Report Title	Joint visits to Tunbridge Wells Hospital at Pembury provided by Maidstone and Tunbridge Wells NHS Trust (MTWT) to gather Patient Experiences of leaving hospital
Author	Healthwatch East Sussex & Healthwatch Kent
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1 Background

Purpose:

- To engage with patients who have been assessed as medically fit for discharge about their experiences leaving hospital on two specific dates
- To gather insight of the provider experiences and challenges via visits to the discharge lounge at Pembury Hospital using a simple survey conducted face to face with the patient and a follow up survey when the patient had been discharged home. These visits were undertaken on Monday 4th and Wednesday 6th August 2014

About Tunbridge Wells Hospital (TWH) at Pembury

TWH at Pembury is a new £225m hospital for west Kent with single rooms and en-suite facilities which began treating its first patients in January 2011. It became fully operational in September 2011when the old Kent and Sussex Hospital in Tunbridge Wells closed for good.

The 512-bed Pembury Hospital, has 10 wards and was built alongside the old hospital, which was demolished.

Address: Tunbridge Wells Hospital, Pembury, Tunbridge Wells, Kent. TN2 4QJ

2 Methodology

Local Healthwatch has tools available as part of its statutory duties to engage with patients and users of services, directly where their care is delivered using enter and view activity. Healthwatch East Sussex (HWES), as part of its work programme has been looking at patients, carers, family and care providers experiences using East Sussex Healthcare NHS Trust (ESHT)* during June and July 2014. Part of the study also was planned to visit the discharge lounge, with Healthwatch volunteers, to undertake a short information gathering exercise in real time, to ask about patient's

experiences of their discharge process, who receive their treatment outside of East Sussex.

(Please see **Appendix 1** for a copy of the face to face survey and follow up prompt sheet volunteers followed. The discharge manager had also arranged for the officers to meet with the various teams in place to support patient discharge).

In dialogue with Healthwatch Kent, it was agreed between both Healthwatch organisations to use the same key lines of enquiry followed by HWES for the two visits to Tunbridge Wells Hospital at Pembury. Visits were planned for Monday 4th August, which comprised of five volunteers and two paid officers (Team Leaders) and Wednesday 6th August, which comprised of three volunteers. (See page 12 for names of volunteers)

The volunteers, who are trained authorised representatives, engaged with patients/family/carers and the officers met with staff members from the Trust's four teams involved in the Discharge Process.

Two authorised representatives (one from Healthwatch Kent and one from HWES) were invited to attend the weekly discharge meetings held at TWH at Pembury and the Maidstone Hospital to observe how the Trust manages any potential delays to discharge.

To facilitate this there was a dedicated planning stage to:

- identify and brief volunteers across both HW organisations
- carry out a pre visit meeting with Tunbridge Wells Hospital staff carried out by Healthwatch Kent
- complete administrative tasks ready to deliver these visits

3 Benefits

The findings from these activities in this report will inform:

- Clinical Commissioning Groups (CCG's) responsible for patient populations using Tunbridge Wells Hospital (East Sussex and west Kent)
- Tunbridge Wells Executive Board and Discharge Teams
- Adult Social Care Assessment Teams, Kent and East Sussex
- Care Quality Commission (CQC)
- Special Inquiry led by Healthwatch England into Unsafe Discharge http://www.healthwatch.co.uk/then-what-special-inquiry "Then what...?" What happens when people get sent home?
- Healthwatch East Sussex local report "Did the Hospital discharge you with care? (Are patients discharged safely and with care following their stay in hospital?

4 Discussions with the Hospital Teams

We were met and made to feel very welcome on the day by the Discharge Manager (DM) who had already identified patients who were waiting to be discharged. The staff teams on the wards and in the discharge lounge were aware of our visits and briefed sufficiently regarding the purpose of our visits. During the morning session, two volunteers visited the discharge lounge and three volunteers set about visiting the wards to talk to patients. After a break for protected mealtime, volunteers resumed their discussions with patients. This information was all prepared for in advance of our visit and made the whole process very efficient.

Talking to staff

The summary of findings from the interviews with the Healthwatch meetings with Hospital Staff from various teams (and initiatives) involved in discharging patient's safely and in a timely way are shown below.

Interview 1 -Team Manager (Kent Social Services) Discharge Referral Service funded by Kent County Council (KCC) for Kent residents only.

This services has two case managers and five assessment officers. East Sussex residents are referred to the Hospital Discharge Liaison Team which is funded by the MTWT and provided by Kent Community Health Trust. The Team Manager attends weekly discharge meetings that look at all patients who have been waiting seven days or over to be discharged. (These are usually patients with complex discharge packages and often older people). This equates to around 30% of patients.

