healthwatch Kent

Hospital Discharge in North Kent

A Healthwatch Kent Outcome Report

#SpeakUp

healthwatch

Making your voice count

September 2019

Hospital Discharge in North Kent

The story so far

You told us about your experiences of being discharged from hospital in North Kent. We heard negative stories about communication and people waiting for care to be arranged so that they could be discharged from hospital.

We spoke indepth to 145 people (including professionals) about their thoughts and experiences on being discharged from Darent Valley Hospital.

We made a number of recommendations based on your experiences. This report details what the hospital has done since to improve your experience of being discharged from hospital.

Healthwatch Kent has been working to *make your voice count*

The challenge

The feedback you gave us needed to reach the ears of decision makers.

What's changed as a result?

- More patients are being discharged quicker from hospital with the support they need than before
- If you need help to make space at home for equipment before you can go return, then help is now available
- Organisations involved in your discharge are working closer together
- Care homes and the hospital now have a better relationship
- Information is available to help patients know what to expect during their stay in hospital and subsequent discharge.
- The needs of Carers are now more widely recognised

Your voice has made a difference

The changes in detail

The Hospital

Our report and our findings were well received by Darent Valley Hospital and we have been able to have an open and honest conversation.

The Chief Nurse, Deputy Chief Nurse and the Manager of the Integrated Discharge Team met with us during our visits, and since, to discuss our findings and talk about what they could do better.

This is what they told us has been done since our visit:

Our recommendation	What has been done?
Continue to invest and support the Discharge Lounge at Darent Valley Hospital and make maximum use of it.	At the time of our visit we observed staff proactively identifying patients who could be moved from the wards to the discharge lounge. We raised questions about the size of the Lounge. The Discharge Lounge couldn't fit beds or trolleys meaning that many patients were unable to benefit from the Discharge Lounge. A new area which will allow access for trolleys and beds, has been found called Mulberry. However, at the time of writing, this space was being used for beds as there was so many patients needing hospital care.

	The Trust talked to us about their ambition to consider how care might be provided differently and more flexibly to enable more patients to use the Discharge Lounge. This included getting staff to think differently about the lounge. They will gather feedback from patients who are using Mulberry to inform this thinking. Healthwatch has offered to help with this.
Continue to support the Frailty Nurses	Two Frailty Nurses remain in place at the Hospital which is great news as we observed the positive impact they have for patients. The NHS 10 Year Long Term Plan, which has recently been published, makes Frailty pathways a priority. The Hospital will be part of discussions about how to make this a reality. This has supported a renewed focus on frailty within the hospital. A review is planned for the frailty service and the Trust is looking to build evidence to fund a Falls Nurse to further expand the frailty work.
Communication with families about the impact on the patient staying in a hospital bed. This could be aligned to communication on pathways such as Discharge to Assess so families and patients understand the benefits of receiving this care outside of hospital. **Closer team working between all organisations** **Improve the availability of double handed care packages**	Red & Green days are now a day to day part of the ward. They provide a visual focus on a patients' discharge process. Red Days are when a patient's discharge isn't progressed, but Green Days signify progress. A patient shouldn't have too many red days and this is a visual reminder for staff. Patient flow boards are going to be reinstated in wards. Coloured magnets – green, red, yellow, can be used against different clinical areas to indicate patients' outstanding treatment/test needs and those completed. Work is still needed to standardise their use across all wards.

	Since our visits, the **Discharge to Assess** service has become established across the hospital. Kent County Council can now take 35 patients per week out of hospital with support from the community service provided by Virgin Care. The majority of these patients are non complex cases. Hilton Nurses currently provide an initial 5 days of care for the patients in their own home. If needed Kent Enablement at Home (KEah), or a care agency will then provide further support. Although working well, the Hospital told us that they still have situations when the care provider doesn't have the capacity to provide the care after the initial 5 days. KCC also have a new service called **Home to Decide**, where an initial 24 hour of care and support is provided. Care can then continue depending on the patient for up to 14 days. The aim of this service is to support the patient to remain in their own home when in the past they may have had to go into a care home. This is a Kent wide initiative and has already supported 29 people from Darent Valley Hospital in the first 6 months (and 134 people across Kent). 67% of these patients have been able to stay in their own home. KCC and Virgin Care colleagues are now based together at the same physical site to enable these services to work closer together and make referrals through a single point of access (SPA). Assessment and respite beds are available at Gravesham Place. These are different from the rehab beds at Gravesham Place which are provided by KCC.

	These respite beds are used for patients who don't need to be in a hospital, but need a little bit more support before they can go home. Similarly, the assessment beds are for those patients who need to be monitored before a decision about what care they may need outside of hospital such as care at home or a care home.
Darent Valley Hospital need to better understand the resource, capacity and service within GP Surgeries and District Nursing	The relationship between the hospital, GPs and District Nurses has been strengthened at a County level as part of the Kent & Medway Sustainability & Transformation Plan (STP). At this level conversations are looking at an integrated urgent care system across Kent & Medway. More locally, there is now an Urgent Care Board which brings together the hospital, KCC, GPs and Virgin Care who deliver community services in North Kent. Resource and capacity issues are part of these conversations and attendees have a better understanding of the pressures facing different parts of the health system.
Discharge paperwork must be completed in a timely way and sent electronically to the patient/carer, the GP and any relevant caring professional.	This has improved since our visits. The majority of the time Electronic Discharge Notifications (EDNs) are done in a reasonable time. Sometimes the systems don't allow electronic transfer of information because different parts of the health system uses different IT systems. This is being addressed at a Kent wide level and will allow organisations to share information easily.

