



Hospital Discharge Event Report December 2009

1 Introduction

21 people attended the LINK hospital discharge event. This included individual LINK members, local voluntary organisations and representatives from North Tyneside Council, Northumbria Healthcare NHS Foundation Trust and North of Tyne PCT.

The aim of the event was to find out about hospital discharge processes and for members to offer suggestions to improve the patient experience and to offer their knowledge of local community based services that can support patients and their relatives/carers back at home.

2 Background

Hospital discharge has been an issue that LINK has been working on since the beginning of 2009. LINK members raised concerns about the process of leaving hospital at our launch events in January and February. North Tyneside's Health and Wellbeing Sub Committee then approached LINK and asked us to consult our members to gather evidence of people's experience of hospital discharge.

In March, LINK held an event inviting member's to come and share their experiences. These experiences were captured and recorded in a LINK report, which was submitted to the Health and Wellbeing Subcommittee (this report is also available online at www.linknorthtyneside.org.uk). This report highlighted issues around communication between medical and social work staff, communication between professionals and relatives/carers and follow up/community based support.

This report was also sent to Northumbria Healthcare NHS Foundation Trust and North Tyneside Council's Medical Social Work Team. LINK met with staff from both of these teams, who were keen to address issues raised by members. Hospital discharge has been an issue for many years and is a priority for several LINKs across England.

LINK brought together Northumbria NHS staff, North Tyneside Council staff and LINK members in September to discuss the issues that had been raised and how to move forward. It was agreed that a further meeting in December would be held to inform LINK members about current discharge arrangements, and to gather feedback and suggestions.

3 Summary

Georgia Douglas Manager of the Hospital Discharge Team (North Tyneside Council) and Lorna Dace, Operation Services Manager for Acute Medicine and Critical Care (Northumbria Healthcare) gave presentations on the discharge procedure from the social services and NHS perspectives. This was followed by a lively question and answer session. Then the four tables of attendees were asked to consider how the hospital discharge experience could be improved for patients and carers. Below is a summary of suggestions;

3.1 Medication

Patients could start taking their new medication on the ward. This would get them used to any changes in their medication regime and would prevent discharges being delayed as a result of patients waiting for their medication to be prepared on the day of their discharge.

3.2 Communication

Improved communication is key to making sure that patients and their relatives/carers have all the information they need about the patient's condition, their medication, any follow up treatment or support, and information about support services in the community. This should include written information with contact details that can be taken away. Fully involving relatives and carers in discharge planning should improve communication between professionals and carers.

Communication between professionals, in particular between medical and social work staff, would improve discharge planning and decisions regarding discharge should be made jointly between consultants and social workers.

Communication between Newcastle Hospitals and community teams in North Tyneside is particularly important to ensure continuity of care for patients being discharge back into the borough.

3.3 Social Work Team

It was suggested that ward staff should be better informed about the hospital discharge and medical social work teams. Knowing what this team can offer would give them a better idea of which patients to refer to the social work team. A further suggestion was that social work staff on wards need to be more recognisable to patients and relatives/carers. This could involve adding their names and photos to ward boards. A contact number for the social work teams should also be displayed, so that people can contact them if they feel they need support once they have left the ward.

It was felt that heightening the profile of social work staff in this way could reduce the anxiety of patients and relatives/carers being referred.

It was recognised that work is already taking place to improve patients and ward visitor's knowledge of social care support services as local authority leaflets have been shared with wards. Georgia's team have also developed leaflets specifically about the Hospital Discharge Team, which will be put on the wards across North Tyneside General Hospital once they have been printed. Georgia has also been working with North Tyneside Carers Centre to improve support to relatives and carers on wards.

3.4 Intermediate Response Team

It was felt that relationships between the hospital and intermediate care team in the community could be strengthened so that the community team get more appropriate referrals and more information on the patients that are referred to them. The Intermediate Response Team also suggested that their contact information should be given to patients and carers so that even if they do not want a referral from the hospital, they can contact the team if they feel they need support once they are at home.

3.5 Other

- 'Hospital discharge' has negative connotations, would prefer 'Transfer of care'.
- The intermediate care response team said it was important that patients referred to them are not discharged from hospital before they have had the chance to do an assessment.
- Ward and social staff should be better informed about services of community teams (Council, NHS/PCT and Voluntary sector) in order to refer patients and their relatives/carers to appropriate support.
- It was suggested that a Community Matron should be in place and that the role would include attending multi disciplinary team meetings.
- Community services are limited and inflexible, this needs to be improved to better support patients

3.6 What works well?

It was felt that having a social worker on each ward is good for communication between the hospital and social work teams. Care facilitators were also considered to be a good service. This service appears to be only for complex discharge cases and attendees wanted to know whether anyone could have access to a care facilitator, and how people would find out about them and get their contact details.

There was also discussion about the new Kielder Unit at North Tyneside General Hospital and the discharge lounge, which attendees thought were both excellent and much needed service.

3.7 Support in the community

Tables were also asked to share their knowledge of services that exist in the community and that could support patients and their carers once they have left hospital. Due to the agenda over running, few tables got the opportunity to discuss this in much depth. LINK has therefore put a call out in its December issue of Stronger Voice asking people to let us know about these services in the community. This information will be passed on to the Hospital Discharge Team and to Lorna Dace so that all staff dealing with discharge can be informed about local services and will be able to signpost patients and their relatives/carers to services that can support them once they leave hospital.

Those community based support services that were mentioned are

- MS society North Tyneside, offers information and support, friendly ear, drop-in services and advice. Also has a national helpline
- Age Concern North Tyneside offers a variety of services to people in the community from day care to befriending, information and advice
- Immediate response team have a dementia service that supports people with dementia at home if their relative/carer is unwell or in hospital.

4 Next Steps

LINK will be taking the following actions as a result of this event;

- LINK will be following up suggestions made in this report with Georgia and Lorna and will feedback progress to the LINK membership.
- LINK will contact community teams about how their information can be displayed in wards.
- LINK will continue to gather information from its members regarding support that can be accessed in the community. This information will be shared with patients, Georgia, Lorna and LINK members.
- LINK will send this report to all those who attended the event, to disseminate amongst their networks and to inform forums and boards that they sit on.
- The issue of communication between Newcastle Hospitals and teams in North Tyneside will be raised with NHS North of Tyne. Newcastle LINK will also be informed of this issue.
- From participant evaluation forms it is clear that members would find it useful to have more information about the roles of community based teams. LINK will gather this information and share it with LINK members.

5 Participant Feedback

All attendees were asked to complete an evaluation form to help the LINK team find out what works well and what we could change for future events. All those who attended found the event *Very Useful* or *Invaluable* and everyone felt able to contribute to the discussions that were had. Comments from the evaluation forms were very positive, and suggestions for action have been included in the Next Steps section of this report.

Comments from attendees:

Very interested to hear about the Kielder Unit which sounds excellent

Well run useful meeting

A very positive meeting, so much work is being done and future plans are very reassuring

A great deal of information was forthcoming.

LINK would like to thank all who attended the event, and in particular Georgia Douglas and Lorna Dace for sharing information about their services and their continued work with LINK.