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PROGRESS UPDATE: Review of Hospital Discharge (Phase 2)

SCRUTINY MONITORING – PROGRESS UPDATE	
Review:	**Hospital Discharge (Phase 2)** (discharge to an individual's own home)
Link Officer/s:	**Emma Champley / Gavin Swankie**
Action Plan Agreed:	**January 2022**

Updates on the progress of actions in relation to agreed recommendations from previous scrutiny reviews are required approximately 12 months after the relevant Select Committee has agreed the Action Plan. Progress updates must be detailed, evidencing what has taken place regarding each recommendation – a grade assessing progress should then be given (see end of document for grading explanation). Any evidence on the impact of the actions undertaken should also be recorded for each recommendation.

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:	**NTHFT**: 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.
Agreed Success Measure:	**NTHFT**: CQC Inpatient survey results – pending. Friends and family test. Incident / complaint analysis.
Evidence of Progress (April 2022):	Dedicated contact number for the Integrated Discharge Team has been available on a permanent basis in hours 08.30-17.00, 7 days per week. This has been made possible by further investment in the workforce to support discharge planning. Contact information shared with domiciliary care providers via the Stockton Provider Forums.
Assessment of Progress (April 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (April 2022):	Monitoring friends and family results on an ongoing basis for any themes. Positive feedback from Provider Forum and further contact made with team members.

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Agreed Action:	**STHFT**: Patient discharge leaflets were distributed to wards for them to add their contact details along with the SPA phone number for the patient's to make contact post discharge. The review of this will be picked up by the STHFT governance and operational management arrangements.
Agreed Success Measure:	**STHFT**: Inpatient survey results and discharge feedback showing positive responses to people being able to contact the ward/person post discharge. Governance and audits completed showing leaflets are being distributed with appropriate contact details.
Evidence of Progress (April 2022):	Leaflets have been revised and redistributed. People are given the ward and individual contact details as appropriate. Some patients are receiving a call post-discharge as part of a pilot to support people with any queries. In addition, the Trust has developed its Transfer of Care Hub with Discharge Facilitators, Patient Flow Co-ordinators, Administrators, Social Workers, Trusted Assessors working together to support wards. Community staff and therapists work closely with the hub team.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Internal audits on discharge processes are being developed. Checking that patient leaflets have been given is part of this audit process. We have been engaging with our Patient Experience Sub-Group to seek their feedback on discharge processes and a review of any discharge-related feedback will take place.
Evidence of Progress (October 2022):	Discharge leaflets are part of the standard ward processes and can be re-ordered by wards as required. Follow up calls are routinely made by the Transfer of Care hub to check all is well with the patients post discharge and is collated to track trends and themes for improvement.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Discharge leaflets are now standard ward-based documents, and themes and issues are tracked via the Transfer of Care hub calls
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	• Safety Plan - 100% compliance for inpatient services

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(April 2022): (include explanation if required)	• 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.
Evidence of Progress (October 2022):	Patient satisfaction questionnaires are completed upon discharge both with patients and carers. This is implemented and monitored weekly by services. There is a monthly audit schedule for both quality and compliance of the safety plan work which will continue to be monitored by services.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)** Agreed success measures in place and will continue to monitor by services
Evidence of Impact (October 2022):	Internal audits completed monthly and provided through governance structure as part of Matron Quality Report.

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:	**NTHFT**: 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.
Agreed Success Measure:	**NTHFT**: 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.
Evidence of Progress (April 2022):	We are in the process of switching to electronic patient records (EPR) using our electronic system *Trak care.* The Senior Clinical Professionals who support hospital discharge and the Home First team are involved in the switch across to EPR and will represent the views of the Committee in the design of the new admission and discharge documentation. Target date for go live for EPR is yet to be confirmed.

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	We have extended access to the integrated single point of access (ISPA) - this is now 24/7 and the team are working with the admission areas including the Emergency Department. This means that the team have access to clinical triage staff who can provide more information to support decision-making. Meeting with Jon Carling from Catalyst, in the diary to refresh connections with Carer forums in Stockton. Strong relationships and regular meetings with Partners to share relevant resources and materials. Working copy of adult core admission document. adult admission document 21.docx
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Positive feedback from areas including the role of the Stroke Association who work with our Stroke teams to support patients, families and carers.
Evidence of Progress (October 2022):	We have daily meetings with locality ISPA to discuss all patients being discharged from hospital, whereby discussions of identifying carers are conducted. The admission document has been reviewed in preparation for transfer to the electronic patient record to include asking if a patient has a carer role to someone. This will be completed upon every admission. HCR430.2 - Nursing Admission Document A research project is underway in partnership with Northumbria University to explore carers and carer organisation views of Hospital discharge. This information will then be used to generate a 'tool kit' of resources that are shared with patients, their families and carers about hospital discharge. SBC Carer engagement Lead to sit on NTHFT Transfers of Care forum.
Assessment of Progress (October 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (October 2022):	Documentation audits / feedback from carers forum.

