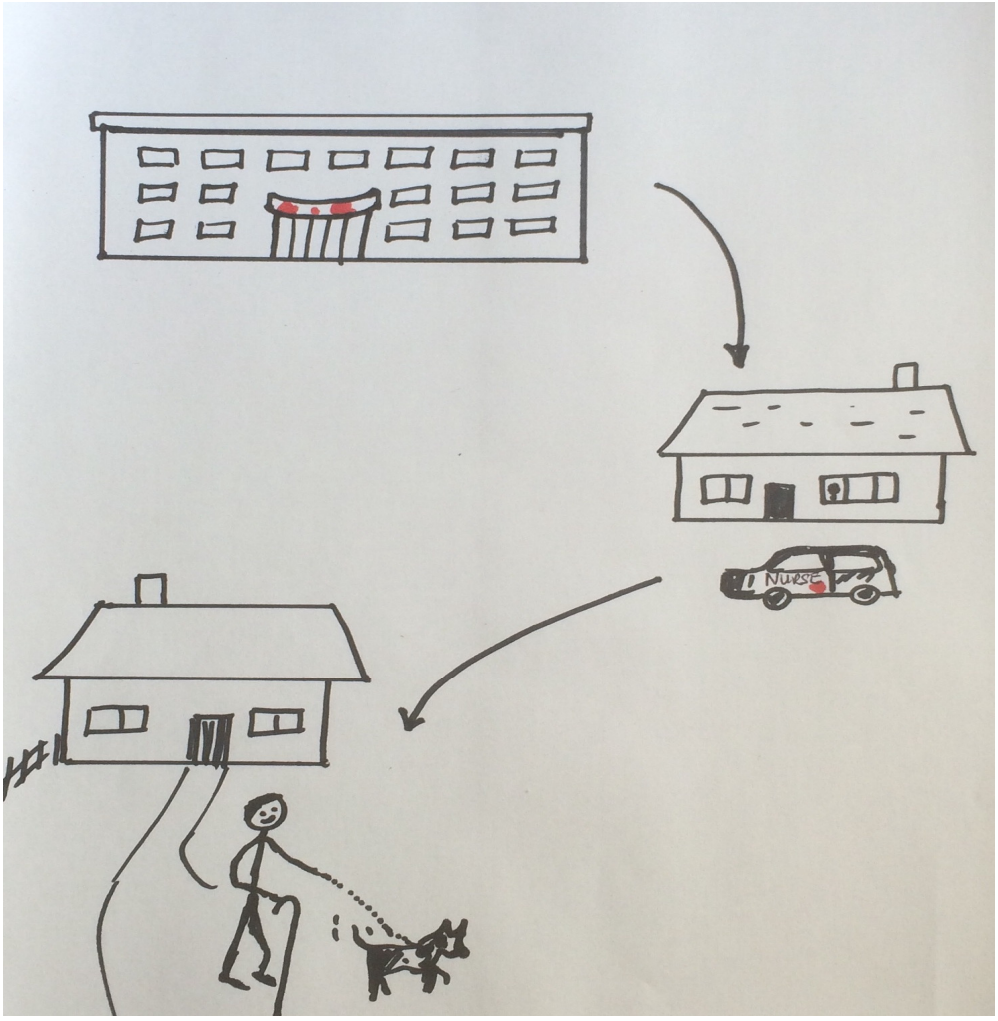
Acute Hospital Discharges

A Review by Derbyshire County Council - Improvement and Scrutiny Committee – Health



Final Report of the Review Working Group
September 2016

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Acknowledgements –

The review working group would like to thank the following people for their kind involvement in this review:-

Helen Hart – Healthwatch Derbyshire

Lee Doyle – Derby Royal Hospital

Debbie Eardley – Chesterfield Royal Hospital
Sally Wilson – Chesterfield Royal Hospital
Rachel Whyman – Chesterfield Royal Hospital
Warren Hutson – Chesterfield Royal Hospital

Andrew Milroy – Derbyshire County Council, Adult Care
Tanya Henson – Derbyshire County Council, Adult Care

Julia Davies - The Milford Group
Stephen Beecham - Amber Lodge Nursing Home, Derby

1. Scope of the Review

The Committee, at its meeting on 16 March 2015, considered a report from Healthwatch Derbyshire on arrangements for discharging patients from Acute Hospitals. The report referred to recent research and evidence gathered by Healthwatch Derbyshire on patient experiences when being discharged from Acute Hospitals, principally the Derby Royal and Chesterfield Royal Hospitals.

