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AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE MEETING

Date: Wednesday, 10 February 2016.

Time: 6.30 p.m.

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford, M32 0TH.

	A G E N D A	**PART I**	**Pages**
1.	**ATTENDANCES**		
	To note attendances, including Officers, and any apologies for absence.		
2.	**MINUTES**		1 - 4
	To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 16 December 2015.		
3.	**DECLARATIONS OF INTEREST**		
	Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.		
4.	**DISTRICT NURSING REVIEW UPDATE**		
	To receive an update from representatives of Trafford CCG and Pennine Care NHS Foundation Trust.		
5.	**DIGNITY IN CARE FOLLOW UP REVIEW**		5 - 104
	For representatives of UHSM, SRFT and CMFT to answer questions in relation to the Dignity in Care report published by the committee December 2013.		

6. **UPDATES ON HEALTH ISSUES**

To receive an update from the Democratic and Performance Services Manager on current health scrutiny issues and the recent work of associated bodies.

(a) **JOINT HEALTH SCRUTINY COMMITTEE 2 FEBRUARY 2016** (Pages 105 - 110) 105 - 110
To receive a verbal update from Councillor Harding and a presentation on developments at Trafford General.

(b) **HEALTH SCRUTINY COMMITTEE CHAIRMAN'S RESPONSE TO CQC RE: UHSM** (Pages 111 - 112) 111 - 112
To receive the response by the Chairman on behalf of Trafford Council's to the Care Quality Commission (CQC) regarding University Hospital of South Manchester.

(c) **BUDGET SCRUTINY 2015** (Pages 113 - 122) 113 - 122
To receive a report from Trafford Council's Overview and Scrutiny Committee.

7. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

THERESA GRANT
Chief Executive

Membership of the Committee

Councillors J. Lloyd (Chairman), Mrs. P. Young (Vice-Chairman), Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, M. Cawdrey, R. Chilton, J. Harding, A. Mitchell, S. Taylor, L. Walsh, Mrs. V. Ward and J. Coupe (ex-Officio).

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray,
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Email: alexander.murray@trafford.gov.uk

This agenda was issued on **Tuesday, 2 February 2016** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford, M32 0TH.

HEALTH SCRUTINY COMMITTEE

16 DECEMBER 2015

PRESENT

Councillor J. Lloyd (in the Chair).
Councillors Mrs. P. Young (Vice-Chairman), Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, M. Cawdrey, R. Chilton, J. Harding, S. Taylor, L. Walsh and J. Coupe (ex-Officio)

In attendance

John Pearce	Acting Corporate Director of Children Families and Wellbeing
Diane Eaton	Joint Director for Adults (social care)
Julie Crossley	Associate Director of Commissioning for Trafford CCG
Debbie Walsh	Joint Head of Service – Adult Health & Social Care Integration (South) Pennine NHS Foundation Trust.
Lesley Merry	Head of Personalised Care for Trafford CCG
Ann Day	Chairman of Healthwatch Trafford
Richard Spearing	Trafford Integrated Network Director - Pennine Care NHS Foundation Trust and Trafford Council.
Peter Forrester	Democratic and Performance Services Manager
Alexander Murray	Democratic and Scrutiny Officer

APOLOGIES

Apologies for absence were received from Councillors A. Mitchell and Mrs. V. Ward

28. MINUTES

RESOLVED:

1) That the minutes of the meeting held on 7th October 2015 be agreed as correct record and signed by the Chair.

29. DECLARATIONS OF INTEREST

Councillor Brophy in relation to her employment by Lancashire Care Foundation Trust.
Councillor Bruer-Morris in relation to her employment within the NHS.
Councillor Chilton in relation to his employment by General Medical Council.
Councillor Harding in relation to her employment by a mental health charity.
Councillor Taylor in relation to her employment within the NHS.

30. CONTINUING HEALTH CARE

The Head of Personalised Care from Trafford Clinical Commissioning Group (CCG) delivered a presentation to the Committee on Continuing Health Care (CHC). The presentation laid out what CHC is, the structure of Trafford CCG's CHC team and the progress that they have made over the year. The Officer reported that there had been massive strides made within this area during the year

so that Trafford CCG is now seen as one of the best CCGs in terms of their approach to CHC.

One area that the Head of Personalised Care focused upon was the Previously Unawarded Packages of Care (PUPoC). A PUPoC is where the family of the deceased may claim that their relative was eligible for CHC before they died. If it was found that they were eligible the family could claim compensation from the CCG for the care that person would have received. Because these awards are for high cost care over a number of years each case awarded is a large financial settlement for the CCG. On top of this the nature of the investigation itself takes up a large amount of time and resource for the CCG. Since PUPoCs were introduced Trafford CCG has identified 181 cases, 40% have been completed and half of those have been awarded.

Committee members asked a number of questions on areas including end of life care, staffing levels, patient tracking, out of borough placements, provision of care within Trafford and the impact of PUPoCs on the CCG. The Head of Personalised Care gave detailed answers to all of the Councillor's questions and Committee Members were satisfied with the answers received.

RESOLVED:

1) That the Head of Personalised Care be thanked for her presentation to the Committee.
2) That the Committee revisit CHC in the next municipal year.

31. DISTRICT NURSING

Councillor Chilton gave a brief verbal update to the committee regarding his recent visit to Firsway Health Centre. Councillor Chilton stated that he was happy with the district nursing service overall but expressed his concerns at the staffing levels at Firsway Health Centre and the general difficulties of recruitment within the service.

The Joint Head of Service – Adult Health & Social Care Integration (South) did not cover District Nursing as a separate presentation to the committee as it was to be covered as part of the Integrated Care presentation.

RESOLVED:

1) That the update be noted by the Committee.

32. INTEGRATED CARE

The Associate Director of Commissioning for Trafford CCG, the Joint Head of Service – Adult Health & Social Care Integration (South) from Pennine Foundation Trust and the Joint Director for Adults (social care) gave a presentation to the Committee on the integration of Health and Social Care within Trafford. The presentation covered the many areas of health and social care which Trafford Council, Trafford CCG and Pennine Care were bringing together into a single model. As well as updating Committee members on the progress made this year, the presentation also covered Pennine and Trafford Council's integrated strategy up to 2020. This part highlighted the growing deficit being accumulated by the Council and Health Organisations in the area with projections indicating a deficit of £111m by 2020.

Once the presentation concluded the Councillors posed a large number of questions to the officers. The questions covered a wide array of points, concerns and services. The Councillors received a number of detailed answers to their questions but due to time restraints many more questions could not be covered adequately.

It was agreed that the integrated health and social care work programme was too large and area to cover within a single meeting. It was agreed that additional meetings between Officers and Committee members be set up to cover integrated Health Care in more detail.

RESOLVED:

1) That the officers from Trafford Council, Trafford CCG and Pennine be thanked for presenting to the committee.
2) That additional meetings be arranged to cover integrated health care.

33. TRAFFORD LOCALITY PLAN CONSULTATION

The Acting Corporate Director of Children, Families and Wellbeing delivered a presentation to update Committee Members on the position of Trafford's Locality Plan. The presentation covered the transformation of services, the goals of the transformation and the dependencies of the plan.

Councillors asked questions about various aspects of the Locality Plan including how Trafford's locality plan compared to other areas, staffing and recruitment, funding and the consultation process. All of these questions received detailed answers and the Committee was satisfied with the information they received. However concern was raised as to the level of integration and communication between mental health services and the other services within the plan. Committee members agreed that this was an area that should be looked into in more detail at a later meeting.

RESOLVED:

1) That the Acting Corporate Director for Children Families and Wellbeing be thanked for his presentation.
2) That the integration and communication links for mental health services be added to the Committee's work programme.

34. HEALTHWATCH TRAFFORD UPDATE

The Chairman of HealthWatch Trafford gave a brief update to the Committee on the work of the HealthWatch in recent months. Councillors thanked the Chairman of Healthwatch Trafford, noted the quality of the reports that were provided and thanked Healthwatch Trafford for the excellent work that they continue to do on behalf of the residents of Trafford.

The Chairman of Healthwatch Trafford mentioned that the organisation was still not commissioned for the 2016/17 municipal year. The Committee agreed to send an email to the Leader and Chief executive of the Council commending the work that Healthwatch Trafford has done.

RESOLVED:

1) That the Chairman of HealthWatch Trafford be thanked for attending the meeting.
2) That the Committee note the quality of the reports submitted by HealthWatch Trafford.
3) That the Chairman send an email to the Leader and Chief Executive of the Council to commend the work that Healthwatch Trafford do.

35. JOINT HEALTH SCRUTINY COMMITTEE

RESOLVED:

1) That the Committee noted the minutes from the meeting held on the 10th November 2015.

36. TASK AND FINISH GROUP UPDATE

The Chairman of the Committee gave a verbal update on the progress of the task and finish groups looking at delayed hospital discharges at Wythenshawe Hospital and stroke rehabilitation services within Trafford. The Committee noted the update and a further update will be provided at the next meeting.

RESOLVED:

1) That the update be noted
2) The Chairman is to provide another update at the next meeting.

The meeting commenced at 6.30 pm and finished at 9.15 pm

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **2nd February 2016**
Report of: **Democratic and Performance Services Manager**
Report Title

Dignity in Care Review – Follow up

Summary

To report on a follow up from the Dignity in Care report published by the Committee in 2013.

Recommendation(s)

To note the report.

Contact person for access to background papers and further information:

Name: Alexander Murray

Extension: 4250

Background

1. In December 2013, Health Scrutiny Committee wrote a comprehensive report based upon the work of members within a topic group (Appendix 1). This group was formed to look at the treatment of Trafford residents within the hospitals which provide them with care. Within the report were a number of recommendations. This report provides an update on progress in implementing the recommendations.

Purpose of the follow up review

2. The purpose of the follow up review is to determine the current levels of care post the publishing of the original report. The answers and information provided by UHSM, CMFT, SRFT, Care Home Managers, Home Care Managers, Trafford CCG, Healthwatch Trafford and Trafford Council Adult Social Care will form the basis of a second report which will go to the Health Scrutiny Committee, Trafford Council Executive and NHS Partners.

3. Members of the Committee have conducted preliminary research prior to the meeting and have posed the following questions to and requests for information from representatives in advance;

    - Could it become standard practice for the hospitals to inform Nursing Homes/Carers at least 24 hours before a discharge is expected to take place so adequate arrangements can be made?

    - Could copies of the standard discharge procedures and what steps are being taken to ensure that these are followed be provided for the meeting?

    - We have had concerns that patients care plans which are sent into hospitals when people need to be admitted urgently do not “follow” the patients when then are admitted into a ward and remain in A & E. Is there any way that care plans could remain with the patients and be sent back on discharge with hospital comments/changes added?

    - What is being done to ensure that patients admitted into hospital do not lose any of their life skills/mobility and are encouraged to do things for themselves – try and wash/dress themselves – walk to the toilets etc…?

4. UHSM provided responses (Appendix 2) and supporting documentation (Appendix 3 - 7) in advance.

5. Members of Healthwatch Trafford have also been invited to the meeting to ask questions and have collected information at the request of the Committee. The information collected by Healthwatch Trafford will be shared with all attendees in advance of the meeting as soon as it becomes available.

TRAFFORD COUNCIL

Report to: **Executive**
Date: **3 December 2013**
Report of: **Councillor P Young ,**
Chairman of Scrutiny Topic Group C

Report Title

Review of Scrutiny Topic Group C: Dignity in Hospital Care

Summary

The above review was selected by Scrutiny Members to be undertaken during the 2012/13 and 2013/14 municipal years.

The following report outlines the Topic Group's findings and recommendations.

Recommendations

1. **That the Executive note and consider the recommendations set out in the report;**
2. **That the Executive Member for Community Health and Well-being coordinate a response to be considered by the Health Scrutiny Committee.**

Contact person for access to background papers and further information:

Name: Peter Forrester
Extension: 1815

Background Papers:

None

Dignity in Hospital Care

Report of Health Scrutiny Topic Group C

November 2013

Scrutiny Review of Dignity in Hospital Care

Executive Summary

The purpose of this report is to present the findings of Topic Group C from a scrutiny review into dignity practices at NHS hospitals. The focus of our review was on the services provided at Trafford General, Salford Royal and Wythenshawe Hospitals.

Overall we found evidence of good practice and many examples of how Trusts ensure the dignity of patients whilst in hospital care. All the Hospitals we visited demonstrated high levels of commitment to provide an environment that respects and delivers good quality care.

We were assured that there are a variety of measures in place to ensure that these objectives are being met. Staff check wards on a frequent basis to see how patients are and has formal systems in place to monitor performance – for example, the use of performance dashboards and the display of performance information. Schemes such as Ward Accreditation support the culture of improvement and care. All the Trusts take complaints and feedback seriously. They have clear procedures and take action to learn from feedback.

There are a number of good examples of patient centred provision. For example, the "This is me" handbook and the "What matters most to me" initiatives. There are good standards of food provision and schemes to ensure that hospitals meet the specific needs of patients.

There are different approaches to discharge. Some use lounges whilst others provide support on wards. There are procedures to ensure that people are not discharged late in the evening and that they are given appropriate clothing. We were told of examples of how hospitals had dealt with cases where these standards had not been met. Procedures are kept under review so that they remain fit for purpose.

However, we did identify worrying areas for concern in practice. We carried out a survey of care homes and received a small number of letters from the public about care in the hospitals. We also visited two care homes to talk to managers about issues they had raised. Many did refer to excellent standards of care but also highlighted a number of areas for improvement. These include

- Problems with discharge procedures
- Weaknesses in communication with carers which has resulted in key information not being passed onto the hospital or recorded incorrectly. For example, information sent to hospitals with patients not following patients through the hospital system.
- Weight Loss and examples of vulnerable patients not being assisted sufficiently with feeding.
- Decrease in mobility in residents discharged from hospital.
- Residents returning home with hospital gowns on and/or not in appropriate attire. There are a small number of examples of residents coming back without dentures or glasses.
- Residents returning home without any medication or not sent in a timely manner.

The Trusts have systems to deal with performance and complaints and so we are assured that problems can be put right. However, each Trust needs to be vigilant in identifying problems and taking appropriate action. We were pleased to find that the Trusts are committed to taking action to continue to improve services for patients and their families.

Recommendations

Our recommendations are as follows:

1. That the Trusts ensure that they are taking all steps to deliver high quality care for elderly patients and review and amend their practice by

    - Ensuring that they are implementing recommendations 236 to 243 of the Francis report (see appendix 2)
    - Continuing to review policies and procedures in light of feedback from patients and carers.
    - Sharing and Identifying best practice to improve services for elderly and vulnerable patients.
    - Regularly checking that staff are implementing discharge procedures.

2. That Commissioners carry out an annual survey of Residential and Nursing Home managers to track progress in the delivery of high quality care for elderly patients.

3. That Commissioners consider establishing a meeting of Residential and Nursing Home managers with the Hospital Discharge Managers to discuss any issues raised by this survey exercise.

4. That the Care Quality Commission and the local Healthwatch are made aware of the report and recommendations.

5. That the Health Scrutiny Committee conducts a follow up review in 18 months' time.

I would like to thank my colleagues on the Topic Group for their work, insight and contribution. The Topic Group comprised of Councillors Brophy, Harding, Lamb, Proctor and Sophie Taylor. All members played a full and active role in this review and contributed fully to its findings.

I would like to make particular reference to the leadership and work carried out by Councillor Dylan Butt. I became Chairman of the Group midway through the review and am exceedingly grateful for the excellent work done by Councillor Butt, who prior to him being elected as Mayor of Trafford Council, developed and shaped the review.

I would also like to thank the managers and staff at hospitals and care homes for their open, honest dialogue with myself and the Topic Group members.

Councillor Patricia Young
Chairman Topic Group C
November 2013

1. Background

This review was included in the Health Scrutiny Committee's work programme at an event in October 2012. The purpose of the review was to explore how elderly residents were looked after whilst in the care of NHS hospitals.

Using the recent report from the Parliamentary and Health Service Ombudsman (PHSO) *'Care and Compassion?: A Report of the Health Service Ombudsman on ten investigations into NHS care of older people'* the Topic Group identified a series of key themes in which to frame their investigations. These were:

- Hospital Acquired Infection;
- Nutrition and Hydration;
- Discharges;
- Pain relief;
- Good nursing practices.

In addition to the use of the PHSO's comprehensive report, Members were also aware that the review would also touch upon the key themes arising from the Francis Review into the Mid Staffordshire NHS Trust. The failings at this Trust have been well documented and Members of the Topic Group were keen to undertake the review in the spirit of the recommendations made by Sir Robert Francis; specifically, in relation to ensuring good patient care and safety.

> *'The events at Stafford Hospital were a betrayal of the worst kind. A betrayal of the patients, of the families, and of the vast majority of NHS staff who do everything in their power to give their patients the high quality, compassionate care they deserve'.*
>
> *Rt. Hon. Jeremy Hunt MP, Secretary of State for Health*

Being admitted to hospital can be a distressing time for patients as well as their families and carers. It is often an unfamiliar environment which may lack the comforts which we are all used to and value highly. This may include eating and sleeping at a time to suit or even preparing refreshments in a particular way. Therefore, it is essential that patients are treated with respect and dignity in order to enable them to retain as much independence as possible whilst receiving care.

> *'We should never allow the needs of an institution take over the needs of an individual's care.'*
>
> *Rt. Hon. Jeremy Hunt MP, Secretary of State for Health*

Since the appalling treatment of patients at Mid Staffordshire NHS Trust, ensuring patient dignity and safety as well as promoting a positive patient experience has been a key issue for the Department of Health. It is with this in mind that the Topic Group wished to explore the issue of dignity with NHS Trusts and examine patient experience in more detail.

2. Scope of the Review

As Trafford residents are able to receive care at a number of sites across the country, the Topic Group agreed to focus their efforts on three hospital sites which are used by Trafford residents:

- Trafford General Hospital (Part of Central Manchester University Hospitals Foundation Trust);
- University Hospital of South Manchester Foundation Trust;
- Salford Royal Foundation Trust.

Members were keen to see, at first hand, how these hospitals delivered patient care. In order to do this, site visits were scheduled to all three hospitals between April and July 2013. Facilitated by Chief Nurses, their deputies and appropriate staff, Members witnessed the delivery of care and questioned NHS staff and patients on the approach to upholding the dignity of patients and their experiences respectively.

Lastly, in order to obtain the views of the public in relation to care they or their loved ones had received at these hospitals, a press release was circulated via the Councils communications team and key partners to stimulate a public response. Additionally, letters and a questionnaire were dispatched to care home managers requesting information relating to the care of elderly residents in hospital.

