Transfer of Care Hub: Current Discharge Pathway Report

Contents

2. About Healthwatch Thurrock and the report

3. Informing the report

5. The Professionals: who did we hear from?

12. The Professionals: a summary

13. The Professionals: recommendations

15. The Patients: what did we ask?

18. The Patients: qualitative experience

22. Case studies

26. By Your Side: Home from Hospital project

27. The Patients: a summary

28. The Patients: recommendations

29. Index

About Healthwatch Thurrock

Healthwatch Thurrock is the independent Health and Social Care champion for the residents of Thurrock. Healthwatch Thurrock presents the voices of local people to help aid in identifying the need for change, considerations before commissioning and to support best practice across services. We are positioned as a critical friend to services on a local level and nationally through Healthwatch England.

Through conversation and engagement with people using local services, Healthwatch Thurrock are able to highlight gaps in service and promote recommended improvements. We know that services are better when people are treated as individuals and are actively involved with shaping support. To do this, services need to be privy to the real stories and lived experience of local people to understand how they can adapt and change to local needs.

For more information about our role, please visit our website.

About this report

Setting the scene:

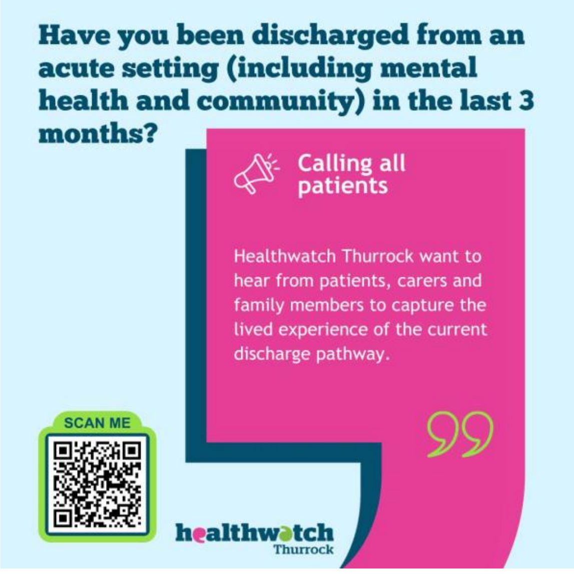
The Transfer of Care Hub (TOCH) project group were keen to commission a qualitative report on the lived experience of discharge pathways in Thurrock. This briefing has been produced to capture the lived experience of both professionals and patients to help inform opportunities for service transformation and change.

Healthwatch Thurrock had received many calls from patients, their families and carers, raising concerns about the discharge procedure following a stay within an acute setting across the Mid and South Essex area, including those discharged from acute mental health settings. The voluntary, charity and providers of care services within Thurrock have raised concerns around the inequality of the lived experience of patients at point of discharge.

With the current plans looking at introducing a TOCH within the Mid and South Essex Integrated Care Partnership area, this is a prime time to carry out a review of professionals and patients lived experience and to ensure those findings and voices are captured and used to co-produce a safer discharge system.

Informing the report:

Healthwatch Thurrock designed two surveys to capture the lived experience documented in this presentation. One for professionals and one for patients and their family and carers.



These were both promoted in the Healthwatch Thurrock newsletter and social media channels (Facebook and Instagram). They were also shared in the weekly Thurrock CVS newsletter and Thurrock CVS Facebook page. The survey for patients was also distributed to a number of community groups such as Thurrock Carers Service, Thurrock Stroke Project and COPD support groups. We also took physical copies of the survey to our regular engagement events. By Your Side Home from Hospital project also encouraged residents they contacted to reach out to Healthwatch Thurrock to share their experience.

For the professionals, we shared the survey with a directory of staff we already possessed.

Both surveys were also sent to the Patient Experience Team at Basildon Hospital and were shared on wards and waiting areas.

Healthwatch Thurrock also held a number of drop in sessions around the borough to invite people to share their experience with us.

The Professionals

Lived Experience

The professionals: who did we hear from?