It is a multi-disciplinary approach and Healthwatch have been invited to attend meetings which take place at Maidstone and at Pembury sites. Outcomes of those meetings will appear in another section of this report.

To understand the experiences and challenges faced by patients living in East Sussex it was suggested a separate meeting take place with designated worker at TWH responsible for out of county patients. (DL). There is approximately 30% footfall of patients from East Sussex using TWH but no designated case worker provided by ESCC ASC

Staff members proactively and confidently seek out patients that could go home on the day or next day as they are aware of systems in place to ensure appropriate support can be put in place. One example given was access to the Enablement package, available up to six weeks following discharge keeping people independent. There is an eligibility criteria (Fair Access to Care) for this service that is cost effective and has good outcomes.

The system does encounter glitches when it comes to East Sussex residents. Recommendation: HWES to explore further why these blockages in the system occur.

Healthwatch Kent were also keen to understand the systems and pathways to receiving appropriate treatment for people using Pembury Hospital who present with mental health diagnosis. There is a mental health liaison team provided by Kent and Medway NHS and Social Care Partnership Trust http://www.kmpt.nhs.uk/Trust-Services.htm. Whilst there is a team based at TWH, further discussion is required to understand how the team respond when specialist input is required. Wider issues regarding where patients go in the community remain a challenge as local in-patient beds have been reduced and resources are scarce in the area. (This also includes safe places for young people in need of crisis intervention. This service for children and young people is provided by Sussex Partnership NHS Foundation Trust) **Recommendation**: Healthwatch Kent will follow up this line of enquiry outside of this report.

For homeless people; this is not a major issue for TWH although it does receive occasional visits from transient people on route to the more favoured coastal towns of Brighton and Hastings during the summer months. With any patient, where there is significant cause for concern, local knowledge and relationships exists within the team to link up with appropriate services i.e. housing schemes and Gateways

General comments and observations; it was very clear from the outset, that co-locating teams in the same or nearby offices enables greater integration of health and social care and allows systems to “talk to each other” and build strong relationships. From a patient experience, the design of the building makes it easier for staff to have private discussions with patients; especially undertaking assessments around finances, respects the patient’s dignity and is better for infection control.

The design of the hospital also means that there is no “escalation resource” during increased demand on services i.e. additional beds or wards cannot be opened to meet increased demand like TWH’s sister hospital in Maidstone, therefore continued investment in a robust integrated discharge pathway for patients has to be a priority.

Challenges; the lack of nursing home beds locally and over the border in East/West Sussex and Surrey, coupled together with the high fee’s and demand from private self-funders, is a daily challenge. This can be especially so for older people with mental health diagnosis. There is good support from within the voluntary sector i.e. AgeUK living at home alone service offered by AgeUk Tunbridge Wells as well as from Crossroads who provide support for carers. The team also has links with support groups who can take care of patient’s pets if they have to come into hospital for an unplanned stay. The Discharge team are look at proactive ways to solve this problem. For example, they are going out to meet with nursing homes and discuss

the number of beds and solutions for homes to accept patients on Fridays or over the weekend (by accessing the Enhanced Rapid Response Team)

Looking ahead; the team manager spoke about plans and discussions taking place to create a fully integrated team at the "front door" Accident and Emergency (A&E) Department, one team, one uniform. This team would include Occupational Therapists, Physios, nurses and social workers.

Interview 2 - Operations Manager for Discharge. Community Liaison Team (CLT), Pilot scheme with a dedicated team linking the Kent Community Health Trust with the Acute Trust.

The trigger for this pilot was the national focus on discharge, the lack of escalation options on site and increased demand on services, "can't stop patients turning up"

The discharge team work a six day week and continually assess data that has been fed into internal system called Trident. This system records details of every patient in the hospital who been declared medically fit for discharge and highlights all patients waiting over seven and 28 days. These patients are discussed at the weekly situational reporting meetings held on Tuesday's at TWH and Monday's at Maidstone Hospital.

The frequent and most challenging issue for the team is around access to Continuing Health Care in a nursing home (bed capacity). For East Sussex residents, there is a greater issue around the timescales for a decision to be made to fund Continuing Health Care from the East Sussex assessment teams. On average this takes up to two weeks and in most cases the decision is not made until the last day of the two week period. (For Kent residents, this happened usually within 3 – 5 days). The time scales are further prolonged following a decision to assess, as date has to be identified for East Sussex Teams to meet and assess the patient. HWES will look into this issue and include a response from the ES Assessment team in the final report. The discharge team at TWH are in dialogue with ES assessment teams to improve pathways and develop stronger relationships by commencing weekly conference calls. The three longest delays transfers of care are for East Sussex residents from the stroke unit waiting for Nursing Home placements.