The Topic Group also discussed emerging findings with Senior Nursing representatives of the three Trusts and visited two nursing homes to get a better understanding of the issues raised.

By combining the information gathered as well as undertaking background research, this report documents the Topic Group's findings.

3. Engagement with Local Trusts

<u>University Hospital of South Manchester Foundation Trust</u>

Members were assured that staff, especially nursing staff, had the confidence to report issues of concern and that Senior Management undertook walkabouts to see for themselves the standard of care delivered. Members welcomed the clear processes for escalating nursing related issues and that system included, where necessary, the Chief Nurse.

The Topic Group welcome the use of intentional hourly/two hourly visits to all patients, known at the Trust as 'Care and Communication Rounds'. These rounds enable nursing staff to monitor the '4P's' of pain, position, patient needs and possessions. Members felt that this was a good example of a uniform approach to ensuring all patients are attended to on a regular basis.

> *'It's about looking at the situation from a patient's eyes – sometimes we have our nurse's eyes on'.*

The Trust uses the safety thermometer to document their performance figures in relation to patient harms and harm-free care. This is a Government scheme to ensure

patient safety and Members noted that the safety thermometer is a reasonable method to establish the care of the elderly given that the performance indicators relate to areas which impact on the elderly the most.

The standards of nutrition and hydration are good. Food surveys have been undertaken with patients and the outcome of these has led to changes in the way in which menus are designed to meet the needs of patients. For example, there is less of an emphasis on two large meals at lunch and dinner and a higher emphasis placed on the provision of snacks and light refreshments. Members felt it was of a good standard with a good level of choice for different palates and cultural needs.

Members also saw the 'red tray' system in which patients who need their food intake monitoring are delivered their meals on a red tray to ensure that nursing staff can monitor food intake.

Members also explored the level of flexibility associated with the catering operation and found that this was also good. The menus are changed every two weeks to ensure variation. Patients on the maternity wards have a more flexible system and patients with cystic fibrosis have a specialised chef due to the unique needs their diet commands. However, they found that whilst snack boxes were available 24/7 they could only be ordered between the hours of 7.45am – 7.30pm.

The Trust is keen to ensure that arrangements are in place to enhance services and that complaints are dealt with in a timely and effective manner. A dedicated Matron with responsibility for patient experience is in place to oversee this. There are a variety of ways in which patients can complain such as via dedicated leaflets or through the website. Bedside Booklets are to be updated shortly which feature ways in which to complain. There are systems in place to ensure that each complaint is dealt with appropriately. Members were impressed that, in the Trust's words, one 'horror story' is being used to educate staff via DVD. It was also reported to the Topic Group that patient experience is considered by the Trust Board on a quarterly basis.

Members enquired what the most common complaints were and were told that this related to communication and the use of clinical jargon. The Trust is attempting to resolve this through communications training for staff who correspond with patients. Clinical incidents are also a feature of their most popular complaints and Members were advised that there had been 24 Serious Untoward Incidents (SUI's) in the last 12 months. Members were assured that there was a Trust-wide approach to dealing with SUI's and overseeing the changes to clinical practices, where appropriate.

Members visited the discharge lounge to see how the process of releasing patients back home and to other residential settings was being managed. Generally, this is effective. There is an integrated team who deal with the discharge process across Manchester and Trafford. A clothes bank exists for patients to access if they have required urgent care and their clothes are damaged as part of their treatment.

However, the Topic Group found areas for improvement. It was noted that not all patients are discharged through the lounge and that there can be delays. Whilst observing the lounge in operation at around 1pm in the afternoon, Members heard that one elderly lady had been waiting for transport home since 8am.

USHM have indicated that they are aware of issues with discharges and are taking corrective action. Members were advised that UHSM are monitoring the performance of the new patient transport provider. A copy of the discharge policy was made

available to Members, as was the Trust's Discharge Lounge Guidance. The Trust have stated that all new policies are sent to all ward managers who are responsible for disseminating the information and implementing the policies.

Trafford General Hospital

The Topic Group were pleased with the overall standards of care at Trafford General Hospital. Members note the recent CQC inspection in which Trafford General met all 7 standards reviewed. In particular, the inspectors has praise for the way in which the patients they spoke with 'felt they were treated with respect and dignity and were involved in making decisions about their care, treatment and support during their stay in hospital'.

The ward accreditation process promotes a culture of continuous improvement, environment of care, communication about and with patients. Good nursing processes must be evident before wards are given a white, bronze, silver and gold award.

The Trust uses an in-patient quality dashboard in which a series of performance indicators monitor issues such as the achievement of a clean environment; ensuring pain is managed effectively. This demonstrates that monitoring quality is of importance to the Trust. It also highlights that mechanisms are in place to provide a snapshot of patient experience and that this information is used to make improvements to patient experience.

The Trust has developed shared care plans and a 'This is Me Handbook' in which individual needs and preferences of patients are noted and used to enable patients to retain as much independence as possible. Members also saw the 'forget me not system' in which the picture of the flower is placed next to patients with dementia. The cards contain key information about the person's tastes and preferences so that hospital staff can help them feel as at home as possible during their time on the Ward.

To assist patients with dementia, the Trust is in the process of installing memory pods and producing distraction boxes which have a 1950's/60's themed environment which is used to provide comforting surroundings to patients. One of the wards is undertaking a dementia pilot to improve and enhance the ward environment for patients with cognitive impairment. Patients and carers have been involved during the planning stages.

Catering Services at the Hospital are good. Members observed the lunchtime service and sampled the food which was to be served to patients. Meals are prepared on site and there is flexibility in meeting the patients dietary requirements. It was noted that there is a good deal of choice, food was piping hot and that the portions were plentiful. The Trust has received excellent feedback on the food it serves to patients and the results of a dining audit are soon to be announced. The Red Tray system (for patients who struggle to eat independently or need to eat required calories) is also in operation.

Topic Group Members were assured that patient experience is a priority for the hospital. The complaints process is effective and staff have an excellent grasp of the requirements of the system. There is awareness that at different stages of a person's life they are more likely to complain themselves or have someone complain on their behalf.

'If someone raises a concern in hospital, when they are in a most vulnerable state, it must be serious'.

The Topic Group also heard that there is a clear system of complaint escalation on the ward and complaints are dealt with as close to the source as possible. It was also raised that the Trust has an expectation that any learning arising from the resolution of a complaint is undertaken within the clinical divisions. Members also received a case study in relation to an incident of day case surgery which did not go as planned. Members were advised that there were clear learning points arising from the incident and demonstrated the value which the Trust puts on experiential learning.

Discharges are managed effectively and Members discussed the arrangements at the Hospital with patients and staff. There is no waiting area or discharge lounge, patients stay on the wards until they are discharged. Members were advised that discharge is a complex process which involves communication and coordination between relatives, carers and a range of clinical and allied health professionals. Members were assured that there existed a clear awareness that discharges late at night were not appropriate. The discharge policy is clear on this and states that that 'unless there is a wish to do so by the patient it is not advised to discharge patients back into the community after 8pm'. Members were assured that the hospital recognised the need for patients to be transported in comfortable clothing and where appropriate this should include day clothing with appropriate footwear.

At the time of the visit, the Trust was in the process of revisiting its hospital discharge processes as part of a piece of work called 'Evidence Based Design' and are working closely with a number of different stakeholders such as social care and other agencies.

It was noted that family engagement in the discharge process can be low and that this can have a negative impact on the overall timeliness of the discharge process. A hand held patient discharge booklet is being developed which aims to improve patient and carer involvement in the discharge process from the point of admission.

<u>Salford Royal Hospital</u>

The Topic Group found a number of good examples of good practice at the Trust and was assured about the quality of care given to patients. Systems are in place to ensure that standards are met. The Trust operates the Nursing Assessment and Accreditation System (NAAS) which measures the quality of nursing care delivered by ward teams. This performance assessment framework is based on the Trust's Safe, Clean, Personal approach to service delivery and combines Key Performance Indicators and Essence of Care standards.

Each ward is assigned a red/amber/green rating and three consecutive green assessments over a 24-month period enables a ward to be considered for Safe, Clean and Personal (SCAPE) status. This category enables the ward sister to be promoted to ward matron and for the ward to operate with a higher level of autonomy. A ward with consecutive red ratings will have targeted support and subsequent failure to improve will result in a review of the ward's leadership.

Members were advised that intentional hourly rounding is in place with records kept to demonstrate that the needs of patients have been met by nursing staff.

Open visiting times are in operation at the Trust, with relatives and carers able to visit patients at any reasonable times of the day except meal times as these are protected. However, if patients struggle to eat independently, family and friends can visit during mealtimes to assist.

Members were also advised that there are 'What matters most to me' signs above patient's beds which document the one 'thing' which is really important to the patient. This is used by staff, including consultants, on ward rounds to identify if patients needs are being met.

Ward performance information is clearly displayed in all wards in a simple and easy to understand format for staff, patients and visitors. This information includes staffing levels, both required and actual, as well as how many days the ward has been free from hospital acquired infection, falls and pressure sores. Members were very impressed by the performance levels they witnessed as well as the effort on the Trust's part to be open and transparent.

Members were also advised of a 'what matters to you clinic'. The example given by the Trust related to a patient with Crohn's disease who wanted to be symptom-free for a year and negotiated the management of her illness, with consultants, with the use of steroids.

In order to enhance the environment for dementia patients, 'memory pods' are being erected in the hospital in order to create safe and familiar areas. Work is being undertaken to explore whether wards could be opened up to allow dementia patients to wander in a safe environment.

Members were very impressed with the Trust's intention to move towards an a la carte menu for all patients, and were piloting the approach at the time of the visit. The approach would enable patients to choose what food they wanted from a lengthy menu of options at a time to suit them. Orders are telephoned though and food is served hot, on custom-made serving plates, within 45 minutes. Vulnerable patients are supported well and work is underway to offer a finger buffet to patients with dementia. The Trust also advised Members that food is available 24/7 for patients that need it.

Complaints arrangements are good. There are posters and leaflets on all wards promoting the service as well as posters above patient's beds for friends/family to call the HELP phone (Hospital Empowerment of Loved Ones) and patients
(A telephone number with a direct line to senior manager on site) if they are worried about the care of their loved one. The Trust are forensic when it comes to investigating complaints and take them very seriously, inviting patients and their relatives to meetings in order to discuss complaints and highlight what the outcome of their complaint has had on the wider organisation. The Trust receives roughly 300 complaints per year and they relate to staff attitude, nursing care and medical treatment. The Board receive six monthly reports on complaints which allows for the identification of trends.

The Patients Association were working with the Trust on a project which examines their approach to addressing complaints. The most common complaints are communication, clinical care/diagnosis and cancelled operations.

Members visited the discharge lounge and were advised that a long stay would be in the region of 3 hours and that an average stay would be 1.5 hours. The Trust

highlighted that the lounge is still a clinical area with medicines being delivered there as well as some clinical procedures being undertaken. To enhance the discharge process, the Trust had commissioned a private ambulance, had their own vehicle and a contract with a local taxi firm.

The Trust provided Members with their discharge policy and procedure. The clear message from the policy is that the planning of discharge starts as soon as is possible 'discharge must be planned for at the earliest opportunity between the primary care providers, the hospital and social care providers, ensuring that patients and their carers understand and are able to contribute to care planning decisions as appropriate'. It is also noted that within all inpatient areas an estimated discharge date will be agreed by the admitting consultant team within the first 48 hours of admission or sooner for shorter stay patients'.

Members were assured that this was a concerted effort on the Trust's part to recognise that hospital stays should be as short as possible and that a discharge was only required when the patient is medically fit to do so.

At the time of the visit, the Trust was trialling a calling card for discharged patients which featured the name and contact number of the Ward Sister and patients who had any questions/difficulties within 2 days of discharge could call for assistance. The card also featured the contact details of Age UK.

4. Patient Experiences

In addition to visiting the Trust sites and talking to senior staff, the Topic Group also wished to get information about patient experiences and these are set out below. It is clear from the limited feedback obtained, that despite the often good procedures in place at local Hospitals, problems still occur. These problems result in a great deal of stress for elderly and sick people and their carers.

The Topic Group issued a press release about the review and asked for feedback from recipients of services or their carers. The Council's Market Management and Safeguarding Team also carried out a survey of all Residential and Nursing Homes in Trafford to gather information about the overall experience of resident's hospital in-patient care and discharges. 10 responses from 34 care homes were received. We also met with senior managers at two Care Homes to allow them to expand on comments they sent through.

The scale of responses was quite low are not statistically valid. In addition, whilst reference was made to all the hospitals, most of the examples given related to Wythenshawe and Trafford General Hospital as these are the main providers for Trafford residents and so cannot provide a full picture. However, we feel that the examples are relevant to all providers and suggest that they should regularly check that their procedures are implemented fully and that patients get the care that they are entitled to.

A small number of local people shared their experiences with us. Some referred to "excellent" standards of care whilst others referred to problems where they felt care had fallen below the level expected. A summary of the main issues that they raised are set out below:

- Long waits in discharge lounges.

- Patients being discharged in pyjamas or dressing gowns in the middle of Winter or in the evening.
- Weaknesses in liaison with carers which resulted in key information not being passed onto the hospital or recorded incorrectly.
- Examples of poor care which patients or carers felt led to infections, non-recording of accidents and food being left out of reach. Other examples included lack of responsiveness to requests or loss of property.

Some of these issues were also highlighted by visits to care homes and in the survey. There were a number of positive experiences reported including the majority of clinical care and a broadly caring approach.

However, a number of areas for improvement were raised and are summarised below.

- **Communication** - Communication between hospital staff teams and the homes that completed the questionnaire were highlighted as needing improvement. Care Home Managers complain that when residents go into hospital they are accompanied with comprehensive and detailed information. However, this information sometimes doesn't get transferred from A&E to the wards or from ward to ward, resulting in numerous telephone calls to the homes requesting information.
- **Weight Loss** - Out of approximately 170 hospital admissions referred to in the survey responses, at least 43 (one in four) of these residents have reportedly experienced significant weight loss. There were some examples of vulnerable patients not being assisted sufficiently with feeding.
- **Function and Ability** - Some providers noted that there is a general decrease in mobility in residents discharged from hospital. One home has had several complaints from families that residents have not been out of bed whilst in hospital and that many residents had been catheterised. One said that almost every resident's mobility was significantly worse after a stay in hospital.
- **Discharges –** examples of concerns about discharge including problems because equipment has not been provided, evening discharges, especially from A and E services, transportation and communication problems with families and clothing.
- **Possessions** - Generally residents returned home with their own belongings. Some homes noted that residents come back with hospital gowns on and/or not in appropriate attire. There are a small number of examples of residents coming back without dentures or glasses.
- **Medication** - The survey highlighted cases where residents returned home without any medication or where it is not sent in a timely manner. One home reported that they had to phone the hospital to confirm medication times and doses because they had not received detailed information.

Nine of the ten homes took some form of action as a result of issues arising from the residents stay in hospital. These ranged from making safeguarding referrals, submitting incident forms or complaints to the hospitals.

Appendix 1 - Evidence Gathered

Document Review

The Topic Group reviewed a number of documents as part of the review including national best practice, the Francis report, inspection reports and documents provided by the Trusts.

Visit to Wythenshawe Hospital – April 2013

The Topic Group met with a number of senior staff including the Chief Nurse, Matron for Patient Experience and the Heads of Nursing for Scheduled Care, Unscheduled Care and Infection Control and Prevention for an initial briefing on the Trust's approach to ensuring dignity, patient safety and a approach to handling complaints. Members also visited two wards at Wythenshawe Hospital, including Urology, and spoke directly with patients and staff.

Visit to Trafford General Hospital – May 2013

The Topic Group met with the Head of Nursing, Associate Director for Surgery and Access, Lead Nurse for Quality, Directorate Manager Medicine, Complaints/PALS Manager and the Clinical Head of Division for briefings on the Trust's approach to ensuring dignity, patient safety and handling complaints. Following this, Members visited wards and spoke directly with patients and staff.

Visit to Salford Royal – July 2013

The Topic Group met with the Executive Nurse, Divisional Director of Nursing, Assistant Director of Patient Safety, Lead Nurse, NAAS and the Assistant Director of Nursing for an initial briefing. Following this, Members visited wards and spoke directly with patients and staff.

Response from the Public – Summer 2013

The Topic Group received eleven responses to the press release from people who have had care at the hospitals or relatives of patients.

Joint Meeting with Representatives of the Trusts – September 2013

The Topic Group met senior representatives of the Trusts to discuss the initial findings in a joint meeting.

Visits to Care Homes – September 2013

Discussions were held with Managers at two care homes in Trafford.

Questionnaire of Residential or Nursing Homes

Survey of 34 homes in Trafford Borough in October 2013. 10 responses were received.

Appendix 2

Caring for the elderly – Recommendations 236 to 243 from the Francis Report

Approaches applicable to all patients but requiring special attention for the elderly

236 Identification of who is responsible for the patient

Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.

237 Teamwork

There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.

238 Communication with and about patients

Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:

- All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.
- Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients.
- The NHS should develop a greater willingness to communicate by email with relatives.
- The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered.
- Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.

239 Continuing responsibility for care

The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.

240 Hygiene

All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.

241 Provision of food and drink

The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.

242 Medicines administration

In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.

243 Recording of routine observations

The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.

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UHSM's response to Trafford Health Scrutiny Committee Member's Questions

- Could it become standard practice for the hospitals to inform Nursing Homes/Carers at least 24 hours before a discharge is expected to take place so adequate arrangements can be made?
    - Yes absolutely, our discharge nurses provide updates to both residential and nursing homes of the status of their resident often taking place 24hrs prior to discharge. This has been agreed with our Heads of Nursing and Matrons as good practice.

- Could copies of the standard discharge procedures and what steps are being taken to ensure that these are followed be provided for the meeting?

  Yes, currently UHSM have the following:
    - Discharge Checklist (Appendix 3)
    - Discharge Policy (Appendix 4)
    - Discharge Destination Policy (Appendix 5)
    - Discharge Lounge Protocol (Appendix 6)

- We have had concerns that patients care plans which are sent into hospitals when people need to be admitted urgently do not "follow" the patients when then are admitted into a ward and remain in A & E. Is there any way that care plans could remain with the patients and be sent back on discharge with hospital comments/changes added?

  Should a patient be admitted with a plan of care then this usually follows the patient to the ward. Sometimes patients do not present with a plan of care. UHSM have their own discharge documentation but there is no reason why, following a discussion with those who have sent in the plan of care, comments/changes cannot be added.

  UHSM are currently trialling a "Patient Passport" (Appendix 7) on the acute admission wards initiated by the acute discharge nurses. A Patient Passport is a document that is populated by medical staff, discharge nurses, social workers, ward nurses, therapists, the patient and/or their relatives/carers. The Patient Passport remains with the patient on discharge and provides an overview of their stay in hospital and contains details of each and every intervention.

