Report for:	Trafford Health Scrutiny Committee
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Subject:	Dignity In Care

1.0 Introduction

Following the Trafford Health Scrutiny Review of Dignity in Hospital Care, November 2013, Trafford Hospital, a division within Central Manchester University Hospitals NHS Foundation Trust continues to be committed to enhancing the patient experience and providing a safe and timely discharge from hospital.

This report provides details about Trafford Hospital's work programme on patient discharge, and responses to questions raised by the Trafford Health Scrutiny Committee in preparation for the meeting on 10th February 2016.

2.0 Patient Discharge Work Programme

The below outlines a number of key areas of development since the 2013 Trafford Health Scrutiny Committee meeting:

Length of Stay

Trafford Hospital has historically had an extended length of stay for patients. Contributing factors include patient demographics (frail older patient group), and delayed discharges from hospital. On average there are between 18 – 20 delayed discharges due to waiting packages of care and nursing home bed availability. This is escalated to commissioners regularly and discussed at joint Trafford CCG and Trafford Divisional senior team meetings.

A number of actions have been taken, aiming to reduce length of stay:

- Increased frequency of length of stay meetings from once to twice weekly, with attendance from social care and community services
- Use of an electronic Egress system to assign actions and identify discharge delays
- Implementation of the discharge policy and improved engagement with families
- Recent review and benchmarking of ward board rounds against Trust standard.

Trafford Hospital Discharge Team

Trafford Hospitals Division reviewed the discharge team roles during 2015 in recognition that additional resource was required to support discharge planning processes. The new team will consist of a Band 7 Discharge Team Managers, Band 6 Discharge Co-ordinator and Band 4 Discharge Facilitator. The Team Manager commences in post on 8th February 2015 and Band 4 is awaiting a start date. Currently the Band 6 is being supported by a Matron who has recently taken responsibility for managing the discharge team and chairing length of stay meetings.

Once the Discharge Team Manager is in post they will attend an established Trafford residential/care home forum, aiming to improve communication between partners in relation to patient admission and discharge arrangements. A forum facilitated by the council will have representation from Trafford Hospital in future.

Adult Discharge Policy

The Trust Adult Discharge Policy was revised and relaunched in March 2015 (copy attached). The policy provides clear guidance for staff to support the planning and timely discharge of patients. Historically it can be difficult to engage with some families to support timely discharge, for example when selecting a care home, and the policy now includes a number of letters for families, identifying timescales for care / residential home choices.

Improved health and social care integration

Trafford Hospital is working with social care and community partners in order to better integrate services and streamline discharge processes. A number of actions have been agreed following a meeting on 26th January 2016 with Diane Eaton, Joint Director of Adult Services (Social Care):

- Feedback following review of current capacity arrangements for discharge. Trafford patients require this to be completed by a social worker which causes delay, whereas this function is completed by Trust staff for Manchester patients
- Agreement to review and streamline discharge paperwork to eliminate duplication
- Co-location of district nurses with social worker/discharge team to move towards a more integrated care model.

Trafford Hospital is working closely with Trafford Carers Centre following appointment of their new CEO. A Trafford Carers Centre key worker spends 1 day per week in the hospital engaging with carers, supporting discharge processes. She will report to and work alongside the discharge team as of February 2015. The Carers Centre are keen to demonstrate the effectiveness of this work and are collating carer/patient outcome information. Carer feedback has been positive to date.

Patient Feedback

Patients are encouraged to provide feedback about their experience in hospital and are offered a 'Patient Experience Tracker' questionnaire during their inpatient stay. If patients themselves are unable to use the device, staff engage with carers to seek their views.

The Patient Experience Data for December 2015 which has been provided for information indicates that 430 patients provided feedback about their inpatient experience, with a positive 92.3% overall patient experience score.

During November 2015 the Care Quality Commission undertook an inspection, with assessors present on site at Trafford Hospital for 3 days. Inspectors engaged with patients and carers throughout the inspection period. The draft/formal report is yet to be received but no concerns were raised during the visit relating to patient safety or experience.

