hospital discharge, there is a ward round at 9am to discuss all patient cases, prioritise who needs to be seen first and what actions may need to be taken. This is to ensure that there is sufficient time to order medication and transport if the patient is to be discharged. PAH colleagues shared that the ward rounds are effective, and it is a robust method of monitoring patients who may be due for hospital discharge.

Non-emergency transport participants additionally expressed concerns over the timings of their service being booked. It was shared that issues can occur when discharges are booked for within the same day as they have limited care packages and certain time scales they need to keep to. Participants spoke of these multiple variables which can make pre-existing complex discharges more difficult. Interestingly, several participants within PAH expressed empathy with the pressures being put on non-emergency transport and recognised that timings need to be thought out when engaging with both external partners and patients.

> *"We deal with much more complex cases and that means that there's other parties involved that we don't have any control of. This includes the doctors on the ward, getting the tablets ready, getting the paperwork done in time, getting the care and equipment in place in the home, getting the patient booked on and ready so that we can physically get them home before the time cut off."*
>
> - Non-emergency transport participant

PAH participants were eager to share both areas they feel are going well, as well as areas needed for improvement. Ward rounds were mentioned by multiple participants as an effective method of evaluating patients on that day and discussing what may be keeping them in hospital. By using this process, it was shared that participants believed that this had improved the hospital discharge process in relation to the time that patients spend in the hospital. The improvement programmes, formerly transformation programmes, were additionally praised as an asset by promoting healthy discussions to improve the process for future patients.

> *"The improvement programmes means that there are teams who can work with our normal workforce to say this has to be done differently to get people discharged earlier and these are five things you need to do. We can then wrap around using the improvement teams to make that happen and so I think that we're resourced well here to help improve the way we're working."*
>
> - PAH participant

3.2 The Patient's Experience

Strong communication between PAH and the patients was deemed very important with participants sharing that there was room for improvement. One patient spoke of the importance of honesty and transparency when arranging the hospital discharge. They shared that it was vital patients and their carers be kept up to date on if there were to be any delays with arranging medication or transport for example. Ensuring that the patient is not taken out of their bed until all necessary arrangements have been made will support the patient's discharge to make it seamless and a comfortable experience.

It was not only patients and their families who shared experiences of being affected by delays with medication, but also a local hospice. St Clare Hospice spoke of the need for the medication to be ready to be passed to them as they do not have large quantities of medication themselves. As they are often unable to acquire this medication swiftly, they are reliant on this being supplied by the hospital. In some cases, if this is unable to be done, the hospice shared that they would not be able to take on some patients. Consequently, PAH hospital beds may have to be taken up by patients who could be in the hospice receiving care if their medication was available.

> *"We do say we need their medication because we are such a small unit, we don't have medications on site. We don't have the facilities to get the medication quickly. What is frustrating for me is the following day when I get told their medication hasn't come and asked if that is okay. There have been a few occasions where I've had to say no, the person needs it. I do understand how difficult it can be for the hospitals to give out the medications that they need but it is frustrating."*
>
> **- St Clare Hospice participant**

VCSE participants recalled supporting carers who were notified that their loved one was going to be discharged on the same day. However, as they hadn't been notified in advance, they were away from the local immediate area or may have other arrangements that could not be postponed. As a result, this can be frustrating for family members and delay the patient's hospital discharge due to a lack of transport being available to get them home or to a place of care.

St Clare Hospice colleagues echoed the patient voice and VSCE participants and additionally spoke of their concerns of witnessing patients being discharged with substantial amounts of medication which the families are unsure on how to use.

> *"We feel frustration sometimes when the family doesn't know about the medication that they're prescribed. They get home and they've got big bags of medications and sometimes it's not always clearly spoken about which are injectable, so that they come home and don't know what's for what and it can cause anxiety. Sometimes the district nurses will have to go through the bag with them."*
>
> - St Clare Hospice participant

Jolene's Story

Jolene is a carer for her husband, Carl, who often is admitted into Princess Alexandra Hospital.

Recently Carl was admitted into PAH for 15 weeks where he received excellent care throughout his stay. On the day that he was due to be discharged, Jolene received a phone call at 9am informing her that they would be discharging Carl that day. Jolene was keen to have her husband home so rushed to PAH expecting him to be ready by the time that she arrived.

