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PROGRESS UPDATE: Review of Hospital Discharge (Phase 2)

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

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

Recommendation 2:	**Existing arrangements around the identification of carers when they themselves are admitted to hospital for treatment, as well as options for post-discharge support until they can resume their caring role, be reviewed by all relevant partners to ensure a joined-up approach.**
Responsibility:	NTHFT / STHFT / TEWV / SBC
Date:	
Agreed Action:	**NTHFT**: On every assessment completed by the Home First and Frailty team as soon as the patient arrives in the organisation it is established whether the patient is a carer themselves. This is discussed with the ISPA and is considered when arranging discharge. Information from local partners is also shared during the daily discharge meetings. Process of checking if the person holds a 'carers card' will also be completed. NTHFT staff are given access to SystemOne and are able to access background information to clarify existing arrangements where it is appropriate to do so.
Agreed Success Measure:	**NTHFT**: All patients being admitted to hospital are asked if they are a carer or they have someone at home who needs support. Audit checks to be completed for assurances that measures to identify carers are being completed.
Evidence of Progress (April 2022):	We are in the process of switching to electronic patient records (EPR) using our electronic system *Trak care.* The Senior Clinical Professionals who support hospital discharge and the Home First team are involved in the switch across to EPR and will represent the views of the Committee in the design of the new admission and discharge documentation. Target date for go live for EPR is yet to be confirmed. We have extended access to the integrated single point of access (ISPA) - this is now 24/7 and the team are working with the admission areas including the Emergency Department. This means that the team have access to clinical triage staff who can provide more information to support decision-making.

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	Meeting with Jon Carling from Catalyst, in the diary to refresh connections with Carer forums in Stockton. Strong relationships and regular meetings with Partners to share relevant resources and materials. Working copy of adult core admission document. adult admission document 21.docx
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Positive feedback from areas including the role of the Stroke Association who work with our Stroke teams to support patients, families and carers.
Evidence of Progress (October 2022):	We have daily meetings with locality ISPA to discuss all patients being discharged from hospital, whereby discussions of identifying carers are conducted. The admission document has been reviewed in preparation for transfer to the electronic patient record to include asking if a patient has a carer role to someone. This will be completed upon every admission. HCR430.2 - Nursing Admission Document A research project is underway in partnership with Northumbria University to explore carers and carer organisation views of Hospital discharge. This information will then be used to generate a 'tool kit' of resources that are shared with patients, their families and carers about hospital discharge. SBC Carer engagement Lead to sit on NTHFT Transfers of Care forum.
Assessment of Progress (October 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (October 2022):	Documentation audits / feedback from carers forum.
Evidence of Progress (March 2023):	Work is underway to implement electronic patient records (EPR) across all adult inpatient areas. The changes recommended in October 2022 will be available on the EPR. Due date for completion Spring 2023.

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	Collaborative working with Stockton Borough council and VCSE Organisations established to maintain arrangements for the identification of carers.
Assessment of Progress (March 2023): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (March 2023):	On-going audits and feedback processes.

Recommendation 3:	**Local NHS Trusts develop relationships with Eastern Ravens in order to strengthen the identification, inclusion and support of young carers in the discharge process.**
Responsibility:	NTHFT / STHFT / TEWV
Date:	
Agreed Action:	**NTHFT**: Contact to be made with Eastern Ravens – meeting to be arranged prior to 30th September to explore building relationships and next steps. Agreed actions and maintain relations to form part of discussion.
Agreed Success Measure:	**NTHFT**: Recurrent meetings to take place between NTFHT and Eastern Ravens or Eastern Ravens attend a relevant forum in which NTHFT are attendees. Evidence is provided that gives assurances young carers are identified and supported during hospital admission / discharge.
Evidence of Progress (April 2022):	First meeting took place in September 2021 and actions to take away included sharing resources and Trust staff visiting Eastern Ravens to share and discuss good practice. Covid prevented site visits, further contact has been made with Eastern Ravens and a meeting set up in April 2022.
Assessment of Progress (April 2022): (include explanation if required)	**3 (Slipped)**
Evidence of Impact (April 2022):	Heightened awareness of service, further collaboration and sharing of good practice.
Evidence of Progress (October 2022):	Meetings in April unable to go ahead due to covid. Rearranged meetings in diary for October 2022
Assessment of Progress (October 2022): (include explanation if required)	**3 (Slipped)**
Evidence of Impact (October 2022):	N/A

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Evidence of Progress (March 2023):	Meeting between Eastern Ravens and NTHFT Representatives 8.3.23, information shared and disseminated across Hospital teams. Contact to be maintained to share any future initiatives.
Assessment of Progress (March 2023): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (March 2023):	Regular meetings and feedback to hospital teams.

