HALTON
BOROUGH COUNCIL

Health Policy & Performance Board

Scrutiny Review of Discharge from Hospital

Report
March 2016

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the findings of the scrutiny review, which:

Focused on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective and emergency care. It examined the services that are already in place and evaluated their effectiveness in meeting the needs of the local population.

1.2 The full topic brief can be found at Appendix 1.

2.0 POLICY AND PERFORMANCE BOARD (PPB)

2.1 This review was commissioned by the Health PPB in June 2015. This report will be presented to Health PPB on 8th March 2016. The report will also be presented to Communities Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1

Councillor Joan Lowe (Chair)
Councillor Stan Hill (Vice Chair)
Councillor Pamela Wallace
Councillor Martha Lloyd-Jones
Councillor Charlotte Gerrard
Councillor Carol Plumpton-Walsh
Councillor Margaret Horabin
Tom Baker
Damian Nolan, Divisional Manager, Urgent Care
Debbie Downer, Policy Officer, Communities

Councillor Shaun Osborne declared an interest which prevented him from taking part in the Scrutiny Review.

3.0 METHODOLOGY

4.1 This scrutiny review was conducted through the following means:

- An information pack provided to Topic Group Members outlining national and local picture of discharge from hospital, summary of the key elements of services delivered in Halton, emerging issues facing hospital discharge and future delivery in Halton.
- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff involved in the Integrated Hospital Discharge teams based at Warrington and Whiston Hospitals;
- Site visits to Warrington and Whiston Hospitals;
- Site visits to Castlefields Health Centre and Beaconsfield Surgery;
- Presentations from local agencies/voluntary organisations;
- Presentation from Care Homes Team;

- Presentation from CCG/GP on commissioning hospital services;
- Presentation from North West Ambulance Service Patient Transport Service.

The final draft of this report was circulated to all participants/presenters to check for accuracy.

4.2 The above methods enabled Member's to:

- Gain an understanding of existing Discharge Planning processes and associated pathways in respect of Halton residents who are admitted to Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.
- Understand the role that all agencies (both statutory and voluntary/community sector) play in the discharge planning process.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Discharge Planning processes to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

4.3 Areas considered as part of this review:

- How are people discharged from hospital?
- Understanding of self-care after discharge.
- What information is given to people and when? Do they know who to contact if something goes wrong?
- Transfer of care into primary care (e-discharge).
- Arrangements for people with supported discharge needs, planning, treatment, care and support for discharge.

4.4 Which enabled Members to consider, in making recommendations;

- National best practice, along with evidence based practice, and how it can be applied in Halton.
- Ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.

The Chair and Members of the Topic Group would like to extend their thanks for the cooperation and contributions made by all those who have taken part in the review.

5.0 INTRODUCTION

5.1 Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

5.2 Discharge planning should ensure that patients are discharged from hospital at an appropriate time in their care and that, with adequate notice, the provision of other services are organised.

5.3 There are some common key elements when planning for discharge, regardless of whether a patient is receiving emergency or elective care. These are:

- Specifying a date and / or time of discharge as early as possible
- Identifying whether a patient has simple or complex discharge planning needs
- Identifying what these needs are and how they will be met
- Deciding the identifiable clinical criteria that the patient must meet for discharge

5.4 About 20 per cent of patients[1] have more complex needs and may need additional input from other professionals. The involvement of additional people makes effective co-ordination and planning even more critical.

5.5 As the older people age group (65+) within Halton are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025[2], it is anticipated that the percentage of those patients experiencing more complex needs and thus requiring more complex discharge planning processes will also increase.

5.6 Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

5.7 Within Halton we experience a high number of emergency readmissions at both 30 and 90 days for people aged 65 and over and this has presented challenges to the Health and Social Care system. As outlined above, effective discharge planning can contribute to helping reduce the number of unplanned/emergency readmissions to hospital and as such there is a need to ensure that current discharge planning processes and associated pathways in place are having a positive impact on Halton's emergency readmission rates.