PAH had got Carl out of his bed, stripped it, and washed everything down however, his medication was not ready, so the hospital did not feel prepared to discharge him. Due to the delay with the medication, they were waiting in PAH until 5pm.

"They had said we had to wait for the medication, we didn't think it would be very long because there's a pharmacy in the hospital. I didn't ever imagine that we'd be there another seven hours."

As Jolene had expected to collect Carl straight away, she had not prepared lunch so was hungry and in discomfort. Carl was also uncomfortable and displeased as he had been sat in the patient chair for 7 hours. Carl and Jolene made a joint decision to leave the hospital without his medication. The medication itself was a drink and not vital medication, of which they had already available at home for that evening. When informing the hospital that they would be leaving without his medication and Jolene

would be returning the following morning to collect it, they were informed that this was at their own risk.

"That for me was very unsettling because I was very nervous to bring him home. Carl was very nervous too after such a long time in hospital."

Jolene and Carl usually have found the pharmacy extremely helpful and believed that the pharmacy was potentially feeling the strain of a high demand of medication for patients. Carl has been delayed twice from leaving PAH and on both occasions, this has been due to his medication not being ready.

"I wouldn't have minded if someone had phoned me to say Carl will be discharged at five o'clock because then I would have known to go there for that time. It was the worst experience and sometimes it masks your whole hospital experience because he was treated with the greatest of dignity and respect for the whole time he was in hospital. So, all of that was very patient-centred but this end bit was a real stumble."

Jolene had additionally been at the Princess Alexandra Hospital to support her mother who was admitted for day surgery who had an alternative experience.

On this occasion, they had a very positive experience and found communication from the hospital to be outstanding. Jolene's mum was admitted in the early afternoon and Jolene was phoned a few hours later to inform her that the surgery had gone well and informed her of the time that they were planning to discharge her. PAH additionally advised Jolene not to come earlier as her mum may not be ready and there could be difficulty parking so to make the discharge pick up as easy as possible, to arrive for a specific time.

"I walked in slightly earlier and there she was with her bag, all dressed. It was a pathway that was just so excellent!"

Jolene and her mum also found the experience of receiving the discharge summary overwhelmingly positive too. Jolene's mum received her discharge letter and other necessary photos/documents ready for her departure and was visited by the consultant as they were preparing to leave. The consultant was keen to see them to say goodbye and to additionally inform them that the discharge letter was now with her doctor.

"Usually, they give you a letter to take to the doctor, but my mum doesn't drive so she doesn't get to the doctors much. He explained fully that the letter contained everything he had done and said that it was with her doctor along with the photos. We all felt very reassured."

Multiple participants spoke of PAH's discharge lounge and the benefits to this. Non-emergency transport colleagues shared they found this to be a huge positive for the

hospital discharge process as it allows their employees to go to one specific area each time instead of visiting different wards.

> *"It really does make it a very efficient move if they can get the patients to the discharge lounge. It would be nice, in an ideal world, for it to be slightly larger and for it to be manned for slightly later into the day. Maybe we'll get that in our proposed new hospital."*
>
> - Non-emergency transport participant

The patient voice participants also expressed that they found the discharge lounge accommodating and pleasant but suggested that improvements could include free coffee and charging points. They additionally shared that this could be a place for patients to fill in feedback forms whilst they wait to leave. If there is a delay to the hospital discharge but the patient has already left their hospital bed, this would be a place of comfort and could reduce any potential anxiety.

3.3 Transparency with Non-Emergency Transport

It was revealed that there is a good and honest relationship between colleagues liaising within PAH and non-emergency transport however, sometimes the discharge process for patients is not always smooth.

Colleagues working within non-emergency transport shared the difficulties that arise when the transport team arrive to collect a patient who isn't ready to be discharged, even if they had previously been reassured that the patient would be ready. This can have a domino effect due to the discharge having to be aborted and then rebooked later in the day. Sometimes the transport team may not have been local to PAH or it may have been a complex case which could require a stretcher, oxygen or a 'two-man team,' which is not always a quick solution to provide. Consequently, there can be an effect on other patients from different areas as the time used to attempt to collect the original patient could have been used for other patients requiring this service.