HWES will attend the weekly situation reporting meeting Tuesday 12th August at TWH to understand this issue experienced by East Sussex residents.

The team have plans to explore with nursing homes the support and assurances they would need to admit patients on Friday's at week-ends. The community hospitals do not take admissions after 7 pm and the CLT only work up until 6 pm Monday – Saturday.

Interview 3 - Junior Matron, Community Liaison Team (CLT)

This team consists of five Band 6 Nurses, one Junior Matron and one Administrative Support Assistant.

The CLT receives referrals from Occupational Therapists (OT's) for patients who have issues regarding mobility in conjunction with ongoing discussions with patient's relatives.

They liaise with the four community hospitals in Kent and the Romney Ward in Maidstone for rehabilitation care. Patients can choose 2/3 of their preferred locations but this cannot be guaranteed by the CLT although every effort is made to transfer and rehabilitate patients close to their home. Patients need to be able to engage with therapists so this option is not always appropriate for patients with mental health issues such as Dementia.

For patients who can be discharged home with a support package, but that support package cannot start immediately, the CLT make a referral to the Enhanced Rapid Response Team (provided by Tonbridge and Maidstone ASC) who can assist with care and support until the full package starts. This service is linked to post code of the GP. HWES to explore how the Rapid Response Team works in East Sussex as feedback from the CLT highlights the benefits of working in a similar way.

There was another issue identified for East Sussex patients who are non-weight bearing. East Sussex CCG's do not commission non-weight bearing patients in acute beds, therefore any such patients in an acute bed at TWH, can be there for weeks. Non weight bearing patients are referred to Community Discharge Team (LS) This is decided on the post code of patient's GP rather than where the patients lives. **ACTION** : Healthwatch East Sussex to discuss with East Sussex CCG

For (elderly) patients who are deemed to lack capacity, wherever possible Mental Capacity Act (MCA) assessments are undertaken as early as possible although this can change, the recurring issues of availability of nursing home placements and out of county placements is also an issue for this team. Again East Sussex residents experience the longest delays.

Patient Transport Service (PTS); this service is provided by NSL Care Services in Kent and Medway http://www.nslcareservices.co.uk/kent-and-medway. The ward staff are responsible for organising patient transport up to 7 pm. The CLT service closes at 6pm. Any patient still waiting to transfer to nursing home after that time will be discharged the following day.

Interview 4 - Discharge Liaison Team (DLT)

The DLT handle **Fast Track Referrals** for patients requiring end of life care. Funded by Continuing Health Care (CHC) for patients wanting to be discharged home (or into a Nursing Home or Hospice) for their end of life care. It is a multi-disciplined

assessment/decision and involves patient, relatives and the Palliative Care Team. It is part of a national programme.

As an overview of discharges from TWH, approx. 80% of patients leave without any intervention, leaving 20% of patients requiring support. Front line staff would realistically put that figure at approx. 30% of patients require intervention and support to leave hospital.

For residents in Kent this package of care is agreed relatively quickly and rarely challenged by the CHC teams. The process however involving residents from East Sussex is not as streamlined or as timely. From our discussions it was apparent the equivalent teams in East Sussex, rarely accept the referrals made by the team at TWH without challenge. This can be for a number of reasons; i.e. the patient's dignity and safety was being maintained in the hospital. This means that the window of opportunity to meet the patient's needs and wishes can be missed meaning they become too ill to be moved and so will end their life at Pembury Hospital.

There is also a difference in the level of support provided by Kent CHC and East Sussex CHC.
Kent currently offers a maximum of four daytime call slots (can be double handed if required) per day, with room for negotiation i.e. if night sits are required, up to the value of nursing home agreed funding of £775.00 per week

In East Sussex they currently offer three maximum call out slots per day which can result in further delays.

For referrals to the Integrated Community Access Programme (ICAP) which includes joint community rehab team, re-ablement team and district Nurses, again it is patients who live in East Sussex that do have an equitable experience transferring to a community hospital closer to home. Our discussions around this issue highlighted inconsistencies in communication methods receiving the bedside assessment i.e. TWH will send across completed referral form electronically to the central portal, where it is then faxed across to the relevant hospital (Crowborough or Uckfield), which does not always receive a prompt response. The hospital will only take admissions Monday to Friday, which can add to the delay.

