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.

Appendix 1

TOPIC BRIEF

Topic Title: Discharge from Hospital

Officer Lead: Damian Nolan – Divisional Manager

Planned Start Date: April 2015

Target PPB Meeting: March 2016

Topic Description and Scope:

This topic will focus 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 or emergency care. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population.

Why this topic was chosen:
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.

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.

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

About 20 per cent of patients[3] 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.

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[4], it is anticipated that the percentage of those patients experiencing more complex needs and thus requiring more complex discharge planning processes will also increase.

[3] NHS Institute for Innovation and Improvement
[4] ONS - Population Projections 2010

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.

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.

Key outputs and outcomes sought:

- An understanding of existing Discharge Planning processes and associated pathways in respect of Halton residents that are admitted to Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.
- An understanding of 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.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Discharge Planning and associated processes/pathways.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services and partner agencies to examine current processes/provision.
- Desk top research in relation to national best and evidence based practice.

Agreed and signed by:

PPB chair ……. **Officer …….**

Date …… **Date ……**

Appendix 2

Health Policy and Performance Board Scrutiny Topic Group – Discharge from Hospital

Visit to Warrington Hospital

9th September 2015

Attendees	
Councillor Joan Lowe	
Councillor Stan Hill	
Councillor Charlotte Gerrard	
Councillor Martha Lloyd-Jones	
Damian Nolan	Divisional Manager, Urgent Care.
Debbie Downer	Policy Officer, People & Economy

A number of the Scrutiny Topic Group, focusing on Discharge from Hospital, 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.

The visit was 2 hours in duration.

The report below summarises the facilities, key findings of the group and feedback from a patient in the Discharge Lounge who spoke to one of the Councillors.

Background

Dawn Forrest welcomed the group and Councillor Joan Lowe provided an overview of the Scrutiny Review Topic Group. Dawn Forrest briefed the group on the background of the Discharge Lounge and STAR (Short Term Assessment & Rehabilitation) unit, which was commissioned as a result of challenges which Warrington Hospital was experiencing.

Discharge Processes

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 MDT meetings include medical staff, OT's and Social Workers.

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.

Discharge Lounge Facilities & Services

The group were taken to the Discharge Lounge in the Daresbury Wing which is a dedicated facility with its own entrance and carpark. The unit was bright and modern with a spacious entrance and level access to a drop off zone immediately outside the main doors. There is a comfortable discharge lounge and a number of private ensuite rooms (single sex) to accommodate bedbound patients. Staff are on hand to provide refreshments, hot drinks and hot/cold meals. Staff also book taxis and ambulances, provide support and information on medication and a 'going home' food package if needed (free of charge).

Monday and Friday are busy times and this is monitored so additional staff can be put in place if needed. Each day at 2pm, there is a staff meeting to assess caseload.

Emerging Issues

A member of the Health PPB raised concerns about delays in hospital discharge due to medication and problems where the person's GP was not notified that they had been discharged.

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.

If there is a delay, Discharge Lounge staff continues to care for the patient until a transfer is 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 care 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 ITU and to support Dementia patients.

There is a new post to work with the Halton Integrated Discharge team to identify and focus discharge to care homes. 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 DNA CPR) 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.

Feedback

A member of the Health PPB spoke to a patient in the Discharge Lounge who is a Halton resident who commented that he had been looked after very well and that the food was really good.

Overall Findings

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.

Appendix 3

Health Policy and Performance Board Scrutiny Topic Group – Discharge from Hospital

Visit to Whiston Hospital

23rd September 2015

Attendees	
Councillor Joan Lowe	
Councillor Stan Hill	
Councillor Pamela Wallace	
Damian Nolan	Divisional Manager, Urgent Care.
Debbie Downer	Policy Officer, People & Economy
Apologies	
Councillor Margaret Horabin	
Councillor Sandra Baker	

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.

The report below summarises the facilities, key findings of the group and feedback from a patient in the Discharge Lounge who spoke to one of the Councillors.

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 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 were involved in the conversations and signposting to voluntary groups was 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).

Rob Cooper confirmed that nursing and support staff administer meds and provide fluids/food. Specialist MH Social Workers support people with MH 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.

Discharge Lounge Facilities & Frailty Unit

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.

OTHER USEFUL HOSPITAL NUMBERS

MAIN NUMBERS:

The main hospital switchboard number is **01925 635 911** which can put you through to both hospital sites 24 hours a day.

Pharmacy Medicines hotline **01925 662238** (Mon-Fri 9am-5pm) can provide advice and information on taking medicines given to you.

Giving us feedback on our services

We are always grateful for your feedback on our services. If you have the time please complete the friends and family test card if you are given one during your stay. Alternatively you can leave feedback on the NHS Choices Website – **www.nhs.uk.** Just search for our hospitals and you can provide feedback that way.

Thank you

Leaving Hospital

Our patient information reference: pinfo 2014_08_02. Ratified: August 2014. Review date: August 2016
Authors: Hospital Discharge Service.

Warrington & Halton Hospitals NHS Foundation Trust
Lovely Lane, Warrington, WA5 1QG
Main switchboard: 01925 635 911
E-mail: enquiries@whh.nhs.uk

Find out more about Warrington and Halton Hospitals and the services we provide at:

www.whh.nhs.uk

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Leaving Hospital

Information for patients, relatives and carers.

Appendix 4

Contents

INTRODUCTION

This booklet is designed to help us plan your discharge from hospital. It explains the different services you may need and arrangements that can be made to support you when you leave.

