patient PERSPECTIVE

SERVICE IMPROVEMENT CASE STUDY: NATIONAL INPATIENT SURVEY

The theme of this case study is patient flow and patient discharge from hospital; enhanced discharge lounges, improvements in discharge summaries.

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January 2024

Contents

1 Introduction

The data collected from the national patient surveys can seem overwhelming, and even when the results are made clear, and trusts have an opportunity to identify strengths and areas for improvement, it can be hard to work out how to go about making changes in response to the feedback patients have given.

Patient Perspective is an approved contractor for the National Patient Survey Programme and has been working with trusts for over 20 years. As part of our service, we have compiled case studies of good practice. Case studies are based on the projects, initiatives and service improvements NHS trusts have undertaken to bring about change.

The case studies aim to highlight and share examples of service improvements made due to several factors including national initiatives, issues and themes highlighted by patients from the national surveys and often linked to feedback from patients from other methods of patient involvement.

Case studies published to date have covered:

- **Inpatient Survey** – Reducing delays on discharge; nutrition and assistance at mealtimes and reducing noise at night and promoting better sleep.
- **Inpatient Survey** - Improvements in discharging patients from hospital.
- **Maternity** – Accommodating partners and visiting times. Telephone triage service, patient flow, and the UNICEF Baby Friendly Initiative.

  Latest Reference 1 **Maternity** - Tongue Tie and Feeding Support.
- **Latest - Urgent and Emergency Care –** projects including reducing waiting times and ambulance handovers, virtual wards and care at home initiatives, also featuring; care bags for children and young people and adults with learning disability/autism.
- **Children and Young People** - Patient and staff engagement, patient passports, an interactive children's website, and healthcare app.
- **Children and Young People -** Youth Service Digital Youth Service; Elective Pathways, Youth Councils & patient information and food.

2 About the Inpatient Survey 2022

The Care Quality Communication published benchmark reports and a summary of the results on the website. Reference 2

This survey looks at the experiences of people who stayed at least one night in hospital as an inpatient.

People were eligible to take part in the survey if they stayed in hospital for at least one night during November 2022 and were aged 16 years or over at the time of their stay.

2.1 What the CQC found

Results show that people's experiences of inpatient care have deteriorated since 2020. The results for the 2022 survey remain generally consistent with 2021 following significant declines for almost all questions in the 2021 survey compared with 2020.

Most respondents reported a positive experience in their interactions with doctors and nurses, such as being included in conversations and having confidence and trust, generally remaining consistent with the previous year, although those receiving clear answers to questions has decreased slightly.

For questions relating to meeting patients' individual needs, such as getting help to clean themselves, help to eat their meals, enough to drink and their pain being controlled, results are generally unchanged, remaining consistent compared with 2021 while still down from 2020.

Hospital waiting times remain a challenging part of people's experiences of care. While elective patients are generally positive about their experience of how long they had to wait before being admitted to hospital, more people felt that had to wait too long. Although half of elective patients reported no change to their health while waiting for admission, around four in 10 felt their health worsened.

2.2 Positive findings

2.2.1 Interactions with staff

- Most people (72% for doctors and 73% for nurses) said they 'always' got answers to their questions they could understand, although this has decreased for both doctors (73% in 2021) and nurses (74% in 2021)
- 81% and 79% of respondents said they 'always' had confidence and trust in doctors and nurses respectively, remaining unchanged from 2021
- 82% of respondents felt they were treated with dignity and respect; consistent compared with 2021

2.2.2 Meeting individual needs

- 70% of respondents reported 'always' getting help to wash or keep themselves clean

- 75% of respondents said they were 'always' offered food that met any dietary needs or requirements they had, which is a small but significant increase from 74% in 2021
- 91% said they got enough to drink during their time in hospital, which is consistent with 2021

2.2.3 Involvement in care

- When asked about being included in conversations, 74% said doctors 'always' included them and 75% said this for nurses, compared with 73% and 75% respectively in 2021

2.3 Key areas for improvement

2.3.1 Waiting times and staffing levels

- 22% of elective patients said they would like to have been admitted 'a bit sooner' and 17% 'a lot sooner' (compared with 20% and 16% respectively in 2021), while 61% said they 'did not mind waiting as long as they did', compared with 65% in 2021
- 41% of elective patients said their health deteriorated while waiting to be admitted to hospital, though 51% said their health remained the same
- 18% of respondents felt they had to wait 'far too long' to get to a bed on a ward after admission, which has increased significantly compared to 2021 (15%) and 2020 (8%), representing a 10-percentage point increase over 2 years
- 52% of respondents thought there were 'always' enough nurses on duty to care for them in hospital, compared to 55% in 2021 and 62% in 2020

2.3.2 Patient discharge from hospital

- 38% of respondents said they were involved 'a great deal' in decisions about their discharge (unchanged from 2021), while 25% said they had little to no involvement (17% said they were 'not very much' involved and 8% said they were 'not at all' involved)
- 48% of respondents said they were given enough notice about when they were going to leave hospital, compared to 50% in 2021

- 45% of respondents 'definitely' knew what would happen next with their care after leaving hospital, remaining consistent with 2021

2.3.3 Overall experience

- 50% of respondents rated their overall experience of inpatient care as a 9 or 10 (where 10 is a very good experience) compared with 52% in 2021. 4% of respondents reported a very poor experience overall with scores of 0 or 1, which remains unchanged since 2021

2.4 How experience varies for different groups of people

People admitted for emergency care and those who were considered frail reported poorer than average experiences for all the questions we explored in the survey.

People aged 16 to 50, those who stayed in hospital for two nights or more, and those who reported having Dementia or Alzheimer's consistently reported poorer experiences of inpatient care.

Respondents with a neurological condition reported poorer experiences for more than half of the questions. In contrast, older people, people who were in hospital for an elective admission, those who stayed in hospital for only one night, and those considered less frail generally reported better experiences.

3 Case Studies

The case studies have been collated from Trust Quality Accounts 2022/23 with hospitals invited to provide any updates on the projects or improvement work featured. This study is a snapshot/indicator of some of the innovative work being undertaken nationally in the NHS to endeavour to improve patient flow and patient experience of discharge from hospital.

It should be noted the fieldwork for the next National Inpatient Survey will takes place January - April 2024 with the benchmark report from the CQC provisionally due August 2024.

