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Stockton-on-Tees
BOROUGH COUNCIL

Big plans, bright future

Adult Social Care and Health Select Committee

Scrutiny Review of Hospital Discharge (Phase 2)

(Discharge to an individual's own home)

Final Report
June 2021

Adult Social Care and Health Select Committee
Stockton-on-Tees Borough Council
Municipal Buildings
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Foreword

On behalf of the Adult Social Care and Health Select Committee, we are pleased to present the final report and recommendations following the second phase of our review of Hospital Discharge.

Following completion of the first phase which focused on discharge to care homes during the COVID-19 pandemic, the Committee was able to resume its original investigation into discharge back to an individual's own home (not care homes), a piece of work which began at the start of 2020. Facilitating safe, timely and sustainable discharges is in the interests of both patient and NHS Trust, and due attention is required for not only discharge planning and the transfer itself, but for potential post-discharge support.

Whilst the review principally provided an opportunity to check that current discharge arrangements were robust and determine whether any aspects could be strengthened, an added feature was around the way in which carers (including young carers) were identified when either requiring treatment themselves or supporting someone who was admitted to hospital. The Committee has long recognised the importance of input from families and carers, and exploring how they were involved in the discharge process was a key aim.

In thanking all who were involved in this review, it is important to remember that the Council and its health and care partners prepared and delivered their contributions in the midst of ongoing challenges presented by the pandemic. The local NHS Trusts in particular deserve special mention for their time and input as they grappled with the early-2021 escalation in COVID-19 cases, and the Committee continues to be grateful for their visibility and openness. This spirit of co-operation, often evident in the joint-working between partners around the discharge process, will be even more important as we eventually emerge into a post-pandemic world.

Cllr Evaline Cunningham
Chair
Adult Social Care and Health
Select Committee

Cllr Clare Gamble
Vice-Chair
Adult Social Care and Health
Select Committee

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Original Brief

Which of our strategic corporate objectives does this topic address?

The review will contribute to the following Council Plan 2019-2022 key objectives:

- Protect the vulnerable
    - protecting people who are subject to or at risk of harm
    - assisting people whose circumstances make them vulnerable
- Help people to be healthier
    - providing mainstream services that are available when needed
    - providing preventive services that are available when needed

What are the main issues and overall aim of this review?

Problems around hospital discharge have been well documented at a national level, particularly around 'winter' pressures and general bed availability. Efforts have been made to improve local discharge arrangements, including the introduction of the Integrated Discharge Team comprising input from both the North Tees and Hartlepool NHS Foundation Trust and Local Authorities.

The NHS provides broad guidance around hospital discharge and each hospital has its own discharge policy. There is a good track record of current local practice providing timely and appropriate discharge of patients, though some concerns have been raised around isolated cases of elderly family and residents being discharged from hospital without the appropriate support and care. This review provides an opportunity to check that current discharge arrangements are robust and whether any aspects could be strengthened.

A further related issue that has been highlighted involves circumstances where a person's main carer goes into hospital and there is a need to ensure that the person left at home has the support they need. When their carer is discharged and may not be well enough to take care of them properly, it is vital that the Council's Adult Social Care service is aware of the situation and can put any necessary safeguards in place.

With a focus on those discharged back to their own home (not care homes), this review aims to:

- Examine the discharge process from local hospitals who provide treatment for the Borough's adult residents, and the wider communication with relevant partner organisations.
- Ascertain the key issues around discharge from both a Trust and patient perspective to ensure a safe and sustained return home following hospital input.
- Explore how carers are identified when needing hospital treatment and the measures required for ensuring the people they care for are supported during their stay in hospital (and potentially for a time following their discharge).
- Determine if any improvements can be made to current policies and procedures.

The Committee will undertake the following key lines of enquiry:

Phase 2

- Current discharge policy and how this has developed over time, including examples of best practice guidance.
- Current communications arrangements in relation to hospital discharge within local Trusts, and between the Trusts and SBC Adult Social Care.

- 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))?
- How are patients involved in the discharge process, and how are families / carers kept informed?
- 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)?
- 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?
- 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?
- Communications with GPs following a patients' discharge from hospital.
- Considerations around medication as part of the discharge process.
- Feedback from people regarding their discharge – is this sought, what has been learnt?
- Better Care Fund – is this being / can this be used to further strengthen discharge arrangements?

Provide an initial view as to how this review could lead to efficiencies, improvements and/or transformation:

This review provides an opportunity to assess whether local hospital discharge arrangements, and any initiatives put in place to improve these, are effective and safe.

1.0 Executive Summary

1.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Hospital Discharge (Phase 2).

1.2 Problems around hospital discharge have been well documented at a national level, particularly around 'winter' pressures and general bed availability. Efforts have been made to improve local discharge arrangements, including the introduction of the Integrated Discharge Team comprising input from both the North Tees and Hartlepool NHS Foundation Trust and Local Authorities.

1.3 The NHS provides broad guidance around hospital discharge (examples include https://www.nhs.uk/nhs-services/hospitals/going-into-hospital/being-discharged-from-hospital/ and https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/) and each hospital has its own discharge policy. There is a good track record of current local practice providing timely and appropriate discharge of patients, though some concerns have been raised around isolated cases of elderly family and residents being discharged from hospital without the appropriate support and care. This review provides an opportunity to check that current discharge arrangements are robust and whether any aspects could be strengthened.

1.4 A further related issue that has been highlighted involves circumstances where a person's main carer goes into hospital and there is a need to ensure that the person left at home has the support they need. When their carer is discharged and may not be well enough to take care of them properly, it is vital that the Council's Adult Social Care service is aware of the situation and can put any necessary safeguards in place.

1.5 This review began in early-2020 but was quickly paused due to the emergence of COVID-19. Prior to its resumption, the Committee agreed to split its work into two phases, the first of which would focus on hospital discharge to care homes during the pandemic (this subsequently reported to Cabinet in November 2020 and the final report can be accessed via http://www.egenda.stockton.gov.uk/aksstockton/images/att39360.pdf).

1.6 The focus of the review's second phase was on the discharge of individuals from hospital back to their own home (not care homes). The Committee's main aims were to examine the discharge process from local hospitals who provide treatment for the Borough's adult residents (including the wider communication with relevant partner organisations around hospital discharge), and to ascertain the key issues around discharge from both an NHS Trust and patient perspective to ensure a safe and sustained return home following hospital input. A further element was to explore how carers are identified when needing hospital treatment and the measures required for ensuring the people they care for are supported during their stay in hospital (and potentially for a time following their discharge). Reflecting on the information gathered, the Committee would then seek to determine if any improvements could be made to existing policies and procedures.

1.7 As evidenced in the first phase of this review (discharge to care homes during the COVID-19 pandemic), national guidance and requirements around discharge from hospital has changed significantly since the emergence of Coronavirus in early-2020. Policies and procedures that were in place when

this topic was originally proposed and initiated have had to be reviewed in order to urgently free-up hospital capacity. However, the basic principle that it is not good for people to stay in hospital if they no longer need acute-based care remains, and to this end, the Committee fully supports the emphasis on getting individuals back to their usual residence at the earliest opportunity (once it is clinically safe to do so) via the *Discharge to Assess* model and *Home First* initiative.

1.8 This second phase of the Committee's assessment of local discharge arrangements focused on the transfer of patients from hospital back to their own home. Data from local NHS Trusts indicated that a vast majority of patients were being discharged back to their normal place of residence and that this was being done, importantly, without undue delay. The Committee did express caution around readmissions, specifically the need for an awareness of individuals who may be readmitted to a neighbouring hospital rather than the one they had recently been to – it was therefore encouraging to hear local NHS Trusts undertaking readmission audits (NTHFT) and full assessments for every new admission (STHFT) which can help in the overall treatment and care plans of those requiring further intervention.

1.9 As with any issue involving patients, proactive and timely communication mechanisms are an essential ingredient in promoting a positive healthcare experience. In terms of discharge from hospital, this applies not only to ensuring appropriate interaction with patients and their family / carers, but also (where necessary) between hospital departments and with partners including Social Care, GPs and transport providers. Evidence of well-established local NHS Trust and Social Care co-working (e.g. Integrated Discharge Team, Integrated Single Point of Access, involvement in discharge planning) was once again widely welcomed, partnerships which senior staff from each domain felt had been further enhanced due to the pandemic. Continuing to work effectively together to ensure safe and sustainable discharge can play a part in reducing demand on hospital services, something which could be an important factor as the NHS tries to tackle a backlog of treatment for a variety of health conditions courtesy of, and delayed by, COVID-19.

1.10 The Committee was conscious that many who come into hospital may not be previously known to services or have required past health and / or Social Care intervention. Some may also not have a family network around them to give assistance following discharge. Identifying individual circumstances / needs during a stay in hospital and providing appropriate support during and post-discharge is an important role for local partners, particularly as these may have been previously hidden prior to any required treatment. Being aware of and, where possible, involving the voluntary, community and social enterprise (VCSE) sector in any discharge arrangements may enable further support options once a person is back home.

1.11 Consistent with the ethos of getting people back to their usual place of residence as soon as possible, the Committee was assured by the approach of local NHS Trusts in planning discharge from the point of admission, as well as the stated involvement of the patient and their family / carers in these discussions (whether virtual or in-person). For those able to return to their own home, professionals must be confident that the individual will be able to manage their usual surroundings post-discharge and have access to basic

supplies when they are initially transferred from hospital. Liaising with family / carers and / or relevant support services to give this assurance is key.

1.12 A further aim of the second phase of this review was to explore how carers were identified when needing hospital treatment and the measures required for ensuring the people they care for were supported during their stay in hospital (and potentially for a time following their discharge). Again, local NHS Trusts confirmed that carers, whether requiring treatment themselves or supporting another patient, were identified as part of initial assessments upon admission and involved in discharge planning. It was also pleasing to hear of the communication with Social Care should a carer go into hospital and be unable to carry out their role, something the Council's Carers Service commendably supports alongside its continued efforts to encourage better identification.

1.13 The Committee was keen to ensure that young carers were afforded the same levels of engagement with health staff when they went into hospital or cared for someone needing treatment, particularly since young people fulfilling such a role have often reported feeling overlooked in comparison to older relatives / carers. Whilst local NHS Trusts gave assurance that a carers' age did not exclude them from being involved in discharge planning, they were also receptive to looking at ways of enhancing processes around the identification of, and engagement with, young carers. To this end, it may be helpful for relevant health professionals to develop relationships with Eastern Ravens which operates a Young Carers Support Service – the survey they carried out in support of this review certainly highlights a need for better engagement, particularly around being provided with information, signposting to other services, and giving feedback on their / their loved one's discharge experience.

1.14 Ensuring any required medication is available at the point of discharge is a vital factor when being transferred out of hospital, and local NHS Trusts outlined the measures in place to understand and provide this prior to a patient's departure. The Committee was also mindful of post-discharge medication needs and was assured that any issues involving a former patient should be able to be addressed by an individual's respective GP (who is sent the relevant medication details by a Trust) or by contacting the hospital ward the former patient was previously on.

1.15 Although a large proportion of patients return home via their own / relatives' vehicles, local NHS Trusts detailed alternative options including ambulance providers, specialist transport, in-house services and taxis. The Committee praised the NTHFT Volunteer Drivers concept, as well as the pilot within Therapy Services to provide wheelchair-accessible transport with multi-disciplinary assessment within patients' own homes – initiatives such as these demonstrate a commitment to strengthening the discharge process and are thus welcomed.

1.16 It was recognised that transport providers had an ability to play a role in identifying any concerns or problems when assisting patients back to their own home, and the Committee was pleased to receive an insightful contribution to this review from ERS Medical, a private transport provider contracted by NTHFT. Whilst some issues were raised, it was reassuring to note that these appeared to be quite rare – nevertheless, NHS Trusts should act on any feedback received from those helping patients return to their place

of residence, and ensure that concerns can be highlighted in a timely and appropriate manner.

1.17 The provision of post-discharge support was considered, and the Committee was concerned to hear data from Healthwatch Stockton-on-Tees following a discharge-during-the-pandemic survey which indicated that 80% of patients had received no follow-up assessment after discharge and 40% of patients said they were not given details of who they should contact if they needed further health information or support (though the sample size was only 15). Local NHS Trusts subsequently affirmed that contact details for hospitals were provided to patients prior to discharge, and in the case of TEWV, formal follow-up mechanisms were in place.

1.18 Further discharge / post-discharge assistance for those returning home was outlined to the Committee including the excellent NTHFT *Home But Not Alone* volunteer service and Five Lamps *Home from Hospital* initiative. The imminent resumption of the former addresses many key issues surrounding this scrutiny topic, whilst the latter has for some time now played a valued role in providing low-level support to local residents following discharge. The Committee note that the three-year funding for the Five Lamps project is due to expire in mid-2022 and therefore encourage relevant partners to ensure plans for the continuation of such a service are in place for beyond this time.