Keep it with you in hospital and following discharge. There are checklists and blank pages in order to note services that have been arranged and things that you want to discuss with your ward team.

There is also a list of telephone numbers which you may find useful.

Thank you.

WHEN WILL YOU LEAVE HOSPITAL?

If your stay in hospital was arranged in advance, your consultant or nurse may have already explained how long you may stay and given you an **expected discharge date**.

If you are admitted as an emergency, within 48 hours into your stay we will inform you of your **expected discharge date.** This date may alter during your hospital stay and if you are well enough before this date you may be discharged earlier - we will, of course, discuss this with you.

When planning your discharge, your ward team will ask you about the situation at the address to which you will be going, agree what transport arrangements need to be in place for you to go home and who will take you home and will also discuss the care available. If needed there are a variety of services available to support you on discharge.

Please let the ward team know of any problems you think you may have.

Leaving Hospital checklist

What is my estimated date and time for going home?		
How will I be getting home?		
Name of family member/friend/carer who is to be contacted?		
Please tick when family member/friend/carer has been contacted		
Will I be using the discharge lounge when leaving the ward?	Yes	No
Did I bring any of my own medications and do I need them to take home?	Yes	No
Has the medication I am taking home been explained to me?	Yes	No
Do I need a sick note?	Yes	No
Do I need assessment by a social worker?	Yes	No
Do I have the contact names and numbers for any services arranged and when I expect to be visited?	Yes	No
Have I got everything in place for me to be discharged e.g. keys, food, valuables, dressings, equipment?	Yes	No
Do I need a follow-up appointment with the hospital?	Yes	No
Do I need any information leaflets about my treatment?	Yes	No

WHAT YOU WILL BE GIVEN ON DISCHARGE

MEDICINES

If you brought medications in, these will be returned to you if it is safe to do so. You may be given more medication when you go home. The pharmacist or nurses on the ward will explain any instructions that you need to follow. Further prescriptions should be obtained from your GP.

DISCHARGE SUMMARY

This is a letter giving details of your hospital treatment and discharge medications; a copy will be sent to your GP and you will also be given a copy. Keep it to show to anybody involved in your care.

The Ward Team will complete a discharge checklist and a discharge card. You will receive a copy of these on your discharge. On the discharge card there are numbers which may be useful to you.

EQUIPMENT

You may be given hospital equipment to take home, e.g. a walking stick or a frame, a feeding pump or machine.

SUPPLIES

A short-term supply of items you will need at home may be provided, eg stoma or catheter bags, dressings or syringes and needles. Once at home further supplies must be obtained by you. The hospitals staff will give you contact details and instruction about what you need, when, and how to get them.

WHAT WILL HAPPEN ON THE DAY OF DISCHARGE?

The aim is for you to leave the ward by 10am.

It is expected that patients will make their own travel arrangements when they leave hospital. Please ensure that if you feel you are unable to travel alone you have someone to accompany you.

In exceptional circumstances hospital transport is available following discussion with the ward team.

Hospital transport can only take you, and one bag/suitcase. Please make alternative arrangements to take any extra personal property.

Please tell us about your stay by using the friends and family test card that is available on the ward. It will help us to continue to improve the quality of our patient care.

WHAT IF I AM PICKED UP AFTER 10AM?

At times when the discharge lounge is operational, the ward team may arrange your transfer to the Discharge Lounge. Refreshments are provided here. Any medicines that you are waiting for can also be delivered to you here.

DISCHARGE PLANS

Together with the ward team, plans will be made regarding your care requirements. This will include clinical management in relation to your EDD (expected date of discharge)

You will be transferred from hospital when your Consultant led ward team decide that you are clinically ready to leave hospital and you no longer require a hospital bed.

Below are examples of services you may require when you leave hospital:

1 Home with community support:
A range of community health and social care services can be provided to support you in your own home including district nursing, community matrons, case management and home-based rehabilitation programmes.

2 Community bed placements:
These beds will be in a local nursing or care home and will be for you if care in your own home is not feasible at the time you no longer require a hospital bed.

Please alert the ward team of any problems that you may have prior to discharge.

VISITORS AT HOME

District nurse: District nurses are qualified nurses with additional training to nurse you at home. They work closely with your GP to support your care at home.

Community matron: If you have a chronic condition, a community matron may visit you at home to co-ordinate the care you need. They will help you monitor and self-manage long-term conditions and help you to avoid a crisis.

British Red Cross – Support at Home Service:
This service provides free short-term support in the home for people after discharge from hospital. The British Red Cross can help with grocery shopping, collecting prescriptions, collecting pensions and paying bills, safe and well checks, confidence building, signposting onto other relevant organisations as well as support for carers who may need a few hours break. Please discuss further with your ward team or contact the British Red Cross direct on

- Warrington: **01925 662 688**
- Halton: **0151 424 7873**

USEFUL CONTACT NUMBERS

Age UK	**01925 639018**
Alzheimer's Society	**0151 420 8010**
Attendance Allowance & Benefits Helpline (Freephone number)	**0800 882200**
British Red Cross Mobility Aids. Loan of wheelchairs, commodes etc.	**01565 682 317**
Cheshire Fire & Rescue Service - Home fire safety checks	**01925 662 688**
Diabetes UK Helpline	**0845 120 2960**
Disabled Living Foundation	**0870 603 9177**
Halton Adult Social Care Team	**0854 0500 148**
Halton Carers Centre	**01928 580182**
Hospital Patient Transport Ambulance Service. Ring 48 hours before appointment time.	**0800 032 3240**
Pension Credit (Over 60-Freephone number)	**0800 991234**
Stroke Association	**0845 3033 100**
Warrington Adult Social Care Team	**01925 444239**
Warrington Sensory and Telecare Services Team	**01925 443979**
Wired Adult & Young Carers Services	**0800 731 6941**

Useful Websites and documents:

Warrington & Halton Hospitals NHS Foundation Trust
www.whh.nhs.uk
The trust's own website provides information on our hospital services and a range of patient and visitor guides that may be useful to you – as well as ways of providing your feedback after your stay with us.