Non-emergency colleagues spoke of their concerns of being viewed as an immediate service or a service that is specific to PAH when they cover all West Essex. The service is pre-booked, but some patients are booked on for an 'on-the-day discharge.' This can create issues for the service as pre-booked discharges take priority and end of life cases are prioritised over them all. This can mean that there is not sufficient time to collect on the day discharged patients especially as the non-emergency transport service is for multiple hospitals and places of care.

> *"The bit that I find quite infuriating is transport will be blamed for 90%, if not more of the failed discharges. In fact, their terminology is failed discharge due to transport, and that is just because the patient has been booked on transport, not because there was an issue with transport."*
>
> - Non-emergency transport participant

Examples were provided of patients being booked to be transported at 3pm with them having to be home by 4pm, regardless of the location and the geographics of getting the patient from the hospital to their home. It was expressed that time frames and the option to extend time allowances should be taken into consideration. Participants discussed whether hospitals may potentially be desperate to free up hospital beds resulting in them booking non-emergency transport when not everything, like medication or community care, is ready.

Non-emergency transport colleagues shared that they often do 'deep dives' to investigate both successful discharges and failed discharges to review what could have been done differently.

> *"I would say 10% are due to us not arriving within a certain time or an issue with our drivers. Maybe we've had an end of life that's taken priority, or we've got crew or illnesses or a vehicle breakdown. But most of the time, the reason why they are not collected and picked up and discharged within their time frame is because it's unrealistic and they haven't got everything prepared."*
>
> - Non-emergency transport participant

Non-emergency transport stressed how good their relationship is with PAH and revealed that they work well as a team to get the morning transport bookings out earlier to free up the flow. There are frequent meetings attended to discuss the process and patients which allow both PAH and non-emergency transport to engage with each other and raise concerns, if there are any. Good communication, transparency and honesty was seen to be key however, it was expressed that PAH employees need to manage expectations as to what is feasible. Non-emergency transport colleagues were unsure if PAH were aware of the planning which occurs when arranging a vehicle and staff to be in place ready for a patient to be transported. Participants stated there needed to be an understanding of all components of hospital discharge and what everyone's roles consists of, so to have more empathy of what this may involve and what information is required.

3.4 Relationships with External Partners

It was shared by multiple PAH colleagues how beneficial working with partner organisations is when preparing patients for hospital discharge. Being able to utilise local voluntary services can streamline some patient's hospital discharge journey and eradicate delays due to their home or place of care not being suitable for the patient. 'Ticket Home' facilitated by Uttlesford Community Action Network was considered to be an appreciated local asset by PAH and VCSE participants with the support they provide. Examples were given of Ticket Home installing key safes, supporting with shopping and meals, and delivering commodes. These examples save time in getting the patient home or to a place of care. It was disclosed that typically the hospital would have to wait until there was a family member of support worker available to help with these which could sometimes add a substantial delay to the patient getting discharged.

> *"What tends to happen is the day the patient is ready to go home, someone says, 'the key safe's broken and that's going to need to be fixed.' This may take two more days to get that fixed so the patient spends two days sitting in a bed. However, if Ticket Home go in and say, "Is there anything we need to sort out before the patient goes home?" they may be able to sort that out and then save the patient two days."*
>
> - VCSE participant

Similarly, Hertfordshire Social Care Team were revealed to be on-site leading on their own assessments which were perceived to be beneficial to the hospital discharge process. By the Team being in attendance swiftly to complete reviews, they can support the patient with any social care needs which may delay the patient from being discharged.

> *"From a commissioning point of view, as a hospital, we don't commission care support for anyone or placements, so that needs to go through the outside system partners. So, from our point of view, it's helpful for the social care team to be here and do their own assessments."*
>
> - PAH participant

Non-emergency transport participants discussed the importance of PAH colleagues being aware that there can be problems which occur after the patient has been discharged. The problems shared included getting the patient into their home, having a key safe and the home not being appropriate for medical equipment. Participants stressed how important it is for the information during the booking of the non-

emergency transport to be correct to ensure that the hospital discharge is completed successfully.