1.19 Gathering feedback from patients on their discharge experience helps identify issues and strengthen arrangements, and the Committee sought information on the ways in which this was collected. Local NHS Trusts demonstrated multiple options for patient / family / carer feedback, though discharge-specific evidence was very limited. Although it can be challenging to obtain constructive comments, the Committee urges all organisations involved in the discharge process to proactively seek the views of those who have been transferred home (as part of a formal follow-up process).

1.20 The second phase of this review has covered three key areas around discharge of individuals back to their own home – discharge planning, the discharge itself, and post-discharge support. Each aspect deserves due attention from health and care professionals to provide the best possible experience and an increased chance of a safe and timely discharge from hospital.

Recommendations

The Committee recommend that:

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.**

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.**

(continued overleaf…)

<u>**Recommendations**</u> (continued)

The Committee recommend that:

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.**

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.).**

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.**

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.**

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.**

2.0 Introduction

2.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Hospital Discharge (Phase 2).

2.2 Following-on from the first phase of this review which examined the impact of the 2020 COVID-19 pandemic on hospital discharge to care homes, the focus of the review's second phase was on the discharge of individuals from hospital back to their own home (not care homes).

2.3 The Committee's main aims for the second phase were to examine the discharge process from local hospitals who provide treatment for the Borough's adult residents (including the wider communication with relevant partner organisations around hospital discharge), and to ascertain the key issues around discharge from both an NHS Trust and patient perspective to ensure a safe and sustained return home following hospital input. A further element was to explore how carers are identified when needing hospital treatment and the measures required for ensuring the people they care for are supported during their stay in hospital (and potentially for a time following their discharge). Reflecting on the information gathered, the Committee would then seek to determine if any improvements could be made to existing policies and procedures.

2.4 The Committee focused on the following key lines of enquiry:

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

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

- 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))?

- How are patients involved in the discharge process, and how are families / carers kept informed?

- 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)?

- 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?

- 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?

- Communications with GPs following a patients' discharge from hospital.

- Considerations around medication as part of the discharge process.

- Feedback from people regarding their discharge – is this sought, what has been learnt?

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

2.5 The Committee received contributions from a range of health and care organisations, including three local NHS Trusts (North Tees and Hartlepool NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, and Tees, Esk and Wear Valleys NHS Foundation Trust), Stockton-on-Tees Borough Council, NHS Tees Valley Clinical Commissioning Group, Five Lamps (home care provider) and ERS Medical (private transport provider). Feedback from surveys undertaken during the course of this review in relation to some key issues around this scrutiny topic was also provided by both Healthwatch Stockton-on-Tees and Eastern Ravens (young carers support service provider).

2.6 Recognising the increasing pressure on the Council's finances, it is imperative that in-depth scrutiny reviews promote the Council's policy priorities and, where possible, seek to identify efficiencies and reduce demand for services.

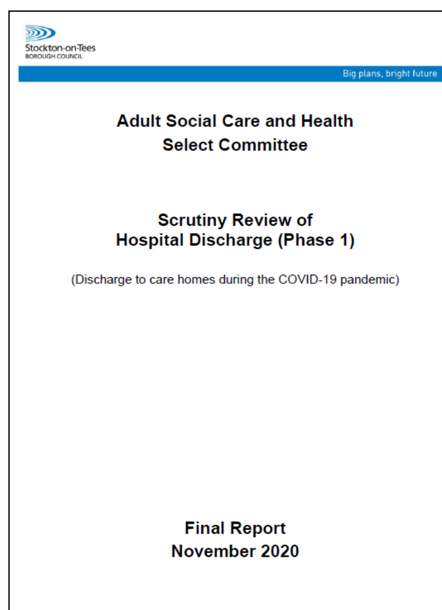
3.0 Background

3.1 Problems around hospital discharge have been well documented at a national level, particularly around 'winter' pressures and general bed availability. Efforts have been made to improve local discharge arrangements, including the introduction of the Integrated Discharge Team comprising input from both the North Tees and Hartlepool NHS Foundation Trust and Local Authorities.

3.2 The NHS provides broad guidance around hospital discharge (examples include https://www.nhs.uk/nhs-services/hospitals/going-into-hospital/being-discharged-from-hospital/ and https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/) and each hospital has its own discharge policy. There is a good track record of current local practice providing timely and appropriate discharge of patients, though some concerns have been raised around isolated cases of elderly family and residents being discharged from hospital without the appropriate support and care. This review provides an opportunity to check that current discharge arrangements are robust and whether any aspects could be strengthened.

3.3 A further related issue that has been highlighted involves circumstances where a person's main carer goes into hospital and there is a need to ensure that the person left at home has the support they need. When their carer is discharged and may not be well enough to take care of them properly, it is vital that the Council's Adult Social Care service is aware of the situation and can put any necessary safeguards in place.

3.4 This review began in early-2020 but was quickly paused due to the emergence of COVID-19. Prior to its resumption, the Committee agreed to split its work into two phases, the first of which would focus on hospital discharge to care homes during the pandemic (this subsequently reported to Cabinet in November 2020 and the final report can be accessed via http://www.egenda.stockton.gov.uk/aksstockton/images/att39360.pdf).


Stockton-on-Tees Borough Council

Big plans, bright future

Adult Social Care and Health Select Committee

Scrutiny Review of Hospital Discharge (Phase 1)

(Discharge to care homes during the COVID-19 pandemic)

Final Report November 2020

The 'Background' and 'Findings' sections of this initial phase final report charts developments around national hospital discharge guidance and requirements since March 2020, including the introduction of a 'discharge to assess' model which acknowledged that most people would be discharged to their own home (the emphasis of the second phase of this review).

3.5 When the originally-intended review around discharge to an individual's own home (phase 2) restarted in December 2020, additional consideration was therefore required around how COVID-19 had shaped discharge procedures and practice, as well as the impact of any changes on individuals going from hospital back to their own homes.

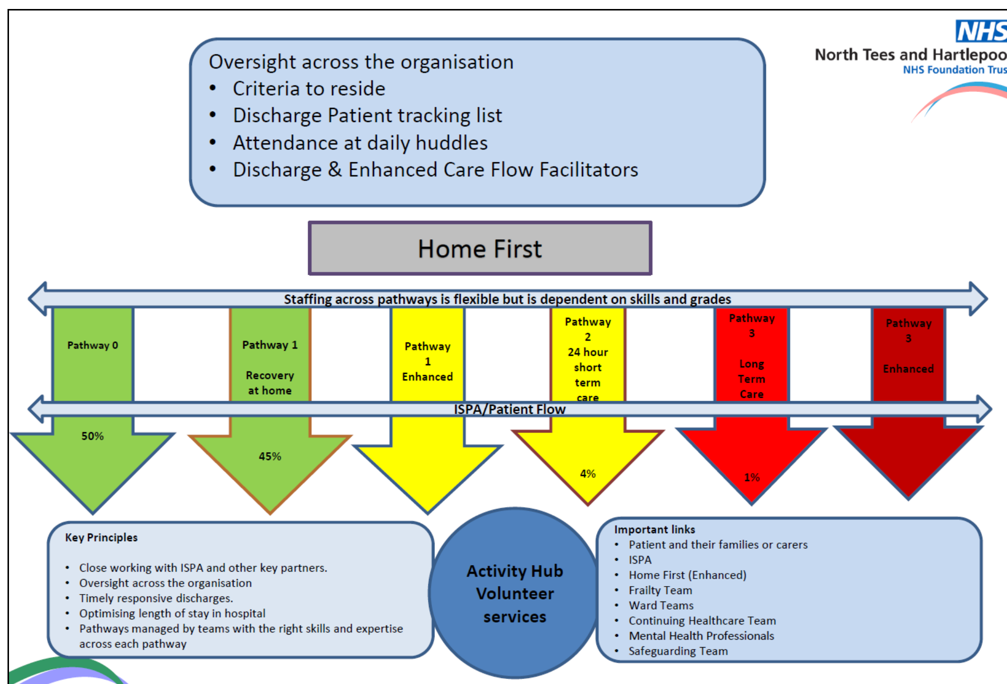
4.0 Findings

Discharge policies

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.1 Prior to the COVID-19 pandemic, the Trust established an inter-agency discharge policy comprising new discharge pathways, a local discharge steering group, and a shift to an Integrated Discharge Team (in 2017) involving cross-working between the Trust, Local Authorities, the Clinical Commissioning Group and the voluntary sector. Performance monitoring (quality of discharges, length of stay, delayed discharges) was an ongoing process and a patient's discharge pathway was considered from the point of admission.

4.2 As evidenced in phase 1 of this review (discharge to care homes during the COVID-19 pandemic – see the 'Findings' section of the Committee's final report: http://www.egenda.stockton.gov.uk/aksstockton/images/att39360.pdf), the emergence of COVID-19 led to several changes in national guidance around discharges, including the acceleration of the *Discharge to Assess (D2A)* model to create capacity, a reinforcement of the *Home First* principle (https://www.england.nhs.uk/wp-content/uploads/2018/12/3-grab-guide-getting-people-home-first-v2.pdf) to promote discharge to a patient's usual place of residence where it is safe to do so. Discussions are held with the relevant Local Authority for anyone on any of the discharge pathways outlined in Appendix 1 and the below graphic (via the Integrated Single Point of Access (ISPA)), and Discharge Patient Tracking Lists, detailing patient demographics, inpatient status, COVID status and relevant discharge information, are used.



4.3 Pre-COVID, discharge had been from multiple areas (emergency and elective) such as front of house (A&E, Urgent Care Centre), hospital unit / ward and discharge lounge. In the last year, nearly all patients had been discharged directly from the clinical area as COVID-19 placed restrictions on the transfer of patients between hospital locations, including the use of the transport lounge. The Trust also emphasised the importance of recognising the work being done to keep people from being admitted to hospital in the first place (e.g. support available within community settings).

4.4 Referencing a previous presentation from South Tees Hospitals NHS Foundation Trust (STHFT), Members noted that STHFT had five discharge pathways, including end-of-life. NTHFT gave assurance that its District Nurses work in hospitals and will meet end-of-life individuals with the aim of getting them home as soon as possible – this particular pathway works very well.

4.5 A query was raised around how homeless people were managed when requiring discharge following a stay in hospital. The Trust stated that it works closely with partners to gather information on the needs of such individuals, though very few patients going through hospital were homeless.

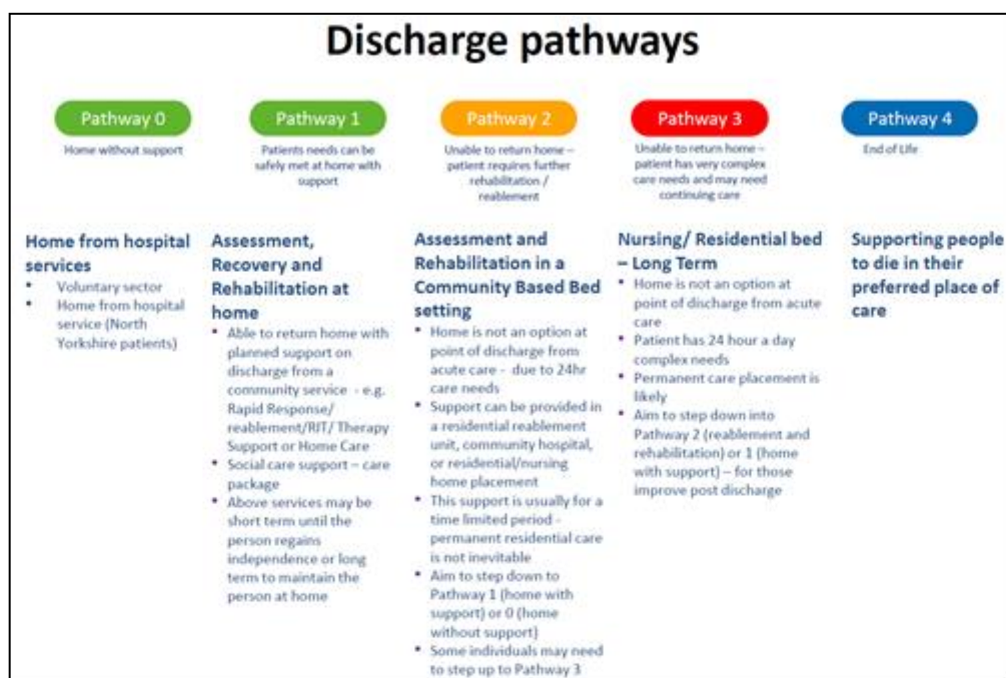
4.6 Historic cases of patients being discharged from hospital dressed in nightwear were raised. A partnership between the Trust and Billingham Foodbank had been formed to provide clothing for patients ahead of discharge who did not have family support. Food parcels were also given to patients who require them.

