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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

CORPORATE EXECUTIVE BOARD

A meeting of the Board will be held on **Wednesday 30 August 2000** at 12:30 in the Large Conference Room, Finchdean House

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AGENDA

1. Apologies for absence

Elizabeth Jorge, David Pugsley

2. Minutes of the last meeting

To agree the minutes of the previous meeting held on Thursday, 15 June 2000. — Attachment (white)

3. Matters Arising

- Service and Financial Framework
- Creation of new Health Authority
- Development of East Hampshire PCT
- Development of Portsmouth City PCT

4. Progress of PCT consultation

To discuss the progress of the PCT consultation (including scenario planning and concluding service configuration of PCTs) — No attachment

5. Continuing Care Budget

To discuss the devolution of continuing care budgets to PCGs. — No attachment

6. Meeting arrangments with Portsmouth Hospitals NHS Trust

To discuss the need for strategic exchanges between the Health Authority, PCGs and PHT. — No attachment

7. Isle of Wight and Portsmouth & SE Hampshire Health Authority

To discuss the resolution of HR issues arising from the proposed "merger" between the IOWHA and PSEHHA. — No attachment

8.	**The NHS Plan**	
	To consider local action in the light of the NHS Plan.	No attachment
9.	**Key performance issues**	
	To consider the current position of key performance issues including waiting lists, lower GI cancers, performance fund and key SAFF targets.	Papers to be tabled
10.	**Review of the Portsmouth & SE Hampshire Health Improvement Programme 2000/2001**	
	To consider the attached paper clarifying the future role and key priorities of the district HImP.	Attachment (blue)
11.	**Cervical Screening Recall Interval**	
	To consider the proposal to reduce the cervical smear recall interval from 5 to 4½ years from 1 October 2000.	Attachment (pink)
12.	**Admission and Discharge policy**	
	To approve the attached district wide policy on admission and discharge arrangements.	Attachment (lavendar)
13.	**Any other urgent business**	
14.	**Date of next meeting**	
	18 October 2000.	

Circulation List:

Ms P Humphris (Chair)
Dr J A Barton
Mr S Carr
Mrs S Clark
Mr J Henly
Dr J Hughes
Dr E Jorge
Mr J Kirtley
Dr C Lewis
Mr D Pugsley
Mrs S Robson
Dr G Sommerville
Mr B Ward
Library

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

CORPORATE EXECUTIVE BOARD

Notes of the Meeting held on 15 June 2000 in the Function Room, Finchdean House

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Present:	Ms P Humphris	Ms A Bullen
	Ms S Palser	Dr G Sommerville
	Mr D Pugsley	Dr J Hughes
	Dr E Jorge	Ms T Green
	Mr B Ward	
In attendance:	Mr S Carr	

No	Discussion	Action

1 Apologies for Absence

Dr C Lewis, Mrs S Clark, Dr J Barton, Mrs S Robson, Mr J Henly, Mr J Kirtley

2 Minutes of the meeting held on 3 May 2000

These were received and agreed as a correct record.

3 Matters Arising

3.1 Service and Financial Framework

David reported that a working group had met for the first time to begin to consider the process needed to address next years SAFF. Mark Wagstaff and Brendan Ward are in the process of putting together a paper that will include preliminary issues for the group to consider.

SERO are still waiting for Ministers to sign off this years SAFF.

3.2 Creation of new Health Authority

Penny reported that the consultation for the new health authority was now underway. The Health Authority was registering its concerns with the RO regarding the financial implications of the new health authority particularly around the issue of the Island premium.

A joint development session is to be held with IOW colleagues on 19th June to consider the future functions of the new HA and PCGs/Ts. The session would also undertake joint work on the management resources for PCGs/PCTs to ensure an equitable approach across the new Health Authority regarding the use of management costs.

3.3 Development of East Hampshire Primary Care Trust

Ann Bullen reported that the final draft of the PCT application document was now ready and would be submitted to the Health Authority sometime in the next week.

Consideration was being given to whether an explanatory leaflet in an easily readable format should be produced for the general public.