> *"If the correct information isn't on the booking, then it can have a huge knock-on effect for the rest of the day's work. It could possibly mean that we are bringing the patient back. We've done that a couple of times because processes weren't followed correctly within PAH and that is within the community care side and social care. I don't like patients going back to hospital if they're well enough to be discharged but we also have a duty of care."*
>
> - Non-emergency transport participant

Non-emergency transport colleagues revealed that they had strong community care connections, who could step in to support difficult situations. However, there is a need for any issues to be addressed before the patient is discharged and not when the patient arrives at home. Suggestions were made by VCSE participants of PAH reviewing why a patient was admitted and seeing if it was preventable. To reduce the possibility of the patient being readmitted due to a similar issue, the voluntary sector and social prescribers could be enabled to support the hospital discharge process and offer advice and guidance to the patient.

> *"I don't know whether this happens to any extent, but it would seem wise when someone is admitted for something like a fall to think, was there anything that could have been done so that this did not happen? As part of the discharge process, advice could be provided to ensure this does not happen again."*
>
> - VCSE participant

The work conducted supporting patients who are being discharged but are homeless was mentioned by several participants as a specific area that they thought PAH exceeded on and they were very proud of. PAH colleagues spoke of having strong relationships with local council services who support the homeless community, including the 'Daisy Project' and 'Compass.' If a homeless person is admitted to hospital, the hospital has a duty to refer them to a support service and participants spoke of there being good outcomes from this relationship. This was disclosed as being an area of hospital discharge not typically spoken about however, understandably deemed important by PAH participants.

> *"Our patient was living in a caravan diagnosed with lung cancer. We got him housed fairly quick into a suitable adapted property. He came back to hospital a week later and*

actually passed away here. The thing is we kind of felt that it was important for him, because he was living with his 20 odd year old son in this caravan mobile home all around Harlow and he didn't want to go anywhere without his son being sorted. So we arranged for both of them to go all together in a tenancy. He knew his son would be sorted. He could let go, he was ready as he knew his son would be ok. So we've got really good relationships and communication with outside agencies, I'd like to say. We kind of pride ourselves on that."

- PAH participant

It was shared that PAH had previously received local charity grants to provide patients who are homeless with warm clothing and provision bags. PAH colleagues shared that they are signatories of the food bank, so they have the opportunity to provide food bank vouchers. By providing the local homeless community admitted with warm clothing and food vouchers, this may help reduce the probability of the patient potentially being re-admitted.

The Care Coordination Centre was mentioned by multiple participants, from different roles, who shared that the Centre had noticeably improved the hospital discharge process. It was described as a central hub that has oversight of different care pathways within West Essex which enables patients to have a smoother hospital discharge. The use of System One additionally allows for professionals to have a look at the patients record and ensure that the patients have access to the appropriate community resources to ensure that they are not re-admitted into hospital. DVC Group participants praised the use of the Care Coordination Centre and shared that it allows the patient to be discharged into one of their services swiftly, if ECL are unable to take the patient. However, it was noted that, similarly to concerns raised by PAH colleagues, the referral forms are not always clear on the patient's background. DVC Group are able to talk to the Care Coordination Centre to gather more information, but it was shared that it would be beneficial for all information to be included from the hospital initially. This would make the discharge process more seamless for both the professionals and patients themselves.

"The hospitals sometimes are not clear about the patient's previous journey. Some referrals we receive, we are not sure what the patient has been going through. We need to have some kind of history of the patient. What was the reason for his hospital admission? What sort of previous medical history he has? We need to have some sort of information, but we have seen some low quality of referrals. So that's the issue which we sometimes face."

- DVC Group participant

Concerns were raised by PAH participants around community capacity which can delay patients' hospital discharge. It was shared that there are occasions when the patient no longer requires hospital care however, there is not the capacity within the community to support that person in their chosen place of care.

> *"There are many times when patients are ready to go home from a medical point of view and no longer need medical input, but they do need other elements of care and accessing that either within their own homes or in a nursing home or care home setting. Accessing this care is where we can find constraints."*
>
> - PAH participant

It was raised by PAH colleagues that the difficulties around community capacity included a lack of nursing home beds within the local area. This was perceived to be particularly difficult to manage and can lead to PAH having to explore different options including the patient going home. This is not always easy due to family members not having capacity to support their loved one, or the concern that the family may be continuing to live in a house which their loved one had passed away in.

