Overall rating for North Tees and Hartlepool NHS Foundation Trust
GOOD

North Tees and Hartlepool
NHS Foundation Trust

Stockton Scrutiny Committee

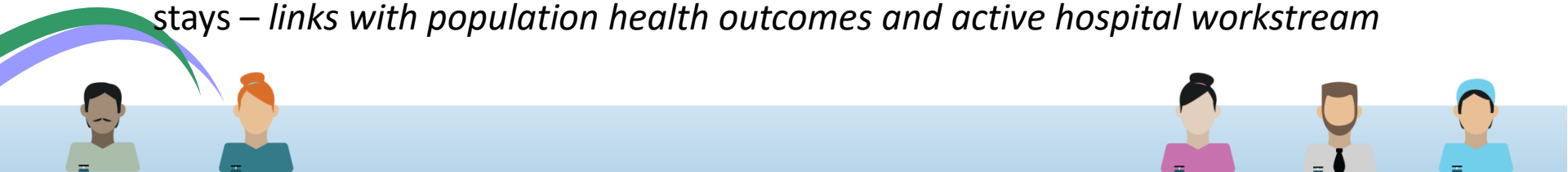
Transforming our services - *Putting patients first* - *Valuing our people* - *Health and wellbeing*

April 20th 2021

North Tees & Hartlepool NHSFT

Phase 2 Line of enquiry - Current discharge policy and how this has developed over time, including examples of best practice guidance.

- Hospital Discharge Service Requirements introduced in March 2020 during the first wave of covid. The requirements built on existing arrangements with an emphasis on discharge to assess arrangements.
- NICE Guidance transition between inpatient hospital settings and community care home settings for adults with social care needs (2015)
- Emphasis on a safe and timely discharge from hospital, discharge planning from admission, access to multi disciplinary support
- Significant increase in delayed transfers of care prompted a national response and the introduction of *Discharge to assess (D2A)*
- Covid expedited this work to create capacity in all Hospitals to allow us to manage the pandemic
- Home First campaign to promote discharge to usual place of residence where it is safe to do so
- Building on our strengths and avoiding deconditioning from extended hospital stays – *links with population health outcomes and active hospital workstream*

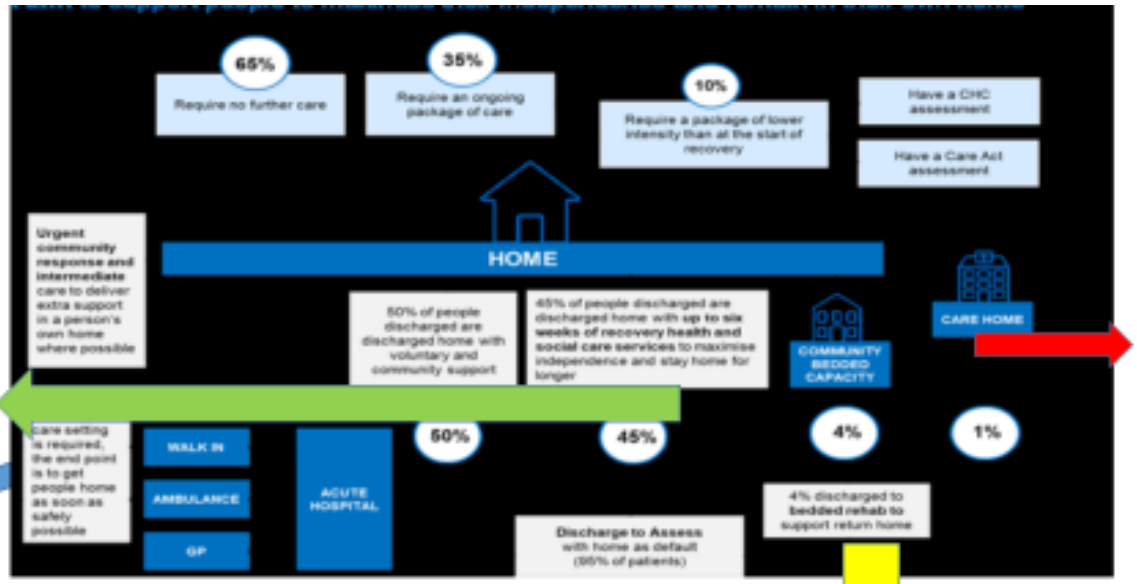


Discharge pathways – National Guidance & Local Pathways

North Tees and Hartlepool NHS Foundation Trust

Pathway 1
Home First

Existing CIIC
Services
Domiciliary care
Packages



Pathway 3
Complex Patients
Community matron
oversight
MDT in Hospital if required

VCSE
Re visit
Home but
not alone
scheme
Five lamps

Consider transitional / assessment beds

Pathway 1 plus – *pilot project*
MDT 72 hour care and support, recovery at home.
Virtual Frailty ward
10 patients
HAST wide
MDT provision
QDS POC
Overnight provision
Interfaces with Intermediate care / Reablement

Pathway 2
Stockton
44 beds at Rosedale
Additional spot beds as required

Pathway 2
Hartlepool
20 beds at West View Lodge
Additional spot beds as required

Phase 2 Line of enquiry - Current communications arrangements in relation to hospital discharge within local Trusts, and between the Trusts and SBC Adult Social Care.