[1] NHS Institute for Innovation and Improvement
[2] ONS - Population Projections 2010

6.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP

6.1 The planning meeting, which took place on 10th June 2015, provided the members of the topic group with an opportunity to review the information pack and identify the key focus areas for the Scrutiny Review.

The areas are as follows:

- Discharge Lounges – in particular who is responsible for patients waiting for transport. What happens when patients are delayed because they are waiting for medication. What consideration is given to patient's needs regarding medical care, nutrition, hydration, privacy and dignity.
- Family Involvement in the discharge process – this was raised in relation to how conversations take place about a person's care after discharge and whether it would be beneficial to have the family present during these discussions.
- Discharges to Care Homes – what happens when a patient is unable to return to their 'home' due to changes in their condition.
- Mental Health Support with the discharge process and people living with dementia – what support is provided in hospital and on returning home.
- Financial information – the group wanted to know what information is provided about care charges within the discharge process.
- How many people in Halton are now going to elective centres further away (Centres of Excellence) and how this affects the information they are offered on discharge.
- The role which NHS Halton CCG/GP's have within hospital discharge.

6.2 **Integrated Discharge Teams (Warrington and Whiston) – Presentations from Eddie Moss and Francesca Smith.**

Staff from Halton Integrated Discharge team (based at Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust) provided the group with information about the Discharge processes at Warrington and Whiston Hospitals.

6.2.1 **Halton Integrated Discharge Team (HIDT) at Warrington Hospital**

The HIDT is a dedicated multi-disciplinary discharge team which incorporates assessment into Accident & Emergency, ensuring a focus on the proactive identification of people likely to require supported discharge.

The team delivers on all the discharge pathways out of Warrington and Halton Hospitals Foundation Trust (WHHFT) including Social Care, Continuing Health Care (CHC), Community Health Services and Intermediate Care. The team also manages discharges for Halton residents in out of area hospitals.

The staff group consists of Nurses, Social Workers, Community care Workers, District Nurses and Community Psychiatric Nurse.

The benefits of this approach to discharge include earlier engagement with patients and families to better manage need and expectations, therefore reducing delays in hospital beds and admissions to long term care.

HIDT undertake a proactive approach to identifying Halton residents within Warrington Hospital and do not necessarily wait for a formal referral to be made. On a daily basis a list of adults (50+) that have been admitted overnight is provided to the HIDT. Designated Care Managers then track and monitor the persons hospital journey during the duration of their stay.

Where referrals to the HIDT are made, these are done via a Section 2 referral notification generated by the Hospital ward; a Section 2 notification identifies the possible need for social work intervention on discharge from hospital.

6.2.2 **Whiston Integrated Discharge Team at Whiston Hospital**

In Whiston Hospital the Integrated Discharge Team ("IDT") is a single point of referral for all St Helens, Knowsley, and Halton resident patients identified by the ward staff as requiring support on discharge. The team comprises of discharge workers, social workers, band 6 nurses, a physiotherapist and support staff, working under a team manager and three assistant managers. This staff group was drawn from both health and social care to create a multi-disciplinary team.

Staff are allocated to specific wards to enable them to build relationships and become involved in decision making at the earliest opportunity. The workers will deal with all Halton, St Helens and Knowsley patients on their allocated wards, regardless of their employing organisation. The Intermediate Care (IC) assessors within the team will respond to referrals for those identified for IC, either via the ward direct or the ward allocated worker.

There are a number of pathways through which people requiring support for and on hospital discharge can be directed. Achieving timely discharge for people who need support is dependent on a number of related factors including:

- Commencement of discharge planning on admission;
- the availability of information about the individuals self-care ability and health status prior to admission;
- frailty of the individual pre and post admission;
- the responsive of diagnostic departments and analysis of results;
- the trajectory of the presenting condition and response to treatment;
- recovery processes;
- involvement of the individuals significant others;

- knowledge of all staff in the relevant agencies of the type and availability of community services (health and social care);
- discharge process management;
- the complexity of different services and pathways criteria's and responsiveness;
- tracking.