3.1 Somerset NHS Foundation Trust

Discharge to Assess (D2A)

It is recognised that staying in hospital too long can result in poorer health and longer recovery times and so as soon as a person is well enough, the multi-disciplinary team within the hospital work together to facilitate a discharge to the best possible place to support a person's recovery; in most cases, this will be a person's home.

Discharge to Assess, also known as D2A has been created to help people get home more quickly, offering a range of services including assessment which focus on measuring a person's health and ability to perform everyday tasks, and rehabilitation to enable people to get back to normal life.

Discharge to Assess supports more than 150 people to leave hospital every month and obtaining feedback from service users is a high priority and helps to shape the ever-evolving service. People using the service are therefore offered a telephone call review after the service has ended to provide verbal feedback on their experiences. The telephone call feedback process enables the service to 'do more' of what works well, as well as learn from experiences which may not have gone as well as they could have. Between August 2021-March 2023, 253 feedback calls took place.

The initiatives below describe some of the ways in which acute and community services are striving to improve discharge planning experiences for the people of Somerset based on the service feedback:

Discharge Facilitator role – there was an increase in the workforce by 25% at Musgrove Park Hospital. The capacity of the weekend discharge facilitator role has been doubled. These roles act as the communication link between families/care givers and the hospital ward teams. Their role aims to improve communication and improve the effectiveness of transfers of care (discharge).

Transport – it is recognised that transport home from hospital can be a challenge. To improve this part of discharge planning, access to a late transport crew is available for times of increased demand. Both Yeovil District Hospital and Musgrove Park Hospital (MPH) were successful in obtaining extra funding for Red Cross transport-home services during autumn / winter 2022/23 which helped an additional 22 people per month to return home with

transport support, and after hospital care if required. The new discharge lounge at MPH has dedicated parking bays outside the lounge to make the collection of patients easier for families / care givers. People are now requesting for their relative to be sent to the discharge lounge because of the ease of collection.

Discharge Lounge – in addition to the transport / collection benefits, the discharge lounge provides an opportunity for patients to leave the ward earlier on the day of discharge. The discharge lounge has a dedicated team of staff and volunteers who are there to double check actions for discharge have been completed, additional explanation around changes to medication and after hospital care instructions. The infrastructure within the discharge lounge provides a peaceful environment and the flexibility for people to either sit out in a chair or rest in bed ahead of the journey home.

Ready to Go Units – Strategic plans are underway in Somerset to reduce the delays in transfers of care, particularly for those needing Pathway 1 and 2 services. Whilst those plans are underway, delays are unwanted, but inevitable. To mitigate the risks associated with staying hospital longer than needed, Ready to Go units have been created. With the support of reablement trained staff and volunteers such as Age UK, patients are being kept active whilst remaining in hospital. In many examples, care needs have been reduced following a stay on the Ready to Go units.

Reference 3 Ready to Go Units Reference 4 Discharge Pathways

Reference 5

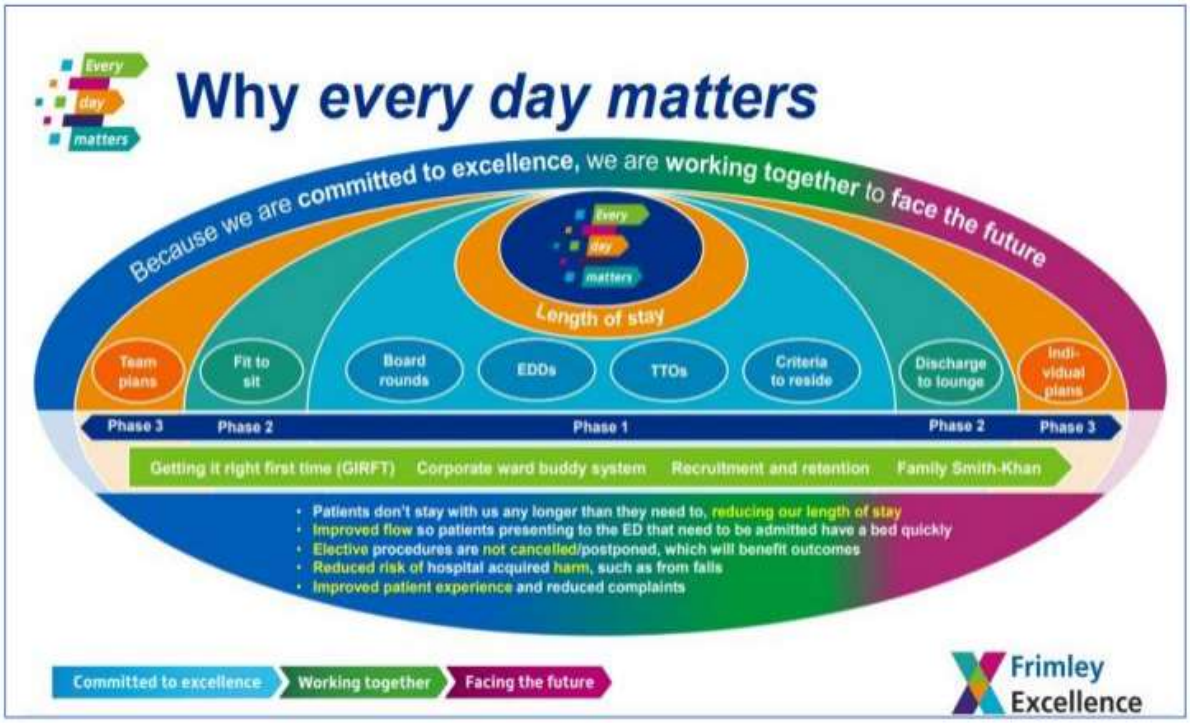
3.2 Frimley Health NHS Foundation Trust

Every Day Matters

The initiative focuses on helping patients get home as quickly and as safely as possible by eliminating delays in the discharge pathway.

Every day matters to patients and therefore the choice of name for the project, with the aim of working to reduce delays to discharge and to help patients get home as soon. This will:

- Improve the quality of care and experience of our patients
- Reduce waiting times and avoid patients' treatment being cancelled
- Reduce pressure on staffing and improve the working life of our teams
- Free up beds and reduce the use of inappropriate and costly escalation areas
- Ensure patients are in the best place for their care and enable our clinical areas and teams to work in the way they are intended.