- What is being done to ensure that patients admitted into hospital do not lose any of their life skills/mobility and are encouraged to do things for themselves i.e. try and wash/dress themselves – walk to the toilets etc…?

  Patients are assessed on admission around their activities of daily living, which includes assessing their safety. All patients are encouraged to be independent if assessed as being able; in some cases this can be a multidisciplinary assessment which would include therapy input.

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Name……..…… NHS No…….

Patient Discharge Checklist		
Expected discharge date-	Met- Initial	N/A- Initial
Ward Contact Card provided		
Patient and family aware of discharge date-		
Pressure areas checked. State observation:		
District Nurse referral completed electronically and copy in notes Where appropriate wound assessment chart, photograph and vascular studies report (if patient has leg ulcers) to be sent Comments:		
Cannula removed		
Valuables returned		
Patient has own keys		
Patient changed into own clothes		
Discharge advice sheet given		
VTE information leaflet & anti embolic stockings given if required		
Medications given and explained		
Anti-coagulation appointment and booklet given		
Fit note given		
Transport booked		
GP discharge letter written and copy given to patient and copy in notes		
Dressing removed and wound checked		
Friends and Family Questionnaire card provided		
Relevant Follow up arranged. State details:		
If nursing/rest home, transfer form completed		
Transfer to Discharge Lounge arranged		
Discharged on Lorenzo system		
Relevant specialist teams aware of discharge. State details:		
Other- State:		

Date and Time Discharged ……..……
Signature & Print discharging Nurse ……

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PATIENT DISCHARGE POLICY

Version:	V1.2
Ratifying Committee:	Healthcare Governance Committee
Date ratified:	January 2016
Name of originator/author/job title:	Karen Hatch– Patient Flow Manager
Name of responsible committee/individual:	Health Care Governance
Date published on intranet:	January 2016
Review date:	January 2017
Target audience:	Trust wide

EQUALITY IMPACT

University Hospital of South Manchester NHS Foundation Trust ('UHSM') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care UHSM aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed by the Healthcare Governance Committee to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Tool at Appendix B.

University Hospital of South Manchester NHS Foundation Trust

VERSION CONTROL SCHEDULE

Version number	Issue Date	Revisions from previous issue	Date of Ratification by Committee
1	August 2012	Previously part of the Admissions and Discharge Policy. Discharge element separated out for NHSLA purposes. Admissions element of original policy still applies.	19/07/12
1.1	September 2013	Section 4.3.1 now contains a recommendation with regards to patient clothing Patient information – for new diagnosis only (pages 13,17,19) Medical equipment now to include the documentation of any equipment and training / support required to go home with the patient (pages 14,19) Issue of Med 3 certificate is no longer a must do (pages 14,19) Contacting the bereavement officer is now advisable and not a must do (pages 14,19) Case notes for audit reduced to 25 (page 19)	23/09/13
1.2	December 2015	Section 3.11 – Discharge Check list now required for all discharges. Section 2 Directory of Service link Section 4.3 Discharge Lounge Guidlines	January 2015

DOCUMENT CONTROL

Summary of consultation process	Initial consultation has been with the Heads of Nursing for each Directorate (which would cover senior nurses and support service managers / leads) and with external partners through the Patient Flow Manager. In line with Trust policy, a 3 week consultation period has been undertaken using the Trust intranet.
Control arrangements	Minimum requirement to be monitored *The process for monitoring this policy will be in the form of an annual audit* *The Patient Flow Manager will be responsible for communicating that the audit needs to be undertaken. The Matrons for the relevant areas will be responsible for ensuring the audits are undertaken by the ward staff.* *The results will be reviewed by the Patient Flow Manager, the Heads of Nursing and the Healthcare Governance Committee* *The Matrons will be responsible for development of action plans to improve compliance in any areas that fall short* *The Patient Flow Manager and Heads of Nursing will be responsible for the monitoring of the action plans and the Healthcare Governance Committee will monitor the overall improvements from the action plans*
Associated documentation and references	The following references have been used to inform this policy: • Essence of Care Benchmark (2001), DOH • Department of Health (2001) National Service Framework for Older People • Department of Health (2006) The Dignity Challenge • Department of Health (2007) Privacy & Dignity report • Health Care Commission (2007) Caring for dignity national report • Department of Health (2010) Ready to go?

Contents

1. Introduction

Demand for acute inpatient care is high and in order to meet this demand it is important that patients are discharged in a timely manner once medically fit for discharge.

This policy has been developed to establish a standard approach to the management of patients' discharges from hospital. It is designed to promote and facilitate a multi disciplinary approach to the assessment, planning and monitoring of all discharges. Planning for discharge must start on admission and the identification of an Estimated Date of Discharge (EDD) must be documented by the admitting Clinician in the patients health records and updated by the ward team (as necessary) to support the discharge planning process.

Available bed capacity for emergency admissions relies on a continuous discharge of patients and therefore consideration should be given to the transfer of the patients care back to primary care when physiologically stable with an anticipated recovery course where community colleagues can support (District Nurses, General Practitioners and Community Matrons).

This policy applies to all staff within University Hospital of South Manchester who are involved in the assessment, planning and monitoring of patients' discharges. It also applies to staff from other health/social care organisations involved in the discharge process.

However, the discharges of certain groups of patients such as children thought to be in need of protection and vulnerable adults, such as those with dementia, learning disabilities, or lacking mental capacity, raise some important and specific issues, which are subject to specific and separate guidelines. The principles in this document still apply to these groups but should be considered along with the recommendations in the other policies. These can be found at the link below under the sub category – Clinical.

http://uhsm-intranet/policies/Pages/default.aspx

2. Purpose of the Document

The purpose of this document is to ensure that employees at UHSM deliver a safe and effective discharge process to all patients admitted to the University Hospital of South Manchester. Discharge or transfer of care is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another care setting following an acute hospital stay.

Directory of Services is available

http://uhsm-intranet/AZ/i/IntegratedHealthSocialCare/Documents/Community%20DOS%202014.pdf

The need for timely discharge and care transfer requires clinicians and others to plan, communicate, negotiate and ensure a smooth transition for individuals and their families. Staff involved in the discharge process have a duty of care to:

- Ensure early and effective communication with all individuals across all care settings to provide a well-planned discharge from hospital to all patients (GP's, District Nurses, Community Matrons etc)
- Consider discharge with primary care support when patients are physiologically stable with an anticipated recovery course
- Align services to ensure continuity of care and thereby provide the patients with the necessary support for a safe and effective discharge
- Ensure efficient systems and processes at ward level to support discharge arrangements and transfers of care
- To ensure that patients / carers and healthcare professionals in other settings are given the appropriate written and verbal information regarding future care management plans
- To ensure that the patient's dignity and wishes are recognised
- To ensure identification of an Expected Discharge Date (EDD) is determined on admission and recognised by the multi-disciplinary team

This policy outlines the roles and responsibilities of the health professionals involved in the patients discharge process and aims to ensure that the benefits of effective discharge planning are recognised for all those involved. It also identifies the overarching discharge requirements for all patients and the information that should routinely be given to patients and other healthcare professionals.

For the patient

- Their needs are met
- Able to maximise independence
- Feel part of the care process, an active partner and not disempowered
- Do not experience unnecessary gaps or duplication in effort
- Understand and sign up to their care plan
- Experience care as a coherent pathway and not a series of unrelated events
- Believe they have been supported to make the right decision about their future care

For the carer(s)

- Feel valued as partners in the discharge process
- Consider their knowledge has been used appropriately
- Are aware of their right to have their needs identified and met
- Feel confident of continued support in their caring role and get support before it becomes a problem
- Have the right advice and information to help them in their caring role
- Are given a choice about undertaking their caring role
- Understand what has happened and who to contact

For the staff

- Feel their expertise is recognised and used appropriately
- Receive key information in a timely manner
- Understand their part in the system
- Can develop new skills and roles
- Have opportunities to work in different ways
- Work within a 'whole system' which enables them to do so effectively

For the Organisation

- Resources are used to best effect

- Service is valued by the local community
- Fewer complaints
- Positive relationships with other local providers of health and social care
- Meet targets and can therefore concentrate on service delivery

3. Duties and Responsibilities

3.1 The Board of Directors

The Board of Directors are ultimately accountable for the effectiveness of the UHSM Discharge Policy.

3.2 The Chief Executive

The Chief Executive is responsible for ensuring that responsibility is delegated to an appropriate Executive Director for ensuring that systems are in place with regard to compliance with the principles outlines in this policy relating to patients discharge.

3.3 The Chief Operating Officer (COO)

As the delegated executive responsible for Patient Flow, the Chief Operating Officer is responsible for ensuring that there are systems in place for safe and effective discharge and that the Trust has up to date policies in place that reflect best practice. The Chief Operating Officer is also responsible for ensuring regular audit of the policy. This can be delegated to an appropriate person identified by the COO. This should be in compliance with the processes in place to promote safety and quality of care within the Trust.

The Medical Director

The Medical Director is responsible for ensuring all Consultant and Junior Medical staff are aware of and compliant with the safe and effective discharge of patients in accordance with this policy.

3.4 The Chief Nurse

As the delegated executive responsible for discharge, the Chief Nurse is responsible for ensuring that there are systems in place for admission, transfer and discharge and that the Trust has up to date policies in place that reflect best practice. The Chief Nurse is also responsible for ensuring regular audit of the policy. This can be delegated to an appropriate person / persons identified by the Chief Nurse. This must be in compliance with the processes in place to promote safety and quality of care within the Trust.

3.5 Patient Flow Manager

The Patient Flow Manager is responsible for ensuring that this policy is kept up to date, reflecting best practice and that it remains compliant with CQC standards. They are also responsible for ensuring that regular audits of the policy occur and outcomes reported back to the HealthCare Governance Committee with any associated action plan for monitoring improvements as appropriate.

3.6 All Medical Staff

Consultant medical staff and their medical teams are responsible for assessing the patients' medical fitness for discharge and for liaising with other members of the MDT and colleagues in primary care regarding arrangements for meeting the patients' care needs in the community. They are responsible for the decision to discharge a patient and ensuring that a detailed discharge plan and an Expected Date for Discharge (EDD) is clearly documented in the patients' health records to ensure an effective and safe discharge from hospital. Consultant medical staff are responsible for ensuring all information required for the ongoing management of the patient is communicated to the relevant personnel as part of the discharge planning arrangements either by themselves or though their medical teams. Changes in the EDD must be noted in the health records if for a clinical reason.

3.7Heads of Nursing

Heads of Nursing are responsible for ensuring all nursing staff are aware of the policy and that the Discharge requirements and principles are followed throughout their areas.

3.8 Matrons, Directorate Managers & Clinical Directors

Matrons, Directorate Managers and Clinical Directors are responsible for ensuring compliance with this policy, supporting audit, reviewing results and implementing change where appropriate. Delays in patients discharge must be monitored and improvements made to processes if the reason for failing to meet the EDD is due to non clinical reasons.

3.9 Ward Managers

Ward Managers are responsible for ensuring that there are systems in place to identify the patients' discharge needs and thereby facilitate a safe discharge from hospital for all patients under their care. Discharge must be coordinated through a multi disciplinary approach by the Ward Manager or nominated deputy. Discharge must be in line with the discharge plan documented by the Consultant and delivered to the EDD where possible.

The Ward Manager must ensure that all relevant Trust policies referenced in this policy in relation to patients discharge are adhered to. It is also the responsibility of the Ward Manager to make sure there are monitoring mechanisms in place to make certain all discharges are safe and effective. Ward Managers are responsible for ensuring that all relevant information is passed to the patient and other relevant personnel responsible for any ongoing care.

3.10 Ward Based Registered Nurses

Registered Nurses are responsible for ensuring that an initial assessment is completed when the patient is admitted and that any issues relating to discharge are documented in the management plan. The Registered Nurse must update the discharge plan following regular review with the MDT and thereby co-ordinate the discharge arrangements; making sure that all necessary assessments are completed in order to achieve a safe and effective discharge. The Registered Nurse will ensure patients relatives and carers are involved in the discharge planning as appropriate.

During the admission the Registered Nurse will identify who else needs be involved in the care / support of the patients' discharge and instigate and co-ordinate the referrals required

to other internal and external agencies. This must be undertaken promptly to ensure that there are no delays to discharge, impacting on the patient's length of stay and reviewed as necessary as their care and treatment progresses.

The Registered Nurse will be responsible for completing the discharge transfer forms and check list whilst ensuring detailed information relating to any ongoing care needs be clearly documented and communicated i.e. pressure ulcer management, nutritional requirement etc.

3.11 Members of the Integrated Hospital Discharge Team (which includes Discharge Nurses, Social Care Assessors, Social Workers & Primary Assessment Team)

All members of the Hospital Discharge Teams have a role to proactively support and manage the discharge of complex patients from hospital in conjunction with the Ward Manager and Registered Nurse. They provide support and education to ward teams in the preparation of discharge plans, especially those requiring complex discharge arrangements.

They are responsible for ensuring referrals to support services are sent in a timely manner and the completion of complex assessments for patients requiring intermediate care / continuing healthcare beds, acting as the mediator between wards and the relevant external agencies (including social services and Residential and Nursing Homes). They should establish contact with patients General Practitioner as early as possible following admission to establish the normal level of functioning for the patient and therefore support decision making with the multi-disciplinary team in relation to discharge arrangements. They should work in partnership with other disciplines such as the Bed Management Team, Matrons, and other relevant healthcare professionals.

Members of the Integrated Hospital Discharge Team are responsible for the ordering of any equipment necessary to support patients' at home and to confirm that equipment has been delivered / installed prior to the patient's discharge. Where equipment is identified as essential for discharge, the registered nurse must liaise with the Occupational Therapist.

The Integrated Hospital Discharge Team must endeavour to ensure that there is no negative effect on a patient's length of stay due to delays in discharge for those patients on their caseload.

Social Workers are responsible for working in accordance with the relevant legislation, policies and procedures appropriate to their professional group. They must provide timely assessment and / or services for a patient being discharged from the acute hospital bed.

3.12 Physiotherapists

The role of the physiotherapist in planning and facilitating a safe effective discharge is to:

- Assess the patient and, if indicated, rehabilitate to achieve an increased level of independence and function Provide a timely and effective holistic functional assessment of the patient and their environment often in conjunction with the Occupational Therapist to maximise their level of rehabilitative potential.
- Liaise with patients and carers and the Multi Disciplinary Team (MDT) regarding goals for discharge

- If clinically indicated, provide / order equipment in advance of the discharge date (if delivery to the patients home is identified and access to the home is not possible the physiotherapist must liaise with that patient or family / carers to arrange collection of equipment from the equipment stores)
- Where indicated the physiotherapist must ensure arrangements are made and communicated to the patient / carer regarding treatment post discharge

3.13 Occupational Therapists (OT)

The role of the occupational therapist is to provide a timely and effective functional assessment as part of the discharge planning process. The assessment must be patient centred and treatment must be given to obtain the optimal (occupational) performance from the patient within the acute hospital setting.

- Responding to referrals for assessment where there is a clearly identified need and outcome for OT intervention
- Providing a holistic assessment of the needs of the patient and carer
- Work with the patient and carers regarding the goals for discharge planning
- Liaise with relevant support agencies both internally and externally to meet the needs of the patient and carer
- Where appropriate, conduct pre discharge environmental visits in order to establish the patient's needs for a safe discharge
- Where required, prescribe and arrange for the provision / fitting of equipment to meet the needs of the patient

3.14 Pharmacist / Pharmacy Technician

The Pharmacist must provide the ward staff with advice and guidance in relation to the patient's medication on discharge. Either the Pharmacist or Technician should be contacted as soon as the prescriptions are written, which should be 24hrs prior to discharge. They will then process the prescription at ward level. It will take longer for prescriptions to be processed if you send them to the Pharmacy Department; always contact your pharmacist or technician first. If they know patients are due to be discharged they will remind the medical team to write the prescription.

3.15 The Ward Clerk

The Ward Clerk is responsible for ensuring all tasks delegated to them to support the patients discharge are carried out in a timely manner. They must ensure that discharge information is sent to the receiving healthcare professionals within the agreed timescale following the patients discharge from hospital.

4 Discharge requirements and principles for all patients

4.1 All patients must have a well-planned discharge from hospital. This must occur in consultation with the patient and / or their carers together with the relevant staff from a multi-disciplinary team; including, where relevant, GP's, staff from nursing and residential homes, community matrons and District Nurses involved with the patient's overall care and well-being.

This policy has been written on the basis of the assumption that patients have mental capacity to consent to arrangements which clinical staff may seek to put in place to facilitate their safe discharge. The discharge principles in this policy still apply to patients lacking mental capacity however, where it is identified that a patient does lack capacity, the Trust Mental Capacity Act Policy must also be followed and can be found via the following link under sub category 'general';

http://uhsm-intranet/policies/Pages/default.aspx

4.2 The key principles for effective discharge and transfer of care are:

- Unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes and the commissioning and delivery of services;
- The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge;
- Discharge is a process and not an isolated event. It must be planned for at the earliest opportunity across primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate;
- The process of discharge planning must be coordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'.
- Staff must work within a framework of integrated multidisciplinary and multi-agency team working, to manage all aspects of the discharge process;
- Effective use is made of transitional and intermediate care services, so that acute hospital capacity is used appropriately and individuals achieve their optimum outcome;
- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make an informed decision about their future care;

4.3 A patient's discharge requirements will also be dictated by the complexity of their condition whilst in hospital and the care they will need following discharge.
The discharge needs and the principles for all discharges fall into 4 distinct groups.

- Simple
- Complex
- Self-discharge
- End of Life

The following groups of patients will also have additional needs to consider:

- Neonates
- Post-natal
- Homeless

The discharge planning process must take into account patients' physical, psychological, social, cultural, economic and environmental needs. Health and Social care service departments must work together with the patient, families, carers and the hospital MDT to plan and deliver a safe and effective discharge.

Patients, where suitable, must transfer to the discharge lounge to await collection. The Trust Discharge Lounge Guidelines can be found at:
http://uhsm-intranet/guidelines/clinical/Clinical%20Guidelines/Forms/Trustwide.aspx
This outlines the key inclusion and exclusion criteria.