Performance

As part of ongoing internal scrutiny performance reports are produced and presented to the appropriate representative boards. These include;

- Length of Stay
- Number of referrals
- Delayed Transfers of Care
- Number of Assessments completed via each discipline
- Assessment outcomes

The range of performance information from last year illustrated the monitoring of hospital processes and outcomes at discharge;

- Last year HIDT received 831 referrals which converted into 818 assessments.
- The average length of stay for all patients referred to the HIDT from admission to discharge is 19.5.
- HIDT tracked 1393 in total.
- The number of referrals received by Whiston last year was 6540, which converted into 4358 assessments.
- On average there are 7 delayed transfers of care (Delayed Transfers of Care (DTOC) reportable delays) each day.

Conclusion

Following the presentation, the group discussed delays caused by transport and medication. Concerns were raised about who is responsible for the care of patients who are waiting to be discharged, in particular nutrition and hydration.

Discharge lounges were discussed and it was highlighted that adequate facilities were not always available for frail, older people.

The group expressed interest in the process for Discharges to Care Homes. For example, when a patient's condition resulted in them being unable to return to the care home they were admitted from.

That discharge lounges work well and the Trusts should ensure that the facility continues to be fully utilised. There are benefits to all patients, not just older people and evidence shows a reduction (20-40 minutes less) in NWAS transfer times.

There are also clear benefits to patients in how medication is provided on discharge.

6.3 Presentations from local agencies/voluntary organisations – Halton & St Helens Voluntary and Community Action (VCA), Age UK, Wellbeing Enterprises Red Cross.

The scrutiny topic group were keen to understand the role and contribution of local agencies in this area and the services they provide for people being discharged from hospital.

Halton & St Helens VCA/Wellbeing Enterprises

Sally Yeoman (Halton and St Helens VCA) and Mark Swift (Wellbeing Enterprises) briefed the group on a project to recruit and support Hospital Ward and Community Volunteers. Funding acquired for the project (9 months) will be used to evaluate whether the work will deliver cost savings and benefits.

Age UK

Age UK work in partnership with Warrington and Whiston Hospitals providing support to people being discharged. Volunteers provide help with supporting people during and after discharge home, this is particularly helpful where the person has been in hospital for some time. Signposting and advice is given relating attendance allowance and help with sourcing care and support. Age UK also provide signposting to the independent living team.

Karen Kenny explained that Age UK were keen to capture Halton residents who attend hospitals out of area. There can be patients from up to five different boroughs on the ward and at weekends there isn't anyone to signpost them.

Dawn Kenwright provided an overview of the survey being undertaken in partnership with Healthwatch to assess hospital discharge patient experience in Halton.

Wellbeing Enterprises

Mark Swift outlined the pilot project which aims to help people to leave hospital sooner and ensure they have support is in place if needed (shopping, heating etc.). The target group are patients who are at risk of re-admittance as identified via the Multidisciplinary Team (MDT) process. Volunteers will work with vulnerable people and act as navigators.

Conclusion

Whilst it was acknowledged that the various voluntary organisations have different skills/specialisms and referrals are becoming more complicated - a plan is needed to clearly map out how all the voluntary organisations will move forward to provide a one stop shop and work collectively with the hospitals.

Referrals are not just home help and shopping, but include issues such as mental illness, hoarding, and alcohol abuse. Whilst Age UK work alongside Red Cross and other voluntary organisations in Halton, it is recognised that there is a gap. The evaluation being undertaken via Healthwatch is working towards mapping what services are out there.

6.4 Presentation from Care Homes Team - Gaynor Cunliffe (Bridgewater Community NHS Trust) Clive Allman – 5 Boroughs Partnership (5BP).

One of the areas of interest identified by the Scrutiny Group is Hospital Discharge to Care Homes including people with dementia.