We received responses from 31 professionals

Types of professionals we heard from included:

- Service planners
- Social workers
- District nurses
- Support planners
- Care pathway facilitators
- Discharge coordinators
- Community nurses
- Clinical leads
- Consultant physicians
- Registered nurses

The profession we heard the most from was social workers. As demonstrated above, we managed to capture responses from a broad range of professions. This in turn enhances the recommendations in this report as they can be identified via the lenses of all the different professions listed above.

The professionals: what did we ask them?

Are you always aware if a patient is going to be discharged?

13 responded **'Yes'**, **13** responded **'No'** and **5** responded **'Other'**

"No, sometimes our residents just turn up without prior warning"

"Usually ICT get a referral, although this does get missed on occasions"

"Sometimes when it is ward led we are not made aware until later"

The 5 responders who selected 'other' all acknowledged that whilst most of the time they are aware if a patient is going to be discharged, there have been occasions where they have not been made aware.

Do you have any concerns surrounding the current discharge system? If so, what are they?

23 responded **'Yes' (74%)** with **8** responding **'No'**

From the responses to the above, we were able to identify a number of themes that were presented as a reason for the concerns. Some of these are:

Poor communication leading to gaps between hospital and community services

Referrals not being received for patients in outlaying hospitals such as Broomfield

Issues around capacity and pressure

Patients being discharged without appropriate equipment and medication

Families need a better explanation of the financial implications of outer borough placement if health funding is not agreed

None or very little notice of discharge

Many of the concerns presented to us were around an increased number of 'failed' and 'unsafe' discharges. A factor that was cited as a possible reason for this is the use of 'medically optimised not fit' as the current discharge criteria that was bought in during COVID 19. Using medically optimised means that some professionals feel as though patients are being discharged too early without the right support in place. However, the use of medically optimised not fit was not the only factor put forward as a possible reason for this.

We also heard of concerns around increase in local demand alongside a lack of capacity within the MSE hospitals. It was clear that professionals had come into contact with patients who were discharged without equipment, the right medication and discharge letters, meaning that consequently they could not then continue care for that patient in a seamless manner.

It was also clear that many professionals shared concerns relating to patient choice, going hand in hand with a lack of communication with patients and their families/carers. An example that was frequently used was when patients are discharged outside an area of familiarity and homes that compromised affordability if the patient is no longer eligible for health funding. From the above, it is evident that each professional sincerely wants to deliver safe, successful and positive discharges and care experiences. However, due to working in an overwhelmed environment at a time when local demand is at its highest, this is not always possible for them.

"My main concern is short notice and insufficient information to enable me to complete my duties to the patient's satisfaction. Lack of cooperation from hospital staff in particular when the case holder is not on duty, we get passed from pillar to post with no solution or tangible facts about the case"

"Referrals often contain a lack of information or incorrect information"

"As they are still using 'optimised', not medically 'fit' as the discharge criteria and due to current pressures, we are seeing huge increases in failed discharge"

"There are many times we are not made aware of a patient being discharged but they have been told that community nurses will visit. We don't always get given all of the relevant information to ensure patients have a good experience. Patients are often discharged without correct or any equipment such as spare catheters which can result in a delay for patients once in the community"

"We do not always get a referral for patients being discharged from outlaying hospitals (e.g. Broomfield)"

"I have significant concerns around Thurrock patients being placed in out of borough high cost placements away from family and the individual/ family not fully understanding the process and what is entailed should health funding not be agreed at the time of DST"

Can you provide examples of when the acute discharge system has worked well?

All 31 professionals gave examples of when the system has worked well

Through the responses from the professionals, we identified some common themes that were all attributed to the current discharge system working well.

Clear and open communication between professionals

Being given relevant information such as changes to medication to continue care

Referrals sent to Thurrock First from the acute trusts

Communication with the patient and making them aware of the processes they will go through

MDT being arranged and a proper discharge plan being put in place

Receiving referrals in time

Running through the extensive examples that were provided to us was the theme of communication. Each example provided described how effective communication between and across; wards, A& E, MDT, IDT, patients, families, and social work teams – allowed for a successful and safe discharge to happen.