Integrated Discharge Team at NTHFT since 2017 including Professionals from across Health and Social Care and the VCSE

Covid provided us with the opportunity to work together virtually with daily meetings in place between the Hospital and the Teams in the Integrated Single point of access (ISPA) – currently 11am every day

Twice weekly complex case discussion with Senior Leaders from NTHFT & SBC

NTHFT have invested in additional Frailty Coordinators and Pathway facilitators to facilitate discharge planning

Head of Social Work from SBC provided on site support during times of surge which helped to inform pathways and support health and social care teams

Introduced Multidisciplinary meetings on Teams – reduced the time taken to coordinate hospital visits

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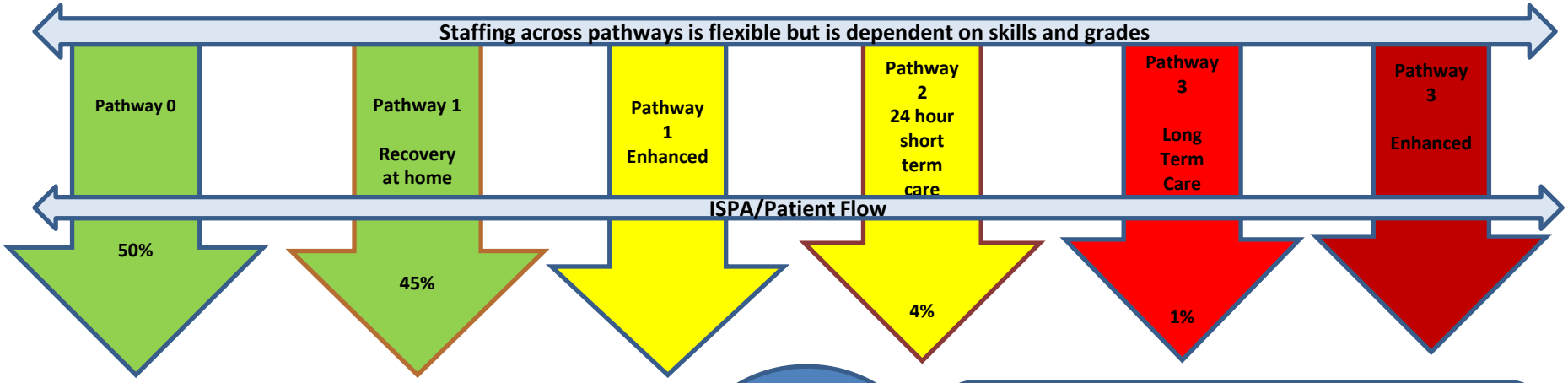
Oversight across the organisation
- Criteria to reside
- Discharge Patient tracking list
- Attendance at daily huddles
- Discharge & Enhanced Care Flow Facilitators

Home First



Key Principles

- Close working with ISPA and other key partners.
- Oversight across the organisation
- Timely responsive discharges.
- Optimising length of stay in hospital
- Pathways managed by teams with the right skills and expertise across each pathway

Activity Hub Volunteer services

Important links
- Patient and their families or carers
- ISPA
- Home First (Enhanced)
- Frailty Team
- Ward Teams
- Continuing Healthcare Team
- Mental Health Professionals
- Safeguarding Team