Referral (Pathway) for Continuing Health Care (CHC) Funding for CHC involves patients with complex, intense and unpredictable needs. (More than the standard support package). TWH use Individual Needs Portrayal checklist (scaled down version of the previous 40 page document) which involves patient, family and the liaison team. Once the form is agreed during a bedside discussion with family and patient it goes to the CHC team. The CHC team agree a date to visit within 72 hours to undertake bedside assessment and the case manager will carry out the assessment. Again they will meet the patient and the family at the bedside and make a decision there and then. If the patient is eligible for CHC, the CHC Nurse starts

talking about and planning discharge immediately with social care. If CHC is not agreed, the patients will stay in hospital for as long as it takes to secure a placement or package.

Pathway for East Sussex residents, the completed form is forwarded to CHC team in East Sussex. It is not usually until the last day of the legal requirement two week timeframe to respond, does dialogue commence between the two providers. Which, when you add into the pathway, agreeing dates for assessments to be conducted, East Sussex residents and their families experience a long process to receiving Continuing Health Care.

5 What Patients Told Us

During the visits to the hospital wards our volunteers were able to talk to **19** patients who were in the process of being discharged. Where disclosed, **7** were male and **5** were female. Patients reflected a broad range of ages, with **1** being 35-44, **4** being 45-54, **2** being 65-74 and **5** being 75+, where disclosed.

Where discussed, patients were given a decision about their discharge either the day before or on the morning of their discharge. No one indicated that they felt rushed to be discharged, if any delays were known, patients were notified with the reasons and alternative arrangements made. Discussions regarding the timings of a patients discharge were often held with another family member present, although on two occasions patients said that this did not happen. One patient stated that they did not have an expected discharge date discussed with them at any time. Two patients also said that they did not feel well enough to be discharged at the time. A further two patients also said that although they felt tired and still unwell, they felt well enough to go home.

When asked, most patients already had in place a family member or friend available to take them home, although a further three patients were still waiting to have confirmed transport arrangements made. Only one patient acknowledged that they would be using the local Patient Transport Service.
Patients reported mixed views of their involvement and how they were listened to in their discharge process. Most were happy with their involvement, although one patient said that they were “frustrated at the lack of physio assessments”, which may have been necessary as part of their discharge process. One patient stated that they were being discharged due to what they were told was a bed shortage and were sent to the discharge lounge to free up space.

Where recorded, patients were aware of the packages of care they would be or the information they needed when leaving hospital. Some of these were existing packages which the patient had in place prior to their stay in hospital. Those who said that they had new equipment or services were also given information regarding these. Only one patient did not appear to have any support in place for their return home. The family of patients were also found to play an important role in the ongoing support needs for a person returning home and were often found to be aware of ongoing support needs and the help required upon discharge. One patient said that they were happy with the immediate support and treatment they were receiving upon discharge, they were unhappy about any support in the future. Due to an ongoing condition they felt that they were not receiving appropriate treatment in the community and were regularly referred at times of need, resulting in repeat delays and frustration for the patient. In this instance the patient said that they would like face to face contact with a support organisation.

Only one patient was aware that their Care Plan was being prepared for their discharge, with a further two confirming that they had a link letter for their GP. Most patients did not seem aware of any information to be passed onto a further health or care support professional.

Most patients who needed ongoing medication as part of their support said that they were happy that any changes and side effects were explained to them fully before they left hospital. They also said that they were told what they would need to do should they find any problems with their medicine and where to get further help, generally from their GP. Patients also felt happy that their GP would be aware of their ongoing medication requirements. In one case a patient also referred to receiving further advice from a dietician in support of managing their condition going forward.

Only one patient said that they received no information about their medication. One patient did state that they felt their initial admission was due to their ongoing condition and a potential reaction with some of their current medications and felt that at the time there was no ongoing plan in place to deal with this.

Overall, all of those who stayed at hospital felt that their experience was a positive one and were happy with the care and support they received. One patient, did remark upon the differences between some of the wards and the effect it had upon their stay – with one ward having time to ‘listen’ in comparison to the other busier wards which they felt did not have time to engage with them.

As part of a follow up exercise, the patients who took part in the survey were invited to return a short survey about how they were coping upon their return home. Only two of these surveys were returned, both of which were positive about their experience and were coping well. Of note, one patient responded that they were glad to be at home due to being able to carry out their own caring responsibilities, which

may have influenced their actions during their stay and discharge from hospital. This may need to be taken in consideration regarding a patient's own health needs, when balanced against the responsibilities they may have when providing support themselves. In this instance the patient appears to have a wider network of support in place.

