TRAFFORD COUNCIL

Report to:	**Health Scrutiny Committee**
Date:	**15th March 2016**
Report of:	**Chairman and Vice Chairman of Health Scrutiny Committee**

Report Title

Dignity in Care Review – Follow up

Summary

To review the findings of the Dignity in Care report completed by the Committee December 2013.

Recommendation(s)

That the Committee agree the following recommendations and refer the report to the Executive:-

1) **That NHS Trust discharge procedures continue to be reviewed on an annual basis and refreshed when required.**

2) **That Trafford Council Adult Social Care, CMFT and UHSM work with Healthwatch Trafford in meeting the recommendations set out within their report.**

3) **That CMFT and UHSM discharge team managers meet on a quarterly basis in order to share best practice.**

4) **That UHSM have a representative attend Residential/Nursing Home forums.**

5) **That the minutes of forums attended by Residential/Nursing Homes and Hospital representatives be sent to Trafford Health Scrutiny Committee for information.**

6) **That CMFT look into broadening the scope of their Patient Passport for Learning Disabilities with support from UHSM.**

7) **That SRFT inform Trafford Health Scrutiny Committee of the results of the trial of the new Transfer of Care Form and if successful (and appropriate) to help other trusts implement a similar form.**

8) **That UHSM look into developing their relationship with Trafford Carers Centre with support from CMFT.**

9) **That Trafford Council discuss locality locations of Trafford Carers Centre with NHS Trusts.**

10) **That the TCCC is consulted by all trusts when making changes to communications procedures and/or technology.**

Contact person for access to background papers and further information:

Name: Alexander Murray

Extension: 4250

Background

1. In December 2013, Health Scrutiny Committee approved a comprehensive report based upon the work of a topic group (Appendix 1). The group was formed to look at the treatment of Trafford residents within the hospitals which provide them with care. The Committee agreed to follow up the recommendations of that review and this report sets out the findings of that process.

Scope

2. As this was a follow up review rather than a full Task and Finish Group topic the Committee gathered evidence from Nursing and Residential Homes, a report from Healthwatch Trafford (Appendix 2) and evidence made available by the trusts online e.g. complaints information. Once the evidence had been gathered representatives from University Hospital of South Manchester NHS Foundation Trust (UHSM), Central Manchester Foundation Trust (CMFT), Salford Royal Foundation Trust (SRFT), Trafford CCG, Trafford Council Adult Social were asked to the Committee meeting 10th February 2016 to answer questions formulated by the committee. The questions that the councillors asked focused upon areas that they deemed the most pressing given the information obtained.

3. UHSM, CMFT and SRFT representatives were sent copies of the evidence in advance of the meeting along with the most pressing questions that the Councillors had. UHSM and CMFT sent responses to the written questions in

advance along with a number of documents. Representatives then attended the meeting and answered further questions from Committee Members. The representatives of SRFT gave their apologies for the meeting and were sent the questions following the meeting via email.

Responses

4. Below are the responses received from each Foundation trust in response to the questions posed prior to and during the meeting. Due to the wide scope of the issues at hand and the integrated nature of health and social care services within Trafford there are also responses from Trafford Council and Trafford Clinical Commissioning Group included.

5. The Responses have been grouped into 4 Issues that were highlighted by the evidence gathered. These four issues are; effective discharge procedures, effective communication with nursing/residential homes, families and carers, Health in Hospital and Care of Patients with Dementia.

Issue 1: Ensure that there are effective discharge procedures

6. Prior to the meeting all three trusts were asked for copies of their discharge procedures.

7. Both UHSM and CMFT have had problems with the number of delayed discharges. This issue is being tackled by a separate Task and Finish Group of the Committee and all responses relating to that issue will be present in the separate report generated by that group.

8. The Councillors noted that the Discharge Procedures of both UHSM and CMFT had recently been refreshed in keeping with the recommendations of the original Scrutiny report. Each discharge policy was exhaustive in terms of details on all aspects of the discharge procedure.

UHSM

9. Representatives of UHSM assured the Committee that the length of the discharge policy was not an obstacle to it being followed. Each ward has a discharge nurse who knows the procedures “inside and out” and is responsible for seeing that the policies are carried out for each patient.

10. UHSM use a discharge lounge system for the discharge of patients. Councillors noted that the opening hours of the discharge lounge did not match those of hours for discharge from the hospital. UHSM responded that they try to avoid late discharges, after the lounge hours, if possible and that they are considering

extending the discharge lounge hours in line with the policy. It was also noted that when a discharge is not happening from the discharge lounge then those who are collecting the patient are informed of the alternate arrangements.