South Tees Hospitals NHS Foundation Trust (STHFT)

4.7 The South Tees health and social care system had 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.

4.8 STHFT works closely with all local Council Social Care departments to facilitate safe and timely discharges from hospital, and were mindful that the length of stay within hospital can have a significant impact upon an individual (particularly older people). 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.

4.9 The five distinct discharge pathways that the Trust follows at all times were outlined (see below graphic), as was the use of the Discharge Lounge if a transfer was delayed (though strict criteria for its use was currently in place).



4.10 In terms of where patients were transferred from, a high proportion of discharges take place on the same day as admission, mostly from the Emergency Department and Same Day Emergency Care (SDEC) Unit or Acute Admission Units. Anyone being admitted to hospital from home will be discharged back to their home unless they need to be placed into a new facility due to their health condition.

4.11 The introduction of the highly-successful COVID Virtual Ward (welcomed by the Committee as an innovative initiative which many have benefitted from) and the more recently-implemented vaccination programme was highlighted, as was the Diagnostic Virtual Ward which helped facilitate the discharge of clinically-stable patients (who require ongoing investigations and diagnostic tests) within inpatient timescales.

<u>Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)</u>

4.12 Further to the existing TEWV Admission, Transfer and Discharge Policy (circulated to the Committee in January 2021), Members were informed that all patients, whether already known to the service or new, are allocated a Care Co-ordinator (who leads on discharge planning) on admission to hospital. The Care Co-ordinator informs the service user's GP on admission and ensures other agencies, family and carers are updated and invited to all reviews. Discharge planning and aftercare arrangements should begin with the Care Co-ordinator (and relevant others) as soon as possible following admission.

4.13 A care plan is agreed prior to discharge with the service user, relatives, carers and relevant other bodies involved – this will include (but is not exclusive to) medicines management and supply, follow-up care and needs, carers' needs, safe transfer provision to community teams, and GP.

Stockton-on-Tees Borough Council (SBC)

4.14 For those on the NTHFT green (1), amber (2) or red (3) pathways (see paragraph 4.2 and Appendix 1), following receipt of a referral from the Integrated Discharge Team (IDT), the SBC Assessment Reablement Team (ART) undertake assessments to identify suitability for post-discharge support / intervention. The assessment includes consultation with wider professionals, the person and their families to establish a robust and informed decision for a safe discharge.

Provision of care services are considered such as Reablement Services who offer care in an individual's own home which can be provided free for up to six weeks. Existing support structures are identified, including informal / formal care arrangements, and other short and long-term interventions are considered (e.g. OneCall / Assistive Technology, aids / adaptations / equipment, community therapy interventions, voluntary sector input – easy-read leaflets are available regarding services).

4.15 SBC has strong communication / working relationships with NTHFT including daily IDT briefings, designated IDT staff covering key wards, assigned direct mobile contacts to all SBC and NHS frontline staff, 1:1 staff supervision and weekly team meetings, monthly informal management catch-up sessions, and structured / planned stakeholder meetings across multi-agencies. Dialogue is direct, open and honest.

4.16 The Committee was subsequently informed that NTHFT was working with the ART to develop increased weekend provision for discharge. Discharge timings were constantly monitored at ward level, and vulnerable patients or those with additional needs would not be discharged late on an evening.

Discharge data

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.17 Between April 2019 and January 2020, 24,846 (57.31%) Stockton residents were discharged from the Trust's hospitals (as per blue rows below):

Address	Number	Percentage
Stockton-on-Tees	19,452	44.87%
Hartlepool	13,381	30.87%
Billingham	4,603	10.62%
Peterlee	2,077	4.79%
Yarm	791	1.82%
Middlesbrough	650	1.50%

For the period 10th January 2020 – 2nd February 2020, there were an average of 74 discharges per day from the Trust's hospital settings.

4.18 2020-2021 data (see Appendix 2), coinciding with the emergence and impact of COVID-19, was presented to the Committee which showed the following:

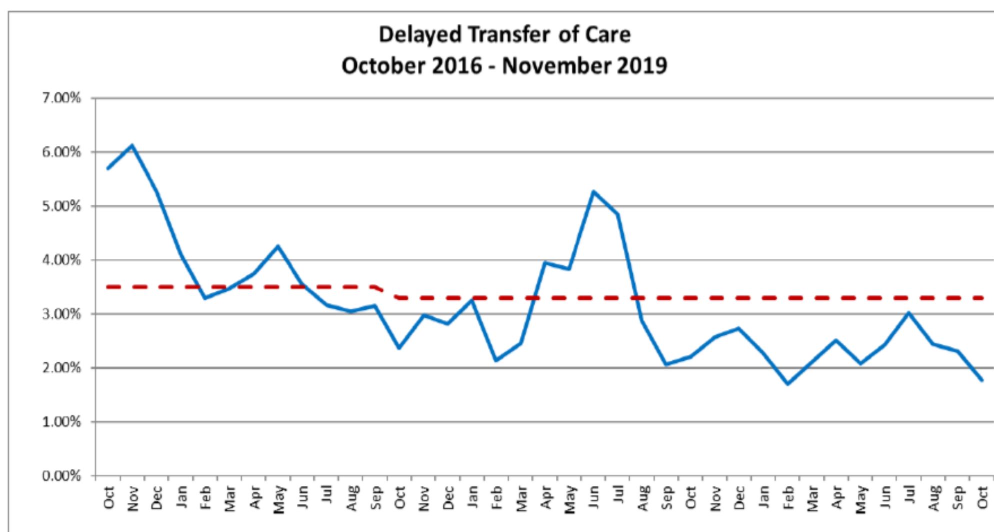
- Total discharges by time of day (per quarter): the most frequent time for discharges throughout 2020-2021 was around 5.00pm, with the majority being transferred between 1.00pm and 7.00pm.

- Timing of discharges for patients on the elective pathway: mostly early / mid-afternoon (2.00pm, 3.00pm).

- Timing of discharge for patients on the emergency pathway: mostly late-afternoon (5.00pm, 6.00pm) as these individuals tended to be admitted later in the day.

- Pathway analysis (not just Stockton-on-Tees data): snapshot provided from January 2021 for the discharge of patients aged over 65 in the previous seven days – vast majority are on pathway 0 (discharge to usual place of residence). Analysis enables the Trust to balance resources in the right places to support the different pathways.

4.19 Since the beginning of 2017, the Trust had performed well in relation to Delayed Transfers of Care (DTOC), and had, for most of this time, kept below the 3.5% target (see graphic below). This was a result of multi-agency task and finish group work to solve problems and refine discharge pathways, weekly audits to work proactively rather than reactively, and shared / actioned daily situation reports.



DTOC reporting was stood down in March 2020 and replaced with daily discharge sitreps – the Trust was performing very well in this area within the Borough, though work is ongoing with partners to identify and understand current and emerging pressures.

4.20 NTHFT conduct audits around readmissions and specifically look at those patients readmitted within 28 days to see if the reason for them coming back into hospital was the same as what they were first admitted for. The Trust was conscious, however, that sometimes there was a need to take positive risks when it comes to discharge, as for most, prolonged stays in hospital had been seen to have adverse effects on an individual.

South Tees Hospitals NHS Foundation Trust (STHFT)

4.21 2020-2021 data (see Appendix 3) on admissions and discharges (both involving home as the discharge destination) for the Borough's residents was broadly similar, suggesting an encouraging flow of patients through the Trust's hospitals and few issues around delayed transfers. A large majority of patients were discharged back to their own home.

4.22 The Trust was asked if data on readmissions was available, whether this be back into a hospital setting or to a care home. Information on emergency readmissions within 30 days of discharge from hospital (measured at Clinical Commissioning Group (CCG) level) was subsequently provided (see https://files.digital.nhs.uk/60/EECB04/CCG_3.2_I00760_D.xlsx), though it was noted that the Trust would not have data, nor be aware of, an individual who was admitted to another hospital or a care home (though may see some of those who are placed into care as it takes time to put together the required care package).

4.23 Concern was raised around the interface between the Trust and its counterparts at North Tees and Hartlepool NHS Foundation Trust (NTHFT) in relation to awareness of readmissions. The Committee was informed that a full assessment was undertaken for every new admission, regardless of where a patient has / has not been before. At present, the Trust does not have an Electronic Patient Record (EPR) system (but is working towards this).

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

4.24 TEWV discharge data covering the period August 2020 - December 2020 was provided as follows:

	Hartlepool CCG	Stockton CCG
Adult Mental Health	57	100
Mental Health Services Older People	14	26
Learning Disability Services	2	67

Healthwatch Stockton-on-Tees

4.25 In October 2020, Healthwatch England, in association with the British Red Cross, published a report on the experiences of people being discharged from hospital during the COVID-19 pandemic (for further details, see https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20201026%20Peoples%20experiences%20of%20leaving%20hospital%20during%20COVID-19_0.pdf). At a local level, Healthwatch Stockton-on-Tees had undertaken their own survey aimed at individuals and their carers, and provided the following feedback to the Committee (noting whether the findings were in line with the experiences of people nationally):

- The national Healthwatch England / British Red Cross survey published in October 2020 received comments from 590 people. The local Healthwatch Stockton-on-Tees survey received 15 responses.

- 60% of patients did not receive information about the new discharge procedure (‘discharge to assess’ model) (nationally it was 61%).

- 12% of patients did not feel that they were ready to leave hospital (nationally it was 19%).

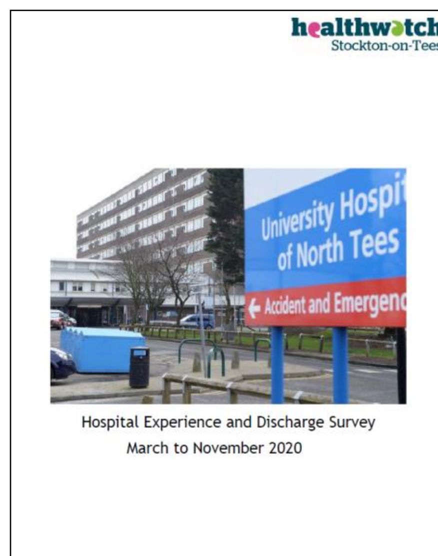
- 60% of patients said they were not asked if they required transport on discharge (nationally the figure was 64% of people who were discharged at night).

- 80% of patients said that there was no follow-up assessment following discharge (nationally it was 82%). There seemed to be confusion over which patients require such an assessment, but the guidance would suggest everyone should receive some sort of follow-up assessment.

- 40% of patients said they were not given details of who they should contact if they needed further health information or support (nationally it was 34%).

Healthwatch Stockton-on-Tees noted that, whilst the local survey did not get many responses (possibly due to the fact that the national survey came first, something which the local team promoted), it did show that the Borough was broadly in line with the position nationally.

4.26 A report on the local survey was published in 2021 (see http://www.healthwatchstocktonontees.co.uk/sites/default/files/hospital_experience_and_discharge_report_final_0.pdf) and included a number of recommendations reflecting the findings within both the local and national Healthwatch reports, most of which are very pertinent to this review.



Hospital Experience and Discharge Survey
March to November 2020

The local report also contained an initial response to these findings and recommendations from North Tees and Hartlepool NHS Foundation Trust, and the Committee note the comments and associated improvement plan.

4.27 Future work around carers and their experiences of living through COVID-19 was also being considered by Healthwatch Stockton-on-Tees, and Members were encouraged to ask any carers they were aware of to contact the local office if they wished to contribute.

Communication around discharge

Within hospitals and with Adult Social Care (and other relevant partners)

4.28 The creation of the Integrated Discharge Team at **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** in 2017 (involving professionals from across Health and Social Care and the voluntary, community and social enterprise (VCSE) sector) had played a significant role in strengthening collaboration with key local partners around discharges. Virtual working (daily meetings) during the COVID-19 pandemic and twice-weekly complex case discussions with senior leaders from NTHFT and SBC had further cemented relationships, and the Trust had also invested in Frailty Co-ordinators and Pathway Facilitators to aid discharge-planning. Virtual multi-disciplinary meetings had been introduced – these had reduced the time taken to co-ordinate hospital visits.

4.29 Work with partners was ongoing in order to optimise the use of the Better Care Fund to support discharge, of which the 24/7 clinical triage (providing direct access to a wealth of information for patients who may require care and support outside of normal hours) was a primary example. The Fund had also been used to allow Community Matron support in the Rosedale Centre (a short-term residential rehabilitation and assessment centre, owned and managed by SBC) and future opportunities to work together with VCSE organisations are to be explored. Assurance was given that processes are reviewed annually to ensure money is being well spent.

