



# Introduction

The NHS Five year forward view sets out an ambition to support people to shape their own healthcare, make informed choices, manage conditions and avoid complications. Evidence shows that a higher level of activation leads to better outcomes, experience of care and fewer episodes of emergency and unscheduled healthcare.

**T**he Severn Major Trauma Network hosted by North Bristol NHS Trust undertook a project funded by the Health Foundation in 2015-2016 delivering a discharge intervention focused on increasing patient activation for those patients who had been treated at Southmead Hospital following serious injury. Results showed an increase in levels of patient activation, an improvement in patient experience and a reduction in unscheduled healthcare attendances (see our results sheet for details). Most importantly feedback from patients has been overwhelmingly positive. This intervention is now being rolled out across the service, network and adopted in other organisations.

Whether it's long term conditions or a one off stay in hospital due to illness or injury every patient should have the right to be made aware of their plan for care and given opportunity to own this plan.

The information in this pack outlines the work which has already been completed for Major Trauma patients, the results, the response from patients and clinicians. It also contains links to further information on the North Bristol NHS Trust website.



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**For any more details, please contact the QPD team**

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**Quality Patient Discharge**

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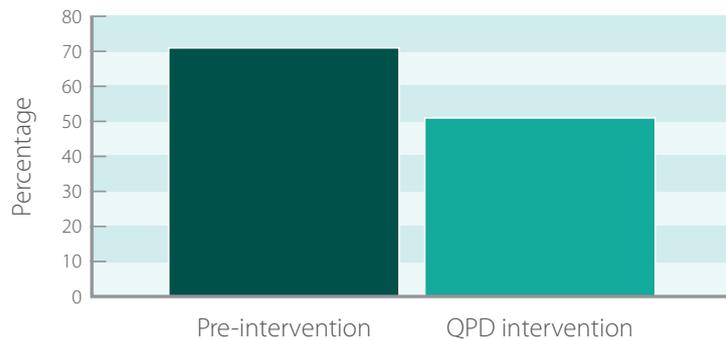


# Results

The effectiveness of the QTD intervention in trauma was measured using 3 indicators.

## Unscheduled healthcare attendances following discharge

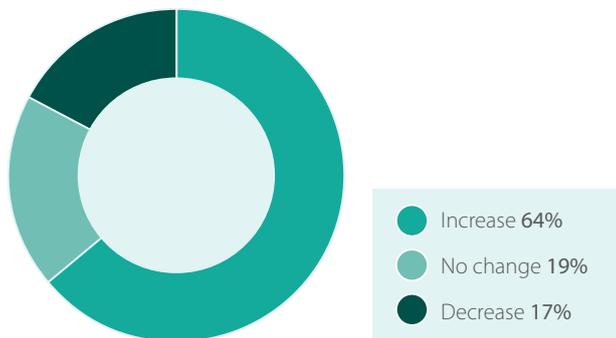
Final results showed a significant reduction in unscheduled GP attendances in the intervention group by 20%.



## Patient Activation Measure® (PAM®) 10\*

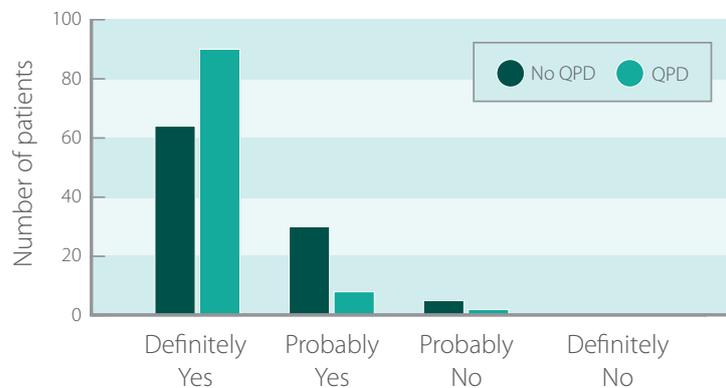
37% of patients demonstrated a higher level of activation.

\* Suzanne E. Mitchell, Paula M. Gardiner, Ekaterina Sadikova, Jessica M. Martin, Brian W. Jack, Judith H. Hibbard, and Michael K. Paasche-Orlow 2013 'Patient Activation and 30-day post-discharge hospital utilization' Journal of General Internal Medicine: 29 (2), pp349-355



## Patient satisfaction

Hospital rating scores and individual patient feedback also improved in the intervention group.



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# Intervention

The Quality Patient Discharge intervention consists of three simple, interlinked elements.

## After Hospital Care Plan or 'My Way Forward' document

A personalised information pack detailing patient-specific information about diagnosis, medication, outpatient follow-up and signposting the patient which way to turn with any questions or concerns. This is to reinforce information which they have already been given during their admission, not to give new information, and should act to empower patients and carers. This document can be issued as a paper copy, however, by utilising an electronic platform accessible to patients and 'invited' others the plan becomes a more dynamic, responsive resource for patient, carers and clinicians.



## Discharge consultation

An Individualised 'discharge counselling' session for the patient and family or carers with an appropriately trained keyworker around twenty-four hours prior to planned discharge. A pharmacist will also see the patient at this time and give education around medication. This one-to-one time should give opportunities for any questions or concerns to be addressed prior to discharge and will be based around the 'My way forward' plan.



Tailoring the discharge package to the patient based on the consultation means that all of the information given, follow up arrangements, contact details and prescribing information are held by the patient or carers in one format.

## 2 week call

Two weeks after discharge, the patient will receive a 'check-up' telephone call from the major trauma team during which any problems or uncertainties can be identified and appropriately managed. Of course, in the interim, patients and families can refer the information and 'signposting' in their record and can contact their keyworker either through the electronic messaging service or via the patient helpline.



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