Appendix 2

Let's get You Home

Summary of Recommendations and agreed actions for improvement

Healthwatch identified recommendations in four key areas:

1. Communication
2. Personalised care
3. Delayed Transfers of Care
4. Independent Living

	Recommendation	Agreed action	responsible officer	impact / date of delivery
1.	**Communication** **Improved patient communication from hospital to home: discharge planning to start within 24 hours after admission; written and verbal communication with every patient, consistent use of one document covering hospital to home patient advice.**			
1.a	Discharge Planning should start within 24 hours of admission	• Work has already started on discharge planning for all patients within 24 hours after admission. • One document covering patient advice is now being piloted in draft form	Head Nursing of Discharge	May 2019

		in key areas. • Existing stock of 'Planning Your Discharge from Hospital' is available on the wards whilst production of the new document is completed. • A continuation of education and coaching on the wards and acute floor is underway with a link role in the Discharge Coordinator Team for Education, and the appointment of a Matron for Integrated Discharge to support the Safety and Quality agenda around Hospital Discharge, whilst supporting the team managerially and operationally, successful candidate is expected to take up post beginning of June 2019.	Head Nursing of Discharge Head Nursing of Discharge	Ongoing March 2019

		• Engagement with senior nursing network planned at Nursing Midwifery Management Board 13/3. • Plan with Head of Nursing for Practice Development to consider the Discharge Planning Document when reviewing all current Admission and Discharge documentation, which will include a prompt to date and sign that the initial discussion around discharge has taken place and documentation has been given to patient/family/carer • There is 7 day HASC social work presence in RSCH to support early discharge planning.	Head Nursing of Discharge And Head of Nursing Practice Development Assistant Director, HASC	
1.b	Written Discharge Planning should be provided to all patients	• The current 'Planning You Discharge from Hospital' document along with the	Head Nursing of Discharge	May 2019

		separate 'Let's get you Home' booklet is currently being provided to patients and families. • The new document will combine these two documents.		
1.c	Communication should be consistent for all patients	• The content structure of the above document (1.b) is consistent		
1.d	Every patient should receive one document covering all patient advice	• One document covering patient advice is now being piloted in draft form in key areas.		
2	**Improved communication between hospital and community-based staff. Information to be consistent, complete and timely; One person should be appointed as having responsibility for the overall discharge planning.**			
		• Established Board Rounds on each ward, which invites all Multidisciplinary Team members to participate and assign actions for the day. • The Discharge Team is now covering 7 days a week since December 2018 and working closely	All divisions Heads of Nursing , Head of Discharge and NHSI support team. lead by COO	Commenced February 2019 Commenced February 2019

		with the community trust to facilitate and communicate around discharge plans. Speak with patients and their families regarding the expectations, wishes and process. • Community In-Reach Team are provided by Sussex Community Foundation Trust and work within BSUH NHS Trust and are very much an integral part of the Integrated Discharge Team 7 days a week • Close working partnership with adult social care partners. • Daily Multi Agency Teleconference held Mon-Fri where every patient who is medically ready for discharge, information shared and actions assigned.	Head of Nursing - Discharge All divisions Heads of	Commenced February 2019

		• Multi Agency events have been held since 2016 in various forms to review all inpatients at specified Lengths of Stay, currently a new process has just been launched supported by NHS Improvement's Emergency Care Intensive Support Team where all patients over the length of stay of 21 days are reviewed, themes and actions are recorded and each ward will be receiving a report with their own performance illustrated along with the Hospital's overall performance. • In 2018 a clinical review took place supported by the S&Q Team at B&H CCG of a number of cases where discharge did not	Nursing , Head of Discharge and NHSI support team. lead by COO	

		go well when discharged to local Intermediate Care Units, this was interesting and gave understanding of some limitations in community care settings and also raised some themes that have been able to improve on. • There is regular HASC social worker involvement in daily board rounds and in teleconferences.	Assistant Director, HASC	
3.	**Hospital staff should maintain a written or electronic record of all discussions taken place with patient and family member/carer about the patient's discharge. This information should be held in one form and patients and family members/carers should be given a copy of this form; the *Discharge plan extension form* should be redesigned to allow this information to be recorded.**			
		• The discharge documentation is being reviewed and this will be taken into consideration. • Discharge Planning	Head Nursing of Discharge	Immediate

		meetings currently are documented but not shared with the patient and family, this is a clear gap in the communication and is relatively simple to resolve. • Best Interest Meetings are a formal process where there is a formal chair and minute taker therefore meeting notes are taken and shared with the patient and family. • The Continuing healthcare Process includes a consent section which initiates a conversation between the Discharge coordinator/Patient/ Family around the expectations and specific discharge process. • Work to focus on the ward Led Simple Discharges	Head Nursing of Discharge with Education Team Senior Nursing Network and Education Team	Ongoing supported by Safeguarding, dementia and discharge teams

		and documentation around these conversations. • HASC, SCFT and BSUH are currently working to develop a joint discharge leaflet.		June 2019
4.	**Personalised Care: Patients and family members, carers or those in their support network should be involved in the decisions about the patient's care both during their stay and also regarding what will happen to them on leaving hospital. They should be made fully aware of any choices and given the opportunity to say for themselves what kind of care they might need at home. Where possible, practical and safe to do so these views should be factored into pre- and post care arrangements; and where not achievable, explanations should always be provided.**			
		• If a patient is admitted from		ongoing

		home every effort is made to discharge them to their home if safe to do so. If the discharge is considered simple, either no care required on discharge or a re-start of their previous package of care, this is led by the wards and the ward or Hospital Rapid Discharge Team will liaise with the patients/families/carers. This is often not happening early enough in someone's admission – so is part of the work to be undertaken around simple discharges and will be addressed through the development of standard work with board rounds and If the discharge is more complex and the patient will		

		require some support to return home this is discussed with the patient and family and planned around their level of need. • If home is not possible or recommended straight from hospital, Letters have been produced to inform patients and family members that perhaps a period of rehabilitation has been recommended or transfer to our sub-acute ward in Newhaven is necessary. The letters invite the patient and family to discuss any concerns with staff members or Discharge Team. • HASC social workers form part of the discharge team	Assistant Director, HASC	

