healthwatch Lincolnshire

Enter and View Report

United Lincolnshire Hospital Trust
Care Planning for Discharge
January 2015

Summary

The following report into care planning and discharge was carried out with support of an enter and view visit to the United Lincolnshire Hospital Trust sites discussing with patients, both whilst in hospital and after discharge, and finally with information received from care home providers.

The work was carried out in direct response not only to national and local media coverage, but also because of feedback Healthwatch Lincolnshire had received from our residents accessing care services.

The report identifies key themes which Healthwatch believe should be raised as a matter of importance not only with the hospital Trust but also with other commissioners and providers of services which are integral to an effective and supportive discharge process.

Healthwatch is mindful that factors outside the control of the hospital have a significant impact on the Trust and often do not fully present the much broader collective challenges affecting patient admissions and availability of community services to speed up effective discharge.

In essence, there are some core themes listed below and as part of this work we have requested that the Trust along with other partners, comment to the findings in the public interest and their responses are included throughout. What is evident is that the challenges are everyone's business and in order to sustain an effective health and care service for the future, partnership working and assessing lessons learned are key. What must also be recognised is the public recognition of the care and support delivered by frontline staff on the wards of the hospitals.

Key Themes:

Seek reassurance that where ULHT Trust staff are making suggestions, that they are being listened to and where possible acted upon.

Consideration as to whether end of life care is truly achieving the aspiration and where multi agency work could alleviate some the frustrations being felt by care staff, patients and family.

A need to identify and address the needs of the Acute Trust and the impact on insufficient community care to support the discharge of patients from Acute Care.

Continual themes regarding capacity, and responsiveness of hospital transport, what the challenges are and those who need to be held to account.

Management and capacity for the prescribing of medications internally and the provision of those effectively as a patient or receiving care provider.

The full recommendations and provider response can be seen at the end of the report.

Contents

Place of Visit:	**United Lincolnshire Hospital Trust Sites**
Address of Visit:	**Greetwell Road, Lincoln LN2 5QY**
Service Provided:	**Acute Care**
Date:	**10, 11 and 16th December 2014**

1. Background

This piece of work has been carried out by Healthwatch Lincolnshire who has a statutory function to enter and view any publically-funded premises providing health and care services. These visits are carried out with the sole intention of collecting information relating to the quality of services provided and gathering the views of patients, relatives and carers of those people accessing and receiving the services.

Healthwatch carried out this work as part of its Operational Plan but also as a direct response to some locally received patient feedback. We have seen both locally and nationally the issues facing hospitals and in particular A&E, however, the overall pressure being placed on discharge as a direct link to the availability of our community and social care services has also been highlighted as a concern and as a major contributing factor to hospital discharge delays.

In addition to carrying out this work, we have a duty to ensure any information gathered is disseminated to the relevant organisations which have a monitoring and commissioning responsibility. We also have a duty to report to the relevant bodies any cause for concern relating to the safety and care of those in receipt of those services.

2. Methodology

Healthwatch authorised representatives were appointed to undertake this piece of work. A questioning framework was produced to enable the representatives to effectively talk with patients, relatives, carers and care providing staff and to make observations during the visits. The framework is not exhaustive, but does provide a background for directing theme-specific questions - *in this case care planning for discharge*.

The focus of this work was to specifically look at what people using services thought about the mechanism of care plans and planning for discharge in their care environment. United Lincolnshire Hospital Trust were selected as the core provider for this enter and view activity as the hospital environment is the most frequent deliverer of care plans to discharge back to the home or care environment. However this work has not precluded other providers, all care home providers in Lincolnshire were approached to offer their views of the provider experience when it comes to discharge from a hospital setting back into care.

To enhance our understanding of the discharge process we asked patients if they were willing to take part in a follow-up study a number of weeks after discharge so that we would have a better overview of the full 360^{O} experience of the patient.

In addition to care planning for discharge, the visit also naturally notes observational records of the provider and where views are expressed by the service user about other elements of care, these were also recorded.

In the interest of confidentiality we do remove the names of those making specific comments although generic comments themselves maybe included within the report feedback.

The Provider.

The United Lincolnshire Hospitals NHS Trust provides a wide range of healthcare services delivered by over 7,500 staff and volunteers. Each year the Trust receives £399 million to provide patient services, most of which are delivered to patients in Lincolnshire.

Sites Visited.

Boston Pilgrim Hospital Ward 6a. This is a female elderly ward. It is located in the tower block on level 6.

Grantham Hospital.

- **Ward 1.** This ward deals with Cardiac and Stroke (rehabilitation) patients, together with General Medicine. It is located on the ground floor of the hospital.

- **Ward 2.** This ward deals Orthopaedic and Surgical patients as well as medical outliers. It is located on the second floor of the old maternity block.

Lincoln County Hospital.

- **Hatton Ward.** This ward cares for elderly patients and their medical needs. It is located on the entrance floor of the main hospital building next to the Waddington Unit.

- **Lancaster Ward.** This is a ward that deals with general medicine for the care of the elderly. It is located on the entrance floor of the hospital following the corridor round and signs to Maternity. It can be found on the left of the corridor opposite to the entrance for Rainforest Ward.

- **Stow Ward.** This is a ward dealing with orthopaedic traumas. It is located on the entrance floor of the main hospital building past the WH Smiths shop turn right and at the end of the corridor.

Acknowledgement.

Following visits to the wards, Healthwatch had an opportunity to feed back the core findings to the Ward staff on site at the time. Many thanks to the teams who took time out of their schedule to facilitate the visits but also to listen and contribute to the conversations around the findings. In addition, we would like to thank all the staff at the hospital sites who offered an open and honest perspective of their working environment and some of the challenges it faced.

3. Respondents.

Prior to any conversation being held with a service user, we introduce ourselves and ask permission for any dialogue to continue as we respect that not all service users will want to engage in this way.

During the visit we spoke to as many patients who wished to and had capacity to talk with us. In addition, we spoke with staff on the wards and where available the Discharge Lounge and Pharmacy staff as well to provide a more holistic view.

A total of 56 patients spoken to during the visits:

- Boston Pilgrim – 9 patients.
- Grantham – 15 patients.
- Lincoln County: 32 patients:
    - Discharge Lounge - 5 patients.
    - Wards - 27 patients.

Post Visit Conversations.

As part of our visit we asked patients if they would be willing to talk to us a few weeks following their discharge. The purpose of post-visit contact was to ascertain how the patients/family members and carers felt after the discharge process had fully occurred and to better understand what worked well and where there had been challenges.

- Agreed to post communication and were contacted – 23 patients.
- Who provided a response upon follow-up communication – 9 patients.

We acknowledge our thanks to those respondents who supported our work after the visit and helped provide a full overview of the patient experience.

We also acknowledge the additional information received from care homes who were able to provide additional and supporting information around hospital discharge and care planning. The number of care homes supporting this work was 18 out of 288 surveyed; from our perspective this is not a statistically significantly sample size, however, the trends from the responses were of notable interest.

4. Findings from Respondent Experience Survey.

The following provides an overview of the service from a lay-person's perspective and separates the sites and wards to provide clarity. However, conclusions and recommendations may be duplicated across sites as a pan-Trust identified needs.

Generally, we need to understand the background of how care planning for discharge should occur.

NHS England says ….

"A person should not be discharged from hospital until all of the following criteria have been fulfilled:

- *They are medically fit (this can only be decided by the consultant or someone the consultant has said can make the decision on their behalf).*
- *They have had an assessment to look at the support they'll need to be discharged safely.*
- *They have been given a written care plan that sets out the support they'll get to meet their assessed needs.*
- *The support described in their care plan has been put in place and it's safe for them to be discharged."*

What is a Care Plan? Often patients are not familiar with the term 'care plan' and this is certainly borne out of our conversation with patients, relatives and carers - so in simple terms, it is a written document that details all the health and social care support and services a patient will need to continue recovery or support for a medical condition prior to and after a patient has left hospital.

The hospital's discharge policy should follow government guidance on discharge of patients and emphasises the importance of involving patients and where they exist, their carers in hospital discharge planning. The guidance says that carers and the person cared for should "be involved at all stages of discharge planning, be given good information and helped to make care planning decisions and choices".

What ULHT say about discharge …

"We aim to give all patients a predicted date of discharge (PDD). We aim to discharge you between 10 am and 11 am. If you are unable to be collected or there is a delay in your discharge, you will be asked to wait in the Discharge Lounge.

For day case patients and inpatients, you will need a friend or relative to collect you. Please could you arrange this prior to your admission.

Your letter of discharge will be electronically sent to your GP. If you wish to receive a copy please ask your nurse. You may also be given a letter to give for your district

nurse, such letters should be passed on as soon as practicable as they contain details of what treatment you should receive.

If you need any medicines you will be given a seven day supply before you leave the ward to tide you over until you see your GP. Please bring your prescription exemption certificate or prepayment certificate if you have one.

If you need an outpatient appointment, a date may be given to you before you leave. Otherwise, a card giving the necessary information will be sent to your home. Before leaving the ward, check that you have collected all your belongings. If you are not going back to your own home immediately, please leave a forwarding address, this will allow hospital staff to send on any mail."

