Piecing it together in 2016
Effective scrutiny of health and social care integration

Insights and recommendations from the Stakeholder Inquiry Day on 'Promoting safe and streamlined discharge. Working together in North Somerset', which was hosted by the Health Overview and Scrutiny Panel on Thursday 31 March 2016 at Nailsea Tithe Barn

For report and follow up by CfPS

1. Background

The Department of Health, NHS England and Public Health England jointly funded the Centre for Public Scrutiny to provide a healthcare, social care and wellbeing support programme in 2015/16. As part of this, CfPS invited councils and their local partners to help shape national learning about the latest developments in planning and delivering healthcare, social care and public health services.

The project supported a small number of areas or partnerships to organise 'Inquiry Days' in early 2016, bringing together leaders from whole health and care systems to:

- Consider the current and future contribution of council scrutiny in assessing local approaches to public health issues and health and social care services
- Identify opportunities and barriers that help or hinder council scrutiny to influence public health issues and health and social care services
- Share learning with whole health and care systems to promote the proactive, valuable role of council scrutiny.

2. Objectives of the North Somerset Inquiry Day

North Somerset's Health Overview and Scrutiny Panel was one of only three O&S committees across England that was accepted onto the national learning project, and chose to focus on hospital discharge, a highly topical issue for the authority and its residents.

The HOSP was responding to local interest in a particular problem, which had been picked up in a recent CQC inspection of Weston General Hospital, relating to patient flows (particularly of older patients) through the hospital. In follow up to this inspection, a Multi-Agency Discharge Event took place at Weston Hospital in the week beginning 18 January 2016 (as part of the national Emergency Care Improvement Programme for the twenty eight different Trusts with weak or real problems around emergency care). The Chair of North Somerset's Health Overview and Scrutiny Panel, Cllr Roz Willis had attended the event and participated in the 'Board rounds', exploring the existing procedures around discharge.

The HOSP also was aware of a recent national Healthwatch report on hospital discharge and the local Healthwatch's report on discharge issues affecting vulnerable patients. The Inquiry Day therefore was intended to test in the local context the five key Healthwatch findings that:

1. People are experiencing unsafe, delayed or untimely discharge due to lack of co-ordination between health, social care and community services
2. There is a lack of support available for people after discharge, often leading to remission
3. Many people feel discriminated against or stigmatised during their care, often feeling 'rushed out the door'
4. People do not feel involved in decisions about their ongoing care post discharge
5. Individuals' full range of needs are not considered when being discharged from hospital or a mental health setting – including their housing situation, carer responsibilities etc.

The HOSP recognised that a range of organisations or parts thereof play a role in enabling efficient patient flow through the health and care system. These include:

- Clinical team providing the elective or emergency care
- Discharge nursing team including flow manager, discharge nurse and discharge chaser
- Hospital pharmacy
- Ambulance service
- Community Partnership
- GP practices
- Physiotherapists
- Ablement and reablement services
- Care homes and nursing homes
- Housing associations
- Council social care teams
- Support agencies and
- Voluntary organisations.

The HOSP therefore proposed that the Inquiry Day would bring together councillors, strategic leaders, commissioners, providers and patient groups in order to have focused discussions on how to embed scrutiny into local actions to tackle North Somerset's immediate healthcare, social care and wellbeing challenges around hospital discharge.

The **aims** of the Inquiry Day were:

- to strengthen the role of scrutiny in contributing to the development and sustained implementation of a collective "whole system" based plan to improve patient discharge in North Somerset, and
- to ensure that this addresses the five key Healthwatch findings set out in its 2015 report.

The objectives from a patient perspective were:

- to build on a shared understanding of where things work, and where they fall down in North Somerset – focussing on those most affected by any malfunctions of the discharge process
- to hear about best practice elsewhere in the region and beyond
- to hear about interventions currently being implemented or planned for delivering improvements to discharge in the area.

The objectives from a scrutiny perspective were:

- to consider the extent to which current or proposed interventions will address the Healthwatch findings and contribute to a "whole system" approach, identifying any potential duplications and/or gaps with suggestions as to how these might be addressed
- to consider the role of scrutiny in contributing to a "whole system" approach to addressing these challenges, and
- to consider how and where scrutiny currently engages in the process and how it might more effectively contribute to the delivering improvements going forward.