4.30 From a **South Tees Hospitals NHS Foundation Trust (STHFT)** perspective, the Discharge Team (headed by the Executive Lead for discharge) that works with hospital wards seven-days-a-week includes staff from community settings, and daily meetings with Social Care staff take place (through the

Integrated Single Point of Access (ISPA)) if an individual requires a care package or placement within the Borough. Existing care packages were taken into account to ensure relevant Social Care staff were involved in discharge-planning.

4.31 Reflecting on the impact of the ongoing pandemic, STHFT felt that relationships with Social Care partners had been further strengthened since the emergence of COVID-19 (this was subsequently backed-up by Stockton-on-Tees Borough Council's Director of Adults and Health).

4.32 Invites to all **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** professionals were sent to review and discharge planning meetings. There was an improved communication flow with weekly meetings to discuss issues, to future-plan and to problem-solve involving different professional agencies, allowing creative approaches and flexibilities in services to ensure safe and timely discharge. Occasional issues around ensuring representation from all professional bodies involved can slow the process though and require re-work and further meetings.

<u>With patients and their family / carers</u>

4.33 For **North Tees and Hartlepool NHS Foundation Trust (NTHFT)**, discharge-planning starts on admission to hospital and is a key part of the core assessment which captures social history, carer information and any concerns. Ward-based multi-disciplinary teams liaise with families and carers to gather detailed patient summaries.

4.34 NTHFT outlined several ways in which it had involved patients and their family / carers during an individual's stay in hospital and in the planning of their discharge. The Trust was supportive of the *John's Campaign*, advocating extended visiting rights for family / carers of patients with dementia in hospitals in the UK (https://johnscampaign.org.uk/), and had held discharge-focused drop-in sessions enabling discussions around ward care, discharge-planning and therapy needs with the Ward Matron, Senior Occupational Therapist and Integrated Discharge Team.

4.35 Condition-specific information was provided by the relevant specialty. New leaflets were distributed in March 2020 in response to COVID-19 and the changes made to the guidance – these included contact details for the hospital and the Health and Social Care teams in the ISPA. QR codes were being examined (trial in the Emergency Department) to streamline information and ensure it is up-to-date. To keep patients and relatives / carers in touch, 'virtual visiting' was facilitated via iPad donations.

HM Government

NHS

Your hospital discharge: going home

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

4.36 The Committee queried if there had been any issues around families / carers accessing virtual multi-disciplinary meetings. NTHFT advised that such meetings had to be re-invented due to the pandemic, and that despite individuals having varying technical expertise, its staff talked them through

joining discussions online or via the phone (or indeed physically now lockdown measures were easing).

4.37 Welcoming the continuation of the *John's Campaign*, the Committee emphasised the need for support to be available for those who were not known to Social Care (for those who require it) as there were a number of lonely people across the Borough (many as a result of COVID-19) who would benefit from already-established support mechanisms.

4.38 The **South Tees Hospitals NHS Foundation Trust (STHFT)** approach is to discuss plans for discharge with patients and their families / carers at the earliest opportunity, though the timing must be appropriate. The patient's existing social and accommodation situation is taken into account, and if a Social Worker is involved, the ward includes 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.

4.39 **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** patients and / or their carers are provided with a care plan prior to and at the point of discharge informing them of the discharge process and dates / times / who will be seeing them in the community – this is on, or no later than 24-hours from, discharge. Details include not only planned care and interventions but also how to access services in crisis situations and relevant contact information.

4.40 Where the patient has the capacity to do so, they are invited to (and will contribute to) discharge-planning along with their family member / carer and Care Co-ordinator. Where the patient lacks capacity, their family are fully involved and, if appropriate, an advocate.

With GPs

4.41 **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** performance-manages itself regarding the timeliness of electronic patient summaries to GPs following the discharge of a patient. Care Co-ordinators are based in primary care with an active role in social prescribing, and quality improvement projects with GP Frailty Trainees have been held to foster cross-learning.

4.42 A discharge letter / e-discharge summary is sent by **South Tees Hospitals NHS Foundation Trust (STHFT)** to the relevant GP post-discharge containing an overview of what the patient was admitted to hospital for, a summary of their health status, and details of any medication requirements following transfer.

4.43 The Committee queried whether GPs had to acknowledge receipt of electronic messages (in keeping with the 'duty of care' from both NHS Trust and GP perspectives). Members were informed that GPs who have a registered protected address for receiving such documentation do not have to provide confirmation and that it is their responsibility to regularly check for any correspondence. If the GP does not have a registered protected address, STHFT follows-up on any documentation which has been issued. It was also

noted that the Trust checks if a patient is registered with a GP upon admission.

4.44 At **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)**, the allocated Care Co-ordinator will inform the service user's GP on admission. Before actual discharge, a GP discharge letter is sent (also sent electronically to the GP within 24-hours of discharge), with follow-up care plans provided within seven days of discharge, and a care plan review scheduled for a month after discharge.

Identification of and provision for carers

NHS Foundation Trusts

4.45 **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** stated that communication with families and carers takes place upon admission as part of the core assessment process. The involvement of carers during an individual's stay in hospital is further demonstrated at paragraph 4.34.

4.46 The Committee asked if provisions were in place to support young carers, as they can often feel overlooked. NTHFT reiterated that they try to engage all appropriate relatives / carers / friends in a patients' care and their subsequent discharge process, irrespective of age. Although dealing with young carers was less common, the Trust was open to investigating further ways in which support could be provided.

4.47 In addition to paragraph 4.38, assurance was given by **South Tees Hospitals NHS Foundation Trust (STHFT)** that carers who require treatment are identified through both planned admissions (via pre-assessment discussions) and unplanned admissions (raised with clinician at earliest appropriate opportunity and Social Care involved as appropriate).

4.48 Communication with young carers who come into a hospital was probed, and the Committee asked if STHFT staff made a point of speaking to them or whether they gravitated to older relatives when a family member is admitted for treatment. The Trust confirmed that it would initiate a conversation to establish who provides care to the individual in question, and that if a young carer is involved, staff would look at things holistically and fully engage with all who cared for the admitted patient. Members noted that young carers often report that they can be side-lined and that all organisations need to focus on ensuring they are sought out and included in discussions. The Trust reported that young carers sometimes do not declare their involvement with an admitted patient, but that the Lead Nurse would be receptive to looking at ways of strengthening identification of, and engagement with, such young people.

4.49 Further to paragraph 4.39, when already in service, the **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** Community Mental Health Teams offer a carers assessment on the patient's initial assessment – carers identified at this point are recorded on the Trust's electronic record system (PARIS). If a carer goes into hospital and other family members are not available to step into their role, the Trust works closely with Social Care to

enhance existing care packages or create safe packages of care. Respite care is an option and working nights would be accessed if available.

Stockton-on-Tees Borough Council (SBC) Carers Service

4.50 Evidence was received from the SBC Carers Service regarding the support it provides around discharge from hospital, as well as the experiences of carers when the person they care for is admitted / discharged, and when they themselves are admitted / discharged. The following key elements were highlighted:

- Service Demand: As of December 2020, there were around 1,600 carers (aged 18+) on the service's register, though this number can change daily.

- Time Out Support: Up to eight hours per month free support for the carer to have a break from their caring role (though no domiciliary care provided as the service is not CQC-registered).

- Carers Emergency (ID) Card: Initiate a conversation with the carer about emergency plans which the service can get involved with if necessary. Around 600-700 cards have been issued within the Borough.

- Partnership-Working: If no care package is in place, the service links people to other organisations (e.g. Five Lamps, MIND, Alliance) – whatever a carer may need in relation to longer-term support.

- Support with Hospital Discharge: The service has trialled having a staff member (Carers Advisor) based within hospital (which will be looked at again for the future), and carers have previously highlighted the good support provided by hospitals, Social Care and other agencies around discharge. Carers understandably endure a lot of stress about the next steps after discharge, and the service has worked with volunteers within the hospital to better identify anyone who is a carer.

4.51 Acknowledging the service's wide-ranging offer, Members particularly welcomed the provision of welfare calls (noting how well these had been received by carers they themselves knew). A query was then raised around how much notice a carer had to give for them to receive ad-hoc support – the service stated that it tries to get people to book support (if required) at the start of each month but that it does respond outside this time (depending on the circumstances). In terms of planning and resourcing, the more notice the better.

4.52 Reflecting on the current pandemic, the Committee questioned if the service had considered other ways of identifying / contacting carers, particularly as access to hospitals has become more restricted. Existing communication mechanisms were noted, including use of social media (though responses via this medium were not very high), an online peer support group, and a paper newsletter circulated to around 300 organisations for sharing (mindful of those who may be digitally excluded). In future, and subject to capacity, the service would like to focus more on welfare checks.

4.53 The Committee asked if the service had been able to maintain its 'Time Out Support' during the pandemic, and was informed that, whilst this had to be suspended during lockdown, staff capacity was used to conduct welfare checks whilst the support was unavailable.

Eastern Ravens

4.54 Feedback was sought from young carers and their families on their experiences of hospital discharge. Eastern Ravens addressed the Committee and began by providing a brief overview of the organisation:

- Formed in 1961, services are provided under contract from SBC and include initiatives within Butterwick Hospice, Roseworth community, Tilery Primary School, youth work and, for the purposes of this scrutiny review, a Young Carers Support Service.

- Established in 2000, the Young Carers element supports 188 people (as at December 2020), and their family members who require care, through a bespoke service that is based on an individual's needs.

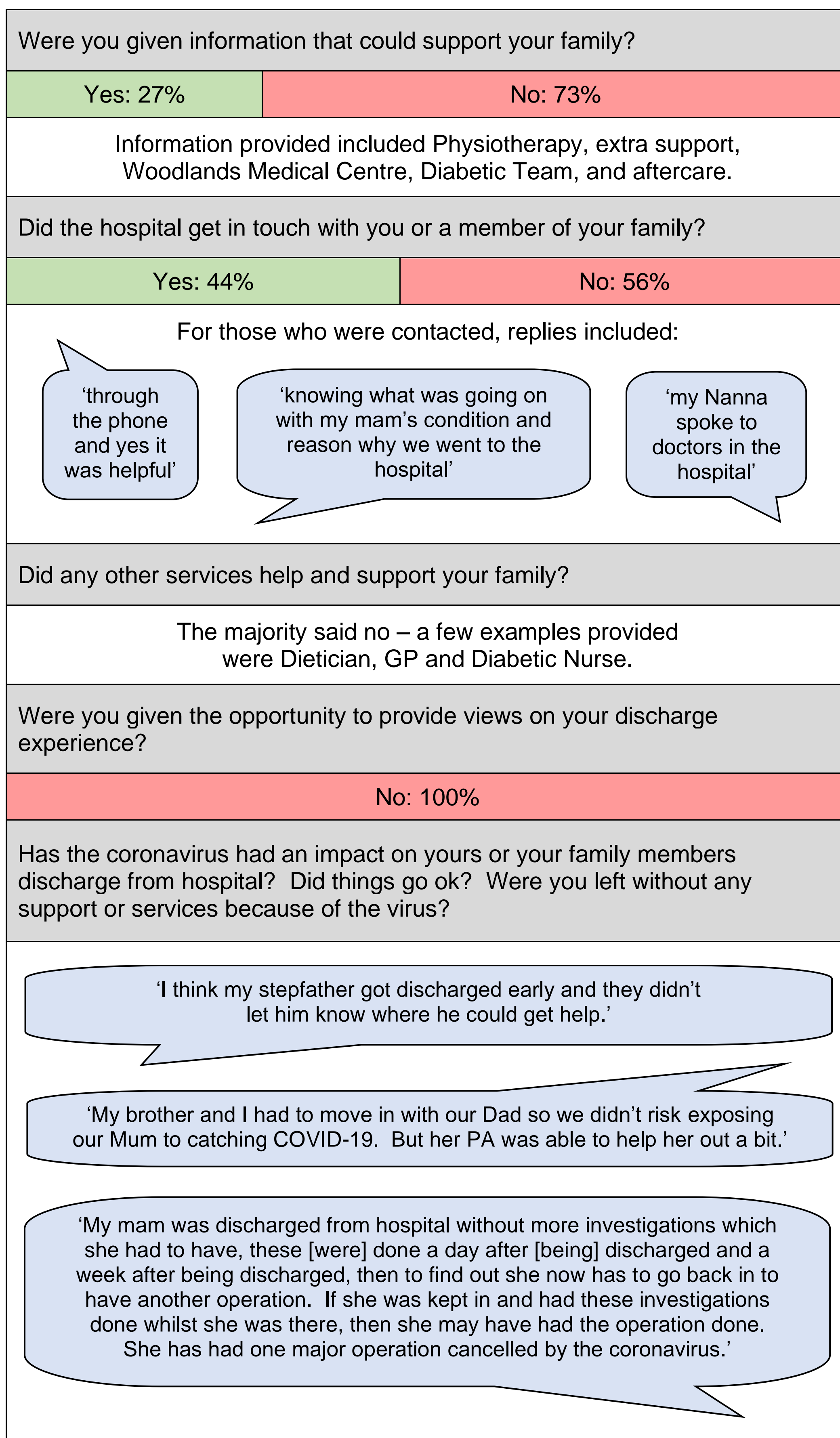
- Carers are offered a Young Carers Card which prevents them from having to explain themselves several times and supports their emotional health and wellbeing – the service also undertakes wellness planning with young carers to ensure they take time to care for themselves. It was noted that young carers provide a raft of different types of support (not just physical) but can miss out on their own childhood and social outlets.

