PROGRESS UPDATE: Review of Hospital Discharge (Phase 2)

ADDITIONAL INFORMATION: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Recommendation 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.**
Responsibility:	NTHFT / STHFT / TEWV
Date:	
Agreed Action:	**TEWV**: Following discharge from hospital all patients and their carers are involved in a multidisciplinary discharge meeting whereby follow up plans are agreed with community / crisis services. Patents and carers also receive details of relevant teams / staff.
Agreed Success Measure:	**TEWV**: Feedback questionnaires to demonstrate positive response to access persons/services when needed.
Evidence of Progress (April 2022):	All patients now receive a copy of a safety plan which details who and which services to contact when I need support.
Assessment of Progress (April 2022): (include explanation if required)	• Safety Plan - 100% compliance for inpatient services • Friends and family questionnaires are sent to all patients on discharge
Evidence of Impact (April 2022):	Progress still to be made in relation to gathering direct patient feedback on their experience of services following discharge. Ward Clerks monitor all letters sent out and ensure follow up within 24hrs. Carer contact is monitored via daily report out and visual display board, contact with carers is agreed on admission and tasks are allocated on a daily basis.

Recommendation 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.**
Responsibility:	NTHFT / STHFT / TEWV / SBC
Date:	
Agreed Action:	**TEWV**: Using Purposeful and Productive Patient Approach (PIPPA) to identify caring roles, links with other agencies and develop supportive networks. Full implementation of Mental Health Leads working into the PCN's across Tees to form smooth links and information sharing and links to electronic systems. Contribute and support the enhanced care into care homes multi professional weekly MDT meetings of which TEWV have representation.

Agreed Success Measure:	**TEWV**: Identification of carers for people who access TEWV services. Shared with relevant family and/or professionals.
Evidence of Progress (April 2022):	A full comprehensive holistic assessment is carried out prior to all admissions into TEWV, if a person is identified to be in a carer role then safeguarding consideration is given in relation to any additional support for the person receiving care. This is in addition to discussing support needs with family.
Assessment of Progress (April 2022): (include explanation if required)	• Specific carer role introduced in older adult's mental health services to support carers • Mind have been commissioned to provide additional carers support within our adult mental health wards
Evidence of Impact (April 2022):	Ongoing evaluation

Recommendation 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.**
Responsibility:	NTHFT / STHFT / TEWV
Date:	
Agreed Action:	**TEWV**: Contact made with Eastern Ravens, awareness sessions with the above and community teams and inpatients services to understand the role and referral process and to build relationships. All relevant people emailed to agree date and times for awareness and to visit Eastern Ravens for better understanding.
Agreed Success Measure:	**TEWV**: Increased awareness and referral into the Eastern Ravens service. Audit young carers linked to TEWV and offer made / accepted. Ensure inclusion of young carers information / access in assessment.
Evidence of Progress (April 2022):	Service have contacted Eastern Ravens link (Simon) who has kindly offered to attend local team meetings to discuss their services and support on offer.
Assessment of Progress (April 2022): (include explanation if required)	Information on the service has been shared with clinical leads (Matrons) alongside the offer for further discussions at team meetings.
Evidence of Impact (April 2022):	

Recommendation 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.).**
Responsibility:	NTHFT / STHFT / TEWV

Date:	
Agreed Action:	**TEWV**: Patients will have updated safety summaries, care plans and contact names and numbers provided on discharge, follow up is provided within a 72-hour period and there is 24-hour support available as a wrap around contingency. If ongoing community support identified this starts before discharge to allow a seamless transition into the community and is discussed at admission and through the pathway based on need.
Agreed Success Measure:	**TEWV**: Discharge audit to evidence all persons received information and contact lists.
Evidence of Progress (April 2022):	All patients on discharge receive a 72hr follow up which assesses progress following discharge and identifies any additional support needs.
Assessment of Progress (April 2022): (include explanation if required)	• 72hr follow up rate – 97% (31 out of 32 March 2022). Outlier was still followed up but the follow up fell outside of the 72hr target. • Discharge letter and agreed plan is also sent to GP within 24hrs of discharge
Evidence of Impact (April 2022):	Progress still to be made in relation to gathering direct patient feedback on their experience of services following discharge.

Recommendation 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.**
Responsibility:	NTHFT / STHFT / TEWV / Healthwatch Stockton-on-Tees
Date:	
Agreed Action:	**TEWV**: TEWV utilise the friends and family questionnaire, we review complaints through a Head of Service review process to ensure we understand the root cause of the complaint and to ensure lessons are learned and improvements made and are feedback. Using Purposeful and Productive Patient Approach (PIPPA) to identify caring roles, links with other agencies and develop supportive networks. Full implementation of Mental Health Leads working into the PCN's across Tees to form smooth links and information sharing and links to electronic systems. Contribute and support the enhanced care into care homes multi professional weekly MDT meetings of which TEWV have representation.
Agreed Success Measure:	**TEWV**: Friends and family survey results. Review and engagement in the complaints process and Head of Service reviews. Involvement of friends / family / carers in discussions and meeting before during and on discharge planning with the patient if agreed with all parties. Identification of carers for people who access TEWV services. Shared with relevant family and / or professionals.
Evidence of Progress (April 2022):	• No complaints or issues raised directly related to discharge home • No concerns raised on our patient experience survey results • All patients receive a discharge planning meeting where relevant care team (including community representatives) and carers / family are invited

	• If concerns around discharge have been identified, then leave is considered as an alternative to discharge. We are also able to offer intensive home treatment support during leave or discharge as additional support
Assessment of Progress (April 2022): (include explanation if required)	
Evidence of Impact (April 2022):	

Recommendation 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.**
Responsibility:	NTHFT / STHFT / TEWV
Date:	
Agreed Action:	**TEWV**: Similar model to NTHFT and STHFT in relation to patient transport. We have local agreements with local taxi providers as well as having access to private ambulances in addition to PTS. Transport arrangement are considered as part of the discharge process.
Agreed Success Measure:	**TEWV**: Not specified.
Evidence of Progress (April 2022):	Access and transport arrangements are in place
Assessment of Progress (April 2022): (include explanation if required)	No further action identified
Evidence of Impact (April 2022):	No issues raised by TEWV patients or carers

Assessment of Progress Gradings:	**1** Fully Achieved	**2** On-Track	**3** Slipped	**4** Not Achieved