The pressure on the NHS nationally has brought press and political attention to the issue of delayed discharges (often cruelly referred to as 'bed blocking'). This week, NHS England's director for acute care told MPs that delayed discharges - situations where patients deemed medically fit to leave hospital have been held-up in doing so due to issues with social care or NHS support - accounted for about 20% of beds over the festive period.

Many factors can lie behind delays, says Betts. Some do directly relate to availability of NHS or local authority-funded resources - for example, there can be a hold-up if the team want to move someone to an NHS rehab bed or council-funded supported living placement but there are none available. Other delays can be down to waits for a funding panel to scrutinise care package proposals, and in some cases, the social care team may have to "push back on discharges" if they identify any risk to patient safety or require further information from medics.

Source: http://www.communitycare.co.uk/2015/01/15/non-stop-hospital-social-work-ae-crisis

Pilgrim Site - Findings.

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the Trust has commented on them, they are included in the report for public interest and information, the action plan developed by the Hospital Trust in response to this work can be find in Appendix A.

4.1 **General Information.**

- On the Boston site we visited Ward 6a. At the time of the visit there were 29 beds in 4 bays. On the day of the visit one bay had been closed and this was reported to have occurred due to staffing capacity, this was supported by the management team to ensure patient care.

- We were told that staff worked collaboratively across the floor incorporating wards 6a and 6b and a staff meeting at 11 am was scheduled each day to discuss and resolve any staffing or capacity

issues. The Trust continues to do this to enable safe staffing across the floor for both numbers and skill mix.

- The ward was seen to be calm and relaxed, with notice boards clearly displaying patient's names and locations and staff available on the ward allocated to support those patient needs. Update : New boards are now in place ensuing this information is even better displayed.

- The ward has the use of a day room shared with 6b and anecdotally, we were told that on Wednesday's young people from the local High School came in to volunteer with the patients. In addition, fund-raising on the ward was being promoted to help purchase memory boxes to support activity with those patients with dementia symptoms. Update : The Trust now has the memory boxes and the students still come into the ward. Knitted dolls and twiddlemuss as recommended by the Alzheimer's society have also been introduced. The Trust also has the pamper kit on Ward 6a to enable patients to have a hand massage, hair and nails done.

- The ward have also introduced a 'petting dog' which has apparently been well received by staff and patients. The Trust felt that this is an excellent aid to communication and encourages people to get engaged where they may otherwise sit alone.

- We were told that 6a was a locked ward, however, patients are free to leave should they wish to and the door system is operated by a visual intercom. The Trust told us that they have a locked door but this wasn't to keep patients in, if there are capacity issues full assessments and Deprivation of Liberty Safeguards are put in place where necessary.

- We were told the ward had received an uplift in staffing by an extra 2.5 health support workers and this was felt to be important as patients are requiring more and more supervision. However, we were told that staffing levels have never been in a position where they could be self-sustainable as a ward. We were also informed that staff were now scheduled on 'long days' which has meant an improvement in care, particularly around continuity of the daily planning for patients. The Trust told us that the staff benefit from the long days off, following a number of staff vacancies on the ward, they have now recruited to full capacity. The Trust told us that staffing to safe levels was a priority each day, some temporary contacts to bank staff supports staffing levels.

4.2 Discharge Specific Information.

- Ward 6a had from the perspective of the visiting team, a very visual team of staff, from Matron, Consultants, Discharge Liaison Nurse and Social Workers all on the ward. The Trust told us they were proud of this and always endeavour to have a full team working and that

Matron is visible in practice every day and undertakes Matron Clinics for staff and patient relatives.

- We were told that the 'ward round' *(physical visit by a consultant and nurse to each patient)* occurred every day to assess treatment, care planning and discharge as appropriate. General ward rounds by staff are routinely undertaken hourly to check patients.

- We were shown the practical tools used to support staff and consultants working collaboratively in the treatment and planning for patients including Blue Patient Sheets, Pre-Discharge Checklist and the Plan for Every Patient Board which tells all staff at what point in treatment a patient is currently at, where delays have been incurred and where action needs to take place. The Trust told us that the board round takes place each morning and that 6a are one of the lowest wards in terms of discharge delays with full multi disciplinary team in place, they also told us that all patients have a planned discharge date.

- We were informed that patients took a variety of routes through discharge. They could be discharged direct from the ward, from the 'Discharge Lounge' or they could be fast tracked back to their home or to a care provider in the event of complex needs or end of life care. The Trust told us that due to the nature of the ward that they try to send all patients to the discharge lounge but patients with dementia are kept on the ward to ensure they do not get disorientated. Also any palliative patients are fast tracked and leave the ward directly to their preferred location for end of life care.

- We were told that the average inpatient time on this ward was around 10-14 days, however, it was previously around the 20 day mark. We heard how wards inherited patient hospital stay time from other departments and wards, for example, if a patient has been in the stroke unit, their length of stay would be added to the time then spent afterwards on Ward 6. This means that when we talk about average length of hospital stay, it may not always mean in one location but may include different areas. Update : The Trust told us at the current time they have length of stay down to 6.8 days however they do still inherit longer stays if stroke patients are stepped down to 6a.

- We were told that when a patient is medically fit an Expected Discharge Date (EDD) is provided by the consultant and is included on the Patient Board for all to be aware of; this should then prompt a number of events to occur to enable that discharge to be planned and carried out smoothly. We were told that one a patient is medically fit for discharge they continue along with the multi disciplinary team to ensure that Occupational Therapists and physiotherapists are happy for discharge to take place. If social work support is required then the Social Work will seek programmes of care or

an independent living team bed. The 'plan for every patient board is used so that planning is clear for every team member.

- We were told and shown the documentation which showed discharge planning started on the day of diagnosis along with treatment plans. The day before expected discharge the 'blue' discharge form would be completed and kept on patient file.

We were told by the ward that delays to discharge could and did occur for a variety of reasons, but some of the core ones were:

- The heavy reliance on the Independent Living Team where capacity was not always available to support people back in the community.

- Update : the Trust told us that that this continues to be one of the biggest delays but over the winter the use of the Rochford unit facility had been invaluable. The Trust said that due to the county being so large and with a predominately elderly population it can be a challenge. When this is the case, the Trust will start to look at other options and continue to work with patients to enable them to get home as soon as possible.

- Where services in the community would need to be delivered by more than one agency or were restricted by rural or geographic location. Where a care package is required in the home, it is co-ordinated by the Social Worker on site and the Discharge Liaison Nurse will ensure the Discharge Checklist is completed. The Trust told us that all of the team are engaged in discharge so that when the discharge liaison nurse is not available, the dedicated social worker and the ward team ensures continuity.

- Delays in medication. Update: Where possible medication is arranged the day before discharge, the pharmacy now opens at weekends which allows for more effective discharge from hospital 7 days per week.

- Delays in transport. Update : Unfortunately the problems with transport persist and the ward do endeavour to book transport the day before to allow for transport to be planned with NSL (contractor for hospital transport). On occasion a patient will be discharged on the same day and it is hard to get an exact time. The use of the discharge lounge helps and it was noted how the dedicated ambulance transport over the winter pressures helped.

- The EDD is signed off on the ward and then the patient is referred to the Discharge Lounge and medication and transport can be managed from the Discharge Lounge until the patient leaves hospital, the ward felt this was an excellent service that they would continue to use.

4. 3 **Discharge Lounge.**

- We visited the Discharge Lounge which consisted of 2 nurses, 2 healthcare support workers and 3 volunteers. There was capacity for 14 ambulatory patients and there were 6 single rooms with en-suite. The Discharge Lounge is open between 8 am and 8 pm and therefore, discharge from wards should not really occur outside of these hours. We were told that all patients should all be discharged from the lounge with the exception of those being fast tracked. However, we were told that Surgical was a poor user of the provision.

- For patients in the Lounge waiting to be discharged refreshments were provided by the restaurant where required.

- We were told how patient transport, if needed, was booked on the ward and then managed by the discharge lounge through to the actual point of discharge. We were told that A&E patients took priority in discharge due to the 4-hour waiting time requirements. The Trust told us that A&E patients are prioritised for collection from the discharge lounge in part due to the national A&E standards. Patients are then discharged when everything is in place with no priority order.

We were told that delays in discharge did occur and these were mainly down to:

- Delays in getting medication.

- Delays in getting transportation. A stretcher-based ambulance required to transport a patient often incurred delays.

- Changes to patient criteria has effected patient transport via NSL.

- Availability and capacity of the wellbeing service has impacted on discharge delays.

- EDDs being signed off too late leading to delayed medication.

- Need for additional checks between EDD and pharmacy to address queries and errors.

- Improved communication was needed to better manage discharge.

As shown there were a number of similarities and trends between the delays experienced on the wards as encountered in the Discharge Lounge. Update: Please refer to the Pilgrim site Action Plan.

4.4 What the Patients said.

- On average, according to the patients spoken to, their average length of stay was 8.5 days (ranging from 2 days to 24 days; the latter included a stay in another acute ward).

