VOICES

VOICES OF INDEPENDENCE CHANGE & EMPOWERMENT IN STOKE-ON-TRENT

Coproducing Hospital Discharge Pathways in Stoke-on-Trent

Recommendations from personal and professional experiences

February 2022

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Expert Citizens

COMMUNITY FUND

VOICES (Voices of Independence, Change and Empowerment in Stoke-on-Trent) is a Fulfilling Lives: supporting people experiencing multiple disadvantage project made possible by The National Lottery Community Fund.

We would like to acknowledge all the partnership organisations involved in the design and delivery of research and activities of this project.

Special acknowledgements to

Lee Dale, VOICES Community Development Coordinator who shared his own lived experiences of hospital discharge and multiple disadvantage with stakeholder colleagues, providing valuable insight that contributed to the development of the final recommendations.

Jane Morton (Advanced Nurse Practitioner - Homeless Health Service), Geoff Davies (SNSCAB) and Fiona McCormack (CHAD – Staffordshire University) for sharing specialist skills, knowledge and experiences in the co-design and co-delivery of a partnership consultation event.

We would also like to acknowledge Baz Tameez – former Service Coordinator for VOICES who took the role of lead Project Officer in the VOICES Transitions, Hospital Discharge legacy project.

Acknowledgments

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Introduction

It has been long recognised that there are challenges and barriers within hospital discharge pathways for individuals experiencing multiple disadvantage. In 2019 VOICES funded a research project undertaken by the Centre for Health and Development (CHAD) and Staffordshire University, to gather local stakeholder perspectives, through a multi-disciplined and coordinated approach, presented a set of recommendations to improve the experiences of hospital discharge for people experiencing multiple disadvantage.[1]

VOICES recognised that the customers that we were supporting as well as professionals across the city continued to face difficulties in securing smooth and sustainable transitions from hospital and identified hospital discharge as a key priority for the VOICES systems change legacy projects. To co-design and co-deliver the legacy project we collaborated with colleagues from a range of services across Stoke-on-Trent. These included Expert Citizens C.I.C., NHS, third sector organisations, Stoke City Council, Stoke and North Staffordshire Citizens Advice Bureau (SNSCAB), CHAD and Staffordshire University.

Purpose

This report is a product of the VOICES Transitions: Hospital Discharge Project and presents key activities that VOICES has coordinated from 2016 -2022. The purpose of the project was to bring key professionals from across the city together with lived experience representatives to form a collaborative group (the project team) to explore the persistent existence of 'wicked issues' in hospital discharge pathways and to coproduce an updated set of recommendations.

The project team developed a coproduction workshop to deliver to key individuals working within the discharge pathways to gain insight of the difficulties and frustrations that they experience and to coproduce updated recommendations.

The recommendations in this report were created by the project team with wider stakeholders and are intended to support frontline staff, managers, organisational leads, and commissioners to improve the experiences of people and professionals in hospital discharge pathways.

As a legacy of the VOICES project this report provides useful insight for Changing Futures leads in Stoke-on-Trent.

[1] https://issuu.com/voicesofstoke/docs/hospital_discharge_report_final_ver_d2e997e9161408

Method

Between 2016 and 2021 VOICES worked with partners across the city to explore and review hospital discharge practice, pathways, and procedures. This included:

- A series of case studies, interviews and articles identifying gaps, barriers, and challenges in hospital discharge from real lived experiences and 'frontline frustrations'
- Research project: Hospital Discharge and Homelessness: Local Stakeholder Perspectives (2019) with the Centre for Health and Development (CHAD), Staffordshire University
- Hosted and coordinated a Stoke-on-Trent Community of Practice series of sessions: hospital discharge
- Regular research and stakeholder discussions
- Delivery of a series of bespoke workshops to Royal Stoke Hospital A and E Department (2018) highlighting key challenges for people experiencing multiple disadvantage and staff working to support them
- Co-delivery of the VOICES Transitions: Hospital Discharge legacy project (2021)
- Hosted a citywide 'Hospital Discharge Pathway in Stoke-on-Trent' Coproduction Workshop – (December 2021)

The coproduction workshop was hosted by VOICES through an online platform and included 32 partnership colleagues from across the city. Attendees included colleagues from commissioning, Expert Citizens C.I.C., Stoke City Council,
Brighter Futures, Restart, Concrete, Staffordshire Fire Service, Revival, SNSCAB, UHNM / NHS.