Reference 6

3.3 University Hospitals Bristol and Weston NHS Foundation Trust

Every Minute Matters

In 2022/23, the University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Every Minute Matters (EMM) programme was initiated, focusing on releasing time, both in term of how long patients spend in hospital, and also how to enable the best use of staff time. After focused planning and preparation in Quarter 2 the EMM workstream went live across the Trust. Initial results were positive and the workstream has been recognised nationally and across the Integrated Care Board as a well-planned and structured delivery programme. The focus going forward has been to ensure sustainability of the initiatives that were identified when commencing the programme.

40 inpatient wards have now completed their 12-week EMM programme. The biggest improvements have been the recognition of the need to have a multidisciplinary team (MDT) touchpoint as early in the day as possible whereby concise updates can be provided about patient progress with a focus on time limited tasks including the discharge of a patient.

The MDT is a clinical team which includes nursing, medical, allied health professionals, and staff from the hospital discharge bureau. The inclusion of the Criteria to Reside data input in the morning board round is progressing well; having this data enables improved understanding of the numbers of patients in the hospital that have criteria to reside against NHS England (NHSE) criteria, and of those with no criteria to reside, and then to identify the reasons why those patients remain in hospital beds.

Such visibility of data enables the hospital to focus attention on those delays to discharge and allow work to take place to resolve the delays and enable the patient to be discharged from hospital.

Patient Flow and Discharge

Use of the reformed digital Transfer of Care Document (ToC Doc) was implemented within UHBW, replacing the Single Referral Form (SRF), encouraging effective integrated working across health and social care.

The ToC Doc is important for identifying ongoing care for patients after discharge from hospital, providing a communication tool between acute and community care. This has meant a reduction in time spent completing and sending forms and means that amendments are possible without needing to complete a whole new form if there are queries.

This document is now embedded in practice and is being monitored within the Flow and Discharge dashboard. As a result, there were positive results in the reduced time from submission of the ToC Doc to discharge.

There has been a steady decrease in the number of days between a patient's admission and their Toc Doc being submitted.

Discharge Lounge

Use of the Discharge Lounge In the year 2022/23, the use of the discharge lounge on the BRI site has increased by 6.7% compared to 2021/22.

EDD (Estimated Date of Discharge)

During the first weekend discharge event in Quarter 4 2022/2023, the ability to use EDDs was tested to focus reviews of patients who were anticipated to be ready for discharge within the next three days, to see if their discharges could be brought forward.

Findings from the weekend indicated that whilst the EDDs highlighted a reasonable number of patients fitting this criterion, there were limited opportunities to reduce lengths of stay. EDDs have been revisited with a focus on ensuring that the data is adding value to patients and supporting inpatient hospital flow. A series of focus groups have been undertaken to collect feedback from a range of hospital teams including nursing, medical, pharmacy and therapy colleagues regarding the EDD process.

The EDD is available to see on digital whiteboards in each clinical area and a change has been developed whereby if the patient has an EDD of today, this will turn red on the board, and if the EDD is set for the following day the EDD will be orange. This helps teams see immediately who is expecting to be discharged on that day / the next day, to also help prioritise any required actions. The value in using EDD has been realised and this will continue to be used with a focus on patients' involvement and awareness of when their discharge is planned so they can also prepare for that discharge date.

There was a significant increase in the daily number of Criteria to Reside reviews completed because of the MDT discussion and the proactive board rounds.

Criteria Led Discharge (CLD)

Data from proactive board rounds is highlighting that Criteria Led Discharge is not used as much as it could be. As a result, the EMM team has been working with two cardiology wards, and a cardiac surgery ward to develop and trial the use of a clinical note (within CareFlow) to support CLD for patients who have undergone cardiac surgery, and pacemaker procedures.

In addition, a 'blank' Criteria Led Discharge clinical note is also in development, with the aim of supporting discharges for patients where medical teams can define the specific criteria at the point of assessment. This would replicate areas across the Trust where paper notes are used to support CLD.

The benefits of digitalising this process would be the ability for the teams that manage patient admissions and discharges to identify patients on a CLD pathway, and support ward teams to progress discharges. The data captured by the digital forms will enable identification of barriers to the CLD being completed and create meaningful objectives for ongoing improvement of the process.

Reference 7

3.4 County Durham and Darlington NHS Foundation Trust

Ensuring a positive patient experience through the discharge process

The trust throughout the year updated their approach to include learning from all previous 'Work As One' and 'Perfect Week' exercises, building on the Next Step Home approach.

Working closely with local authority partners helps to support early discharge using trusted assessment and time to think beds.

The Trust's Safeguarding teams have introduced thematic working groups with Discharge Facilitators / Coordinators to embed all learning arising from sub-optimal discharge reports submitted via our Local Authority colleagues. A number of actions were identified and implemented following the completion of two quarters of data.

Positive feedback was received from a Care Provider who commented on the encouraging changes made by the Trust following concerns previously raised in relation to a client's discharge.

Top five scores for CDDFT:

Survey Section	Question	CDDFT Result (0-10)	Trust Average (0-10)
Leaving hospital	Q46: After leaving hospital, did you get enough support from health or social care services to you recover or manage your condition?	7.0	6.5
Leaving hospital	Q42: Before you left hospital, did you know what would happen next with your care?	7.2	6.8
Leaving hospital	Q37: Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	8.9	8.7
Leaving hospital	Q44: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	8.5

System leadership

A System Wide Discharge Co-coordinator was recruited. This is a nationally mandated post to provide system support to the discharge process, including implementing of a transfer of care hub (ToCH) which is currently in development.

The County Durham and Darlington ToCH will operate as a system-level coordination centre for local health and social care joining-up all relevant services to support safe, timely and effective discharge wherever they live within our localities. The hub will take responsible for developing timely, person centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'.

Discharge and Choice Policy

The Discharge and Choice Policy has been updated to align our approach to nationally-mandated pathways and best practice.

Early Discharge Planning

The Discharge Management Team provides guidance and support to help ward teams make the necessary referrals to ensure the correct agencies are involved in relation to discharge.

Multi-disciplinary Working

Multi-disciplinary working is fundamental to effective discharge planning and to improving discharge pathways. We have introduced daily interagency calls which includes all partners involved in discharge. The calls focus on finding solutions to any challenges preventing a patient from being discharged when they are ready to leave hospital. The multi-disciplinary approach to discharge planning for patients able to return home or who need temporary placements is proving effective, as we are seeing a reduction in the number of people remaining in hospital for more than seven days after they are medically-optimised, and particularly for those waiting more than 21 days.

All wards now have a directory of services available to support discharges across Durham, Darlington and North Yorkshire. 'Home group' assist this new initiative by supporting those with low level mental health needs with housing and financial problems pre and post discharge.