- Of the 9 patients spoken to 66% (6) had been spoken to about discharge in some way, either about expected discharge dates or about possible reasons why they may have to wait longer for discharge *(these included reasons such as extra tests required, the need to arrange for equipment in the home and the need to arrange carers in readiness for the patient returning home)*. The majority of patients spoken to who did not have any care within their home although carers, neighbours and family members away from their home were all cited as people who would help once they were discharged.

- It seemed clear that for those patients that had received diagnosis and who were aware of their treatment that home circumstances, next of kin, possible discharge scenarios had been discussed. For the others, discharge had not been discussed in any way the patient recognised. However, of those who felt they *had* been engaged in the process only 50% felt like they actually understood what was happening, these patients were additionally concerned about transport, arranging care in the home, how they would support others if they were the main carer and how they would get medication. Of those who reported that they had been spoken to about diagnosis, treatment and discharge they told us conversations with Doctors and nursing staff and OTs had happened within 1 -2 days after admission.

- The majority of patients didn't know who to speak to about discharge and instead referred their queries and concerns to the nursing team. This did create some anxiety for a number of patients who were frustrated when asking nursing staff about their discharge and only being told "it was up to the doctor", given that patients may only routinely see the doctor on a limited number of occasions in any one day this did cause stress and anxiety for some. Update: The ward told us that every ward round is fully attended by a doctor and nurse to ensure better communication and passing on of information. The discharge team have done lots of teaching on the ward so that everyone knows how the process work. The ward now has substantive consultant and they all work as a team discussing every patient, every day. Each patient now has a name board above their bed to ensure they have a named nurse every shift who can answer queries and reduce stress.

- Generally where patients were aware of discharge, they told us that they felt they had been adequately involved even if they didn't always understand the detail and language around it which could lead to confusion and anxiety for the patient. The ward feel that it is essential that each patients leads their discharge and has full involvement.

- Without exception, the patients expressed their praise of the staff teams on the ward and in the discharge lounge. They felt they worked hard and were very caring. Patients thought the hospital food was good and generally had no complaints.

4.5 Common Themes and Conclusions.

- It was observed that staff were not using hand sanitisers when passing between patients and bays, however, good usage was noted on the entrance and exit to the ward. We were informed that nurses and staff would not routinely be required to use hand santisers if they were not actually coming into physical contact with the patient. In response the ward were reassured that staff were seen using it before and after coming onto the ward and assured full compliance in line with weekly hand hygiene audits and the staff are reassessed with the 'Glow and Tell' hand cleaning machine.

- Patients generally told us that when they asked for an update or information around when discharge would take place they were told that "it was up to the doctor". This was on occasion perceived to be unhelpful, whereas a full explanation of the discharge process and where the patient was in that pathway would be more beneficial. We were told that the hospital is hoping to pilot a placemat type approach for patients and it was hoped that this would better inform patients about their hospital journey. Update: The placemat is currently in design, in addition the ward are developing their information leaflet in line with the one used on the stroke unit. They ward told us they are currently looking at what is called a 'ticket home', this is given on admission to the patient and family to fully engage with them in the discharge process from day one.

- Patients also told us that they didn't know who to talk to about concerns or issues relating to discharge. They did just say they told the nurse. The ward felt that 'the nurse' was the correct person to tell, and that the discharge nurse predominately focuses on the extremely complex discharges, the nursing team and the multidisciplinary team lead on all others.

- We were told and observed that call bells were sometimes left to ring. We were told that due to the type of patients on the wards and the dependency levels, it often takes more than one staff member and additional time to treat an individual patient's needs, however we are also aware that safe staffing levels are intended to incorporate a fluctuating need depending on patient levels and specific needs). This can further be hindered depending on the time of day. We were also told that volunteers were not permitted to support call bell response. We were told that staff had a call bell priority profile and also told us that call bells frequently break so they couldn't be solely reliant on them. The ward told us that their call bell system is on the risk register

and awaiting replacement. They also told us that when there is a breakdown they use a wireless system and nurses are based in each of the 4 bays so they can be called easily. Increase supervision and dependency of patients does impact on bell answering time and on occasions all staff can be behind a curtain providing care but as soon as it is safe, staff go to bells and prioritise patients requests. Volunteers do not make up paid workforce so are not allowed to do patient care but our domestics and ward clerks will also attend bells and tell staff where they are needed.

4.6 **Recommendations.**

- Recommended that all staff on the ward and in the discharge lounge be informed of the patient feedback relating to the good quality of care. **Trust Response**: This has been actioned.

- On the pre-discharge checklist we were told that staff would like to have patient property included to avoid any confusion upon discharge, although it was acknowledged that this may have to be regularly updates as friends and relatives may bring in additional items during the stay. We request that the Trust consider this suggestion which would clearly support the process of discharge from the ward. **Trust Response**: Our Ward Clerk is currently formatting a better form for property checks.

- Review the issues relating to the delays in medications, specifically the errors made on EDDs/TTOs which require the pharmacy to have to chase the consultant for clarification. Also review the timeliness of getting the TTOs through to the pharmacy - if pharmacy are not receiving TTOs until late in the morning then delays will occur. It was noted that we were told that 3 x Band 7 Pharmacy posts had been added and it was hoped that this could help support a 7-day week discharge programme which would increase appropriate discharge. There was a concern here that delays and potential medication mistakes could be seen as safety risks.
  Trust Response: We use Board Rounds each day to highlight potential discharges for the next day to enable pharmacy to have the information the day before discharge.

- The Trust to look at the maintenance of call bells where they are reported to be frequently failing.
  Trust Response: They are on the risk register.

- We were encouraged to hear about the care pathway placemat pilot and would request that, if successful, it is rolled out across the Trust at the earliest opportunity. This may alleviate some of the anxiety felt by patients when they were told the nurse couldn't inform them of discharge updates and that would be up to the doctor.
  Trust Response: The placemats and leaflets are currently being developed. The Stroke Unit have their leaflets up and running and the

same template will be utilised, these will be ready over the next few weeks.

- Recommendation that Lincolnshire County Council and Lincolnshire Community Health Service urgently work to identify and address the needs of the Acute Trust and the impact on insufficient community care to support the discharge of patients from Acute Care. Hospital is recognised as not the environment for anyone who is medically fit and by hindering this transition from hospital to the home or another care environment is not supporting the patient, the Trust, those patients in real need of acute care or the overall economic impact on our commissioned services.
  Trust Response: This work is currently being addressed via the CCG (Clinical Commissioning Group) Resilience Group and is on-going.

Grantham Site - Findings.

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the Trust has commented on them, they are included in the report we will include those within the report for public interest and information, the action plan developed by the Hospital Trust in response to this work can be find in Appendix A.

4.1 **General Information.** On the Grantham site we visited Wards 1 and 2. **Ward 1** has Cardiac and Stroke (rehabilitation) patients, together with general medical patients. **Ward 2** has Orthopaedic and Surgical patients as well as medical outliers. There is no Discharge Lounge within Grantham Hospital and therefore patients are discharged direct from the Ward (ward led) however there is a centralised Discharge Team covering the site.

Ward 1.

- A ward made up of Cardio patients (heart failures and heart attacks), 5 stroke beds and capacity for General Medical. At the time of the visit the 28 bedded ward had 6 beds closed which we were told was due in the main, to staffing levels and there were also heating problems in 4 of the patient rooms which had closed them.

- The ward appeared calm and relaxed. There was a large display board for the ward detailing patient details, staff with different colours identifying different specialities, for example consultants in creams were assigned to the stoke patients, at the time of the visit there were 12 patients per consultant. The 'plan for every patient' detailed the progress of the patient during their stay, assessment, treatment, delays, actions required, EDD etc were all listed on the Board which helped ensure the continuity of patient care during their inpatient stay.

- During the visit we viewed a large amount of therapy and interaction between patients and staff teams including Christmas crafts, hand massage and jigsaws.

- It was noted that there were no visible PALS posters or leaflets on the ward and also that the management structure provided on the information notice board was significantly out of date.

- Patient dignity was provided by either private rooms or curtains, however, conversations were still very audible. All patients looked well care for and during our visit we did not observe call bells ringing and being unanswered.

Ward 2.

- We were told that the ward catered for medical and surgical patients and that great care was taken in ensuring that medical and surgical are kept separate due to the risk of contamination and infection. We were informed that all orthopaedic patients were put onto an enhanced recovery programme and that the staff used the 'This is Me' booklet.

- The ward had at the time of the visit 28 beds. They had a full staff compliment and all beds were available. OTs and Physiotherapists are based on the ward and where a social worker is required they will be notified and make ward visits.

4.2 **Discharge Specific Information.**

Ward 1.

- There is no discharge lounge within Grantham so discharge is co-ordinated between the ward and central team. Once a patient is deemed medically fit they are moved to an 'anticipated' status. Social Worker referrals are made on site when required and the Social Worker was seen frequently on the ward during the visit. The Occupational Therapist (OT) and Physiotherapist are ward based and generally this was seen as an asset when caring for patient's needs, assessing their readiness to go home and arranging discharge. The ward clerk was the staff member designated to arranging patient transport where needed.