*Other examples mentioned patient's choice and personalised care **"End of life patient discharged home with 24 hour care** as **did not want to go into a care home"** – this demonstrates that successful and positive outcomes happen when good and effective communication is in place.*

From the examples provided we were also able to ascertain that the system works well when the practical details of someone's discharge are correct as it allows for other teams to continue providing care in a seamless way. For example, when the right medication, correct referrals, appropriate equipment and discharge paperwork is put in place, not only can care continue either in the community or at home, it means other teams do not have to spend time chasing these things, to then provide care.

“When resident returns with equipment, correct medication and a discharge letter”

“Cases when MDT has been arranged, all professionals work together, information has been shared and the patient and family were fully involved”

“Working with Thurrock First is an absolute pleasure. They are always helpful, responsive and willing to support in any way they can for the individual as well as colleagues”

“When we receive notification of discharge in time, which enables us to do the reports as well as sourcing care providers in time”

“If there has been direct contact from the support planner or social worker involved to give accurate information”

“When we are given referrals in a timely manner with the relevant information and the patient is fully aware and prepared with the next steps on how community services are going to support them moving forward”

“When the hospital social work team have been involved, discharges go well”

As a professional can you identify any barriers within the system that prevent every discharge working well?

26 responded **'Yes' (83%)** with **5** responding **'No'** and **1** responding **'Other'**

The 25 professional's that answered 'Yes' and the 1 that responded 'other' to the above were able to provide us with examples of barriers. The 5 that responded 'No' did not provide any further comment. Below are the most noted barriers to effective discharge highlighted by professionals who took part in the survey:

Communication was cited 11 times directly within the responses

Lack of transport

Lack of understanding of the different process each service has to complete

Inaccurate information and lack of information

Capacity

Not a holistic approach

Patient expectation raised by the acute side i.e. promising home visits to non-housebound patients

From the 25 respondents who answered 'yes' to the above, there was a feeling of frustration with the current system. It was noted that the system does not provide a holistic approach for patients or professionals which can lead to teams working in silo. It was also evident that there is a lack of understanding of different processes each service has to complete for a positive outcome and also the limitations of some services. This can provide false hope for the patient at the heart of the discharge, which can potentially lead to blame, and dissatisfaction for the patient.

A lack of transport and communication to patients around transport options was also regularly cited as a barrier – this is important to note as it demonstrates how every single factor of the process is important in providing a safe discharge. Without a way home or to a patient's next place of care, they can only stay in hospital or use transport such as taxis that cannot provide any clinical help if needed. This can lead to a stressful situation for the patient and for the professional trying to discharge that patient.

Similar to concerns and examples of when the system works well identified by professionals, communication comes out on top as the main factor running through barriers identified by professionals. A lack of communication alongside a lack of knowledge around processes can present barriers to all individuals involved in the discharge process.

“Lack of understanding of the different processes each service has to complete to ensure positive outcomes for the individual”

“Inaccurate information which can lead to an unsafe discharge and patients being discharged without the appropriate equipment in place”

“We do not have enough capacity at BTUH to meet local demand”

“Time constraints, lack of staff to enable detailed referrals to be sent to the team for ongoing care needs – we need a clearer referral form”

“Poor communication, poor understanding of community services and their limitations. Lack of time and staff to carry out referrals in a timely manner with appropriate information”

“The pressures on the acute to discharge patients, the staffing pressures in the community and patient expectations raised by the acute side e.g. promising home visits to non-housebound patients”

“Not a holistic approach”

“Lack of communication and blame culture. Not working together/working in silo”

The Professionals: a summary

The most common theme cited by different professionals working in the same system is clearly highlighted as communication. As one respondent said "***not all hospital discharges need adjusting – the main issue is good communication and relevant information***".

Within the responses, communication is highlighted as the biggest barrier to effective discharge and the key to the discharge system working well.

This is relative to communication between medical and community settings, multi-disciplinary teams, the three Mid and South Essex Hospitals and with patients and their families/carers.

The feedback from professionals allowed us to identify that there are other concerns that could present as obstacles for good communication to always happen, and that could lead to unsafe or failed discharges.