A simple check that all elements have been achieved must be recorded in the patient's medical notes. As a minimum it must include
Appendix

4.3.1 Simple Discharge (including discharge from ED)

Simple discharges must include:

- An understanding of the circumstances the patient will be discharged to (possible temperature of accommodation, availability of food, darkness, home alone etc) and give support to ensure patients safety
- An awareness of the time of discharge and whether this is appropriate (patient in agreement, family / carer(s) / nursing or residential home aware etc)
- Assurance that the patient can enter accommodation at destination
- An awareness of the patients clothing for discharge. Where possible patients / families should be encouraged to bring outdoor clothes in for discharge, however patient choice will be honoured.
- Appropriate transport arrangements. Ambulance bookings should be in line with PTS eligibility criteria
- Medications to take home (TTO's) with full explanation
- The removal of any medical equipment (as appropriate) including cannula, Sutures and dressings as appropriate

- The documentation of any medical equipment to remain in situ or go home with the patient along with confirmation that relevant training / support is in place
- Reinforcement of any special instructions with written information where possible or an approved patient information booklet
- An electronic discharge summary – a copy of which should be given to the patient
- Sufficient dressings / appliances provided to the patient to cover the seven days post discharge (more if Bank Holiday or weekend discharge)
- The return of all the patient's property, including valuables must be given to them by the nursing staff prior to discharge
- Details of any outpatient appointments or other follow up appointments the patient needs to be aware of
- All medical and nursing personnel providing ongoing care / support to the patient made aware of any infection control issues

Medical Staff may issue a Med 3 Certificate at the patients' request as appropriate.

It is advisable that the Bereavement Officer is informed so that they can undertake the necessary communications to the patients General Practitioner and where appropriate the manager of a patient's nursing / residential home, within 24 hours of a patient's death, with the exception of Bank Holidays and weekends; when they will notify the General Practitioner and manager on the first working day following the Bank Holiday or weekend.

4.3.2 Complex Discharge

Complex discharges follow all the principles of the simple discharge plus the following additional criteria

- The early identification, planning and communication of any Continuing Health Care (CHC) needs in accordance with the eligibility criteria and appropriate referral to the Integrated Hospital Discharge Team for assessment. Details for CHC can be found via the link sub category Continuing Health Care:

  http://uhsm-intranet/AZ/d/Discharge/Pages/Discharge.aspx

- Early assessments from all health and social care partners involved to ensure planning happens in parallel with the patient's medical management to becoming medically stable to commence discharge planning before becoming suitable for discharge
- Early contact with the General Practitioner to establish the normal level of functioning for the patient to inform discharge planning
- The discharge from Physiotherapy and Occupational Therapy services and where required, referrals made on to community services with details being given to the patient / relative / carer
- Confirmation from Social Services that any care package or ongoing support is lined up to commence in an appropriate timeframe following the patients discharge
- Any referral for District Nurse, Community Therapy or Rehabilitation Services have been sent and details given to the patient / relative / carer of what to expect on return home / transfer to another care setting
- Any equipment that is required has been confirmed as being in place

- For patients requiring compliance aids on discharge nursing staff must speak to their pharmacist or technician in advance of the patient leaving the hospital. Requests must be made 24 hours prior to discharge as they take at least 4 hours to complete. Requests for compliance aids will not be accepted by pharmacy after 3pm or after 1pm at weekends, at the Pharmacists discretion
- Plan to access to patient's property has been discussed prior to them leaving the hospital
- All relevant relatives and carers are aware of the patient's discharge date and time
- All medical and nursing personnel providing ongoing care / support to the patient made aware of any infection control issues

4.3.3 Self Discharge

If a patient wishes to take their own discharge, the Ward Manager / Registered Nurse must contact either:

- A member of the medical team (in hours) or
- The Duty Manager (out of hours)

A member of the Hospital Discharge Team must be informed in hours who will then inform social services, if appropriate.

Patients wishing to take their own discharge must be advised by the medical and / or nursing staff to stay (if appropriate). The medical staff must encourage the patient to stay if they believe leaving hospital is not in the patient's best interest medically.

If the patient remains adamant that they wish to leave the nurse must ask the patient to sign the self discharge form which must be countersigned by a member of staff. This must then be placed in the patient's health records. If the patient refuses to sign the self discharge form this must be documented in the patient's health records and signed by two members of staff.

If it is felt that the patient requires a district nurse, this must be discussed with the patient to be established if the Trust must contact the DN service or if the patient wishes to make their own arrangements. If this is the case, the relevant contact number must be given to the patient. The decision and action must be documented in the patient's health records.

4.3.4 End of Life

The End of Life Care Strategy (DH 2008) requires that assessment is made of the patient's preferred place of care and where they wish to be cared for at the end of life. Every effort must be made to ensure that all practicable steps are taken to allow the patient's wishes to be carried out.

The Registered Nurse looking after any patient with a life limiting illness whose preferred priority of care is to be discharged from hospital to home / local hospice / community palliative care bed must contact the Integrated Hospital Discharge Team as soon as possible after the decision is made by the patient and / or family, carer. The Discharge Team will then arrange to fast track the patient to the Continuing Healthcare Team in the relevant Primary Care Trust.

For discharges home during normal working hours, the Discharge Team will then organise District Nurse support, any necessary equipment, take home prescriptions and transport to the preferred destination within the same day. Patients referred to the Discharge Team late in the day will be discharged to their preferred choice of care where available within 24 hours from the point of referral. Discharges outside of normal working hours will be facilitated by the Specialist Nurses for Palliative Care.

All supportive care and equipment necessary to support the dying patient in their preferred place of care will be arranged and facilitated through the Discharge Team to ensure a safe and effective discharge.

Discharges outside of normal working hours will be facilitated by the Specialist Nurses for Palliative Care. If medication is needed the Specialist Nurse should contact the on-call Pharmacist who will facilitate the supply of medication.

4.3.5 Neonates

Discharge arrangements from the neonatal unit must be followed as outlined in the local Admission – Discharge Policy for the Neonatal Unit via the following link; sub category guidelines and neonatal & paediatrics.

http://uhsm-intranet/policies/Pages/default.aspx

4.3.6 Post-natal

The transfer of post-natal care from hospital to home must follow the guidance set out in the Trust's Inpatient Postnatal Guidelines.

4.3.7 The Homeless

During the admission process all homeless people must be identified and contact established with the relevant agencies (Social Services for > 65's and a local homeless unit for < 65's). Timely referral and liaison with the agencies is essential to support the discharge of individuals who are homeless, ensure that they have access to primary care services who can oversee their clinical care following discharge and ensure acute facilities are not used inappropriately.

http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Prevention%20of%20homelessness%20protocol%20v1.1.pdf

4.5 Information to be given on discharge

On discharge information relating to the patients admission and ongoing care must be shared with other appropriate health care professional.

4.5.1 Discharge information to be given to the receiving healthcare professional

Actions must be taken to ensure a number of administrative procedures are completed on discharge of a patient from the acute hospital bed. These include: -

- The Consultant or his/her deputy will, on discharge, complete a discharge summary which must be either be sent electronically or posted to the patient's General Practitioner within one working day of the patient's discharge. This must contain the date of discharge, relevant diagnosis, details of medication, advice on patient management and follow-up arrangements
- A full discharge summary letter to the GP must be dictated by Medical staff, typed by the relevant secretary and sent to the GP within 14 days of the patients discharge from hospital
- Suitable, accurate information on any infections the patient has must also be clearly communicated to receiving healthcare professionals
- If a patient dies, the Bereavement Officer will inform the GP within 24 hours of the patients' death (by fax preferably or telephone). Weekends and Bank Holidays are the exception but the notification must occur on the first working day following the weekend or Bank Holiday

All actions taken and documentation given / sent must be noted within the patient's medical notes. As a minimum this must include;

- A discharge summary
- Infection Control Information given (if applicable)

4.5.2 Discharge Information to be given to the patient

All relevant information to support the patient on discharge must be given to the patient prior to leaving the hospital. This must include a copy of the IDS (discharge summary) and must also include relevant patient information leaflets for those patients leaving hospital with new diagnosis. Information must also include, as appropriate, the patient's ongoing management plan along with any contact details of professionals who can support the patient on their return home. Outpatient appointment details must also be given if known on the day of discharge. Any information given must either be documented as being given in the health records by the Registered Nurse. As a minimum this must include;

- A copy of the IDS Discharge Summary
- Patient Information (new diagnosis)
- Contact details for supporting professionals (if applicable)

4.6 Medicines on Discharge

Medicines management plays an important role in preparing patients and their carers for transfer / discharge, which has an impact on the recovery and / or maintenance of their condition following discharge.

Whilst a patient is in hospital it is possible that a familiar medication pattern will be changed. In order to take the changed medication as the prescriber intended the patient and / or their carer(s) must understand the rationale for the medication regime as well as be able to physically manage to take their medication. This explanation and assessment must be undertaken by the person responsible for the discharge.

The patients General Practitioner must also receive timely up to date information so that any revised prescription can be continued on discharge. This is covered on the IDS Discharge Summary.

Patients TTO's must be prepared to support an effective and efficient discharge and must not be a reason for any discharge being delayed or postponed.

4.7 The Out of Hours Discharge Process

It must not be usual practice for patients to be discharged during the 'out of hours' period between 22:00hrs and 07:00hrs. However, in some circumstances this will happen and staff must always ensure that this only occurs with the full agreement of the patient and their family and /or carer.

Staff must always ensure they fully understand the situation in which the patient will go home to (temperature, light, home alone etc) and ensure that the discharge arrangements are appropriate.

Simple Discharges: Staff facilitating a patients discharge 'out of hours' must clearly document in the patient's medical records the reason for the late discharge along with confirmation there was agreement with the patient, family and/or carers.

Complex Discharge: Patients with Complex discharge needs must not be discharged during the 'out of hours' period.

For patients remaining on the ward who are waiting transport (PTS) to transfer or discharge and this hasn't arrived by 22:00hrs then the patient must not be discharged and transport arrangements cancelled and re-booked for the following morning.

5 Monitoring Compliance and the Effectiveness of the Policy

The CQC Risk Management Standards outline a number of minimum requirements and processes that need to be in place to promote safety and quality of care in Acute Trusts in relation to managing the risks associated with the discharge of patients and the Trust must demonstrate the process for monitoring compliance with all of these requirements.

In accordance with CQC Risk Management Standards audits of compliance with key stages in the discharge process will be undertaken twice per year.

The audits will identify compliance with;

1) The Discharge requirements for all patients
    - Time of discharge
    - Transport arrangements
    - TTO's (given and explained)
    - Removal of all medical equipment
    - Training / support for patients leaving with appropriate medical equipment
    - Any patient information given
    - Any ongoing care arrangements for the patient
2) The information to be given to the receiving healthcare professional
    - A discharge summary
    - Infection Control Information given (if applicable)
3) The information to be given to the patient on discharge
    - A copy of the IDS Discharge Summary
    - Patient Information (new diagnosis only)
    - Contact details for supporting professionals (if applicable)

The sample will be 25 discharges from each Directorate. This will be audited by the Patient Flow Team. The results will be collated and presented at the Health Care Governance Committee along with any required action plan. The actions required for improvement will be discussed with the Directorate Matrons who will be responsible for ensuring improvements are made to ensure compliance.

Name……..…… RM. No…….

Patient Discharge Checklist		
Expected discharge date-	**Met- Initial**	**N/A- Initial**
Ward Contact Card provided		
Patient and family aware of discharge date-		
Pressure areas checked. State observation:		
District Nurse referral completed electronically and copy in notes Where appropriate wound assessment chart, photograph and vascular studies report (if patient has leg ulcers) to be sent Comments:		
Cannula removed		
Valuables returned		
Patient has own keys		
Patient changed into own clothes		
Discharge advice sheet given		
VTE information leaflet & anti embolic stockings given if required		
Medications given and explained		
Anti-coagulation appointment and booklet given		
Fit note given		
Transport booked		
GP discharge letter written and copy given to patient and copy in notes		
Feeding guidelines completed		
Dressing removed and wound checked		
Friends and Family Questionnaire card provided		
Relevant Follow up arranged. State details:		
If nursing/rest home, transfer form completed		
Transfer to Discharge Lounge arranged		
Discharged on Lorenzo system		
Relevant specialist teams aware of discharge. State details:		
Other- State:		

Date and Time Discharged ……..……

Signature & Print discharging Nurse …….

APPENDIX B

PLAN FOR DISSEMINATION

Title of document:	**Discharge Policy**		
Date finalised:		**Dissemination lead: Print name and contact details**	Karen Hatch Tel: 291 6475
Previous document already being used?	Yes		
If yes, in what format and where?	Trust wide Admission and Discharge Policy – Trust Intranet		
Proposed action to retrieve out-of-date copies of the document:	Remove current policy from Intranet and replace with revised policy.		

Describe the plans for dissemination of the document to specific people / groups in specified formats and if appropriate with relevant training

All Trust Staff – Electronic format via e-mail communication to the Heads of Nursing for local dissemination

Social Service Staff – Manchester and Trafford – Electronic Format via e-mail and through the Integrated Hospital Discharge Team Management Structure

Community Services (via commissioners) – Manchester and Trafford - Electronic Format via e-mail and through the Integrated Hospital Discharge Team Management Structure

Dissemination Record - to be used once document is ratified.

Date put on register / library of policy or procedural documents		**Date due to be reviewed**	

Notes

APPENDIX C

EQUALITY IMPACT ASSESSMENT – DISCHARGE POLICY

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay, bisexual and transgender people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to [N/A], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact the Corporate HR Manager

University Hospital of South Manchester NHS
NHS Foundation Trust

Discharge Destination Policy
Version 1.0

(Previously known as Home of Choice Policy)

Lead executive		Mandy Bailey			
Name / title of author:		Tracey Edwards, Patient Flow Manager Angela Watts, Directorate Manager			
Date reviewed:	August 2014	**Date ratified:**	17/09/2014	**Ratifying Committee:**	Executive Committee
Target audience:	Trust-wide				
Policy Summary:	This policy sets out the procedures in place for the management of all patients that are deemed medically fit for discharge to ensure they leave the acute hospital bed in a safe and timely manner. This will be achieved by placing the patient into a suitable interim setting, should their choice of destination be unavailable.				
Equality Impact Statement:	University Hospital of South Manchester NHS Foundation Trust ('UHSM') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, UHSM aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore had an initial assessment, in accordance with the equality impact proforma incorporated in 'the Checklist for Review and Ratification of UHSM-wide Documents', to ensure fairness and consistency for all those covered by it regardless of their individuality. **This initial impact assessment indicated that the potential discriminatory impact is none.**				
Training impact and plan summary:	Training required will be carried out as part of the dissemination plan via Heads of Nursing, Matrons, Ward Manager and departmental meetings.				
Outline plan for dissemination:		Trust Intranet, Team Brief, Divisional and Directorate Meetings, Matron and Ward Team meetings			
Dissemination lead: name / title / ext n°		Patient Flow Manager - 6475			
This version n°		1.0	**Date published:**	22/09/2014	

Version Control Schedule			
Version number	**Issue Date**	**Revisions from previous issue**	**Date of ratification by Committee**
V1		New document(Previously known as Home of Choice Policy)	17/09/2014

Document Control	
Summary of consultation process	Standard consultation procedure – Trust wide Consultation via Discharge Process Sub Group – Medical Model / Integration Work Discharge Team Trust Solicitors Patient Experience Committee Complex Health and Social Care Directorate
Control arrangements *[Review usually every 3 years, but more frequently if required]*	Compliance monitoring arrangements: Annual audit to be undertaken by the Lead Discharge Nurse. Audit results to form part of annual discharge report to Healthcare Governance Committee Lead Discharge Nurse and Patient Flow Manager are responsible for developing and monitoring improvements required in the form of an action plan to be tabled at the bi monthly Discharge Team meetings and bi annually through Healthcare Governance Committee The Guidance will be reviewed every 2 years by the Lead Discharge Nurse
Associated documents	Mental Capacity Act 2005 UHSM Patient Discharge Policy UHSM Mental Capacity Act Policy UHSM Safeguarding Vulnerable Adults Policy UHSM Complaints and Feedback Policy V3
References	Discharge from Hospital; Pathway, Process and Practice (DoH 2003) NHS constitution 2009 Community Care Delayed Discharges Act 2003 The National Framework for NHS Continuing Healthcare and NHS Funded Capacity 2007

Document Compliance Monitoring Arrangements	
Process for monitoring	Regular audits
Responsible individual / group/ committee	Integrated Health and Social Care Team
Frequency of monitoring	Annual
Role responsible for preparation / approval of report and action plan	Patient Flow Manager
Committee responsible for review of results / approval of action plan	Executive Committee
Individual / group / committee that is responsible for monitoring of action plan	Executive Committee

Contents

1. Introduction and purpose

The NHS is under considerable pressure to only use hospital and community beds for those who need specific hospital treatment for their illness. Beds occupied by people waiting for arrangements outside of the hospital setting (including those waiting for a place in their chosen care home) significantly impact on the daily availability of hospital beds for those patients who need them. Therefore active discharge planning should start on the patient's admission to hospital. This document should be used in conjunction with UHSM's 'Ticket Home', 'Home on Time' and the Patient Discharge Policy.

The decision identifying the on-going needs of a patient should be made, where possible, with the patient and the multidisciplinary team (MDT) normally consisting of a Consultant or Senior Medical Doctor, a Nurse, Allied Health Professional(s), a Social Worker and, if appropriate, a Mental Health Nurse. The relatives / carers should also play an active role in the decision making.

The decision to live in a nursing or residential home is a major one and a number of factors may need to be considered including:

- Proximity of the home to relatives,
- The quality of life the patient will experience,
- Cost of the accommodation.

It is important to recognise that it is not appropriate or in the best interests of the patient to remain in a hospital bed until a place becomes available at the chosen home. This document seeks to deal with these situations and recognise that staying in a hospital setting once medically fit and ready for discharge can be detrimental to the patient's health.

Discharge Planning will commence on admission using the 'Ticket Home' poster and leaflet, and the patient and their family / carer should be fully aware of the process for managing the discharge of a patient once they no longer require acute hospital care. Clear communication from an early stage can avoid the escalation of confusion and subsequent delays in the discharge process. An information leaflet is available outlining the process (Appendix 8).

Where a person's care needs are identified as needing to be met in a residential or nursing home setting, it is acceptable for a patient to move to an interim or transitional placement if their preferred discharge destination is not available once the patient is medically fit for discharge.

The aim of this document is to enable staff to support the patient's transfer from the acute hospital environment to a more appropriate care setting at an optimum time in the patient's care pathway. It applies to patients that require complex discharge arrangements including discharge to residential or nursing home care following their inpatient care episode.

This will ensure that we endeavour to meet the patient's best interest by not remaining in a hospital bed until a place becomes available at the chosen discharge destination as doing so carries the risk of potential harm to the patient. These include:

- Risk of reduced independence
- Increased risk of acquiring an infection
- Increased risk of breakdown in the patient's care network.