- We were informed that there could be up to a 2 week wait for 'new' care packages to be put in place and more recently an issue in arranging the care package for palliative care. The Continuing Care process for palliative care is new, however, sourcing care, funding and equipment on occasion could be challenging. The staff found this particularly challenging as they felt strongly that end of life was such a critical part of the patient journey that is needed to be given a high priority in sourcing the funding and care needed.

- We were told the ward had 3 trained nursing staff and 3 untrained nurses along with consultants, junior doctors, OT and physio. We were told that in the previous weeks and months staffing had been difficult, however, they hoped it was now more stable.

- Where discharge is anticipated, the medications to take home (TTOs - To Take Out) are sent down to pharmacy the day before if no changes are expected. However, if patients are on new medication and blister packs pharmacy must be given 4 hours' notice prior to discharge. Staff told us that when a patient is new to blister packs the ward staff need to ensure that there is a local community pharmacy to the patient that will be able to provide continued service for them after leaving hospital. It was reported that Lloyds pharmacy in Grantham has currently too many blister packs on it case load. Faxes of EDD and prescriptions need to be faxed to the pharmacies to ensure they can supply and requires a considerable amount of communication. **Trust Response**: The Trust felt that blister packs/dosette boxes and community capacity issues have a potential impact on medication safety for patients on discharge.

- We were told that delays in discharge may occur when patients are being discharged back into care where their circumstances and needs have changed as this will require an assessment of the patient by the care home before discharge can take place and where necessary another placement identified.

- We were told by the pharmacist that pharmacy physically go round and look at the patient boards for anticipated discharges but many times the patient details are not listed on the board the day before. The pharmacist told us that the pharmacy had to frequently chase the doctors and consultants after receiving the EDDs for various reasons including queries over patient dosage and missed items.

- In broad terms we were told that there was a real strain on reablement services, Independent Living Teams and those other organisations that provide care in the community. We were told that the mix of providers can prove challenging in co-ordinating effective care packages, for example a ward can prescribe TED stockings as a preventative measure upon discharge, however, within the community there is no one to help maintain them if the patient can't. Another similar case regarding a back brace was also reported to us.

Ward 2.

- Discharge starts at the point of admission and the discharge discussion with the patient and family is started as soon as possible. Doctors complete a blue patient record, this information is transferred by the nurses to the patient board and everyone has access to this patient data. The staff on the ward felt the system worked well.

- We queried how staff ascertained whether a patient has adequate support at home (where needed) and whether a care package would need to be arranged. We were told that whilst the staff talked to the patients they also made other checks with family and where family and visitors are not available, a risk assessment may be required.

- We were told that transport was a challenge for the discharge of patients and particularly the use of NSL. We were told that even when transports is booked for 11 am and even with a number of follow up calls, transport can still be delayed for hours at a time, this causes frustration and anxiety for patients and blocks bed for new in-patients.

- Staff told us that they missed the collaboration with PACT organisations and particularly LACE in ensuring patients were discharged with a coordinated care package quickly and effectively. They also felt patients were better supported with a PACT representative accompanying the them home meaning that any delays to a care being put in place could be supported by the PACT team, the staff felt the loss of this service impacted on the delivery and quality of service.

- We were told that care homes were reluctant to take patients after 6 pm which then meant that patients were required to stay in hospital for longer than intended. We were told that the ward on occasion, was used inappropriately as a 'rehabilitation ward'. For example where a patient is being transferred to another hospital for rehabilitation and transport is delayed, rehabilitation will start on the ward while transport is rearranged. Also where a patient refuses to be transferred to another hospital, it causes delays and by the time issues are sorted out the patient may be well enough to leave the ward and be discharged back home.

- We were told that Ward 1 at Grantham was able to use a prescribed taxi service for patients, however, we were told that the taxi service used was not wheelchair accessible.

- We were told that doctors were getting better at preparing TTOs (to take out medication) and the acknowledgement that TTOs can be done in advance for surgical patients. However, it was noted that doctors were still leaving medical patient's TTOs until the last minute and were displaying risk adverse discharge by requesting last minute tests etc when the patient is already and deemed to be medically optimised.

- We were told that pharmacy was very stretched due to volume and errors in prescriptions and told that there were frequent errors between the patient ward notes and the TTO prescription. The pharmacist told us that a lot of time is lost having to chase up missing items and dosage queries. We were told that an extra pharmacist was available over the weekend to support the winter pressures, however, we were also told that this would only remain in existence until Christmas.

- In general the feeling that a patient could have a really good experience while in hospital in terms of quality of care, but then the discharge process can be so stressful for patients that it is the only lasting memory from their experience and whose fault it is doesn't matter was a frustration for the staff at the hospital Trust.

4.3 What the Patient said.

Ward 1.

- On average according to the patients spoken to, their average length of say was 9.5 days (ranging from 3 days to 28 days, one patient was staying on the ward whilst waiting for a bed in Lincoln hospital and we were told another patient was awaiting a bed at Newark hospital and discharges from Grantham would be delayed until this could be arranged for these patients. This was also echoed by some of the discussions with staff about medical outliers, this happens due to the lack of beds in medical wards and patients can be placed in other wards or departments. Medical outliers can we were told, have an extended length in hospital stay compared to others, we were also informed that it was company policy that a patient could not be moved more than once, however we were told by a patient that they had been on 3 wards. Staff assured us this was not the case, however a patient may be moved between 'bays' but remain in the same ward which understandably for an unwell patient can cause disorientation.

- Patients felt the wards were a little tired and would benefit from redecoration, in addition there was feedback about the signage for the wards, particularly ward 1 and 2 and being on different floors and caused confusion and some anxiety particularly for friends and relatives of patients in the ward description.

- For a number of patients their discharge pathway had not begun from the patient's perspective as they were still awaiting further tests and assessments. Where patients had been talked to about discharge, this had happened within 1-2 days of them arriving on the ward and in general, most at least partially understood the process but were sometimes confused about the level of support once they had left hospital and who would be responsible for arranging it.

- Without exception all staff were praised for their level of care, a number of patients felt that the staff were overworked and this sometimes left call bells unanswered, but 100% of patients said that they had been cared for effectively and they talked with great affection about the staff treating them.

Ward 2.

- Patients told us that the standard of care was excellent and that they really felt cared for, they also told us that the staff were run off their feet and that this could sometimes lead to call bells not being answered quickly.

- Patients were mixed in their knowledge of discharge, one patient told us that after 1-2 days they were spoken to about discharge and given a discharge leaflet, others knew they couldn't go home until they had achieved certain tasks (such as steps and stairs), others knew they were

waiting for care home or care packages to be put in place. Only one patient told us that they didn't know anything about the discharge process and that they were confused about who was going to arrange the ambulance for them to get home. On the whole the ward team appeared to be more transparent when talking to patients and made it clear with patients that they were discussing discharge and its implications.

- Patients where they were identified as being aware of the discharge process felt that they had been involved in decision making, in another case the patient had to be totally reliant on a family member to organise discharge and the care package.

- One patient on this ward said that they just wished someone had the time to come and help wash their hair. **Trust Response**: This was raised verbally at the time so that the ward could address this straight away.

4.5 Common Themes and Conclusions.

- It was noted that notice boards may need revisiting to ensure that information provided is up to date and provides useful information for patients, family and friends, specifically the reference to an out of date corporate structure chart and the absence of PALS information.

- The signage for both wards 1 and 2 was reported to be confusing for patients and family and friends alike.

- Whilst the majority of patients had awareness of the discharge process the use of the 'patient passport table mat' would prove supportive of the discharge process. It seemed apparent that despite staff talking to patients within a day or so of being on the ward about their home circumstances etc the patients did not understand or relate this as part of their discharge planning.

- Patients told us about sleep disturbance due to patients exhibiting dementia symptoms, the nursing staff were also aware of these issues and wherever possible tried to keep the disturbance to a minimum, they told us dementia patients have a twilight hour where they can become very agitated and distressed and the best was done to calm the environment.

- It was felt that in some areas doctors and consultants were risk adverse when it came to discharge. We were told that there are occasions where medically optimised (fit) patients whose discharge was being delayed because the doctors/consultants were requesting last minute tests.

- Within the Grantham area it was felt that there was a lack of capacity when it came to step down care home facilities. We were told for the

Grantham site that the Independent Living Team were also non-existent and this had a direct impact on discharge.

- We are told anecdotally (and not related specifically to this hospital) that family members did not feel as engaged as they might about the discharge of a family member, particularly where the family member needed either a step down 30 day bed or a residential care home environment. Family members felt that they were left without any help, support or guidance to find suitable care home services, neither did they feel advice was given about getting financial assessment or different types of care that would be required.

- We were also told that there was a general lack of confidence in the transport systems and they too also hampered the discharge of patients. **Trust Response**: The Trust felt that this should be raised with the commissioners and be directed to Greater East Midlands Specialist Commissioning Unit (GEMS).

- Finally we noted that patients felt cared for and looked after by the nursing staff, however, the comment that one patient made about just wanting to have their hair washed highlights the need and capacity to accommodate the individual's needs, human rights, dignity and respect.