Evidence showed some positive patient experiences but there was sufficient negative feedback to warrant further investigation to assess areas for potential improvement.

The Scrutiny Review of Acute Hospital Discharges will look at the current processes used to discharge patients, identify delays and other obstacles and ascertain potential improvements which could be implemented to achieve a more efficient discharge process and better patient experience. An emphasis will be placed on the discharge of frail, elderly and vulnerable patients.

It is proposed that evidence will be sought from a number of sources including;

- Acute Hospital Managers and staff,
- Care Home managers
- Social Care managers/workers
- Healthwatch Derbyshire

The key outcome of the review should be the identification of potential improvements to the discharge process which would be referred to the service provider organisations for consideration.

2. Initial Research and Evidence

2.1 Evidence from Healthwatch Derbyshire

In the course of Healthwatch "Enter and View" visits to Care Homes during 2014, a theme emerged in respect of the discharge process from hospital back to care home, with many examples of unsatisfactory discharge experiences being highlighted as a concern by some of the homes involved. Examples include:

- Some homes sent care plans with residents and felt that this was a useful resource although on some occasions information had been lost by the Acute Care providers, or at least not used to its full potential.
- Other useful information about the resident does not move between wards and gets misplaced, as can medication, personal possessions and aids.
- Discharge information is sometimes lacking in detail or inaccurate about future care needs.
- Provision of the correct medication at discharge is variable.
- Communication about discharge arrangements is often poor.
- On some occasions residents are inappropriately dressed for discharge.

Some of these issues simply present an inconvenience to the care home, but in some circumstances situations have occurred which caused distress to the resident and, at worst, have presented a risk to patient safety.
One incident highlighted involved a resident who had to be immediately returned to hospital because appropriate actions had not been taken to control their diabetes during the discharge period.

Healthwatch considered that there was enough evidence to warrant referring this issue to the Health Scrutiny Committee which led to this review being undertaken.

The working group noted that, at the beginning of this review, the situation surrounding discharging patients from Acute Hospitals remained the same as it was when Healthwatch undertook their original investigations in 2014. There were still delays, due in the most part to poor communication between the divisions within the hospitals. This had resulted in some patients being discharged without the basic necessities when they reach their home, such as;

- Food
- Warmth
- Medication
- Carer at home if necessary

A common example of lack of communication is having no access to pharmacy services at the time a patient was being discharged (often as this was when the pharmacy was closed). This usually results in either the patient remaining at the hospital for longer than necessary, or medication having to be sent to the patient's home at a later stage, often by taxi.

Another major factor in delaying discharge is ensuring that funding for care packages needed to be in place for the patient as they arrive home. This again required efficient communication between the Acute Hospitals and providers of on-going care.

2.2 Evidence from Derby Royal Hospital

The working group met at Derby Royal Hospital with Lee Doyle (Derby Royal Hospital General Manager, Integrated Care and Discharge) and received the following information;

- In 2012 the Derby Royal Hospital (DRH) had identified that there were a number of issues causing delays to the discharge process. Lee Doyle had been appointed to implement transformation to improve the patient experience.
- Many problems arose around the discharge of a patient when they had to go from the Hospital to a new care setting (residential or nursing home) as a result of their additional needs following their acute illness/injury.
- Working with South Derbyshire CCG, the Hospital has created a "Pull Team" comprising nurses and adult care professionals and introduced a "white board" electronic system to facilitate a more efficient discharge process. The system was demonstrated to the working group and it showed how it used a "traffic light" method of alerting all key staff to the discharge date of a patient and the needs they had to have addressed before that date arrived. The system was linked to Derby City Council services for the necessary referrals and work was in progress to enable Derbyshire County Council to use it too, although the larger geographical area of the county, with its 4 locality teams, required additional work to achieve full efficiency.
- DRH was working with Chesterfield Royal (CRH) and Derbyshire County Council Adult Care teams to try and improve the working relationships with Care Home settings and they were currently trying

to get 2 or 3 homes to work with them on this. If Derby City Council, Derbyshire County Council, the CCGs and the Acute Hospitals worked together they could improve the process for getting patients into the most appropriate care setting for their needs – thereby releasing acute beds more swiftly. It was noted that the review working group would be meeting with the Chief Nurse at Chesterfield Royal in due course.