Care Homes Team

Gaynor Cunliffe is a Nursing Sister and her role encompasses 17 care homes within the Halton area. GC works to ensure services are in place and identifies training needs for nurses in care homes.

In answer to an enquiry regarding an area which could be improved, GC suggested that a Community Matron just for care homes who would be able to carry out medication reviews and could attend instead of the GP. A recent home closure led to a resident being moved and medication needed changing at the same time, but GC was not able to prescribe. If there was a Care Homes Community Matron this could be picked up sooner.

GC gave an example of the challenges of getting information on a patient who is being discharged, particularly if residents needs have changed. In some cases, Nurses don't know patients well enough and there are no case notes. The process works better if the nurse knows the patient well.

When a resident is admitted to hospital, a yellow transfer form is completed which provides the hospital staff and ambulance crews with important information about the resident. The forms are shared with GC, however not all care homes complete them. The same applies for Medication Records, which should go with a resident when they admitted to hospital.

There followed a discussion about the differences in the discharge process for mental health as they had access to hospital systems and were notified in advance of pending discharges. GC confirmed this wasn't always the case and the team are not routinely made aware of hospital discharge.

Care home managers go into hospitals to speak to the ward prior to a resident being discharged, however if they are unable to speak to a Nurse who knows the resident well, readmission becomes more likely.

Later Life & Memory Services (LLAMs)

Clive Allman's role focusses on dementia and mental health in addition to providing care homes with awareness and training. He carries out drug regime reviews, offers general advice and being in the homes means he can be proactive and address issues early.

There are 2.5 people in the LLAMs team (including an Occupational Therapist) focussing on Halton who work closely with community mental health teams. Cover is provided on a 9-5 basis but can flex to meet the needs of families. There is no weekend cover and concern was expressed on arrangements for holidays/sickness and DN and CA confirmed that GP's often pick this up if no-one else is available.

CA confirmed he is unable to prescribe and this function needs to go via a GP. In care homes they don't have the same access as someone at home does, putting pressure on GPs and leading to delays in treatment. Each care home can have 6/7 different practices with GP's coming out to patients (or a locum if out of hours).

Conclusion

There was an identified need for a Community Matron assigned to Care Homes who has the capacity and skills to prescribe and monitor medication.

6.5 Hospital Visits – Warrington & Halton Hospitals NHS Foundation Trust

A number of the Scrutiny Topic Group made a planned visit to Warrington Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had a tour of the Discharge Lounge and spoke with Dawn Forrest, Associate Divisional Director Unscheduled Care and a number of staff from the Discharge team. A full report of the visit is included in appendix 2.

Background

DF gave an overview of improved outcomes as a result of an increase in therapy on the ward which focussed on moving patients towards independence as part of the discharge process. Weekly Multidisciplinary Team meetings include medical staff, Occupational Therapists and Social Workers.

Discharge Process

The Discharge process starts from admission and has separate pathways by condition (Stroke, Heart Attacks, Frail/elderly) and includes preventative work to prevent readmission. Visiting times have been extended to make it easier for families to be present when discussions/assessments are taking place so they are involved in the decision making process. Care is taken to ensure patients are at the centre of the process, and not just a focus on medical needs. Patients are also signposted to voluntary agencies (such as Red Cross) who provide services to people once they are home from hospital. Red Cross are based in A&E at Warrington Hospital and are currently working to identify vulnerable people who have a high risk of re-admission.

A recent new initiative (Quality Ward Round) is a Nurse-led Ward Round where a Nurse accompanies the Doctor after prioritising the patients who are due to be discharged. Ongoing work to improve 21 day delayed discharge will be helped by the move to Lorenzo (electronic records) which will help to reduce duplicate paperwork.

A member of the HPPB highlighted an example of delays in hospital discharge due to medication and problems where the person's GP was not notified that they had been discharged.