- Awareness of the service has been raised via a number of local schools and is well linked-in with other carers services.

Young Carers Definition

The term 'Young Carer' includes children and young people under 18 who provide regular and ongoing physical and emotional care, personal care or practical support to a family member who is physically or mentally ill, disabled or misuses substances.

4.55 To aid this review, Eastern Ravens issued an anonymous online and paper questionnaire (promoted via email to parents / carers and through their bespoke text service) seeking responses to a range of questions around their experiences of hospital discharge. Targeted at those aged 8 and over, there were 32 respondents – feedback was provided as follows:



Were you given information that could support your family?	
Yes: 27%	No: 73%

Information provided included Physiotherapy, extra support, Woodlands Medical Centre, Diabetic Team, and aftercare.

Did the hospital get in touch with you or a member of your family?	
Yes: 44%	No: 56%

For those who were contacted, replies included:

‘through the phone and yes it was helpful’

‘knowing what was going on with my mam’s condition and reason why we went to the hospital’

‘my Nanna spoke to doctors in the hospital’

Did any other services help and support your family?

The majority said no – a few examples provided were Dietician, GP and Diabetic Nurse.

Were you given the opportunity to provide views on your discharge experience?
No: 100%

Has the coronavirus had an impact on yours or your family members discharge from hospital? Did things go ok? Were you left without any support or services because of the virus?

‘I think my stepfather got discharged early and they didn’t let him know where he could get help.’

‘My brother and I had to move in with our Dad so we didn’t risk exposing our Mum to catching COVID-19. But her PA was able to help her out a bit.’

‘My mam was discharged from hospital without more investigations which she had to have, these [were] done a day after [being] discharged and a week after being discharged, then to find out she now has to go back in to have another operation. If she was kept in and had these investigations done whilst she was there, then she may have had the operation done. She has had one major operation cancelled by the coronavirus.’

4.56 It was not known by Eastern Ravens if hospital discharge documents ask questions around families / homes or whether young people would even tell hospitals that they were a carer due to some remaining stigma around such a status.

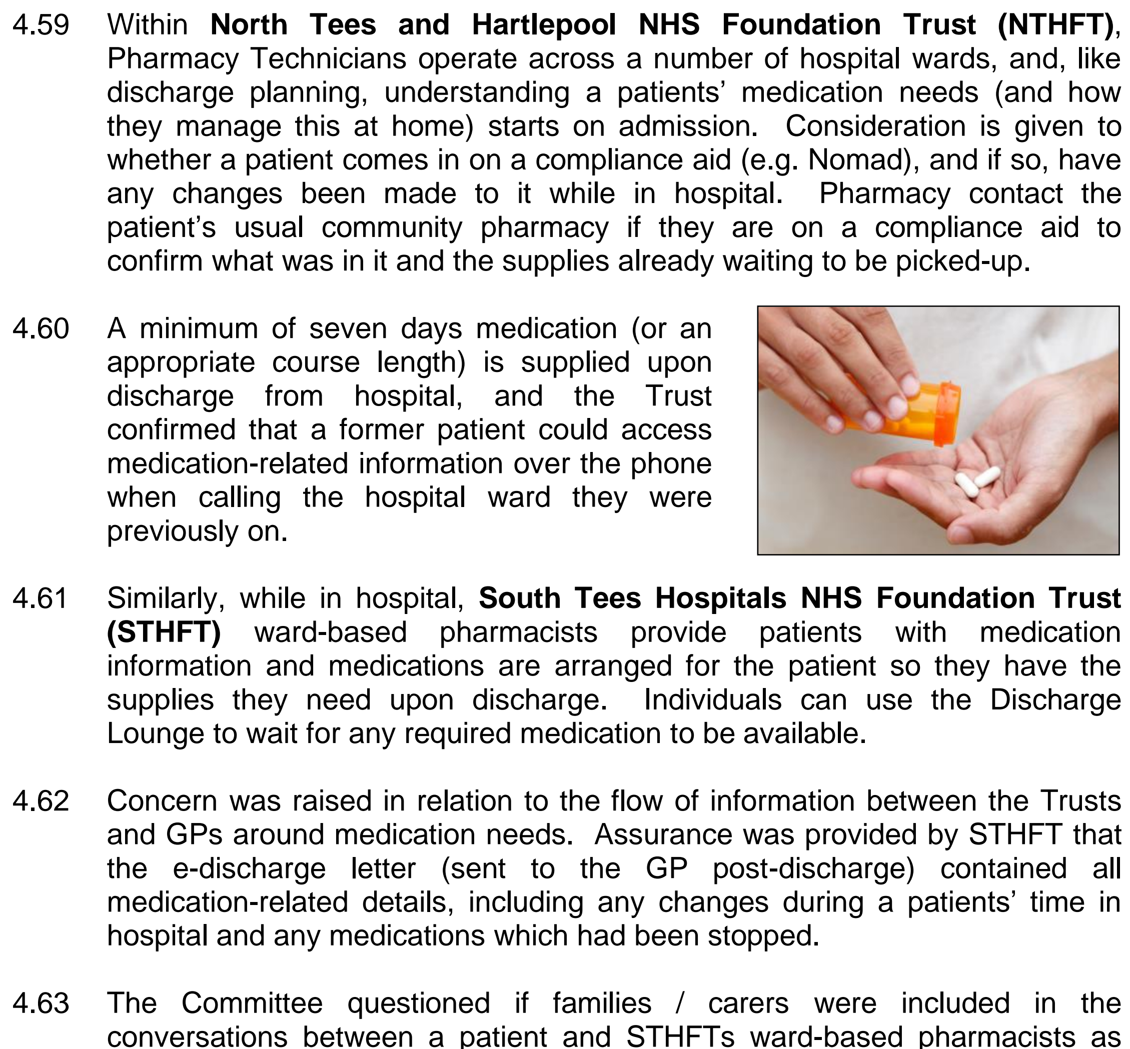
4.57 The Committee commended the work of Eastern Ravens in supporting young carers across the Borough, and questioned whether, for those who were contacted by the hospital, health professionals spoke to the young carer themselves or their older relative. It was confirmed that, as is often the case, professionals generally liaised with adult relatives (unless the young person was the primary carer), and that it was uncertain how hospitals communicate discharge processes to younger family members who may also be involved in the care of an older relation.

4.58 Comments were made around the need to continue raising the profile of young carers, with suggestions put forward around a potential Time Out support service (akin to what is available through the SBC Carers Service) and the introduction of some form of Carers Champions for hospital discharge.

Medication

4.59 Within **North Tees and Hartlepool NHS Foundation Trust (NTHFT)**, Pharmacy Technicians operate across a number of hospital wards, and, like discharge planning, understanding a patients' medication needs (and how they manage this at home) starts on admission. Consideration is given to whether a patient comes in on a compliance aid (e.g. Nomad), and if so, have any changes been made to it while in hospital. Pharmacy contact the patient's usual community pharmacy if they are on a compliance aid to confirm what was in it and the supplies already waiting to be picked-up.

4.60 A minimum of seven days medication (or an appropriate course length) is supplied upon discharge from hospital, and the Trust confirmed that a former patient could access medication-related information over the phone when calling the hospital ward they were previously on.



4.61 Similarly, while in hospital, **South Tees Hospitals NHS Foundation Trust (STHFT)** ward-based pharmacists provide patients with medication information and medications are arranged for the patient so they have the supplies they need upon discharge. Individuals can use the Discharge Lounge to wait for any required medication to be available.

4.62 Concern was raised in relation to the flow of information between the Trusts and GPs around medication needs. Assurance was provided by STHFT that the e-discharge letter (sent to the GP post-discharge) contained all medication-related details, including any changes during a patients' time in hospital and any medications which had been stopped.

4.63 The Committee questioned if families / carers were included in the conversations between a patient and STHFTs ward-based pharmacists as

they can often know as much, if not more, about their loved ones' needs. In response, STHFT confirmed that, with the patient's consent (if they have capacity – this is assessed too, the result of which will determine the level of interaction with relatives), it always tries to engage with the wider family / carers. It was, however, noted that COVID-19 had prohibited face-to-face contact in this regard.

4.64 28-day discharge medication was provided by **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** to the patient unless the patient was at risk of overdose (then it is seven). Considerations were also taken about locked boxes and medication management in the community. Medication information was included in the GP discharge summary.

Transport home

NHS Foundation Trusts

4.65 **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** confirmed that patients use their own transport where possible, though other options exist such as an ambulance provider and specialist transport (e.g. palliative ambulance for end-of-life care). The Committee was made aware of the Trust's Volunteer Drivers (https://www.youtube.com/watch?v=ZeXjADFPZs0) initiative as well as a pilot project within Therapy Services to provide wheelchair-accessible transport with multi-disciplinary assessment within patients' own homes. Any transport-related concerns were raised via the Trust's Site Management Team in and out-of-hours who could then seek advice and support from the multi-disciplinary team and the IPSA.

4.66 In terms of the pilot project within Therapy Services to provide wheelchair-accessible transport, the Committee asked if the assessment of an individual's home is conducted prior to discharge. NTHFT advised that relevant staff take the patient on a pre-discharge visit to check the person's cognitive abilities whilst in their own home, as well as assess their needs within the property. On occasion, the patient has not required to go back to hospital following a visit.

4.67 Most patients return home from **South Tees Hospitals NHS Foundation Trust (STHFT)** hospitals using their personal / relatives' vehicles, though the Trust does operate its own transport service in addition to that which is available through the North East Ambulance Service (NEAS) and Red Cross.

4.68 Transport is provided by **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** for a patient to return home, however, the Trust no longer has access to the Patient Transport Service and therefore taxis are used as an alternative.

ERS Medical

4.69 The Committee received a presentation from ERS Medical, a private transport provider contracted by **North Tees and Hartlepool NHS Foundation Trust (NTHFT)**. ERS Medical operates nationally from 20 sites across the UK (employing 1,000 staff and 500 vehicles) and provides a wide range of

specialist patient transport / courier services to the NHS and the wider healthcare sector, as well as a comprehensive selection of internal / external training.

4.70 ERS Medical supply three double crew stretcher vehicles 365 days per year based out of its site in Bowburn, Durham. The service is carried out between the hours of 9.00am–10.00pm, and an adhoc service is also provided through the night outside of the contracted times. Mental health secure transport vehicles are also available to carry out sectioned / non-sectioned transfers including covert and cell vehicles. Extra vehicles are provided as required to facilitate out-of-area discharges – these are used to reduce pressure on contracted resources. In 2020, an average of 450 discharges per month were carried out on behalf of the University Hospital of North Tees.

4.71 Highlighting the Cleric system which provides real-time support designed to maximise operational efficiency to reduce waiting time and delays for service-users, it was noted that this system was also being utilised to instantly report any concerns that staff had when assisting in the discharge of individuals from hospital to their home.

4.72 Staff have little or no involvement in home provisions or medication requirements. However, previous issues the crews had encountered regarding patient discharge include:

- Medication not ready when transport had been booked.
- Care packages not in place as expected, potentially leading to the return of the patient to hospital.
- Patients' family or carers not aware the patient is returning home.
- Equipment not in place to support the patient's home-living.
- Access to property (key safe).
- Lack of information at time of booking delaying the transfer.

4.73 The impact of COVID-19 on the organisation was detailed, including measures needing to be put in place to slow the spread of the virus (which reduce the efficiency of the service as well as adversely affect quality, performance and cost). Shielding high-risk patients, staff absence reducing manning levels, deep cleaning after transporting COVID-positive patients, and increased use of PPE was also noted.