Guest speakers at the workshop included

- **Lee Dale**
  Community Development Coordinator, VOICES; sharing real lived experiences
- **Jane Morton**
  Advanced Nurse Practitioner, Homelessness Health Service, sharing professional knowledge, insight, and experiences
- **Geoff Davies**
  Specialist Housing Adviser, SNSCAB, sharing guidance on laws relating to the Duty to Refer
- **Alicia Simmons & Baz Tameez**
  Service Coordinators, VOICES – presentation and hosting of event
- **Fiona McCormack**
  Researcher, Staffordshire University – sharing recommendations from the 2019 CHAD report

Coproduction Workshop Aim

Working with key stakeholders to review past recommendations in relation to Hospital discharge, and through sharing experiences and knowledge, co-design an up to date set of recommendations to present to strategic leads and for wider distribution to share findings. The project team agreed that the final recommendations would need to

- put the patient experiencing multiple disadvantage at the centre of discharge
- provide a safe and positive discharge experience for people and professionals

Findings

Consultation with participants demonstrated that the barriers, gaps, and challenges experienced in hospital discharge processes remain similar to those identified in the 2019 CHAD report. There was collective agreement that although professional curiosity is more prominent today, the recommended strategic changes remain fragmented or yet to be implemented. Lack of resources were highlighted as a key barrier. The High Impact Change Model (2) (Local Government Association et al) was created in 2015 and updated in 2020; it identifies eight changes which, if implemented, could have a significant impact on effective transfers of care – in summary these changes are

- Early discharge planning
- Monitoring and responding to system demand and capacity
- Multi-disciplinary working
- Home First
- Flexible working patterns
- Trusted assessment
- Engagement and Choice
- Improved discharge to care homes
- Housing and related services (2020 update)

The first point 'Early Discharge Planning' was highlighted as a key priority in the CHAD 2019 report and by stakeholders involved in this project; issues raised include that it **does not appear to be clear where the hospital admission paperwork is sent following completion; discharge facilitators are not currently the priority receivers of this information, therefore often leaving little time for effective planning and transitions – influenced by the ongoing dilemma of bed-blocking.** The depth and quality of information gathered on admission records was also explored and it was found that **questions are 'closed', and responses not always explored** – for example, rather than just asking for an address on admission this could be further explored by asking for the type of property / tenancy ownership; people being admitted of no fixed abode and rough sleeping / sofa-surfing could be identified during the admission process. If this information was then communicated promptly to discharge facilitators (flagged up) immediate actions could be taken to identify appropriate accommodation for the person being discharged thus, contributing to the reduction in the bed blocking issue. Of course, it's not just a matter of making a referral for housing; this highlights the need then for external services to engage the person in support whilst they are still in hospital to identify appropriate accommodation prior to discharge. Previous partnership work delivered by VOICES found that it is not uncommon for external services to wait until the person is discharged from hospital (or any other establishment) before engaging with them. The person responsible for the discharge then is faced with the emergency dilemma of trying to secure somewhere for the patient to move to. VOICES also found however, that our local Royal Stoke Hospital welcomes services to engage with patients to support recovery and the journey to discharge.