Staff explained that Warrington hospital has recently moved to electronic discharge and if medication is required, this is now flagged up and Pharmacists (who have specialities such as respiratory) work alongside ward staff to focus on the medication requirements of discharge to ensure this doesn't cause delays. Pharmacists are also able to provide training to patients on how to use inhalers. In the pharmacy, a tracker system highlights patients who are being discharged and these prescriptions are given priority to ensure beds are freed up to prevent A&E delays. Patients are also given the choice to go home without medication if not essential and they are able to reach a pharmacy independently once home.

In the event of a delay, Discharge Lounge staff continue to care for the patient until a transfer was arranged, via private ambulance if necessary. The improvements in loading times (down to 30 minutes) through better accessibility (drop off zone) meant more ambulances were available thus reducing delays.

The new Discharge Lounge can accommodate patients with complex needs/Dementia, whereas in the past they would have been kept on the ward. A single room is reserved for patients who need additional support and there is also a room in A&E for Mental Health patients which is safe/secure with a psychiatric liaison team on call. This team's brief has now been extended to the Intensive Therapy Unit and to support Dementia patients.

A member of the HPPB queried Discharge to Care homes and staff confirmed that a new post has recently been put in place to work with the Halton Integrated Discharge team to identify and focus on this group of patients. There have been issues where Care Homes are reluctant to re-admit residents whose needs have changed whilst in hospital.

There have also been issues where residents have been admitted who are end of life, particularly where DNA CPR (Do Not Attempt Cardio-pulmonary Resuscitation) and Care Homes could do more to assess resident's health to avoid unnecessary distress in moving a resident at this stage. Patients who are end of life are sometimes discharged at night, with the family's support and agreement and the Discharge Team work closely with NWAS/private ambulance to facilitate a fast track discharge.

Conclusion

The group were impressed with the discharge lounge facilities at Warrington Hospital and it was clear that there have been beneficial changes made to the discharge process which have contributed to improved outcomes.

After speaking to Managers and Nursing Staff, the group could see that there was a clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward.

Feedback from a patient who was in the Discharge Lounge was very positive.

The layout of the unit was patient centred with an emphasis on privacy and dignity.

A copy of information provided to patients is included in appendix 4.

6.6 **Hospital Visits – Whiston**

A number of the Scrutiny Topic Group, focusing on Discharge from Hospital, made a planned visit to Whiston Hospital with a view to gaining an insight into hospital discharge and what processes are in place to support vulnerable people with complex care needs.

The visit was facilitated by the Divisional Manager, Urgent Care. The group had discussions with Jenny Farley, Interim Deputy Director of Operations and Rob Cooper, Assistant Director of Operations followed by a tour of the Discharge Lounge and the Frailty Unit. The visit was 2 hours in duration. A full report of the visit is included in appendix 3.

Background

Jenny Farley welcomed the group and Councillor Joan Lowe provided an overview of the Scrutiny Review Topic Group. Jenny Farley commented on how impressed she was regarding the Integrated Discharge team at Whiston and how beneficial they were for complex discharges. JF described the two different types of discharge – complex and standard.

Discharge Processes

JF gave an overview of the kind of information people are given depending on whether their discharge is complex or standard. JF described how the conversations about discharge begin on admission and it is very quickly established if help will be needed at home. Where the Integrated Discharge Team was involved in the process it worked very well, and JF was working with Francesca Smith to raise staff awareness of the team to broaden their reach. There are dedicated discharge co-ordinators outside of Nursing resources.

Family are involved in the conversations and signposting to voluntary groups is provided. Rob Cooper stated that this worked very well at Wirral and could be improved at Whiston. (Age UK are a relatively recent presence at Whiston).

Nursing and support staff are responsible for patients whilst they are in the discharge lounge to administer meds and provide fluids/food. RC confirmed that specialist Mental Health Social Workers support people with mental health problems and there was a Liaison Psychiatrist based in A&E. Dedicated dementia staff were alerted on admission and focussed on whether the patient was newly diagnosed or if they already had a package of care either in the community or at home.