The discharge to access process was shared as being effective in trying to negate the impact of a lack of nursing home beds. PAH participants shared that some patients are unable to go home for reasons which may include living with dementia or not having a home as such to go home to. By using the discharge to access process, it allows PAH to use nursing home beds for patients where they will be able to have their health and social care assessments.

> *"It can be difficult however because choice is limited because they're block purchased. You can't necessarily choose which one to go into, and that's sometimes they'll cause a tension between families and patients."*
>
> - PAH participant

PAH colleagues disclosed that with general care support, this can be arranged very quickly, sometimes as quickly as the same or next day, which can make the hospital discharge process for those patients very efficient. Placements were shown to be where there are more likely to be delays, especially with patients who may require additional care and support. Some patients may present behavioural issues, dementia, or mental health conditions which, on occasion, may lead to local residential homes declining to take them into care due to not having the capacity to care for these patients.

> *"We work on a home first approach as in everybody that can go home, should go home and only the very extreme cases we say can't go home. The extreme cases will unfortunately have to wait until a nursing home says yes and that they can meet the patient's needs."*
>
> - PAH participant

St Clare Hospice echoed this and shared that they found that patients being discharged directly from the hospital to the community worked well. They receive the referrals just before the patient goes home or as they are leaving which they disclosed as an effective and positive process. Participants, however, encounter difficulty contacting the hospital to find out information regarding a patient that is due to be discharged into their care or if they have a hospice resident who may need to be taken into hospital.

> "At Princess Alexandra Hospital, they have a new system where they ring each other but we don't have that. So, if we can't get hold of them, I'll try to ring the CNS and the wards to say we are taking a patient and we need to let the families know, we rely on them to do that. Sometimes you cannot get through to the wards, so you are relying on the CNS to send an alert to the ward."
>
> - St Clare Hospice participant

St Clare Hospice spoke of issues on occasions where they have attempted to contact PAH when a bed is available. Sometimes they can be ringing multiple times, which is time consuming, and causes delays when they wait to hear back from the wards. If the ward says no, St Clare Hospice must start again and go on to the next patient on the waiting list to see if they will be taking a bed. Sometimes, this can mean that a sought-after bed is empty for the day whilst the Hospice is trying to get in contact and wait for a response. By having direct contact with the wards, this may reduce the time spent trying to find patients and reviewing their suitability to be placed into the care of the Hospice.

3.5 Managing Expectations

Participants working within PAH disclosed that they believed that there could be improvements in how they manage the public's expectations. Examples were provided of patients expecting them to be able to place them within a nursing or residential home permanently from the acute trust, which is not feasible for PAH.

> *"I think we're getting better at having the conversations, but I don't think we're getting better at managing expectations. I can't fix the hole in the booth. I can't stop loved ones from falling. I can't put a 24-hour living care room in for free. I can't do some of the things that that we're being asked to do."*
>
> - PAH participant

Participants shared that at PAH, as soon as a patient is admitted, if not as an accident or emergency, then colleagues start working together to name a date which they believe is reasonable for discharge. This is discussed with patients however sometimes the patients do not respond well and feel they are being "kicked out." PAH colleagues stressed this not to be the case but highlighted the need to be honest and transparent when engaging with patients to reassure them. This would also include patients being discharged into other forms of care once PAH had supported the patient with the medical aspect of their care. It was highlighted by PAH colleagues that some patients do not feel well enough to return home and live independently when they have been told they are being discharged. This again shows the need for transparency and honesty with all patients and therefore staff should reassure and explain what the next steps will be for them.

> *"Patients need to recognise that there's difference between medical care and other care, and they may be leaving hospital to go home or a care home, even if they're not feeling 100%. The medical part is over, but they just need care whether it's with eating, drinking, with mobilisation, as in walking or with help with a frame or crutches, or any of that which they maybe could have done themselves, but now they can't. They'll say, "how can I go home if I can't do that?" Well, actually the message is you can, but with other care support."*
>
> - PAH participant

We spoke previously about managing expectation, which also extends to family members. PAH colleagues shared that there are often difficult conversations to be had with families, which can make the hospital discharge slower and more complicated.