4.6 **Recommendations.**

- Recommended that all staff on the wards be informed of the patient feedback relating to the good quality of care.

- Review the issues relating to the delays in medications, specifically the errors made on TTOs which require the pharmacy to have to chase the consultant for clarification.

- Encouraged about the care pathway placemat pilot and would request that this if successful it is rolled out across the Trust at the earliest opportunity.

- Recommendation that Lincolnshire County Council and Lincolnshire Community Health Service urgently work with to identify and address the needs of the Acute Trust and the impact on insufficient community care to support the discharge of patients from Acute Care. Hospital is recognised as not the environment for anyone who is medically fit and by hindering this transition from hospital to the home or another care environment is not supporting the patient; the Trust; those patients in real need of acute care or the overall economic impact on our commissioned services. **Trust Response**: The Trust stated that they agreed with this recommendation.

- We ask that the hospital look at issues relating to a 'preferred provider' taxi service and assess their capacity to deliver an appropriate service which could accommodate wheelchairs.

- We ask that a review of hospital transport be conducted and the challenges be identified so that those who need to be held to account can be.

- We ask the hospital consider the statement of the patient just wanting someone to have the time to help them wash their hair, we acknowledge that not all patients will have family or friends available to support in this holistic way and would look to what other infrastructures could be put in place to support peoples dignity and respect.

Lincoln Site – Findings.

The following provides the detail of the visit feedback and should be acknowledged that this information was taken at a point in time. If changes have been made since the visit and the Trust has commented on them, they are included in the report we will include those within the report for public interest and information, the action plan developed by the Hospital Trust in response to this work can be find in Appendix A.

4.1 **General Information.**

- Three wards were visited at the Lincoln site. These were Lancaster, Stow and Hatton. It should be noted that Stow no longer exists as it did on the day of the visit. Patients have been repatriated to another wards to allow for refurbishment and the restructuring of patients to take place.

- The Lincoln site does have a discharge lounge and the majority of patients should be discharged through this means.

Hatton Ward.

- Hatton ward has a mix of patients with dementia at varying degrees of severity and other long term conditions such as diabetes and also some patients receiving palliative care, there are 27 beds all of which were occupied at the time of the visit.

- We were told that the hospital generally was looking to reduce admissions onto the wards as it was felt that with sufficient community and home support that patients could avoid being admitted.

- 3 weeks prior to our visit, staff numbers had resulted in a closure of beds, we were told that trained nurses were amongst the most common forms of staff shortages.

- On the ward we viewed the 'Plan for every patient board' with specific details about patient care, this is updated by nursing staff and used by the various disciplines who need to plan and deliver patient care. In addition to the board, individual patient details are kept within their notes.

- The ward was 'functionally tidy', however the Hatton Ward nurses station was very busy and did look chaotic to those not engaged in the operational side of the ward, it is anticipated that this view would apply equally to patients and visitors. **Trust Response**: The ward is in the process of redeveloping Hatton. The new ward will not have a traditional nurses station, but will focus care within the patient bays. In this way we will hopefully reduce the chaotic appearance of the reception area. In the meantime staff have been reminded about this initial impression and the need for a tidy environment.

- We were told that the hospital was working more to dementia friendly wards and that Burton had already been addressed and that Hatton was next to be developed into being dementia friendly.

4.2 **Discharge Specific.**

- On the day of the visit there were 4 medically fit and 1 potential patient awaiting discharge, in reality none of the patients were discharged. We were told that there were issues around getting appropriate care packages in place including community capacity and with sourcing a step down facility. We were told that the availability of Independent Living Teams was putting a strain on the ability to get patients discharged in a timely manner. **Trust Response**: There is a severer and on-going lack of community capacity for community 'at home' support packages that means many patient (30-60 daily) remain in hospital when they could be safely cared for at home.

- We were also told that the hospital was working towards 7 day discharge, with the use of an electronic discharge trained doctor, 19 discharges had taken place on a Saturday and a further 11 on a Sunday in December, and the positive impact of this does relieve pressure on bed availability. **Trust Response**: The Lincoln Discharge Hub now operates 7 days per week with input from ULHT staff as well as LCHS.

- The ward staff seemed very determined to tackle discharge delays and to keep the patients informed. On the ward (although not specific to Hatton) we were introduced to a Sister responsible for discharge and in addition there is a specific discharge lounge and discharge nurse on the site. **Trust Response**: Working in support of discharge is a Band 7 lead nurse and 4 staff nurses. These staff work within a discharge hub alongside partners in LCHS and Adult Social Care, working to an integrated model. The hub is support by a Band 3 discharge hub coordinator. The Trust are always exploring ways of increasing the size and scope of this team and we have recently deployed an experienced matron to work exclusively with the discharge team to further streamline our processes. The discharge lounge is staffed separately and has its own staff nurse.

- We felt that the team ethos on the ward was evident and this came across in terms of the well briefed and seemingly organised staff teams across all the main disciplines.

4.3 **What the Patient said.**

Hatton Ward.

- All the patients told us that they felt cared for and that nothing was too much trouble for the staff. Patients held all staff in high regard irrespective of their role and felt treated with respect and courtesy.

- Although not all the patients spoken to understood the full process for discharge they did say they felt engaged generally where their care was concerned and they knew what was medically wrong with them and what the intended treatment plan was, even if they were not aware of being talked without about future discharge arrangements.

- Two of the patients spoken too where fully aware of the discharge plan but also understood there were delays for them.

  Trust Response for all 3 points above: We are grateful that Healthwatch also witnessed the high level of patient satisfaction expressed by in-patients on our older peoples wards; this is our own consistent finding.

- Patients couldn't tell us which staff member was allocated to their care or discharge, instead they referred to their point of contact as 'the nurse' and were confident that they could rely on them for information should they need it. **Trust Response**: We are taking steps to ensure we comply with national guidance and display the nurses name clearly at every bed space. We are also rolling out the 'Hello My Name Is' initiative to promote nurses properly introducing themselves to patients.

- At the time of the visit there were 4 patients medically fit for discharge and one anticipated however all remained on the ward, whilst patients were frustrated with the delays they were informed as to why, and two of the patients we spoke to said that their care package was taking longer than anticipated to put in place.

Lancaster Ward.

- Lancaster Ward hosts elderly patients with complex needs, at the time of the visit there were 20 beds and at full capacity, there are 10 patients each side of ward consisting of bays and side rooms, 1 nurse allocated to 10 patients.

- There was a full complement of staff but one staff member was loaned from Dixon ward.

- Lancaster is a locked ward however family can assist patients to go out (most patients are not well enough to go alone).

- The ward appeared clean, well-organised and calm.

- We noted a screen across a fire exit, at the time of the visit we did not ascertain the reason why the screen was obstructing the exit. **Trust Response**: This has since been removed.

- Visiting hours are 2pm-4pm and 6pm-8.30pm. This may change soon to 2 pm-9 pm.

- Protected meal times are in operation but if the visiting times change the evening meal would no longer be protected, but it is hoped that more family members will get involved in supporting patients during this period. This can have the benefit of patients eating and drinking better when a family /loved one is present.
  Trust Response: We support all the comments made in relation to Lancaster ward which is indeed a well run ward with high standards. The screen across a fire exit has since been removed.

4.4 **Discharge Specific.**

- During the morning rounds doctors write on the blue patient notes and nurses transfer the information to "Plan for every patient "board which is available for all the staff to review this includes the physio and OT on the ward and also the ward social worker who acts as a conduit between patient and community social workers where required.

- All staff write on shared patient notes. All patients are free to know what is written about them although there may sometimes be information governance processes to follow (eg if they want to take a copy). Notes are not routinely shared with families as this would breach our duty of care in regards to confidentiality. In practice what will typically happen is that when a patient and their family ask about the medical plan, a nurse or doctor will sit down with the notes and discuss what has been written with the patient and their family.

- Patients are discharged from the discharge lounge which is next to Dixon ward where a morning and afternoon session approach to discharge is adopted. However some patients including those with dementia or those at end of life are discharged directly from the ward.

- The wards, OT and physio hold 'Best Interest Meetings' where it is established what the current patient situation is, for example if a patient says a neighbour/daughter etc. will be at home to care for them the ward assesses if this is possible or indeed a reality. A risk assessment will be carried out, sometimes a volunteer or Chaplain will give an insight into any concerns a patient or family member may have. If there are any concerns for mental capacity Independent Mental Health Advocacy (IMHA) advocates will be contacted. **Trust Response**: Best

interest meetings are only held in circumstances where a patient lacks capacity to make a decision in their own best interest. In such cases, we meet with all key people including an independent advocate where necessary before reaching a consensus decision.

- Once a week the Sister, Doctors, Physio & OTs hold a discharge meeting which also includes a liaison nurse from the Independent Living Team.

- The Discharge to Access is a model that is aspired to by both the hospital and the wider health community. The aim is that patients will be discharged as soon as they have completed consultant led care, and all subsequent assessments will happen in their home or in a placement. There is currently sufficient resource in the wider health community to achieve this in practice. It is something that is being worked towards and remains an aspiration.