11. UHSM has recently commissioned Saint John's Ambulance Service for the discharging of patients. Healthwatch Trafford noted the services excellent manner in working with patients.

12. When discharging a patient to a care home UHSM's discharge nurses provide updates to the home of the status of their resident, often 24hrs prior to discharge. This has been agreed by UHSM's Heads of Nursing and Matrons as good practice.

13. Despite the excellent discharge policies Healthwatch Trafford did note a number of problems during their observations. Within the report are recommendations for work to alleviate these problems.

CMFT

14. Since the discharge policy was re-launched in 2015 a large scale training regime has been undertaken to ensure staff are familiar with the practices.

15. Trafford General does not have a discharge lounge but still ensures that patients are discharged in a timely and dignified manner. If any patient is discharged outside of the hours stated within the policy then an incident report is raised.

16. In Trafford General 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.

17. Once CMFT's new discharge team manager is in post they will attend an established Trafford residential/nursing home forum, aiming to improve communication between partners in relation to patient admission and discharge arrangements. Another forum which is facilitated by Trafford Council will have representation from Trafford General in future.

18. Healthwatch Trafford noted that Trafford General had excellent discharge procedures and noted areas of good practice within their report. However there were a number of areas for improvement linked to the creation of packages of care as laid out within the report.

SRFT

19. All newly qualified nursing staff take the Preceptorship Programme 2 year course for Patient Flow & Discharge Planning. SRFT also make staff aware of the policies via the Trust's intranet site synapse. Work is directly being undertaken within wards around discharge planning & patient flow through the Patient Pathway Managers.

20. Nursing & Care Homes attend the hospital and assess patients and inform SRFT when they have bed capacity and availability. The date is always agreed in advance as it is the care/nursing homes that inform the Trust as to availability. SRFT take this approach as it is understood that they are a private business and won't, for example, take patients on a Friday, take patients over the weekend or take more than 3 admissions a day. Where possible SRFT try to negotiate what time the patient will be discharged to the care home. SRFT aim for discharges to be conducted as early as possible but this is dependent upon transport.

21. If a patient is going home with a Package of Care and will require assistance administering medications this should be identified during the assessment by the social worker and details of those medications should be included within the care plan for the care agency. For patients who require assistance with medications arrangements can be made for the TTO's to be in a dosette box which indicates what medication is to be taken when in order to support care providers with administration. For patients requiring more complex support with medications such as Tinzaparin a District Nurse Treatment sheet should be sent to ask District Nurses' to administer.

Issue 2: Ensure effective communication with nursing/residential homes, families and carers e.g. ensuring documents submitted by these parties on admission stay with patients.

UHSM

22. When documents are submitted with a patient during their admission UHSM tries to ensure that those documents follow the patient to the ward. UHSM have a standard set of discharge documentation already in place but they expressed their willingness to make changes to these documents following a discussion with carers/care providers.

23. UHSM are currently looking at implementing a new electronic records management system. This system will enable staff to scan all documentation that is presented with the patient which will then be added to that patients file. The project team have weekly telephone conversations with the Trafford Care Coordination Centre (TCCC) to ensure that the new system will work with the TCCC to maximise its effectiveness.

24. UHSM are currently trialling a “Patient Passport” on the acute admission wards, which was initiated by the acute discharge nurses. The Patient Passport is a document that is filled out 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. At the meeting CMFT commented that they would like to bring in a similar document and UHSM said they would be happy to help.

25. The gap in communications between UHSM and patients families/carers was one of the main issues identified by Healthwatch Trafford. Whilst UHSM did state that they are willing to liaise with carers there is no clear conduit in place for this to happen such as the rapport which has been established by CMFT.

CMFT

26. CMFT have made a number of strides to improve the levels of communication between the trust, families, carers and social care professionals. Healthwatch Trafford noted the high levels of communication between CMFT, TMBC and community services within their report.

27. Trafford General 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.

28. 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.

29. 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.

SRFT

30. If a care plan arrives with the patient, it is kept with their Emergency documentation whilst they are in ED (Emergency Department). RNs are expected to read accompanying paperwork and the information contained may assist in the completion of ED paperwork (electronic). As a patient leaves ED and is admitted to the admissions unit or ward, the paperwork sent in with the patient is scanned onto the Trust Electronic Patient Record system, where it is available to be viewed by other Trust staff.