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Agreed Action:	**STHFT**: Work has started with Carers Together to improve the identification of carers on admission. The organisations details have been added to the patient discharge leaflet. Raising awareness of the Carers Together support within the organisation including the potential to co-locate the staff with discharge team.
Agreed Success Measure:	**STHFT**: Increase in referrals to Carers Together. Reduction in readmissions. Reduction in complaints.
Evidence of Progress (April 2022):	The Carers Together information has been added to the leaflet as planned and included in the discharge policy. The team is attending a workshop with the Transfer of Care Hub team (discharge facilitators and social workers) and therapy team to brief on what they can provide and the importance of identifying carers early in the patient's admission. Social workers will support carers and link with other agencies. We will continue to liaise with Carers Together around referral rates and outcomes.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Early indications are that there has been an increase in people contacting Carers Together. In addition, the resumption of limited visiting as part of COVID-19 de-escalation provides additional support for patients and carers.
Evidence of Progress (October 2022):	Transfer of Care hub have attended training in relation to social care, the Care act and the legislative requirements to support carers. Carers Together and Social work link in with the ToC hub to support carers and the needs of the person they care for.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Monitoring responses from the carers survey, and enhanced awareness within the hospital teams.
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.

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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.
Evidence of Progress (October 2022):	As above a full comprehensive assessment is completed upon admissions where a carer would be identified. MIND attend the service once per week and the service would refer any identified carers into MIND for support. Carer's training has also been delivered to staff across the service and they will provide this to any new starters. Carer leads have been identified on each of the wards across the site to take a lead and be a point of contact. Each ward has an updated triangle of carer assessment, and we have a monthly carer meeting that has recently just been relaunched in the service.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)** All agreed success measures are in place and will continue to monitor.
Evidence of Impact (October 2022):	Monthly carers meetings in place and will continue to review through governance structure as part of the Matron Quality Review.
Agreed Action:	**SBC**: 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.
Agreed Success Measure:	**SBC**: Regular meetings are held and resources are shared with relevant partners.
Evidence of Progress (April 2022):	Carers service spent 2 weeks at UHNT in the IDT and based on the wards to promote the service and build relations with staff and patients. Staff attended wards, attended huddles, spoke to staff and accessed some of the day units. Several referrals picked up as part of this work. Initial discussions following this about the possibility of an area near the main concourse where carers service could set-up once-a-week to be available for carers (including those carers also employed by NTHFT) to come and speak with an advisor and also enable us to pick-up footfall and raise awareness Discussion of the possibility of an honorary contracts to carers team to enable them to access wards and speak to carers during visiting times.
Assessment of Progress (April 2022): (include explanation if required)	**3 (Slipped)** Pandemic halted this piece of work, however, is due to recommence in the coming weeks / months.
Evidence of Impact (April 2022):	Heightened awareness of service, further collaboration and sharing of good practice.

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	Staff were very receptive and eager for information and felt they would be able to refer many carers.
Evidence of Progress (October 2022):	SBC carer's service and representatives of SBC carer's service sit on several meetings. Supporting collaboration and discussions that take place across health and social care for carers. Posters of the carer's service are shared with partner organisations and displayed in respective establishments. Quarterly resource packs are shared with GPs', University of North Tees Hospital and Chemist's. Carer's service attend promotion events and distribute resources to health settings. Bulletin email updates are sent to individuals with key networks and reach in health settings to support raised awareness amongst workforce within the University Hospital of North Tees.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Raised awareness of carers in multiple health settings including hospitals. Fingertip access to information and advice to the workforce providing care and support to carers. Embedded practice of information sharing and collaboration, continuing to raise profile of identifying and supporting carers.

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:	**NTHFT**: Contact to be made with Eastern 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.
Agreed Success Measure:	**NTHFT**: Recurrent meetings to take place between NTFHT and Eastern Ravens or Eastern Ravens 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.
Evidence of Progress (April 2022):	First meeting took place in September 2021 and actions to take away included sharing resources and Trust staff visiting Eastern Ravens to share and discuss good practice.