4.74 With reference to the list of identified issues in relation to discharge, the Committee asked if these were merely one-off incidents or whether some were more common than others. Medication concerns were most prevalent (though this impacted more on admission to care homes rather than an individual's own home), whereas care packages not being in place was less of a problem as ERS Medical work alongside hospitals to ensure these were as expected. If family or carers are not aware that someone is returning home, their house might be cold, but this, along with all other issues, occurred very rarely. Members were assured that ERS Medical crews did not wish to leave any individual in a vulnerable position.

4.75 The Committee explored the process for raising issues back to NTHFT and asked if the Trust had a designated person that ERS Medical staff could contact in relation to discharge concerns / problems. Assurance was subsequently given that the organisation works closely with the hospital (particularly call handlers) on a daily basis to reduce any risks and rectify any issues.

At the point of any incident, staff raise this on the 24-hour RADAR system. Once completed, an email is received by the care team and the Senior Operations Manager alerting them to a RADAR healthcare event. At this point, the Senior Operations Manager informs the hospital of a possible incident and an initial investigation will be carried out at site, taking incident reports and statements from any staff involved. A copy of any booking information received from the booking hospital through the Cleric online booking system is also taken, and an investigation will also be carried out by the ERS compliance team.

Once all the information has been collected and reviewed, the Senior Operations Manager receives a technical review of the incident and any action plan the care team feel needs to be in place to reduce future risk or any lessons learnt. Once completed, the hospital is provided with the findings. These will be reviewed at the monthly contract meeting with the hospital or, if needed, a meeting will be put in place at the earliest opportunity to agree on the actions required depending on the incident. If the incident reported relates to safeguarding, a referral will be put in place immediately.

4.76 A query was raised as to what happens if no care plan is in place and there is no food at the home of a returning patient. In these circumstances, ERS Medical staff try not to take people back to hospital and will contact the Senior Operations Manager (or other service leads) whilst waiting with the individual until family / carers can come out or the hospital responds. It was reiterated that staff would not leave a person alone.

4.77 Regarding COVID-19, the Committee asked about the impact of requiring more time cleaning down ambulances and whether more crews were needing to be deployed. ERS Medical liaised with hospitals around the former, who responded by setting-up cleaning points at the hospital site to reduce vehicle downtime. In relation to the latter, the organisation monitors the numbers due to be discharged and can send additional support if required (an ad-hoc crew can be made available).

Discharge / post-discharge support

NHS Foundation Trusts

4.78 The **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** volunteer *Home But Not Alone* service was detailed involving help with morning discharges, supported transport home (via Volunteer Drivers), and checking if heating is on (if required), the TV works and food is in the property (involve local food banks if necessary). Up to 28 days of neighbourly support and transport to outpatient appointments was offered, and the service would also look to involve wider VCSE organisations where appropriate. NTHFT had to

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suspend the service due to COVID-19 but stated that it would be resuming from the start of June 2021.

4.79 The contact number for the relevant hospital ward was provided by **South Tees Hospitals NHS Foundation Trust (STHFT)** so discharged patients can get in touch about any subsequent concerns / issues which the Trust can then look to address / support.

4.80 All service users who have had a period of **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** inpatient admission must receive a follow-up within seven days (best practice is within three days) of hospital discharge by the person identified on the care plan. The Adults Mental Health service had two breaches in the seven-day follow-up during August 2020 - December 2020 – there were no breaches for MHSOP and LD services in this time period.

4.81 All patients are followed-up post-discharge either by their Care Co-ordinator or by a Nurse from the Intensive Community Liaison Service. Follow-up is within 72-hours from leaving the ward unless the patient is at high-risk of self-harm or suicide (if so, it is 48-hours or earlier). This is monitored closely by staff on the ward.

<u>Five Lamps</u>

4.82 The Committee received information from Five Lamps, a registered charity based in Thornaby which delivers an integrated range of social, economic and financial inclusion services within which it seeks to transform lives, raise aspiration, remove barriers and offer choice. Part of its offer is to provide support for people to live independently in their own home, and their contribution focused on the commissioned service that Five Lamps delivers, as well as the Lottery-funded *Home from Hospital* initiative which provides low-level hospital discharge support. A separate 'Home from Hospital –

Impact Report (July 2019 - December 2020)' (for further details, see http://www.egenda.stockton.gov.uk/aksstockton/images/att39714.pdf) was also provided.

4.83 The main issues highlighted / discussed in relation to Five Lamps' commissioned home care service were as follows:

- The Rapid / Hospital Discharge commissioned service provides support for 14 days (160 hours per week), though some individuals had been supported for longer. Referrals should be via email and follow-up call (latter does not always happen), and those received from hospital are often with limited information. Five Lamps have previously provided feedback to hospitals regarding a small number of unsafe discharges.

- Those individuals who are referred to Five Lamps are not always informed that Five Lamps are not their permanent provider and have flexibility on call times. Next-of-kin are involved at the point of discharge.

- Social Workers should make contact with Five Lamps seven days after receipt of referral – this sometimes does not happen and Five Lamps need to chase.

- Weekly meetings with Stockton-on-Tees Borough Council (SBC) and the other Rapid / Hospital Discharge provider had improved communications and led to smoother discharges – Five Lamps are now informed if a discharge will be delayed (historically, there have been incidents of a carer being sent to a person's home when they are still in hospital) and sometimes get follow-up contact by a person sending a referral to check everything is in order, which is helpful.

- There has been a much greater focus on care homes than home care / extra care providers during the COVID-19 pandemic. Keeping staff safe was an important priority, but Care Assistants only received regular testing from December 2020. Currently must chase-up COVID-19 test results on discharge; if no result, the individual was treated as COVID-positive.

- Receiving a lot of positive support from SBC in relation to the pandemic, but now the additional 5% funding for personal protective equipment (PPE) had stopped, the free Government supplies are not enough. In addition, the current Service Level Agreement (SLA) for the commissioned service had expired and there was uncertainty around the future of the project despite it receiving good customer feedback.

4.84 The Committee asked how Five Lamps was coping with the effects of the pandemic. As a result of staff being furloughed, the organisation had to change its delivery model and had tried to secure funding to cover this period. Its care service had experienced the greatest impact, with a number of staff either absent from work or self-isolating – this in turn affects income which impacts upon the overall business.

4.85 Concern was expressed in relation to the need to chase Social Workers following a referral, and the Committee asked if there was anything it could do to address this. The SBC Director of Adults and Health was unaware of such an issue and felt that the weekly meetings involving both SBC and Five Lamps gave an opportunity to raise any concerns. However, this would be

followed-up internally with relevant staff (note: no issues were subsequently raised by either the Council or Five Lamps itself).

4.86 Regarding the 160 hours per week commissioned support, the Committee queried how many staff involved in an individual's care that equated to, as people tend to prefer the same carer coming to help them. Five Lamps stated that, whilst it does try to provide consistency in those giving care to an individual, this has been a significant challenge due to staff sickness and self-isolation. It was acknowledged that continuity is vital for clients, and staff familiar to an individual can pick-up on any emerging issues much quicker.

4.87 The Committee questioned what was being done about the inadequate PPE supplies from the Government. Five Lamps confirmed that it did have adequate levels of PPE at present (January 2020), but that cost was a challenge (need to have enough over and above the norm). As mentioned previously, SBC had provided significant help around PPE, but costs were increasing.

4.88 Five Lamps' *Home from Hospital* project was outlined:

- Started in October 2017 and was initially funded via Catalyst's Health Initiatives Fund. Successful project, performing above contract targets.
- Whilst Catalyst funding expired in March 2019, Lottery funding was secured for a further three years, with the service re-commencing in July 2019.
- Provides low-level hospital discharge support (transport home, shopping, collecting prescriptions, attending appointments, liaising with other services, signposting and referral) for people aged 50+ for up to 14 days post-discharge from the University Hospital of North Tees.
- Some issues were noted – had seen customers readmitted, occasions where Five Lamps had to organise medication due to miscommunication on discharge, and referrals not always with full information (e.g. customers needed more support and / or were COVID-19-positive).
- *Pandemic Support Project* highlighted – Lottery-funded for six months (from August 2020) delivering services to the most vulnerable across the Borough and supporting individuals who were shielding or self-isolating with daily telephone calls to help reduce social isolation and help with food shopping, picking-up medication, and sorting any immediate problems out that would reduce their level of anxiety. Store cupboard essentials and cleaning packages were also available for each customer to reduce the stress of trying to find home products and reduce the risk of infection.

4.89 Addressing the data within the 'Home from Hospital – Impact Report (July 2019 - December 2020)', the Committee noted the slight reduction in the rate of referrals to the service over the last six months (July 2020 - December 2020) compared with the previous year (July 2019 - June 2020), but queried if the needs of those being referred were now greater. Five Lamps confirmed that referral rates were starting to increase and that some individuals did indeed require a higher level of support. As demonstrated by the self-referral rate, leaflets about the service were given to hospitals and it appeared that

people were receiving this prior to discharge as well as contacting Five Lamps soon after they left hospital.

4.90 The Committee expressed concern about the medication issues raised and questioned if there was a dedicated contact within the hospital that Five Lamps go to regarding this. Members were informed that there was no single contact and that staff had to chase-up individual wards.

4.91 The relationship between Five Lamps and hospitals was explored. It was explained that there were no significant communication issues and that the *Home from Hospital* staff had built up a good rapport with hospital personnel. Similarly, there were no particular concerns in relation to specific wards, though it was acknowledged that any problems arising from a referral to the service might be a result of which staff member made the referral and what pressure they were under at the time.

Learning from patient experience

NHS Foundation Trusts

4.92 **North Tees and Hartlepool NHS Foundation Trust (NTHFT)** gather feedback from compliments, complaints, patient stories, local and national surveys, and the national Friends and Family feedback service. The monthly Transfer of Care Group (with representation from key organisations, including SBC and a Community Governor who brings the patient's voice) is very informative.

4.93 National surveys were paused during the pandemic, therefore no patient feedback was gathered via this source for the majority of 2020 and early-2021. The National NHS Inpatient Survey had now recommenced and includes 11 questions regarding 'leaving hospital' – the results are due for publication in November 2021.

4.94 In addition to the family and friends questionnaire which is used to inform thinking and improve the approach to discharge, **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** medics are asked for feedback and a group of carers and previous service users also help shape how services operate. In light of the ongoing COVID-19 situation, the Trust was offering daily contact with carers (if desired).

4.95 TEWV asks for the family and friends questionnaire to be completed on both an individual's admission to, and discharge from, hospital. Completion rates were low (despite it being an anonymous questionnaire), but assurance was given that any issues raised are followed-up. The Trust also encourages people to relay any concerns via the Patient Advice and Liaison Service (PALS).

4.96 The Committee drew attention to those individuals who were without family / friends and asked how they were supported through the discharge process. In response, the TEWV advocacy service was noted, as was the chaplaincy service and the excellent support provided by a number of volunteers.

ERS Medical

4.97 On-board patient survey cards were handed out and completed daily. Providing both positive and negative feedback, the information received was cascaded across all ERS Medical sites to provide shared learning and measures were then put in place as required. Further training would also be implemented if the need arose due to the feedback received.

5.0 Conclusion & Recommendations

5.1 As evidenced in the first phase of this review (discharge to care homes during the COVID-19 pandemic), national guidance and requirements around discharge from hospital has changed significantly since the emergence of Coronavirus in early-2020. Policies and procedures that were in place when this topic was originally proposed and initiated have had to be reviewed in order to urgently free-up hospital capacity. However, the basic principle that it is not good for people to stay in hospital if they no longer need acute-based care remains, and to this end, the Committee fully supports the emphasis on getting individuals back to their usual residence at the earliest opportunity (once it is clinically safe to do so) via the *Discharge to Assess* model and *Home First* initiative.

5.2 This second phase of the Committee's assessment of local discharge arrangements focused on the transfer of patients from hospital back to their own home. Data from local NHS Trusts indicated that a vast majority of patients were being discharged back to their normal place of residence and that this was being done, importantly, without undue delay. The Committee did express caution around readmissions, specifically the need for an awareness of individuals who may be readmitted to a neighbouring hospital rather than the one they had recently been to – it was therefore encouraging to hear local NHS Trusts undertaking readmission audits (NTHFT) and full assessments for every new admission (STHFT) which can help in the overall treatment and care plans of those requiring further intervention.

5.3 As with any issue involving patients, proactive and timely communication mechanisms are an essential ingredient in promoting a positive healthcare experience. In terms of discharge from hospital, this applies not only to ensuring appropriate interaction with patients and their family / carers, but also (where necessary) between hospital departments and with partners including Social Care, GPs and transport providers. Evidence of well-established local NHS Trust and Social Care co-working (e.g. Integrated Discharge Team, Integrated Single Point of Access, involvement in discharge planning) was once again widely welcomed, partnerships which senior staff from each domain felt had been further enhanced due to the pandemic. Continuing to work effectively together to ensure safe and sustainable discharge can play a part in reducing demand on hospital services, something which could be an important factor as the NHS tries to tackle a backlog of treatment for a variety of health conditions courtesy of, and delayed by, COVID-19.