The overarching objectives were:

- collectively to agree an action plan that will incorporate a set of outcome-based actions relating to the five key Healthwatch report findings, together with any agreed outcome measures and a commitment to engage with the Scrutiny Panel at an agreed point in the future to review outcomes.

3. Issues considered in the Inquiry Day

During the Inquiry Day participants mapped out the rich picture of connectivity that influences the efficiency of patient flows through health and social care. This included participation in a 'Market Place' of display and advice space to enable members of the HOSP and others to meet key stakeholders and better understand how they work within the patient journeys, as well as a platform for presentations to outline the current arrangements for subsequent discussion.

Through opening presentations, the Inquiry Day heard from a range of stakeholders across North Somerset to share information with each other about the issues that present, particularly around delayed discharge and to understand each other's challenges and proposed solutions. Whilst there may be clear procedures in the discharge pathways, it appeared that there may be varying capacities, pressures, priorities, risks and systems to make it work for all patients.

The majority of time was spent in small group discussions focused on the key themes of:

1 Health and social care integration

2 Information about and access to support (including equalities issues)

3 Pathways of care and discharge

4 The patient experience (including equalities issues)*

5 The interface between health services, social care, GP practices, housing and agencies

Discussions sought to address the challenges and propose solutions.

The concluding plenary discussion brought these findings together, and in concluding, the Chair indicated that the HOSP will draft a potential strategy and action plan with clear responsibilities for follow up to test with Inquiry Day participants and service users, in follow up to the event.

4. Introduction to the issues

The Chair of the HOSP, Cllr Roz Willis, opened the Inquiry Day, describing it as a unique moment to capture information and address concerns. Cllr Willis explained that the Health Overview and Scrutiny Panel does not merely focus on offering criticism, but seeks to provide a constructive challenge and to help find solutions by talking with patients, service providers, commissioners and other stakeholders eg Home from Hospital and others so that we can help each other to improve the patient experience and outcomes, to deliver services well and to provide a positive experience for families and carers, who otherwise have to pick up the pieces of poor care, patient journeys and outcomes. Areas to consider include identification of best practice and gaps in services. There is a wealth of services in North Somerset for all ages, but we need to ensure that information about access is widely available and that we work more closely together.

The opening presentation to set the scene was given by Mark Ellis, the North Somerset Lead for the National Emergency Care Improvement Programme. The briefing notes explained that “ECIP is a clinically led programme designed to offer intensive practical help and support to urgent and emergency care systems to deliver improvements in quality, safety and patient flow. The programme has a particular focus on improving whole system performance across health and social care in the winter months when emergency care systems are working under additional pressure.

ECIP is focusing on helping the 28 urgent and emergency care systems across England that are under the most pressure, and will help implement evidence based tried and trusted improvements they know work. The success of ECIP will be measured against patient outcomes and experience as well as improvements to the emergency care four hour waiting time standard and ... will make best use of information and analytics to improve performance management methods.”

These issues, alongside the Healthwatch report, were set out in five introductory presentations.

a) ECIP

Working with ECIP from a nursing background, Mark Ellis gave a detailed presentation on Promoting Safe and Streamlined Hospital Discharge (slides available separately). He outlined the national context and the management of risk. He suggested that "black has become normalised", that daily telephone conferences to address pressures are time-consuming and short-termist and that "crowding is not ok in A&E".

Whilst patient flows are definitely not all about accident and emergency departments, but also about increased admissions to hospital, delayed ambulance handover, delayed transfers of care and community health and care capacity, in reality crowded emergency departments deliver worse patient outcomes. Key emerging issues are frailty, as people live longer, and the impact of the time of day of admission on the length of stay. Mark also highlighted capacity issues eg where there is only one geriatrician in an acute trust, and the long term viability of small district hospitals.

