NHS
North Tees and Hartlepool
NHS Foundation Trust

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12 February 2021

Mr G Newton
Health watch Co-ordinator
Health watch Stockton on Tees
geoff.newton@pcp.uk.net

Dear Mr Newton

Re: Health watch Stockton on Tees draft Report – Hospital Experience and Discharge Survey, March to November 2020.

Thank you for giving us the opportunity to comment on the report's findings. North Tees and Hartlepool NHS Trust are committed to providing excellent care and service to our service users and the Trust welcomes the opportunity to comment on the feedback from the Health watch Stockton on Tees draft report 'Hospital Experience and Discharge Survey, March to November 2020'.

We would like Health watch to consider the enclosed response and Improvement Plan on behalf of the Trust.

It is extremely useful to receive feedback to enable us to improve and enhance our services and we look forward to working closely with you in the future.

Yours sincerely

L V Robertson

Lindsey Robertson
Chief Nurse

Enc: Response and Improvement Plan

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Draft report received from Healthwatch for comments from North Tees and Hartlepool NHS Foundation Trust

Hospital Experience and Discharge Survey March to November 2020 produced by Healthwatch, Stockton on Tees

Healthwatch
Healthwatch have been set up across England to create a strong, independent consumer champion to strengthen the collective voice of citizens and communities in influencing local health and social care services to better meet their needs, and to support people to find the right Health and Social Care Services for them by providing appropriate information, advice and signposting.

Healthwatch Stockton on Tees works with local people, patients, service users, carers, community groups, organisations, service providers and commissioners to get the best out of local health and social care services. This does not just mean improving services today but influencing and shaping services to meet the needs of the local communities tomorrow.

Healthwatch Stockton on Tees have continued to engage with local people during the Coronavirus pandemic in order to find out their experiences and view of the pandemic and how this has impacted on their lives and wellbeing.

Background to the report
At the beginning of the Covid 19 pandemic the NHS urgently needed to free up capacity in hospitals to cope with the anticipated surge in demand from Covid 19 patients. To support this a new hospital discharge process was introduced nationally. This focused on getting people out of hospital quickly to free up 15,000 beds and support the faster movement of patients in and out of hospital. People leaving hospital who may need out of hospital support to recover would now have their ongoing support needs assessed after they were discharged (usually in their own home), rather than in hospital. The 'Discharge to Assess' model placed a new responsibility on acute hospital teams to work closely with community health and social care services to ensure people get the support they need after leaving hospital.

On 19 March 2020 the Government issued national guidance on hospital discharge that all hospital trusts, community health services and social care providers in England have been required to adhere to. Each acute and community hospital is required to discharge all patients as soon as it is clinically safe to do so on the appropriate pathway:

- pathway 0 – no input from health/social care.
- pathway 1 – support to recover at home/able to return with support from health and/or social care.
- pathway 2 – rehabilitation or short term care in a bed-based setting.
- pathway 3 - people require on going 24 hour nursing care, often in a bedded setting; long term care is likely to be required.

An update to the hospital discharge guidance was issued in August 2020 and maintained the same key principles:

- Information explaining the new hospital discharge process should be shared with all patients on admission to hospital.
- Patients should be discharged on the same day that a decision to discharge is made.
- Patients should be discharged onto one of four pathways according to individual need:
    - Patients discharged on pathway 0 should receive short-term assisted living support for the voluntary care sector.
    - Patients on pathway 1-3 should be assessed for a recovery support package after leaving hospital. A lead professional or multidisciplinary team should visit patients at home on the day of or day after discharge to arrange the support they need.
    - For patients who require a rehabilitation bed or care home (pathway 2), they are not allowed to wait in hospital until their first choice of home is available. Co-ordinators should follow up to ensure that they are able to move as soon as possible to their first choice.
- All post-discharge community support from 20 March to end of August 2020 was fully funded by the NHS, from 1 September 2020 post discharge care is funded for six weeks. During this time patients should receive an eligibility assessment for further funding (pathways 1-3).
- From 15 April 2020 anyone being discharged to a care home (pathway 2) should be tested for Covid 19 and the results shared with the care home before discharge, unless otherwise agreed.