Discharge Meetings attended by Volunteers

Maidstone Hospital on the 4th August; the following observations were noted:

Overall the representative concluded that this was a good model and had the best interest of the patients at the heart of all discussions.

There were some issues identified around the attendance of Kent Social Services. They were not in attendance and some recent restructuring has meant their attendance at the Maidstone discharge meeting is now patchy which is slowing up the process.

In total they discussed around 70 patients. The Ward sisters came to talk about their relevant patients and they seemed to have a good personal knowledge of each patient. Where there was no family member involved or the patient was not deemed to have capacity, they discussed the patient with care and sensitivity and it was clear they wanted what was best for the individual patient.

Other points to note:

- Dementia advocates are in short supply though
- Shortage of palliative care was apparently mentioned, however no further details emerge to support this, but will require following up
- Shortage of care home beds was a recurring theme as outlined in discussions with staff

Tunbridge Wells Hospital on the 12th August; the following observations were noted:

Overall, the authorised representative reported, the model, (albeit only observed on one occasion) presented more as a "patient status update" than a Discharge Planning Meeting. On this occasion it was not apparent which discussions related patients being discharged into East Sussex.

All attendee's had a printed copy of the bed management system used in the hospital called Trident*. Throughout the meeting, various Matrons/Ward Mangers came in and gave updates on a number of patients who were approaching discharge or those who had been in the hospital for some time; in one case, a patient had been there for 81 days. (The reason for this delay was not discussed)

The Hospital Discharge Booklet and the nature of the discussions at this meeting, highlighted the level of importance attached to maintaining a robust discharge

programme at the hospital (Reflecting the financial cost to the Trust for patients who experience delays to discharge after being declared medically fit for discharge and the lack of beds to implement any escalation plans)

Example given:

That day, a patient was due to be discharged but their house key was locked in the house and their relative was due to come the following day with a spare. The solution was to “Get a locksmith (A name was given to contact) to gain access and charge the patient!” The cost of a bed; £250 - £360 a day" was the explanation offered to justify this action. However, when speaking to patients, there was one patient, whose family could not take them home the previous day, resulted in having to spend another night in hospital. These two examples, one quite extreme, highlight that consistently applying a robust discharge programme is not without its challenges.

The Discharge Booklet also states that wherever possible patients, relatives and friends were encouraged to provide assistance with transport arrangements. (As outlined in the Discharge booklet stating that patients will only get hospital patient transport if they have a medical need, that Patient Transport Service (PTS) need notice in advance and that they will only carry the patient and one bag of personal effects).

Good practices examples observed included:

- Discussions around where two patients who developed Diarrhoea and Vomiting on the day, were not discharged.
- Two members of staff from Kent Adult Social Care teams were in attendance

6 Our findings

Talking to the Hospital

From all our interviews with staff members it was evident that staff teams work in an integrated way that allows for staff to be proactive and innovative in identifying solutions to improve the experience for patients. Our interviews identified issues for Healthwatch East Sussex to take forward on behalf of its residents who use the Tunbridge Wells Hospital at Pembury.

Talking to Patients

Most of the experiences of patients who we spoke to were positive about their discharge process and found that they were well involved with the planning and were aware overall of their ongoing support and medication needs. It should be acknowledged patients declaring themselves well enough to go home, there is a

small concern that some patients may be placing their ongoing care and support of others before their own health. Where patients are known to have a spouse, family member or other individual who is reliant upon receiving support from the patient themselves, this should be considered in the patients discharge planning.

Discharging a patient who declares themselves well enough to go home, when they may need some further time to recover, in order to continue with their own caring responsibilities could have a detrimental effect for not only the patient, but also the person they care for. This perhaps could be further explored as part of the early discharge process.

7 Recommendations for Healthwatch

- Healthwatch Kent to follow up with the mental health liaison team at Pembury Hospital to better understand the discharge options and process for mental health patients
- HWES recognises that conclusions drawn from these snap shot visits do not represent all patients who receive care and treatment out of county and will plan to look at replicating similar activity with other providers as part of its wider work programme.
- Follow up how patients with Dementia are assessed for a residential placement and the time allocated for the patients to engage as much as possible in the assessment i.e. the assessment should be a “process” rather than an event.

8 Acknowledgments

Acknowledgements

- All the Healthwatch volunteers who took part from both East Sussex and Kent
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- Staff we spoke to on the day including members of the Discharge Lounge, Community Liaison Team. Kent Social Services and the Discharge Team

Volunteers undertaking activity

- Chris Carter
- David Morris
- Libby Lines
- Liz Allen
- John Curry
- Elizabeth Keating
- Margaret Stanton