Development of Portsea Island Primary Care Trust

Tracy Green reported that the recommendation to proceed to Primary Care Trust status went to PIPCG's recent public Board meeting following the mandate given to the PCG by local GPs. The results of the informal survey carried out amongst GPs in Portsea Island demonstrated that 84% were in favour of proceeding to PCT status in April 2001. A formal application has now been submitted to the Health Authority.

Tracy Green thanked Max Millett for the hard work he had done behind the scenes and East Hampshire Primary Care Group for their assistance in preparing the application document.

3.4 Primary Care Group Boundary Review

Penny reported that on 6 June the Health Authority accepted the recommendations contained in the recent boundary review. Public consultation on the proposals would now form part of the Health Authority's overall consultation for the proposed East Hampshire and Portsmouth City PCTs.

Penny has written to all those involved advising them of this decision and thanking them for taking part in the review.

3.5 Future Services for Gosport and south Fareham

Penny Humphris reported that the first tranche of nurses were now working at Haslar in preparation for the launch of the Haslar Accident Treatment Centre on 1 August 2000. Ambulance crews were in the process of being recruited and a communications strategy was being prepared.

PHT has announced that it will be necessary to increase staff in QAH accident & emergency to accommodate the extra workload. It has been agreed that an external review would be undertaken.

The DSCA had advised that there were problems with SHO anaesthetic cover at Haslar resulting in no night cover. Discussions on how this might be overcome were in progress between PHT and RHH.

4 Terms of reference and arrangements for Corporate Board.

Penny reported that there had been some significant changes since the decision was taken to merge the PCG Leads meeting and the Corporate Executive Board.

A high level group, consisting of the 6 Chief Executives and representatives from both Hampshire and Portsmouth social services, is to be established for a temporary period to work as equal partners, in a whole systems approach to deal with urgent issues facing the local health economy. The main areas to be covered initially are waiting lists, acute pressures and intermediate care. Each group will have a designated project manager who will lead across the whole health care system.

With the formation of this group it is considered likely that other groups, like the District Wide Waiting Lists Group and the Chief Executive's Think Tank, whose work overlaps with the remit of this newly established group will be disbanded.

Additionally, with the creation of a new health authority and the establishment of primary care trusts from April 2001, the way of conducting business in the local health economy will face considerable change in the coming months and it was not considered an appropriate time to change the working arrangements of these two groups.

5 District Commissioning Group

Tracy Green and Ann Bullen presented the minutes from the District Commissioning Group of 19th and 30th May 2000 and highlighted key areas of discussion.

6 Performance Fund 2000/01

Sharon Palser gave a brief report on the Health Authority's progress against the criteria for triggering money from the Performance Fund 2000/01.

Funds will be released on a quarterly basis to those health communities that have met the published criteria on waiting lists, financial position and winter planning. The intention is to reward consistent performance throughout the year. It was noted that the criteria change from quarter to quarter.

Sharon summarised the local position and reported that the targets for the first payment on 1 June have not been achieved. Although two of the criteria have been achieved, the waiting lists target has not.

Sharon agreed to circulate an updated progress report with the minutes.

7 Proposal for Financial Risk Sharing Arrangements in 2000/01

Tracy Green introduced this paper proposing a framework for financial risk sharing between the Health Authority and its constituent Primary Care Groups.

A workshop is to be held on 28th June for further discussion.

8 Relocation of Cancer Services to the SGH site

It was agreed to ask Dr Nick Hicks to prepare a health economy wide response NH

to SUHT's paper on the relocation of cancer services from the RSH to the SGH site.

9 Any other urgent business

9.1 Drug Action Team boundary changes

Brendan circulated a paper providing information on the changes to the drug action team boundaries and the implications that this will have for substance misuse services for the Health Authority.

10. Date of Next Meeting

The date of the next meeting of the Corporate Executive Board is Wednesday, 30th August 2000 at 12.30 in the Large Conference Room.

Circulation List:

Ms P Humphris (Chair)
Dr J A Barton
Mrs S Clark
Mr J Henly
Dr J Hughes
Dr E Jorge
Mr J Kirtley
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Mr B Ward
Mr S Carr
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Briefing Paper: Implications for Substance Misuse Provision in this Health Authority , following a meeting with the UK Anti-drugs Co-ordinator on the 14th of June 2000

1. DAT boundary changes :

The DAT boundaries will be changing from being based on health authority areas, to being based on Local Authority areas. For this health authority this will mean that we are reporting to and being part of two DATs, one for Portsmouth City Unitary Authority and one for Hampshire County Council.