Discharge Patient Tracking Lists (DPTL) – working document

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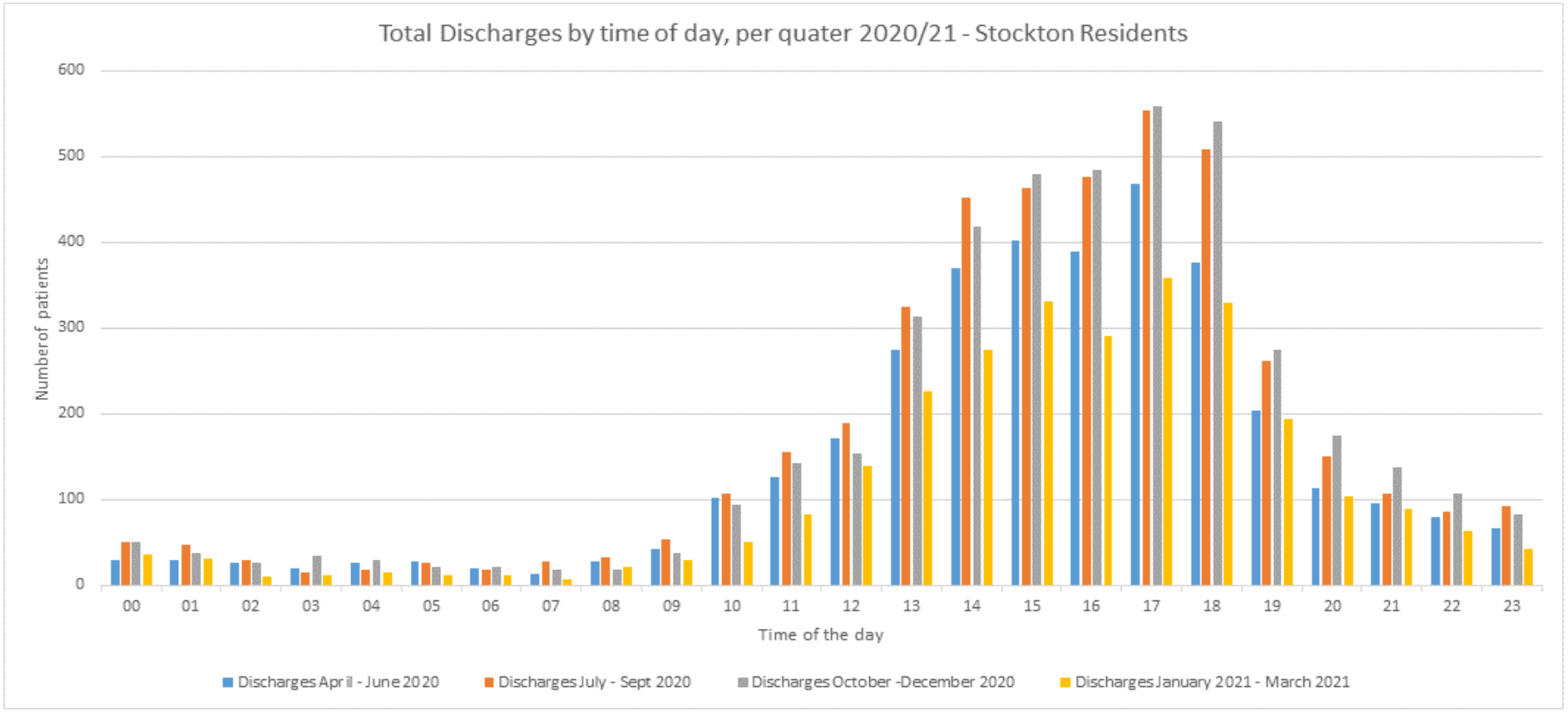
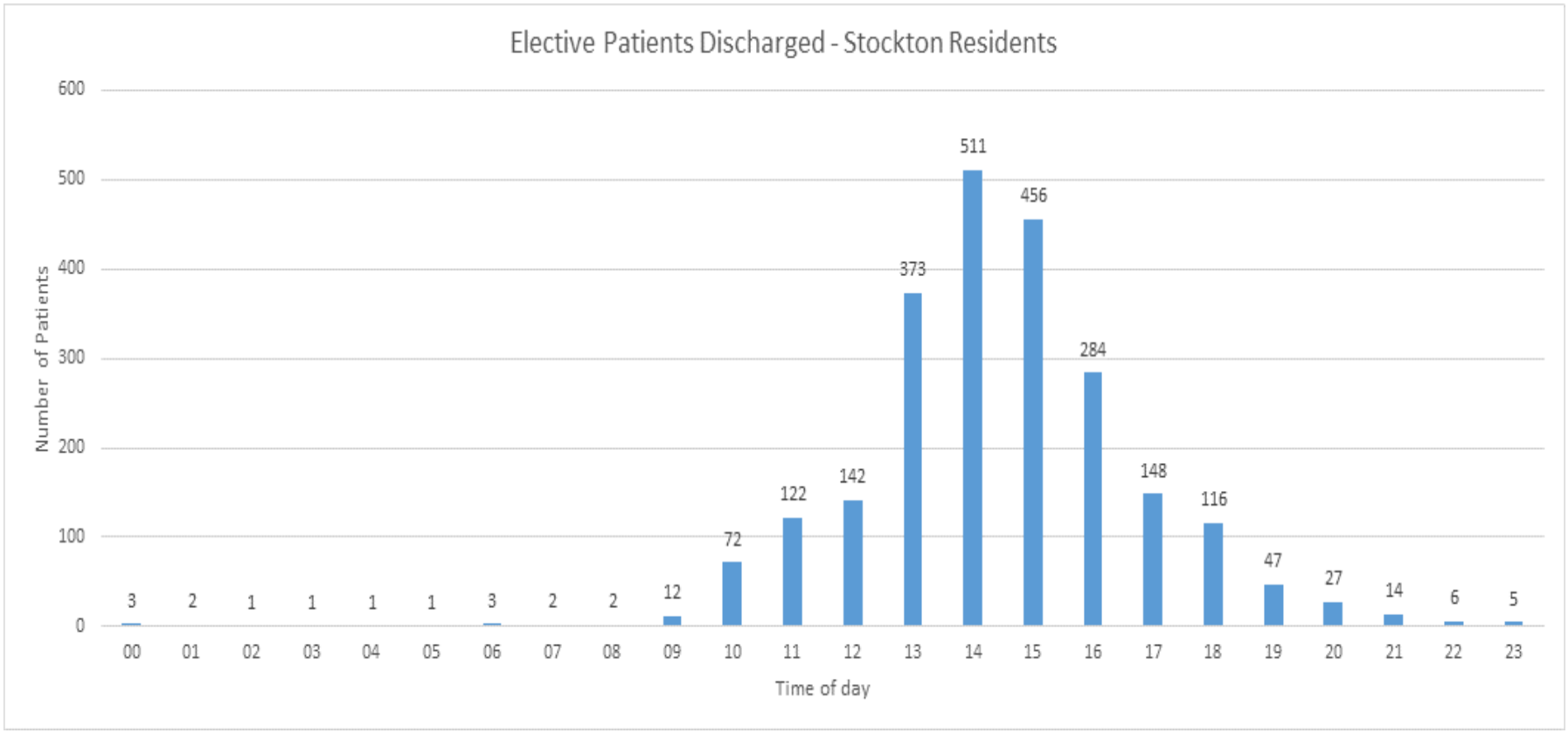
Patient Demographics				In Patient Status							Covid Status		Discharge Information		
Name	NHS No / CRN	DOB	Locality	Admission Date	Ward	Medically Fit Y/N	Date patient doesn't meet criteria to reside	Time from patient not meeting criteria to reside (no. of days)	Assessment Notification Sent (Date)	Assessment Notification Update (Date)	Covid status (Test Date)	Current Covid Status	PDD	Case Manager	Narrative (free text)
Jo			ool	01.01.21	26	No	12.01.21	6	09.01.21	13.01.21	01.01.21	Resolved	MF		17.01.21 Had been for discharge to Brieton Lodge 15-01-21 TA Stated NMF: BNO, SALT, TWOC. 19.01.21 NMF 21.01.21 MF TA to r/v
Ba			ool	05.01.21	25	Yes	15.01.21	3	05.01.21		10.01.21	Positive	24.01.21	Designated setting wait	17.01.21 Awaiting a Rehab bed 21.01.21 NMF
Fr			ool	30.12.20	41	No	15.01.21	3	20.01.21		06.01.21	Positive	?21.01.21	Designated setting wait	17.01.21 Awaiting an assessmnt bed.ISPAwould like more detail aroud his mobility and rationale for assessmentand rationale for assessmnt as opposed to rehab.18.01.21 NMF 21.01.21 WVL today
Ju			ool	17.12.20	26	No	NMF		21.01.21			Resolved		TA	17.01.21 Paperwork had been sent back to the ward. Request is for Ax bed. Weekend therapy to prompt ward with paperwork. NMF. 18.01.21 NMF ween oxygen.19.01.21 update needed. 20.01.21 MF awaiting paperwork for assessment bed. 21.01.21 TA to review Paperwork recieved for assessment bed
Au			ool	11.01.21	42	No	18.01.21	0			10.01.21	Positive		Sarah Beasley	18.01.21Awaiting paperwork for red pathway 19.01.21 NMF 20.01.21 NMF 21.01.21 NMF ? Gretton short stay bed
Sh			ool	06.01.21	26	No	18.01.21	1	20.01.21		12.01.21	Resolved	?21.01.21	TA	18.01.21 NMF 19.01.21 MF for assessment bed. 20.01.21 MF Awaiting placement ?1-1 overnight TA confirmed wandersome/distresssed/agitated/confused21.01.21 looking at WVL admitted as a Positve and isolation ended 12.01.21 Enhanced care and 1-1
Br			ool	10.11.21	41	No						Resolved		Julie Winship	17.01 21 red pathway ? Walkergate first 18.01.21 Julie W to speak with wife regarding adaptations. 19.01.21 NMF 20.01.21 Awaiting MDT ?alternative placement Julie has asked to ring family. 20.01.21 Walkergate declined asked. 21.01.21 NMF IVABX for red pathway family would like Brieton.
Ri			ool	11.12.20	42	Yes	17.12.21	1	19.01.21		22.12.20	Resolved	Discharged 21.1.21	Julie Winship	18.01.21 Red pathway. Julie to assess today 19.01.21 Paperwork sent for general nursing on Red pathway 20.01.21 S/W sarah Beasley looking at brieton lodge awaiting assessment with the ward.
Mi			ool	14.12.20	33	No					29.11.20	Resolved			18.01.21 NMF 19.01.21 NMF 20.01.21NMF 21.01.21 NMF
Th			ool	25.12.21	32	No					Covid contact 28.12.21	Negative			18.01.21 NMF 19.01.21 nmf 20.01.21 NMF 21.01.21 NMF