ONCE HOME – WHAT IF?

What if the district nurse does not arrive?

A: Contact your GP surgery which will advise on a 24-hour number.

What if I need more dressings?

A: Ring the GP surgery or district nurse who can ensure you receive a supply.

What if my feed does not arrive at home?

A: Contact the home enteral feeding company.

What if my recovery is not going as expected?

A: Contact your own GP or call NHS 111 which is free of charge to call at any time of day & night – 7 days a week, 365 days a year.

What if my medication supply is running out?

A: The hospital pharmacy will usually give you at least a short supply of medications. Contact your GP surgery for further supplies of medications.

THIS PAGE IS FOR YOU TO WRITE DOWN NOTES, QUESTIONS OR OTHER CONTACT NUMBERS OF *SERVICES THAT YOU MAY NEED:*

If you have any worries or concerns about your care or treatment following your discharge from hospital; you may want to contact the ward team for advice

Your stay in hospital was on:_____

The direct dial number for this ward is:_____

The ward manager is: _____

The ward manager works shifts: please contact the ward and ask to speak to the nurse in charge.

The matron for this ward is:_____

If you are still concerned please contact your GP or telephone **NHS 111**

If you need this booklet in another format – for example, large print, Braille or a language other than English – **contact the PALS office on 01925 275512**

What will happen on the day I am discharged?

- We will aim to discharge you before midday.
- You may need to be prescribed medication to take with you when you are discharged. This will be requested by your doctor and prepared by the Pharmacy staff.
- You will need to arrange your own transport from the hospital, unless you meet the criteria for an ambulance. This will be arranged by the ward staff.
- You may be escorted to the Transfer Lounge to wait for your transport and for any medication.
- Alternatively, you, or a relative or friend, may wish to return to the ward you were on later in the day to collect your medication.

If you need this information in any other language or format, please ask the nurse who is looking after you to contact the Patient Experience Team on T: 0151 430 1376 www.sthk.nhs.uk

Created by: Medical Care Group
Date: January 2015
Review Date: December 2015

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Planning your discharge from hospital

Welcome to St Helens and Knowsley Teaching Hospitals NHS Trust.

We aim to provide '5 Star Care' every time you are in hospital. The staff will make every effort to make your stay as comfortable as possible, ensuring you leave hospital safely and as soon as you are well enough.

If you or your family/carers would like to ask any questions about your care or if you have any concerns, please raise them immediately with the nursing staff on the ward.

Getting you ready for home

- The length of time you spend in hospital will depend on the care and treatment you need.
- The staff in the hospital will talk to you and your family/carers throughout your stay about what you may need on discharge. These discussions will start on the day you are admitted to hospital.
- They will also let you know how long they think you will be in hospital and what date they think you will be ready to leave. This is called your **Expected Date of Discharge**. This date may change during your time in hospital depending on the treatment and tests you need.
- Other people such as social workers, therapists and district nurses may also be involved in your discharge planning.
- Some patients may need some extra help to recover from illness. This is called rehabilitation.

What do we need to know?

- Were you receiving any help at home before you came into hospital? This help may have been from social services, private carers, friends or family.
- Will you need any help when you go home or any equipment to assist you?
- Are the people who care for you available to help with your discharge planning?
- There may be a number of things that need to happen before you can be discharged from hospital to make sure that you are safe.
- **If there is going to be a delay in you leaving hospital of more than 48 hours, the Trust may transfer you to an out of hospital placement to wait for your discharge arrangements to be put in place.**

Care Home placements

- You might be leaving hospital to go into a care home.
- If you have selected a care home but there are no places available at the time of discharge, you may be looked after in another care home, until a place is available in your chosen home.
- If you or your family/carers have not selected a care home, you may be looked after in another care home temporarily to give you and your family more time to look.
- A member of the Trust Integrated Discharge Team will support you and your family/carers through this process and will keep you involved and fully informed at all times.

Your Comments / Concerns

If you have any compliments, comments or concerns about the Patient Transport Service then please telephone: **0345 112 6500** and speak to one of the Making Experiences Count team.

If you require any further information about the PTS, or would like to view our Patient Charter please visit: **www.patienttransport.nwas.nhs.uk**.

The Patient Transport Service can be contacted by telephoning freephone: **0800 0323 240*** or for mobile phone users telephone:

- Patients living in the Mersey area telephone: **0151 261 2580**
- Patients living in the Lancashire area telephone: **01772 904 919**
- Patients living in the Cheshire area telephone: **01244 651 311**
- Patients living in the Cumbria area telephone: **01228 403 064**

For haemodialysis and cancer patients, please telephone freephone: **0800 0289 224*** or mobile phone users telephone:

- Patients living in the Mersey area telephone: **0151 261 2581**
- Patients living in the Lancashire area telephone: **01772 904 919**
- Patients living in the Cheshire area telephone: **01244 651 311**
- Patients living in the Cumbria area telephone: **01228 403 064**

*some mobile phone providers may charge you to telephone a freephone number.