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	Covid prevented site visits, further contact has been made with Eastern Ravens and a meeting set up in April 2022.
Assessment of Progress (April 2022): (include explanation if required)	**3 (Slipped)**
Evidence of Impact (April 2022):	Heightened awareness of service, further collaboration and sharing of good practice.
Evidence of Progress (October 2022):	Meetings in April unable to go ahead due to covid. Rearranged meetings in diary for October 2022
Assessment of Progress (October 2022): (include explanation if required)	**3 (Slipped)**
Evidence of Impact (October 2022):	N/A
Agreed Action:	**STHFT**: Contact with carers services and establish future working relations of STHFT and Younger carers service.
Agreed Success Measure:	**STHFT**: Working relations with young carers are agreed and maintained to form business as usual.
Evidence of Progress (April 2022):	The Carers Together information has been added to the leaflet as planned and included in the discharge policy. The team is attending a workshop with the Transfer of Care Hub team (discharge facilitators and social workers) and therapy team to brief on what they can provide and the importance of identifying carers early in the patient's admission. Social workers will support carers and link with other agencies. We will continue to liaise with Carers Together around referral rates and outcomes.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Early indications are that there has been an increase in people contacting Carers Together.
Evidence of Progress (October 2022):	Carers Together embedded into hospital process and liaising with Social workers around their local services to support local services.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Monitoring responses from the carers survey, and enhanced awareness within the hospital teams.

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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):	
Evidence of Progress (October 2022):	Eastern Ravens have attended leadership meetings to educate and promote their service for those it is applicable to.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Awareness of Eastern Ravens within the service.

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:	**NTHFT**: 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.
Agreed Success Measure:	**NTHFT**: All patients discharged from hospital are provided with information on discharge, including key contacts.
Evidence of Progress (April 2022):	Hospital discharge policy to be reviewed as per new national guidance. Hospital discharge leaflets to be reviewed as per updated policy.

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Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	NTHFT discharge policy available.
Evidence of Progress (October 2022):	Discharge Policy has been updated. Discharge leaflets require review following updated discharge policy and feedback from research project.
Assessment of Progress (October 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (October 2022):	Annual compliance audit to commence 2023.
Agreed Action:	**STHFT**: The SPA and community services are able to support patients and their families / carers. The Trust is working with the VCS to facilitate signposting to existing services through its SPA. The patient leaflet has been updated to include a section for the patient to capture follow appointments and who to contact post discharge.
Agreed Success Measure:	**STHFT**: Reduction in readmissions. Reduction in complaints.
Evidence of Progress (April 2022):	A pilot scheme has been launched on several wards to follow-up people post-discharge to check if there is any additional support (alongside that already available) they require. We have mapped current VCS services and are currently exploring the ability for the SPA to be able to signpost people to VCS and Local Authority services in addition to signposting that is already in place. The SPA MDT team currently signpost people to existing services. The patient leaflet and checklist have been distributed and the leaflet includes a section for people to add contact details and any future appointment details. Any feedback will be reviewed within the discharge project board. A dashboard is currently being developed to show trends overtime for discharge specific data.  ST0217 Your Hospital Discharge pc  ST0656 Your Hospital Discharge DL  ST1864 Hospital Discharge Informatior
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Readmission rates remain below 2019/20 rates.

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	Discharge-related feedback is being summarised as part of a newly developed dashboard that will be reviewed at the Discharge Project Board.
Evidence of Progress (October 2022):	Discharge leaflet, and follow up calls are embedded into processes, monitoring and dealing with issues as they arise. A discharge survey is now in place for patients to complete.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Discharge leaflets are now standard ward-based documents, and themes and issues are tracked via the Transfer of Care hub calls.
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.
Evidence of Progress (October 2022):	As above, all patients have a multi professional discharge meeting prior to plan discharge which will include any services that will be supporting them upon discharge, key contacts are also identified as part of the safety plan. All patients discharged from service are provided with a 72 hour follow up to monitor their progress following from discharge and the date and time of this is provided to patients. This is a performance metric that is monitored and although at times fall outside the 72 hour timescale, there have been no genuine breaches to report.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)** Agreed success measures in place and will continue to monitor as a service.
Evidence of Impact (October 2022):	Process in place for receiving feedback on discharge from patients. Audit schedule/monitoring in place to review performance in relation to safety plans, discharge letters and 72 hour follow up.