He			ool	05.01.21	32	No						Negative	Discharged 21.01.21	Vicky Ward 523351	18.01.21 Red pathway when medically fit 19.01.21 placement being identified SW needs more info 20.01.21 TWOCD ?recatheristraised Willowdean to assess. 21.01.21 Discharge today to willowdean
Ke			ool	11.01.21	38	No	19.01.21	1	19.01.21		16.12.20	Resolved			19.01.21 for assessment bed TA to r/v NMF 20.01.21 NMF 21.01.21 NMF
Id			ool	09.01.21	38	Yes	19.01.21	1	19.01.21		09.01.21	Negative			19.01.21 sent for a POC 20.01.21 NMF 21.01.21 NMF
Ar			ool	09.01.21	26	Yes	19.01.21	1	21.01.21		07.01.21	Positive	Discahrged 21.01.21	Martin Mckenn	19.01.21 Awaiting paperwork for return to Queens Meadow 20.01.21 MF 21.01.21 Sarah Bone will speak to Martin Mckenna and let us know the plan.
Ir			ool	23.12.20	25	Yes	19.01.21	1	19.01.21				Discharged 21.01.21	Debbie Ord	19.01.21 For care package 20.01.21 LTOT 4l required for discharge care package starting 21.01 Jamie will lokk at holdforth at home
La			ool	01.01.21	28	Yes	19.01.21	1	19.01.21		20.1.21	Negative	?21.01.21	TA	19.01.21 TA assessment bed 20.01.21 Awaiting palcement Mattress/?bed rails seaton Hall 21.01.21. 21.01.21 For discharge to seaton hall today pending equipment Laura Ta liaisng Seaton hall not happy to take was a contact
Pa			ool	07.01.21	37	Yes	19.01.21	1	19.01.21				Discharged 21.01.21	TA	19.01.21 TA Assessment bed 20.01.21 Awaiting placement Ax1 no equipment . 21.01.21 For WVL today no equipment needed
El			ool	15.01.21	32	Yes	20.01.21	1			15.01.21	Negative			20.01.21 Awaiting paperwork 21.01.21 NMF
Ka			ool	18.01.21	33	Yes	20.01.21	1	20.01.21		19.01.21	Positive	?21.01.21		20.01.21 Increase care package 21.01.21 ISPA checking plan sophie waites looking at it
Ev			ool	13.01.21	42	Yes	21.01.21	1			14.01.21	Suspected			21.01.21 For return to Queens Meadow ward to send paperwork
Ei			ool	06.01.21	33	Yes	20.01.21	1			12.01.21	Positive			20.01.21 Awaiting paperwork for ax bed therapy were speaking to family. 21.01.21 NMF behavioural charts speak to family Look to ?1-1
Jo			ool	08.12.20	33	Yes	20.01.21	1	20.1.21		02.01.21	Resolved			20.01.21 For an Alice house bed non available at present SPC will review 21.01.21 No beds at hospice
Ch			ool	07.01.21	33	Yes	20.01.21	1			09.01.21	Positive		TA Designated Setting Wait	20.01.21 Awaiting paperwork assessment bed. 21.01.21 NMF
Ma			ool		27	Yes	20.01.21	1	20.01.21						20.01.21 Fast Track 21.01.21 EOLCP to stay in hospital
Ph			ool	30.012.20	41	Yes	20.01.21	1	20.01.21		04.01.21	Contact		TA	20.01.21 assessment bed 21.01.21 NMF
Ka			ool	15.01.21	32	Yes	20.01.21	1	20.01.21		15.01.21	Negative			20.01.21 care package 21.01.21 Sarah to check POC and will let us know
Mi			ool	24.10.30	37	Yes	21.01.21	1	21.01.21		20.01.21	Negative			21.01.21 Care package holdforth at home.
Ga			ool	14.12.21	27	No						Resolved			13.01.21 – NMF – from WVL but needing to look at alternative placement. – needing a look on red pathway for nursing oversight due to repeated admissions 17.01.21 IVABX NMF, needs bloods 18.01.21 NMF 19.01.21 NMF 20.01.20 Therapy rv Jessica redpathway jess to relook at then liaise with kirsty 21.1.21 NMF. 21.01.21 NMF