- South Derbyshire CCG have commissioned a number of care home beds to use as a "step-down" facility which will help release acute ward beds but ensure the patient receives additional care before going back to their own home or a new full time care home placement.
- Additionally, it was proposed that there would be an increase of "virtual ward" beds based in Community Hospitals to provide a further "step-down" facility.
- It was considered by the Derby Royal Hospital that Derbyshire County Council is a very helpful Authority in supporting those people who are self-funding under the new regulations introduced by the Care Act and the Council provides useful advice to people who have to buy in their own care. The hospitals also help with this as they can advise patients and their carers about the level of care they will need once they are discharged from acute care, and sign post them to the appropriate care settings they should consider. It is in the interests of the acute hospitals to assist patients to move back to their own home or into residential care settings as soon as they are discharged and offer as much advice as possible.
- Reference was made to incidents where the families of some patients blocked the system to keep their relative in the acute hospital ward to delay placing the patient in a care home setting, whether for cost issues or, as in the case of one example, while adaptations were being made at the patient's home. This was an abuse of the system and an inefficient use of acute hospital resources.
- There were also additional delays with patients from across the county borders and there was a need to improve the working relationship with the Adult Care teams in Leicestershire and Staffordshire County Councils.
- The DRH had implemented a system where the families of vulnerable patients were notified by letter (one for each week that their relative remained in acute care after their discharge date) that

they should make arrangements for alternative care or – after a period of 4 weeks, the hospital would find alternative accommodation on behalf of patient with the expense being passed on to the family.

- Access to Dementia care beds was a particular issue as there is a shortage of facilities and dementia care nurses with a limited number of providers of this type of care.
- Once a patient has been discharged to a care home setting, DRH works with the CCG and the appropriate local authority to try and return the patient to their own home. This does depend on their needs, especially in respect of night care.
- In respect of seasonal pressures, the DRH has created a "Ready to Go" programme. At the date of the discussion (August 2015) this method operated across 16 wards, with a further 8 wards scheduled for inclusion. The "Ready to Go" programme facilitates an efficient communication stream for each patient and ensures that, as the patient is signed off for discharge from acute care (by an appropriate clinician) they are informed that they are "ready to go" and all relevant parties to their discharge process – such as pharmacy, transport and follow on care – contribute to the process at the same time so that there are no blockages in the process. This is a relatively new scheme and the DRH was currently raising awareness amongst clinicians and senior nursing staff to ensure that all the needs of the patient are addressed in time for the discharge date.

How can Care Home settings help with the process?

- The DRH often has to wait until it is convenient for a Care Home to accept a patient (particularly this has to be when a home manager is available). As this is not a 24/7 option, delays are often caused. It was noted that, to offer an incentive to Care Home providers, Chesterfield Royal Hospital offered a £100 payment to accept a patient at the time/date the hospital wished to discharge them.
- The acute hospitals would like information from Care Home providers to ascertain how the discharge process can be improved upon and would welcome suggestions to facilitate a more efficient process.

Transport

- It was noted that the onus was being placed on patients to request transport home – instead of this being offered as a default option.
- A new contract for hospital to home transport was to be awarded in April 2016.

"One Stop Shop" Hub

- Before leaving the hospital, the working group visited the Hub office near the main hospital reception. Here, patients and their carers and visitors to the hospital had access to information on a broad range of services including Welfare Rights, Adult Social Care, Fire Service and voluntary groups including Age Concern and a "home from hospital" volunteer support service. This facility provided advice and support on many issues which were pertinent to patients leaving the hospital and helped to enhance the patient experience of the discharge process.

2.3 Evidence from Adult Care Department Officers

The working group met with Andrew Milroy, Assistant Director, and Tanya Henson, Group Manager, of the Council's Adult Care Department. In advance of the meeting the officers had supplied Members with a briefing paper which set out the current discharge processes and improvements that had recently been achieved by collaborative work with NHS partners. This paper also set out the potential development opportunities which the Adult Care team has identified and also the challenges envisaged in working with numerous partner agencies. The meeting used this as the basis for a more detailed discussion and the following issues were noted;

- It was considered that the challenges facing the NHS and their partners, particularly in respect of winter pressures, were increasing every year. This was due to an aging population and financial pressures faced by the NHS service providers and the County Council.
- The review working group Members discussed their findings following the meeting at Derby Royal Hospital with Lee Doyle when it had been noted that considerable improvement had been made in respect of the internal communication process, achieved

predominantly through the introduction of the “intelligent” whiteboard system described earlier in this report.