Please refer to individual mobile service providers for information on call charges.

The Patient Transport Service can also be contacted by emailing: **pts@nwas.nhs.uk**.

Contact Us

Your opinions are important to us. If you have any views about this document or if you would like to receive this document in large print, braille, on audio tape, or in an alternative language to those shown below, please contact us.

Arabic
اذا كنت تحتاج لهذه الوثيقة بلغة اخرى او بشكل آخر يرجى الاتصال بنا

Chinese
如果您需要本文件任何其它语言或格式的文本，请直接与我们联系。

Gujarati
જો તમને આ દસ્તાવેજ બીજી કોઈ ભાષા કે સ્વરૂપમાં જોઈતો હોય, તો કૃપા કરીને અમારો સંપર્ક કરો.

Polish
W celu otrzymania niniejszego dokumentu w innym języku lub formacie, należy się z nami skontaktować.

Somali
Haddii aad ku rabto xaashadan luqad ama qaab kasta oo kale fadlan nala soo xidhiidh.

Urdu
اگر آپ کو کسی اور زبان یا فارمیٹ میں دستاویز کی ضرورت ہو تو ہم سے رابطہ کریں۔

Trust Headquarters

Ladybridge Hall, Chorley New Road, Bolton, BL1 5DD Minicom: 0151 260 8628
Email: nwasenquiries@nwas.nhs.uk Website: www.nwas.nhs.uk

Photography courtesy of Jason Locke

For further information visit the website, email or call

0845 112 0 999 (charged at local rate)

www.facebook.com/nwasofficial

www.twitter.com/nwambulance

North West Ambulance Service NHS
NHS Trust

Delivering the right care, at the right time, in the right place

Patient Transport Service
Information for Patients

You can ask to use the Patient Transport Service (PTS) if you have a medical or clinical condition which may stop you getting to your appointment by any other means. The service provides transportation for appointments between 08:00 hrs and 18:00 hrs, Monday to Friday (excluding Bank Holidays)*.

*If you are a haemodialysis patient or a patient receiving treatment for cancer, please speak to the hospital you are receiving treatment at to find out their specific operating times as these do vary.

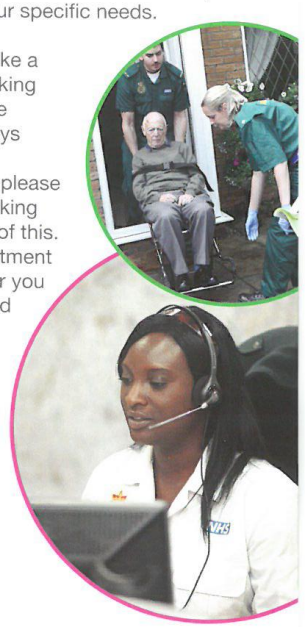
Booking Transport

The clinic you are attending may book transport on your behalf. If not, you may need to ask your GP or clinic to provide you with the telephone number of where you can book your PTS.

Staff will ask you some simple questions to make sure you are eligible to use the service. You will need your NHS number to hand to make a booking and it is available from your GP.

Please make the call taker aware of your mobility and any additional needs you may have, so the right type of transport is provided for you. We can also provide special aids such as our Pictorial Handbook for patients who are hard of hearing or who experience language barriers. In order to help you, we need to be fully advised of your specific needs.

If you would like a transport booking reminder to be provided 3 days before your appointment, please make the booking centre aware of this. If your appointment is cancelled or you need to amend your booking e.g. you only require transport home, please let the booking centre know as soon as possible.



Appendix 6

If you require haemodialysis treatment, then you will be assessed by your relevant unit/clinic before commencing your treatment and then re-assessed every six months to ensure you still qualify for hospital transport. If you are a cancer patient, you will be assessed every three months by your clinic. Once you have been assessed, you do not have to book any transport yourself; this will be done by the staff at the unit or clinic you attend.

Your Mobility

We provide a range of vehicle types and levels of care appropriate to your medical needs to ensure that you travel as safely and comfortably as possible. **It is important to make the call taker aware of your mobility and any additional needs you may have** (including walking frames, wheelchairs, steps at your home address), so that the right type of transport can be provided for you.

Escorts

If you have a physical or mental incapacity you may be entitled to take an escort and you should mention this to the booking centre. The escort may be either a professional, a relative/carer or a guide/hearing dog and their attendance is subject to meeting the assessment process mentioned above. Only one escort can travel with you on your journey.

Patients under the age of 16 must be accompanied by an adult.

Before You Travel:

- If you have been given an appointment card or letter please show it to the ambulance crew and bring details of any medications that you need with you.
- Please be aware that you may be away from home for a number of hours. It is a good idea to bring with you a packed lunch, a drink, a newspaper or book to occupy yourself with and any medications that you may need during the day.

The Journey to Hospital/Clinic

- **Please be ready to travel at least 90 minutes prior to your appointment time. When possible, we will give you a more specific estimated collection time at the point of booking.**
- Please note that you may not necessarily have a direct journey to your destination. The vehicle you travel to your appointment in may have to collect other patients who are attending the same hospital as you or other hospitals in the surrounding areas.
- We are committed to respecting and maintaining the dignity of all our patients.
- Please remember there may be both male and female patients on the vehicle and ensure you are appropriately dressed to travel, particularly in cold weather.
- When you arrive at the hospital, we will escort and book you into the clinic you are attending.