Some examples are lack of capacity, lack of understanding around all the different processes each team has to complete for a discharge, an increase in local demand, lack of staff and pressure to discharge.

The above also meant that some professionals felt there was not a holistic approach within the discharge system, which can lead to a fragmented experience for both the professional and the patient.

This fragmentation has presented as patients being discharged without the right medication, inappropriate equipment or aids, discharge papers, or referrals into community services.

Without these elements to someone's discharge process being in place, it can become harder for some professionals to provide continued care for a patient in a seamless manner, in turn making some jobs more challenging.

An increase in local demand, pressure to discharge, and lack of capacity within hospitals has created an environment where it is not possible for effective communication to take place, preventing a streamlined discharge system 100% of the time.

All of the professionals who took part were able to provide us with examples of when the discharge system has worked well, and it was evident that all professionals wholeheartedly strive to provide safe and successful discharges 100% of the time. It is not a lack of care or consideration, but the current environment that can sometimes cause issues around a patients discharge.

The Professionals: recommendations

1. **Enhanced education and true understanding around the different processes each service has to complete for a positive outcome:** Throughout the responses from professionals, it was clear that there is a lack of understanding and clarity around the processes and limitations of other professionals and services working within the same discharge system.

2. **A review into the current referral form with an outcome of a clearer process:** In the responses, there was a need for a more concise referral form. Due to time constraints and lack of staff, the detail needed can't always be captured.

3. **Mandatory minimum 8 hour notice period for discharges into community:** It was clear that referrals into community are not always made, meaning a delay in care for the patient. With a mandatory minimum in place, we are hoping this gap can be bridged.

4. **To ensure transparency around implications of outer borough placement, including the financial aspect to this (i.e. top up fees, health funding not being agreed). Clarity is needed around who this responsibility sits with and who can provide clear answers to any questions:** Many professionals cited this example as their main concern, alongside concerns around patient choice and patient capacity.

5. **Ethos of holistic approach to be embedded into the system, to create an enhanced experience for both professionals and patients:** It was evident that some professionals felt there was a blame culture present, and that a lack of communication has led to teams working in silo. This in turn, does not create a holistic environment for professionals to work together for the best outcome, and only creates a fragmented experience for the patient.

The Patients

Lived Experience

The Patients: what did we ask?

We had 21 direct responses to the survey. Some of the case studies in this section did not directly respond to the survey, but wanted to share their experience with us.

Was your discharge planned?

12 responded **'Yes'**, **8** responded **'No'** with **1** responding **'Other'**

The responded who chose 'other' explained that their discharge was pending the bridging team.

Were your family members/carers made aware of the date/time you were going to be discharged?

7 responded **'Yes'**, **11** responded **'No'** with **2** responding **'Other'**

Those who responded 'other' explained that they were either given a date or a time, or that they were given a date and time but the discharge did not end up happening at that given date and time.

"I had to tell them myself"

"We was told the next day which was a Friday, but did not happen until the Monday night. I did get a call telling me roughly when the transport would be bringing my father home"

Did you feel confident that everyone who needed to know you were being discharged was made aware?

9 responded **'Yes', 11** responded **'No'** with **1** responding **'Other'**

The responded who chose 'other' explained that their response was not in relation to a family member or a carer but medical – they answered ***"I had no info from the hospital re aftercare, so I contacted my surgery re aftercare for daily surgical dressing changes"***

How much notice were you given at point of discharge?

2 responded **'More than 24 hours', 16** responded **'Less than 24 hours'** with **2** responding **'Other'**

Those who responded 'other' provided us with the further explanation that the notice period they were given changed due to their point of discharge changing.

"I was given one hour, but I needed longer to organise care and travel"

Were you discharged with medication?

16 responded **'Yes', 2** responded **'No'** with **3** responding **'Other'**

Those who responded 'other' explained that whilst they were, they had to ask for it or were given the wrong medication/dosage.

"Yes, but wrong (high) strength, so I was admitted again"

Were you discharged with equipment and aids to support your discharge?

7 responded **'Yes'**, **9** responded **'No'** with **5** responding **'Other'**

Those who responded 'other' either didn't need equipment or aids, or already had them at home.