Mark cited good practice as the 'Poole Silver Phone', where earlier senior review has led to more patients' discharge home the same day. Better care coordination from multi-disciplinary teams can mobilise better around the patient and shift discharge to earlier in the day. North Staffordshire Trust has improved its case management, introducing a 'Dragon's Den' where clinicians have to defend why a patient remains longer in hospital than deemed necessary. Multi-agency discharge events facilitated by ECIP brings the whole system together to shadow the Board rounds and consider ways to expedite discharge from hospital. The event in Weston, which was attended by the HOSP Chair, identified 52 constraints and opportunities to improve the discharge processes, resulting in 14 focuses for action, including:

- Tackling avoidable admissions
- Optimising hospital care through early assessment
- Improving patient flow through the hospital
- Prioritising discharge planning
- Increasing assessment at home after discharge to a patient's usual residence
- Developing short stay and ambulatory care
- Eliminating a blame culture where "It's someone else's fault".

Tasks are being allocated with detail regarding the responsible person and timescales. Mark stressed that the priority for the health and care system is to get patients **'Safer Faster Better'**. He highlighted the current approach that provides for too much waiting time between clinical care interventions.

ECIP has identified principles of great patient flow:

- *Early* senior review
- *Daily* senior review
- A focus on discharge and case management

- Continuity of care
- Appropriate standardisation and matching capacity to demand
- Key services must run seven days a week and late evenings
- Implementation of the SAFER bundle

This is “a combined set of actions to improve patient flow and prevent unnecessary waiting for patients. If we routinely undertake all the elements of the SAFER patient flow bundle we will improve the journey our patient’s experience when they are admitted to our hospital.”

These actions are:

S **Senior Review** - all patients will have a Consultant Review before 11am

A **All patients** will have an **Expected Discharge Date** (that patients are made aware of), based on the ‘medically suitable for discharge’ status agreed by the clinical teams

F **Flow of patients** will commence at the earlier opportunity (by 10 am) from assessment units to inpatient wards. Wards are expected to ‘pull’ the correct patient to their ward before 10 am

E **Early discharge** - 35% of patients will be discharged from base inpatient wards before midday. TTO’s (to take out; medicines given to patients on discharge from a hospital stay) for planned discharges should be prescribed and with pharmacy by 3 pm the day prior to discharge

R **Review** - a weekly systematic review of patients with extended lengths of stay (of more than 14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust.

Areas to develop included the hospital pathway, the system interface and the community offer. As well as tackling avoidable admissions, the system must optimise hospital care. A challenge is to manage more effectively the increasingly complex case mix of frail older people with multiple chronic conditions though a diminishing bed base.

b) North Somerset Council

David Jones, Interim Assistant Director, Adults' Support and Safeguarding at North Somerset Council and Cath Weylie, Access Hospital Support Team Manager, outlined the impact of delayed transfer of care on the wider picture of social care and other public services. A priority is to prevent admissions, especially of frequent attenders and to focus support on the more vulnerable.

Care planning by an integrated care team covering health and social care is essential. ECIP recommendations have been helpful, as well as partnership working, strategic developments and the sourcing of credible data, especially in the context of funding pressures. These have led to the loss of capacity within the system as two key posts in the Council are cut, relating to care planning and admission avoidance.

Patients from North Somerset increasingly are being admitted to Bristol hospitals, outside the local authority, and evidence is needed to understand why this should be so. The three hospitals have to work with different councils and community health teams. They are keen to ensure that there are in-reach and outreach teams available from local authority care teams in order to help address pressures through admissions. Care coordination is need to ensure that the medically fit are safe for discharge and that care planning is effective to avoid immediate readmission. Better reablement and discharge to assess all contribute to reducing admissions and length of stay, but have capacity and resourcing issues. Communications and relationships need to be developed to improve care coordination around the patient.

Legal issues arise for commissioners and providers from the Care Act 2015 and the Mental Capacity Act, including around liability for safe discharge. There also are funding issues around continuing health care and end of life planning.

Care studies were provided by Maggie Simpson, Care Manger, People and Communities and Maggs Windram, Care Co-ordinator, People and Communities:

- one around avoiding unnecessary admission through collaboration between the Care Partnership, Home from Hospital and voluntary organisations
- the other around putting packages in place for a vulnerable patient and spouse around falls prevention, early referral for physiotherapy assessment, reablement, community health, attendance by a frailty doctor and personal care packages.