There have also been improvements in reducing the need for patients to re-attend because such additional needs have not been met.

Improved Discharge to Care Homes

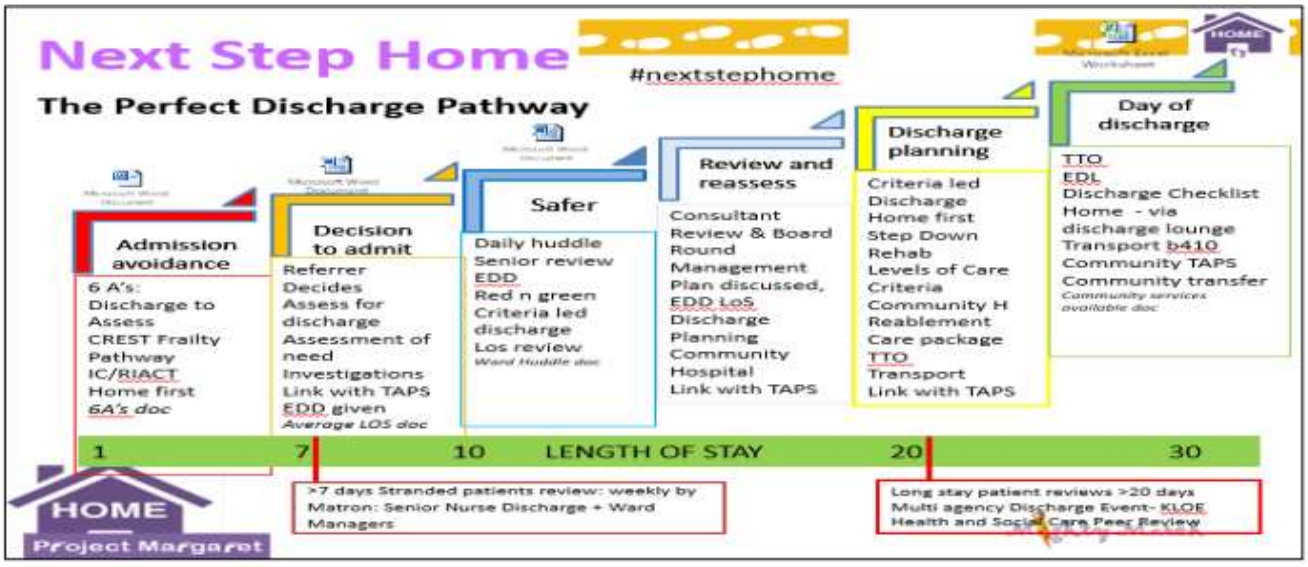
Care Home Select (CHS), a brokerage/trusted assessor service for care homes, has worked closely with the Trust and social services to reduce the time in hospital for those requiring more permanent placements particularly for those who are approaching end of life.

The Trust has representatives on several care home groups/forums which focus on improving discharge pathways.

In addition, the community nursing service receive daily lists of admissions and discharges from care homes to facilitate communications and appropriate follow up care which continues to work well.

Monitoring and responding to system demand and capacity

Daily medically optimised patient lists are used to track patients, enabling those involved in discharge to be able to identify and action the next steps required in the discharge process.



Reference 8

3.5 North Cumbria Integrated Care NHS Foundation Trust

Effective Medical Discharge Summary

Minimal formal education is provided in writing discharge summaries, yet deficiencies are persistent features in incidents affecting patient safety. The aim of this project was to improve quality and timeliness of discharge summaries through educational interventions.

A framework for ongoing education is now in place. The project requires subsequent cycles to make a statistically measurable educational and cultural impact. It also will benefit from expansion to include more allied health professions, senior doctors, and West Cumberland Hospital

In addition to the targeted improvement work on medical discharge summary, the Trust have introduced a range of other improvements to support an effective and safe discharge for our patients these include: -

- Agreed system wide discharge policy across the Trust/Council and Integrated Care Board – signed off in September 2022, over 300 staff attended training.
- Discharge lounge in place across both Cumberland Infirmary (CIC) and West Cumberland Hospital (WCH) sites.
- Discharge coordinators on wards
- Front of House discharge navigator role in place
- Dedicated Transfer of Care Hub – multidisciplinary hub to oversee discharge, based at both acute sites operating 7 days a week and delivering both multidisciplinary and interdisciplinary working
- Two permanent system wide discharge posts; Home First and System Flow Coordinator and Transfer of Care Hub Manager
- Additional education around use of the discharge checklist
- Discharge checklist added to Web V, with auditing functionality
- Transfer of Care/Patient Flow dashboards developed and used to track and monitor people though the system so everyone has a plan
- Electric prescribing and Medicines and Administration (ePMA) project rollout – to support discharge medications
- Inclusion of carers support workers within the Transfer of Care Hub (ToCH) to support Trust in statutory duties to engage carers – reached over 1000 carers since service started in May 2022

- Patient Tracker system in place in the Acute Medical Unit (CIC and WCH) to monitor patient flow from the Emergency Department
- Established a Patient Flow Rapid Improvement Group – weekly meeting

Reference 9

3.6 Torbay and South Devon NHS Foundation Trust

Improved experience for people being discharged

Preparing patients and their families around discharge home is a key priority. Ensuring that patients are involved in decisions about their care and the appropriate arrangements are made to ensure that the transition home is safe, personal and compassionate is crucial to their wellbeing.

Patient feedback through the NHS patient survey 2022 showed performance in the top 20% in the following:

- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Improvements achieved:

✓ home for lunch: in March 2023 19.3% of people were discharged before 12 noon compared to 67.3% before 5pm

✓ enhanced discharge lounge – promoting a positive step to discharge - the number of people transitioning through our discharge lounge has doubled

✓ deep dive review underway looking at preferred place of discharge, current data shows 74% patients were discharged to their preferred place of care

Key interventions included:

✓ introduced home for lunch Initiative

✓ enhanced discharge lounge

✓ targeted support for wards where there is underperformance

✓ review of preferred place of discharge

✓ follow-up of patients around person centred care

Reference 10

3.7 Mid Cheshire Hospitals NHS Foundation Trust

Discharge Lounge

The discharge lounge facility provides a comfortable area to await 'take home' medications and/or transport, promoting a quality discharge experience for patients. The release of core beds to the discharge lounge allows appropriate clinical placement for UEC patients to be expeditated, supporting safe and timely transfers out of the emergency department. It provides 9 reclining chairs and three beds which can accommodate a range of patients.