The Journey Home

- Once you have finished your appointment please tell the clinic that you have travelled with the Patient Transport Service and that you are ready to go home. The nursing staff will notify the PTS that you are ready and where you will be waiting for collection.
- You may have to wait for other patients who are scheduled to travel on the same vehicle that has been planned for your return journey.
- When you reach your homeward destination the transport staff will escort you to your front door and make sure you are safely inside before leaving. Transport staff members are not allowed to drop you anywhere else other than the address supplied at the time your ambulance was booked.

Quality Standards

- **Appointments** - We are contracted to ensure that 90% of all patients will arrive no more than 45 minutes early or 15 minutes after their actual appointment time. If you do arrive prior to your actual appointment time, you may still have to wait until your scheduled time to be seen by a doctor. However, if you arrive up to 15 minutes after your actual appointment time, please do not worry - you will still be seen by the doctor.

  If you are attending for haemodialysis or cancer treatment, we are contracted to ensure that 90% of all haemodialysis and cancer patients will arrive within 30 minutes of their appointment time.

- **Returning Home** – Once your appointment is finished and we are notified that you are ready, we aim to collect 80% of patients within 60 minutes and 90% within 90 minutes.

  If you have attended for haemodialysis or cancer treatment, we aim to collect 85% of patients within 60 minutes and 90% within 90 minutes of being notified that you are ready to travel home.

NWAS PTS Training Syllabus

	Classroom Sessions	Workbook Topics
Subjects	• Oxygen Therapy • Basic Life Support • Resilience • Conflict Resolution Training – Practical • Prevent • Proportional Response • Non-emergency Driving • British Sign Language • Information Governance • Moving and Handling Equipment - familiarisation and demonstration • Moving and Handling – practical • Safeguarding/Moving and Handling/Risk Assessment Scenarios • AED Familiarisation • Patient Experience	• Security • Fire Safety • Infection Prevention & Control • Hazards, Risk Assessment and Decisions • Manual Handling • Slips, Trips and Falls • Patient Report Forms • Information Governance • Resilience (Major Incidents) • Equality and Diversity • Dignity at Work • Communication and Conflict Resolution • NHS Protect (Fraud) • Corporate Governance • Psychosocial Resilience • Alzheimer's and Dementia • Patient Experience • Duty of Candour • Safeguarding

All staff undertakes mandatory training annually through a combination of workbook exercises and classroom sessions.

Health Policy & Performance Board (PPB) Scrutiny Group – Discharge from Hospital

Visit to Castlefields Health Centre, Village Square, Castlefields, Runcorn

Monday 23rd November 2015, 1:00pm – 2:00pm

Present:
Councillor Joan Lowe, Chair, Health PPB, Halton Borough Council (HBC)
Councillor Stan Hill, Vice-Chair, Health PPB, HBC
Councillor Pauline Sinnott, Health PPB Member, HBC
Damian Nolan, Divisional Manager, Urgent Care, HBC
Natalie Johnson, Policy Officer, HBC
Dr David Lyon, GP, Castlefields Health Centre
Maria Stacy, Practice Manager, Castlefields Health Centre
Angela Furnival, IT Manager, Castlefields Health Centre
Sarah Stenson, Health & Safety Officer/Admin Support, Castlefields Health Centre

Notes of the discussion:

There were introductions around the room and Cllr. Lowe explained the purpose of the visit in connection with the Health PPB's Discharge from Hospital Scrutiny Topic, which commenced around June of this year and has involved visits to hospitals and presentations from various services. At the last meeting, Dr Mick O'Connor invited the group to visit a GP surgery to find out more about the information that is transferred between hospitals and GP surgeries. Members of the group are also visiting Beaconsfield Surgery in Widnes on 3rd December.

Cllr. Lowe also explained that a report on the findings will be prepared (including the information shared at today's visit); it will also include recommendations for improving practice. Those present today will have the opportunity to view the report before it goes to Health PPB, Executive Board and Full Council for approval.

Question: What works well and what issues/opportunities for improvement are there in terms of exchanging information between general practice and hospital?

Maria explained that there are problems communicating with hospitals at times. Maria provided an example of on occasion where a clinician was working late and needed to provide some information to a hospital re a patient that would be admitted. Initially, there were difficulties even getting through to the ward and once the call was answered, there was no way of transferring the information about the patient as the ward's fax was broken and they could offer no alternative communication method (e.g. email).

Simple measures to improve this process could include having contact numbers for wards (due to issues with going via the main switchboard), with someone taking responsibility (e.g. ward clerks) for answering calls in a timely manner. It was acknowledged that wards probably receive calls constantly from various people, including worried relatives; perhaps there should be a separate number for professionals to use to ensure clinical information can be shared.

Question: What does general practice look like on a day-to-day basis/how does it run?

Copy of organisational structure provided – see Appendix A.

There are around 12,000 patients.

Currently in the process of splitting the reception team into two – one for dealing with appointments and the other for prescriptions.

As well as GPs running appointment based clinics, there is also a GP based behind reception each day to provide a triage service. The receptionist will take brief information from the patient and the GP will call back.

Mondays are characterised by responding to the backlog generated over the weekend.

Question: How does information come into the practice from hospitals?