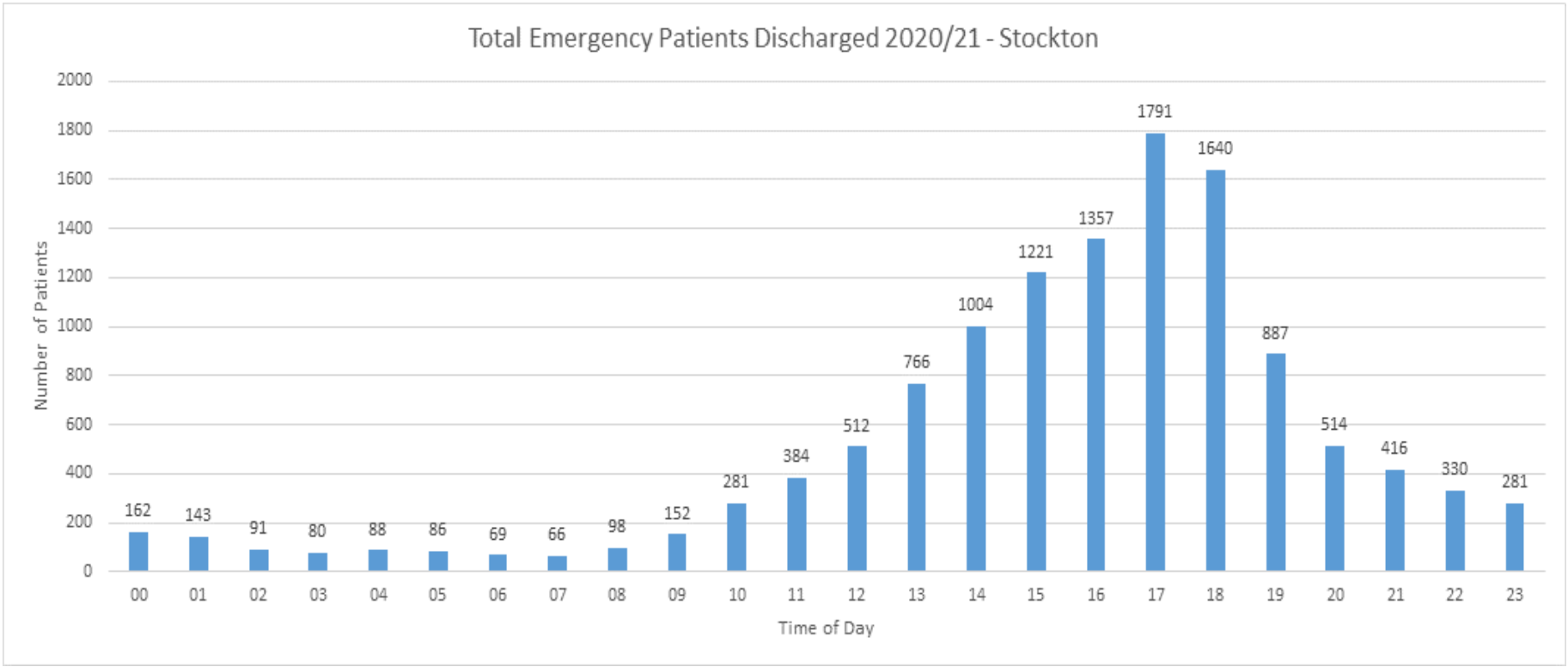
Phase 2 Line of enquiry - Data on the numbers of local residents discharged from local Trusts, including seasonal variances in terms of discharge pressures. Any examples of previous / current discharge delays / issues identified (e.g. Delayed Transfers of Care (DTOC))?