- We were told that the big challenge for discharge is provision of services in the community. Once the patient is medically fit they should leave but unfortunately care is not available in the community and patients can be left with a 5 day wait for discharge.

- TTO and medication does not appear to be a problem in delaying discharge for this ward (Lancaster), however transport as on the other sites can prove to cause delays even though it is booked in advance. The delayed transport has consequences for patients being discharged into residential care homes as most care homes will not accept patients after 7 pm/or dark even if they are returning to their usual home. This causes a lot of stress for the patient and also blocks an acute bed.

- Delays in transfer of care can cause long delays- waiting for handover to reinstate care in the community is a concern. Independent Living Team offer temporary care, but in reality they have no capacity.

- At a team meeting a decision may be that a "2C" date is set after extended delays. *(This is where Social Care have to start paying for the hospital bed)*

- The ethos of the ward is that they are only borrowing the patient from the community giving them consultant care and then giving them back as soon as possible, mindful that a reduced length of stay impacts on reduced mortality rates.

Lancaster Ward.

- Patients in this ward were very goal orientated, in that many of those spoken to told us what it was they needed to achieve in order for them to be allowed to leave hospital, whether that be assessments, allocation of a care home bed or respite or OT and Physio approval.

- Patients we spoke to had been in hospital anything from 2 days to several months in some cases (although for the longer stays it was not ascertained whether this was on the same ward).

- Patients told us that they were very happy with standard of nursing care, clinical care, food and accommodation. **Trust Response**: Again we are pleased that the Healthwatch experience was the same experienced on the ward.

- Patients did however tell us that they did not really understand the discharge process or where they were on that pathway. A number of patients told us that they had been spoken to about who was at home and what help did they have available at home, but they did not clearly link those conversations to the discharge process. However, there is an argument here that patients may be more likely to exaggerate their support and capability at home if they knew the questions were being asked in relation to discharge.

- As a direct consequence of patients not being aware of discharge related questions, 90% of the patients we spoke to were not aware of what would happen to them during the discharge process. One patient did tell us that they were aware that they could not go home and instead would be discharged to a care home, another patient told us a similar story however, a care home placement could not be found and the interim suggestion of movement to another hospital had been refused by the patient.
  Trust Response: Due to the incredibly convoluted nature of funding arrangements for complex discharges, it can be difficult to explain the available discharge pathways to patients in way they are easily understood. We do however try to keep people informed, and you note further down that we do involve patients and families in discussions at an early stage. We are working collaboratively with all providers to try to simplify these pathways.

  There are themes identified later in the document relating to discharge to care homes, where a variety of complaints have been made about poor handover. We introduced a handover document aimed at providing a high quality handover to other care providers that should be used consistently, but clearly this is not the case. This is something that will be raised through the matrons who will be asked to rectify.

- However it was clear after speaking to family members and visitors that despite the patients being unclear, that other relatives and friends had been involved in discussions about discharge from quite an early stage.

Stow Ward.

- At the time of our visit Stow ward was in the process of being moved and all patients seemed to be aware of the move and atmosphere was calm and relaxed and the teams managing the patients move were positive and fully of energy regarding the changes. The ward consisted of 4 four,

6 bedded bays and 4 individual rooms. Trust Response : The ward has since moved location and remains a calm, relaxed and positive environment for patients. The ward team is fully motivated in care delivery and key performance indicators have been sustained. The longer term plan for the ward is to have a full refurbishment to provide a dementia friendly environment for the delivery of patient care.

- On the day of the visit there were male and females on the wards, ages ranging from 16 to 102 years. **Trust Response**: The ward requires a large amount of varied equipment to facilitate the moving and handling of patients who have had traumatic injuries, and requiring rehabilitation. This equipment is required 24 hrs a day and is used by all disciplines involved in patient's rehabilitation. In an effort to maintain tidiness and ensure the ward is clutter free as much as possible, an 1100hrs "bay inspection" takes place daily, led by the ward sister/co-ordinator to ensure the ward remains a tidy and clutter free environment. Unfortunately, there is no space on the ward to store patient's belongings, and patients are advised daily to send unnecessary belongings home with relatives.

- Due to the kind of ward there was a lot of equipment around and an additional problem was the lack of storage for patients belongings, the staff tried to encourage patients and families to keep to a minimum what was brought in but still suitcases were seen at the end of the patients bed because there was nowhere else for them.

- We were told that all patients are discharged from the discharge lounge unless there was a clinical reason for doing so which included dementia, safeguarding concerns or fast tracked end of life care. **Trust Response**: The ward is an emergency assessment area and receives direct admissions from A&E, clinic, and ICU. Bed availability on a daily basis to receive these patients is dependent on effective use of the discharge lounge which is routine practice for the ward. Feedback from patients using the discharge lounge has been positive and the lounge has become an important element of a patients discharge journey.

- We were told that Stow was an acute trauma ward and therefore patients being discharged from this ward are more likely to be discharged to another ward/or care environment for rehabilitation, patients can be received into the ward from fracture clinic, A&E and ICU in the main. Again we were told that the provision for ILT beds was a real problem when trying to discharge patients. **Trust Response**: The ward undertakes a "Plan for every patient" review daily, and any patient identified to transfer to another ward for rehabilitation is identified during this process. Patients who are medically fit and have a delayed discharge, for whatever reason, are escalated to the Operations Centre daily, where there is a "Plan for Every delay" review undertaken daily.

- On Stow there was an automatic referral to the OT and Physio and this is reviewed daily, we were told that the ward was well supported by the discharge team however even when a patient is deemed medically fit

there were still delays. During the 'best interests' meeting both the OT and Physio need to agree before a patient can be signed off for discharge and to ensure that any equipment is clarified.

Stow Ward.

- Patients spoken to on Stow appeared very informed about the discharge process and seemed to have a good understanding of where they were in the process with assessment, treatment plans or what was going to happen next. **Trust Response**: To facilitate communication and engagement with patients and relatives, the ward have developed and implemented a 1400 hrs Standard Operating Procedure for patient engagement. This involves the nurse caring for each patient, undertaking a review of each patient's needs, with the patient and relatives during visiting time to ensure all are happy with the standard of care being delivered, know their current management plan and discuss discharge planning. This feedback from patients supports this process as it demonstrates patients were involved with their care and discharge planning.

- Patients also told us how they felt cared for on the ward and that staff were working very hard. One patient told us that they got very upset in surgical assessment unit that a doctor was happy for the patient to be discharged home without actually seeing the patient on their feet, after complaints by the patient that they would not be able to cope if discharged they were admitted to Stow and now felt much more confident in the care being received. **Trust Response**: Positive patient feedback, regarding their care and involvement in care planning and discharge is indicative of the many positive changes that have taken place on the ward in last few months.

- Patients generally appeared informed and knew that they were being moved to another ward.

Lincoln Discharge Lounge.

- All patients being discharged from the hospital are routed through the lounge, however there are a few exceptions to this including mental capacity and end of life.

- The discharge lounge explained some of the issues they had around discharge and described that typically 20-25 patients would be discharged in any one day but that there were many more medically fit but couldn't be discharged for various reasons including:-

    - Transport.

    - ILT beds/support.

    - Care package not in place.

- Equipment not in place.
- No availability for Care Home places.
- Rehab into Newark is problematic.
- Late (too late discharge) into care homes.

- We were told that transport arrangements with Arriva could be problematic, however the Trust dealing with the Wellbeing Service in this area had so far been well received.

- The patients we spoke to in the discharge lounge were all happy with the level and quality of service received during their stay. Patients said they understood delays with medication changes, care packages and equipment did happen as part of the process, the only real issue was the length of time people felt that had wait before they could physically leave the hospital. For example we had cases relayed to us where patients had been seen on the ward at 7.30 - 8.30 am and told they were being discharged, at 11 am they were discharged to the lounge and then it wasn't until early to mid-afternoon before they could actually leave, patients said that communication from the outset could have been better about the different stages of discharge.

- All patients in the discharge lounge spoken to said they had been given or would be given the necessary documentation to take home with them.

- During our visit we spoke to one patient who had been moved from a ward to a discharge lounge bed at around 10pm, however disruptive this was at the time, the patient was pleased as it meant he had 1.1 care and had a peaceful night's sleep, the eventual discharge of this patient did not occur until later in the afternoon.

4.5 Common Themes and Conclusions.

- We noted that the theme of pharmacy on discharge did not seem to present quite the same level of disruption and delay as it did on the other sites, however, the issues around transport and ILT and community services were again noted.

- The degree of bed blocking on some wards due to the lack of community based capacity to support medically fit patients was quite shocking and demonstrated the challenges the acute sector faces in trying to manage its patient population.

4.6 Recommendations.

- Recommended that all staff on the wards be informed of the patient feedback relating to the good quality of care.

- Encouraged about the care pathway placemat pilot and would request that this if successful it is rolled out across the Trust at the earliest opportunity.