Information comes in via EDT – Electronic Document Transfer – or in a paper-based form.

Warrington, Halton, Whiston and St Helens Hospitals all use EDT.

EDT displays information such as 'There are X documents waiting to be seen' along with a description of the type of document (e.g. outpatient letters).

Practice staff will then attach the document to the relevant patient record and send to their GP and this also automatically links in with EMIS (electronic patient record system/software used by GPs) using date of birth / NHS number.

There is no-one dedicated for dealing with medication following discharge from hospital but there are plans to establish Prescription Clerks within the practice and they will be trained by GPs to assist with medication changes etc. following discharge from hospital. This will help to reduce the amount of work for GPs.

Commonly finding that information is coming from hospitals with an instruction for a patient to start medication in, for example, two weeks but this information is not received until the two week period has passed.

Also, hospitals/out-of-hours may ask a patient to contact their GP following a visit over the weekend – the patient will think that the practice receives the information immediately but that is often not the case.

Question: What is the process for dealing with any follow-up care required after discharge from hospital, e.g. if the patient requires district nurses?

There is a process separate to GP practices for district nurses – the ward will contact the district nurses directly.

Question: What would improve the communication process from hospitals?

Dr Lyon explained that there is some current discussion between Doctors, the Royal Colleges and the BMA (British Medical Association) that the clinician who orders a test should be the one to follow it up. Therefore, it is bad practice for hospitals to be asking GPs to follow up with patients.

With the above in mind, an agreed set of principles would be of assistance, which should include the requirement for consultants to follow up on any tests they have requested, in line with agreed good practice.

Speed of communication would also be another basic principle and this could be addressed by enabling the different systems used by hospitals/GPs to link in with one another. There is some software that would achieve this – the Multi-Interface Gateway (MIG). There is money set aside for this and the Scrutiny Group received a presentation on this software during one of the earlier meetings.

Another issue that creates delay in the communication process is the fact that consultants dictate their letters onto voice recorders and then this is typed into a letter by the secretarial teams. However, there have been devices available for some time that can be talked into and will automatically generate an electronic document, which is simultaneously displayed on screen.

The ICE system for requesting tests and recording results (e.g. CT scans, pathology) was discussed – GPs can link into this and often access the information before the consultant – why can't letters be transferred this way also?

It was noted that Warrington Hospital will be implementing the 'Lorenzo' system which will speed up the transfer of information but realistically it will be 12 months before this is fully functional.

Currently, there is information coming into the practice from Warrington that is not very detailed – it has date of admission, date of discharge and the text says that a summary cannot be produced at this time. Therefore, practice staff cannot identify what the patient has been in for etc. and cannot send this information onto the GP; it is simply filed. IT Manager will check if there is any information included such as ward/consultant etc. *Update following the visit – ward/consultant information is included but there are no medication details, therefore, the practice cannot make use of this information and question the purpose of it being sent. See anonymised example included at Appendix B.*

There was some discussion around the volume of paper generated – a patient can present with one issue, first to a walk-in centre, then they may be transferred to A&E, then to EAU (Emergency Assessment Unit) and finally they may be admitted to a ward – this would generate at least four pieces of paper. It was questioned if all would be classed as admissions, are we getting a true picture?

Ultimately, the solution is IT and relevant information being fed in to the systems put in place.

Question: What is communication like from the walk-in centres?

The practice receives information the following day – may be later in the day and the patient will often get in touch first thing (they may, however, be misinterpreting the instruction from the walk-in centre in terms of when they should contact their GP).

It was noted that walk-in centres are successfully dealing with most issues without the need for onward referral to A&E.

Question: When does communication work well and why?

It works well when information is received quickly and in a typed format so it is readable.

Practice in Poland was discussed as an example where the patient is given a copy of everything that their GP will need following a visit to hospital. **Question – would such practice work here as an interim measure whilst IT systems were being implemented?**

It is possible that this would be a good way of reducing delay, especially in terms of medication following hospital discharge.

The Government wants the public to have access to their records so involving them is a positive thing and anything that empowers them to take responsibility is good because the level of trust people have in the NHS can sometimes mean they don't question inevitable glitches in the system.

It was noted that hospitals still have a lot of paper records, whilst in the practice everything has now been scanned so is in electronic form, even historical records.

Question: What is the process for people in nursing homes?

From a practice perspective, it is the same as people in nursing homes are patients in the same way as those not in nursing homes. Regarding medication, nursing home staff should get information as they have strict rules to abide by in this respect.

There are glitches in the practice receiving information following someone staying in a rehab unit – e.g. information may be received re admission but not discharge.

End of discussion.

On behalf of the board, Joan thanked the practice staff for their valuable time.