Timing of discharges for Patients on the elective pathway (April 20 – March 21)



Timing of discharges for Patients on the emergency pathway (April 20 – March 21)



Delayed Transfers of Care (DTOC) reporting stood down in March 2020 and replaced with daily discharge sitreps – yellow fin developments support access to live information

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Admissions - by method

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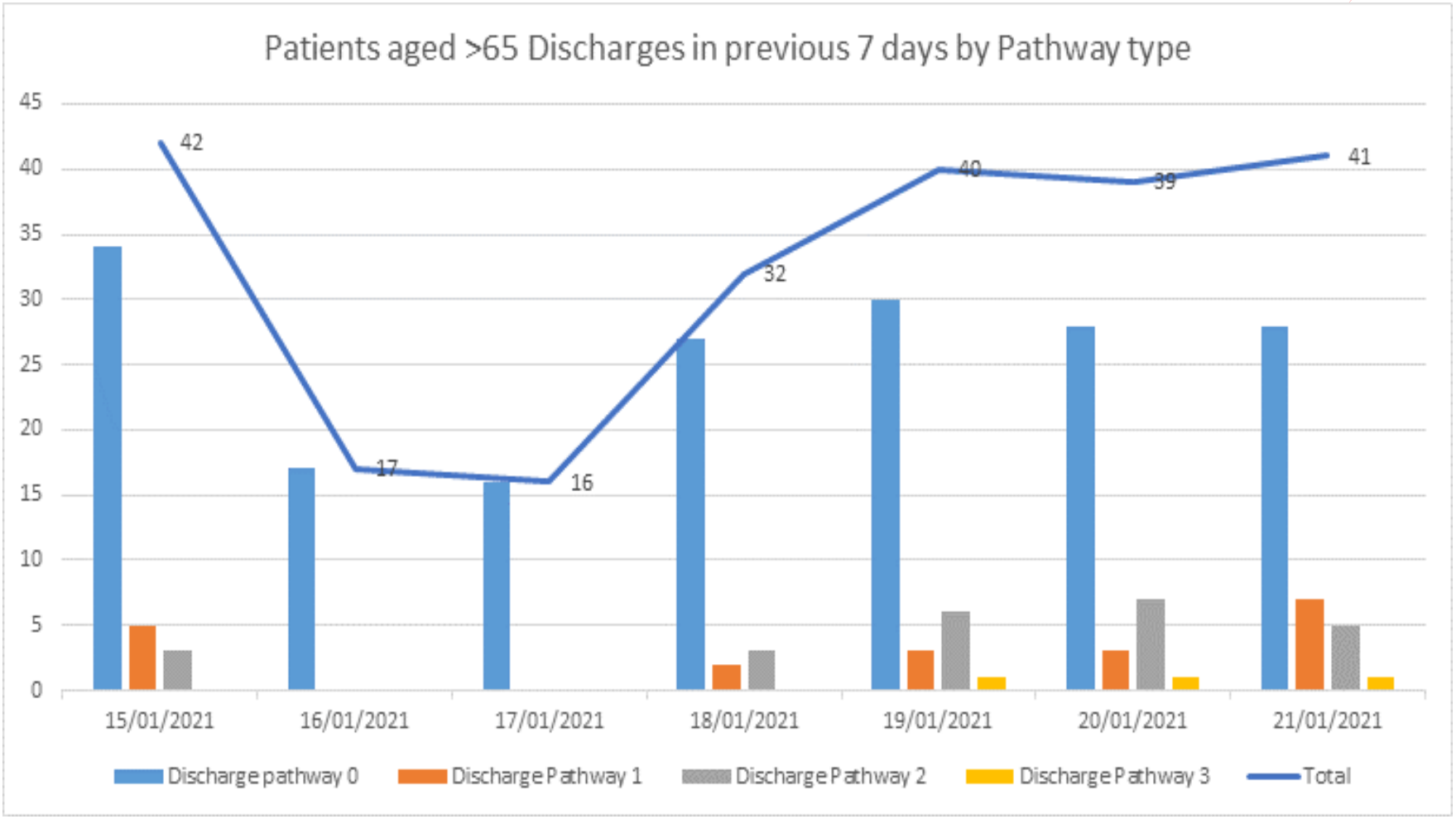
Ages 65 and over

Count CRN	AdmMethod									
FCEMonth	Consultant Domiciliary Visit	Emergency Other	Other - Paitients from another hospital	Planned/Elective - booked	Planned/Elective - Planned	Planned/Elective - waiting list	Via A&E	Via Bed Bureau	Via GP	Via Outpatients
Jan'21	1	115	0	84	248	68	266	39	76	4
Dec'20	0	338	1	218	726	216	651	94	240	19
Nov'20	0	392	1	232	782	263	619	70	204	9
Oct'20	0	376	3	250	872	342	667	72	244	19
Sep'20	2	317	0	221	771	342	635	99	245	21
Aug'20	0	318	4	201	680	128	573	88	246	11
Jul'20	0	318	0	243	640	110	591	127	244	15
Jun'20	0	390	3	138	599	87	515	98	185	16