Both exemplified the importance of a multi-agency approach, sign-posting of services, early assessment and intervention, care packages at home and funding. Discharge planning is key, including the assessment process and support in the community.

c) North Somerset Healthwatch

Georgie Bigg from North Somerset Healthwatch then outlined the issues from a patient perspective. She referred to the introduction of Healthwatch as the voice and champion of the patient, under the Health and Social Care Act 2012. She set out the background to and findings of the Healthwatch England report Safely Home.

Georgie reminded participants of the five key Healthwatch findings that:

1. People are experiencing unsafe, delayed or untimely discharge due to lack of co-ordination between health, social care and community services
2. There is a lack of support available for people after discharge, often leading to remission
3. Many people feel discriminated against or stigmatised during their care, often feeling ‘rushed out the door’
4. People do not feel involved in decisions about their ongoing care post discharge
5. Individuals’ full range of needs is not considered when being discharged from hospital or a mental health setting – including their housing situation, carer responsibilities etc.

It is important to understand and manage expectations of health and social care, and to ensure that the whole system enables people to stay well at home to avoid readmission and where admitted that workstreams in hospital enable fast and safe discharge.

d) Weston Area Health NHS Trust

Suzanne Loxton, Patient Flow Matron of Weston Area Health NHS Trust, concisely outlined the actions being taken by the Trust to address issues around hospital admissions and discharge. She expressed the commitment of the Trust to safe and timely discharge, and highlighted the outcomes from work with ECIP at the hospital.

e) North Somerset Clinical Commissioning Group

Dr Mary Backhouse, Chair of the North Somerset Clinical Commissioning Group, reinforced the comments made by Mark Ellis and Suzanne Loxton. She succinctly outlined the progress being made in follow up to the ECIP programme at Weston Hospital, and the commitment of the CCG to working with partners to address concerns and develop whole systems working.

Following the five helpful scene setting briefings, the HOSP then used the Inquiry Day to work in small groups of a cross-section of stakeholders in order to gather further information about procedures, to explore the significant challenges and collectively to seek solutions, all of which could be tested by the HOSP with service users, commissioners and providers at a later date.

5. Group discussions at the Inquiry Day

The first discussion focused on working together to identify challenges, causes and possible solutions relating to hospital discharge around:

1. Health and social care integration
2. Information about and access to support (including equalities issues)
3. Pathways of care and discharge
4. The patient experience (including equalities issues)
5. The interface between health services, social care, GP practices, housing and other agencies

The second discussion focused on working together to develop a strategy, drawing on the challenges and their possible solutions. Proposals are to be followed up by the HOSP.

In discussions, reference was made to the importance of communications, including the use of the questions suggested by Dr Ian Sturgess, a clinician who is working on ECIP, so that a patient would know what to expect in the following regard:

- What is wrong with me? (assessment)
- What is going to happen today and tomorrow? (case plan)
- What needs to be achieved to get me home? (clinical criteria)
- When is this going to happen? (expected date of discharge)

These questions could help to empower patients and their families and carers.

A communications plan could help to advise the population on health and social care services, and provide behavioural messages, including the fact that a hospital is not always the safest place for care. It can be difficult to connect with the potential service user.

There are challenges around the use of language, contrasting cultures and the layers of organisation looking after health and social care. Partner organisations could use different jargon. Communications may be improved through using agreed common language, sharing information more frequently and more widely, having a single point of access about where to go and multi-disciplinary language, whose content is shared as good practice.

Integration

Challenges around integration were identified as the number of different hospitals which North Somerset residents use, the differing IT systems within the health and care system (which is a huge issue), the different funding streams and the accreditation system. Better communications are essential, especially given the challenges that make fully integrated IT systems unlikely (though attempted in recent times). One very practical and specific issue is mobile phone coverage, with reception being a problem at some of the Bristol hospitals.

Holistic care is essential for integration, but the current workforce and planning is constrained by silo working, resource limitations, capacity and falling specialisation.

In respect of integration, it is important to promote the cultural change that can deliver better Value for Money.