CASTLEFIELDS HEALTH CENTRE - PRIMARY HEALTH CARE TEAM (27.07.2015)

Practice Directly Employed Staff

(M) = "Management Team" Member
42 employed staff

- Dr. David Lyon (M) — 9 sessions — GP Partner
- Dr. Rachel Millerchip — 5.75 sessions — GP Partner
- Dr. Matthew Kearney — 2 sessions — GP Partner
- Dr. Zoe Rog (M) — 5 sessions — GP Partner/Trainer
- Dr. Rachel Arnold — 4 sessions — GP Partner/Trainer
- GP Partner — Vacancy
- Dr. Sarah Cunningham — Sal G.P. — 4 sess/wk
- Dr. Sharon Cowap — Sal G.P. — 6 sess/wk
- Practice Manager — Maria Stacy 30 hrs (M)
- Deputy Practice Manager — Julie Shaw 34 hrs (M)
- Dr Lindsey Davies — Sal GP — 6 sess/wk (Start date: 01.09.2015)
- Dr Clare Lanceley — Sal GP — 4 sess/wk (Start date 23.06.2015)
- Dr Steve Coogan — G.P. Reg. — 8 sess/wk
- Locum GPs — (as needed)
- Nurse Clinician — Ann Riley F/T
- Nurse Practitioner — Hayley Lawson (M) — 30 hrs
- Nurse Practitioner — Sheena Harris — 30 hrs (Start date: 02.07.2015)
- Special Interest Practice Nurse — Sue Wright 20 hrs (Mon & Tues) (Asthma, COPD, INR, GPN)
- Special Interest Practice Nurse — Susan Watson F/T (CHD, RA, INR, GPN)
  - Assistant Practitioner — Sue Fletcher 32hrs
- Special Interest Practice Nurse — Becky Turner F/T (Over 75s - Improving Services for Older People)
  - Health Care Assistant — Nicky Griffiths F/T
- Special Interest Practice Nurse — Diane Clarke F/T (Diabetes, INR, GPN)
  - Assistant Practitioner — Ruth Newall F/T

Counselling Team
Rhian Taffler 10 hrs (Tues & Wed)
Jim Anderson (qualified) 3 appts/wk (Tues)
Jayne Wainwright (qualified) 3 appts/wk (Wed
Bell Walsh (qualified) 3 appts/wk (Tues)
Leana Hughes (trainee) Currently on Mat Leave 3 appts/wk (Tues)
Deb Jones 2 appts/wk (Wed)
Lisa Faulkner 3 appts (trainee)
= 27 counselling appts/week

Medical Receptionist Team
Lorna Danson (Snr Rec) 38 hrs (M)
Vicky Marsden 30.25 hrs
Julie Whitehead 25 hrs
Sue Robertson 15 hrs
Linda Burrows 34 hrs
Karen Brown 30 hrs
Jill Kinsella 27.5 hrs
Lynn Parker 27.5 hrs
Yvonne Leach 27.5 hrs
Doris Chimes 10 hrs
Alison Rae 24 hrs
Lisa Kilburn 20 hrs

Administration Team
Ann Thomson 7.4 hrs
Diane Hesketh 37 hrs (M)
Angela Furnival 37 hrs (M)
Sarah Stenson 37 hrs
Emillie Davies 20 hrs
Danielle Hesketh 28.75 hrs
Carole Kinsella 37 hrs
Doris Chimes 17.5hrs
Matthew Skidmore (M) (Apprentice) 37 hrs

CRI Employed Staff

Substance Misuse Nurses
Tracey Kennard
Viki Ashcroft

Elite Employed Staff

Alison Atkinson (Supervisor) 20 hrs
Emma Bates 20 hrs
Tracey Given 10 hrs
David Feehan 10 hrs
Michelle Highdale 20hrs

HBC Employed Staff

Social Care In Practice Worker
Helen Owen (F/T)

NCHs Trust Employed Staff

Phlebotomist
Jo Gayter/Cover when off
X5 weekday mornings

Bridgewater Community Healthcare NHS Trust Employed Staff

Community Matron
Currently Vacant
HCA
Roisin McKiernan P/T
Mon, Tues & Wed

District Nursing Team
Carrie Hunt 7 F/T
Julie Noble 6 F/T
Elaine McManaman 5 F/T
Rebecca Garner 5 F/T
Kate Kane 5 P/T
Liza Mitchell 5 F/T, Paul Howard 5 F/T, Kath Scott 3 P/T Michaela Fagan Admin

Health Visitors Team
Louise Evans F/T, Becky P/T HV, Teresa Rooney P/T HV, Gemma Barnett P/T HV (Mat Leave May 15 ->), Leoni Student HV P/T
Karen Anwyll 4 F/T FSW
Barbara Travis H/V Clinic Asst P/T
Emily Harding (Clerk) P/T

Midwife Team
Gill Bleasby F/T
Catrina Shallcross F/T

Cardiac Nurse
Patricia Wainwright

Podiatrist (Various)
7 Sessions p/wk (worked Mon-Thursday, not Wed PM))

Physio's
Andy Ward Mon pm
Paul Barnham Full Day Wed
Anne Morgan Thurs am
Paul Barnham Full Day Fri

Appendix B

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Discharge Summary - GP COPY

10 November 2015

GP Name: [redacted] GP Address: Castlefields Health Centre The Village Square Castlefields Runcorn WA7 2ST GP Nat Code: [redacted] Practice Code: N81019	Patient Name: [redacted] Patient Address: [redacted] Dob: [redacted] Hospital No: [redacted] New NHS No: [redacted]

Ward: [redacted] **Consultant:** [redacted]

Admission: 03/10/2015 **Date of Discharge:** 04/11/2015

Dear [redacted]

Your patient has recently been discharged from our hospital.

It has not been possible to provide you with medication details for this admission.

If applicable, medication details will follow in a letter provided by the consultant.