- As well as the improved internal communication systems (such as the one in place at DRH) there also needs to be good communication between the Acute Hospitals and partners who have to put measures in place to receive discharged patients.
- It was noted that Derbyshire County Council had been identified as an exemplar of good practice in that no patient had been delayed from discharge from acute care due to lack of funding being in place for their follow on care. The Council has an excellent record of assisting patients in accessing – and funding - their appropriate after-care needs. This had also been highlighted at the meeting with DRH.
- Derbyshire County Council’s Adult Care Department has produced a leaflet for patients and their families on what to expect whilst in acute care – and upon discharge.
- The meeting with DRH made reference to some discharge delays being created by patients’ families who were slow to arrange alternative accommodation for their relatives on leaving acute care. It was agreed that this did occur but not sufficiently frequently to make a huge difference to the discharge process as a whole.
- Examples of initiatives to enable speedy discharge processes were discussed, including Doncaster Royal Infirmary’s “Discharge to Assess” policy. This entailed moving the patient from the acute ward to an assessment setting to enable their needs to be considered prior to them being fully discharged. This worked successfully providing there was capacity in the final destination, whether that was returning to the patient’s own home (with care packages in place if necessary) or to a suitable care home setting.
- The Council’s Adult Care Department was working to mitigate problems of delayed discharge from acute care to residential care homes through negotiations for contract renewals with private care home companies. Reference was made to the potential for Acute Hospitals to offer financial incentives to care homes to accept a patient as swiftly as possible. The working group Members had concerns over this initiative as, although it may be cost effective for the Acute Hospital, it may not necessarily be in the patients’ best interest and, in extreme cases, could compromise patient safety.
- The following points were highlighted as having the potential to improve/speed up the discharge process;

- The increase in Hospital consultants being present 7 days per week
- An assessment process beginning prior to patients being referred or admitted to Acute Care – or as soon as possible if taken in on an emergency basis – so that "exit strategies" can be planned as soon as possible. This should provide patients with a plan, shared with their family members, which explains their discharge from acute care and how their needs will be addressed at that stage.
- Developments under transformation programmes, such as the #21C Care agenda, aim to provide a more seamless care pathway in local communities and this should take into account the transfer of patients across different care requirements.
- Social worker placements in GP practices to identify social care needs and to support patients either through the Acute Hospital care process – or to help prevent them being referred to acute care in the first place.
- The use of "MARAC" style processes (Multi Agency Risk Assessment Conferences) for the most vulnerable patients to include input from all relevant stakeholders in a patient's care, such as GPs, Housing providers, Adult Care services and care home managers. These may prevent a patient having to be admitted for Acute Care, or assist in the discharge process by having care in place at the appropriate time. The MARAC process was commonly used to support victims of domestic violence and is an example of best practice in drawing together a number of agencies to provide a bespoke package of support for an individual.
- A change of culture within health and social care provider organisations which embraces flexibility to suit the needs of each patient/client.

At the conclusion of the meeting it was agreed that the Adult Care officers would be invited to contribute to the formation of the review recommendations and their briefing paper would help inform decisions on the recommendations to be developed.

Members requested that feedback on the progress of work with the Acute Hospitals be provided to the working group via the Improvement and Scrutiny Officer.

2.4 Evidence from Chesterfield Royal Hospital (CRH)

The working group met with the following staff at Chesterfield Royal Hospital;

Debbie Eardley - General Manager, Medical/Emergency Care (M/EC) Division
Sally Wilson - Matron, Clinical Operations, M/EC Division
Rachel Whyman – Head of Nursing, M/EC Division
Warren Hutson – Discharge Co-ordinator, M/EC Division

The Hospital representatives outlined their roles and the Acute Care discharge process at CRH was discussed. It was noted that;

