Joined Up Care Derbyshire

Improving Patient Flow (Discharge Pathways)

'People are supported to receive personalised care, in the right place and the right time. Returning home is the aspiration for every person'.

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Panel

Dean Wallace – Chief Operating Officer DCHS, Executive Lead for Discharge

Dom Fackler – Head of Community First, Derby City

Jo Warburton – Discharge Flow Lead, JUCD

Tanya Henson – Assistant Director Transformation and Partnerships, Derbyshire County Council

Warren Hutson – discharge lead nurse, Chesterfield Royal Hospital

Mandy Grogan – General Manager, Integrated Discharge team, UHDB

Purpose and Outline of Presentation

- Engage with public and gain feedback about people's expectation and experience of discharge from hospital
- Outline work taking place to improve discharge and support more people to return home
- Improve awareness of discharge process in Derbyshire

Overview of Hospital discharge Pathways in Derbyshire

Returning home is the aspiration for every person

4 outcomes on discharge from hospital:

- Pathway 0
- Pathway 1
- Pathway 2
- Pathway 3

Our population access hospital care from over 12 acute hospitals. We have two large hospitals in Derbyshire, a mental health trust across three sites and 6 community hospital wards

How discharge is planned

- What matters to me?
- Planning for discharge from day of admission
- Who is involved?
- How the discharge hubs support discharge
- What is a discharge assessment unit / Discharge lounge
  - comfortable and relaxing environment for patients to wait away from the ward area, while the final parts of their discharge/transfer of care are being arranged

How we are using feedback

- Healthwatch report published Autumn 23
  - Total of 20 visits to discharge units across University Hospital of Derby and Burton and Chesterfield Royal hospital
  - 100 people shared their views
- Key issues
  - Improve communication with patients about the process of leaving hospital
  - Provide information that patients and their relatives and carers can understand and remember
  - Provide realistic timescales to patients and their carers
- What have we done?

What we are working to improve

- Increasing access to reablement support AT HOME so more people return to independence
- Working with Voluntary sector to support discharge
- Increasing access to Dementia support on discharge
- Improving access to transport to support discharge if required
- Communication about discharge process
- Improving our processes, focus on discharge hubs and decision making, integrating our community services to work as one team
- Using a better system to track tasks required to enable someone in hospital to return home

Questions?