National Survey

A survey was undertaken nationally following publication of the guidance for hospital discharges by Healthwatch supported by the British Red Cross, with almost 600 people passing comment. Healthwatch list a number of positives from the national report including:

- National funding and dedicated funding for hospital discharge reduced bureaucracy by quickly setting up more efficient ways of working between health and social care and standardising handover processes.
- a new improved collaborative working and information sharing between health and social care.
- Most patients who were provided with information around their discharge found this to be clear and easy to understand.
- Most respondents discussed where they were to be discharged to and were moved to their preferred location, although 28% did not have these conversations.
- The public valued hospital staff for their caring attitudes, clear explanations and treatment during an extremely challenging period.

The areas of concern identified in the national report include:

- The survey found 82% of respondents did not receive any follow up visiting, as required under the 'Discharge to Assess' procedure and 18% reported having unmet needs.
- More than one in three respondents did not receive contact details of a health professional they could get in touch with if they required further support or advice after leaving hospital.
- Almost two thirds did not receive information about the new discharge process. Family members encountered difficulties being kept up to date.
- Nearly one in ten survey respondents were discharged at night with two thirds not asked if they needed transport.
- 30% of those tested for Covid 19 did not receive their test results before discharge.

Local position

Healthwatch wanted to liaise with the residents of Stockton on Tees with the aim to identify if the findings were replicated locally. Two surveys were arranged – one for people who had been in hospital since March 2020 and another for family members/carers. They were promoted on social media outlets and well as in regular Healthwatch newsletters, distributed to over 500 subscribers. The survey was open from 15 September 2020 to 30 November 2020. It is disappointing that only 15 people responded, 10 responses from patients who had been in hospital since March 2020 and 5 from family member/carers.

Patient survey results

- In response to 'When you were in hospital were you given information explaining that the process of leaving hospital had changed due to coronavirus?' Three people said they were given this information but six were not and one was unsure. However, those that did receive the information confirmed it was clear and easy to understand.
- When asked 'How long did you wait between being told you were well enough to leave hospital and actually leaving?' The biggest majority, six people, waited between 2 and 24 hours whilst the others were discharged between 1 and 2 hours. Three people explained the wait was for transport, three for medication and two to be seen by a doctor.
- Three people felt well prepared for leaving hospital whilst five felt somewhat prepared. One felt they had not been adequately prepared.
- Seven out of ten people said they had not been told they would get a follow up visit once they had been discharged from hospital.
- Six people were given information about who they should contact for further help or advice.
- Seven people received a test for Covid 19 and six were given the results before discharge.
- Six people were not asked whether they would need transport once they were ready for discharge, although it is noted that six did not require transport whilst only two said they did and this was arranged. One person required hospital transport and this was arranged, eight were collected by friends and family.
- One person was discharged to a care home and although the home was not their first choice they did move to their preferred setting at a later date.
- Eight did not receive a discharge assessment after leaving hospital with one explaining they still had needs that had not been met. Two people received this visit on the day after they were discharged.

Family member/Carer survey

- Of the five respondents, three people had been given information about changes to the discharge procedure and it was clear and easily understood. One said they had not received this information and one was unsure.
- Four said the wait to leave hospital after being discharged was between 2 and 24 hours. It was pleasing to note that everyone who responded was of the view their relative/friend was prepared for discharge.
- However, two people had not been advised of a follow up assessment. One person was not given details of who to contact in the event of further health advice or support.
- Four of the five had been informed of their relatives Covid 19 test result before discharge.
- Four out of five patients were discharged to their own homes with one going to stay with family members. Only one required hospital transport, although three said that no discussion had taken place about transport.
- Four out of the five respondents advised that a discharge assessment following discharge had not taken place.

Conclusion

Although uptake on the survey locally was very limited (10 patients and five family or carers) the findings very much replicate those contained in the national report from Healthwatch England in collaboration with the British Red Cross.

