

WANDSWORTH BOROUGH COUNCIL

ADULT CARE AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE
- 4TH APRIL 2011

EXECUTIVE – 11TH APRIL 2011

Report by the Director of Adult Social Services on improving the provision of hospital discharge and aftercare in Wandsworth

SUMMARY

Background

The Wandsworth LINK have reported on how people experience hospital discharges focussing primarily but not entirely on patient/service user experiences from St Georges Hospital. This is a joint response from the key stakeholders; St Georges Hospital, NHS Wandsworth, South-West London and St Georges Mental Health Trust and Wandsworth Adult Social Services following a meeting with the LINK. This response will be presented for information to the shadow Health and Wellbeing Board.

Policy

Hospital discharge was chosen as one of Wandsworth LINK's four priorities for 2010/11 within their statutory remit. The LINK utilised their Enter and View powers undertaking two separate visits to St Georges Hospital.

Issues/Proposals

The hospital discharge process is a key interface between health and social care services as it is often a critical period for determining opportunities and approach to the effective rehabilitation or "Reablement" of the patient following a hospital stay.

Director of Finance comments

None.

Supporting Information

Wandsworth LINK report "Improving the provision of hospital discharge and aftercare in Wandsworth" (December 2010) is attached as Appendix 1 to this report

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Conclusions

The LINK report recognises strong partnership arrangements in Wandsworth to support hospital discharges and identifies a number of areas where further improvements can be achieved. These are broadly recognised by the Council, St George's Hospital, NHS Wandsworth and other health providers who are working together on joint action plans to embed further improvement.

GLOSSARY

LINK	Local Involvement Network
GP	General Practitioner

Recommendations

1. The Adult Care and Health Overview and Scrutiny Committee are recommended to support the recommendations in paragraphs 3.
2. If the Overview and Scrutiny Committee approve any views, comments or recommendations on the report, these will be submitted to the Executive/General Purposes Committee for their consideration.
3. The Executive is recommended to receive this report for information.
4. **Introduction.** This report is a joint response from NHS Wandsworth, St Georges Hospital Trust and Wandsworth Adult Social Services to the Wandsworth Local Involvement Network's report on 'Improving the Provision of Hospital Discharge and After Care in Wandsworth (December 2010)'.
Wherever the patient's medical condition allows it, forward planning of discharge should take place to ensure that there are no delays in discharge, in providing medication, transport or writing discharge summaries.
5. The full LINK report is attached at Appendix 1. This joint response has focussed upon chapter five detailing the recommendations proposed which have been responded to below:-
 - (a) **Wherever the patient's medical condition allows it, forward planning of discharge should take place to ensure that there are no delays in discharge, in providing medication, transport or writing discharge summaries.**

St. George's Hospital recognises the importance of effective discharge planning and that further improvements can be made. Actions recently put in place include incorporating discharge planning in the patient's main notes to aid communication and the introduction of a new discharge planning checklist and increasing the number of Nurse Facilitated

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Discharges. From a community perspective the proposed recruitment of GPs and social workers within the “Virtual Wards” scheme will help support care arrangements to be in place to receive the patient on discharge from the hospital.

(b) **Discharge should not be postponed overnight if everything is in place.**

This is agreed by all parties. Once the patient is deemed fit and preparations have been made for any further support at home they should be discharged. Support is available to patients returning home after 8 pm but often they state a preference not to go home late at night. A joint protocol on discharge planning including consideration of how to support effective discharge earlier in the day will be followed up.