Access to care at home might be helped by developing co-location of set down desks and by providing carers with parking passes enabling them to park nearer patients' homes, so that time is maximised with patients and travel and parking time reduced.

Capacity for end of life care could be boosted, with more care homes developing a hospice role.

Care homes also might benefit from learning and development around engaging with social care providers.

Hospital choice has had an impact with patients now opting for care further from home, necessitating better coordination across health and social care in different localities regarding repatriation of patients to their home.

Without a pooled budget, there can be delays relating to uncertainty as to who will pay. Greater funding flexibility will help to enable a 'do it now, pay later' approach.

Information and access to support

Access to support should develop to ensure the availability of services in the community through better joined up working and the consequent increase in discharge home.

Awareness could be raised of the Home from Hospital Team, where patients have a single point of contact, a key worker, (together with being a single point of contact for Homeless patients at the Hospital linking in with North Somerset Council's Housing Advice Team) - by extending advertising of the services.

Communication issues can be addressed through appropriate coordination and single points of contact.

The 111 service is proving to be a challenge, and it was suggested that it might be helpful to revert to the model of NHS Direct.

Information is needed specifically to reach hard-to-reach groups eg with specific workers liaising with minority ethnic communities.

There seems to be too much reliance on emergency services and GPs, which requires increased and stricter triage procedures and increased awareness of pharmacies and the support, help and advice that pharmacists might give. This appears to be the case where care homes are too quick to refer patients to A&E, rather than consider alternatives or approach social care services for support.

Hospitals appear too risk averse, and might develop more challenging procedures such as charging for missed appointments and inappropriate emergency department visits. An education and advertising campaign could encourage residents to "stop and think" about where to access appropriate care.

Hospital staff retention can be an issue, which might be addressed if Weston General specialised in care for the elderly and dementia services. A lack of evening and weekend care capacity is a major concern. Trainee doctors and medical students could be used to provide care in holiday time, and zero hours contracts should be changed. There can be better use of nurse practitioners for frailty services. Better coordination of handovers is important through integration.

Pathways of Care

There is a lack of confidence in the method and pathways, which need to be reviewed. It is important to manage critical points regarding admission and discharge.
There are perverse incentives; hospitals may save other parts of the health and care sector money by admitting patients, taking the pressure off community facilities.

Pathways can be helped by tools such as the Silver Phone (devised by Poole) that enables a comprehensive assessment from stage 1 when people call an ambulance or present at A&E. More specialists are needed in dedicated frailty units.

It is helpful to have in-reach teams with in the hospital to connect patients with the Community Partnership ahead of discharge.

It is critical to identify ways to reduce the time in hospital and maximise care whilst in hospital. A priority is to improve weekend discharges. The ideal is within seven days, or on Friday afternoon if to a care home.

Discharge planning can change from day to day, and clinicians recognise the risk if discharge happens too soon. It could be helpful for patients to be made aware of likely pathways, even if those have to change (and be explained again to patients).

Change has been radical rather than piecemeal, with one Trust covering all community and hospital facilities, but having different strategies.

Political and commercial commitment from across the stakeholders is needed that is led by stakeholders to facilitate cultural change. Measurable objectives are needed; ‘To do’ and ‘To measure’.

It is important to make pathways appropriate for North Somerset’s elderly population. This would require more specialists, use of the ‘silver phone’ approach for early assessment and faster discharge, a comprehensive geriatric assessment in multi-disciplinary teams with more specialist consultants, and multi-disciplinary teams in specific frailty units.

Ambulatory care needs a culture change so as not to de-condition people and reduce their independent living. Early mobility plans should be put in place and silo specialisms should be avoided, where patients have complex conditions. A more sophisticated risk stratification is needed.

Workforce capacity issues present in terms of number of staff and their skills. A recruitment strategy is needed for both specialists and generalists.

Given the plethora of agencies, it would be helpful to have a ‘multiple single point of access’, the integration and coordination of contact points, sign-posting relevant services, for outcome based commissioning.

It could be useful to located GPs in hospitals to divert patients from unnecessary A&E admissions.