- Portsmouth Unitary Authority - for Portsea Island PCG area
- Hampshire County Council - for East Hants PCG area and Fareham & Gosport PCG area.

For the health authority this will mean duplication of representation at the DATs.
Possible that two differing systems of operation may develop.
Issues of inequality in service development may occur when working to two DAT teams / areas but within one health authority.
Changing the boundaries also has the potential for destabilising the positive , collaborative work that has been developed to date. It is anticipated that the current DAT members across the county will strive to maintain these positive links as far as is practicable and permitted, particularly in light of the fact that a number of big initiatives , such as Arrest Referral , have been commissioning on a county wide basis.

2. Pooled budgets:

All budgets that are headed ' substance misuse ' , from all agencies , are to be pooled.
That is the budgets of the Police , Probation, Social Services, Health Authority and any other budgets in this category.
It is anticipated that this pooled budget will come through to health authorities for managing but the purchasing of services will be managed via the DAT.
Substance misuse commissioning will **not** be transferring to the PCG's as previously detailed and any work on transferring responsibility must now cease.

Issues and implications :

- The DAT's are being reconfigured on Local Authority boundaries but the pooled budget is going to be managed on health authority boundaries; this leads to obvious conflict.
- This health authority will have budget responsibility for two DAT's (one whole and one in part)– Fareham/Gosport/ East Hants being part of the new county DAT and Portsea Island being part of Portsmouth Unitary Authority DAT.
- The DAT will have responsibility for the strategic development of all service provision across it's area. Again , the emphasis is that this health authority will cover two DAT areas. Therefore there will be the need for ensuring equity of access to services for all of the authorities residents.
- As the budget management is due to come down to health authorities, this authority must have someone in place or identified for this work.
- The time scale for implementing this new approach to budgets is very tight. Details of how it's to start will be issued to all agencies in July of this year, for actioning by October 2000.
  The message from Government is that this new way of delivering services must / will be in full operation before the next election (April).
- There are still a few areas of work to support the pooled budget approach that have not been made clear to us yet –

  1. Legislative changes that will be required to support this new approach, given that Parliament will be in summer recess. How will this happen?
  2. Who will hold the ' duty of care ' aspects to service delivery , if for example someone is not happy with the care package they have received ?
  3. The impact that centralising the budget will have on ancillary services , that perhaps are contracted through drugs budgets but are not labelled as such.

Rachel Lennon
Programme Manager - Substance Misuse & Sexual Health

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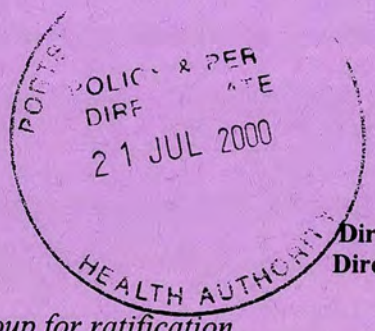

SDK/slp

Richard Samuel
Health Authority Business Manager
Policy and Performance

To go on Next Exec Team or appropriate group for ratification

18 July 2000

Dear Colleague

Re: Admission and Discharge Policy

I enclose a copy of the final version of the policy for ratification and implementation by your organisation.

My apologies for the delay in sending out this version but we have attempted to include appropriate comments made since draft circulation. As a result of this work and a number of recent discussions there are two key areas which need action outside the scope of this policy.

Appendix B: Joint Agreement on Discharge Arrangements

> This agreement was made seven years ago by agencies which no longer exist in the same shape. Whilst the standards must still apply this agreement needs urgent high level review.

Continuing Care Eligibility Criteria

> A number of comments requested that the policy incorporated the continuing care arrangements. Whilst there are clear links there is the potential for confusion. The question is whether it is timely to review the arrangements in particular guidelines for staff and written information for patients and perhaps resolution of disputes.

The policy builds on good practice within the district and has been kept purposefully broad, so that different organisations and care groups can develop their own procedures for implementing the policy and the standards within it.