(c) **The patient, his family and/or carer should be informed about discharge plans well in advance to enable them to make preparations accordingly. The communication of the discharge plan to the patient and family or carer should be recorded.**

Communication of the discharge plan is now recorded in the patient’s main medical notes. The expectation is that the patient will inform their family/carers about their discharge unless the patient is unable to make decisions for themselves and this message will be actively reinforced. To further improve communication the partner organisation will prepare a booklet which clearly states responsibilities and signposts where advice, information and other support can be sourced;

(d) **Hospital staff should consider the patient’s home situation and the housing situation when planning each hospital discharge.**

This is agreed and all patients are asked about their home situation on admission and encouraged to raise any concerns. There is close working between Adult Social Services and Community Services Wandsworth to ensure a responsive service enabling patients to be cared for in their own home. Where appropriate a home assessment takes place or a referral is made to the Adult Social Services by the hospital;

(e) **At discharge, all patients should be given a discharge summary which is copied to their GP. The information given to the patient should include written guidance on how best to recover as quickly as possible, what to expect and whom to contact if in doubt about their recovery.**

The hospital aims to get all Discharge Summaries to the GP within 24 hours with a copy to the patient and where feasible this is handed to the patient at the point of discharge. Integration of Community Services Wandsworth with St Georges Hospital has enabled improved sharing of

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patient lists to help identify where input is most required. A workstream has been identified within St Georges to review working arrangements and will report back to the LINK separately;

- (f) **Discharge Co-ordinators should receive more training on the role of social care assessment staff (care managers) and community support services.**

Over the past nine months a number of events have been held to engage and promote improved joined up working and the further potential is recognised. In 2011/12 a training and events programme will be implemented to promote further integrated working, build networks and break down cultural boundaries to benefit the patient/carer experience.

- (g) **The Discharge Co-ordinator should routinely make telephone contact with the discharged patient 2-3 days after discharge to check if the discharge arrangements are working out well. The Discharge Coordinator must ensure that the patient's GP is informed.**

It is not feasible for all patients to be contacted by phone on discharge but where the discharge has been particularly complex Discharge Coordinators will continue to contact these patients. GPs are informed by means of the Discharge Summary and patients are also encouraged to contact their primary care links where appropriate. Community Services Wandsworth has a pilot scheme operating where intermediate care staff make telephone contact with the patient post discharge and if any concerns are reported a senior nurse or therapist will attend to make an assessment;

- (h) **It is imperative that the work of the Discharge Co-ordinator is extended to cover weekends as well as week days.**

This point has been considered in depth and it is not thought to be an effective solution in improving discharges. The discharges that occur at the weekend have either been planned in advance by the discharge coordinators or are simple discharges of patients that the ward staff manage.

- (i) **GPs must take more responsibility for their registered patients post-discharge. Especially where the patient was hospitalised as a result of a referral by the GP, the GP should contact the patient within 2-3 days of discharge.**

GPs are responsible for their patients but they are not always aware that the patient has been hospitalised. As stated above the aim is to ensure that GPs are advised within 48 hours if a patient has been admitted and thereon they will be kept informed;

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- (j) **The focus given to hospital discharge at St George's is something we would like to see in all hospitals. Such focus should be given bearing in mind the need to work in conjunction with Community Services.**

Whilst the initial work of the integrated community service is being led by St George's, it is a pan-Wandsworth project and will interface with other providers i.e. Kingston, Chelsea & Westminster and Guys and St Thomas's Hospitals. It is the intention to test with St Georges Hospital and roll out to all other Trusts in the area. Therefore it is agreed that discharge arrangements will be afforded a similar priority in all hospitals with an intake of Wandsworth residents.

- (k) **Processes should be put in place for periodic review and monitoring of hospital discharge processes and practice.**

Both health and adult social care services are awaiting further details of the Government's proposed performance framework which it is anticipated will encourage joint working and offer opportunity to promote more complementary arrangements. This will include periodic reviews of hospital discharge processes and practice. All health and social care partners in Wandsworth are committed to this approach.

6. In making this joint response the health and social care commissioners and providers in Wandsworth have provided assurance that many of issues identified in the report were already identified and being acted upon. However, recognising the overarching importance of the approach to hospital discharge and aftercare in Wandsworth the recommendations from the LINK supports the constructive partnership approach which is focussed upon achieving service improvement for the patient/service user and carer.

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25th March 2011

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Background papers

There are no background papers to this report.

All reports to Overview and Scrutiny Committees, regulatory and other committees, the Executive and the full Council can be viewed on the Council's website (www.wandsworth.gov.uk/moderngov) unless the report was published before May 2001, in which case the committee secretary can supply it if required.