South Tees Hospitals
NHS Foundation Trust

# Stockton-on-Tees Borough Council
# Adult Social Care & Health Select Committee

South Tees Hospitals NHS Foundation Trust

16 March 2021

## *Current discharge policy and any significant changes historically and / or due to COVID-19  learning from people's feedback regarding discharge to their own home*

- The South Tees health and social care system has been working collectively to embed a Home First culture, including implementation of the national discharge policy
- When an individual no longer requires inpatient hospital care they are discharged as soon as possible
- Health and social care colleagues discuss patients that are ready for discharge on a twice daily basis to enable people to be discharged to the next safe place for their care/recovery
- Patients are reviewed on a daily basis to identify and agree if they can be discharged home or transferred to a non-acute setting
- Transfer from a ward to a discharge lounge

***Current communications arrangements in relation to hospital discharge within the Trust (between departments), and between the Trust and SBC Adult Social Care.***

Executive lead for discharge

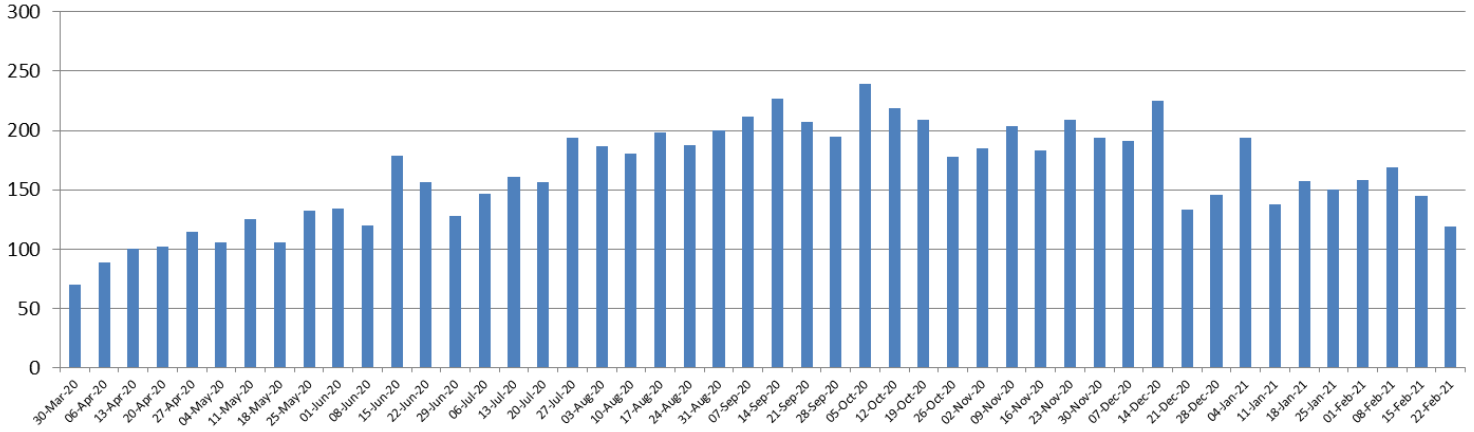
Discharge team works with wards 7 days a week

Daily meetings between discharge team and social worker representatives

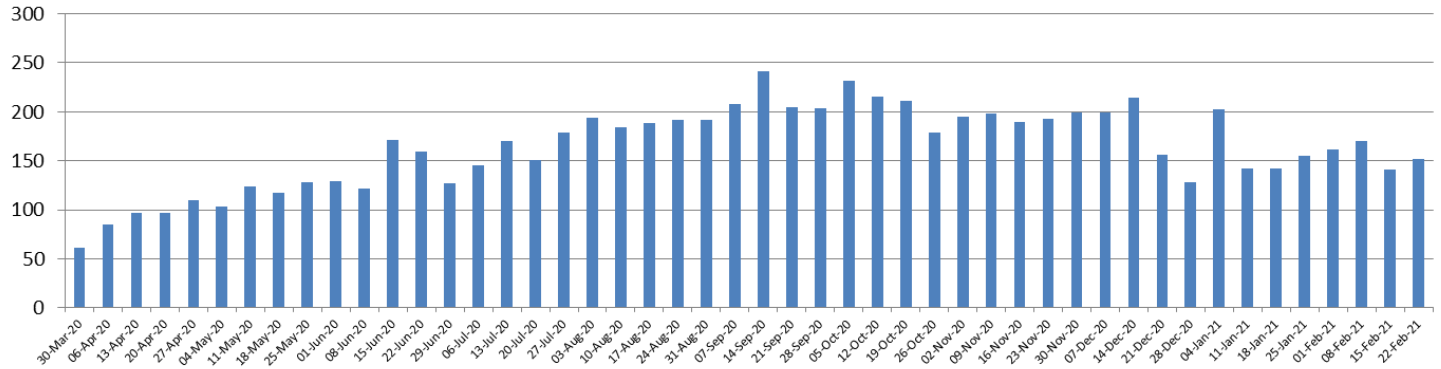
Weekly system calls

***Any data on the number of the Borough's residents discharged from the Trust back to their own home, including seasonal variances in terms of discharge pressures. Any examples of previous / current discharge delays / issues identified?***