The Trust have been working with colleagues from the Local Authority and the Clinical Commissioning Group to operationalise the new hospital discharge guidance. For patients discharged on pathways 1-3 then follow up after discharge is in place from the relevant service. The Trust are happy to work with Healthwatch to look at the guidance and the interpretation that all patients should be followed up. The Head of Specialist Services has asked the Senior Clinical Professional from that area to liaise with a member Healthwatch Stockton to take part in an engagement session.

Recommendations from the Healthwatch Report and Trust comments

It is important for the Trust to gather as much feedback as possible various sources to enable us to further identify any areas which require development or indeed identify high performing areas as a good exemplar. There were a number of issues highlighted from the feedback, although it is appreciated that only a very small number of the people discharged from hospital and their family members/carers have taken the opportunity to provide feedback to Healthwatch, the Trust has taken the opportunity to provide our comments below. We have also included an action plan, please see Appendix A, to indicate the areas we are currently working to improve.

The Trust have also shared the recommendations with Partners from Stockton Borough Council and the Hartlepool & Stockton CCG to ensure that, where appropriate, any local actions are taken forward in collaboration.

Healthwatch Recommendation	**Trust comments in relation to the recommendation**
(A) Always assign a single point of contact following discharge from hospital. Hospitals should work with their partners to ensure patients are assigned a point of contact for further support, in line with national policy.	The Ward Matron/Nurse in Charge/Consultant with the support of the Integrated Discharge Team lead discharge at ward level. The majority of patients discharged from Hospital do not require any follow up care, they are safely discharged to their usual place of residence with care and onward support provided by primary care. When follow-up care is required patients are referred to the most appropriate service, specialist team or they may require a further review appointment by the consultant on discharge. For the remaining patients, particularly those over the age of 65 who require additional support due to a temporary increase in their needs or due to a significant life-changing event, their additional needs are met using pathways 0 to 3 (as per Government national guidance). However, it is accepted that Trust staff need to highlight the importance and function of the Integrated Single Point of Access (ISPA) with patients, families and carers during and post discharge of patients. (This can be accessed via the current Single Point of Access - 01429 522500). Please see Appendix A, Proposed Specific Action (1). To improve communication with patients during the pandemic patients were provided with specific information leaflets in regards to hospital discharge. As we continue to work with Partners we need to agree an appropriate way forward in regards to patient information. Please see Appendix A, Proposed Specific Action (2).
(B) Ensure families and carers also know who to contact: Hospitals should also give families and carers this information, so they have a point of contact for the	Families and carers are given details of who to contact if they require specialist support or referral to District Nursing Services etc, however it is accepted that communication around this can always be improved and is highlighted as an action. Please see Appendix A, Proposed Specific Action (1).

follow up support of their loved ones or clients.	The Trust are working on introducing QR codes that can be scanned and accessed by patients, their families and carers. The QR codes will direct people to relevant materials about hospital discharge including contact details for the ISPA. The Integrated Discharge Team, ISPA and Frailty Co-ordinators who currently co-ordinate and facilitate discharges are to work with Healthwatch and care providers to look at the best way to communicate information. A Healthwatch representative will be invited to attend this working group. Please see Appendix A, Proposed Specific Action (2).
(C) Always ask about transport home, as part of a wider conversation about people's non-clinical needs. This should involve conversations with family members as this will help to ensure that patients have the immediate support they need to get home safely.	The Covid 19 Pandemic has provided us with added challenge in providing transport to facilitate discharges. We have continued to work with our private transport providers to maintain efficient ambulance journeys for those that require an ambulance. However, we would expect if the patient has capacity and are able that they speak with their relatives to collect them from hospital. Where transport is required the Ward Matrons/ward staff discuss transport requirements with the patient and include the family and arrange a suitable mode of transport in line with the patient's needs. The Trust has also piloted the use of a wheelchair accessible a vehicle arranged by our therapy teams who have facilitated the patient's discharge, and therefore can provide further input at the patient's own home, supporting the patient through their own front door and ensuring the discharge home is safe with any further follow up initiated on the day of discharge. This is in addition to our usual transport provider and has proved a vital resource to provide the discharge to assess pathway. The story for this can be found through the link below https://www.nth.nhs.uk/news/driven-home-for-christmas/ We have also provided additional volunteer drivers and provided links with the drivers to the Integrated Discharge Team. This is an initiative we are keen to promote as an additional method of transport moving forward.
(D)Clarify and promote the hospital discharge policy to frontline staff. This includes clarifying guidance to avoid different interpretations of discharge pathways.	• The Integrated Discharge Team worked closely with local partners to implement the new discharge guidance framework at the start of the Pandemic. This guidance is due to be refreshed and relaunched at the end of 2020-21. The interim framework remains in place and there is ongoing discussion with Partners about how we will operate moving forward form the end of March 2021. • The Trust has introduced a number of service improvements to improve communication and clarity of discharges with our staff, patients and their family and carers, and to encourage discharges earlier in the day.