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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:	**NTHFT**: NTHFT will provide feedback from patients / families / carers about their discharge home to the Committee when it becomes available.
Agreed Success Measure:	**NTHFT**: CQC Inpatient survey results. Friends and family results.  Friends & Family Test Feedback.pptx
Evidence of Progress (April 2022):	Ongoing analysis on a quarterly basis via Transfers of Care Forum includes representative from the Hospital User Group (HUG).
Assessment of Progress (April 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (April 2022):	 CQC Survey results.docx
Agreed Action:	**STHFT**: Feedback utilised to inform improvements.
Agreed Success Measure:	**STHFT**: CQC inpatient survey results.
Evidence of Progress (April 2022):	Since January 2022, the Trust has been providing a Home First Service that provides care at home for up to 5 days post-discharge while the individual is assessed and any ongoing care is arranged. There has been positive feedback from patients about this service. Following patient feedback, the Trust is promoting requests for medications for discharge the day before discharge.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	In January 2022, the Trust was ranked 'consistently better than expected' for medical inpatient care in the 2020 CQC Adult Inpatient Survey. In addition, we have been reviewing trends from any discharge-related feedback. This information is discussed in the discharge project board. Any themes are discussed and actions agreed. 2020 CQC Adult Inpatient Survey.

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Evidence of Progress (October 2022):	Follow up calls for patients on pathways 1-3 are initiated and collated by the Trust. This allows for trends and issues to be highlighted and acted upon appropriately.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Internal capture of information and acting on trends and themes is embedded into process.
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):	
Evidence of Progress (October 2022):	As above, no concerns or complaints raised as part of patient feedback questionnaires. Any concerns with regards to discharge will be picked up and discussed during a patients comprehensive discharge meetings which family and carers attend.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**

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Evidence of Impact (October 2022):	Patient satisfaction feedback.
Agreed Action:	**Healthwatch Stockton-on-Tees**: 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.
Agreed Success Measure:	**Healthwatch Stockton-on-Tees**: Not specified.
Evidence of Progress (April 2022):	Appropriate public and patient feedback (and more targeted engagement with specific groups of people) in relation to the discharge process is communicated to all relevant responsible bodies/service providers, through regular attendance at the SBC ASCH meetings, other local partnership service meetings, and by presentation of Healthwatch Stockton-on-Tees (HWS) reports (based on public and patient feedback). Based on public feedback and local intelligence, HWS have no additional information to feedback in relation to discharge at this time.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Discharge information reported to Healthwatch is made available to partner organisations to support future learning.
Evidence of Progress (October 2022):	Feedback data and intelligence is shared with the committee on an annual basis or when requested. Healthwatch is both proactive and responsive in sharing information and intelligence on hospital discharge.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Committee is sighted on all information Healthwatch holds on hospital discharges.

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:	**NTHFT**: 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.

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	Patients, families and carers are provided with options for discharge transport, whether this be completed by themselves, the ERS / NEAS (STHFT only) / Direct Medical (STHFT only) Patient Transport service or volunteer drivers. The Trust also utilises trust vehicles with therapy staff supporting patients who require 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.
Agreed Success Measure:	**NTHFT**: 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.
Evidence of Progress (April 2022):	Approximately 55% of all discharges are discharged by 5pm, inclusive of consideration of care home cut-off times.
Assessment of Progress (April 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (April 2022):	Monitored through national criteria to reside sitreps.
Agreed Action:	**STHFT**: As per NTHFT above.
Agreed Success Measure:	**STHFT**: As per NTHFT above.
Evidence of Progress (April 2022):	Transport services are arranged through the discharge lounge team. We are encouraging transport to be booked before the day of discharge. The patient and staff checklist prompts the booking of transport as part of the discharge planning. Checklist for the booking of transport in place as part of discharge planning.
Assessment of Progress (April 2022): (include explanation if required)	
Evidence of Impact (April 2022):	Regular auditing to take place around early booking of transport.
Evidence of Progress (October 2022):	Discharge Planning education is now embedded within the Transfer of Care Hub. A dedicated member of the team is visiting wards, providing education on discharge planning and this includes planning for transport. The Discharge lounge and Bed Bureau have a number of crews available from ERS and Direct Medical providers to assist in the discharge of patients to their home or place of residence. This is factored in by the wards for patients discharging.

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Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Internal capture of PTS jobs on a daily basis, along with daily transport logs by each individual provider.
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 arrangements 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.
Evidence of Progress (October 2022):	No further actions identified as above.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	As above – no issues raised by TEWV patients or carers.