Assessments are prioritised for people being discharged to care homes as this group of patients often experience delays when finding a suitable bed and liaising with family on home of choice. The choice of care homes offered depends on the person's needs and condition – the Integrated Discharge Team tailor choices to the needs of the patient.

A member of the HPPB queried how soon are family informed about costs as this could potentially cause extra worry and stress. RC confirmed that information is provided as part of the discharge process by the Integrated Discharge Team. The financial assessment is done at home, to minimise the length of time in hospital.

RC confirmed that recent improvements to processes between Discharge teams and Pharmacy has resulted in a reduction in the time (to under an hour) between when drugs are dispensed and handed to the patient. Delays do sometimes happen, usually if discharge is later on in the day. Pharmacy

technicians are working with nurses on the ward (being piloted at the moment) to reduce delays.

JF confirmed that Respiratory Nurses were on hand to support and provide training.

A member of the HPPB outlined the case of a patient was discharged without anti-coagulant medication (Warfarin) who subsequently died and asked how Whiston informs GPs on discharge and medication. RC confirmed that Whiston has electronic discharge, however if the letter needs to be taken to the GP, it prints out in red.

Facilities

The group then moved onto the Discharge Lounge and the staff provided an overview of the processes used. Patients who still need a high level of nursing care stay on the ward as there are not suitable facilities to support them in the discharge lounge. Patients can also use the day rooms located near the wards. The lounge is also used by patients who are waiting for a bed, transport or medication. The unit is not open at weekends or Bank Holidays.

The visit continued into the Frailty Unit. Age UK (St Helens) are newly established in the unit and staff also refer to Sure Start to Later Life. The information board showed a range of areas where patients come from and those who had carers were identified to enable staff to provide extra support.

The ethos of the Frailty Unit was to ensure people were not on the ward for longer than 72 hours and to identify patients who can go home quickly. A medical assessment unit for the elderly includes medical/functional skills for those who have had a prolonged stay in hospital and have lost independence. The assessment aims to reduce levels of readmission. Visiting times are flexible to enable family to visit at times when the consultant is present and for them to be involved in assessments.

Patients are provided with a going home food parcel if needed.

Conclusion

JF explained how reductions in the number of beds had impacted the hospital and when there was a shortage of beds, people were sent out of the area.

RC outlined that the biggest challenge in delayed discharge was changing the perception of families who feel the safest place for their relative is in hospital. In reality they are more at risk of infection and a loss of independence.

There was an opportunity to further enhance the support provided by the voluntary agencies at Whiston, around signposting and information with charging. Information/signposting could be provided in the information leaflet given to patients on admission regarding discharge. This would help people move back to independence and improve patient experience. Age UK (St

Helens) are newly established in Whiston (Tuesdays) and could assist Age UK (Halton) to also make connections.

The group were impressed with the Frailty Ward at Whiston Hospital and after speaking to Managers and Nursing Staff, the group could see that there was a clear commitment to providing a quality patient-centred service and a continued focus on improvement moving forward. In particular, the group were very pleased to see that Carers were identified and supported. A home visit bag was also noted, which contained helpful items for staff when they were doing home visits.

A copy of information provided to patients is included in appendix 5.

6.8 Presentation from Halton NHS Clinical Commissioning Group (CCG) on commissioning hospital services – Dr Mick O'Connor (GP)

Dr O'Connor briefed the group regarding the scope of NHS Halton CCG and how the organisation commissions NHS services for Halton.

NHS Halton CCG monitors services such as discharges (weekends and emergency re-admissions), levels of delayed days and rate of re-admissions after 14/28 days. Dr O'Connor outlined the various reasons for delayed discharge, such as completion of assessment, Patient or Family choice, awaiting residential care/nursing home placement etc.

Halton is currently running at 15-17% re-admission within 30 days, which is quite high. CCG have commissioned a piece of work to scrutinise the reasons for re-admission, particularly at 7 days following discharge.