- An assessment of each patient was undertaken by a multi-discipline team on the Acute Care wards. As well as the appropriate health professionals, teams would include County Council Social Care staff if care packages were needed to ensure a patient could be discharged safely.
- The discharge teams were aiming to identify any social care needs as soon as possible – preferably as soon as a patient was admitted to Acute Care – as this would prevent any delays when a patient was ready to leave Acute Care.
- At the time of discharge, the ward sister would make a patient referral to their local community nurse and other carers as appropriate.
- The Hospital used a Discharge Checklist and a copy of the form would be supplied for the information of the working group Members, along with the associated information booklet.
- The Hospital and the Council's Adult Care team were attempting to improve their joint working arrangements and this was progressing well with the use of the "First Response" system.
- The Hospital and its partners had, for the past few months, used a "Discharge to Assess and Manage" programme where professionals such as therapists, nursing teams and adult social care service staff assessed patients in their own homes, thereby giving a real picture of their capabilities and needs.
- It was considered that the local Community Hospitals were crucial in helping patient transition and freeing up acute care beds.
- Hardwick CCG had, last winter, introduced the incentive scheme where Care Homes were offered £100 to take a discharged patient at an appropriate time and help prevent delay. The review working

group Members asked if this approach could potentially compromise the interests of the patients but it was noted that there had been relatively little take-up of the incentive by local Care Homes and patient safety and wellbeing had not been compromised.

- There is a national Re-Admissions process which monitors patients who are re-admitted to acute care within 30 days of being discharged previously for the same condition. This had not been identified as an issue for Chesterfield Hospital.
- There had been occasional instances of “inappropriate” admissions by local GPs where it would have been better for a patient to have care in the local community rather than admission directly to acute care. This was specific to a number of GP practices and it was noted that many were very good at assessing the best route of care and monitoring the progress of their patients who had been referred to acute care or other care services.
- Community Matrons were very useful for acute care providers and the development of the Community Matron facility would assist with an efficient discharge process.
- CRH had a transitional ward and a discharge lounge which helped considerably in freeing up acute care beds. The hospital also used a “white board” system similar to that demonstrated to the review working group at Derby Royal Hospital to inform all health professionals of the status of each patient and ensure that everything was in place for their discharge from acute care. The aim is to have at least 60 – 70% of patients going home in the mornings.
- A proportion of patients admitted to CRH acute care were from outside the county, predominantly the Sheffield area. This presented an additional challenge in liaising with other service providers, such as adult care services, in the neighbouring Authorities.
- Transport to home was mostly good and it was very helpful to have a volunteer scheme to ensure patients’ homes were warm and there were basic provisions of food and drink etc. Access to a handyman service for minor alterations to patients’ homes could also accelerate their return home.
- It was considered that Care Homes could do more to support acute care hospitals in accepting patients more speedily. It would benefit the review working group to consider the systems and processes of the local Care Home sector to ascertain if improvements could be made to their part in the process.

- The hospital was to undertake a training and education programme on the discharge process for all its staff so that anyone connected with a patient would understand their role in working towards an efficient discharge from acute care.

2.5 Evidence from Care Home Managers

To discuss the discharge experience for Care Home residents, a meeting was held with representatives of two private Care Homes, Julia Davies of the Milford Group and Stephen Beecham of Amber Lodge Nursing Home in Osmaston Road, Derby.

The following key points were noted;

- The Care Home managers informed the meeting of the areas their establishments covered – The Milford Group had homes in Belper, Alfreton, Milford and Ashbourne and the Amber Lodge establishment was in Osmaston Road, Derby. The Amber Lodge residents mostly received hospital care at the Derby Royal Hospital but, for the Milford Group residents, Chesterfield Royal Hospital, Kingsmill, and the Queens Medical Centre in Nottingham were also used.
- The main problem which impacts on the efficient discharge process is lack of good communication between the hospitals and the care homes. For a patient returning to their Care Home from hospital there needs to be an assessment of their requirements to ensure that everything is in place so that they can be cared for safely on their return. Often the hospital staff members assume that patients can go almost as soon as the assessment visit (by the Care Home staff) has taken place. In reality, there usually needs to be a lead in time to get additional care needs addressed at the Home setting before a patient can be received back. This takes longer when a patient is leaving hospital to Care Home accommodation where they have not resided before.
- In addition, the provision of re-ablement facilities can take up to 6-8 weeks to get in place and an earlier lead in time, with better communication between the hospital and home at an earlier stage.
- It would help if, during the assessment process, the Care Home assessor could meet with a hospital staff member who knew the details of the patient's requirements to help form their follow-on care plan.