- Recommendation that Lincolnshire County Council and Lincolnshire Community Health Service urgently work with to identify and address the needs of the Acute Trust and the impact on insufficient community care to support the discharge of patients from Acute Care. Hospital is recognised as not the environment for anyone who is medically fit and by hindering this transition from hospital to the home or another care environment is not supporting the patient; the Trust; those patients in real need of acute care or the overall economic impact on our commissioned services.

Follow-Up Telephone Discharge Outcomes.

Following our visits to the hospital a number of patients agreed for us to follow their journey post discharge. During the follow-up we established the following:

- All except one patient felt they were fully involved in the discharge.

- All except one where happy with the eventual experience of the in-patient and then discharge process.

- Only two of the 9 respondents were discharged on the original planned date, others were delayed between 1 and 7 days.

- No patients felt they were overly delayed on the actual day of discharge.

- Compliments made directly about the Grantham and Pilgrim site for care and discharge.

- 3 of the patients said they received no guidance on any follow up checks and weren't sure what to expect once they got home.

- Patients who had been delayed were reportedly delayed due to lack of respite provision, community care provision and availability of carers over the Christmas period.

- General observations from patient conversations was that they were glad to be back in their own homes or original care environment. They were grateful and appreciative of the care received and the efforts made across all agency staff and were, retrospectively understanding of the delays in discharge.

5. The Care Home Perspective.

From the 288 care homes contacted to undertake a focused questionnaire which would complement this work, 17 returned a response. It must, therefore, be recognised that this does not necessarily represent the views of the whole care home population for Lincolnshire, nonetheless it still has a valid contribution to make to some of the health and care sector challenges and concerns of discharge. In addition, it also adds a balanced dimension to when the process works well and should be celebrated.

The responses came from around the county including Sleaford, Grantham, Lincoln, Mablethorpe, Market Rasen, Spalding, Stamford, Alford and Boston. Over half of the homes responding had 30 day/step down/respite beds with a mixture of homes providing residential care, residential with dementia, nursing care and nursing care with dementia or a mixture of the groups.

Of those that responded 82% (14) detailed significant challenges around the impact of hospital discharge on their services and the impacts on patients. Across all locations the issues were very similar.

The key themes were:

- Lack of information from the hospital or ward about the discharge (prior to).
- Missing discharge paperwork when the patient arrived back to the home.
- Medication not arriving with the patient and limited administration information for medications. It was reported that frequently no information was being received at all.
- Not enough detail about the patient and the GP and next of kin details were often missing.
- Late discharge from hospital.
- Discharge from A&E perceived to be very poor, including premature discharge requiring readmission, no notes and no medication from A&E was common.
- Documents received on discharge have too much jargon and are not easily understood by the care staff.

We were also told of the following arrangements that supported the discharge process effectively:

- We were told Grantham Hospital has held meetings with some care homes to try and improve discharge and this has helped communication and understanding.
- Homes felt that early notification of anticipated discharge and the ability to go and assess the patient made the process much better.

- Care homes felt it useful when contacted by the social worker prior to patient discharge to discuss patient needs and specifics related to continuing care.

- There was good feedback also about Louth Hospital, however, there was a continued theme that the effectiveness of the discharge process varied between provider site and ward and that it wasn't consistent.

In general terms the majority of homes felt that the communication with the wards discharging a patient into their care was good, however, complications arose when patients were returned without prior knowledge; transport caused delays or at the end of the discharge journey when patients arrived with incomplete packages of support including discharge information, medication detail and prescriptions and equipment etc.

The responses suggest that the 'process of discharge' and the eventual patient experience is managed as well as possible under the current system, however, there are a number of opportunities for risk and for discharge not be providing the best possible experience for patients, families or the care providers. This is not the responsibility of one organisation or department but several and this exacerbates the challenges, the number of admissions from A&E, through to how the doctors discharge on the ward, through to how prescriptions are managed, reliance on transport services and ILT and Care providers in the community and the expectations of those receiving patients are all factors in the complex process.

There were some specifics which highlight the consequences of disjointed discharge and a small number are included below which were raised by the care homes. We also recognise that in most cases these are exceptions rather than the norm.

"Patient discharged with a DNAR (Do not attempt to resuscitate) where the family had no knowledge that the DNAR was in place and the care home had to explain once the patient arrived back at the care home."

"A patient was discharged back to the care home and sent with insulin which was actually the patient for another patient."

Common Themes and Recommendations:

- There is a common theme across at least two of the Trust sites (County and Pilgrim) that there are issues in patients receiving timely and accurate medications. As with the main body of the report we would ask that the Trust look at the mechanisms and issues facing pharmacy across the Trust and how it can be improved.

- There was a theme across a number of the responses which referred to the jargon included within medical documents following the patient which caused confusion for the continuing care providers once back in the community. As a result we would request that the Trust gives consideration to how written communication is relayed to the community sector, removing or explaining jargon and adopting a plain English approach.

- We acknowledge the positive feedback received about the Grantham Trust site and particularly some of the work the hospital has been doing with the local care home providers. We would ask that the Trust reviews this work for lessons learned that can be applied where appropriate across the Trust and care home providers to support understanding, communication and improved processes for all.

6. General Overview of Observations & Conclusion.

Across the 3 hospital sites it was noted that all 3 operated slightly differently and with different operational constraints for example Grantham did not have a discharge lounge. It was notable that within Pilgrim and Grantham both had considerable but potentially manageable issues relating to the organisation of patient prescriptions and these fundamentally fell to the working methods adopted by the doctors and then the requirement of pharmacy to chase the doctors for clarification.

There was suggestion that there are some risk adverse decisions being made around whether a patient should be discharged or not and the strong stance that ULHT is an acute setting and patients should be there for the least possible amount of time, whilst this latter view is held by the nursing staff there appears still in areas a reluctance to discharge until every patient risk is eliminated.

On all sites there is a clear issue related to bed blocking and when looking at the cost implications of this and the impact on patient safety and wellbeing this is an issue which urgently needs addressing. The ILT has limited or no capacity in some areas, respite, step-up, step-down care is limited, patient transport is a challenge and the need to manage end of life are all pinch points in the wider issues of economic sustainability and patient satisfaction.

It is clear to see that improvements in the premises, trials of new systems (like the placemat pathway) are all taking place, however, this does need to be a pan Trust co-ordinated approach, otherwise how do we know that a project that works well at Pilgrim will be as effective at Lincoln County?

7. Final Recommendations.

In our view the following core observations and recommendations need to be considered by the commissioners and providers of care:

Healthwatch ask that in addition to the specific recommendations below, that all the observations and recommendations made at ward level or as part of the feedback from Care Homes is also considered and acted on in equal measure.

1. Healthwatch was encouraged at the feedback from the respondents in all the areas covered. We would, however, like assurance that all patients, family and friends are aware of the processes of raising an issue or concern and what the expected action should be. We noted that whilst PALS information was available in the main hospital

corridors, the posters according to patients didn't really mean anything. The posters do not tell patients and families that if they have a problem in the 'here and now' they can inform and work with PALS. It was also noted that PALS information on the wards was very limited or non-existent in the case of a couple of the wards. We would like reassurance that this has been addressed by ULHT.

2. We recognise and would seek reassurance that at all locations where ULHT Trust staff are making suggestions (such as the need for property to be on the discharge checklist and the significant feedback from pharmacy) that they are being listened to and where possible acted upon.

3. We recognise across all locations that similar issues are affecting patient discharge which could impact on patient experience, patient safety and effective management of an acute patient throughput. The hospital sites should consider its collective pinch points and seek to resolve this collectively through the means they have available to them both operationally, strategically and politically.

4. We would also like ULHT to consider the views from patients after being told they will be discharged by the doctor in the morning, through to the perceived lowered patient experience of a later than expected discharge and also the reliance of the doctor to provide answers to questions from patients rather than the nursing staff available on the ward. We would ask that ULHT looks at ways of remedying this either by the discharge passport or via a clearer explanation from doctors or nursing staff about what is involved in discharge and where there may be potential for delay.

5. The Trust needs to ensure that where it displays organisational information that it is timely and still up to date. We recommend that ULHT reviews its publically displayed information and updated where necessary.

6. Healthwatch acknowledges the efforts to make wards dementia-friendly. In addition, we would ask how it will improve patient care and experience for all when combining patients displaying dementia symptoms on wards with those who don't.

7. Healthwatch values the efforts made to ensure that patients and families have the end of life experience they want and Healthwatch also appreciates the frustrations when this doesn't happen due to community care capacity. Healthwatch recommends that this is reviewed with all partners and relevant organisational bodies to identify and alleviate any pressures at this critical point of a patient pathway.

8. Recommendation that Lincolnshire County Council and Lincolnshire Community Health Service urgently work with to identify and address the needs of the Acute Trust and the impact on insufficient community care to support the discharge of patients from Acute Care. Hospital is recognised as not the environment for anyone who is medically fit and by hindering this transition from hospital to the home or another care environment is not supporting the patient, the Trust, those patients in real need of acute care or the overall economic impact on our commissioned services.