	• The discharge team has expanded to support the current surge and introduced 'Home First' champions to facilitate dissemination and collection of information as well as increasing the number of Frailty Co-ordinators to support complex discharge planning. • It has been necessary to change our discharge documentation to reflect the new pathways as outlined in the Discharge Policy and we are also in the process of moving the discharge notifications to be electronic to support staff and reduce delays. • We are due to integrate the current Integrated Discharge Team with the Patient Flow Team. This will encourage co-ordination of all pathways of discharge from pathway 0-3. • Teaching sessions were undertaken prior to the Covid 19 Pandemic regarding discharge and the different pathways, although the Trust is aware that this needs to be continuous as we change at pace. Once the Trusts de-escalates education in support of discharge will continue. This is already on the Trust's Preceptorship Programme for new nursing staff and is included as part of ward education and induction. The Integrated Discharge Team are the experts and continue to support and educate the ward teams with the very complex discharge packages.
(E)Check in on every patient after discharge over the phone or in person. Everyone leaving hospital should receive a wellbeing check-in after discharge. These check-ins should cover people's holistic needs, linking them into support services where appropriate. (These checks are even more important during the pandemic while people are self-isolating and waiting for their COVID-19 test results after leaving hospital, shielding, or managing additional anxiety related to COVID-19. We understand such arrangements may have been put in place and it is important that such services are being utilised correctly).	The majority of Patients discharged from Hospital do not require any follow up care, they are safely discharged to their usual place of residence with medical oversight from primary care. As mentioned previously, when follow-up care is required patients are referred to the most appropriate service, specialist team or they may require a further review appointment by the consultant on discharge. For the remaining patients, particularly those over the age of 65 who require additional support due to a temporary increase in their needs or due to a significant life-changing event, their additional needs are met using pathways 0 to 3 (as per Government national guidance). Trust staff will continue to work to highlight the importance and function of the Integrated Single Point of Access (ISPA) with patients, families and carers during and post discharge of patients - please see Appendix A, Proposed Specific Action (1). In response to the pandemic, Community Hubs were established within localities and these offered care and support from voluntary and community sector organisations. The staff in the ISPA were able to signpost and access these services. The Enhancing Health in Care Home framework which was introduced in October 2020 also supports this recommendation and every patient discharged into a care home whether this be an existing return or a new admission

	is reviewed by a Community Matron or can be discussed with a wider multi disciplinary team (MDT) including the GP. The Integrated Intermediate Care Team in Stockton and Hartlepool already follow up and support those patients who require care at home and link to further community services through the ISPA. The Intermediate Care Team at Hartlepool also work alongside social care to provide care at the patient's home in an integrated approach. We continue to work with Members of the Voluntary, Community and social enterprise sector to develop our hospital discharge services. We work closely with our local Volunteer Service Manager to develop schemes locally that promote safe and timely discharge. In 2019 we embarked on a 'Home but not alone' project in partnership with Helpforce. We looked at utilising our popular volunteer driver scheme and enhancing this with additional care and support on the ward, within the patients and home and up to 28 days following discharge. The scheme was well received by volunteers and patients and we plan to reignite this work when we are able to do so. The Five Lamps Organisation in Thornaby provide a 'settle in service' to support patients to return home and access their communities. The Service is supported by the Big Lottery fund and provides an efficient service to those patients being discharged within the Stockton locality.
(F)Put in place special arrangements to improve communication and involvement with family and carers.	The Trust have implemented a number of processes to improve communication with family and carers whilst visiting is suspended due to Covid restrictions. All ward areas have received an iPad and process to allow Virtual Visiting to take place. The Patient Experience Team manage calls from relatives to arrange Virtual Visits with their family/carers. The visits are facilitated by ward staff. As an example the number of virtual visits arranged is 56 and more than 70 for January 2021 from as far as Spain, Belgium and Australia. In addition, personal belongings, presents and letters of love from family and carers are delivered to the Patient Experience Team who ensure they are delivered to the patients on the wards. During the festive period, the trust also allocated a drop off point for Christmas presents for patients. The wards recently introduced a process whereby during daily ward huddles to discuss updates on patient care, a staff member is identified to make courtesy calls to family/carers. Where a more in-depth clinical discussion is required this is also highlighted and a mutually suitable appointment time arranged.
(G)While visitation restrictions continue, special arrangements need to be put in place to ensure families and carers	Relatives are able to have discussions with any of the MDT which includes discussions around the discharge process. In addition, the Trust continues to promote John's Campaign which allows a family member or carer to attend