- Another aid would be if Care Home managers, as the patient's prime carer, could be given the same status as the patient's next of kin insofar as obtaining information about their treatment and medical condition, whether over the phone or otherwise.
- Where dressings and similar items are needed – 14 days' supply should be provided by the hospital on discharge. Usually the patient only receives a small amount of items when leaving hospital and this may be a hospital budget issue?
- It was noted that the Care Homes represented at the meeting had a good service from their local GPs. – although for out-of-hours services, Homes had to use 111 or 999 services.
- Weekend admissions to hospital which resulted in a death could involve problems where neither a GP nor a consultant could sign the death certificate. This often caused anxiety to a patient's family as the death has to be referred to the coroner.
- Local Care Homes were able to access the Care Home Advisory Service which facilitates Care Home representatives joining together to discuss issues and provides a network through its twice-yearly forums. (The most recent forum at the time of this meeting was on January 13th 2016 at Derby Royal Hospital. There was a similar organisation in Nottinghamshire (The Nottingham Manager Forum). It might be possible to use such networks to engage with the Acute Hospitals to help improve the discharge experience for patients.
- In conclusion, it was suggested that the following changes would help improve the discharge process;
    - improved communication between hospital/home, including allowing Care Home representatives the same status as the patient's family in respect of access to information,
    - a longer lead in period would help decisions, and necessary actions, to be taken well in advance of the discharge date and hence avoid delays.
    - patients should be sent home during the morning, preferably, or in any event before 6pm.
    - patients should have an adequate supply of the correct medications/dressings sent home with them, and these should not follow on later.

3. Review Conclusions

The review working group has reached a number of conclusions from the evidence detailed in this report. Key points that the working group Members would like to highlight are;

3.1 The professionalism and common aim of providing the best care to patients, by the managers and staff of the organisations contributing to this review, is very evident. The working group was impressed by the dedication of NHS and Adult Care Services staff and Care Home Managers in ensuring that people in their care received the best attention and care they could provide.

3.2 The working group Members are also mindful of the increasing pressures placed upon NHS and Care Service organisations, with greater demands due to the aging population at a time when financial resources were also diminishing in real-terms.

3.3 The information gathered at the commencement of this review was based mostly on a "snap-shot" of the situation at the time of Healthwatch Derbyshire's "Enter and View" visits to Care Homes in 2014. The working group acknowledges that work has been undertaken by the Acute Hospitals and the County Council's Adult Care Service over the last 2 years, resulting in some improvements to the discharge process.

3.4 It is recognised that there is an ever-increasing need for NHS and Care Service providers to continue to work in close partnership. This is already being addressed by a number of cross-service initiatives aimed at developing more efficient systems with "seamless" service provision, irrespective of the different providers. The Clinical Commissioning Groups working across the county of Derbyshire have joined with partners to develop large scale programmes, often reaching across the county boundaries. In addition, the on-going introduction, by NHS England, of Sustainability and Transformation Plans (STPs) is intended to build multi-year service plans around the needs of local populations. These major initiatives are designed to facilitate more efficient systems of care provision – both in the use of resources and improved patient experience.

3.5 It is the improvement of care and patient experience that can be influenced, challenged and supported by the Health Scrutiny Committee. The transition of patients from Acute Care to their home environment – and the provision of continuing care by

other service partners - has been the specific subject of this review and the working group Members understand the need to develop more “joined up” services to assist this process.

3.6 The review acknowledges that there are a number of initiatives, either already in place or being planned, to improve the experience of patients being discharged from Acute Care Hospitals. The introduction of the “whiteboard” discharge system at Derby Royal Hospital and the use of discharge support teams – whether provided via hospital staff based on wards, or through voluntary groups in local communities – are good examples.

3.7 There is one main issue which does continue to impact on the efficiency of the discharge process. The communication processes, between Acute Care hospitals and Care Homes in particular, could be improved through better understanding, between both parties, on the processes to which they are obliged to work. There may be potential for the local Care Home Advisory Service to support work to improve communication between Hospitals and Homes in this respect.

3.8 The Health Scrutiny Committee, through its current work programme, is aware of the proposals to reconfigure health and care services as part of “joined up care” initiatives – and the impact of the introduction of NHS Sustainability and Transformation Plans across the “footprint” of Derbyshire. Initiatives such as the #21C Care programme in the north of the county propose a more joined up approach between the numerous organisations which provide care, support and health services to older people. It is quite evident that pivotal to the success of such programmes is the smooth transition from service to service, with different types of care and support often provided concurrently. This will be achieved only through effective communication between service and care providers, patients and their families and the availability of care and health service resources.