Quality Improvement Work

The Trust, through 'Brilliant Basics' focuses on a key element of patient care on a quarterly basis, one of which is 'Leaving Our Care'. All inpatient wards are expected to undertake relevant improvement work which is displayed on a Brilliant Basics board for staff, patients and carers to review.

Manchester Orthopaedic Centre (MOC) Improvement Work

In November 2015, the Manchester Orthopaedic Centre undertook an Improving Quality Programme (IQP) module to support and improve patient and relative communication and information about discharge.

Patient/carer feedback indicated there was insufficient information provided about aspects of the discharge process. Actions taken as a result of the improvement work include:

- Daily length of stay board round meetings with the multidisciplinary team, led by the nurse co-ordinator
- Therapy team attendance at ward rounds to improve interdisciplinary communication, and communication with patients
- Improved referral process to district nursing services
- Improved communication with patients specifically about discharge
- Launch of a Road to Discharge form (attached) on 11th January 2015 which is retained at the patient's bedside, aiming to develop a shared ownership for discharge planning, identifying

key milestones within the discharge process. This has not been formally evaluated, however patient feedback has been positive.

MOC Patient Experience Tracker data for December 2015 indicates that 100% of patients were aware of 'who to contact if they were worried about your condition after they left hospital?'. This compares to 80% in March 2015.

Complaints Process and Concerns Raised

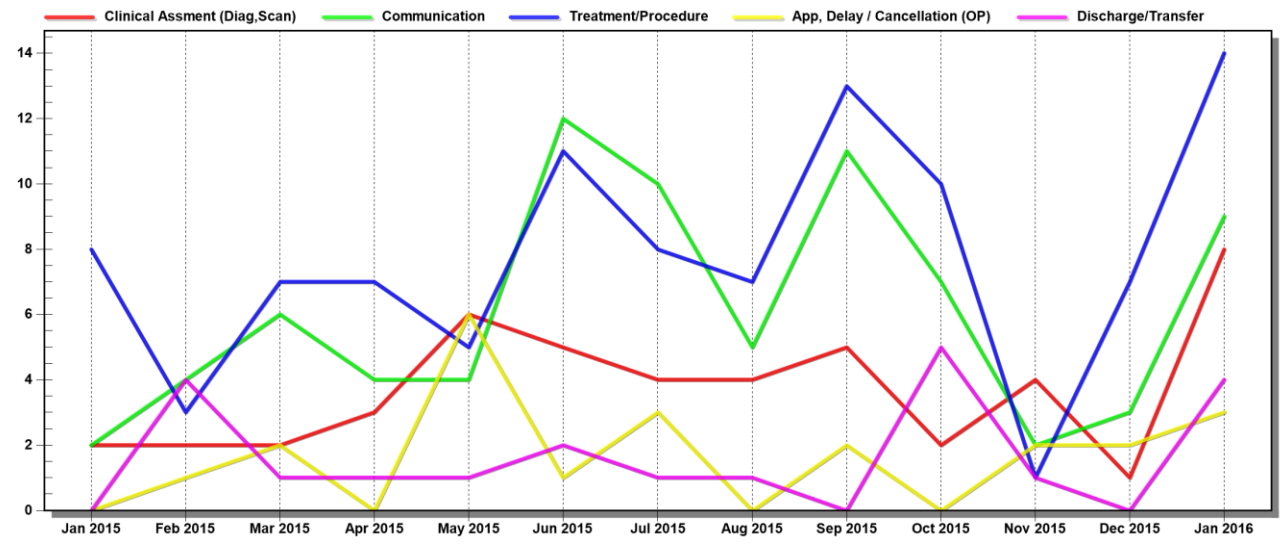
The table below includes the number of PALS concerns and formal complaints received in relation to discharge/transfer since January 2015.

