Discharge from Health and Social Care Settings

	Recommendation	Recommended to	Update
Healthwatch York made 4 recommendations to York Hospital in our report on the Enter and View Visit to the Discharge Lounge			
1	Consider ways in which reliance on family and friends for transport home can be reduced. For example working in partnership with voluntary organisations such as Age UK York and York Wheels to make sure patients have access to affordable and safe transport home	York Hospital	We do work with Age UK. Family and Friends will be encouraged to provide transport to enable support to be targeted to most vulnerable groups.
2	Patients should be given at least 24 hours notice of their discharge time and this time should be kept to as closely as possible	York Hospital	50% of patients have an EDD with 24 hours notice. Remaining 50% are same day discharges where late result investigation or final doctor reviews required. Patients and family are aware but not guaranteed a time.
3	Consider whether patients who are ready to be discharged could be 'fast tracked' so that they receive their medication from the pharmacy as quickly as possible	York Hospital	TTOs are already fast- tracked through pharmacy.
4	Review the frequency with which the IT system is updated with the expected date of discharge for	York Hospital	The EDD status on the Trust's EPR is updated at least daily to reflect the status of patients and aid with discharge planning. It allows filtering on

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	patients. This would help the facilitating rapid elderly discharge (FREDA) team correctly identify patients who were ready for discharge and not spend time with patients who were not actually ready to go home		patients marked as ‘ready for discharge’ either today or tomorrow, but also identifies any actions which are required prior to discharge.
Further Recommendations			
5	Consider giving patients the option to request that a family member/carer be notified of their discharge time at the same time as the patient themselves	York Hospital	Hospital to give further time to consider as could be difficult to administer.
6	Consider how to improve the consistency of approach to conversations between hospital staff and patients about what follow up care they will be receiving and the organisations they are signposted to	York Hospital	A pilot is being undertaken in Community Hospitals 15/16 to address these concerns. CCGs looking to move follow ups to primary care from hospital settings.
7	In order to increase awareness and understanding of patients' pre-existing conditions, consider the use of health 'passports' which can be referred to at all	York Hospital	This would have to be considered with partners as to make this work it would need a multi-agency approach to ensure it was kept up to date.

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	stages of a patients' hospital stay and discharge		
8	Consider all the relevant feedback in this report when delivery of the new mental health contract begins in October 2015	Tees, Esk and Wear Valleys NHS Foundation Trust	People from York and Selby requiring admission to acute mental health in patient care are currently accessing TEWV hospitals out of locality due to the closure of Bootham Park Hospital in Sept 2015. Discharge planning is started at the point of admission with a formulation of the person's needs within 72 hours of admission. A daily report out is held by clinicians to ensure all aspects of assessment and relevant treatment/interventions are undertaken and to monitor progress. A multi disciplinary, discharge planning meeting which includes the person and their family is held before discharge from hospital at the soonest point indicated in the person's recovery. This process is called PIPA (Purposeful In Patient Admissions). Because of the current and unusual circumstances in York of having no acute mental health beds, a Discharge and Liaison Team has been established to support people in out of locality admission and their discharge back to their home area. The team attends the ward daily to participate in the report outs, formulation meetings, discharge planning meetings and Mental Health Act Tribunal meetings when required.

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			The team also facilitates home leave which is an important step for people in their recovery journey and support transport back to York, either for periods of leave or discharge from hospital. An appointment within 7 days, following discharge is arranged before the person leaves hospital and is carried out either by the Discharge Liaison team or the community mental health team. A letter is sent to the person's GP within 24 hours of discharge. Additional support for people on leave or discharge is provided by the Home Based Treatment Team, with close links to the Crisis Team. The combined work of all of these services in close collaboration with in patient service often results in the person being discharged more quickly with community based support.
9	Consider using patient participation groups at GP Practices to gather feedback from patients who have been discharged back to their GP to make sure that the process is working effectively	• NHS Vale of York CCG • GP Practices	Patient Participation Groups have been active across the Vale of York. The CCG is working with the Council of Representatives to analyse feedback on local services.