The discharge lounge has its own doctor who completes patient discharge and take-home medication summaries reducing the delays on core wards. Departmental pharmacists work alongside the Doctor to streamline the prescriptions of take-home medications.

In the six operational months of opening, the Discharge Lounge has welcomed over 2000 patients, which has released 8508 hours of core beds and 354 bed days. In addition to this, the Discharge Lounge patients have priority access to take-home medication and transport, meaning that on average the patients discharge was completed in around 2 hours and 20 minutes in March 2023, a reduction from 3 hours 45 minutes in August 2022. This ensures a better patient experience and enables those more vulnerable and elderly to return home within daylight hours, leading to better outcomes of discharge success.

Interim targets of 100 patients per week have been succeeded and the Discharge Lounge is working towards its new target of 150 patients per weeks, maximising utilisation throughout the 12 hours of opening, a 10% increase in discharge from core wards through the discharge lounge has been recorded over the 6 months.

Future aims are to achieve 10 patients by 10 am in the lounge, supported by the admission of the first five patients who will have been identified the previous night as the first patients to be accessing the lounge at 8 am.

The nursing team in the discharge lounge, provide regular contact with care providers, patients, relatives, and transport providers and failed discharges have been reduced. The feedback from patients and relatives and service users has been extremely positive, with FFFT feedback obtaining 100%.

Reference 11

3.8 North Tees and Hartlepool NHS Foundation Trust

Hospital Discharge Service

The Trust and partners in Social Care have worked together to implement the discharge policy and continue to reduce delayed transfers of care.

The trusted assessor model has reduced the time it takes from referral to transfer. The model is fully supported by Partners in Hartlepool and Stockton Borough Council, and this continued as a Model through 2022-2023.

Through 2022-2023 there have been a range of new initiatives that supports patient flow across acute to community services working in collaboration with system partners.

Integrated Coordination Centre (ICC)

The implementation of an ICC has supported prediction, planning and responding appropriately to patient flow. The ICC brings together:

- The Patient Flow Team (Bed Mangers/Site Managers)
- Integrated Discharge Team
- Discharged Transport Scheduler. The aim is that this integration brings about the biggest reward regarding flow. In addition, using the electronic systems to support this decision-making at the earliest opportunity to maximise our capacity and demand response.
- Visual management is an approach that communicates important information to those that need it in a visual and immediate manner.
- There are several systems which empower the team to make specific patient-level plans based on 'live' rather than historic data.

Introduction of Discharge Flow Facilitator role

Since the introduction of OPTICA in April 2022 there was a need recognised to develop the workforce who are responsible for the maintenance of information that is input on to the tool, ensuring it is a constant live version of events. There are two Discharge Flow Facilitators (DFF) that work in the ICC 8.00-17.30 Monday – Friday and 8.00-16.00 Saturday – Sunday. They communicate with all members of the Integrated Discharge Team, the Patient Flow Teams, wards, local authorities, and care providers to gather information for patients discharge journey, allocating discharge checklist tasks to the

responsible assignee group. The DFF escalates any tasks that extend beyond reasonable timescales (identified within OPTICA) to ensure delays are minimised.

Help Force – Home but not alone scheme

The scheme is volunteer led and a service delivered to support patients through the discharge process. This programme was reintroduced to 6 wards across the Trust and recently other Discharge areas, including the Discharge Lounge, Emergency Assessment Unit, and the Emergency Department.

Those patients who live on their own or would like someone to talk to are referred onto the programme. Volunteers meet them, whilst they are inpatients or at the point of discharge to discuss their needs upon discharge and post discharge. Volunteers have access to local Foodbank's emergency food parcels and clothes for those in need. There is a volunteer driver service which can transport these patients home following a period of hospitalisation. Drivers can also deliver medication where appropriate and can also provide transport to outpatient appointments post discharge if they are on the scheme. The volunteer team can travel home with those patients who need support; when doing this they help the patients to settle back at home, (checking that heating/TV works and they get a cup of tea). Volunteers follow up after discharge for 28 days to encourage the patients to get involved in local befriending services, involvement in local community activities; also, to take advice from support networks e.g. CAB, etc.

Across this last financial year, the small team have supported 60 patients. At the point of discharge the team has issued emergency food parcels, patients have benefitted from the supply of emergency clothing and a number of these patients have been taken home by a volunteer. Post discharge, the team has undertaken 94 contacts. Information about community services and support has been shared with patients.

Reference 12

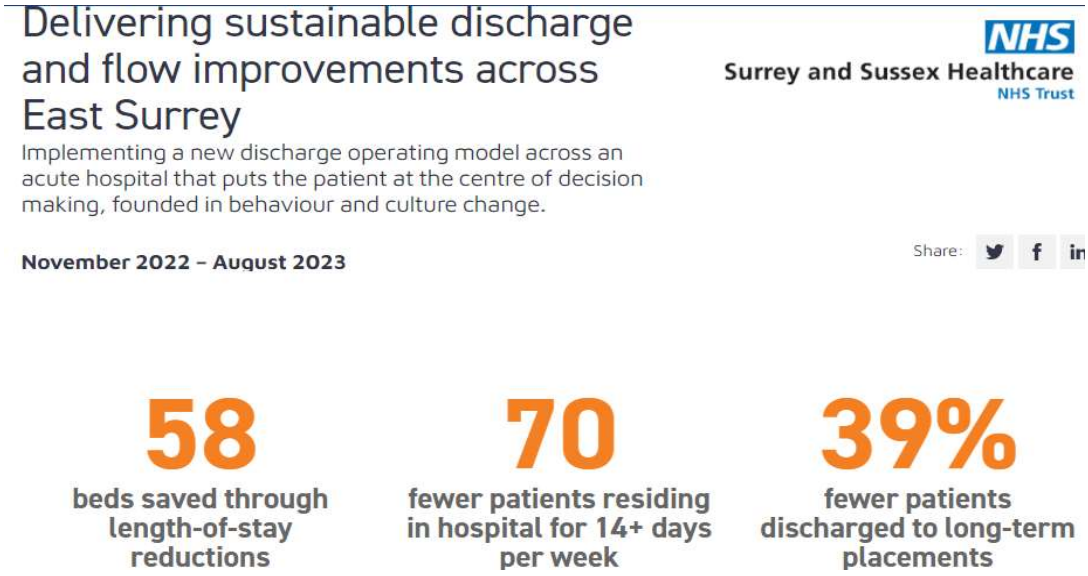
3.9 Surrey and Sussex NHS Trust

Discharge Flow and Transformation Programme

In 2022/23 the trust focused on discharge and the delays across the system to ensure the patient was discharged to their optimal destination to meet their ongoing health and care needs after the acute phase.