5.	**Hospital and community care services should differentiate between patients living with, or regularly supported by family and/or friends, and those living alone and unsupported.**			
	Our Hospital Rapid Discharge Team work in the Emergency Department, Acute Floor and Care of the Elderly Wards, screen everyone who meets their criteria, the screening document initiates an initial conversation about what support the patient previously had and is documented on a specific screening tool. This is not used widely as is quite comprehensive and the standard admission document covers patients less likely to have complex discharge situations. In April 2019 we are launching new nursing documentation which will be less detailed but prompts initiation of the conversation. HASC social workers form a key part of the rapid discharge team. HASC social workers provide support and formal assessment for carers where required.			
6.	**Reduction of delayed transfers of care (DToC) :The hospital should identify and implement workable actions that reduce the number of stranded patients, particularly for this age group (65 years old plus).**			
		Multi-agency DToC summit held with ongoing weekly meetings since August. Focus is reducing DToC For 'stranded' patients: • ASC support with weekly in-patient review • Daily Multi Agency Teleconference which reviews each medically ready patient, defines what we are waiting for and what the next step is. Also records whether the patient is considered an actual Delayed Transfer of care – this is in discussion with all on the call. A set of DTOC principles have been produced in line with	CE of system including BSUHT, CCG and B&HCC All system partners	reduction in DToC from 6% to 3.2& by December 2018 Ongoing

		the National Guidance to support the clarification of DTOC's, e.g. Timeframes from referral to assessment, confirmation that referrals have been received, Has all internal assessments and information been provided? If the Discharge Plan was initiated that day, is there anything that would prevent the patient from being discharged, if the answer is no, then they are a Delayed Transfer of Care. • A robust database is kept which is used in the background on the Daily Multi Agency Teleconference and generates a daily report which shares the updates and actions for and a performance dashboard indicating the DTOC figure for the day, Discharges facilitated from the medically Ready caseload and also	Head Nursing of Discharge	Ongoing

		informing of what services and localities patients are delayed waiting for. • This daily report will then feed into the weekly sitrep reporting process which is reported to NHS England. • The target of 3.2% has been achieved and held consistently with an occasional variance. • A heightened focus on weekend discharges with community and Adult Social care support is hoped will drive the number of medically ready and pts who are delayed down even further with a consistent daily approach rather than 5 days a week service. • New Superstranded process supported by ECIST in the implementation with an aim to reduce the number of superstranded (LOS 21+ days) considerable	Head Nursing of Discharge All system partners All system partners	Reviewed and reported weekly Under on-going review Weekly reviews undertaken and evaluated

		and identify themes to resolve that can prevent future delays. • Regular and Accurate Information being provided by community partners informing the acute trust which patients have been referred to their services and what capacity is available is vital in the preparing patients for transfer and discharge.	All system partners	
7.	**The hospital should maintain services such as blood tests, x-rays and access to medical prescriptions during the weekend at the same level of service as during the week.**			
		The desire and ability to provide a 7 day discharge service has improved somewhat with Discharge Coordinator, Hospital Rapid Discharge Team also covering the weekends, along with community partners and adult social care cover. To provide 7 days service in all specialities would involve a high level of investment and services are examining how they can re-organise their services without severely		

		compromising weekday activity		
8.	**Independent Living: All patients who are discharged home should receive an assessment for independent living and where needed, provided with the appropriate support structure (adaptation) to enable independent living.**			
		Where possible the Home First model is implemented where patients are discharged home and assessed within their own home rather than being assessed in hospital. (This pathway is primarly funded by the CCG.) When care capacity allows this is an excellent model, however capacity has been reduced and we now see patients waiting in hospital for Home First Discharges. First and Foremost Hospital Discharge is always aimed to return the patient to their home and encourage independence as much as possible. Where possible we utilise Age UK and Red Cross Hospital Discharge Services to support the patients discharge.	SCFT/ASC and B&H CCG	
9.	**All patients should be provided with written advice about living independently post-discharge. This should include advice about how to maintain good hydration and nutrition and how to access local support groups and activities e.g. the Brighton and Hove Ageing Well service.**			

		All patients now receive advice on nutrition and hydration and accessing community groups. BSUH are providing information that will go into the new Discharge Information. The current stock of hospital documentation is being used in conjunction with the Lets Get You Home leaflets until stocks are used. Whilst the new documents are being completed and produced.	Head Nursing of Discharge	May 2019
10.	**Better follow-up arrangements: Every patient to be provided with advice on who is likely to contact them and who they should contact should a problem arise. Each patient to be provided with a suitable support structure at home. Service provision discussed in the hospital should be followed through to service provided at home.**			
		The new discharge document will include useful contacts if a problem arises.	Head Nursing of Discharge Sara Allen	May 2019