9. If a patient is new to blister packs the ward staff need to ensure that there is a local community pharmacy to the patient that will be able to provide continued service for them after leaving hospital. It was reported that Lloyds pharmacy in Grantham has currently too many blister packs on it case load and that this supply load coupled with

10. needs for faxes to be sent can require a considerable amount of communication and resource. Healthwatch would like the Trusts perspective on whether there is an issue with caseloads for blister pack pharmacies in some areas of the county and also whether there is a better way of managing the communication between Trust and pharmacy.

11. We were told that some wards missed the collaboration with PACT organisations and particularly LACE in ensuring patients were discharged with a coordinated care package quickly and effectively. They also felt patients were better supported and the loss of this service impacted on the delivery and quality of discharge. Healthwatch request who ULHT feels should be commissioned to provide this kind of care and whether substitute services are as effective.

12. We are told anecdotally (and not related specifically to any one hospital) that family members did not feel as engaged as they might about the discharge of a family member, particularly where the family member needed either a step down 30 day bed or a permanent residential care home environment. Family members felt that they were left without any help, support or guidance to find suitable care home services; neither did they feel advice was given about getting financial assessment or different types of care that would be required. Healthwatch asks ULHT who they feel should be providing this family liaison support and where it exists, whether it is effective and where it doesn't exist, why doesn't it?

13. We ask that the hospital look at issues relating to a 'preferred provider' taxi service and assess their capacity to deliver an appropriate service which could accommodate wheelchairs.

14. We ask that a review of hospital transport be conducted and the challenges be identified so that those who need to be held to account can be.

15. We ask the hospital consider the statement of the patient just wanting someone to have the time to help them wash their hair. We acknowledge that not all patients will have family or friends available to support in this holistic way and would look to what other infrastructures could be put in place to support peoples dignity and respect.

16. Hatton Ward (Lincoln) nurses station was very busy and did look chaotic to those not engaged in the operational side of the ward. It is anticipated that this view would apply equally to patients and visitor. Healthwatch asks if this has been raised previously and whether there are intentions to improve?

17. There was a theme across the care home responses which referred to the jargon being included within medical documents following the patient which caused confusion for the continuing care providers once back in the community. As a result we would request that the Trust gives consideration to how written communication is relayed to the community sector, removing or explaining jargon and adopting a plain English approach.

18. We acknowledge the positive feedback received about the Grantham Trust site in specific relation to care homes and particularly some of the alleged work the hospital has been doing with the local care home providers. We would ask that the Trust reviews this work for lessons learned that can be applied where appropriate across the Trust and

care home providers across the county to support understanding, communication and improved processes for all.

Healthwatch wishes to thank everyone involved in the visit and particularly the respondents, Hospital and Care Home staff and Healthwatch authorised representatives. It is acknowledged that if, at any time any patient, family member or carer wishes to talk to Healthwatch relating to compliments, concerns or complaints they can do so in confidence.

Following the report being finalised:

- Healthwatch will submit the report to the Provider.
- Healthwatch will submit the report to CQC.
- Healthwatch will submit the report to LCC or NHS England
- Healthwatch will publish the report on its website and submit to Healthwatch England in the public interest.

Glossary of Terms

TTO	'To Take Out' (medication/prescriptions to take home)
EDD	Expected Discharge Date
EDD	Electronic Discharge Document
OT	Occupational Therapist (work with patients to overcome difficulties caused by illness, age, disability or accident)
Physio	Physiotherapist
LCHS	Lincolnshire Community Health Services
ILT	Independent Living Team
DNAR	Do not Attempt Resuscitation
Step Down	Care provided on a temporary basis normally in care home environment

Appendix A

Action Plan for Healthwatch – discharge planning Grantham site			
Action Plan		**Date of Compliance Visit……**	
Issue being addressed	**Action to address underperformance**	**Identified person**	**Date to be completed**
Information on notice boards out of date and insufficient re corporate structure and PALs information	All areas to check notice boards for up to date info and ensure PALs information is displayed.	Ward sisters	
Signage for ward one and ward 2 confusing as doesn't match floor numbers	This is being addressed through Procure 21 so that ward 2 will be renamed ward one and be on first floor and ward one will be renamed ward 2 and be on second floor. It will be 6 months before this can be fully achieved to fit in with building work of Procure 21	Estates site lead	
Poor understanding of discharge planning by patients – use of "patient passport tablemats" to be considered Developed from Leadership into Practice project by patient experience team lead	Continue Implementation – already in place on EAU and ward 6.	Patient Experience lead with ward sisters	
Patients sleep disturbed by dementia patients	Make use of side rooms and pressure mats to reduce risk of falling and wandering. With Procure 21 work looking at having "dementia friendly" rooms for patients with dementia.	Ward sisters	
Patient dignity provided by either single rooms or curtains – conversations very audible	Whenever possible patients and relatives are taken to a quiet room for "difficult" conversations	Ward sisters	
Last minute requests of diagnostics on patients told that they were medically fit delayed discharges	Monitor implementation of daily senior reviews and the plan for every review imitative ensures early diagnostic decision making occurs	Clinical Director	
Poor engagement of relatives and family members when 30 day bed or residential care needed	Continue with effective/improved communication with MDT.	DLN	

Accommodating individual needs re human rights, dignity and respect – one patient had been waiting to have her hair washed	Issue will be escalated to individual ward and more widely to all inpatient areas as a learning point	Matrons	
Delays in medications – particularly prescribing errors with TTO's which require pharmacy to chase consultant for clarification	More education and training needed for medical staff	Site clinical director	
"Preferred provider" taxi service needs to accommodate wheelchair pts/discharges	Education of staff so that they are aware of other providers that have wheelchair service. In addition facilities to review current contract	Estates site lead	
"Care plan" is a term that patients are not familiar with.	Staff ensuring that jargon is not used when communicating with patients	All ward staff	
ULHT says all patients will have a PDD GDH patients do not routinely given a PDD	Current documentation supports recording of PDD but medical engagement is needed to take this forward .	Site Clinical director	
ULHT says all patients will be asked to wait in the discharge lounge. GDH don't have a discharge lounge.	Continue discussions on site re viability of discharge lounge	Matrons	
Difficulty in sourcing funding for care and equipment for End of Life patients	Need to encourage early escalation to discharge team	All ward staff	
Outlying of patients – one patient said they had been moved 3 times.	Bed managers to ensure that outlying is one ward move only as per patient policy	Bed managers	
Poor information for patients on medication following discharge	To be escalated to ULHT medication Safety Committee	Site lead for Meds Management	

Action Plan for Healthwatch – discharge planning Pilgrim site			
Action Plan		**Date of Compliance Visit……**	
Issue being addressed	**Action to address underperformance**	**Identified person**	**Date to be completed**
Delays in getting medication. EDDs being signed off too late leading to delayed medication. Need for additional checks	Discharge documents to be completed the day before planned discharge, so that Pharmacy can obtain medications in a timely manner	Clinical Director/ Head of Pharmacy/ Ward Sisters	

between EDD and pharmacy to address queries and errors.			
Stretcher ambulance delays required to transport a patient often incurred delays	Wards to pre-book the day before for any patients who are to be discharged the following day	Ward Sisters	
Poor understanding of discharge planning by patients – use of "patient passport tablemats" are in use in some areas as a pilot Developed from Leadership into Practice project by patient experience team lead	Continue Implementation – already in place on AMU and AEC.	Patient Experience lead with ward sisters	
Changes to patient criteria has effected patient transport via NSL NSL	Full assessment of the patients ability and discharge environment to take place the day before discharge, so the right transport is requested	Ward Sisters	
Availability and capacity of the wellbeing service. discharge delays.	Wellbeing service to relax criteria and take patients from all over the site not just the front door.	Deputy Director of Operations/Site managers	
Improved communication was needed to better manage patient discharge	To develop better communication with patients. To develop information leaflets about who to contact after discharge if any problems occur, LIA/Patient experience team working on this project currently, to cascade to all wards.	All Doctors, Ward Staff, Patient experience lead.	

discharge.			
Staff would like property lists for patients.	Individual wards to discuss the use of property lists and implement them if required	Ward Sisters	
Poor information for patients on medication following discharge	To be escalated to ULHT medication Safety Committee	Site lead for Meds Management	
Delays in medications – particularly prescribing errors with TTO's which require pharmacy to chase consultant for clarification	More education and training needed for medical staff	Site clinical director	
Call bells failing frequently.	Contingency plans in place to utilise mobile/portable call bell system in event of call bell failure. Engineer on site 24/7	Head of Facilities	
Insufficient care in the community, leading to longer delays for medically fit patients.	Rochford unit being utilised currently for all LCHS delays, discharge team to work closely with social work to help reduce delays and LOS.	Lincolnshire County Council, LCHS, Discharge Lead	
Wards to have feedback shared from patient experience	Friends and Family tests and PALS to feedback to our wards directly about patient experience.	PALS, Patient experience lead	
Better communication/explanation from ward staff about discharge.	Work with nursing staff to empower them to give a full explanation about discharges and improve communication through education and leadership.	Heads of Nursing, Ward Sisters	

Healthwatch Lincolnshire
1-2 North End
Swineshead
BOSTON
PE20 3LR
01205 820892