Kind regards

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 9

Hospital Discharge Scrutiny Review 2015/16

Beaconsfield Surgery Visit, Thursday 3rd December 2015. 3pm-4.30pm

In attendance:

Councillors:
Joan Lowe
Stan Hill
Charlotte Gerrard
Sandra Baker

Halton Borough Council Officers:
Damian Nolan – Divisional Manager
Emma Bragger Policy Officer (note taker)

Beaconsfield GP Surgery Staff:
Dr Mick O'Connor - GP
Diane Henshaw – Practice Manager

The group attended a visit to Beaconsfield Surgery, Widnes, to gain insight into the hospital discharge process from the view point of general practice, looking at how patients are discharged to general practice and the role of the GP.

The visit was facilitated by Dr O'Connor and Diane Henshaw, to which Cllr Lowe extended thanks on behalf of the group for the opportunity to visit the practice and for their time.

Hospital Contract Key Performance Indicators (KPIs)
Dr O'Connor explained to the group that the hospitals have KPIs around discharge from A&E, Ward and Clinic – these KPIs are facilitated by the use of electronic discharge (E-discharge) in some cases.

Whiston & Warrington Hospitals have a target of 90% of discharge communication within 24 hours. Currently Whiston is achieving 77% and Warrington a bit lower. Both hospitals are aware that this is an issue, but it is acknowledged by both Hospital and general practice that staff resource is needed to be patient focused, and discharge communication is sometimes a lower priority. Some discharge notices come outside of the 24 hour target, some do not arrive at all.

Dr O'Connor reported that the Hospital CQUIN (incentive payment based on performance) is not sufficient to make it a viable incentive to hospital trusts.

Discharge notices received into the GP Practice
Although e-discharge notices are received every 2 hours throughout the day, the system at Beaconsfield downloads them into the GP's email in box once in every 24 hour period. This enables a more structured workflow for the GPs. There are some mandatory fields on the e-discharge forms, which provides a fuller picture. However, not all Trusts are on the e-discharge system. Many discharge notices still come in the form of a paper letter that must be scanned in to the system. Both Warrington and Whiston send discharge summaries as e-discharge. Warrington are in the process of moving to electronic patient case notes and discharge summaries will be automatically populated from this system. Whiston are looking to implement an electronic pharmacy system which will populate the medication discharge information.

Quality of Discharge Notices
Dr O'Connor reported that the quality of the discharge notice, where received, can affect the chances of readmission for a patient. Where the quality of the information is poor, the GP may not have the full picture of the patient's condition or reason for admission, in order to treat effectively in general practice, resulting in a readmission to hospital. Building the full picture of what has happened to the patient whilst in hospital is aided by the fact that all GP practices have electronic access to radiology and laboratory data, so they are able to see what tests/results have been undertaken.

Prescribing in Hospital
Whiston is moving towards e-prescribing, which will speed up the discharge process. Completion of prescribing data will be done through a selection of pre populated lists, saving time against manually inputting drug, quantity and frequency. As well as saving time, especially where people have a large number of drugs prescribed, it will also lessen the chances of human error or misreading of handwritten notes. Warrington are planning something similar after the electronic patient case note system is implemented.

Follow up of hospital tests and result, post discharge
Currently national guidelines state that test results should be followed up and acted upon by whoever has requested the tests. However, in practice, GPs are getting requests from hospital to follow up tests results, and action, on their behalf. Dr O'Connor reported that this issue is an ongoing conversation with the local Trust's Quality Groups, regarding the role of GPs in test follow up.

The future role of IT in discharge
There is work taking place to look at how the various health and mental health systems interface with each other, rather than getting everyone on the same system. That way information from all health stakeholders can be accessed to provide a full picture. There is work underway for practices to be able to access other GP practice information. There is a pilot taking place at the Health Resource Centre, Widnes, known as 'GP Access'. The patient gives the clinician consent to see their medical record, which gives potential for people to visit other places to access services, not just their own GP.

There is a need to link pharmacy into the electronic system – in the future there may be no need for prescription pads!

Demonstration of EMIS Web by Dr O'Connor
Dr O'Connor demonstrated the appointment system, prescriptions, full patient record, and discharge letters.

Dr O'Connor showed examples of a variety of discharge letters showing the type of information contained, level of detail etc. He showed e-discharge and letters that had been scanned on to the system. It was clear to the group that there was little consistency between the various Trusts about what information was provided. Some provided too much, others provided too little. Some was good quality, others less so. It demonstrated the amount of work that the GPs have to do on receipt of the discharge notice, and their required follow up.

Patients will have access to their records on line in future. They are able to see only 'coded' elements of their record ie diagnosis, tests they have had. These coded elements are one word descriptors of conditions, results etc, selected form a pre populated drop down list. The patient is not able to see 'free text', which are the manually typed notes inputted into the patient's record by the GP.

Dr O'Connor showed a patient who has a rare syndrome requiring frequent hospital attendances to manage the condition. Community alternatives are being explored with a a range of services and the further development of the Urgent Care Centre's could assist the management of this type of condition. It was noted that this type of admission is currently coded as a readmission (for one patient upto 100 in a year).

There is work underway around risk stratification of patients using the electronic patients records by doing reports based on 'read codes'– identifying those who would benefit from review. This work is valuable in preventing readmission to hospital by those most likely to be admitted to hospital.

End of Visit

Cllr Lowe thanked Dr O'Connor and Diane Henshaw for their time and contribution. Cllrs Lowe and Hill took a short tour around the Practice facilities with Diane.

NICE National Institute for Health and Care Excellence

NICE guideline

Transition between inpatient hospital settings and community or care home settings for adults with social care needs

NICE guideline
Published: 1 December 2015
nice.org.uk/guidance/ng27