They spoke of families having disagreements due to the patient not wanting to go into a nursing home, with the family believing they are not capable of looking after the patient in a home setting. Participants spoke of the need to educate the public on what their plans are for when they get older including if they would be willing to go into a nursing home. This in turn would make the hospital discharge process smoother and more efficient if these conversations had already taken place.

> *"I think one of the things we need to get better at as a system is how patients can access services in the Community, how we can start to plan for people that this might be their next step and how might we be looking at it and making it very much more of a planned approach."*
>
> - PAH participant

PAH colleagues emphasised that not all patients will be discharged of good health and there will be times where some will be discharged to receive palliative care in a place of their choice. The hospital discharge process is sometimes delayed as families are trying to arrange last minute planning which may include ensuring that wills are completed, and all relatives are notified. There is an additional complication if PAH ask families about where their loved one would like to die if the patient has not made the decision themselves, which can be stressful for relatives who may be unsure on what to do. Participants shared that this decision sometimes must be made in a short window of time which can be difficult.

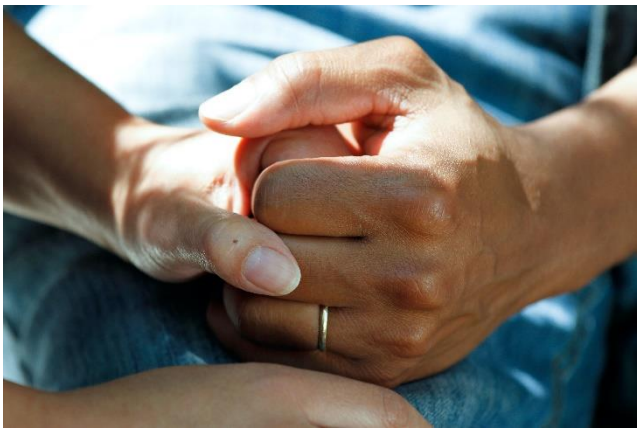
> *"I think there is a disconnect and a tension between professional services wanting to do the best and trying to support and trying to help navigate some of those decisions with the families. They need to reflect, consider, estimate, get to terms with all of that stuff and I think that's where some of the tension comes."*
>
> - PAH participant

Some PAH participants reflected on time pressures, and the need for there to be more understanding on how difficult this process can be for families from a staff perspective too. Being able to have conversations earlier where possible within the patient being admitted can give the families time to have their thought process and make decisions.

> *"Our thinking process is much quicker and so I think we've got to get better at allowing time for patients and relatives to have those thought processes. However, we're in an acute hospital, we haven't got time so how do we come to some balance? It's probably that we need to get better at having the conversations earlier in the patient's journey. We*

probably need to get better at being specific about what that might mean and being specific about what engagement we need for patients and or families."

- PAH participant



Non-emergency transport participants disclosed that from their perspective, discharging and transporting end of life patients is usually seamless. They spoke of the prompt and effective communication from PAH notifying them of the patients' situation. They shared that they pause the current job and are diverted to the PAH patient to which they have a 60-minute window to get them back to their chosen location.

It is important to note that the areas of improvement suggested by the participants could be deemed as not specific to Princess Alexandra Hospital as similar experiences are evident within local Essex and Hertfordshire hospitals.

John's Story

John is a carer for his wife, Sally, who is living with multiple health conditions and was admitted into Lister Hospital 16 times within 12 months.

John and Sally have encountered multiple negative experiences, whilst being discharged, one resulting in a safeguarding complaint about the hospital due to them discharging Sally with a category 4 wound.

On one occasion, Sally was admitted into hospital with a UTI to which John was able to join her due to her being in such poor health. John had overheard the consultant say to the ward sister that Sally was not to go home until she had two clear blood tests come back. Unfortunately, there was a lack of bed capacity leading to a pressure on staff to discharge Sally even though one of her blood tests had come back only just

clear. Sally was discharged and her health deteriorated quickly resulting in her having to be admitted straight back into hospital. When the second blood test result came back, it was discovered that Sally had sepsis.