The policy will be audited through the QPP, against standards on a quarterly basis and implementation will be evaluated in 6 months. Amendments can be made to the policy on an annual basis to ensure it remains a live document.

If you have any comments or queries please let me know.

Yours sincerely

Code A

Sue Damarell-Kewell
Quality Manager
Sue.Damarell-Kewell@portsha.swest.nhs.uk
X400: C=GB;A=NHS;P=NHS S and W HN;O=NHS Portsmouth and SE Hants HA;OU1=GW;G=Sue;S=Damarell-Kewell

PORTSMOUTH AND SOUTH EAST HAMPSHIRE DISTRICT WIDE ADMISSION AND DISCHARGE POLICY

1. Introduction

Good discharge planning is fundamental to the provision of efficient and effective health care and helps equip patients and carers with the knowledge, understanding and support to prevent or minimise further episodes of ill health. The costs of poor discharge planning include: inefficient use of beds; longer waiting lists; re-admission to hospital; increased patient and carer distress; increased work loads for community nurses and general practitioners.

The Patient's Charter states *"The Charter standard is that before you are discharged from hospital a decision will be made about any continuing health or social needs you may have. Your hospital will agree arrangements for meeting these needs with Agencies such as community nursing services and local authorities social services departments before you are discharged. You and, with your agreement, your carers will be consulted and informed at all stages."* This policy has been jointly developed by the local health services, in consultation with local Social Services Colleagues, and is based on the Health Service Accreditation Standards for Discharge Care.

Discharge planning should begin, where-ever possible at the first point of contact with the patient; e.g. outpatient clinic, pre-admission clinic, at the time of admission for elective admissions or within 24 hours for emergency admissions (in the early stages this may simply consist of information gathering about the home situation). Delayed discharge in the case of people who no longer need specialised services is an issue of great concerns for a number of reasons. The patient may understandably wish to go home as soon as possible. A delay may mean that access to the specialist services is denied to someone else, constituting inefficient use of scarce resources. Discharge planning is therefore essential.

The standards within this policy are based on agreed best practice. It is recognised, however, that there may be circumstances when some standards cannot be met (e.g. notice of discharge during a bed crisis). Exceptions should be rare and should only be made in agreement with all parties. If a discharge is arranged in a hurry, the need for good communication is even more important.

The patient's wishes are paramount, even when his/her preference for care on discharge places them at risk (unless he/she is formally assessed by a psychiatrist as mentally unfit to make judgements on their care)

2. Purpose

To ensure patient centred care through effective communication between health and social care teams, when patients are discharged from hospital or transferred from one service to another by:

- Ensuring that patients are discharged from hospital in a timely fashion to a clinically appropriate and safe environment.
- Ensuring that the receiving health or social care services are prepared to meet the patient's needs.
- Providing appropriate information, medication, equipment and minor environmental adaptations to enable independence for the patient and carer.
- Involvement of and consultation with the patient and relatives/carer at all stages of the discharge process. (It should be remembered that relatives and/or carers can only be given information with the agreement of the patient)

3. Scope of Policy

This policy applies to all care groups and sets the general principles for planning discharge care. Where particular services require more specific guidance this should supplement, not replace this policy. The policy refers to the discharge of patients to their own home, to other accommodation in the community or from one hospital to another. The principles should apply to all discharges but especially to those with complex needs. The following people may be at risk unless adequate arrangements are made:-

- people who are frail or elderly
- people who live alone, including those in sheltered housing and warden assisted accommodation
- people living with carers who may have difficulty coping
- people with a serious illness who may be returned to hospital for further treatment
- people being discharged for a trial period
- people who are terminally ill
- babies and children, particularly those at risk of abuse
- people who usually care for others at home
- people who are confused, have a mental illness or impairment
- people with special needs requiring equipment, training or supplies
- members of travelling families or the homeless
- people with language difficulties, including those for whom English is not their first language
- people with temporary or permanent disability

4. Responsibility

Managers are responsible for ensuring that all staff who are involved in the discharge process (including medical, nursing, professions allied to medicine and some clerical staff) are familiar with the requirements of this policy. Within each service the service manager is responsible for ensuring that the requirements are met or for reporting problems which need to be addressed. Clinical managers and team leaders are responsible for ensuring that action is

taken in individual cases so that people receive the right amount of care at the right time.