**Stockton LA – Admissions per week (discharge destination home)**




**Stockton LA - Discharges per week (discharge destination home)**



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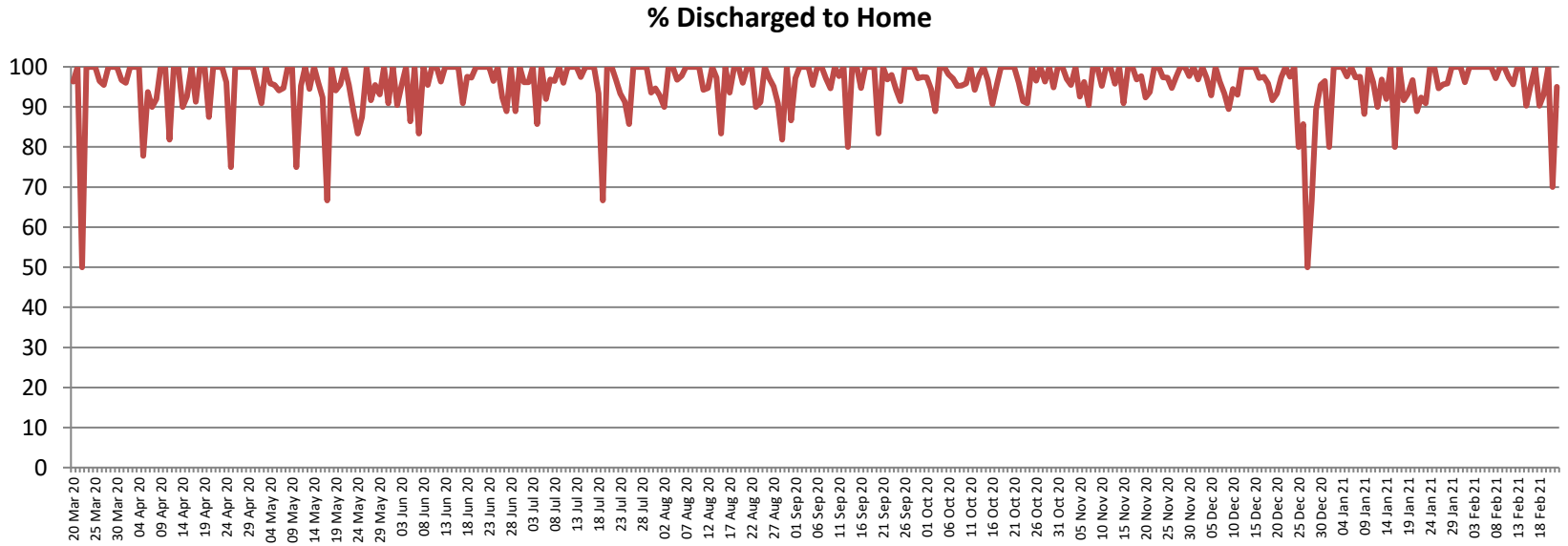


**The discharge team work with the integrated Single Point of Access if there are any queries for people needing a package of care or placement in the Stockton area.**

## *What information is given to people prior to discharge from hospital?*

- The plans for discharge are discussed with patients and their family/carers.
- The patients existing social and accommodation situation is taken into account.
- If a social worker is involved, the ward include the carer information on the referral form for the social care team and they liaise with the family as well as the ward.
- There are specialty/treatment specific leaflets that are given to patients as well as the discharge leaflets provided as part of the national discharge policy.

***Where are patients being discharged from (different areas of the hospital)?***

- Emergency Department and Same Day Emergency Care unit (SDEC)
- Acute admission units
- James Cook Hospitals wards
- Friarage Hospital wards
- Primary Care Hospitals

***Are carers identified when requiring hospital treatment, and if so, how are the people they care for informed / supported in their absence? What communications take place with carers when the people they care for go into hospital?***

**Planned admission**

- Pre-assessment discussion

**Unplanned admission**

- Raised with clinician at earliest appropriate opportunity and social care involved as appropriate

***Assistance with transport back to an individual's own home – how is this provided; are services picking-up any issues when patients are returned to their homes (how is this raised and how does the Trust respond)?***

Hospital and NEAS transport service

Red Cross transport service

Ward contact details provided to patients

Home First

**A discharge letter/e-discharge summary is sent to the GP post-discharge**

## *Considerations around medication as part of the discharge process.*

- Ward-based pharmacists provide patients with medication information
- Medications are arranged for the patient so they have the medications they need on discharge
- The information about medication is included in the discharge letter/summary for the GP records

***Any other factors impacted by COVID-19 in relation to discharge of an individual back to their own home.***

- Packages of care and community services are provided for people if they need health or social care support post discharge
- COVID virtual ward and vaccination programme

# COVID virtual ward and vaccination programme



I'VE HAD MY COVID VACCINATION

# Diagnostic Virtual Ward

- The DVW can facilitate the discharge of clinically stable patients who require on-going investigations and diagnostic tests, within in-patient timescales

- Patients must be clinically stable
- Patients must be safe for discharge
- Patients must have adequate support at home
- Patients must have easy access back to hospital to attend for diagnostic tests and avoid DNA

- The Co-ordinator tracks the appointment, attendance and result and inform the patient's consultant.

# Thank you