2. Policy Statement

This document is provided to support the management of patient care, along with the patient's family / carers / advocate, during the decision making process. It aims to ensure that;

- All patients are treated fairly and without discrimination;

- Patients, relatives and carers should be fully involved from the beginning in the discharge planning process which should be initiated when the patient is admitted to hospital and a proactive approach taken to ensure the discharge is appropriate, safe and timely;

- The patient, where practicable, should agree with the discharge destination;

- The MDT will always seek the permission of the patient to allow full involvement of relatives / carers in the discharge planning process. Where patients are unable to present their own views or wishes, relative / carer / advocate views will be obtained ensuring where possible that their interests or wishes do not conflict with those of the patient;

- Processes outlined in the Continuing Health Care (CHC) guidance should always be followed;

- Formal discussions with the patients and records of all decisions will be recorded in the patient's health records and discharge planning documentation. All entries must be signed and dated;

- At all times, Health and Adult Social Care staff will act in the best interest of the patient;

- Where the patient is discharged to an interim placement outside the Trust, an allocated Social Worker / Care Manager will maintain contact with the patient and will ensure that when a place becomes available in the patients home of choice, and where funding arrangements permit, that arrangements will be made to transfer the patient to that home if that is still their wish. CHC processes in local authorities may differ and agreements are dependent on local CHC guidance.

3. Scope and Exclusions

This policy applies to all UHSM employees including the Integrated Health and Social Care Team.

4. Processes

4.1 Application of this Policy

This document applies to patients in the following situation:

- Patients for whom an agreed multidisciplinary assessment has identified that discharge from hospital or community health facility is appropriate but who require care home (residential or nursing) placement. This placement will be funded by Social Services, the NHS or the patient, dependant on the outcome of financial and health assessments;

- Patients who have identified a care home of choice but accommodation is not immediately available, or are having difficulty identifying a home of choice;

- Patients who are awaiting packages of care to be arranged, and / or completion of aids / adaptations to their home or housing issues such as decorating, cleaning;

- Patients who have stated that they are unwilling for transfer of care to take place until a bed is available in a care home of their choice;

- Patients for whom an interim placement has been identified which meets their assessed physical or mental needs.

This process will be fully supported by members of the Integrated Health and Social Care Team.

If at any point during the application of this policy, challenges are made towards members of staff (for example, the threat of legal action) this must be escalated to the Chief Operating Officer with immediate effect.

4.2 Patients who Lack Capacity

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that a patient lacks the capacity to decide where to be discharged to an assessment of capacity should be undertaken. If the assessment identifies that the patient does currently lack the capacity to make that decision, a Best Interest Meeting will be organised prior to the decision regarding the choice of accommodation is made. ***The process outlined below for handling the discharge will apply but letters replaced with those in Appendix 7 (for stage 1 of the process) and Appendix 8 (for stage 2 of the process).***

The principles of the Mental Capacity Act (2005) should be adhered to at all times. For further information and guidance see the Trust's Mental Capacity Act Policy (1) and Safeguarding Vulnerable Adult Policy (2)

(1) http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Mental%20Capacity%20Act%20Policy%20V2.00.pdf
(2) http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Safeguarding%20Vulnerable%20Adults%20Policy%20V3.00.pdf

4.3 Process for Patients Waiting in a Hospital Bed for Care Home Placement

This guidance should be followed where the MDT assessment of the patient indicates that the patient is close to being fit for discharge and therefore not requiring any further inpatient care. The full MDT should be satisfied that the patient's condition cannot be further improved by inpatient rehabilitation or intermediate care and that placement in a residential or nursing home is the most appropriate option to meet the patient's needs. The key component of the assessment process will be the involvement of the patient at all stages (Appendix 2).

Some local authorities use an interim care setting to have the patient's needs further assessed and / or receive further treatment from the MDT. It is acceptable for a patient to move from an acute setting to an interim placement until a permanent / alternative choice becomes available.

The Integrate Hospital and Social Care Team (IHSCT) for the patients' ward will be responsible for ensuring that appropriate discussions take place with the patient at all stages of the assessment and planning process. All such discussions will be recorded in the patient's health records and on the discharge planning documentation.

Patients, families and carers should be directed to the Department of Health's Discharge Guidance if they have any queries or concerns with the proposed management of the discharge.

All internal process and assessments must be completed before the following process is implemented:

4.3.1 Stage 1: Day 1 – Day 7

Once all assessments and meetings are complete the patient and/or family / carers will receive written confirmation of discharge plans (Stage 1 letter, Appendix 3), the date and to whom this was given / sent will be documented in the patients records by the issuer. Where possible, this will be given directly to the patient and / or relative by the Ward Manager or Discharge Nurse.

The patient, family / carers will engage with the IHSCT within 7 days to facilitate discharge to the discharge destination. A copy of this policy should be given to the patient, family / carer.

In the case of a patient requiring a nursing / residential home placement, a shortlist of appropriate establishments with vacancies will be provided along with the preferred provider lists for the relevant local authority. Patients, families / carers will be made aware that the list provided is non exhaustive and a full list can be found at www.cqc.org.uk.

All further information and support required is to be provided by the IHSCT to facilitate a safe and efficient discharge to the appropriate destination.

If the family cannot be contacted following receipt of the initial confirmation, the patients discharge / transfer plans will still continue to ensure that their best interests of the patient are being addressed by hospital staff.

For patients who are self funding, escalation to the Divisional Director of Operations and Chief Nurse will be required due to the potential need to commence legal proceedings or the family being billed for the on-going care in hospital.

4.3.2 Stage 2: Day 8 – Day 10

In the event of;

- A discharge is delayed beyond the timeframe outlined in the Stage 1 letter, a member of IHSCT will ensure that all the necessary information and support has been given to the patient, families / carers.

- If the patient remains medically fit for discharge and the MDT assessments identify no changes.

- If the patient, families / carers have not engaged with IHSCT to facilitate discharge or the delay is due to the points set out in section 3.3 of this guidance.

The following actions will be taken:

The IHSCT will arrange a review meeting with the patient, family / carers within 3 working days. This meeting is to be chaired by a Trust Matron or Manager from the relevant Directorate (or the IHSCT manager if no local representative is available) and attended by at least one health professional and one social care worker from IHSCT. This meeting is to be documented in the patient's health records and an invitational letter (Appendix 4) will be issued to the patient family / carer.

The person chairing the meeting will:

- Confirm with IHSCT that an appropriate interim placement is available;
- Ensure that all information and support required to facilitate discharge has been given;
- Reiterate the patient no longer requires an acute hospital bed and remaining in hospital is not an appropriate course of action as it is detrimental to the patients health and wellbeing;

- Explain the next part of the process is that a further timeframe (maximum of 7 days) is to be given from the date of this meeting and the patient, family / carer will be asked to agree to a local vacancy for interim placement;
- A formal letter will be issued outlining the plan (including timeframe) from the meeting and the interim options available to the patient, family / carer;

The relevant Head of Nursing and Divisional Director of Operations will be informed of the meeting and the outcome.

4.3.3 Stage 3: Day 17 – Day 24 (following time given to the family as described in Stage 2)

If there is no interim placement identified and agreed by the date specified in the letter and there is no indication of availability at the discharge destination of choice, a member of the IHSCT should inform the patient's consultant. Divisional Director of Operations should then convene a final review meeting inviting the patient, family / carer to finalise discharge arrangements. This will be confirmed in writing (Stage 3 letter, Appendix 5).

The Chief Nurse and Director of Operations should be informed that such a meeting is being convened as it may result in the patient being transferred and/or that legal proceedings may be considered.

This planning meeting where practicable will be convened within 3 working days of the agreed timeframe to ensure all risk issues have been considered. The meeting will include where practicable:

- The Divisional Director of Operations
- Adult Social Care Manager
- IHSCT Nurse
- Consultant
- Trust Executive or Representative
- Trust Legal Team Member
- GP

Once the meeting has been arranged with the relevant Trust staff a final meeting letter should be issued (Appendix 6) to the patient, family / carers.

The outcome of the meeting will be documented in the patient's health records and written confirmation of the outcome will be sent to all present at the meeting. The patients discharge will then follow the agreed plan.

4.4 Governance

Any complaints regarding the discharge process will be investigated by the relevant Head of Nursing or Directorate Manager as per UHSM's Complaints and Feedback Policy.

4.5 Performance Monitoring

An annual audit of the use and outcome of this policy will be undertaken by the IHSC Team Manager and the Senior Specialist Discharge Nurse. Outcomes will be reported through the Clinical Standards Sub Committee.

5. Duties related to the implementation of this policy

Employees

All employees have a duty to read and be aware of this policy and to ensure it is adhered to and used appropriately for the safe and timely discharge of UHSM patients.

Managers
All Managers have the responsibility to ensure this policy is communicated effectively with their department's employees, any training requirements are fulfilled and the policy is used appropriately by all members of their team.

Appendix 1

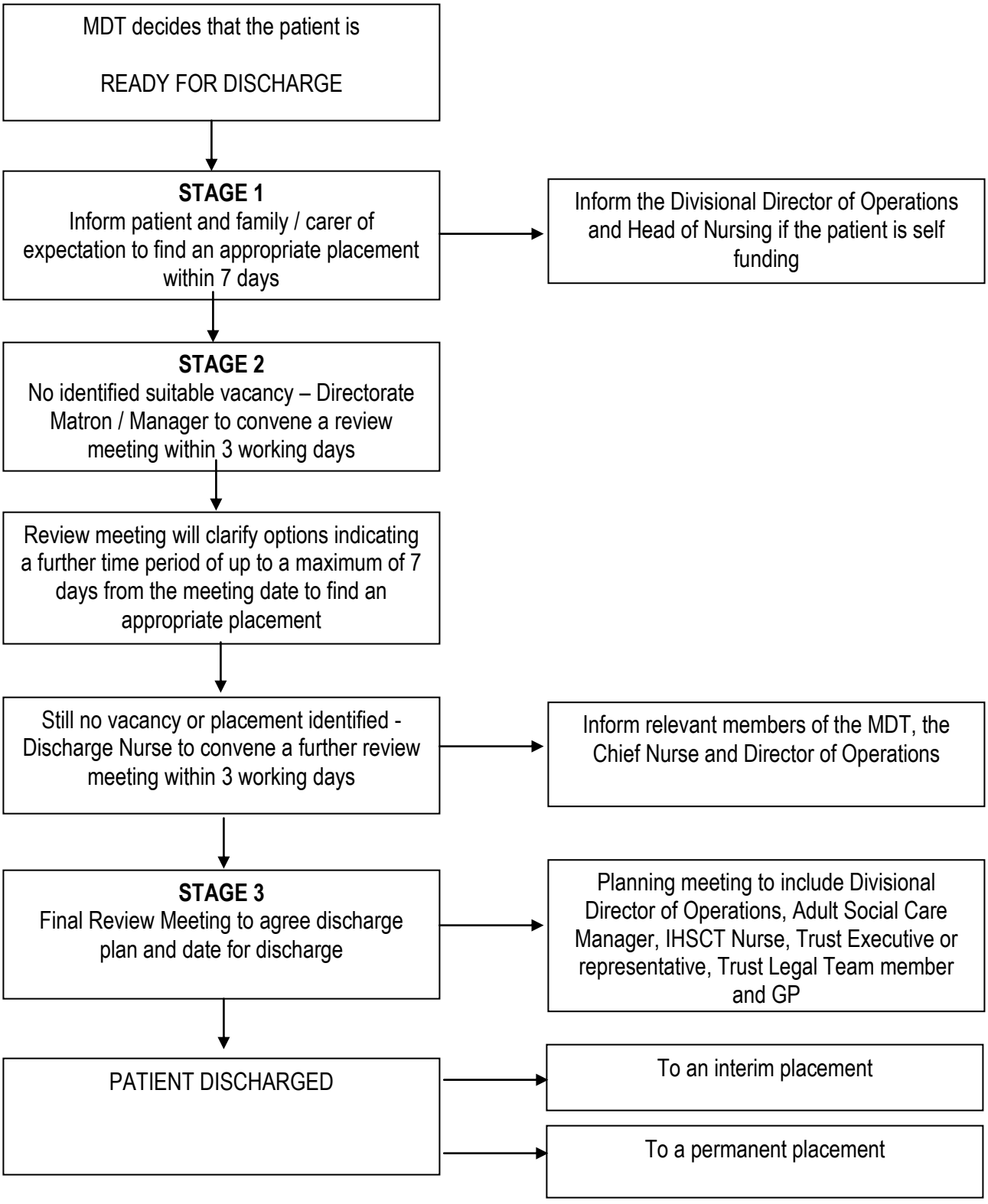
University Hospital of South Manchester NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT of Discharge Destination Policy

		Yes/No	Comments
1.	**Does the guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay, bisexual and transgender people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the guidance likely to be negative?**	Yes	Patients may be moved against their will or to a home not of their choice. Risk of negative feedback regarding the Trust from patients, relatives/carers.
5.	**If so can the impact be avoided?**	Yes	Patients can remain in an acute bed unnecessarily at the risk to their own health and this will deny other patients hospital admission and the treatment they require. Involving the patient, relative/carers in discharge planning from admission ensuring clear communication at each step.
6.	**What alternatives are there to achieving the guidance without the impact?**	Nil	Nil alternatives
7.	**Can we reduce the impact by taking different action?**	No	

Appendix 2

Process Flow Chart for Patients Waiting for Care Home Placement



Appendix 3

Stage 1 letter

Dear

Your consultant [INSERT NAME] informed you that you were medically safe for transfer / discharge on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAMED NURSE AND MEMBER OF INTEGRATED HEALTH & SOCIAL CARE TEAM] who explained that following assessment, we would like you to identify a care home for [INSERT PATIENT'S NAME] on-going care needs.

We do not wish to cause you any additional anxiety or distress, but you will be aware that there are many people requiring hospital care and we need to be able to offer treatment to all patients at the earliest opportunity. We are asking you to let us know of your preferred care home within 7 days of the date on this letter.

A member of the Integrated Health and Social Care Team will be available to support you during the next 7 days and will provide you with information relating to local care homes and current vacancies. In the event of no decision being made in this timescale hospital staff will begin the process of finding an interim solution. We may also have to do this if the care home of your choice does not have a vacancy.

If you are unhappy with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you lave hospital with support and understand the reasons for the decisions which will always be made in the patients best interests.

If you have any further questions please do not hesitate to contact a member of the Integrated Health and Social Care Team.

Yours sincerely

Chief Executive

Appendix 4

Stage 2 letter

Dear

Your consultant [INSERT NAME] has let us know that you were medically ready for discharge on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAMED NURSE AND MEMBER OF INTEGRATED HEALTH & SOCIAL CARE TEAM] who explained how your continued care would need to be met therefore I sent you a letter on [INSERT DATE]. We asked you to identify a care home to us within 7 days of the date on the letter.

The Multidisciplinary Team responsible for your care have been over your records and identified that there is no change in the decision that you no longer in need of active acute hospital care.

Within the next 3 days you will need to meet with a management team member to review the position so far and to discuss interim arrangements pending your decision and / or a vacancy being available at your preferred care home.

The aim of the meeting will be to explore the options available to you with you and your family / carer and members of the multidisciplinary team. You will then be given a further 7 days to identify a placement with our support.

We do not wish to cause you any undue anxiety or distress, but you will be aware that there are many people requiring hospital care and we need to be able to offer treatment to all patients at the earliest opportunity. As mentioned in the first letter, as a result of no care home being identified we are now in a position to identify an interim solution. This will be discussed with you at a meeting scheduled for [INSERT MEETING DETAILS].

If you are unhappy with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact the Nurse in Charge or a senior member of staff.

Yours sincerely

Chief Executive

Appendix 5

Stage 3 letter

Dear

Your consultant [INSERT NAME] has informed you that you were medically stable and fit for transfer/discharge on the [INSERT DATE]. I understand that your preferred place of residence following discharge is [INSERT NAME OF CHOSEN ESTABLISHMENT] but that they are not able to accommodate you at the present time.

A meeting will now be convened with a member of the Executive Team and the Trust Legal Team to agree that we have been compliant with Trust Discharge Destination Policy, a copy of which was made available to you at the start of this process.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment and care. It is therefore important that those patients who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also rarely in a patient's best interests to remain in hospital once they are fit for discharge. We therefore request that you accept the interim arrangements offered and accept that your transfer out of the hospital will occur by [INSERT DATE].

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Yours sincerely,

Chief Executive

Appendix 6

Final meeting letter arrangements

Dear

Your consultant [INSERT NAME] informed you that you were medically stable and fit for discharge/transfer on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAME] who explained how your continued care would be met and how any interim care arrangements would work. We again met with you on [INSERT DATE] to discuss arrangements should the situation remain unchanged 7 days from the meeting date. Despite recent communications you have still not made arrangements to allow us to transfer your care to a place of your choice.

A meeting will now be convened with a member of the Executive Team and the Trust Legal Team to agree that we have been compliant with Trust Discharge Destination Policy, a copy of which was made available to you at the start of this process.

Whilst we do not wish to cause you any undue anxiety or distress, you will be aware that there are other people requiring acute hospital care and we need to be able to offer treatment to these patients at the earliest opportunity. Unless you make arrangements to leave the hospital the Trust will have no choice but to take steps to ensure the safe discharge / transfer of [INSERT PATIENT'S NAME] to a setting able to provide the appropriate support, which may include legal action for which you could be required to pay our legal costs. I hope such steps will not be necessary.

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Yours sincerely

Chief Executive

Appendix 7

STAGE 1 LETTER – (Carer/Relative Letter)
PATIENT WHO LACKS CAPACITY

Dear

We are pleased to hear that the Consultant responsible for [INSERT PATIENT'S NAME] treatment in hospital has confirmed that [INSERT PATIENT'S NAME] is now medically fit to be discharged from hospital.

A Health and Social Services Assessment has been completed and [INSERT PATIENT'S NAME] care needs have been fully discussed with you and with [INSERT PATIENT'S NAME], as far as appropriate.

As you may be aware, [INSERT PATIENT'S NAME] has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with the family and friends of [INSERT PATIENT'S NAME] to identify an appropriate placement for [INSERT PATIENT'S NAME] in line with his / her "best interests".

[INSERT NAMES] of the Integrated Health & Social Care Team have discussed this with you and we would be grateful if you could now inform us of your views regarding appropriate accommodation for [INSERT PATIENT'S NAME] so that your preferences can be taken into account in reaching a decision, and to ensure that [INSERT PATIENT'S NAME] can be discharged safely and promptly. It is hoped that professionals and family and friends will be agreed on their preference for an appropriate placement. We are asking you to inform of us your preferred care home within 7 days of the date on this letter.

If you have any queries or wish to discuss this further, please contact a member of the Integrated Health & Social Care Team on [INSERT CONTACT NUMBER].