The ambition has been to establish a 'one team' approach testing and embedding interventions to improve the experience for our populations aligned to the national strategic ambition. To achieve this IMPOWER have been working with SASH since November 2022 as part of a wider hospital discharge and flow transformation programme commissioned by Surrey County Council. With the aim to improve patient outcomes, relieve pressure on the hospital, and reduce avoidable long-term costs for adult social care, the team have worked with targeted adult inpatient wards. By supporting greater integration between frontline health and care teams the programme has supported increased flow out of assessment units and piloted the model for future intermediate care wards. This work has seen a reduction in the proportion of discharges direct to long-term placements and doubled average weekly discharges.

The trust has also been a partner organisation engaged in the Sussex ICS Front Runner programme. The learning from these work programmes will feed into wholescale transformation to improve outcomes in the coming year.



Reference 13

3.10 South Tees Hospitals NHS Foundation Trust

Planned, safe and effective discharge from our hospitals

improvement work in relation to discharge has been undertaken on a selection of pilot wards across Trust sites, to facilitate an effective, co-designed and patient centred process.

Progress

- Preceptorship programme for newly qualified staff, promoting good, safe and effective discharge with the patient at the centre.
- Discharge educator role created for ward-based learning.
- Series of discharge-related workshops held across the Trust and wider system.
- Implementing 'model ward' approaches, including timely ward rounds, improved discharge letters and processes and focus on priority discharges to enable early and good patient flow.
- Opened purpose-built discharge suite to facilitate safe and timely discharge.

- Involvement with patients, carers and families on admission to establish date of discharge and requirements to return home safely.
- Transfer of care hub created in collaboration with local authorities to support ward colleagues and social workers to return people safety home after their hospital treatment and help to ensure social care support is available in the community.
- Patient and carer feedback used to increasingly inform and design discharge pathways and arrangements.
- Single point of access integrated across health and social care in Teesside and North Yorkshire.
- Posters and letters sent to all Care Home Managers across Redcar & Cleveland, Middlesbrough, and North Yorkshire local authority areas to advise that the transfer of care hub is the main point of contact in relation to hospital discharges.
- To address the national and local challenges in social care, proportionate care implementation used to maximise the care resource and support people at home.
- Rapid improvement methodologies used to achieve a significant 66 per cent reduction in delay for patients moving to primary care hospitals and a 32 per cent increase in the suitability of patients utilising these beds.
- A renewed focus around pathway has been put in place following winter pressures.

Discharge related information

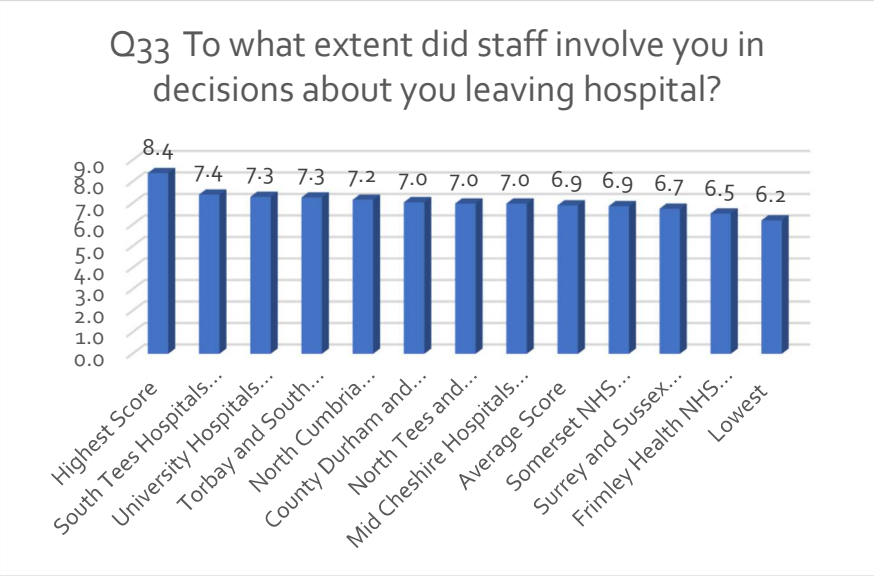
Timely and safe discharge is a quality priority for the Trust, and significant progress has been made. Challenges within social care persist and joint working will continue to focus on addressing these in partnership. In addition, the Trust continues to make improvements in the patient journey through the development of a number of schemes and initiatives. National and local targets are monitored through the discharge board and quality assurance committee.

