Adult Social Care and Health Select Committee

Review of Hospital Discharge

Aim of this review;

Problems around hospital discharge have been well documented. This review provides an opportunity to check current discharge processes are robust and if aspects could be strengthened.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) have been asked to identify key mental health issues identified around this topic.

Current discharge policy (attached) - Key points from the policy in relation to discharge are:-

On admission to Hospital the Care Co-ordinator maintains the lead role. This includes leading on discharge planning.

The Care Co-ordinator will inform the service user's GP on admission and ensure other agencies, family and carers are updated and invited to all reviews.

Work should begin with the Care Co-ordinator and relevant others to consider discharge planning and aftercare arrangements as soon as possible.

The standard Trust GP discharge document can also be used as a summary for the transfer of care outside of the Trust. The Care Co-ordinator or lead professional to co-ordinate this planning which must involve all relevant members of the multi-disciplinary team and other services or providers of support.

Before actual discharge a GP discharge letter is sent, follow up care plans provided within seven days of discharge, care plan review planned for a month after discharge, on discharge GP letter shared with GP, Patient and Carer/family.

All service users who have had a period of TEWV inpatient admission must receive a follow up within seven days (best practice is within three days) of hospital discharge by the person identified on the care plan.

A care plan will be agreed prior to discharge with the service user, relatives, carers and relevant other bodies involved. This will include but is not exclusive to medicines management and supply, follow up care and needs and carers' needs, safe transfer provision to Community teams and GP.

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Communication arrangements:-

As outlined above invites to all professionals are sent to review and discharge planning meetings. As a local Trust there is an improved communication flow with weekly meetings to discuss issues, to future plan and to problem solve involving different professional agencies, allowing creative approaches and flexibilities in services to ensure safe and timely discharge. Occasional issues on ensuring representation from all professional bodies involved can slow the process and require rework and further meetings.

Data on the number of local residents discharged from local Trusts, any examples of previous / current discharge delays and issues identified:-

Discharge data from August to December 2020 TEWV

	Hartlepool CCG	Stockton CCG
Adult Mental Health	57	100
Mental Health Services Older People	14	26
Learning Disability Services	2	67

Adults Service had two breaches in the seven day follow up in this time period. There were none for MHSOP and LD services in this time period.

How patients are involved in the discharge process and how are family / carers kept informed?

Where the patient has the capacity to do so they are invited to and will contribute to discharge planning along with their family member/carer and care coordinator. Where the patient lacks capacity their family are fully involved and if appropriate an advocate. Upon discharge the patient and/or carer is provided with a care plan informing them of the discharge process and dates/times/who will be seeing them in the community. This is on or no later than twenty four hours from discharge.

Information given prior to discharge:-

All patients are followed up following discharge either by their care coordinator or by a nurse from the Intensive Community Liaison Service. Follow up is within seventy two hours from leaving the ward unless the patient is at a high risk of self-harm or suicide and then it is forty eight hours or earlier. This is monitored closely by us on the ward as are GP discharge letters which are sent electronically to the GP within twenty four hours of discharge.

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Care plans given prior to and at the point of discharge with planned care and interventions but also how to access services in crisis situations and relevant contact information.

Are carers identified when requiring hospital treatment and if so how are the people they care for informed/ supported in their absence:-

When already in service our Community Mental Health Teams offer carers' assessment on the patient's initial assessment, carers identified at this point are recorded on our electronic record system (PARIS). If a carer goes into hospital and other family members not available we work closely with Social Care to enhance existing care packages or create safe packages of care. Respite care is an option but as gold standard working nights would be accessed if available.

Assistance with transport:-

Transport is provided for the patient to return home. Unfortunately we no longer have access to the Patient Transport and so taxis are used as an alternative.

Consideration with medications:-

Twenty eight day discharge medication is provided to the patient unless the patient is at risk of overdose then it is seven. Considerations are also taken about locked boxes, medication management in the community etc. Medication information is included in the GP discharge summary.

Feedback from people regarding their discharge:-

Family and friends questionnaire are sought on admission and discharge and used to inform thinking and improve approach.

TEWV
January 2021