NHS Response

Improving Discharges from hospital in Oxfordshire **Healthwatch Oxfordshire Report recommendations**	**NHS response:**
1. Hospital trusts should take immediate action to increase the percentage of patients whose estimated date of discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway. `	• It is important to understand that not all patients require an estimated date of discharge (EDD) to be set within 36 hours of admission. Many patients are admitted for less than 36 hours and for some complex patients it takes more than 36 hours to complete all the diagnostic tests required to allow the clinician to decide on how best to manage the patient. • However, it is the aim of all hospitals in Oxfordshire to ensure that a planned discharge date be set within 36 hours for all relevant patients • Patients are reviewed twice daily in what is known as 'board rounds' during which their EDD is reviewed. Regular audits take place to check the setting and accuracy of EDD.
2. Patients should be assigned a named discharge co-ordinator and be given the details of how to contact that person at the point of their estimated date of discharge.	• We do not agree that every patient requires an allocated discharge coordinator. The Discharge liaison nurses add value in supporting those very complex discharges through a case management approach. We are reviewing the way the current discharge liaison team functions to provide greater support across the trust for very complex discharges. • The named nurse should be identified to the patient and their family as a main point of contact in the event of any queries regarding discharge.
3. The planning for discharge ward poster produced by the OUHT should be redesigned as the leaflet is given to all patients and their families. Their discharge co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.	• We are jointly reviewing discharge posters and leaflets for patients. The aim is to have a single comprehensive leaflet, which will include standard useful information, but will also include a section with personalised discharge information for that patient. Healthwatch approved the wording on the current poster and it is likely we will adopt the same language in the patient leaflet. • A discharge care plan will be developed for each patient, which will include the named nurse and provide contact numbers in the event of discharge queries.
4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care	• We don't agree that every elective patient requires an allocated discharge coordinator. However, the named nurse will be identified to the patient as a point of contact in the event of discharge queries. • For elective patients – a pre-operative assessment processes will include a discussion on any caring

arrangements for those they are caring for can be put in place.	responsibilities the patient may have and this will be incorporated into their admission and discharge plans. If necessary, a Section 2 referral can be made to social care for an assessment of need. • For patients admitted non-electively, then the admission assessment should include a question about any caring responsibilities and if necessary a S2 referral can be made to social care. New Contract (Carers' Support Services): The contract will continue to be delivered through Carers Oxfordshire for the coming 3 years. It brings together a new alliance of the county's leading carer support providers Action for Carers Oxfordshire, Rethink and Guideposts into this new partnership. The support available to assist carers includes; Access to information, support and advice; Face to face support ; Volunteer respite; Peer support and information and training. Carers' Assessments: Carers are also invited to access Carers' assessments. These assessments are provided jointly by the Oxfordshire Clinical Commissioning Group (OCCG) and Oxfordshire County Council (OCC). Support plans, including relevant information, registration for the Emergency Carers Support Service (ECSS) and potentially a 'one off' Personal Budget to address health and wellbeing needs, will then be produced from these Carers' assessments. Respite: Carers who care for someone who is eligible for social care may also benefit from respite care and support.
5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them.	• Each patient will have a named nurse who will be the main person to communicate with families. In the event of a patients having more complex discharge needs then one of the discharge liaison nurses will support the communications with families. • A Trust-wide multidisciplinary discharge workshop was undertaken in October 2015 which was well attended by large groups of staff. This included training in the management of complex discharges and communications with families as well as information on services available to patients and their families. An ongoing program of discharge workshops is planned.
6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be	• The Trust agrees that for patients with complex or specific discharge needs a personalized discharge plan should be in place that the patient could take home. This will be included in the new patient discharge leaflet. For very simple discharges where the patient does not have any specific post discharge needs then standard discharge information will be provided.

given to the patient and the carer every time this is updated and reviewed.	
7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services.	• The Trust agrees that this is appropriate for patients with specific or complex discharge needs and this personalized information will be included in the patient discharge leaflets which they will take home.
8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: • Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged. • Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why. • Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. • Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.	• Electronic prescribing and administration of medicines has been implemented across the OUH since May 2015 apart from JR maternity. • It is currently in place as part of the commissioning contract to prescribe 2 weeks take home medication on discharge. • The OUH has an electronic pharmacy tracking system. Ward staff are able to track at patient level through the prescribing, dispensing and checking process each patient's TTO is up to. This enables them to provide update to date information to the patient and to escalate any delays. • The Trust has agreed pharmacy turnaround times which are monitored through the Trust discharge assurance group. • Regular reports on prescribing are published on the Trust business information system and are available to all divisions. TTO prescribing performance is monitored through the Trust discharge assurance group.
9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.	• The discharge summary is being redesigned with input from clinical staff including GPs and pharmacists.
10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to	• The discharge summary is sent electronically to GPs and is monitored weekly by the OUH and OCCG. • A hard copy is given to the patient when they are discharged.

the patient and his/her carers when s/he leaves hospital.	
11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.	• The Trust agrees this is good practice and consultants and senior nurses will regularly contact GPs to discuss individual patients on an individual basis where appropriate.
12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.	• Hospital doctors take responsibility for acting on tests they request as per GMC guidance. Some results may only be completed once the patient has been discharged and agreement will be made with the GP on how these results are followed up.
13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.	• Sharing agreement already in place.
14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.	• We review readmissions to hospital in a number of ways: 1. Readmission rates to hospital within 30 days are monitored every month. 2. We use software to alert the hospital and CCG if any specialty appears to have an increased rate of readmissions and we investigate these alerts to make sure there are no patient safety issues. 3. We undertake an annual readmission audit to ensure there are sufficient services in the community to support patients following discharge from the hospital 4. If a patient suffered harm as a result of being discharged too soon, the hospital would undertake an investigation to prevent similar incidents