can participate in decisions made during and after the discharge process, particularly for patients with disabilities or additional needs.	hospital to support their loved one. The importance of communication with our patients and their relatives and carers is discussed during daily huddles and ward meetings to continually reinforce the importance of good communication with family members/carers.
(H)Limit the need for discharge late at night especially where access to transport cannot be guaranteed.	Within the Trust we are very mindful of late night discharges. This is managed through the Patient Flow Team in relation to ambulance discharges. It has been our practice for a long time not to discharge patients late at night from our ward areas. The only patients that would be discharged out of hours are from the Emergency Department (ED), Surgical Decisions Unit or the Ambulatory waiting area and this would only take place if patents are deemed as safe. If transport is not available, then the patient would remain in hospital and a discharge would be arranged for the next day. The Trust will soon be able to provide a 24/7 clinical triage based within the Urgent Care Centre alongside out of hour nursing support for our patients. This will provide additional support when patients choose to be discharged home should any issues arise.
(I)Ensure all patients are ready for discharge and have their belongings and a supply of medication with them.	The Ward Matron and Nurse in charge of the patient ensure the patient is ready for discharge. This is part of the discharging process. It is recommended that patients are discharged with their medications, however with the agreement of the patient/family, there are occasions when a family member will return to collect medication or we have delivered the medication later the same day. However, there is always an opportunity to improve this process and reflect and adapt accordingly. Patient feedback in relation to the discharge process is monitored and reported at various meetings and committees via Complaint, Friends & Family Test and Compliment data.

Appendix A

North Tees and Hartlepool NHS Foundation Trust

Health watch visit Improvement Plan – outstanding actions from the Hospital Experience and Discharge Survey March to November 2020

Care Group: Care Groups for Healthy Lives, Response Care, Collaborative Care **Developed by:** Jill Foreman

Date: 3 February 2021

Recommendation	Problem/Issue/Identified gap in service	Specific Proposed Actions:	Responsibility:	Planned completion date:	Date Completed:	Final Evaluation of Impact
A	Always assign a single point of contact following discharge from hospital. Hospitals should work with their Partners to ensure patients are assigned a point of contact for further support, in line with national policy.	(1) Working Group to improve communication around the importance and function of the Single Point of Access (ISPA) during and post discharge.	Jill Foreman Mel Cambage (In partnership with colleagues from the Local Authorities and the CCG).	31.3.21		
		(2) To continue to work with Partners to facilitate improved communication with patients during and post discharge.	Jill Foreman Vicky Cardona	31.3.21		

B	Ensure families and carers also know who to contact: Hospitals should also give families and carers this information, so they have a point of contact for the follow up support of their loved ones or clients.	(3) Introducing QR codes that will direct people to relevant materials about hospital discharge including contact details for the ISPA.	Bob Warnock Jill Foreman	31.2.21		
E	Check in on every patient after discharge over the phone or in person. Everyone leaving hospital should receive a wellbeing check-in after discharge. The check-ins should cover people's holistic needs, linking them into support services where appropriate.	See Specific Proposed Action (1)				