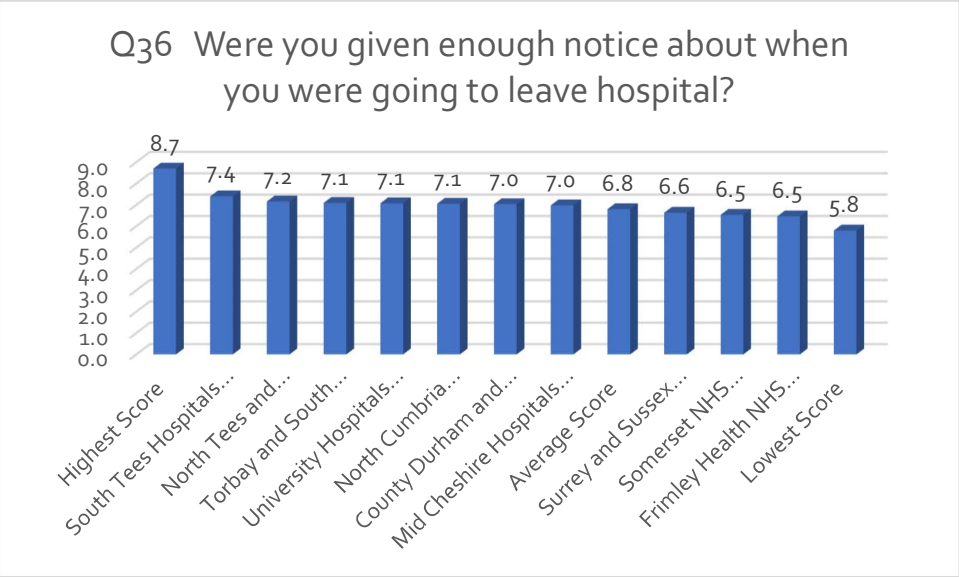
Reference 14

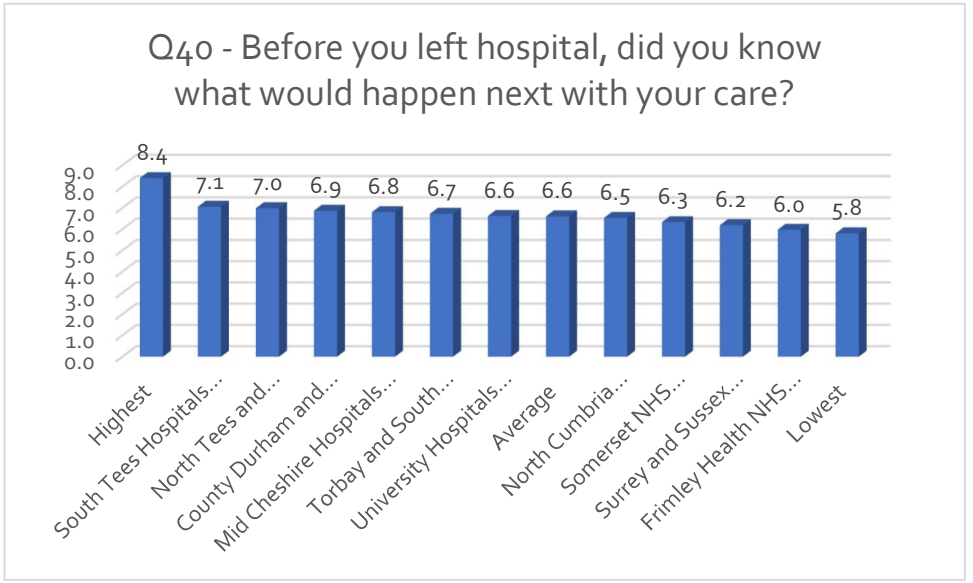
4 Questions patients are asked in the national inpatient survey about leaving hospital

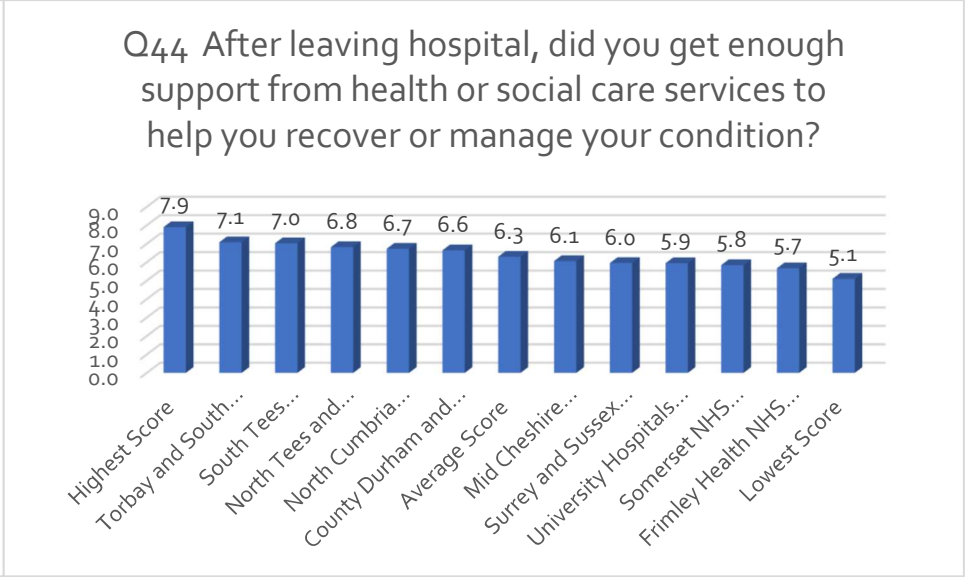
- To what extent did staff involve you in decisions about you leaving hospital?
- To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?
- Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?
- Were you given enough notice about when you were going to leave hospital?
- Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written or online information.
- To what extent did you understand the information you were given about what you should or should not do after leaving hospital?
- Thinking about any medicine you were to take at home, were you given any of the following: An explanation of the purpose of the medicine, an explanation of side effects, how to take the medication, written information about the medication.
- Before you left hospital, did you know what would happen next with your care?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? Please include any services from a physiotherapist, community nurse or GP, or assistance from social services or the voluntary sector
- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

5 Graphs **CQC National Inpatient Survey 2023 – Trusts (included in study) results of six questions linked to discharge (compared to all trusts)**




Q36 Were you given enough notice about when you were going to leave hospital?
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
8.7
7.4
7.2
7.1
7.1
7.1
7.0
7.0
6.8
6.6
6.5
6.5
5.8
Highest Score
South Tees Hospitals...
North Tees and...
Torbay and South...
University Hospitals...
North Cumbria...
County Durham and...
Mid Cheshire Hospitals...
Average Score
Surrey and Sussex...
Somerset NHS...
Frimley Health NHS...
Lowest Score


Q40 - Before you left hospital, did you know what would happen next with your care?
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
8.4
7.1
7.0
6.9
6.8
6.7
6.6
6.6
6.5
6.3
6.2
6.0
5.8
Highest
South Tees Hospitals...
North Tees and...
County Durham and...
Mid Cheshire Hospitals...
Torbay and South...
University Hospitals...
Average
North Cumbria...
Somerset NHS...
Surrey and Sussex...
Frimley Health NHS...
Lowest



It can be noted that South Tees NHSFT scored Better or Somewhat better than other trusts on 4 out of the six questions related to discharge above.

Torbay and South Devon NHSFT scored Better than other trusts on Q44.

