ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

SCRUTINY REVIEW OF HOSPITAL DISCHARGE (PHASE 2)

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.**

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.**