"The issue is that these are people's lives. There could be horrific consequences from not just keeping her in the bed just to do that second blood test, one double check. Yes, they freed up four hospital beds but they put Sally's life at risk."

Sally had also encountered issues with her discharge summaries and was once discharged with a discharge summary that did not belong with her and was for a male patient. This also contained a DNR notice which they understandably found deeply concerning. On another occasion, her discharge summary mentioned a tablet and had the acronym TBD next to it. John was unsure what this meant so phoned up the hospital to which he was told that this meant two times daily. A little while later, John and Sally went to a follow up appointment due to Sally's spasms. When informing them how many of these tablets she was taking, they were informed that this was the wrong amount.

"So they said, how much of this stuff have you been given her? I said twice daily and they went no, no, no, that that means 3 days. I thought why not put two or three tablets on the discharge summary then?"

As reflected in the experience of Lister Hospital above, hospital discharge is often greeted with a multitude of challenges for all individuals involved however, reflecting on comments made by participants may support easing bed capacity pressures being placed on PAH.

3.6 Recommendations

1. PAH Staff Training

Staff who complete referral forms for the Transfer of Care Team to receive training on how to fill out the referral form accurately to ensure that the patients' information is correct. Incorrect or missing information on the referral form can delay discharge unnecessarily. By training not only current staff, but also new nurses too ensures that all staff who complete the referral forms understand the importance of an accurate referral form.

Training to include encouragement of staff to think about the patients needs after the hospital discharge. There can be issues encountered including difficulty accessing the home via key safes, equipment not being in the home to support the patients or hoarding for example. By looking at each patient individually, it can be reviewed what their needs may be once they are home or in their place of care. Their needs being considered reduces the probability of a patient not being able to be placed into their home or place of care and returned back into hospital.

Training could include patients and families with lived experience sharing their stories of hospital discharge. Participants shared that staff need more empathy when dealing with families however there can be time pressures meaning quick decisions have to be made. Hearing from people with lived experience may emphasise the need for transparency and honesty when having difficult conversations with patients and their families.

2. Utilising Local Charities and Organisations

PAH to continue utilising support from local charities and organisations including Ticket Home. These organisations can aid patients when they are due to be discharged and support them in their home or place of care. As mentioned above, this may minimise the pressures on hospital bed capacity as there will be less of a delay to discharge the patient and reduces the potential of the patient having to be returned to hospital if their property isn't suitable.

3. Public Engagement Workshop

PAH and non-emergency transport to work together to facilitate a meeting or workshop to understand more of each other's roles and what is involved to ensure a smooth hospital discharge. The communication between coordinators is very strong however, there needs to be more of an understanding by wider staff of potential limitations and what can be done to negate any potential difficulties or delays.

4. **Direct Ward Contact Numbers**

St Clare Hospice to be supplied with ward contact numbers which can be used for when there are time pressures to getting a patient to a hospice bed. Having the option for direct contact reduces the wait time for the hospice to hear from PAH if a patient can be transferred and reduces the possibility of a hospice bed being empty for a day when there is a waiting list.

4.0 Conclusion

By engaging with individuals from a variety of professions and people with lived experience, valuable insights have been gained on how to improve the hospital discharge process at Princess Alexandra Hospital.

There was a clear need for staff training identified which included emphasising accurate completion of the form and developing skills of anticipating and subsequently addressing the potential needs of the patient's post-discharge. The staff training could be supported by the incorporation of lived experience and engaging with patients and their families. Working with local support charities and organisations establishes a positive continuity of care but also can help create open and transparent relationships with the external stakeholders.

By incorporating the above and continuing the highlighted areas of good practice which include supporting the homeless community when admitted, daily ward rounds, strong communication with external stakeholders and the usage of the discharge lounge will support the transition of the patient either home or to continued care, ultimately improving patient experience.

Healthwatch Essex
49 High Street
Earls Colne
Colchester
Essex
CO6 2PB

www.healthwatchessex.co.uk
0300 500 1895
enquiries@healthwatchessex.co.uk
@HWEssex
/healthwatchessex
@HWEssex
/healthwatch-essex
@hiddenvoiceshwe