Pharmacy delays can cause delayed discharge, so there needs to be better planning of the estimated discharge date and earlier notification to the pharmacy.

Reduced availability of services in the community through funding pressures on social care requires ever better planning and responsive social care.
There needs to be better liaison between those who assess medical and therapeutic fitness.

Patient Experience

Communications was a significant concern, and the use of ECIP questions were encouraged to empower patient and family.

Discharge led policies means that other models prepare alongside, trying to gather understand and build on knowledge in order to address the difficult questions. It is helpful to empathise about what is going on, to shake the system up and improve the systems and relationships for effective scrutiny and a safe journey home.

It is important to release 'time to care', especially at Acute Trusts. Resources are limited so it is important to make better use of the time hospitals have. Handovers need to be sensitively managed to social care.

Vulnerable patients need particular support and the system needs capacity to cater for their specific, often complex, needs.

Concern was expressed that there are occasions when people do not take up the appointments that they are given nor change them to a time they can attend.

By looking at the system, it should be possible to see the best customer experience and to map the process and develop it eg working with relevant stakeholders.

It is also important to manage expectations around pre-hospital admission and in hospital care. It would be helpful to increase the public's knowledge about the criteria, cost and options of health and care.

The interface between services

There is the potential for duplication, despite the public sector being short of resources. It is important to identify overlap and duplications to avoid waste, focusing members on particular Trusts. An integrated IT system is essential to connect care and the connecting care board.

Systems need to be simplified. All three Acute Trusts have different systems and all of the affected local authorities (the catchment area for each Trust) need to understand and work with them. It could be useful to review all three acute processes and respective capacity with the CCG. Similarly it is important to benefit from system wide electronic whiteboards that enables system wide assessment of capacity at any bedded facility at a particular time.

It will be helpful to instigate key workers and liaison workers who would manage patient journeys. They need not be clinical, but would work with clinical teams. The Intensive Support Team is developing a specialist business eg regarding elderly care. Block purchasing of specialist care could share resources across all the hospitals.

A discharge logger is a useful tool in Bristol Royal Infirmary.

Pharmacists need a bigger role, and in-hospital pharmacies need earlier notification of planned discharge so that they can ensure that necessary medication is available in time, so as not to delay the patient's return home.

It would be helpful to simplify reablement pathways and make hospital staff aware of what is available.

Strategies are needed to improve communication with the patients, carers and voluntary organisations through connectivity to care. Local pharmacies will know if a change of medication is required. However, there might be times when the GP may not even know their patient is or has been in hospital.

Care Homes have a role in terms of providing better help and more training with additional support to provide care when residents are discharged from hospital to care homes.

It was suggested that Avon and Wiltshire Partnership have developed a very good commissioning model, from which others might learn.

Doing differently is not just about money nor experience. It is about working smarter rather than depending upon additional resources. There are a tremendous amount of services for patients, but communications, sign-posting, admission, prevention of admission, care in the community and early discharge if admitted will improve care and value for money in use of resources.

6. Recommendations and next steps

Solutions considered through the ECIP have included:

- the development of a Responsibility Charter with the agreement of all
- the establishment of a specialist ward for older or more vulnerable patients, which is under consideration
- the proposed development of dialogue between Weston Hospital and care homes
- support from Home from hospital
- housing issues
- risk management of care homes
- timescales for extended care plans and discharge plans
- family support
- weekend arrangements
- the range of interventions required; and
- liaison and effective communications to enable safe care back in the community.

The Inquiry Day made a number of recommendations on which the HOSP will consult stakeholders and review.