[2] https://www.local.gov.uk/sites/default/files/documents/25.1%20High%20Impact%20Change%20model%20CHIP_05_1.pdf

Example of Positive Practice 1

In 2019 a VOICES customer was admitted to the cardiology department at Royal Stoke Hospital under the care of Dr Satchi and Dr Elizabeth Whittaker due to a potentially fatal heart infection. As the customer was experiencing substance dependency, they found inpatient stays very difficult due to the withdrawal effects. The VOICES Service Coordinator visited the customer in hospital regularly. Dr Satchi noticed the visits and took time to learn more about the support being offered – this provided valuable insight to the consultants, enabling deeper understanding of the difficulties that people experiencing multiple disadvantage face. The team requested that the Service Coordinator record the visits and actions taken in the patient's hospital record -this was to ensure that all involved (internal and external) were aware of updates, interactions, changes, and triggers. Working in this way provided an efficient communication pathway and demonstrated the holistic approach that was developing.

Dr Whittaker later contacted VOICES to request support with coproducing a learning event to raise awareness of the difficulties experienced by people experiencing multiple disadvantage within the context of a healthcare setting*. The event took place online due to Covid-19 lockdowns; guest speakers shared their specialist skills and knowledge from a range of services, including personal lived experiences. The event focused on the value of inter-professional relationships and challenged attendees to consider how they view their working team. During the event Dr Satchi announced,

> **"Let's be the patient's team – regardless of our position in the organisation – let's be their team of support – together"**

— Dr Satchi & Dr Whittaker

winners in the 'Learning' category at the Expert Citizens INSIGHT Conference 2020 for coordinating this work with VOICES.

In-reach work in health care settings provides improvements in the recovery journey and communications. The notion that the 'team' includes all those working to support an individual demonstrates the symbiotic relationship between health care professionals and those working in community settings. Dr Satchi's statement also reflects that the input, expertise and experience of people working in external services within the patient's recovery process is highly valued by the health care teams.

The 2019 CHAD report recommendations included:

- Specific training for frontline staff around identifying people who are currently experiencing homelessness. Their needs, and the requirements under HRA
- Develop site specific pathways to standardise hospital discharge in relation to HRA
- Improve identification and recording housing need on presentation to hospital
- Reinstate the previous Homeless Matron role which was de-commissioned*

These recommendations reinforced the need for improvements in awareness of people experiencing multiple disadvantage and service responsibilities under the Homelessness Reduction Act (2017), the need for in-depth assessments on admission to enable early identification of wider needs (not just health), and improved communication with an efficient system for communicating complex needs to staff with discharge responsibilities.

**Since the CHAD report was published the North Staffordshire GP Federation, in partnership with Brighter Futures and Stoke-on-Trent City Council, delivers a Homeless Health Service Project led by Advance Nurse Practitioner, Jane Morton.*

During several of the workstream activities various colleagues have suggested that it would be beneficial for the city to commission an online service directory. VOICES were able to offer a description of an online database that does already exist along with insight into how to access and navigate the database[3]. This resource is delivered alongside the Staffordshire Mental Health Helpline service by Brighter Futures Housing Association.

Consultation with partner colleagues identified training for health care staff as an area for change. It was agreed that, at all levels within the NHS, there is a lack of insight in relation to lived experiences of multiple disadvantage, responsibilities of healthcare workers in discharge planning and knowledge of services and support available for people, pre and post discharge. Hospital staff will encounter people experiencing multiple disadvantage and exclusions through admissions to Accident and Emergency departments because of the difficulties they face when trying to access primary health care. Therefore, it is crucial for staff to be able to understand the external and often unseen influences on a person's ability to self-advocate effectively during assessments.

Example of Positive Practice 2

In 2018 Sharon Sharman (Director) and Lee Dale (Community Development Coordinator) from the VOICES team delivered a series of bespoke workshops to staff at Royal Stoke Hospital University Hospital within the Accident and Emergency Department, highlighting the above as one area for improvements in admissions to discharge for people experiencing homelessness. Feedback was extremely positive, and the department committed to making improvements – these included.