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Thank you for your co-operation.

Yours sincerely,

Chief Executive

Appendix 8

STAGE 2 LETTER – (Carer/Relative Letter)
PATIENT WHO LACKS CAPACITY

Dear

We are pleased to hear that the Consultant responsible for [INSERT PATIENT'S NAME]'s treatment in hospital has confirmed that [INSERT PATIENT'S NAME] is now medically fit to be discharged from hospital. A Health and Social Services Assessment has been completed and [INSERT PATIENT'S NAME]'s care needs have been fully discussed with you, and with [INSERT PATIENT'S NAME], as far as appropriate.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment and care. It is therefore important that those who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also rarely in a patient's best interests to remain in hospital once they are fit for discharge.

As you may be aware, [INSERT PATIENT'S NAME] has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with family and friends of [INSERT PATIENT'S NAME] to identify an appropriate placement for [INSERT PATIENT'S NAME] in line with his / her "best interests". We have discussed [INSERT PATIENT'S NAME] with you and have taken into account your views about where he / she should now live.

[I understand that your preferred place of residence for [INSERT PATIENT'S NAME] following discharge is [INSERT NAME OF CHOSEN ESTABLISHMENT] but that they are not able to offer accommodation at the present time it has been decided that they are not the most appropriate placement to meet [INSERT PATIENT'S NAME] needs.

We have considered what placements are available that can meet [INSERT PATIENT'S NAME]'s care needs, and have decided that [INSERT PATIENT'S NAME] should move to [INSERT NAME OF ESTABLISHMENT]. [*This is a temporary placement, until the chosen placement becomes available* – DELETE WHERE APPLICABLE].

[NAME OF PLACEMENT] has confirmed that a bed will be available for [INSERT PATIENT'S NAME] on [INSERT DATE]. We therefore intend to discharge [INSERT PATIENT'S NAME] from the hospital on that day. We would welcome your assistance with the move process, if possible. If you have any queries, or if you wish to discuss this further then please contact a member of the Team on [INSERT CONTACT NUMBER].

Unless arrangements are made for [INSERT PATIENT'S NAME] to leave the hospital it may be necessary for the Trust to take steps to compel them to leave, including possible legal action. I hope such steps will not be necessary.

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.
Yours sincerely

Chief Executive

Appendix 9

"YOUR MOVE"

Information to help you when discussing your move from hospital or a Residential or Nursing Home

Moving on from Hospital

Since you were admitted to hospital the Doctors, Nurses, Therapists and Social Workers who have been involved in your care have been working together with you to assess your needs for health and social care support when you leave hospital.

It is now agreed by you and/or your family / carer and the hospital team that your needs will be best met in a Residential or Nursing Care Home. We are seeking to safely make this move so that someone else who is waiting for treatment can come into the hospital.

We understand that the decision to live in a Residential or Nursing Home is a major one and one that involves important and significant changes for you and your family / carers.

This leaflet provides you, your family / carers with information you will need to make your decisions once you no longer need hospital treatment or are ready to be discharged to a Residential or Nursing Home.

Advice and guidance on choosing a home

Our integrated team of Discharge Nurses and Social Workers will offer you advice and guidance about planning your discharge from hospital. This will involve discussing your care needs with you and your family / carers giving you written information about the homes that can meet your needs.

Social Workers will offer advice and assistance with any funding that you may be entitled to and can provide you with information on the Residential and Nursing Homes. Independent advice can also be sought from other agencies such as Age Concern.

Timescale of Events

It is important that you continue to receive care and support in the most appropriate environment. To help us to do this, we need your cooperation and support to find a Residential or Nursing Home.

We will therefore ask you, your family / carers to make a choice of accommodation that is suitable without undue delay.

Once you and your family / cares have chosen a home you may have to wait until a place at that home becomes available. If the wait is likely to be more than 7 days we will work with you to find an acceptable alternative until the vacancy becomes available at your home of choice.

If you do not identify a choice of accommodation, or refuse the alternative temporary accommodation offered within a further 7 day period, the Trust will be required to take the necessary steps to discharge you to an alternative place of care.

Appendix 10

Underlying Principles

Discharge from Hospital Pathway Process and Practice, Department of Health 2003
Key Points:

- Unnecessary admissions are avoided and effective discharge is facilitated by a "whole system approach" to assessment processes and the commissioning and delivery of services.
- The engagement and active participation of people who use the services and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge.
- Discharge is a process and not an isolated event. It has to be planned at the earliest opportunity across the primary, hospital and social care services, ensuring that patient and their carer(s) understand and are able to contribute to the care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by an acting named person who has responsibility for co-ordinating all stages of the patient journey. This involves liaison with the pre-admission case co-ordinator / care manager / community matron, district nurse or social worker in the community at the earliest opportunity and the transfer of those responsibilities on discharge.
- Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process.
- Effective use is made of transitional and intermediate care services so that existing acute hospital capacity is used appropriately and patients achieve their optimal outcome.
- The assessment for and delivery of health and social care needs is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decision about their future care.

National Framework for NHS Continuing Healthcare and NHS Funded Care 2007
Overview:

The Department of Health describes continuing care as the provision of care over an extended period of time as the result of disability, accident or illness to meet both physical and mental health needs. It can be provided in a range of settings from an NHS Hospital, Care Home or Hospice to a person's own home.

Continuing Care can include both health and social care funding. This may vary between local authorities. Every patient over age 18, who may have continuing care needs must be considered for eligibility for NHS Continuing Healthcare before any long term plans are put in place.

If individuals, following a multi-disciplinary assessment are identified as possibly meeting the criteria and a referral made to a team of funded NHS care assessors team. They will carry out their assessment and apply the criteria to determine eligibility. The above applies regardless of whether the individual is in a hospital, care home or their own home. The NHS is responsible for arranging as well as funding continuing care services.

Mental Capacity Act 2005
Overview:

The Mental Capacity Act (MCA) applies in England and Wales to everyone who works within the Health and Social Care. The MCA is based on best practice and creates a single coherent framework for managing mental capacity issues. It puts the individual at the heart of decision making and places a strong emphasis on supporting and enabling the individual to make their own decisions.

There must always be a presumption that a person has capacity to make decisions. Do not assume that people with cognitive/mental health issues lacks capacity on all decisions.

The assessment of capacity must be a particular decision at a particular time and not a range of decisions.

The MCA set out 5 key principals which underpin the legal requirements. These are;

1. A person must be assumed to have capacity unless it is established that they lack capacity;

2. A person is not to be treated as unable to make a decision unless all practicable help to enable him / her do so has been taken without success;

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision;

4. An act done or decision made on or on behalf of a person who lacks capacity must be done, or made, in his / her best interest;

5. Before the act is done, or decision is made, it must be considered whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive to the person's rights and freedom of action.

No one can assume that a person lacks capacity because of old age, how they look or how they behave. No one can assume a person cannot make a decision because of their inability to make complicated decisions or because they have not been able to make a decision like that in the past.

Where a person has to make a decision on behalf of a person who lacks capacity, they must decide what is in the person's best interest.

This can only be done properly by listening to what the person wants, consulting people who know them, and making sure they are involved at every step of the process.

Assessing Capacity

The person who assesses an individual's capacity to make a decision will usually be the person who is directly involved with the individual at the time the decision needs to be made. The decision to be made will determine who completes the capacity assessment. The establishment of capacity to consent is the responsibility of the person proposing the medical treatment or social care.

The Functional Test of Capacity

In order to decide whether an individual has the mental capacity to make a particular decision, you must decide whether there is an impairment of, or disturbance in the functioning of the person's mind or brain (permanent or temporary).

If impairment is established, the second question you must answer is, does the impairment or disturbance make the person unable to make the particular decision?

The person will be unable to make the particular decision if after all appropriate help and support to make a decision has been given to them they cannot do the following things:

1. Understand the information relevant to that decision, including understanding the likely consequences or making or not making the decision;

2. Retain the information;

3. Use or weigh up that information as part of the process of making the decision;

4. Communicate their decision whether by talking, using sign language interpreter, or other means.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate.

An assessment must be made on the balance of probabilities i.e. is it more likely than not that the person lacks capacity? You should show in your records why you have come to the conclusion that the person lacks capacity to make a particular decision.

Independent Mental Capacity Advocate (IMCA)

If a person lacks capacity and medical treatment and / or a move is being proposed and there is nobody other than paid staff to consult with on behalf of the person who lacks capacity to consent then the relevant NHS body or local authority must instruct an IMCA. Staff will need to await the IMCA's "report" before they can proceed to a best interest decision, unless it is urgent or an emergency.

Any act done or decision made on behalf of a person who lacks capacity must comply with the five principals set out in section 1 of the Act.

Advanced Decisions

The Act also introduces the legal framework for advanced decisions. An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment. It has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision. If the advance decision refuses life-sustaining treatment, it must:

- Be in writing (it can be written by a someone else or recorded in healthcare notes);
- Be signed and witnessed, and
- State clearly that the decision applies even if life is at risk.

To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- Has done anything that clearly goes against their advance decision;
- Has withdrawn their decision;
- Has subsequently conferred the power to make that decision on an attorney, or
- Would have changed their decision if they had known more about the current circumstances.

Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.

NHS Constitution 2009
Key points:

The Constitution establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe one another to ensure the NHS operates fairly and effectively.

In respect of discharge, the patient has the right to:
Respect, consent and confidentiality

- Each person will be treated with respect and courtesy
- Personal information will be kept confidential, patient records will be kept safe and secure
- Patient's can have access to their own health records, including any letters sent between clinicians about their care.

Informed Choice

- Patients have a right to make choices about their NHS care and to information to support these choices.

Involvement in Healthcare

- Patients have a right to be involved in discussions and decisions about their healthcare, and to be given information to enable them to do this.

The NHS commits to:

- Make the transition between services / discharge as smooth as possible
- Ensure decisions are made in a clear and transparent manner.

Patient's and Carer's Discharge Standards

Patients being discharged from hospital have the right:

- To full information on their diagnosis and the assessment of their health and social needs in preparation for discharge
- To be fully involved in planning their own discharge, together with a relative, carer or friend as appropriate
- For the discharge plan to start on or before admission where possible
- To full information on the services available in the community relevant to their care
- To full information on short or long term nursing or residential care; including financial implications
- To be given an appropriate contact number where they can get help or advice on discharge
- To be given a clear, legible discharge letter detailing the support services provided for them, where appropriate
- To full information on health authority eligibility criteria for continuing care
- The discharge planning team to be available as a point of contact to offer support and advice to patients, carers, statutory and voluntary agencies
- Information on advocacy support
- To have access to the Trust complaints procedure and any complaint regarding their discharge arrangements investigated and a full explanation given
- If still not satisfied, then to be given access to the Health Service Commissioner.

Source: *Discharge from hospital: pathway, process and practice, Appendix 4.3 Department of Health 2003 [Page 45].*

Appendix 11

Intermediate Care Service / Discharge Destination Policy 2014

There are 39 Intermediate Care beds in South Manchester as part of UHSM community services. Patients are admitted to these beds following a period in hospital or directly from home to prevent an unnecessary hospital admission. The average length of stay is approximately 27 days. The vast majority of patients (86%) return to their own homes following a period of rehabilitation on the unit. Some patients (12%) are unable to return safely to their own homes and are assessed as needing to transfer from Intermediate Care to either a Residential or Nursing Home.

This document applies to patients in the following situation:

- A patient for whom an agreed multidisciplinary assessment has identified that discharge from an Intermediate Care bed is appropriate but who now require a care home (residential or nursing) placement;

  This placement will be funded by Social Services, the NHS or the patient, dependant of the outcome of financial and health assessments;

- Patients who have identified a care home of choice but accommodation is not immediately available, or are having difficulty identifying a home of choice;

- Patients who have stated that they are unwilling for transfer of care to take place until a bed is available in a care home of their choice;

- Patients for whom an interim placement has been identified which meets their assessed physical or mental needs;

- Patients who are being treated by UHSM but whose home address lies outside of the Manchester area.

This process will be fully supported by the Intermediate Care Service and the wider organisation.

Patients who Lack Capacity

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that the patient lacks the capacity to decide where to be discharged to, an assessment of capacity should be undertaken. If this assessment finds that the patient lacks the capacity to make that decision, a Best Interest Meeting will be organised prior to the decisions being made regarding the choice of accommodation type.

The process outlined below for handling the discharge should apply but letters replaced with those in Appendices 7 (for Stage 1) and 8 (for Stage 2).

The principles of the Mental Capacity Act (2005) should be adhered to at all times. For further information and guidance see the Trust's Mental Capacity Act Policy and Safeguarding Vulnerable Adult Policy.

Process for patients waiting in an Intermediate Care bed for nursing or residential placement:

This guidance should be followed where the MDT assessment of the patient indicates that the patient is close to being fit for discharge and therefore not requiring any further inpatient care. The full MDT should be satisfied that the patient's condition cannot be further improved by Intermediate Care and that placement in a residential or nursing home is the most appropriate option to meet the patient's needs. The key component of the assessment process will be the involvement of the patient at all stages.

Some local authorities use an interim care setting to have patients / client's needs further assessed and / or receive further treatment from the MDT. It is acceptable for a patient to move from an Intermediate Care setting to an interim placement until a permanent / alternative choice becomes available.

The MDT will be responsible for ensuring that appropriate discussions take place with the patient at all stages of the assessment and planning process. All such discussions will be recorded in the patient's health records and on the discharge planning documentation. Any care plan will clearly state who the key Discharge Nurse and Social Worker are for the patient.

Patients, families and carers should be directed to the Department of Health's Discharge Guidance if they have any queries or concerns with the proposed management of the discharge.

Stage 1: 1-14 DAYS for ICT

The process of planning discharge will adhere to the current Trust Patient Discharge Policy and the appropriate local authority discharge guidance.

All patients, families / carers identified as requiring discharge support will be issued the Intermediate Care leaflet. The date and to whom the leaflet was given will be documented in the patient's records by the issuer.

Once all assessments and meetings are complete the patients', family / carers will receive written confirmation of discharge plans (Stage 1 letter, Appendix 2), the date and to whom this was given / sent will be documented in the patients records by the issuer. Where possible, this will be given directly to the patient and / or relative.

In the case of a patient requiring a nursing / residential home placement a shortlist of appropriate establishments with vacancies will be provided along with the preferred provider lists for the relevant local authority. Patients, families / carers will be made aware that the list provided is non exhaustive and a full list can be found at www.cqc.org.uk.

All further information and support required is to be provided by the unit MDT to facilitate a safe and efficient discharge.

If the family cannot be contacted following receipt of the initial confirmation the patients discharge / transfer plans will still continue to ensure that the best interests of the patient are being addressed by Trust staff.

Stage 2: Day 14-16 for ICT

In the event of:

- A discharge is delayed beyond the timeframe outlined in the Stage 1 letter, a member of the MDT will ensure that all the necessary information and support has been given to the patient, families / carers;

- If the patient remains medically fit for discharge and the MDT assessments identify no changes;
- If the patient, families / carers have not engaged with the service to facilitate discharge or the delay is due to the points set out in section 3.3 of this guidance in the main section of this policy.

The following actions will be taken:

The MDT will arrange a review meeting with the patient, family / carer within 5 working days. This meeting is to be chaired by a Senior Nurse or Manager from the unit and attended by at least one other health professional and the social care worker for the patient. This is to be documented in the patient's health records and an (invitational letter) will be issued to the patient, family /carer.

The person chairing the meeting will:

- Confirm with the Social Worker that an appropriate interim placement is available;
- Ensure that all information and support required to facilitate discharge has been given;
- Reiterate the patient no longer requires an Intermediate Care bed and that remaining in such a bed is not an appropriate course of action and could be detrimental to the patients health and wellbeing;
- Explain the next part of the process is that a further (maximum of 7 days) is to be given from the date of this meeting. The patient, family / carer will be asked to agree to a local vacancy for interim placement;
- A Stage 2 letter (Appendix 3) will be issued outlining the plan (including timeframe) from the meeting and the interim options available to the patient family/carer;

Stage 3: Day 17 – Day 24 (following time given to the family as described in stage 2)

If there is no interim placement identified / agreed by the date specified in the letter and there is no indication of availability at the discharge destination of choice, a member of the MDT should inform the patient's consultant. A Senior Manager should then convene a final review meeting inviting the patient family/carer/ advocate to finalise discharge arrangements. This will be confirmed in writing (Stage 3 letter, Appendix 4).

The Chief Nurse / Director of Operations should be informed that such a meeting is being convened as it may result in the patient being transferred and/or that legal proceedings may be considered.

This planning meeting where practicable will be convened within 2 working days to ensure all risk issues have been considered. The meeting will include where practicable:

- The Divisional Director of Operations
- Adult Social Care Manager
- IHSCT Nurse
- Hospital Executive or Representative
- Hospital Legal Team Member
- GP

The outcome of the meeting will be documented in the patient's health records and written confirmation of the outcome will be sent to all present at the meeting. The agreed patients discharge will then follow the agreed plan.

Governance

Any complaints received will be investigated by the Senior Nurse / Clinical Lead along with other members of the MDT as appropriate as per the Trust's Complaints and Feedback Policy.

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University Hospital of South Manchester NHS
NHS Foundation Trust

Discharge Lounge Guidelines
Version 3

Lead executive		Mandy Bailey, Chief Nurse			
Name / title of author:		Sarah Everitt – Lead Discharge Nurse			
Date reviewed:	November 2015	**Date ratified:**	23/11/2015	**Ratifying Committee:**	Divisional Team
Target audience:	Trust-wide				
Guideline Summary:	This guideline sets out the procedures in place to ensure the safe and timely use of the Discharge Lounge for patients deemed medically fit for discharge.				
Equality Impact Statement:	University Hospital of South Manchester NHS Foundation Trust ('UHSM') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, UHSM aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore had an initial assessment, in accordance with the equality impact proforma incorporated in 'the Checklist for Review and Ratification of UHSM-wide Documents', to ensure fairness and consistency for all those covered by it regardless of their individuality. **This initial impact assessment indicated that the potential discriminatory impact is yes and supports the End of Life Pathway. An additional step in the discharge process would be inappropriate for this client group.**				
Training impact and plan summary:	It is not anticipated any further training will be required.				
Outline plan for dissemination:	Policy will be disseminated via the Lead Discharge Nurse and Deputy Head of Patient Flow in e-mail format				
Dissemination lead: name / title / ext n°	Karen Hatch/ Head of Patient Flow Manager - 6475				
This version n°	3	**Date published:**	24/11/2015		

Version Control Schedule			
Version number	**Issue Date**	**Revisions from previous issue**	**Date of ratification by Committee**
V1	Aug 2012	New document	19/07/2012
V2	Jul 2014	Addition to inclusion criteria	
V3	Nov 2015	Reviewed	23/11/2015

Document Control	
Summary of consultation process	Standard consultation procedure – Trust wide Consultation via Emergency Flow Project Group Discharge Team and Discharge Lounge Staff
Control arrangements *[Review usually every 3 years, but more frequently if required]*	Compliance monitoring arrangements: Annual audit to be undertaken by the Lead Discharge Nurse. Audit results to form part of annual discharge report to Healthcare Governance Committee Lead Discharge Nurse and Patient Flow Manager are responsible for developing and monitoring improvements required in the form of an action plan to be tabled at the bi monthly Discharge Team meetings and bi annually through Healthcare Governance Committee The Policy will be reviewed every 2 years by the Lead Discharge Nurse
Associated documents	Discharges from Hospital: pathway, process and practice (DoH)
References	N/A

Document Compliance Monitoring Arrangements	
Process for monitoring	Regular Audits
Responsible individual / group/ committee	Senior Discharge Nurse Heads of Nursing
Frequency of monitoring	Every six months
Role responsible for preparation / approval of report and action plan	Heads of Nursing
Committee responsible for review of results / approval of action plan	Heads of Nursing Meeting
Individual / group / committee that is responsible for monitoring of action plan	Heads of Nursing

Contents		
Section		Page

1. Introduction

Discharge planning is a process made up of several steps and in some cases will end with the patient leaving the Trust via the Discharge Lounge.