In respect of communications, proposals were:

- The use of an identity badge with the four ECIP questions for frequent use on the back to remind staff and patients
- The need for cultural and behavioural messages to reaffirm that hospital is not always the safest or most appropriate place to receive care
- A communications plan to help people to choose health services well
- Joined up and consistent health messages in a system wide approach
- Care homes to increase staff training on supporting discharge seven days a week
- The 111 service reverting to the NHS Direct model
- Use of the 'silver phone' model of early and comprehensive assessment with more multi-disciplinary teams and more specialist frailty units
- More integrated IT systems
- Better communications with patients carers and supporting agencies, connecting care and sending discharge summaries to pharmacies and GPs
- Simplify complex systems and achieve more BNSSG wide best practice
- Pharmacies require earlier notification to support better planned EDD
- Joined up working is needed to boost the availability of services in the community; there seems to be too many agencies performing similar roles

In respect of funding, proposals were:

- Centralisation of common high volume clinical activities
- Joined up contributions to focus purchasing power so that health budgets reflect demographics
- Cultural change regarding seeking value for money
- Charges for unattended appointments without prior notice
- Making seven day discharge safe and affordable, whilst reducing weekend admissions

In respect of workforce issues, proposals were to:

- Instigate key worker/liaison workers for every patient to manage the patient journey

- Explore the AWP commissioned model eg intensive support teams
- Develop specialisms for Weston Hospital eg specifically care of the elderly
- Promote block purchasing of specialist consultant across Bristol, North Somerset and South Gloucestershire
- Build workforce capacity and address skills shortages and silo working

Overall, it was suggested that demand needs to be managed, a responsive system with appropriate pathways needs to be achieved, a system-wide electronic whiteboard should be provided, current systems mapped to avoid overlap and processes need to be optimised.

Improved communications at all levels was a common and frequent theme in the Inquiry Day, especially more information around integration and single point of access solutions with collated knowledge.

Multi-disciplinary teams were considered to be essential and it would be worthwhile to explore other Trusts' good practice, including non-doctor led models.

Radically, one Trust could provide all the community and hospital health and social care with a single budget and shared measurable and agreed objectives and goals. Political and commissioner commitment would be needed to achieve this, as well as a culture change.

Conclusion

The Inquiry Day was proactive and positive, and North Somerset Council is grateful to all presenters, market place contributors, facilitators, scribes, participants and the organisers, Cllr Roz Willis and Leo Taylor.

The HOSP will test these proposals and draft an action plan for consultation with relevant stakeholders, the partners and agencies in the health and care system in North Somerset or that are used by North Somerset residents. The HOSP will then monitor progress.

Appendix 1: Inquiry Day Programme

10 am **Welcome, house-keeping, objectives and introductions**

- Welcome and house-keeping by Cllr Roz Willis, Chairman of the HOSP
- Outline of the project and the Inquiry Day
- Name round indicating the role each person plays in the health and care system (by table only)

10.15 am **Session 1 – Working together to set the scene**

Perspectives on hospital discharge procedures from:

- Emergency Care Improvement Programme
- North Somerset Council
- Healthwatch North Somerset and England
- Weston Hospital
- North Somerset Clinical Commissioning Group

Small group discussion (Task 1 on page 14) to prepare, then provide in plenary:

- Questions for clarification
- Comments on current procedures and challenges in the system

11.15 am Comfort break; move to the table that matches the **number** on your badge

11.30 am **Session 2 – Working together to identify the challenges**

Group discussions to list the key challenges, the likely cause(s) and the possible solution(s), (Task 2 on page 15):

7. Health and social care integration
8. Information about and access to support (including equalities issues)
9. Pathways of care and discharge
10. The patient experience (including equalities issues)
11. The interface between health services, social care, GP practices, housing and other agencies

12.45 pm	Lunch break; participate in the Market Place of information and advice; then move to the table that matches the **letter** on your badge

1.30 pm **Session 3 – Working together to develop a strategy**

- Small group discussion to consider the challenges and possible solutions from the thematic groups (copies will have been made of the worksheets from each table for all participants to consider in their new cross-thematic group)
- Feedback to the plenary of each table's proposals of action points and responsibilities for a joint strategy (Task 3 on page 16)
- Development of a joint strategy with action points and responsibilities, working together across North Somerset

2.45 pm **Closing comments by the Chairman of the HOSP, including next steps**
NOTE - the HOSP will test the proposals with service users and individual stakeholders, then present findings and recommendations to decision makers