Were you discharged with referrals to community nursing support if required?

3 responded **'Yes'**, **11** responded **'No'** with **7** responding **'Other'**

Those who responded 'other' either didn't need community nursing support, or had transferred into different hospital due to needs. Some were unsure if the hospital had sent their referrals for community nursing through or already had this in place such as a COPD nurse every 6 months.

Did you fully understand why you had been an inpatient and were any follow up appointments/treatments discussed with you?

15 responded **'Yes'**, **4** responded **'No'** with **2** responding **'Other'**

Those who responded 'other' explained that whilst they did, when they were in hospital other health issues were identified but remained unsure what was going to be done about the new issue or the next steps.

Which acute setting were you discharged from?

Broomfield: 1

Southend: 2

Basildon: 19

Did you have a full assessment of needs before being discharged?

6 responded **'Yes'**, **9** responded **'No'** with **6** responding **'Other'**

Those who responded 'other' were either unsure if they had had one, or discharged to another hospital due to needs.

"My father possibly did but I wasn't present to confirm or deny as I would have questioned his ability. My father is able to make decisions on his own, but I would have challenged them, with his best interest at heart"

What is your current situation?

We had a range of responses to this question such as;

- At home recovering
- Waiting on referrals from being discharged
- Now an inpatient
- Receiving palliative care

The Patients: qualitative feedback

We asked respondents to the survey to provide feedback on how their discharge could have been improved. In the following pages we have shared their lived experience to paint a picture of what would have enhanced a discharge experience from a patient's point of view.

“Nothing at all”

“I do feel I would have benefited from some form of after support, due to the fact I’m still weak but need to maintain a house/shopping/looking after children”

“I feel they didn’t know anything about my background or family situation they just wanted me out of my bed. There was a man in a bed waiting outside my room all day waiting for me to leave so he could go in there, it’s no fault of the man or the staff, just lack of beds”

“It took so long”

“Everything could have been handled with more care and information. I have Parkinson's and mental health problems and have attempted suicide twice in the last six months. They could have been much kinder to me and more informative”

“Improve the night care settings on wards... I was on Linford Ward at Basildon Hospital and it was awful. I highly praise the day care team. My mental health drained and a couple of nurses didn't help with taking their issue out on me”

“More cohesion with patients i.e. patients not having to ask for medications or dressings etc.”

“I am waiting for a letter 3 weeks later”

"Discharge was a total mess up, left an 89 year old, my mum, waiting all day to be sent home. They called me to say she was coming home, then a few hours later couldn't get transport or carers ready but didn't tell her. I went to visit, ended up taking her home as she was so distressed and I bridged her care until it could be sorted. Absolutely awful to treat an elderly person like that. The OT told my mum she was coming home at 11, but failed to let the transport or ward know until after 1 when the cut off was. Why wasn't she informed? She was left with her bags packed ready to go until 5pm when I got there. I am filling this in on behalf of my mum"

"Was mixed messages...no transport, no wheelchair, was not happy about taking walker even though my husband could not walk without one. Asked to leave in pj's, dressing gown in pouring rain. Having to try and walk to relations car. In a lot of pain"

"Discharge was not good my mother's blood sugars dropped to 2 before discharge but this was not conveyed to me. It was another patient on the ward who informed me. They kept us waiting 6 hours for her medication. I was told I could take her home and come back. I refused as it is a 60 mile round journey from my mother's house. Nobody checked if at 98 she needed any assistance at home"

"I don't think it could've been improved, I was very well looked after and everything was put in place for me to come home safely"

“Hospital was very helpful. Staff were wonderful”

“The staff couldn't have been more helpful, it was like being in a hotel you were that well looked after, many thanks”

“There was no communication - I was sent home with a sharps box to remove my own staples and told I couldn't have district nurses as I am out of area”

“Mum has dementia and was dropped off about midnight last night was given half an hours’ notice. This morning carers came and realised she had been discharged with a canular still in her arm and an oversized catheter bag, wrong size type you fix to a bed, nothing was in place for her discharge”