This guidance has been developed to establish a standard approach to the management of patients who may be suitable to utilise the services of the Discharge Lounge as part of their discharge from hospital. It is designed to promote and facilitate optimum use of the facility and to improve patient care and inpatient flow within the Trust. The Discharge Lounge provides a facility which can assist with the operational management of beds by supporting effective and efficient transfer of care throughout the hospital.

The objective of the Discharge Lounge is to provide a facility which can smooth the patients' transition from hospital to home (or other place of safety) whilst allowing acute beds to be made available as soon as possible for the admission of acutely ill patients.

This guidance sets out to ensure that the inclusion and exclusion criteria for admission to the Discharge Lounge are clearly defined as well as the roles and responsibilities of staff involved in patient care.

2. Policy

The purpose of this document is to provide all wards at UHSM with the relevant information to enable them to utilise the Discharge Lounge ensuring a positive end to any inpatient stay. The document aims to keep the patient experience at the heart of all we do.

3. Scope and Exclusions

The policy applies to all UHSM employees, particularly acute hospital staff and discharge lounge team.

4. Key Definitions

Discharge: Discharge from hospital is a process and not an isolated event. It involves the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan.

Discharge Lounge: The discharge lounge is a comfortable, staffed area where patients can wait for transport home once they no longer require the level of nursing care offered on an in-patient ward. Patients can be collected from these areas by family members or transport services to take them home. Meals, drinks and basic nursing care are all available. The discharge lounge is located in the hospital where there is easy transport access for ambulances. Beds are provided for patients to wait in but for the majority chairs are provided.

5. Processes

5.1 Location and Facilities of the Discharge Lounge

- **Location:** The Discharge Lounge is located on the Ground Floor of the main hospital and entrance 5 is the nearest entrance. There is car parking available in the main visitor car park with disabled parking outside the Discharge Lounge exit. The PTS ambulance parking is also directly outside of the Discharge Lounge exit.

- **Opening Hours:** The hours of opening are Monday to Friday 08:00hrs – 20:00hrs.

- **Facilities:** The Discharge Lounge has wheelchair and stretcher / bed access and can accommodate 2 bed patients and 14 patients sitting in arm chairs. The Lounge also has disabled access to toilet facilities. There is also a patient hoist and resuscitation equipment in the case of an emergency. There is provision for patients to change out of their nightwear and into day clothing however, patients should usually arrive into the Discharge Lounge wearing their day clothes. There is however no piped oxygen or suction which is why only limited numbers of patients using oxygen can be taken.

- **Catering:** The Discharge Lounge can provide limited catering for patients throughout their stay. Regular hot and cold drinks will be provided and sandwiches will be made available for those patients in the Lounge at lunch and evening meal times. Toast, cereal and a hot drink will be provided to those arriving early in the morning. Any special dietary requirements must be identified to the Discharge Lounge staff on handover and special meals ordered from the ward should be sent down to the Discharge Lounge for the patient.

- **Medication:** All patients must have had TTO's written before sending the patient to the Discharge Lounge. If patients are likely to require medication during their stay in the Discharge Lounge they must come with TTO's and instructions regarding medication given to the nurse on handover.

- **Infection Control:** Patients with known infections should be discussed with the Infection Control Team and the Discharge Lounge staff prior to transferring the patient. Failure to do this may impact on discharge lounge capacity being available pending the appropriate cleaning of the area.

5.2 Key Inclusion and Exclusion Criteria

The criteria for admission to the Discharge Lounge aims to be as broad as possible to ensure that a wide range of people can use the facility whilst ensuring the safety of both staff and patients in the facility. Therefore the exclusion criterion is as limited as possible, and if a patient does not fall within the exclusion criteria they are appropriate for the Discharge Lounge.

Exclusion Criteria

- End stage palliative care patients (Not all palliative patients are unsuitable for the discharge lounge. If the patient has a terminal diagnosis but is not receiving end of life care they may utilise the lounge)
- Limited patients requiring low levels of oxygen (maximum of 2 patients)
- Patients transferring to other hospitals (this depends on the patients medical condition, if they are being repatriated, transferred for rehab, ICT, or are medically stable they can be transferred to the lounge)
- Patients who have not had their TTO's prescribed
- Patients with known infections should be discussed with the Infection Control Team and the Discharge Lounge staff prior to transferring the patient.

5.3 Transfers from the Ward

Patients should always be informed early in their stay if they are to be discharged home via the Discharge Lounge.

As the aim of the Discharge Lounge is to smooth the transfer of patients from hospital to home it is essential that sufficient information is relayed to the discharge nurses to enable the staff to continue to provide the right care until the patient is discharged to their final destination.

Where possible the wards should notify the Discharge Lounge of their intention to send a patient there the day preceding discharge. The Discharge Lounge can then support the ward to transfer the patient to the Discharge Lounge on the day of discharge. The wards are responsible for organising any porters if required. Patients should be ready for transfer if being collected by one of the Discharge Lounge staff.

All patients who are travelling home via ambulance should have their transport booked prior to transfer to the discharge lounge. This should be done before 14:00hrs on the day before discharge.

Therefore, when a patient is to be discharged via the Discharge Lounge the ward will need to ensure they have all the relevant information for the discharge lounge to complete their handover document (see appendix 1).

5.4 Medical Emergencies

If the patient's condition gives the staff cause for concern they should contact the responsible medical team for that patient. They should come and review the patient and make a decision regarding any treatment and whether that patient can still be discharged. If they can no longer be discharged the Discharge Lounge co-ordinator must liaise with the bed management team to secure an appropriate bed. Where at all possible this bed should be on the ward the patient was transferred from, but if this is not possible the patient should remain the responsibility of their current medical team and a bed should be found in this directorate. When this is agreed to inform the patient, their next of kin and anyone involved in their on-going care.

If an appropriate bed is not readily available and the patient's condition continues to deteriorate it may be necessary for the patient to be transferred to the A&E department. This should be discussed with the appropriate nursing team, the relevant medical team and the bed managers.

In the event of a cardiac arrest the staff will telephone 2222 to alert the cardiac arrest team to attend. There is a resuscitation trolley within the Discharge Lounge.

5.5 Fire

In the event of a fire alarm, Trust procedures should be adhered to. On the sound of the continuous alarm evacuation should be commenced. The fire assembly point for the Discharge Lounge is outside the main building.

5.6 Security

In the event of any security issue the staff will contact 2818. Otherwise they should contact the Lead Discharge Nurse and / or the Patient Flow Manager. Due to a recent spate of thefts from the discharge lounge it is now locked outside working hours. It will be locked down daily from 22.00-06.00 and from Friday 22.00- to 06.00 Monday morning. If access is needed out of hours security can assist.

5.7 Governance

Any incidents occurring in the Discharge Lounge or to a transfer to the Discharge Lounge should be reported via the Trust HIRS system. Any complaints received about the Discharge Lounge will be investigated by the Lead Discharge Nurse and/or the Patient Flow Manager.

5.8 Performance Reporting

Monthly Utilisation of the Discharge Lounge by each ward will be reported to Ward Managers and recorded in Ward KPI's.

6. Duties and Responsibilities of individuals and groups

Discharge Lounge Co-ordinator's Responsibilities

The staff nurse rostered on for that day will adopt the role of Discharge Lounge Co-ordinator. At 08:00 hrs each morning the co-ordinator should check the Patient Transport List web based booking screen to ascertain who has pre-booked transport for that day, and then contact all wards to: -

- Review with ward staff all patients with transport booked and then take a hand-over of these patients and agreed a suitable time for collection.
- Identify and trouble-shoot any prospective problems for that day's transfers to the discharge lounge, including identification of mode of transport from ward to lounge.
- Ensure appropriate levels of communication between all concerned parties, including Arriva Transport Solutions and the family

- Check and review TTOs with the patient. (Liaise with Pharmacy re prescribed TTOs as necessary)
- Ensure that all patients have transport booked if required, with a booking reference number, prior to their transfer to the Discharge Lounge. Alternatively, that an agreed plan has been made with the designated Band 6 discharge nurse.
- Effectively manage healthcare support worker (HSW), ensuring roles and responsibilities are defined and understood, delegating accordingly.
- Ensure that all patients are asked every hour if there is anything they need, including beverages and sandwiches, and that their dignity is maintained at all times. Make sure that this is documented on the Discharge Lounge paper-work.
- Where necessary liaise with patient's family, carers or social worker regarding their estimated time of discharge, and then when they actually leave the Discharge Lounge.
- Maintain accurate records of admissions and discharges through the Discharge Lounge.
- Make sure that patients are discharged promptly from Lorenzo once that have left the unit.
- Make sure the patient leaves the unit with all their personal belongings, discharge summary and medication.
- Liaise with ward staff regarding patient case notes and ensure any notes are returned to the appropriate ward.
- Ensure safe environment is maintained at all times.
- Liaise with the Discharge Team, Bed Managers and ward staff to identify patients for discharge the following day.
- Report any deterioration in patient's condition to the appropriate medical team.(see also section 6)
- Ensure that all patients received from Out Patients Clinic have transport booked or relevant cost code.
- Challenge ward staff SMART board EDD, to pull patients through the system.

Health Care Support Workers Responsibilities

- Ensure transportation to the lounge is identified i.e. walking, chair, bed.
- Collect patients from ward, check transfer documentation and identification band.
- Ensure that that the patient does not still have a venflon in situ.
- Ensure that all patients are appropriately dressed if possible in their own clothes.
- Ensure regular pressure area relief to appropriate patients and document.
- Liaise with Arriva to ensure they are aware that the patient has been transferred to the Discharge Lounge
- Orientate patients to the discharge lounge and introduce all staff on duty.
- Provide meals and beverages as required (at least every hour and more frequently if necessary). Ensure that all care given is clearly documented on the Discharge Lounge pro-forma
- Maintain safety and comfort of patients (including assisting with toileting as required).
- Return all medical notes to the appropriate ward once the patient has been discharged
- Assist and act on instructions from the Discharge Lounge Co-ordinator and Band 6 Discharge Nurses.
- Fax transport list to the bed managers each morning
- Complete morning and evening checks to ensure smooth and safe running of the discharge lounge.

Ward Responsibilities

- Liaise with Discharge Lounge Co-ordinator & identify appropriate patients to use the facility, and give a verbal hand-over.
- Ensure that the patient has their TTO's written
- Inform patients & relatives of the transfer where possible.
- Complete all discharge arrangements prior to transfer (including transport if possible).
- Ensure all patients have been assessed as medically fit for discharge.
- Where possible ensure that patients receive their TTO's and medication counselling prior to transfer – however this is not essential and can be undertaken on the discharge lounge itself if need be.
- Complete the nurse transfer documentation/letter (where applicable e.g. where patient is being discharge to a nursing home).
- Ensure the patient has an identification band on prior to leaving the ward.
- Ensure all venflons have been removed.
- Ensure relevant information and referral forms have been communicated (such as completed District Nurse referrals, social care packages etc.)
- To ensure the patient reaches the discharge lounge In time for on going transportation

Lead Discharge Nurse

The Lead Discharge Nurse is responsible for the day to day management of the Discharge Lounge. They are responsible for ensuring the correct policies and processes are adhered to in order to ensure the safe and effective discharge of patients from the Trust

Appendix 1

TRANSFER TO THE DISCHARGE LOUNGE PROFORMA

PATIENTS FULL NAME: **NHS NUMBER:**	**DATE:**
DISCHARGING WARD:	**NAMED NURSE:**
ADDRESS PATIENT BEING DISCHARGED TO:	**NEXT OF KIN:** **TEL NO:**
DETAILS OF COLLECTION: ○ **RELATIVE** ○ **FRIEND** ○ **AMULANCE Ref No =** ○ **OTHER**	**NAME OF PERSON COLLECTING PATIENT:** **CONTACT NUMBER:** **AWARE OF MOVE TO THE LOUNGE:** ○ **YES** ○ **NO**
EXPECTED TIME OF DEPARTURE:	**ID BAND IN SITU** ○ **YES** ○ **NO**
BRIEF DIAGNOSIS:	**RELEVANT MEDICAL HISTORY:**
<u>ASSESSMENT OF PATIENT NEEDS</u> **MOBILITY:** **HOIST SLING WITH PATIENT:** ○ **YES** ○ **NO** **DIET:** **WARFARIN:** **CONTINENCE:** **WATERLOW SCORE:** **ANY PRESSURE RELIEVING AIDS:** **(PLEASE STATE)** **FALLS RISK** **OTHER:**	**<u>ACCESS TO PROPERTY</u>** **DOES THE PATIENTS HAVE THEIR KEYS:** ○ **YES** ○ **NO** **IF NOT HOW WILL THEY ACCESS THE PROPERTY:** **IF STRETCHER PATIENT IS THERE CAPACITY FOR ACCESS TO THE PROPERTY:** ○ **YES** ○ **NO** **<u>ON DISCHARGE</u>** ○ **PATIENT IS APPROPRIATELY DRESSED** ○ **VENFLON REMOVED** ○ **TTOS IN PATIENTS POSSESSION** ○ **DISCHARGE SUMMARY**

MEDICATION	TTO SENT IN A TAXI
○ DOES NOT REQUIRE MEDICATION ○ TTO GIVEN ON WARD ○ TTO TO BE COLLECTED BY LOUNGE STAFF TTO CHECKED BY:	NAME OF TAXI FIRM SIGNATURE OF DRIVER

Appendix 2

COMMUNICATION SHEET

(PLEASE DOCUMENT ALL CARE GIVEN TO PATIENTS WHILST ON THE DISCHARGE LOUNGE, INCLUDING PRESSURE AREA CARE, DIET TAKEN, ETC)

DATE & TIME	COMMENTS

Please Record What Medical Notes Received from Ward (please specify if only loose papers received)

Medical Notes Returned to Ward on Date ----------

Signature of Person Receiving Notes and Their Designation ----------

University Hospital of South Manchester NHS
NHS Foundation Trust

My Health Care Passport

What I need you to know, a health and care record for me, my family and carers.

UHSM Your Hospital

My Healthcare Passport is a unique individual health care record, designed for anyone who is living with a medical condition which requires on going care and support.

Living with a medical condition may involve meeting many new people; keeping family, carers, health staff and care workers updated about changing requirements, and can be difficult, repetitious and tiring.

This passport aims to act as a core record of how my individual health is evolving and of information required to support my health and wellbeing.

It is designed to be completed, updated and kept primarily by me, the passport owner, or any member of my family or carers on my behalf. Health care staff may all so add to, change and up-date it.

If for any reason I am unable to communicate for myself, for example due to ill health; the Health Care Passport explains the day to day requirements for my care. It may also contain important information about my preferences and wishes regarding healthcare should my health deteriorate for any reason.

This Health Care Passport belongs to:

Address:	I like to be known as:
E-mail:	
Telephone:	Date of birth:
NHS Number:	
Religion:	Nationality:
Prefered language:	

Next of kin:

Address:	Patient calls me:
E-mail:	
Telephone:	Relationship:

Second contact:

Address:	Patient calls me:
E-mail:	
Telephone:	Relationship:

All About Me

My GP's name:

Surgery Address:

Telephone:

My normal weight:

I have been diagnosed with the following conditions:

Aids & Equipment I need:

Walking aid:_____

Glasses:_____

Hearing aid:_____

Wheelchair:_____

Dentures:_____

Other aids/equipment:_____

My Care Package

My main carer:

Address:

Patient calls me:

E-mail:

Telephone:

Out of hours:

Do I have Power of Attorney in place? Yes No

Name of holder:

Address:

Patient calls me:

E-mail:

Telephone:

Relationship:

My current Home Care Package provider:

Address:

Telephone:

I have _____visits a day_____days a week, with _____carers.

_____ fund my care Package.

Other info:

Community services:

Do I have any of the following services:	Telephone:
Community Matron:	
CPN:	
District Nurse:	
Neighbourhood Teams:	

Other Information:

(*Reason for vulnerability. e.g. learning difficulties, dementia etc.)*

S.O.S. information *e.g. allergies*

My Current Medication:

1:_____

2:_____

3:_____

4:_____

5:_____

6:_____

7:_____

8:_____

9:_____

10:_____

11:_____

12:_____

13:_____

14:_____

15:_____

My Current Medication continued:

16:_____

17:_____

18:_____

19:_____

20:_____

21:_____

22:_____

23:_____

24:_____

25:_____

26:_____

27:_____

28:_____

29:_____

30:_____

Mobility
(Getting in & out of bed, walking around)

How I Communicate
(How I show my wants and needs, eg. hunger, happiness, pain, distress or satisfaction)

Toileting & Personal Hygiene

Safety
(How to keep me safe from harm)

Dressing & Undressing

Sleeping and Bedtime

Eating & Drinking
(Swallowing difficulties etc.)