Ages under 65

Count CRN	AdmMethod												
FCEMonth	Emergency Other	Maternity - Antepartum	Maternity - Postpartum	Other - Babies born in dist hpl	Other - Born on the way to hospital	Other - Paitients from another hospital	Planned/Elective - booked	Planned/Elective - Planned	Planned/Elective - waiting list	Via A&E	Via Bed Bureau	Via GP	Via Outpatients
Jan'21	192	139	1	72	0	1	132	195	143	211	57	207	14
Dec'20	465	362	8	209	0	4	413	586	344	589	103	522	37
Nov'20	480	348	14	216	0	7	462	720	393	517	96	537	40
Oct'20	483	355	6	194	0	11	470	761	456	601	101	566	25
Sep'20	442	359	11	227	1	6	356	656	489	577	90	493	42
Aug'20	453	378	7	189	1	9	324	505	216	512	98	467	18
Jul'20	477	334	10	216	1	10	372	539	228	493	100	535	22

Pathway analysis (snapshot from Jan 2021)



Phase 2 Line of enquiry - How are patients involved in the discharge process, and how are families / carers kept informed?

- Discharge planning starts on admission to Hospital – key part of the core assessment
- Home First Frailty Team covering Emergency Care areas 0800 – 2000
- Ward based multi disciplinary teams who will liase with families & carers to gather detailed social history
- John's Campaign
- Virtual visiting – telephone bookings for updates

From admission to discharge I was truly amazed how professional and caring all levels of staff were

The care provided from admission to discharge was absolutely first class, all the staff were really lovely

The Therapists helped me to get back home, which is where I wanted to be, I was so grateful!

The work to plan my discharge was exceptional

Comments from Friends & Family Test 2020

Phase 2 Line of enquiry - What information is given to people prior to discharge from hospital, and how can we be assured appropriate information is being provided (e.g. how to access Adult Social Care and other services)?

HM Government

NHS

Your hospital discharge: going home

The picture can't be displayed.

This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

If you need more care now than when you came into hospital, this additional care will be provided free of charge for up to six weeks to support your recovery. After this time, you may be required to contribute towards the cost of your care.

Who can I contact?

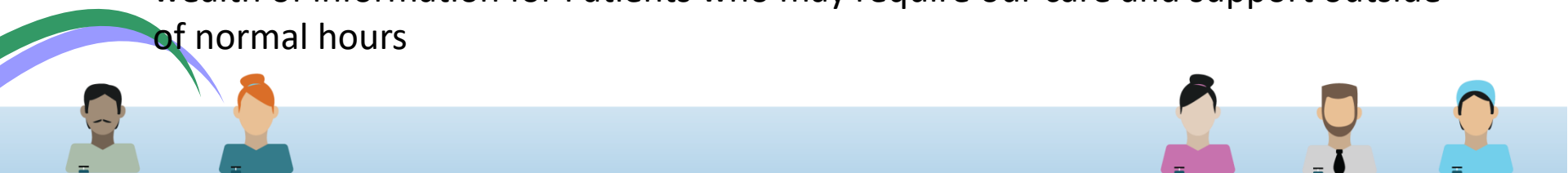
After you have been discharged, if you have any immediate concerns regarding your discharge, you can contact your discharging ward via switchboard on: **01642 617617**
For any ongoing queries regarding care and therapy in the community please contact:
Stockton ISPA:
Hartlepool ISPA:

www.nhs.uk

- Condition specific information is provided by the relevant speciality
- New leaflets distributed in March 2020 in response to the pandemic and the changes made to the guidance
- The leaflet includes contact details for the Hospital and the Health and social care teams in the ISPA
- QR Codes are being examined to streamline information and ensure it is up to date

Phase 2 Line of enquiry - Any differences in the experiences of those being discharged from hospital after a short-term or long-term stay in hospital, or at weekends / out-of-hours? Where are patients being discharged from (different areas of the hospital)? 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?

- Evidence tells us that extended hospital stays have a negative impact on an individuals physical and psychological well being
- In the last 12 months nearly all patients have been discharged directly from the clinical area. Covid placed restrictions on the transfer of patients between areas including the use of the transport lounge
- Communication with families and carers takes place upon admission as part of the core admission process
- Frailty Home First Service 7 days per week 0800 – 2000 - work across all admission areas, working closely with families to facilitate a safe discharge
- ISPA Clinical Triage was extended to provide a 24/7 Service and direct access to a wealth of information for Patients who may require our care and support outside of normal hours



Phase 2 Line of enquiry - Communications with GPs following a patients' discharge from hospital.

- Electronic discharge summaries
- Enhanced health in care homes – multidisciplinary & PCN meetings to facilitate the discharge of the most frail patients
- Virtual frailty ward – supported by the multidisciplinary team
- Care Coordinators in primary care – active role in social prescribing
- Quality Improvement Projects with GP Frailty Trainees – learning from each other
- Urgent 2 hour response – collaboration with Primary Care, North East Ambulance Service to deliver care closer to home and where appropriate avoid transfer to Hospital

Phase 2 Line of enquiry - Considerations around medication as part of the discharge process.

