WEST DUNBARTONSHIRE COUNCIL

Report by the Director of the Community Health and Care Partnership

Community Health and Care Partnership Committee: 20 October 2010

Subject: Quality of Discharge Information

1. Purpose

1.1 This paper is designed to update committee on the arrangements for providing appropriate and timely information following isolated reports of failings in the discharge information sharing process which resulted in expected care provision being delayed.

2. Background

2.1 As patients are discharged from hospital it is important that community services in health and social work have timely and accurate information to ensure a smooth transition to home or care setting, This includes referral to service in primary care, home care, care homes and for special needs equipment.

3. Main Issues

3.1 There are clear arrangements in place for the transfer of information and, where these arrangements fail, clear systems in place to review and to make improvements.

Home Care

3.2 Services provided by Home Care are dircetly accessed by hospital staff and we provide services to a standard of 24 hours notice and in some cases within that timescale. No hospital discharges have been delayed due to delays in providing service. The Section has recently introduced a referral information data form which ensures that complete information is received from hospital to enable appropriate allocation and service delivery.

Special Needs Equipment

3.3 Hospital services are able to order equipment for discharge and where referral to Occupatuonal Therapy is involved no requirement for equipment should incur a delay in discharge.

Tranfer to Care Homes

3.4 All tranfers to care homes will be the subject of a Single Shared Assessment and for discharge from Medicine and Medicine for the Eldelry Services a summary medical assessment is provided with information to support continuity of care.

Older Peoples Teams

3.5. These teams operate from co-located settings and referral to these services can be made by hospital staff directly.

Hospirtal Discharge and Liaison

3.6 Health and Social Work managers meet monthly with hospital discharge coordinators to review hospital discharges and to ensure that discharge arrangements are working appropriately. The current hospital discharge teams will be devolved from the Acute sector to CHCPs in early 2011 which will mean that all of the staff working the interface between hospital and home will be managed together with one point of access for ward staff. This will ensure better transmission of information between sectors. It should also improve liaison with primary care services including community pharmacies which have a critical role in ensuring that changes to prescribed medication are actioned quickly.

4. Personnel Issues

4.1 There are no personnel issues other than to ensure that the new referral form mentioned at 3.2 above is introduced effectively and employees are made aware of how to use it.

5. Financial Implications

5.1 There are no financial implications.

6. Risk Analysis

6.1 The main area for risk around the sharing of information is that systems in place fail and that unformation needed to provide a timeous service is not effectively communicated. The new referral form to be used will reduce this risk.

7. Equalities Impact

7.1 On screening for any equalities impact it was assessed that the current access to services process and the improvement arising from the use of the new form should be positive.

8. Conclusions and Recommendations

8.1 Arrangements are being developed to improve the information sharing arrangements between hospital and primary and community services. Members are asked to note the report and note that a further report will be provided on the development of integrated discharge services in Spring 2011.

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Director

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Appendix:	None
Wards Affected:	All Wards