31. SRFT already have a Hospital Passport which can be used in a community setting as well. The family or carer for any patient with a cognitive impairment is offered one to complete to support care delivery. This is kept with the person at the bedside and is designed to be referred to before any care is delivered.

32. The hospital passport has an emphasis on personal information e.g. events from the patients past or their previous occupation etc. and how to keep them safe. Staff try to ensure contact details are kept up to date for who to involve in care, if needed, and who knows the patient best. This passport should be scanned into the electronic patient record and the original taken away with the patient. In this way if there are future admissions the information just has to be updated and not started again.

33. The SRFT Emergency Village have begun discussions with Salford CCG Safeguarding to pilot a standardised document to be used when patients attend ED from care homes. This Transfer of Care form has been designed in consultation with the Safeguarding Provider Forum, NWAS, SRFT, Care of the Housebound Group and Multi Agency Network. The aim is for the care homes to complete the form for each resident and review it on a monthly basis to ensure accurate interpretation of needs.

34. The transfer of care form will be kept in the front of the patients file, so that it is easily accessible, and given to NWAS prior to them leaving the care home. NWAS will pass this information to ED staff on arrival at hospital. The aim of the document is a one way process, with no requirement for the documentation to be returned to the care home once the patient is discharged from hospital, on the basis that a new transfer of care form is to be completed on readmission to the care home to reflect the changing needs of the patient.

35. The form has been designed to be utilised in all care homes within Salford. 2 nursing homes and 1 residential home have agreed to pilot the document.

36. When a patient is discharged from a general ward, a discharge summary is supplied and any significant changes to care are included. Ward staff will ring the

care home, usually a day or 2 before discharge, to discuss any changes in condition or care.

Trafford Council

37. Trafford Council are currently looking at the configuration of Trafford Carers Centre. The Acting Director for Education, Health and Care Commissioning stated that the council would be happy to discuss the community location of the carers centre with carers and the three NHS Trusts in order to redesign the service in a way that reflects the needs of service users and carers.

Trafford CCG

38. The implementation of the Trafford Care Coordination Centre is to be the key to the development of communications within Trafford. If correctly utilised the TCCC has the potential to align all aspects of Health and Social Care within Trafford and to utilise the data gathered to develop smarter ways of working. It is hoped that care homes and home care providers within Trafford will be able to sign up to the TCCC so that records will be consistent across all areas of health and social care.

39. The Health Scrutiny Committee recognises the pivotal role that the TCCC is to play within the future developments of the health landscape within Trafford. Because of this they were particularly happy to hear that UHSM consult with the TCCC on a weekly basis regarding the creation of their new records management system and highlighted this communication as an example of best practice.

Issue 3 – Patient Health in Hospital

UHSM

40. UHSM assess all patients on admission to Hospital around their activities of daily living, which includes assessing their safety. All patients are encouraged to be as independent as possible in line to what they are assessed as being able to do; in some cases this can be a multidisciplinary assessment which would include therapy input.

41. UHSM use the red tray system whereby patients who are identified as requiring assistance with eating or as having lost weight are served their food on a red tray so that staff are aware of their requirements.

CMFT

42. 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.

43. 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.

44. CMFT also use the red tray system for those identified as needing assistance eating or having lost weight.

45. Both UHSM and CMFT strive to respond to weight loss of patients, by making adjustments to policy and the way that food is prepared and offered to patients, it is recognised by all that Hospital is not the best environment for people to be in. As such CMFT, UHSM, Trafford CCG and Trafford Adult Social Care are working together to minimise patient's length of stay and avoiding unnecessary admissions to hospital in order to reduce the impact on residents health.

46. Both UHSM and CMFT confirmed to the Committee that Catheterisation of patients during their stay only occurred for clinical reasons. Both Trusts keep a log of all patients that are catheterised and should any carers believe that a patient had a catheter fitted for no reason then this should be raised with the trust.

SRFT

47. All SRFT patients are individually assessed and plans of care are developed following that assessment. Where patients are able to do this unaided SRFT, as a nursing service, ensure that this is understood. Where patients need support and assistance then this too is assessed against the patient's individual needs. At all times maintenance of independence is considered a priority.

48. It was noted within the original report that SRFT had excellent dietary support in place. However, they have also been striving to reduce patients' length of stay (LoS) and over the last year they have achieved a reduction for both elective and non-elective LoS when compared to the previous year. Reducing LoS was designed into many work streams within this financial year which has supported

the reduction. These include; the redesign of the patient flow team to support complex discharge arrangements, reconversion of surgical activity from inpatient to day case, redesign of pathways to support weekly discharge with support from primary and community services.