Recommendation 4:	**Local NHS Trusts make clear to patients and their families / carers whether (and by when) they will receive a follow-up after being discharged, and, for those not requiring immediate health and / or care input, provide appropriate information on who to contact if any significant issues are identified on return home and / or for future post-discharge support (i.e. GP, Community Hub, VCSE links, etc.).**
Responsibility:	NTHFT / STHFT / TEWV
Date:	
Agreed Action:	**NTHFT**: Patients are provided with a discharge leaflet as per the hospital discharge policy which provides details for ongoing support in the community via the ISPA. The ISPA and First contact teams are then able to support the patient if help is required at home utilising services across the voluntary and social enterprise sector (VCSE) and Community Hubs.
Agreed Success Measure:	**NTHFT**: All patients discharged from hospital are provided with information on discharge, including key contacts.
Evidence of Progress (April 2022):	Hospital discharge policy to be reviewed as per new national guidance. Hospital discharge leaflets to be reviewed as per updated policy.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	NTHFT discharge policy available.
Evidence of Progress (October 2022):	Discharge Policy has been updated. Discharge leaflets require review following updated discharge policy and feedback from research project.
Assessment of Progress (October 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (October 2022):	Annual compliance audit to commence 2023.

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Evidence of Progress (March 2023):	Discharge leaflet drafted and once finalised will be ratified as per local processes. Due for completion Spring 2023. Health and social care staff continue to provide contact details for the Single Point of Access to patients and families.
Assessment of Progress (March 2023): (include explanation if required)	**1 (Fully Achieved)**
Evidence of Impact (March 2023):	Audit to be carried out as per interagency discharge policy.

Recommendation 5:	**Local NHS Trusts / Healthwatch Stockton-on-Tees provide the Committee with any available discharge-specific feedback from patients / families / carers in relation to those discharged back to their own homes.**
Responsibility:	NTHFT / STHFT / TEWV / Healthwatch Stockton-on-Tees
Date:	
Agreed Action:	**Healthwatch Stockton-on-Tees**: Healthwatch Stockton-on-Tees to complete a post discharge audit for patients / families / carers who have direct experience with a hospital discharge to home address.
Agreed Success Measure:	**Healthwatch Stockton-on-Tees**: Not specified.
Evidence of Progress (April 2022):	Appropriate public and patient feedback (and more targeted engagement with specific groups of people) in relation to the discharge process is communicated to all relevant responsible bodies/service providers, through regular attendance at the SBC ASCH meetings, other local partnership service meetings, and by presentation of Healthwatch Stockton-on-Tees (HWS) reports (based on public and patient feedback). Based on public feedback and local intelligence, HWS have no additional information to feedback in relation to discharge at this time.
Assessment of Progress (April 2022): (include explanation if required)	**2 (On-Track)**
Evidence of Impact (April 2022):	Discharge information reported to Healthwatch is made available to partner organisations to support future learning.
Evidence of Progress (October 2022):	Feedback data and intelligence is shared with the committee on an annual basis or when requested. Healthwatch is both proactive and responsive in sharing information and intelligence on hospital discharge.
Assessment of Progress (October 2022): (include explanation if required)	**1 (Fully Achieved)** *The Committee asked that an audit be undertaken before their element of this recommendation was signed-off as 'fully achieved' (the assessment of progress would therefore be amended to 'on-track').*

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Evidence of Impact (October 2022):	Committee is sighted on all information Health watch holds on hospital discharges.
Evidence of Progress (March 2023):	No response provided
Assessment of Progress (March 2023): (include explanation if required)	No response provided
Evidence of Impact (March 2023):	No response provided

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