> **"Refer to homelessness services as soon as we are aware, not waiting until someone is discharged"**
>
> **— NHS staff member, Royal Stoke University Hospital[4]**

The series of bespoke workshops were followed by learning opportunities to introduce Trauma-Informed practices. Royal Stoke Hospital continued this work by seeking funding to commission specialist knowledge brokers to deliver learning that supports teams and organisations to create psychologically informed environments,

As part of the coproduction workshop Lee Dale and Jane Morton presented the need for development of training and were able to explain and exhibit the current difficulties faced by those experiencing multiple disadvantage. It was clearly recognised that NHS staff do work extremely hard and in difficult circumstances and that, over recent years have enhanced their levels of professional curiosity in multiple disadvantage. It is felt now that strategic leads, commissioners, and management within the health care structures could better understand the needs of their teams and respond with further relevant learning and development opportunities to equip the staff on the frontline with the skills, understanding and knowledge required to effectively support people who have long-term and multiple traumas. The CHAD recommendations (2019) state that specific training is required in relation to the Duty of Care Homelessness Reduction Act (HRA) 2017.

In relation to information-sharing it was found that awareness sessions to clarify GDPR legislation would be beneficial to healthcare services. It is often said that, "I can't share that due to Data Protection", when, in fact, in some circumstances information should be shared to enable safe progress of someone's recovery. There was agreement that important details are not always shared with the relevant services.

[3] http://www.stokementalhealth.info/startpage.aspx
[4] https://www.voicesofstoke.org.uk/2018/11/02/small-change-system-change-stoke-trent/

Our Recommendations

On the frontline

- Use the online service directory in daily practice
- Stop the use of abbreviations in records and discussions shared with other services to avoid confusion as some abbreviations are service-specific and others mean completely different things within different services
- NHS staff should welcome external services to conduct in reach assessments and support
- Conduct in-depth conversations with open and exploratory questions during admission and ongoing assessments to identify patient needs at earliest opportunity
- Communicate needs to discharge facilitators as urgent and update ongoing throughout the patient journey
- Discharge staff should communicate needs to external support services as they arise to organise in-hospital support prior to discharge and to develop a team plan together

On Management

- Develop staff guidance to include information of external services and the online service directory and methods of sustaining updates
- Review and amend assessment procedures, processes, language, and environment and create a framework for an exploratory conversation with open questions that can better identify wider support and care needs – embed the VOICES Multiple Needs Toolkit into daily practice
- Link with external services to develop and sustain relationships and actively invite professionals to be part of the patient's team
- Review communication pathways from admission to discharge and create changes to ensure that discharge facilitators are supported to receive notification of the patients need immediately after assessment should referrals / support from other services be required
- Provide GDPR training and explore / clarify when information should be shared

On Strategic Leads / Commissioners

- Ensure that frontline staff are aware of the online directory of services through allocation of budget allowance that enables widening of marketing activities
- Conduct reviews of assessment procedures, paperwork, language, and environment – lead on making positive changes
- Seek opportunities for change within communication pathways between admission staff, discharge teams and external services - shared CRM system, for example
- Ensure opportunities for staff to develop deeper understanding of the importance of information-sharing whilst complying with GDPR regulations

ALL

It is recommended that staff at all levels, including commissioners, have access to regular learning opportunities that provide enhanced understanding, empathy, skills, knowledge, and experience in supporting people experiencing multiple disadvantage. Relevant themes and topics would include:

- Trauma-Informed Care
- Solution-Focused Practice
- Understanding Multiple Disadvantage
- Creating Psychologically Informed Environments
- The Duty to Refer and the Homelessness Reduction Act (2017)
- The Care Act and Multiple Needs Toolkit
- GDPR and information-sharing
- Service awareness sessions

What next?

VOICES will distribute this report to services across the city and will communicate the recommendations to Strategic Leads and Commissioners who are in positions to integrate them into the new Changing Futures programme in Stoke-on-Trent. It is proposed within this structure, that a Centre of Excellence will be developed – this provides the opportunity to embed the learning recommendations above as a legacy of this project.

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