“The assessment to see if my father could walk down stairs etc. was done on the Wednesday. They said he would be discharged Friday, but this didn't happen due to the bridging team not being available. He was not discharged until Monday night, but he was not exercised daily after passing his assessment, therefore he hadn’t had any exercise for 5 days. When he arrived home his mobility was terrible and he fell the following morning and he has had to increase his care package because of this. I am disgusted that people are pushed to complete the assessment and the exercise regime is not kept up until the time they actually leave the hospital. Muscle wastage happens so quick in elderly frail people”

Case studies: **In this section we have chosen some case studies that highlight some of the concerns and success of the current discharge system noted so far in this report. All the names have been changed and any issues presented resolved.**

Case study 1: Unsafe discharge

Background:

Lisa needed surgery for cancer and she was told this would be done at Southend Hospital.

Lisa's surgery took place and she was in hospital for 6 days. On the 6th day one of the sisters on the ward came up to her and said "you're meant to be going home today" - a doctor had written her discharge letter and not told anyone. It was too late for Lisa to arrange transport to get home that day so had to wait until the next afternoon.

Lisa was sent home with a sharps box, syringes to inject herself and a staple remover to remove her stitches. She was told the district nurses won't do it as she is out of area as a Thurrock Resident.

Whilst in recovery at hospital, Lisa had little contact with any staff re her operation. Following on from this surgery all Lisa knows is that the cancerous tumour and the ovary it was attached to has been removed. She does not know if she needs any further treatment, if there are any other tumours, or if she still has cancer.

Since being discharged from Southend she has heard nothing. When she has called the hospital to get more information she was told someone would get back to her in a week or so.

Lisa still had not heard anything or had any answers to her questions 8 weeks post operation. When Lisa has tried to phone the specialist nurses in Oncology at Southend she is met with the reply "histology report isn't back yet, might have been sent to another lab for a second opinion".

Outcome: Lisa came through via the By Your Side service who alerted Healthwatch Thurrock. Healthwatch made contact with the PALS service at Southend Hospital on behalf of Lisa and raised the issues in this case study to the MSE ICB.

Case study 2: Pressure to discharge

Background:

Kate was referred to Broomfield hospital to have three teeth removed. Kate was happy to be put to sleep for the procedure. Kate also explained her reasons to make sure she is kept overnight which was agreed with the assessing anaesthetist. Kate was sent a letter with the procedure date which also stated she would be staying overnight.

Kate went under the anaesthetic, and had two teeth removed. After the procedure, the surgeon told Kate that she was fit to go home and it was his intention to send her home, perhaps in a taxi.

Kate told the surgeon she was booked in for an overnight stay and the nurse gave her a paper who came to check her blood test which states which ward she was going to after recovery.

In the first recovery room, Kate was allocated a nurse to monitor her. Another nurse came in and told Kate she needed to go home. Kate stood her ground and said why she could not go home (caring responsibilities towards husband, no one to monitor her). Kate witnessed nurses arguing over this. Her allocated nurse ensured she stayed the night.

In the morning Kate was ready to go home. Despite seeing the doctor around, she was finally discharged at around 1pm. Her nephew collected her from the hospital. Kate did not get any help when leaving the ward. The nurse looking after Kate wanted to get some help but another nurse said Kate's nurse could not leave the ward. Kate was worried about using the stairs with her two bags while still might be under the influence of anaesthetic.

Kate's overall thought: If it wasn't for the nurse who was looking after Kate, and also for her own strong will, she would have been discharged on the same day which could have been an unsafe discharge.

Case study 3: By Your Side prevention

Background:

Paul was referred to BYS by a discharge facilitator for a wellbeing call after a stay in hospital.

Support provided:

A volunteer called Paul to see if they had support at home and if there was anything he needed, that BYS could support with. Paul confirmed that they were fine but had only been discharged the day before from Broomfield so took the BYS number just in case.

Paul called the office a few days later as he was quite concerned that he had been discharged with drains in his back and was told nurses would visit but he had been at home the best part of a week and in his words "no – one had been near or by". With his consent, By Your Side called Thurrock First and spoke to an operator who confirmed that there was nothing on the system. The operator at Thurrock First said she would make a referral to the community nurses there and then.