5.4 The Committee was conscious that many who come into hospital may not be previously known to services or have required past health and / or Social Care intervention. Some may also not have a family network around them to give assistance following discharge. Identifying individual circumstances / needs during a stay in hospital and providing appropriate support during and post-discharge is an important role for local partners, particularly as these may have been previously hidden prior to any required treatment. Being aware of and, where possible, involving the voluntary, community and social enterprise (VCSE) sector in any discharge arrangements may enable further support options once a person is back home.

5.5 Consistent with the ethos of getting people back to their usual place of residence as soon as possible, the Committee was assured by the approach

of local NHS Trusts in planning discharge from the point of admission, as well as the stated involvement of the patient and their family / carers in these discussions (whether virtual or in-person). For those able to return to their own home, professionals must be confident that the individual will be able to manage their usual surroundings post-discharge and have access to basic supplies when they are initially transferred from hospital. Liaising with family / carers and / or relevant support services to give this assurance is key.

5.6 A further aim of the second phase of this review was to explore how carers were identified when needing hospital treatment and the measures required for ensuring the people they care for were supported during their stay in hospital (and potentially for a time following their discharge). Again, local NHS Trusts confirmed that carers, whether requiring treatment themselves or supporting another patient, were identified as part of initial assessments upon admission and involved in discharge planning. It was also pleasing to hear of the communication with Social Care should a carer go into hospital and be unable to carry out their role, something the Council's Carers Service commendably supports alongside its continued efforts to encourage better identification.

5.7 The Committee was keen to ensure that young carers were afforded the same levels of engagement with health staff when they went into hospital or cared for someone needing treatment, particularly since young people fulfilling such a role have often reported feeling overlooked in comparison to older relatives / carers. Whilst local NHS Trusts gave assurance that a carers' age did not exclude them from being involved in discharge planning, they were also receptive to looking at ways of enhancing processes around the identification of, and engagement with, young carers. To this end, it may be helpful for relevant health professionals to develop relationships with Eastern Ravens which operates a Young Carers Support Service – the survey they carried out in support of this review certainly highlights a need for better engagement, particularly around being provided with information, signposting to other services, and giving feedback on their / their loved one's discharge experience.

5.8 Ensuring any required medication is available at the point of discharge is a vital factor when being transferred out of hospital, and local NHS Trusts outlined the measures in place to understand and provide this prior to a patient's departure. The Committee was also mindful of post-discharge medication needs and was assured that any issues involving a former patient should be able to be addressed by an individual's respective GP (who is sent the relevant medication details by a Trust) or by contacting the hospital ward the former patient was previously on.

5.9 Although a large proportion of patients return home via their own / relatives' vehicles, local NHS Trusts detailed alternative options including ambulance providers, specialist transport, in-house services and taxis. The Committee praised the NTHFT Volunteer Drivers concept, as well as the pilot within Therapy Services to provide wheelchair-accessible transport with multi-disciplinary assessment within patients' own homes – initiatives such as these demonstrate a commitment to strengthening the discharge process and are thus welcomed.

5.10 It was recognised that transport providers had an ability to play a role in identifying any concerns or problems when assisting patients back to their own home, and the Committee was pleased to receive an insightful contribution to this review from ERS Medical, a private transport provider contracted by NTHFT. Whilst some issues were raised, it was reassuring to note that these appeared to be quite rare – nevertheless, NHS Trusts should act on any feedback received from those helping patients return to their place of residence, and ensure that concerns can be highlighted in a timely and appropriate manner.

5.11 The provision of post-discharge support was considered, and the Committee was concerned to hear data from Healthwatch Stockton-on-Tees following a discharge-during-the-pandemic survey which indicated that 80% of patients had received no follow-up assessment after discharge and 40% of patients said they were not given details of who they should contact if they needed further health information or support (though the sample size was only 15). Local NHS Trusts subsequently affirmed that contact details for hospitals were provided to patients prior to discharge, and in the case of TEWV, formal follow-up mechanisms were in place.

5.12 Further discharge / post-discharge assistance for those returning home was outlined to the Committee including the excellent NTHFT *Home But Not Alone* volunteer service and Five Lamps *Home from Hospital* initiative. The imminent resumption of the former addresses many key issues surrounding this scrutiny topic, whilst the latter has for some time now played a valued role in providing low-level support to local residents following discharge. The Committee note that the three-year funding for the Five Lamps project is due to expire in mid-2022 and therefore encourage relevant partners to ensure plans for the continuation of such a service are in place for beyond this time.

5.13 Gathering feedback from patients on their discharge experience helps identify issues and strengthen arrangements, and the Committee sought information on the ways in which this was collected. Local NHS Trusts demonstrated multiple options for patient / family / carer feedback, though discharge-specific evidence was very limited. Although it can be challenging to obtain constructive comments, the Committee urges all organisations involved in the discharge process to proactively seek the views of those who have been transferred home (as part of a formal follow-up process).

5.14 The second phase of this review has covered three key areas around discharge of individuals back to their own home – discharge planning, the discharge itself, and post-discharge support. Each aspect deserves due attention from health and care professionals to provide the best possible experience and an increased chance of a safe and timely discharge from hospital.

Recommendations

The Committee recommend that:

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.**

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.**

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.**

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.).**

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.**

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.**

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.**

APPENDIX 1: North Tees and Hartlepool NHS Foundation Trust – Discharge Pathways

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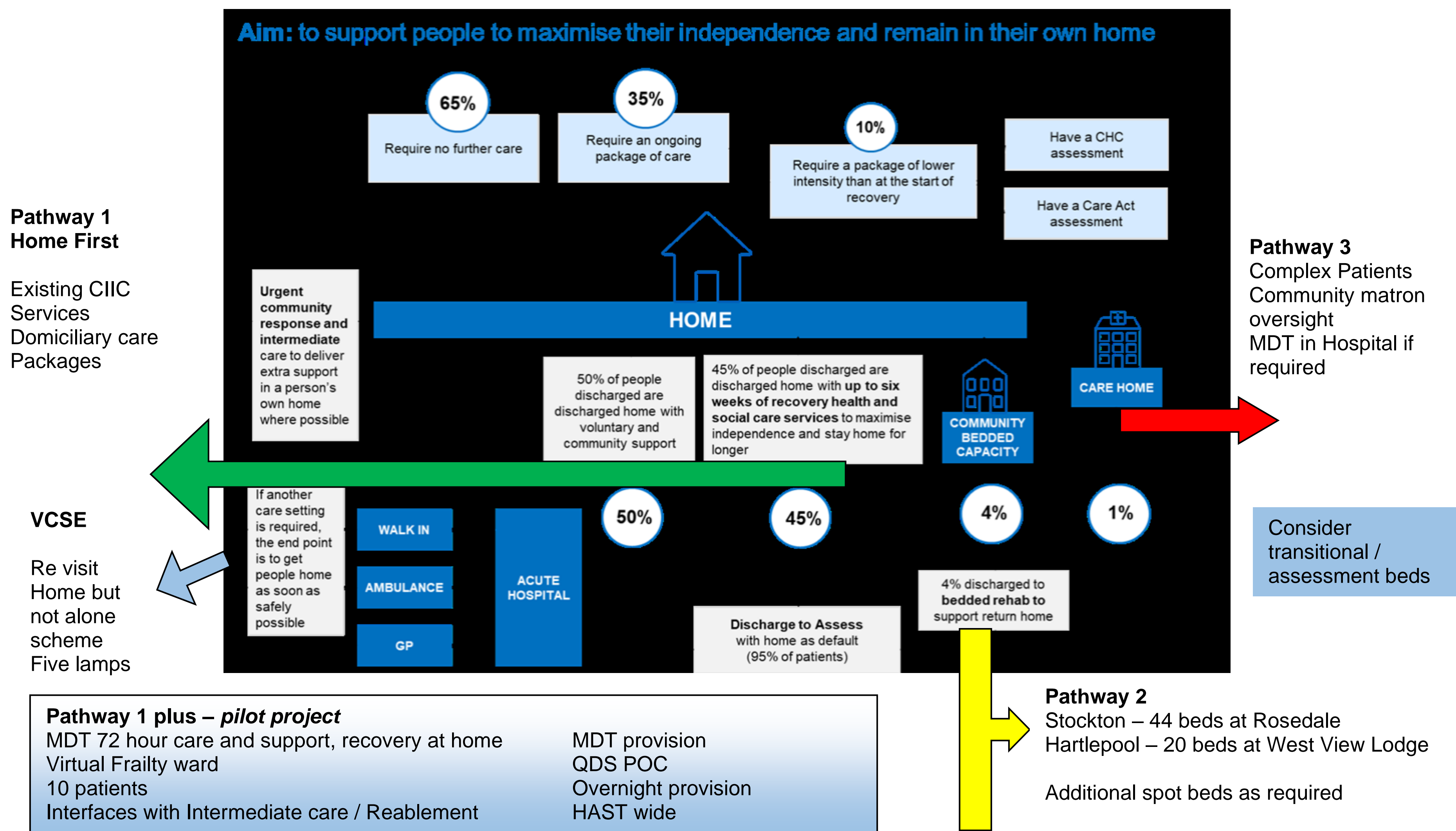
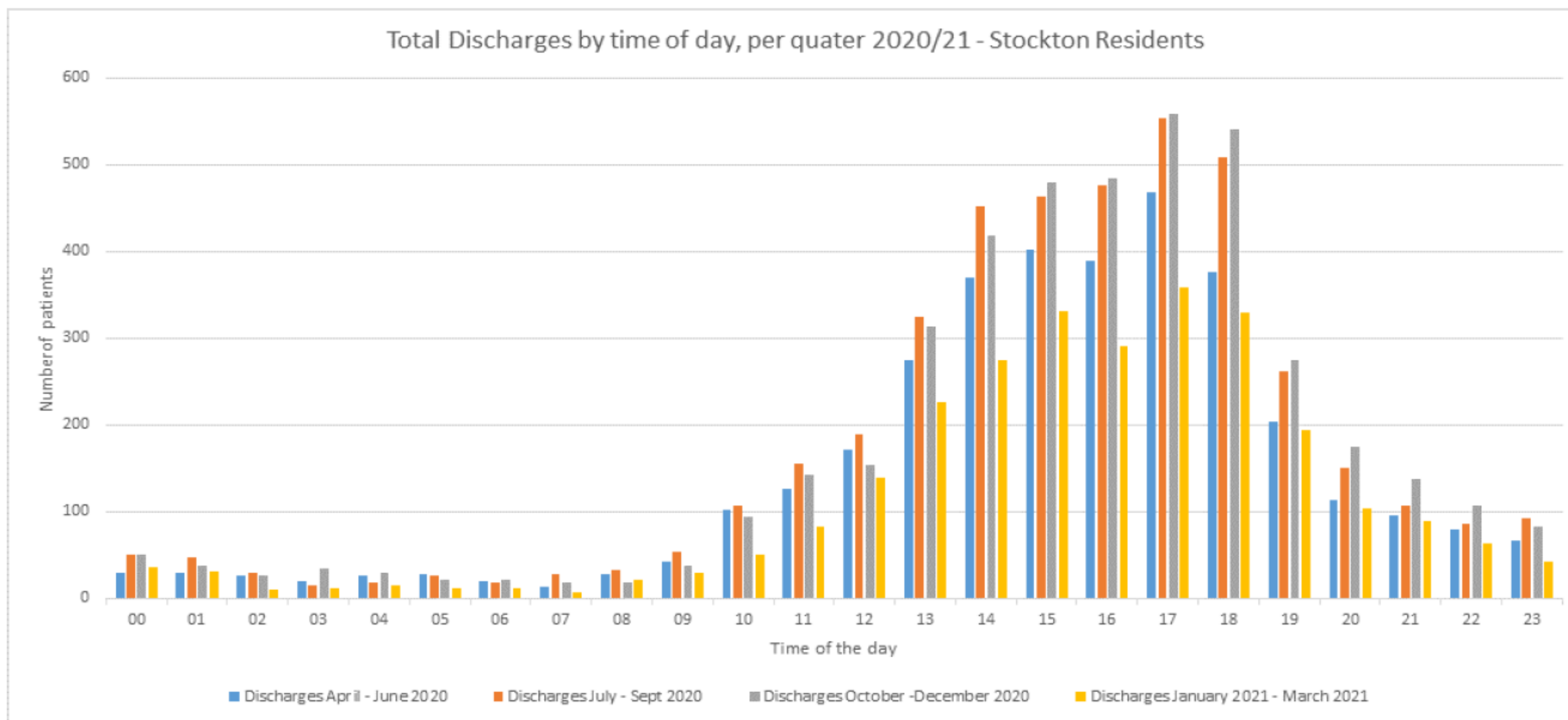