A discussion followed regarding the challenges in accurately pinpointing the reasons for re-admission. It can be challenging to identify a single reason for re-admission and the Contract Review Board and Quality Review Group regularly discuss and review data.

NHS Halton CCG manage contracts via CQUINs (Commissioning for Quality and Innovation) and set targets, one particular area being electronic discharge 4/5 years ago into both trusts. The introduction has improved the accuracy of information transmitted to primary care and 70/80% of patients (highest in the region) now receive an electronic discharge. The remaining 20/30% is due to reasons such as staffing issues and weekend discharges and is monitored on a monthly basis.

Patient records are still handwritten, and neither trust currently has electronic patient records. This would improve performance at weekends. With demand rising due to an increase in the elderly population and complicated drug regimens, manual records can run to 3 pages for a standard discharge with a junior doctor having to type out by hand.

There are some GPs not signed up to e-discharge and this raised concern for patients discharged at the weekend, particularly if the patient has been prescribed warfarin and needs either more medication or a blood test. Dr

O'Connor pointed out that all practices in Halton are signed up for electronic discharge and the letter given to some patients on discharge is actually a copy of a letter, which is sent electronically to their GP.
GP's use a system called DocMan within each practice and it manages all appointments, blood results, patient messages, and letters for patients from hospitals. A letter may indicate that medication/blood tests are required and the system records action taken. A&E admissions also generate letters, and patients are contacted according to risk.

The new CQUINs targets groups of people with chronic conditions (Chronic obstructive pulmonary disease (COPD), Diabetes, and Stroke) to ensure discharge includes additional information. GPs have more data, so they know what is 'normal' when they see a patient and can therefore detect any functional deterioration. Reviewing discharge procedures for people with these conditions will improve quality of care in hospital and the community as well as reducing the likelihood of readmission.

The level of intervention, which is appropriate for that person by condition, is also detailed. This information can potentially prevent re-admission with care provided in the community instead.

When asked what the frustrations were, Dr O'Connor gave the example of a patient treated for an apparent heart condition and whose discharge notes did not include adequate information. The eventual diagnosis was that it was probably a pulled muscle but the investigation led to a great deal of follow up correspondence with the consultant.

Another issue is patients discharged with outstanding tests, which should have been completed in hospital. This can cause problems, as it is not always clear why the test was ordered and patients may end up being referred back to the hospital for test results. This kind of work take patient contact away as doctors spend time doing paperwork. The problem was highlighted with the Clinical Quality Review Group and has resulted in an improvement.

There has been recent work on re-admissions in the frail and elderly and every GP practice runs Multidisciplinary Team meetings (including Community Matrons, District Nurses, GPs, and Occupational Therapists) and carries out risk stratification. This work proactively manages the risk of readmission via a register of patients who are more likely (according to condition/ circumstances) to have an unplanned hospital admission.

Both trusts are performing well on end of life discharges and patients are fast tracked with a phone call to notify District Nurses and Macmillan. Care at home is put in place with a GP visiting within a couple of hours of people arriving home/ or to a care home.

Dr O'Connor offered the Scrutiny Group a GP Practice tour during a protected learning time session (Thursday afternoon once a month). This enables people to understand what goes on behind the scenes and understand how a GP practice works.

Conclusion

The group subsequently visited Castlefields Health Centre and Beaconsfield Surgery – notes from the visits are included in Appendix 8.

6.9 Presentation from North West Ambulance Service Patient Transport Service (PTS) – Ian Stringer and Vicky Dodd.

Ian Stringer gave an overview of how the Patient Transport Service (PTS) is commissioned and how it links in with hospital discharge.

PTS are a commissioned service led by NHS Blackpool Clinical Commissioning Group (CCG) on behalf of all CCGs in the North West. PTS is a standard service across the area for patients registered within the commissioning area. Discharge activity forms part of the standard service. There is dedicated resource for Warrington and Whiston when required outside of contract arrangements.

