APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
1	Where not already supplied (e.g. specialist teams), consideration be given to providing the name of a designated hospital staff member/s (i.e. those involved in the care of an individual whilst in hospital) for a former patient to contact rather than / in addition to a general ward number.	Discharge pathways have been further developed to include identified pathway leads who are on duty and contactable every day. Single contact number for the Discharge Team based on the North Tees site in situ, 7 days per week 0830 – 1700. Outside of these hours contact should be made via the ward. The discharge flow facilitators support the line and they provide telephone advice / updates to other members of the health and social care team or patients / family members or carers who are involved in the discharge process.	CQC Inpatient survey results – pending. Friends and family test. Incident / complaint analysis.	**NTFHT** Vicky Cardona Jill Foreman	
2	Existing arrangements around the identification of carers when they themselves are admitted to hospital for treatment, as well as options for post-discharge support until they can resume their caring role, be reviewed by all relevant partners to ensure a joined-up approach.	On every assessment completed by the Home First and Frailty team as soon as the patient arrives in the organisation it is established whether the patient is a carer themselves. This is discussed with the ISPA and is considered when arranging discharge. Information from local partners is also shared during the daily discharge meetings. Process of checking if the person holds a 'carers card' will also be completed. NTHFT staff are given access to SystemOne and are able to access background information to clarify existing arrangements where it is appropriate to do so.	All patients being admitted to hospital are asked if they are a carer or they have someone at home who needs support. Audit checks to be completed for assurances that measures to identify carers are being completed.	**NTHFT** Vicky Cardona Siobhan Smith Jill Foreman	

APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
		Build and maintain relations with SBC carers service. Senior Clinical Professional to arrange 'meet the team' session and gain access to relevant materials to promote the services available.	Regular meetings are held and resources are shared with relevant partners.	**SBC**	
3	Local NHS Trusts develop relationships with Eastern Ravens in order to strengthen the identification, inclusion and support of young carers in the discharge process.	Contact to be made with Easter Ravens – meeting to be arranged prior to 30th September to explore building relationships and next steps. Agreed actions and maintain relations to form part of discussion.	Recurrent meetings to take place between NTFHT and Eastern Ravens or Eastern Raven attend a relevant forum in which NTHFT are attendees. Evidence is provided that gives assurances young carers are identified and supported during hospital admission/discharge.	**NTHFT** Jill Foreman	Contact made 2nd Sep 2021 – awaiting return contact
4	Local NHS Trusts make clear to patients and their families / carers whether (and by when) they will receive a follow-up after being discharged, and, for those not requiring immediate health and / or care input, provide appropriate information on who to contact if any significant issues are identified on return home and / or for future post-discharge support (i.e. GP, Community Hub, VCSE links, etc.).	Patients are provided with a discharge leaflet as per the hospital discharge policy which provides details for ongoing support in the community via the ISPA. The ISPA and First contact teams are then able to support the patient if help is required at home utilising services across the voluntary and social enterprise sector (VCSE) and Community Hubs.	All patients discharged from hospital are provided with information on discharge, including key contacts.	**NTHFT** Vicky Cardona Care Group Managers	

APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
5	Local NHS Trusts / Healthwatch Stockton-on-Tees provide the Committee with any available discharge-specific feedback from patients / families / carers in relation to those discharged back to their own homes.	NTHFT will provide feedback from patients / families / carers about their discharge home to the Committee when it becomes available. Healthwatch Stockton-on-Tees to complete a post discharge audit for patients / families / carers who have direct experience with a hospital discharge to home address.	CQC Inpatient survey results. Friends and family results.  Friends & Family Test Feedback.pptx	**NTHFT** Vicky Cardona **Healthwatch**	Committee to specify
6	Local NHS Trusts ensure that the identification of any transport requirements enabling subsequent discharge is a key part of all initial and subsequent patient assessments, and, where necessary, is supported when an individual can be transferred out of hospital.	Discharge planning including access to discharge transport is part of the adult core admission assessment. Hospital discharge transport information has been updated to support utilisation of all forms of transport available to us to facilitate a safe and timely discharge. The transport scheduling role, to facilitate this work has been extended to cover 7 days. Patients, families and carers are provided with options for discharge transport, whether this be completed by themselves, the ERS Patient Transport service or volunteer drivers. The trust also utilises trust vehicles with therapy staff supporting patients who require	All patients identified for discharge are discharged home using the most suitable mode of transport within a suitable time period. Where possible, and not including emergency attendances, patients should be discharged home within daytime hours.	**NTHFT** Vicky Cardona	

APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
		wheelchair access and further therapy assessment within the home environment. The Trust also has an agreement with a local taxi service to support transport where appropriate.			
7	A future update on the NTHFT *Home But Not Alone* pilot (due to re-start in June 2021) and the Five Lamps *Home from Hospital* initiative be provided to the Committee, including feedback from those individuals the initiative has supported.	Our Home but not Alone pilot restarted on the 14th June with 5 volunteers covering our 5 pilot wards Mon- Fri. We are awaiting the start of a further three volunteers to build the team and the impact they make. This is a new opportunity for all but two of the volunteers, so they have spent their time visiting our pilot wards and developing their working relationships with the staff and ward based volunteers, whilst developing their own knowledge of the processes in place. The numbers of referrals are currently low. This is to be expected as we are concentrating more on testing/developing the processes we have in place than numbers. We have discussed this balancing act between a full promotional campaign across the Trust and the ability/knowledge of the existing/developing team to cope with the expected demand. We will review late Aug to explore expanding the support available to other wards taking into account the numbers of volunteers	Number of referrals into the scheme – qualitative feedback about the Service.	**NTHFT** Paul Wharton	

APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
		and their capacity to take on more. We are mindful to offer as much support as possible as we move into winter. Home from hospital: Please see attached updated impact report which covers an update on the second year of the Lottery funded Home from Hospital Lottery project  HFH 2020-2021 Report.pdf **Total Referrals to the Service** • **July 2020 – June 2021 = 140** Five Lamps Home from Hospital project has been operational since October 2017 (originally funded from Catalyst's Health Initiative 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). Five Lamps subsequently secured funding from The National Lottery Fund (Reaching Communities) and delivery of the project, re-commenced in July 2019. Funding has been secured for 3 years until June	Routine updates to continue. Positive performance metrics to continue. The value and impact on people who require this service continue to be demonstrated within future reports. Funding for this service to be made permanent in acknowledging positive performance.	**Five Lamps**	

APPENDIX 1

ACTION PLAN: Review of Hospital Discharge (Phase 2 – discharge to an individual's own home)

No.	Recommendation	Proposed Actions / Progress	Success Measures	Responsibility	Date
		2022. Without future funding, Five Lamps will not be in a position to continue delivery of this much needed service.			