3 pm **Close**

Appendix 2: Participants

Alliance Living		
Team Supervisor (Support)	Karen	Disney
Support Caseworker	Jenny	Keeley
Support Assistant	Caroline	Wilson
Alzheimer's Society		
Project Manager	Helen	Harvey-Foster
Avon and Wiltshire Mental Health Partnership		
Access Service Manager	Emmy	Watts
Modern Matron	Jon	Williams
Avon Local Pharmaceutical Committee		
Chief Officer	Richard	Brown
Curo		
Team Leader - NS Temporary Accommodation	Michelle	Jacobs
Emergency Care Improvement Programme		
Intensive Support Manager	Mark	Ellis
Healthwatch North Somerset		
Chairman	Georgie	Bigg
Chief Executive	Eileen	Jacques
Healthwatch	Joanna	Pritchett
North Bristol NHS Trust		
Head of Transformation - Patient flow	David	Alinson
North Somerset CCG		
Associate Director for Transformation	Julie	Kell
Chief Clinical Officer	Mary	Backhouse
Commissioning Manager	Ruth	Gazzane
Lay Chair	Kathy	Headdon
Service Improvement Manager	Jan	Blews
North Somerset Community Partnership		
Deputy Director of Nursing and Quality	Robert	Nicholls
Heald of Operations Urgent and Managed Care	Darren	Lawrence
North Somerset Council		
Care Coordinator, People and Communities	Maggs	Windram
Care Manager, People and Communities	Maggie	Simpson
Chairman, Adult Services and Housing Overview and Scrutiny Panel	Cllr Reyna	Knight
Chairman, Health Overview and Scrutiny Panel	Cllr Roz	Willis
Councillor	Mary	Blatchford
Councillor	Robert	Cleland
Councillor	Ann	Harley
Councillor	Tom	Leimdorfer
Councillor	Liz	Wells

Councillor	Sarah	Codling
Democratic Services and Registration Officer	Shauni	Brocklesby
Director of People and Communities (NSC)	Sheila	Smith
Executive Member Adult Social Services (NSC)	Cllr Dawn	Payne
Head of Strategic Housing	Mark	Hughes
Housing Advice Manager	Lynn	Trigg
Interim Assistant Director	David	Jones
Interim Director of Public Health	Natalie	Field
Scrutiny Officer	Philippa	Penney
Scrutiny Officer	Leo	Taylor
Team Manager, Adult Care	Catherine	Weylie
Patient Participation Group		
Chairman - Long Ashton	Carol	Wessel
Patients Council (WAHT)		
Chairman	Margaret	Blackmore
Patients Council (WAHT)	Frederick	Vickery
University Hospitals Bristol NHS Foundation Trust		
General Manager, Division of Medicine and Complex Discharge Lead	Julia	Wynn
Weston Area NHS Trust		
Patient Flow Matron	Suzanne	Luxton

Appendix 3: Healthwatch England Special Inquiry

'Safely home: What happens when people leave hospital and care settings?' July 2015
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf

What were people's experiences?

1. People are experiencing delays and a lack of co-ordination between services
2. People are feeling left without the services and support they need after discharge
3. People feel stigmatised and discriminated against and that they are not treated with appropriate respect because of their conditions and circumstances
4. People feel they are not involved in decisions about their care or given the information they need
5. People feel that their full range of needs is not considered

The cost of readmission

In 2012 - 13 there were more than one million emergency readmissions within 30 days of discharge, costing an estimated £2.4 billion. When discharge goes wrong, it comes at significant cost, both to individuals and to the health and social care system.

Use of discharge checklists

Responses received from 120 trusts indicated that:

- Almost all had a discharge checklist but less than half check whether people have a safe home/place to go when discharged, or whether there is basic food, water, heating etc.
- 1 in 3 do not ensure notes about new medication are properly recorded and passed on to GPs or carers.
- 1 in 10 trusts do not routinely notify relatives and carers that someone has been discharged.
- We established that trusts used a variety of guidance from 57 different documents – creating huge variation

Getting discharge right

Across all groups, we found that people expected some simple things from the discharge process. They expected:

- To be treated with dignity, compassion and respect
- Their needs and circumstances to be considered as a whole – not just their presenting symptoms
- To be involved in decisions about their treatment and discharge;
- To move smoothly from hospital to onward support available in the community, and
- To know where they could go for help once discharged.