By Your Side made a second wellbeing call to Paul and he confirmed that he had been visited by a community nurse.

Outcome: By Paul calling By Your Side, he managed to get the treatment he needed and a potential infection leading to readmission may have been avoided.

Case study 4: Human learning system in practice

Background:

BYS went to drop off a food shop and found Amanda on the floor, Gareth, her husband and carer, had been taken into hospital and she was home alone.

A BYS worker tried to use Amanda's Careline pendant but this wasn't working. The BYS worker called Careline from her mobile to be told she had already had 2 falls, this would be her 3rd in 6 hours. They wouldn't come and instead, gave the number for UCRT.

UCRT passed on the district nurses number and advised to call 999.

Despite saying they couldn't attend, Careline came and used their inflatable cushion to get Amanda standing and carers supported her to get back into the chair. They advised not to cancel UCRT as they would be able to check her.

UCRT found that Amanda wasn't straightening and weight bearing on one of her legs. They took her bloods and checked her over – they told us not to cancel the ambulance as they would decide if she needed a visit to hospital.

Amanda had been reluctant to take a respite offer but with discussion and a promise from BYS to pop in and see her so she didn't feel alone, she agreed. BYS and LAC packed her case and made sure she had what she needed while social worker found an emergency placement.

BYS made a few visits over the week as promised alongside wellbeing calls and a shop. Was then handed back to LAC and social worker. The social worker was made aware BYS will support Amanda to settle home safely if needed.

Outcome: Collaborative working from BYS, LAC and social worker. BYS did find it was not as easy as expected to get help and passed their concerns on to their manager. BYS were able to help the lady get into respite care.

Case study 5: Sandra’s safe discharge

Background:

Sandra was admitted to Basildon Hospital to undergo a kidney transplant. This was a significant procedure that required careful attention and support from the medical staff.

Sandra appreciated the level of care she received during her stay, noting that the staff were attentive to her needs and made sure all her needs were met during her recovery period. She expressed gratitude for the excellent care she received and felt well looked after throughout her stay. The hospital staff informed Sandra about her discharge more than 24 hours in advance and was impressed by the communication and coordination of her discharge from the hospital. This ensured that all necessary arrangements were made for her safe return home and contributed to a smooth transition between hospital and home.

Overall, Sandra's experience at Basildon Hospital was positive, with her feeling well looked after and supported by the medical team. She was grateful for the care she received during her kidney transplant and felt confident in her safe discharge from the hospital.

Outcome: An example of a safe and positive discharge. Sandra’s story shows us that good communication, detailed orientated care and forward planning are all key factors in positive outcomes, which illustrates the successes of a holistic approach.

By Your Side: Home from Hospital Project

Like Healthwatch Thurrock, By Your Side is one of the Health and Social Care projects that sit under Thurrock CVS. The By Your Side project supports people in Thurrock, often elderly or vulnerable to settle home from hospital with the support of volunteers.

BYS

The project has really made a difference, especially to those who may not always have family or friends around them to help them following their discharge from hospital.

The By Your side project receives referrals directly from practitioners working with individuals leaving hospital. By Your Side can offer friendly face to face support for up to 6 weeks to help with shopping, collecting prescriptions, or helping to rearrange light furniture to accommodate walking frames or hospital equipment. Following the 6 weeks support, they can help connect people back into their local community or voluntary sector organisations.

The project is also able to loan and install a temporary key safe for up to 30 days, or a permanent key safe if requested at an additional charge.

Between April 2023 and March 2024 By Your Side…

- Had **3562** referrals into their service
- Made **2925** wellbeing calls to residents out of hospital, either one off or over several weeks
- And saved **3543** bed days

The Patients: a summary

The patient feedback that we received was extremely varied. This can be attributed to multiple factors such as which discharge pathway a patient was on (0-4), the patient's expectation, the complexity of needs, and the amount of support they have around them from family members and carers. All of this feeds into the need for a holistic approach to be the ever present goal at all times to make sure that the patients' needs are met at each stage of the discharge process.