Taking My Medication

Most recent Admission to Hospital

Date: Reason:

Patient Discharge Checklist	***Please Intial***	Met	N/A
Expected discharge date: ____ / ____ / _____			
Ward Contact Card provided			
Patient and family aware of discharge date Pressure areas checked. State observation: District Nurse referral completed electronically and copy in notes. Where appropriate, wound assessment chart, photograph and vascular studies report (if patient has leg ulcers) to be sent. Comments:			
Cannula removed			
Valuables returned			
Patient has own keys			
Patient changed into own clothes			
Discharge advice sheet given			
VTE info leaflet & anti embolic stockings given *if required*			
Medications given and explained			
Anti-coagulation appointment and booklet given			
Fit note given			
Transport booked			
GP discharge letter written and copy given to patient and in notes			
Feeding guidelines completed			
Dressing removed and wound checked			
Friends and Family Questionnaire card provided			
Relevant Follow up arranged. State details:			
If Nursing/Rest Home transfer form completed			
Transfer to Discharge Lounge arranged			
Discharged on Lorenzo system			
Relevant specialist teams aware of discharge. State details:			
Other- State:			

What Has Changed For Me During This Admission

Admisssion Date ____ / ____ / _____

Discharge Date: ____ / ____ / _____

Change	Action Required

Notes

Notes

Notes

University Hospital of South Manchester
NHS Foundation Trust
Southmoor Road
Wythenshawe
Manchester M23 9LT

Useful Contact Numbers:

Manchester Social Services: **0161 234 5001**
www.manchester.gov.uk

Trafford Social Services: **0161 912 5199**
www.trafford.gov.uk

Stockport Social Services: **0161 419 5880**
www.stockport.gov.uk

Carers UK: **0808 808 7777**
www.carersuk.org

IMPORTANT

If you are caring for me:

Please read and, where appropriate, help to complete, my Health Passport.

This passport gives hospital staff ***vital*** information about me and my health conditions.

Central Manchester University Hospitals NHS
NHS Foundation Trust

Trafford Urgent Care Centre

Update to Manchester and Trafford Joint Health Scrutiny Committee

January 2016

Background

- Established November 2013
- Operates 8.00am – midnight
- Treats a wide range of illnesses and injuries requiring immediate attention
- Patients with the most serious cases go to comprehensive A&E services – UHSM, MRI SRFT
- Staffed by experienced, trained nurses and specialist A&E doctors

New Health Deal

- “New Health Deal” consultation considered various options, including a model staffed by specialist nurses
- Preferred staffing model was a mix of specialist doctors and nurses, in the first instance
- Consultation stated that this would turn into a nurse-led service “in two to three years”
- Patient flows changed following implementation of the New Health Deal changes
- Activity levels stabilised fairly quickly, and the changes were consistent with the plans

Review of Trafford UCC

- Patients using Trafford UCC now generally do not need the care of a specialist A&E doctor
- Numbers attending later in the evening are very small
- Trafford CCG and CMFT have started discussing how best to provide the UCC service going forwards
  - analysis of UCC activity and case mix
  - dialogue with staff providing urgent care services

Service modelling

- A revised model might not result in any significant change to the patients who can be cared for at Trafford UCC
- Changes to patient flows could be very limited
- The service modelling has to be driven by the analysis, and tested with staff and partner organisations
- Messaging to patients/the public will need to ensure the Trafford UCC continues to be fully utilised

Communications

- Media coverage during w/c 18 January 2016 – some of the messaging was unhelpful
- Subsequent briefing and discussions for staff, colleagues and key partners
- Commitment to communicate pro-actively with all stakeholders as the results of the data collection and analysis become clear
- Progress analysis during February and brief further in March

Trafford Town Hall,
Talbot Road,
Stretford,
M32 0TH.

Telephone: 0161 912 4250
Fax: 0161 912 1277
Email: Alexander.murray@trafford.gov.uk
Minicom: 0161 912 4250
When phoning ask for: Alexander Murray
Our ref:
Your ref:
Date: 27/01/2016

Dear CQC Inspector,

Trafford Council's Health Scrutiny Committee has had a lot of contact with UHSM in the last year mainly in relation to the developments of the New Health Deal for Trafford. The Joint Health Scrutiny Committee representing Manchester and Trafford Councils was set up specifically to look at the New Health Deal for Trafford and you can view the minutes of those meetings at https://democratic.trafford.gov.uk/ieListMeetings.aspx?CId=139&Year=0. When looking through the minutes you will notice that UHSM has an excellent record of attendance at these meetings and always responds quickly to the requests made by the Committee which is a good reflection of our overall impression of the organisation.

Whilst there have been a number of issues brought to our attention relating to UHSM they are always the first to inform us. In the last year there has been concern over the number of delayed discharges at Wythenshawe Hospital. UHSM has worked closely with Trafford Council's Adult Social Care services in order to identify the cause of this problem and to formulate solutions. This issue has led to the Health Scrutiny Committee setting up a task and finish group to try to identify the cause. UHSM have been exemplary in their conduct and communications with this group; they are prompt when responding to requests for information or the availability of officers to arrange meetings.

It is because of their continued excellent attitude towards scrutiny combined with the high levels of praise received from our constituents, and the exceptional care that members of the committee have received at Wythenshawe hospital, that the Committee backed them so steadfastly during their bid to be one of the single shared service hospitals as part of Healthier Together.

If you would like further details of Trafford Health Scrutiny Committee's contact with UHSM please contact Alexander Murray alexander.murray@trafford.gov.uk who can provide you with all records of meetings and feedback in relation to the trust.

Yours sincerely,

Councillor Judith Lloyd,
Chairman of Trafford Council Health Scrutiny Committee

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TRAFFORD COUNCIL

Report to: **Executive**
Date: **25 January 2016**
Report for: **Consideration**
Report of: **Scrutiny Committee**

Report Title

OVERVIEW AND SCRUTINY REVIEW OF THE EXECUTIVE'S DRAFT BUDGET PROPOSALS FOR 2016-17

Summary

The Executive's Draft Budget Proposals for 2016/17 were agreed at its meeting held on 16 November 2015. The Leader of the Council gave a presentation to the Scrutiny Committee on 18 November setting out the proposals.

Two Scrutiny Task and Finish Groups were then held during December with relevant Executive Members and senior officers attending to give background to the proposals and answer questions.

This report reflects the outcome of those discussions and summarises issues for the Executive's further consideration in developing its final proposals and response.

The Budget Scrutiny report identifies that Scrutiny Members feel that there are three key areas where the Executive needs to satisfy itself of the robustness of the proposals. These are

- Ensuring that the savings projections and assumptions are soundly based
- Making sure that effective risk management arrangements are in place
- That Equality Impact Assessments are produced and fully understood by the Executive in making their final decisions and that appropriate action is taken to mitigate the effect of any changes on vulnerable residents.

The Scrutiny Committee have also identified a number of areas where significant savings are to be made and where they intend to carry out follow up work next year to ensure that they are achieved and that the impact of changes is known and addressed. These include:

- Robustness of income projections.
- Car parking fees
- Proposals to collaborate with other
- All Age Front Door Transformation Project
- Recommissioned contracts
- Joint Venture Contract
- The impact on users whose packages of care are reduced
- Integrated Health and Social care

- Trafford Care Coordination Centre.
- Reablement services

Recommendation(s)

1. That the Executive consider and respond to the report and recommendations made.

2. That the Executive note that the Scrutiny Committee and Health Scrutiny Committees are intending to follow up work on a number of areas as part of their future work programmes.

Contact person for access to background papers and further information:

Name: Peter Forrester, Democratic and Performance Services Manager

Extension: 1815

Background Papers: None

BUDGET SCRUTINY REPORT - 2016/17

Foreword by the Chairman and Vice-Chairman of Scrutiny Committee

We welcome the Executive's decision to consult widely on its budget proposals, and the opportunity for Scrutiny Members to review and comment on them at an early stage.

Budget Scrutiny 2016/17 has once again been a challenge for, and made significant demands on, all those involved. On behalf of Scrutiny Members, we would like to thank the Executive, Corporate Management Team, Scrutiny Councillors and Co-opted Members for their patience and contribution to the process. We would particularly like to thank Councillor Judith Lloyd for chairing one of the sessions.

Members acknowledged that the Council continues to work within an increasingly challenging financial climate and the focus of Scrutiny input has been on the robustness and deliverability of the current proposals in the light of experience of budget savings already made in previous years, and the potential impact on communities and service users.

We hope that our Budget Scrutiny will contribute to the decision making process and in ensuring that robust processes are in place to manage changes. We have identified areas where we feel that there are risks to delivery and to users and we look forward to receiving details of how the Executive will address these.

Councillors Jonathan Coupe and Mike Cordingley
Chairman and Vice-Chairman, Scrutiny Committee.
December 2015

1.0 Background

This year the approach to budget scrutiny was agreed by Scrutiny Committee, with a programme designed to forward any recommendations / observations to the Executive at the earliest opportunity in response to its consultation.

Two Task and Finish Group meetings were held to look at the proposals. The approach this year was to look at the proposals using the themes identified for budget consultation. Scrutiny members noted that the approach to the budget shortfall for 2016/17 and later years has focused on a "One Council" approach by taking a cross directorate view to the savings that need to be achieved by applying the following themes:-

- **Maximising Income** – maximising income from our services or generating income from assets such as advertising.
- **Working Smarter** – looking at the way things are done such as redesign of the workforce.
- **Buying Better** – working with our partners and suppliers to ensure we get best value for our expenditure.
- **Eligibility and Access** – reviewing current care packages and all new applications applying the reshaping social care policy utilising equipment, assistive technology and adaptations.
- **Joining Up and Working Together** – looking at how we deliver community health and social care services for adults in Trafford.
- **Promoting Independence** – helping people to help themselves, through our care strategy.

The meetings raised a number of questions which were dealt with at the meeting or were clarified following the meeting. Scrutiny Members were disappointed that some information was not available at the meeting and felt that this hindered their ability to provide scrutiny. This is something that will be reviewed in determining the process for budget scrutiny next year.

Members also expressed concerned at the low turnout for the public consultations and the costs of the exercise. The Committee recommend that the Executive review its arrangements for public consultation in 2016 so that it represents better value for money.

The main findings from the two meetings are set out below.

2.0 Key Messages

Scrutiny Members identified a number of issues that cut across all of the budget proposals.

- **Savings Projections and Assumptions –** Some proposals are based on estimates of income generation and future work programmes. Whilst it is recognised that these are based on a solid evidence base and are made conservatively there are still a number of assumptions which savings and income generation targets rely upon to be delivered within the year. Scrutiny Members would ask that, if these assumptions prove to be incorrect or change in year, they are shared with Scrutiny at an early stage. This should include an analysis of the

impact in comparison to the projections made within the budget and the action to be taken.

- **Risk Management –** The budget proposals contain a number of workstreams to deliver savings. A recurring theme from discussion was to ensure that there is effective management of risk across key workstreams. It was clear from the Executive's responses that there are recognised and well managed risk identification procedures with risk logs maintained by each team and equality impact assessments conducted for each project. Scrutiny would like these logs and assessments to be made available to the relevant Scrutiny Committees along with details of plans to mitigate the risks identified throughout the year.

- **Equality Impact Assessments –** Concerns were raised as to the impact of the budget proposals on the most vulnerable residents of Trafford and at this stage, there are no equality impact statements in place. Scrutiny would like assurance that these are produced and fully understood by the Executive in making their final decisions and that appropriate action is taken to mitigate the effect of any changes on vulnerable residents.

3.0 Specific Comments by theme

Maximising Income

- As mentioned above, questions were raised about the robustness of income projections and the potential impact if they proved to be inaccurate. The Scrutiny Committee stated that they would look at this as part of their programme for 2016/17.
- The Committee raised questions about the levels at which car parking fees were set. Officers explained the importance of getting the correct balance to ensure prices do not reduce footfall in Town Centres and ensuring they are affordable for staff working in these areas. Members asked that information about parking fee income projections and any impact on footfall is included in the Town Centre updates that are periodically brought to the Scrutiny Committee.

Working Smarter

- Proposals to collaborate with other Councils to process telephone calls and share HR and ICT services were discussed. Scrutiny Committee would like updates on progress with these initiatives and progress in achieving savings identified in the budget.
- The Executive were not yet able to predict with accuracy the levels of savings that the All Age Front Door Transformation Project would be able to deliver through the reduction of duplication of work. Health Scrutiny Committee would like an update on this to come to a future meeting.

Buying Better

- Scrutiny members heard that there are a number of savings to be attributed to the recommissioning of contracts that are due to end in 2015/16. The members asked a series of questions about the length and clauses of these contracts and would welcome further updates on the level of savings that are achieved and how they compare to the budget projections.
- Members highlighted the importance of scrutinising services now provided by Amey as part of the Joint Venture Contract. Members identified concerns raised including

whether Amey would be reinvesting savings back into services, and what will happen in future when new efficiencies are more difficult to achieve. A continued review of the JVC is already part of the Scrutiny Committee work programme, but the Budget Scrutiny sessions reaffirmed the importance of this. Amey Officers will be present at the next Scrutiny Committee meeting in January 2016. The Scrutiny Committee will assess how to proceed from there.

Eligibility and Access

- Concerns were raised about what the impact on those users whose packages of care are reduced and the ability of providers to track this. It was recognised that this situation will improve with the implementation of the TCCC and members welcome the additional information that this system will be able to provide. They would welcome an update to a future meeting of the Health Scrutiny Committee.

Joining Up and Working Together

- Scrutiny Members were informed of the various projects that are currently underway which will further integrate Health and Social care services. This is already an area being monitored by the Health Scrutiny Committee and the Committee will continue to do so. The Committee would welcome more information on savings achieved and any impact on users.

Promoting Independence

- It is apparent throughout the budget proposals and subsequent questions posed by Scrutiny, that a large amount of the work planned in 2016/17 is reliant upon the improved communications and patient tracking that will be brought about through the Trafford Care Coordination Centre. Given the importance of the TCCC, Scrutiny would like to be kept abreast of the impact it has in two ways. Firstly scrutiny would like to be informed of the progress of the TCCCs implementation and informed of the knock on effect of any delays that occur. Secondly, Members of Scrutiny would like an explanation of the new information that the TCCC makes possible so that they have a clear idea as to how this new resource can help shape Health, Social Care and Scrutiny going forward.

- Scrutiny members were disappointed that a review and redesign of the reablement service had been conducted without input from scrutiny. They were also concerned by the information that the Ascot House reablement service had not been meeting its targeted outcomes for users. Members asked questions as to what the new reablement offer was and were told that this will be developed further in the coming months. As such members requested that the findings of the recent reablement review be brought to Health Scrutiny as soon as possible and that the details of the new services be made available to scrutiny once in place.

BUDGET SCRUTINY ACTION PLAN

Issue	Scrutiny Recommendation	Executive Response
Information Provision - Some information was not available at the meeting.	Scrutiny and Executive to review approach to the process for budget scrutiny next year to ensure that all information is available.	
Public Consultation - Low turnout for the public consultations and the costs of the exercise.	Executive review its arrangements for public consultation in 2016 so that it represents better value for money.	
Savings Projections and Assumptions – Some proposals are based on estimates of income generation and future work programmes. Whilst it is recognised that these are based on a solid evidence base and are made conservatively there are still a number of assumptions which savings and income generation targets rely upon to be delivered within the year.	Scrutiny Members ask that if assumptions prove to be incorrect or change in year that they are shared with Scrutiny at an early stage. This should include an analysis of the impact in comparison to the projections made within the budget and the action to be taken.	
Risk Management – The budget proposals contain a number of workstreams to deliver savings. There are recognised and well managed risk identification procedures with risk logs maintained by each team and equality impact assessments conducted for each project.	Scrutiny would like these logs and assessments to be made available to the relevant Scrutiny Committees along with details of plans to mitigate the risks identified throughout the year	
Equality Impact Assessments – Concerns were raised as to the impact of the budget proposals on the most vulnerable residents of Trafford and at this stage, there are no equality impact statements in place.	Scrutiny would like assurance that these are produced and fully understood by the Executive in making their final decisions and that appropriate action is taken to mitigate the effect of any changes on vulnerable residents.	

Income Projections - As mentioned above, questions were raised about the robustness of income projections and the potential impact if they proved to be inaccurate.	Scrutiny Committee to look at this as part of their programme for 2016/17.	
Car Parking Fees - The Committee raised questions about the levels at which car parking fees were set. Officers explained the importance of getting the correct balance to ensure prices do not reduce footfall in Town Centres and ensuring they are affordable for staff working in these areas. Members asked that information about parking fee income projections and any impact on footfall is included in the Town Centre updates that are periodically brought to the Scrutiny Committee.	Information about parking fee income projections and any impact on footfall be included in the Town Centre updates that are periodically brought to the Scrutiny Committee.	
Collaboration - Proposals to collaborate with other Councils to process telephone calls and share HR and ICT services were discussed.	Scrutiny Committee would like updates on progress with these initiatives and progress in achieving savings identified in the budget.	
All Age Front Door Transformation Project - The Executive were not yet able to predict with accuracy the levels of savings that the All Age Front Door Transformation Project would be able to deliver through the reduction of duplication of work.	Health Scrutiny Committee would like an update on this to come to a future meeting.	
Recommissioning of contracts - Scrutiny members heard that there are a number of savings to be attributed to the recommissioning of contracts that are due to	Health Scrutiny Committee would like further updates on the level of savings that are achieved and how they compare to the budget projections.	

end in 2015/16.		
Joint Venture Contract - Members identified concerns including whether Amey would be reinvesting savings back into services, and what will happen in future when new efficiencies are more difficult to achieve	Amey Officers will be present at the next Scrutiny Committee meeting in January 2016.	
Care Packages - Concerns were raised about what the impact on those users whose packages of care are reduced and the ability of providers to track this. It was recognised that this situation will improve with the implementation of the TCCC and members welcome the additional information that this system will be able to provide.	Update to a future meeting of the Health Scrutiny Committee.	
Joining Up and Working Together - Scrutiny Members were informed of the various projects that are currently underway which will further integrate Health and Social care services.	This is already an area being monitored by the Health Scrutiny Committee and the Committee will continue to do so. The Committee would welcome more information on savings achieved and any impact on users.	
Promoting Independence - It is apparent throughout the budget proposals and subsequent questions posed by Scrutiny, that a large amount of the work planned in 2016/17 is reliant upon the improved communications and patient tracking that will be brought about through the Trafford Care Coordination Centre.	Health Scrutiny Committee would like to be kept abreast of the impact it has in two ways. Firstly scrutiny would like to be informed of the progress of the TCCCs implementation and informed of the knock on effect of any delays that occur. Secondly, Members of Scrutiny would like an explanation of the new information that the TCCC makes possible so that they have a clear idea as to how this new resource can help shape Health, Social Care and Scrutiny going forward.	

Ascot House - Scrutiny members were disappointed that a review and redesign of the reablement service had been conducted without input from scrutiny. They were also concerned by the information that the Ascot House reablement service had not been meeting its targeted outcomes for users. Members asked questions as to what the new reablement offer was and were told that this will be developed further in the coming months.	The findings of the recent reablement review be brought to Health Scrutiny Committee as soon as possible and that the details of the new services be made available to scrutiny once in place.	