The key performance indicators of the service include 80% of patients collected after treatment within 60 minutes of being notified as ready for collection. The services focus is on planned discharges but this sometimes means that targets for acute trusts are not met.

The same service provision applies regardless of where the patient is receiving treatment or where they live although who responds to the request for transport will differ according to area.

The main challenges facing PTS are that 10% of all activity is discharge activity with 80% planned which take place between 3-6pm. There can be issues with long stay patients with delays in medication or care package. Ward staff arrange for a take home parcel of food if needed and some patients are given a packed lunch.

Occasionally patients are transported individually particularly if the hospital needs to free up a bed. If a patient is not mobile (needs a stretcher) or has complex needs this can cause delays. However in cases like this, the patient needs are the priority, not the contract. PTS work with practitioners to make sure the discharge is safe rather than timely.

PTS receive a briefing beforehand to make them aware of patients' needs and to make sure any additional equipment is available. IS described the process PTS use in the event of safeguarding concerns/social care needs. NHS 111 will enhance this, so that NWAS know all the agencies involved.

Complaint numbers are low and nearly always related to timeliness – even if within contractual timescales. During periods of bad weather patients are prioritised (oncology and renal). PTS will contact families if needed and patients kept in overnight if required - safety is priority.

Discussion followed regarding vulnerable patients and IS stated that PTS work to reschedule activity until someone can take care of them. Adult Learning Disability (ALD) passports are utilised and there is a similar scheme for dementia. This helps staff awareness especially if it is the first time they have transported the patient. PTS ask for additional information during the booking process and this is part of the staff induction to raise awareness of the needs of vulnerable people.

The discharge lounge in Warrington Hospital has improved the process and led to quicker turnaround, particularly for stretcher patients. Where there are discharge lounges and they are operating efficiently, this does help.

IS confirmed that staff are trained in basic first aid, safe moving and handling, infection control, dementia, and dignity. There are challenges around systems and meeting contract standards when patient's needs are paramount. Sometimes hospitals in their haste to meet targets and free up beds, don't always do what is best for patients.

Patient information leaflets are handed out to people being transported and their carers. They are also distributed in GP surgeries and hospitals. A copy is included in appendix 6.

Conclusion

It was clear that the PTS is delivering a high quality service with an ongoing investment in staff to meet the needs of patients (a training calendar is attached in appendix 7.

7.0 RECOMMENDATIONS TO HEALTH PPB

Issues identified and recommendations made:

- There is a lack of co-ordination/collaboration between the Voluntary Sector in Halton around hospital discharge. There is an opportunity to further enhance the support provided by the voluntary agencies regarding signposting and information about charging. A plan is needed to clearly map out how all the voluntary organisations will move forward to provide a one stop shop and work collectively with the hospitals. This work can be done within existing resources.

- A Community Care Matron with the capacity and skills to prescribe and undertake medicine reviews dedicated to care homes and attend instead of a GP. This is within the budget allocation for this services

- A review of the process for patients who are repeatedly readmitted via the use of an alternative pathway. A possible solution may be that admission is coded as open access (outpatient), rather than categorised as a readmission. There may be an opportunity to utilise the urgent care centre to enable the patient to

self-manage their condition and for NHS Halton CCG and its partners to re-code readmissions for patients who require frequent hospital attendance for management of their condition.

- It is acknowledged by the Scrutiny Review Topic Group members that discharge lounges work well and Trusts should ensure that the facility continue to be fully utilised. There are benefits to all patients, not just older people and evidence shows a reduction (20-40 minutes less) in NWAS transfer times. There are also clear benefits to patients in how medication is provided on discharge.

- Across all of the presentations and visits undertaken by the topic group, communication - particularly relating to IT - and timely access to clinical information, was a common thread. The topic group recognises that effective communication is key to ensure safe and effective discharge and systems should continue to develop to improve this.