

Scrutiny Review of Hospital Discharge

12 January 2020



Head Office:

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About Five Lamps

- **Registered Charity** (established 30+ years) based in Thornaby
- **Mission:** To transform lives, raise aspirations, remove barriers and offer choice

Domiciliary Home Care

- ✓ Rapid/Hospital Discharge
 - ✓ Community
- ✓ Parkside Court Extra Care Scheme
- ✓ Continuing Healthcare (CHC)
 - ✓ Private

Home From Hospital

- ✓ Lottery Funded
- ✓ Low Level Discharge Support

Youth Services

- ✓ 4 x Evening Youth Club Activities
 - ✓ Outreach
- ✓ Joint Accountable Body for Open Access Provision

Enterprise & Employability

- ✓ Youth Enterprise Initiative
- ✓ New Enterprise Allowance
- ✓ Enterprise Mentoring & Start-Up Support

Community

- ✓ Breakfast Clubs
- ✓ Pandemic Support Project
 - ✓ Food donations
- ✓ Christmas gifts for isolated and lonely older people and struggling families
- ✓ Thornaby Community Partnership
- ✓ Pop-Up Events with Little Sprouts

Personal Loans

- ✓ Community Development Finance Institution
- ✓ Part of Fair4All Finance's Affordable Credit Scale Up Programme

- ✓ **We employ 135 staff**
- ✓ **75 of which are Care Assistants (56%)**
- ✓ **Vast majority of staff live within Stockton & Tees Valley**

Hospital Discharge - Commissioned

- Rapid/Hospital Discharge – 160 hours per week commissioned (limit of 3 referrals in 24 hours) – South of Borough and mobilised within 2 hours

Communication around discharge with statutory partners (e.g. NHS Trusts, Local Authority, NEAS) – how and when does Five Lamps get involved; do you / have you provided feedback to hospitals regarding an individual’s discharge from hospital in the past?

- Referral from ISBAR Team/ Social Worker/ District Nurse (provided with a Support Plan and Individual Service Order (ISO))
- Referrals from Hospital (often with limited information)
- Five Lamps does Risk Assessment & Care Plan
- Referrals should be via email and follow-up call (call does not always happen)
- Previously provided feedback (very small number of unsafe discharges)
- We provide support for 14 days

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Hospital Discharge - Commissioned



Are those you've cared for aware of avenues of support when discharged to their homes? Are an individual's family / other carers aware and informed?

- Dependent on referral source and Social Worker
- Customers not always informed that we aren't their permanent provider and have flexibility on call times
- We involve next of kin upon discharge (if the customer does not have capacity, we include family with assessment and care plan)
- Birdie App – real time care information
- Families often contact us directly
- Identify needs and further support via Care Plan
- Signposting and referral

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Hospital Discharge - Commissioned



Any specific issues relating to hospital discharge that you / your staff have experienced regarding those you've provided care for (e.g. medication requirements)

- Social Workers should make contact with us 7 days after receipt of referral – this sometimes doesn't happen and we need to chase
- Have provided customers with support for 14 days+
- Improvements now we have weekly meetings with SBC and the other Rapid/Hospital Discharge provider
- Smooth discharge and improved communication – we are now informed if discharge will be delayed; we do sometimes get follow-up contact by person sending referral to check everything is ok – this is helpful
- Care at Home – If customer is in Hospital for over 2 weeks, we can end their package – we try not too and should be provided with 24/48 hours notice to re-start package – often discharged via D2A rapid route; not necessarily right route

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Hospital Discharge - Commissioned

Impact of COVID-19 on discharge from hospital back to an individual's own home (not a care home) and impact on your organisation in relation to this issue.

- Significant impact
- Care Assistants only received regular testing in December 2020
- Government focus has been on Care Homes not necessarily Care at Home or Extra Care
- We currently have to chase up Covid-19 test results on discharge; if no result we treat as positive
- Example of Covid-19 customer being discharged twice (for 2 hours on both occasions)
- SBC were providing additional 5% for PPE; stopped but free Government supplies aren't enough
- Infection Control Funding
- Support from SBC

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Hospital Discharge - Commissioned



Anything else you feel is relevant in relation to this scrutiny topic (linked to the key lines of enquiry on pages 2 and 3 of the attached scope)

- No current SLA and uncertainty of future of project
- 2 providers in Borough – expectation we will pick up cases North of the Borough – difficult to plan for
- Good customer feedback

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Hospital Discharge – Home From Hospital



- **Started delivery in Oct 2017 - funded via Catalyst’s Health Initiatives Fund**
 - Despite delivering the project successfully (readmission, onward referral rates and customer satisfaction rates were higher than our contract target), Catalyst confirmed that there was no future funding beyond the extension date (31 March 2019)
- **Secured funding from The National Lottery Fund (Reaching Communities)**
 - Delivery re-commenced July 2019
 - Funding for 3 years (June 2022)
- **Support people aged 50+ for up to 14 days post-discharge from North Tees**
- **Low level discharge support:** transport home; shopping; collecting prescriptions; attending appointments; liaise with other services; signposting and referral
- Have seen customers readmitted – occasions where we have to organise medication due to miscommunication on discharge
- Referrals not always with full information – customers need more support and Covid-19 positive
- **Pandemic Support Project**
- Report attached

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