3.9 Included in current public consultation on the #21C Care programme is a potential reduction in the number of Community Hospital beds available for patients who are transferring from Acute Care to their own homes. Given the important value of the Community Hospital bed facility as part of the discharge from acute care process, the Committee will seek assurances that the discharge process will not be compromised through the lack of availability of this “transitional care” option.

The review working group wishes to make reference to endeavours it has made to seek the views of patients and their families during this process. It has not been possible, during the timescale of the review, to have a meaningful dialogue with a sufficient number of patients and their families. The working group Members appreciate that there are great emotional and logistical pressures placed on patients and their families when leaving acute hospital care. It is therefore proposed that the issues already raised in this review will be addressed through a number of recommendations – one of which will be that, after a reasonable period of time, an extensive survey of patients/carers will be undertaken to measure the patient acute care discharge experience.

These conclusions have been used by the review working group to form its recommendations which are set out in the final section of this report (page 18)

4. Considerations

Health considerations are set out in this report.

The relevance of the following factors has also been considered in preparing this report; Human Relations, Human Rights, Financial, Prevention of Crime and Disorder, Equality and Diversity, Property and Transport.

5. Background Papers

Held by the Scrutiny Team – Legal and Democratic Services Division.

6. Recommendations

The review working group Members make the following recommendations:

6.1 That the Health Improvement and Scrutiny Committee acknowledges the efforts being made by Hospitals, Adult Social Care Services and Care Home providers to facilitate the efficient transition of patients discharged from Acute Care. It also acknowledges the increasing pressures being placed on health and care service providers due to diminishing resources and the growth in the elderly population.

6.2 The Acute Care hospitals serving the communities of Derbyshire, local Care Homes and Adult Care service managers should, together, explore ways in which communication processes can be further developed to improve the patient experience at discharge from acute care. The Committee will request the Clinical Commissioning Groups responsible for Derby Royal Hospital and Chesterfield Royal Hospital to consider how they can help facilitate communication improvements.

6.3 To help facilitate recommendation 6.2, the local Care Home Advisory Service network should be included in discussions.

6.4 Improvements to communication between Acute Care wards, Adult Care Services and Care Homes should be included by Clinical Commissioning Groups in their “joined up care” programmes to help develop more “seamless” services.

6.5 The local Clinical Commissioning Groups be informed of this Committee’s concerns of proposals to reduce Community Hospital bed facilities and the potential adverse impact on the Acute Care hospital discharge process. Evidence should be provided by the CCGs and the Acute Care Hospitals, detailing alternative arrangements to fill any gaps caused by fewer Community Hospital beds.

6.6 Following a reasonable time period, to allow these recommendations to be implemented, a survey of patients and carers will be commissioned by the Committee to re-assess the discharge experience. This will include the “Ready to Go” method and an assessment of the transport to home service which was commissioned in 2016.

I & S Committee - Health

Review of Acute Care Discharge Process – September 2016

Recommendations Action Plan

Rec No.	Recommendation Wording	Implementation (Y/N)	Responsible Officer	Progress report to Committee	Action taken
6.1	That the Health Improvement and Scrutiny Committee acknowledges the efforts being made by Hospitals, Adult Social Care Services and Care Home providers to facilitate the efficient transition of patients discharged from Acute Care. It also acknowledges the increasing pressures being placed on health and care service providers due to diminishing resources and the growth in the elderly population.				
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	from acute care. The Committee will request the Clinical Commissioning Groups responsible for Derby Royal Hospital and Chesterfield Royal Hospital to consider how they can help facilitate communication improvements.				
6.3	To help facilitate recommendation 6.2, the local Care Home Advisory Service network should be included in discussions.				
6.4	Improvements to communication between Acute Care wards, Adult Care Services and Care Homes should be included by Clinical Commissioning Groups in their "joined up care" programmes to help develop more "seamless" services.				
6.5	The local Clinical Commissioning Groups be informed of this Committee's concerns of proposals to reduce Community Hospital bed facilities and the potential adverse impact on the Acute Care hospital discharge process. Evidence should be provided by the CCGs and the Acute Care Hospitals, detailing				

	alternative arrangements to fill any gaps caused by fewer Community Hospital beds.				
6.6	Following a reasonable time period, to allow these recommendations to be implemented, a survey of patients and carers will be commissioned by the Committee to re-assess the discharge experience. This will include the “Ready to Go” method and an assessment of the transport to home service which was commissioned in 2016.				