6 References

6.1 Reference 1

https://patientperspective.org/case-studies

6.2 Reference 2

https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey

6.3 Reference 3

https://www.somersetft.nhs.uk/?news=trust-colleagues-to-showcase-ready-to-go-units-at-new-scientist-conference

6.4 Reference 4

Pathway Definitions

Intermediate Care Pathway Definitions	**Pathway 0**	Pathway 0 is the default pathway for people leaving hospital. This is people returning to where they normally live with no change, or no substantial change in their circumstances, including restart of any previous care package. N.B: support from voluntary agencies, district nursing, complex care team, community rehab services and hospital at home, or needing equipment are also categorized as pathway 0 discharges.
	Pathway 1	Pathway 1 should only be considered when the default pathway 0 has been ruled out. Pathway 1 is for people who can return home but require additional support. Pathway 1 includes a period of enablement and assessment in a person's own home to identify what support they need to maximize their independence, with input from therapists as required. Pathway 1 can include night service, live-in services if these are assessed as required.
	Pathway 2	Pathway 2 is for people are not able to be supported where they normally live and need a temporary period of active reablement/rehabilitation that can't be provided in their home environment. Pathway 2 is for people who are able and willing to participate in active reablement/rehabilitation. Pathway 2 is located in community beds; either in a care home setting, or a community hospital. Pathway 2 beds are for people where there is an ambition that they will return to where they normally live after the period of support and assessment.
	Pathway 3	For people who have such complex needs that they are likely to require permanent 24-hour support in a care home setting. Pathway 3 includes people discharged to a care home for the first time, or where their existing care home can no longer meet their needs. (e.g residential home resident, requiring nursing care)

https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

6.5 Reference 5

https://www.somersetft.nhs.uk/about-us/wp-content/uploads/sites/148/2023/09/FINAL-Somerset-FT-Quality-Account-Report-2022-23.pdf

6.6 Reference 6

https://www.fhft.nhs.uk/staff-area/your-voice-our-future/every-day-matters/

6.7 Reference 7

https://www.uhbw.nhs.uk/assets/1/uhbw_quality_account_2022-23.pdf

6.8 Reference 8

https://www.cddft.nhs.uk/media/1061475/cddft%20quality%20accounts%202022-23%20-%20final.pdf

6.9 Reference 9

https://www.ncic.nhs.uk/application/files/7716/9167/9383/NCIC_Quality_Account_2022_23_Final_Approved_By_Board_with_signatures_access_checked.pdf

6.10 Reference 10

Quality Account 2022/2023 (torbayandsouthdevon.nhs.uk)

6.11 Reference 11

https://www.mcht.nhs.uk/application/files/2216/8613/1288/Final_copy_MCHFT_Quality_Account_2022-23_V20_.pdf

6.12 Reference 12

For further examples - https://www.nth.nhs.uk/resources/quality-accounts-2022-2023/

6.13 Reference 13

https://www.impower.co.uk/case-studies/delivering-sustainable-discharge-and-flow-improvements-across-east-surrey/#:~:text=Following%20an%20initial%20commission%20from,better%20outcomes%20that%20cost%20less

6.14 Reference 14

https://www.southtees.nhs.uk/resources/quality-account-2022-2023/

7 Evidence Summary and Review

Thank you to Mid Cheshire Hospitals NHS FT library service for providing the following information.

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Ibrahim, Halah – Multi-disciplinary discharge coordination team to overcome discharge barriers and address the risk of delayed discharges *Risk Management and Healthcare Policy* 15, 141-149, 2022

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Cao, Hong – Construction and validation of a risk prediction model for delayed discharge in elderly patients with hip fracture *BMC Musculoskeletal Disorders* 24, 2023

Staunton, Peter F. – The role of a seven-day physiotherapy service in reducing length of stay and improving cost-effectiveness in arthroplasty surgery *Cureus,* 15(1), 2023

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Saragosa, Marianne – The hospital-to-home care transition experience of home-care clients: an exploratory study using patient journey mapping *BMC Health Services Research* 23, 2023

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Armold, Sarah – Discharge delay: how can we help ourselves, patients, and families *Professional Case Management* 28(2), March-April 2023

Redwood, Sabi – How latent patterns of interprofessional working may lead to delays in discharge from hospital of older people living with frailty: "patient more confused than usual?" *Ageing and Society* 43(3), 576-597, March 2023

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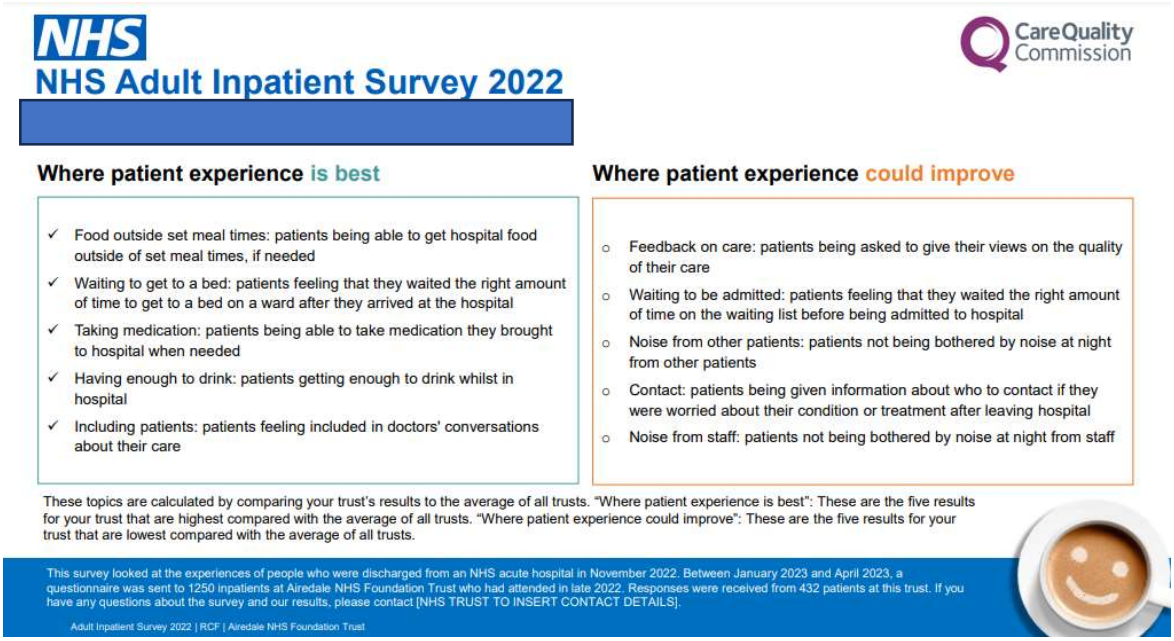
8 Promoting results

The CQC Benchmark reports all include a template poster highlighting five results for each trust that are lowest compared with the average of all trusts who took part in the survey.



9 Patient Perspective

If you would like more information on services from Patient Perspective visit https://patientperspective.org/. If you have further examples to add to the case study, please email us and we will include them in an update. If there are other topics you are interested in receiving case studies about or you have good examples you wish to share with others please also let us know. **sue.pickup@patientperspective.org**