Better relationships with local Care Homes must be developed including a clear process **To establish a clear feedback mechanism that Care Homes can use to communicate any issues they have relating to a client's discharge and more general concerns.**	Since our visit, Care Home managers, commissioners, Kent County Council and the Hospital Trust come together to share information and work on new ideas. This Forum has strengthened relationships between the attendees and helped develop a "pick up the phone" relationship. Hospital staff have also visited care homes, and care home managers have visited wards and spent time with the Integrated Discharge team.
Single assessment for each patient	A new model has been developed which is being tested by six Care Homes. The models enables members of the Integrated Discharge Team at the hospital to assess patients on the wards on behalf of the care homes for discharge back to the care home. This is called the Trusted Assessor Model. It doesn't cover the initial assessment of a patient before they can join a Care Home but does support patients who are already residents at the home. It is hoped the model will be rolled out across other Care Homes in North Kent shortly.
Communication with families about the impact on the patient staying in a hospital bed.	The Trust have produced, with input from KCC, Virgin, commissioners and Healthwatch Kent, a leaflet for patients which sets out what a journey of a patient might look like and what they can expect and need to consider during their stay in hospital and their discharge. However, Healthwatch has heard from patients that this leaflet isn't always being used by staff.

	We have raised this with the hospital and there is now a meeting with senior nurses/matrons to remind staff that all patients should receive this. Healthwatch has asked that families/carers should always be involved in discharge planning whilst appreciating that on some occasions there can be conflicting agendas from family members. The Hospital told us that it is common practice to involve carers and families in discharge planning unless the patient specifically declines their involvement. The Hospital will consider amendments to the leaflet for the next print run.
The level of physiotherapy available should be reviewed, particularly at Elm Court, for those patients whose mobility needs to improve before they can be discharged.	The hospital told us that there are still some gaps in therapy staff but ongoing therapy programmes can be delivered by other staff. They encourage some therapy to be self administered by the patient following a designed programme. The Trust agreed that more Occupational Therapy support is needed to visit/assess the home environment but this is a pressure due to the difficulty in recruiting for this staff group.
A better system needs to be developed when people need help to make space for equipment	Support is available from The Peabody Trust (was Family Mosaic) to help move furniture and make space for hospital equipment in someone's home. Carers First also support families about the need for change at home. At the time of our report, we saw no evidence of this support from The Peabody Trust. The Peabody Trust have recruited a Health and Housing Coordinator funded by Dartford, Sevenoaks

	and Gravesham Councils. They support people who are waiting to be discharged but need new housing or adaptations to their current home. The Hospital told us that delivery of equipment is rarely delayed now. Any delays are usually caused by difficulties getting access to the patient's home. A Care Navigator is also available through IMAGO to help people find the care they need. For example, completing housing applications. The Care Navigator can also provide support to families and Carers.
Better integration and working practices between the professionals involved in discharge	Since our visits, the hospital has created a Rapid Improvement Event which brought together key staff from Dartford and Gravesham NHS Trust, Virgin Care, Kent County Council, Dartford and Gravesham Clinical Commissioning Group, the voluntary sector and Healthwatch Kent, to look at the whole process of patient flow. This work enabled the average stay of a patient in hospital to be reduced from 9 days to 4 days. Work is still on going to build better relationships between teams such as co-locating Virgin Care and Social services together. Now that KCC and Virgin Care are co-located conversations can take place on a daily basis to support discharge planning. Daily visits take place to the wards where patients have been referred for social care assessments.

More support and interventions for carers, particularly when the carer themselves becomes ill	Since our visits, Carers are getting more support. Carer/Patients are now being regularly referred for support by professionals particularly from the Occupational Therapy teams. The hospital is exploring the idea of actively engaging Carers in the pathway of their patients.

The commissioner

Dartford, Gravesham and Swanley Clinical Commissioning Group, who commission hospital services at Dartford and Gravesham Hospital Trust, have been informed about our findings and have been supportive of the improvements that the hospital has been making.

Politicians

It is important that politicians hear about the experiences of their constituents. We have shared the findings of our report with District & County Councillors as well as local MPs.

GP Practices

We know that GPs are seeing many patients who have recently been discharged from hospital. We made sure our report, its findings and our recommendations were shared with them.

Social services

We involved and informed Kent County Council during our visits and shared our findings with them.

We will use this report to highlight the importance of working together to improve services for North Kent residents.

It starts with you……tell us your story

Have you been discharged from hospital recently? How was your experience?

Call us for free on 0808 801 0102 or email info@healthwatchkent.co.uk

What next?

What else needs to be done?

Your views: We will continue to share your experiences of being discharged from hospital to improve services

Commitments: We will continue to work with the Trust on the content and distribution of the Patient Information Leaflet

Review: we will work with the Hospital Trust to talk to patients about their experience of the Discharge Lounge

Making your voice count

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