APPENDIX 2: North Tees and Hartlepool NHS Foundation Trust – 2020-2021 Data



APPENDIX 2: North Tees and Hartlepool NHS Foundation Trust – 2020-2021 Data

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

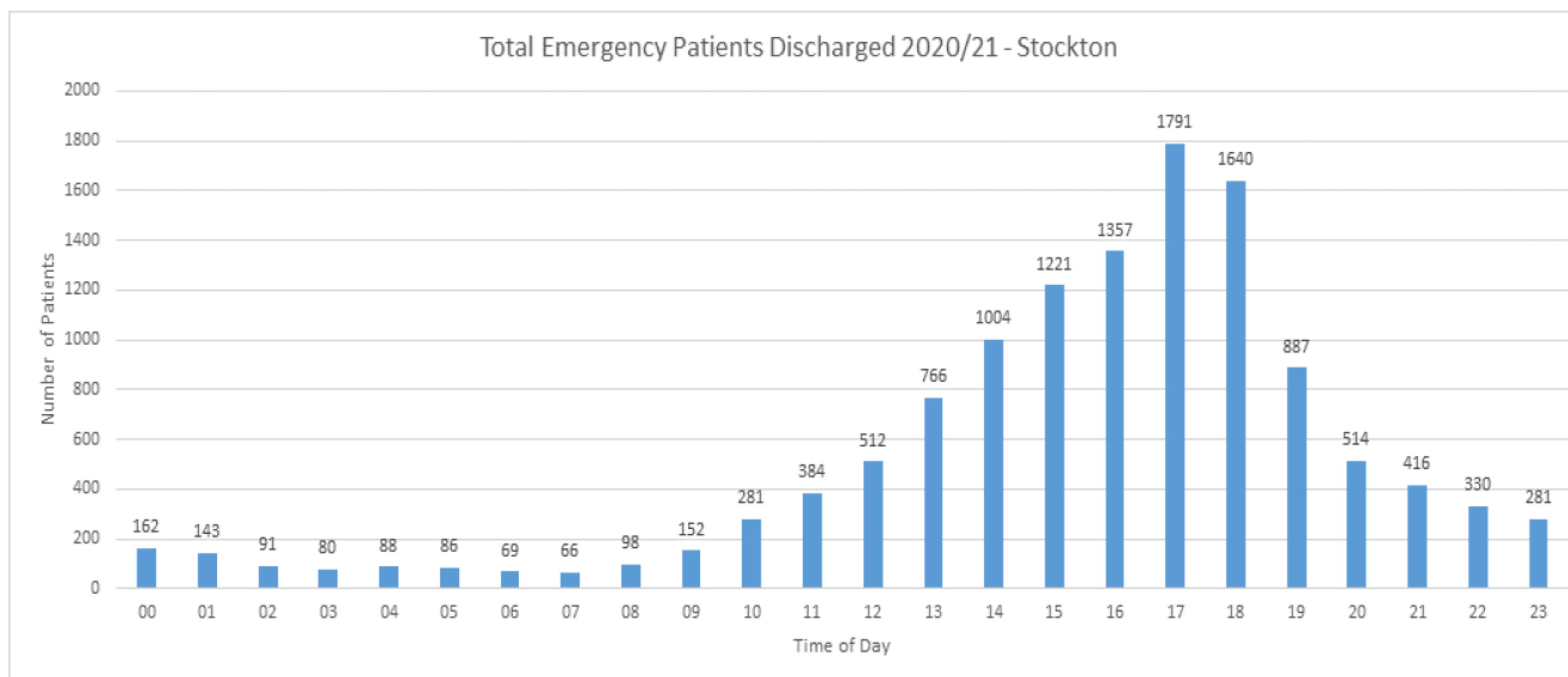
Elective Patients Discharged - Stockton Residents

Number of Patients

Time of day	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Number of Patients	3	2	1	1	1	1	3	2	2	12	72	122	142	373	511	456	284	148	116	47	27	14	6	5

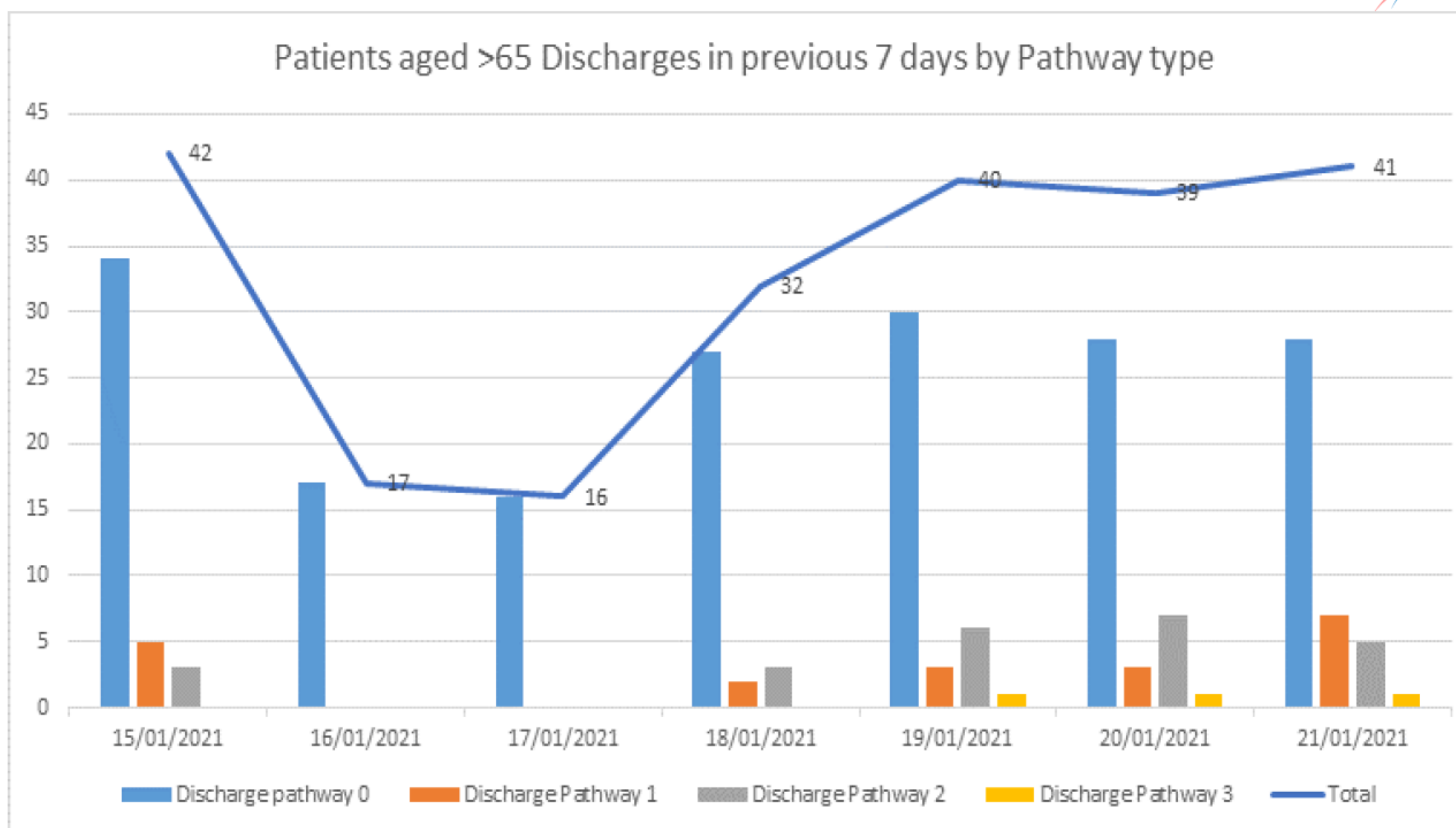
APPENDIX 2: North Tees and Hartlepool NHS Foundation Trust – 2020-2021 Data

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

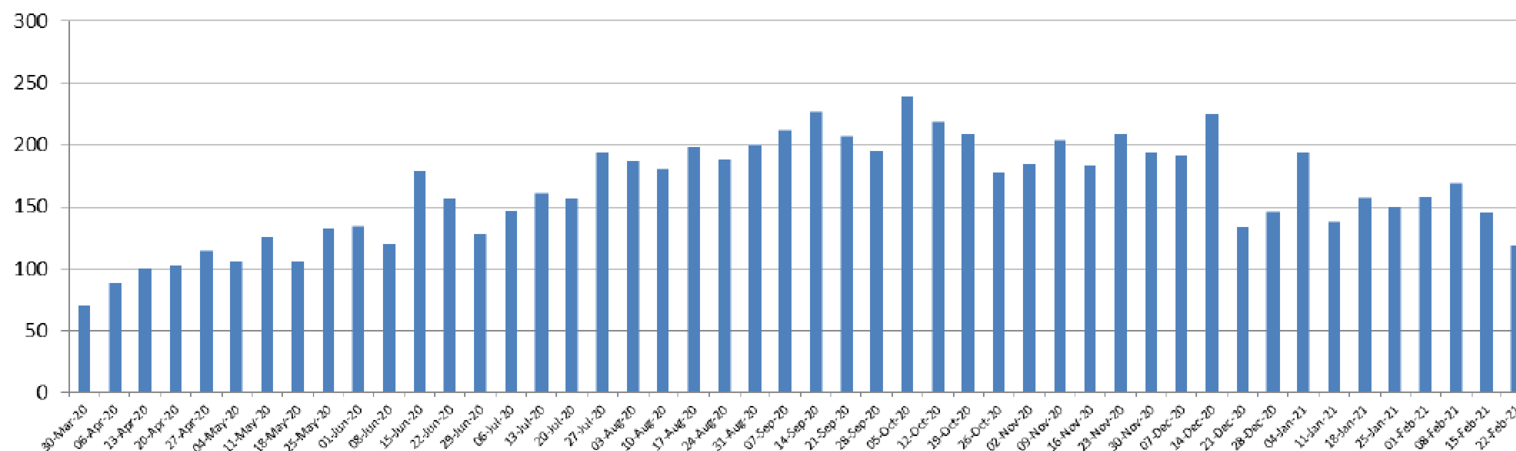


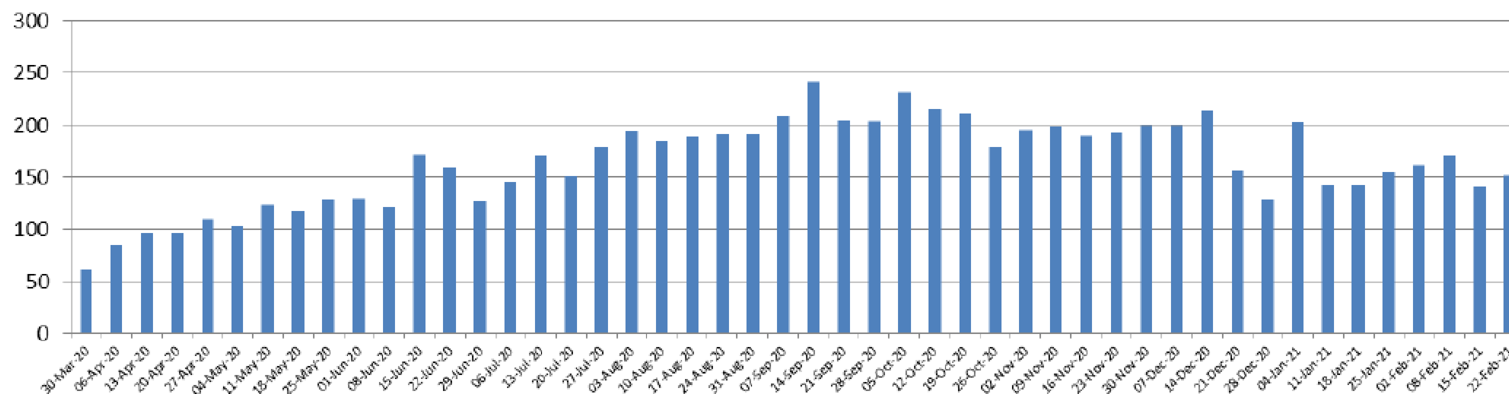
APPENDIX 2: North Tees and Hartlepool NHS Foundation Trust – 2020-2021 Data

Pathway analysis (snapshot from Jan 2021)



APPENDIX 3: South Tees Hospitals NHS Foundation Trust – 2020-2021 Data





APPENDIX 3: South Tees Hospitals NHS Foundation Trust – 2020-2021 Data