- Reconciliation starts on admission - How do our Patients normally manage their medication at home?
- Did they come in on a compliance aid, e.g. NOMAD, and if so have any changes been made to it while in hospital? Pharmacy contact their usual community pharmacy if there are on a compliance aid to confirm what was in it and the supplies already waiting to be picked up.
- Do Patient's have supplies of medication with them in hospital or at home? Are they still appropriate to be used?
- Is there any newly started medication or discontinued medication that we need to counsel the patient about?
- A minimum of 7 days medication (or an appropriate course length) is supplied on discharge from hospital

Phase 2 Line of enquiry - Feedback from people regarding their discharge – is this sought, what has been learnt?

Within the Trust we gather feedback from **compliments, complaints, patient stories**, **Local and National Surveys** and the **National Friends and Family Feedback** service

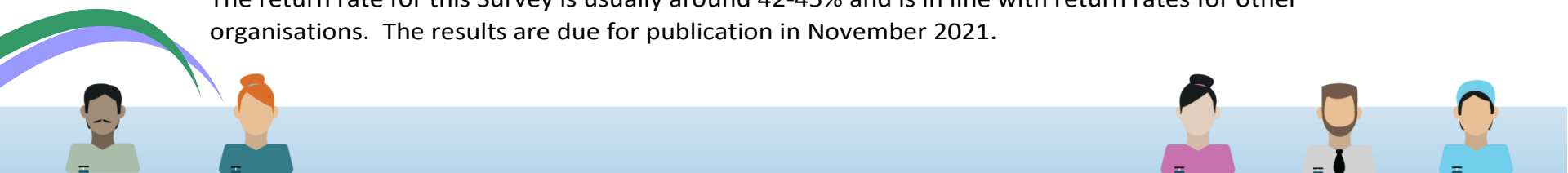
Monthly Transfer of Care group with representation from all Organisations including a Community Governor who brings the Patient's voice

Patient Surveys

National surveys were paused during the Covid-19 Pandemic therefore no patient feedback was gathered via this source for the majority of 2020 and early 2021. However, the National NHS Inpatient Survey has recommenced and is currently ongoing and includes 11 questions regarding 'Leaving Hospital', an example of the questions are below:

- To what extent did staff involve you in decisions about you leaving hospital?
- To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?
- Before you left hospital, did you know what would happen next with your care?
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?
- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

The return rate for this Survey is usually around 42-45% and is in line with return rates for other organisations. The results are due for publication in November 2021.



Friends & Family Test Feedback

North Tees and Hartlepool NHS Foundation Trust

From email received: Ward 33 June 20

I would like to give my sincere thanks to all work on Ward 33 from my recent stay at North Tis Hospital. Everyone made my stay pleasant And rewarding. The care package I received was excellent and I would like to commend all those who work on 33. for All the work on this ward.

Ward 40 Aug 20

Pt's daughter wanted to compliment OT on her great work for planning safe discharge for her dad. Daughter stated she was really good at making her feel at ease in the situation and put her mind at rest. Stated she went above and beyond to help and had a lovely attitude.

Ward 31 Aug 20

Patient who had been transferred to another ward from ward 31 came up to see R/N K.D. to say thank you for helping to sort out accommodation once he is discharged from hospital, as he was homeless prior to being admitted to hospital.

Ward 33 Sept 20

EH: STAFF THANKED FOR GOING ABOVE AND BEYOND TO SORT DISCHARGE MEDS OUT

Ward 38 Sept 20

Thanks for arranging discharge quickly as part of fast track. gave more time for their wife to spend at home with family

Ward 25 Oct 20

To all staff on ward 25 we would like to thank you for everything you have done for our mam. you have made her stay with you comfortable and did everything possible to ensure that she got the best care. doctors and nurses have gone above and beyond our expectations to ensure that her final weeks with us were comfortable and for ensuring that her family are ok. thank you

Phase 2 - In terms of the contribution around patient experience, the main thing we're trying to understand is around those people going home who do not need Social Care support – what role do the Trust's volunteers take; do they find people have the social / family support they need; what have they found in terms of homes being cold / no food in the house / etc.; what steps are taken if issues are discovered?

Home but not alone

- Helpforce pilot project 2018-20
- Evaluation & Impact in partnership with Health & Social Care Colleagues
- Impact of covid on volunteer
- Next Steps….

Phase 2 Line if enquiry - Assistance with transport back to their home – how is this provided; are services picking up any issues when patients are returned to their homes and how is this raised?

- Patient's own transport – where possible
- Volunteer Drivers
- Ambulance Provider – including provision for specialist transfers
- Discharge to assess – pilot project within Therapy Services to provide wheelchair accessible transport with multidisciplinary assessment within patient's own home
- Concerns raised via the Site Management team in and out of hours who can then sort advice and support from the multidisciplinary team and the Integrated Single Point of Access

Phase 2

North Tees and Hartlepool NHS Foundation Trust

Better Care Fund – is this being / can this be used to further strengthen discharge arrangements?

- On going work in collaboration with Partners from Stockton Borough Council and Tees Valley CCG – focus on discharge to assess
- Clinical Triage – integral to the development of the integrated single point of access
- Community matron support in Rosedale
- Future opportunities to continue to work together with Partners in the VCSE

Thank you for your time, over to Stockton Borough Council