Recommendation 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.**
Responsibility:	NTHFT / STHFT / Five Lamps
Date:	
Agreed Action:	**NTHFT**: 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

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	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 and their capacity to take on more. We are mindful to offer as much support as possible as we move into winter.
Agreed Success Measure:	**NTHFT**: Number of referrals into the scheme – qualitative feedback about the Service.
Evidence of Progress (April 2022):	We currently have 6 volunteers involved directly with our 'Home but not Alone' project. Recruitment hasn't developed as much as we'd liked. Some volunteers have moved to other duties or left the Trust. Covid-19 has continued to have an impact. We are currently waiting for 2 applicants to complete their application and join the team. The existing team is working well together, supporting each other, the patients referred to them and the staff within our pilot wards. The internal processes have been tested and are working well. The team have built a good network of contacts with the wider volunteer group who refer to the programme as appropriate. Further updates. NTHFT have met with MiND, HASH and Five Lamps to develop effective working relationships with their social prescriber/befriending teams. This will develop the internal to external processes, making it easier to offer extra support and enhance the offer made by the Home but not Alone service. Representatives of each of these organisations will be invited to present at the next Volunteer Seminars, where all volunteers across the Trust will learn about the 'Home but not Alone' initiative and the support offered by these organisations. This should have a further positive impact on the referral numbers, whilst broadening the role of more volunteers helping and supporting more patients. The numbers of referrals have grown since June 2021. To date we have had 66 formal referrals and a further 12 other requests for support that did not require support from the volunteers. 37 of those referrals have been made since 1st Jan 2022. From those referrals, 17 food parcels have been issued, volunteer drivers have transported 15 patients' home and we have supplied 5 patients with suitable clothing. Taking into consideration that most of our pilot areas have had some period of isolation/closure to volunteers since June 21, I feel that these numbers are heading in the right direction. The growth over the last three months is particularly encouraging.
Assessment of Progress (April 2022):	**1 (Fully Achieved)**

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(include explanation if required)	
Evidence of Impact (April 2022):	We have collected feedback from those patients who were happy to offer some. Comments include the following: '*Calls make me feel that somebody cares, I have not been forgotten'.* *'Appreciate the chance to talk to someone and getting the food parcel'.* *'Everything has been brilliant, you have provided fantastic support'.* *'I feel reassured that someone has taken an interest in me'*. Of a sample checked, 25% (17 records) of those who supplied feedback said that they were either 'likely' or 'extremely likely' to recommend the service. Further review and analysis will be completed in June 2022 (12 months after the restart).
Agreed Action:	**STHFT**: The Trust is working with the LAs and VCS organisations to develop a signposting and post discharge service. The organisation is building on the Home from Hospital service that North Yorkshire have in place. A baseline exercise has been undertaken with the VCS organisations across Middlesbrough and Redcar & Cleveland to support people post discharge. The Trust is also exploring the utilisation of therapeutic volunteers in its community hospitals and how this model can be adapted for support in the home. The Trust is recruiting to a support service which will also contribute to the Same Day Emergency Care (SDEC) service to avoid admission or expedite discharge.
Agreed Success Measure:	**STHFT**: Reduction in readmissions.
Evidence of Progress (April 2022):	The Trust and CCG have mapped current VCS services and are currently exploring the ability for the SPA to be able to signpost people to VCS and Local Authority services in addition to signposting that is already in place. The SPA MDT team currently signpost people to existing services. Since January 2021, the Trust has been providing a Home First Service that provides care at home for up to 5 days post discharge while the individual is assessed and any ongoing care is arranged. There has been positive feedback from patients about this service.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Readmission rates remain below 2019/20 rates. Discharge-related feedback is being summarised as part of a newly developed dashboard that will be reviewed at the Discharge Project Board.

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Evidence of Progress (October 2022):	Home First service is embedded into the Transfer of Care routines, and is the default option for patients who are due for discharge who may need further short term support.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (October 2022):	Reduction in the number of patients who are medically fit for discharge and do not meet the criteria to reside. Our Trust target is 90 and we are currently consistently sitting between 70 and 80 patients not meeting the criteria to reside.
Agreed Action:	**Five Lamps**: 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 2022. Without future funding, Five Lamps will not be in a position to continue delivery of this much needed service.
Agreed Success Measure:	**Five Lamps**: 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.
Evidence of Progress (April 2022):	• Care planner, used to record notes of visits and updates of service users. • Annual impact report completed by HFH Manager for yearly update, performance, targets, feedback, and stories of service users, working partnerships and staff. • Succeeding past referral annual targets every year. • Postcode and NHS numbers collated in data. • Feedback questionnaires- prove positive performance and impact. • Good news stories - prove positive performance / impact on service users.
Assessment of Progress (April 2022): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (April 2022):	Proof of evidence, which shows positive impact upon service users. • Recorded and planned visits through calendar.

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	• Care Planner. • Excel Monitoring spreadsheet to collate data for number of referrals a month, along with where they referred from, to and how long supported. • KPI's collated for month-to-month referral numbers and signposting. • Feedback questionnaires and good news stories. • Annual Report. • Supporting information. HFH Discharge Update.docx
Update (October 2022):	Five Lamps Update Report.docx

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