A barrier we faced in doing this piece of work was distinguishing feedback around a patients care in hospital, and just obtaining feedback around their discharge alone.

It was evident that whilst professionals are aware of the 'medically optimised' not 'fit' criteria – patients are not aware of why they are now being asked to leave hospital sooner than they may feel appropriate, and why conversations around leaving hospital happen so early on. Patients may need reassurance that they are being sent home in a safe condition to alleviate their concerns.

Many patients received less than 24 hours' notice of discharge meaning they did not have sufficient time to organise travel or care. This can be linked back to the theme of communication we spoke about in the professional's summary – and that the need for good and effective communication is always essential.

It is important to note that there were many cases where issues occurred due to a patient being a Thurrock resident being discharged from Southend or Broomfield. The merger of the three MSE Hospitals should in an ideal world not be felt in a negative way by the patient at hand and should receive a seamless service irrespective of which site they are seen at.

Similarly the lack of capacity and the pressure we spoke about earlier on in the report is being felt by patients whilst they are in hospital which is clearly highlighted in case study 2.

With this said – many of the people we heard from were extremely happy with their discharge process and felt that everything was in place for them to return home safely or to be moved to a new place of care.

The Patients: recommendations

1. **Production of guidance around the discharge process, including important numbers for the patient/carers to contact if there is a problem once they are home. I.e. BYS and Thurrock First, to extend knowledge of services in the community. This in turn could reduce emergency calls, A & E visits and readmission:** It appeared that there was a lack of knowledge around community support for patients post discharge, and a lack of clarity around the discharge process itself.

2. **The continuation of the By Your Side project:** It is evident that By Your Side has an essential role to play in the reduction of bed days, prevention of readmission and support for the residents of Thurrock post discharge.

3. **Better communication and consideration regarding patients, carers and community services, when completing a discharge plan:** It was felt by both professionals and patients that the current system does not have a holistic approach, which is needed for a more personalised and cohesive outcome for all.

4. **Patients should have continued support from physiotherapists if their discharge is delayed (post assessment) to ensure that muscle wastage doesn't occur during the delay:** It was noted by carers that their loved ones had not been exercised post assessment and the time and date of discharge being agreed. This then leads to a decrease in mobility which can cause injury once out of hospital.

A final overview

Throughout this report we have looked at both professionals and patients lived experience of the current discharge pathway. Whilst every respondent shared their own personal experiences, concerns and successes, it is evident throughout this report that all of the concerns and successes come down to communication. The theme of communication is present in every single persons lived experience, whether this be positive or negative.

Firstly – the issues around communication and systems between the three Mid and South Essex hospitals. In April 2020, Basildon, Southend and Broomfield hospitals merged into one trust – the Mid and South Essex Foundation Trust. We have seen multiple times throughout this report examples of patients from Thurrock who have attended Broomfield or Southend not being discharged back correctly into Thurrock. The merge between the three hospitals should not affect patients in a negative way, but enhance their care experience in a seamless manner.

Following on from this, the current pressure to discharge, lack of capacity and increase in local demand can all be felt by the patient. This can be seen in case study 2 where Kate “witnessed the nurses arguing” over a decision to discharge, and respondents saying they felt like staff “just wanted me out of my bed”. Whilst the current environment clearly creates barriers and a cause of concern for staff – it also impacts the patient and creates a fragmented experience for everyone involved.

The high pressure environment patients and professionals are currently in, can be seen to create a level of anxiety and concern around the accuracy of care provided, which could equate to a lack of trust. It is clear there is more support needed for both professionals and patients to operate effectively in the given environment.

In response to this, Healthwatch Thurrock would like to have an agreement for us to facilitate a workshop between the most relevant representatives and work through some case studies to identify where the breakdown in communication was. This is to aid in a positive way, for both professionals and patients.

Healthwatch Thurrock
The Beehive Community Resource Centre
Grays
Thurrock
Essex
RM17 6RU

www.healthwatchthurrock.co.uk
t: 01375 389883
e: admin@healthwatchthurrock.org