49. The SRFT's position regarding catheterisation is that a patient will only be catheterised when there are clinical indications that a catheter is required. If a catheter is in situ for any other reason than those defined by the Catheter Urinary Tract Infection Collaborative it would be deemed as inappropriate and there would be an expectation that the catheter would be removed at the earliest opportunity.

50. The latest Safety Thermometer Data indicates that on average approximately 18% of hospitalized patients within SRFT have a catheter (this is a reduction from approximately 22% in the last 18 months).

Trafford Council

51. Trafford Council has recently introduced a Stabilise and Make Safe (SAMS) service which is showing promising results and Trafford plan to commission additional resource in this area. Trafford Council is also looking at improving the homecare service provision in order to streamline the process so patients can return home quicker.

Trafford CCG

52. Trafford CCG has commissioned an additional 18 intermediate care beds at Ascott House and is looking to expand this service further. Trafford CCG has also re-shaped their Continuing Health Care (CHC) procedures to ensure that Trafford has one of the most efficient CHC teams in the Country.

Issue 4 - Care of Patients with Dementia

UHSM

53. UHSM have dementia champions on their elderly patient wards and are looking to expand this. UHSM have implemented a Nurse training scheme where by those nurses on a band five can receive dementia speciality training so they can move up to a band six within a year.

CMFT

54. 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.

55. 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.

56. 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.

SRFT

57. There is a dementia link nurse on every ward at Salford Royal Hospital. This has been the standard procedure for the last three years.

Health Scrutiny Response

58. The Health Scrutiny Committee members were happy with the responses given by all those who attended the meeting and those received from SRFT via email. Councillors were also impressed by the level of work that was evident from the documents provided. All of the organisations showed that they are continually striving to improve performance and there were clear signs of integration in all areas of work.

59. The work by CMFT to set up communications with Trafford Carers Centre and working with Trafford Council in establishing communications with Nursing and Residential Homes were two areas that the Committee would like to highlight. This work goes a long way to overcoming the standard silo approach which has been taken to Health and Social Care in the past and creating a truly integrated service within Trafford.

60. UHSM's work with Trafford CCG and Trafford Council is another area that the Committee recognised as a sign of working collaboratively in order to tackle the challenges that the sector faces. This was most evident within the meeting itself where every single response to each question involved representatives from multiple organisations. The Committee welcomes and encourages this relationship and hopes that it can help play a role in furthering its development.

61. The Committee are very interested in the development of the Transfer of Care Form being developed by SRFT and would like to be informed as to how successful it is during the trial with the two care homes. With their responses SRFT have shown that they carry out best practice across the board which is

reflected in the small number of recommendations which apply directly to them. Because of the high standards at SRFT the Committee hopes that SRFT will adhere to those recommendations that request the sharing of information and best practice amongst trusts.

62. Despite the positive nature of the responses given by the trusts the Committee would like to point out that while gathering their evidence for this review there were still worrying accounts of instances where patients were falling through the gaps. The committee recognises the volume of work that is being done within Trafford and that the instances which were reported are the statistical anomalies that make up a tiny proportion of the cases that each organisation deals with.

63. Whilst the instances may be statistically insignificant those cases are extremely significant to the people it happens to. It is the role of Health Scrutiny to ensure that patients are at the heart of all health and social care practices, policies and decisions so the Committee will continue to scrutinise all Health and Social Care organisations whenever such cases are brought to them. The Committee hope that when instances do occur in the future that the trusts respond in the swift positive and open manner with which they responded to both the original report and this subsequent review.

64. The Committee recognise that it is practically impossible to remove all errors from the process. However, It is hoped that by continuing on the path of collaboration and spreading communication networks to encompass carers, residential and nursing homes and homecare providers that instances where things go wrong will be reduced and gaps within policies, procedures and practices will be identified and resolved as quickly as possible.

65. Finally the Committee would like to thank Healthwatch Trafford and their volunteers for the role they played in the gathering of evidence for this review. The report that they produced and the recommendations made within it were of great help to the Committee in the preparations for and creating of this follow up report.

Recommendations:

1) **That NHS Trust discharge procedures continue to be reviewed on an annual basis and refreshed when required.**

2) **That Trafford Council Adult Social Care, CMFT and UHSM work with Healthwatch Trafford in meeting the recommendations set out within their report.**

3) **That CMFT, UHSM and SRFT discharge team managers meet on a quarterly basis in order to share best practice.**

4) **That UHSM have a representative attend Residential/Nursing Home forums.**

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