The Healthwatch Trafford 'Report on drop-ins and patient feedback gathered for Trafford General Hospital' April 2015 refers to a telephone call received from a resident regarding an unsafe discharge (pg.11). The complainant subsequently contacted the Patient Advice and Liaison Service (PALS) to lodge a formal complaint, however consent was not received in order to progress this further.

All formal complaints are quality assured by Mary Burney, Trafford Divisional Director and have accompanying action plans in place to address any shortfalls in care. Completion of action plans are monitored by the respective directorate.

'Tell Us Today' commenced at Trafford in August 2014 and is now well embedded, providing patients and carers with the opportunity to access a telephone number 24 hours a day where they can speak to a member of staff independent to the ward. To date 34 calls have been received,
10 of which include an aspect of care relating to discharge. Concerns are responded to within an hour by a senior member of staff, aiming to address patient/carer concerns proactively. Tell Us Today has resulted in 4% of contacts being escalated into formal complaints and has been considered a success by the Trust.

Top 5 Category Types - PALS and Formal Complaints



Trafford Health Scrutiny Committee Questions

1. Geriatric Wards have Dementia/Alzheimer champions however some dementia and Alzheimer's patients are staying on other wards. When will all wards have Dementia/Alzheimer champions?

All medical wards at Trafford Hospital have a Registered Nurse and Nursing Assistant designated as dementia champions. Monthly meetings have commenced for dementia champions to support development of the role.

The Trust works closely with the Whitworth Art Gallery and a number of activity boxes have been made available to ward areas where patients with dementia are cared for i.e. Arts and Craft boxes. Staff and carers are encouraged to utilise the boxes to engage with patients. A number of hospital volunteers are also trained to use the activity boxes. Recently it has been agreed that each ward will advertise and recruit a Nursing Assistant with a particular interest in activities to optimise patient experience for this patient group.

225 members of Trafford Hospital staff have attended a 1 day dementia study day since April 2012. Age UK have also delivered training to 90 members of staff over the last 2 years on 'behaviours that challenge and therapeutic activities'. Dementia was chosen as a Hot Topic in March 2014. This comprises of a 1 hour training session, delivered twice daily throughout the month. 262 members of staff attended with excellent feedback. 'Barbara's Story' will be launched as a Hot Topic during 2016 to raise awareness of the impact of the healthcare system on patients with dementia and how we can enhance patient experience.

2. 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?

All nursing/residential homes assess patients for suitability prior to acceptance, therefore all homes are aware of any patient transfers that have been agreed, including discharge date. A printed copy of the discharge letter is provided for nursing/residential homes on discharge.

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

The Trust revised Adult Discharge Policy March 2015 has been provided as requested. The report provides an overview of discharge planning arrangements within the hospital and examples of improvement work.

4. 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?

Urgent Care Centre (UCC) staff have been requested to ensure that any patient documentation provided on admission accompanies the patient once admitted. Trafford Hospital has agreed care planning documentation that is used for all patients to support the delivery of person centred care. At present there are no arrangements in place for return of the original care plan provided by the resident/nursing home. The Discharge Team Manager will be asked to discuss discharge arrangements and provision of information at the appropriate nursing/residential home forum.

There is a well established individualised passport for Learning Disability patients, which remains throughout the inpatient stay, accompanying the patient on discharge. Trust staff contribute to the passport content as required.

5. 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…?

   On admission patients undergo a comprehensive nursing assessment including an evaluation of the patient's usual baseline in maintaining their activities of daily living. On the Acute Medical Unit patients are considered for referral to the Community Enhanced Care Team within 72 hours of admission to promote early discharge.

   A number of wards accept direct admissions, including stroke rehabilitation, neuro rehabilitation, complex discharge and fragility fracture/rehabilitation. All wards are supported with Allied Health Professional staff, physiotherapist and/or occupational therapist whose role involves assessment, goal planning and implementation of a plan for discharge. Patients where possible are encouraged to mobilise and engage in normal social activities, to promote and encourage independence and a sense of wellbeing.