5. Requirements

The standards for the different stages of discharge planning, listed below, should be followed:

5.1 Pre-admission/admission

5.1.1 Referral letters should contain the locally agreed referral information (see appendix A)

5.1.2 Where pre-admission clinics are held, discharge planning should commence through; a) documentation of relevant information about the patients social circumstances and b) providing the patient/carer/relative with information on length of stay, mobility restrictions, possible environmental adaptations, e.g. rails, height of bed/chair etc., c) referral to social services where needs are complex and likely to need a care management assessment.

5.1.3 GPs, district nurses and care managers etc have a responsibility for sharing information on social circumstances, to facilitate discharge planning. Information contained in the referral letter should be confirmed with the patient/carer/relative at the time of the pre-admission clinic or admission to a ward.

5.1.4 The admission care assessment should highlight the need for referral to other services e.g. Occupational Therapy, Physiotherapy, Specialist Nurses Social Services etc.

5.1.5 When a high level of community support will be required on discharge (e.g. district nursing, social services etc.), contact should be made with the relevant service, within two working days of admission or the medical condition being stabilised, to gather information and facilitate early planning for discharge.

5.1.6 Where community services are already providing care prior to admission, they have a responsibility for sharing information (with the patient's permission) which would inform discharge planning.

5.1.7 The anticipated length of stay should be documented and shared with the patients/carer within 24 hours of admission and regularly reviewed there after. (This is an estimate to be used as a planning guideline and is not a fixed date).

5.2 Inpatient Episode

5.2.1 The named nurse or key worker is responsible for co-ordinating the plan of discharge and ensuring that all necessary actions and/or assessments take place.

5.2.2 Where a need for community care assessment is identified, social services will appoint a care manager in line with the local agreement. (see appendix B)

5.2.3 Each patient's care plan should include information on discharge planning, including completion of a discharge checklist (see appendix C for suggested content).

5.2.4 Patients/carers/relatives should participate in the developments of the discharge plan and be kept informed at all stages.

5.2.5 Where it is perceived that a patient may need a package of care following discharge a referral should be made to the relevant social work department, with the agreement of the patient/carer. Referral will be necessary when:

- The patient is unlikely to be able to return to his/her previous place of residence
- The patient can only return to his/her previous place of residence with new or enhanced support form community services provided through social services
- The patient has an existing package of care which needs re-starting (Appendix B contains a summary of the Joint Health Social Services hospital discharge arrangements).

5.2.6 The patient/carer/relative should be informed of the final planned date of discharge at least 48 hours in advance.

5.2.7 Any service providing support following discharge should be informed of the planned date of discharge at least 48 hours in advance.

5.2.8 Patients/carers/relatives should have a clear understanding of what services are to be provided post discharge and by which service and when.

5.2.9 Patients/carers/relatives should be given information and consulted on:

- future self care and life style
- medication and treatment
- transport arrangements
- use of equipment

5.2.10 When a home visit is deemed necessary, carers and relatives should be involved.

5.2.11 When equipment or home adaptations are needed patient/carer/relatives should agree with the choices made and be provided with suitable training.

5.2.12 The joint arrangement for the care programme approach should be

followed for those people with a mental illness.

5.2.13 When a patient has an infection such as MRSA or C. DIF, the relevant infection control policy should be followed.

5.2.14 If a patient takes self discharge, the GP (and other community services as appropriate) should be informed as soon as possible and no later than 12 hours when there is concern for the person's safety; otherwise on the next working day.

5.3 Discharge from Hospital

5.3.1 Discharge should not take place until the responsible clinician states the patient is medically fit for discharge, in consultation with the multi disciplinary team, and all essential support services/equipment are in place.

5.3.2 Patients should not be discharged after 5pm, without agreement by patient/carer, or any community service needed to provide care on the day of discharge.

5.3.3 Patient's with complex support needs must not be discharged at the weekend/bank holidays unless there is prior agreement with the supporting services.

5.3.4 The discharge checklist should be fully completed prior to discharge.

5.3.5 Medication/Dressings/Treatments

- TTO's should be prescribed, where ever possible, 24 hours in advance of discharge
- TTO's should arrive on the ward no later than one hour before the planned discharge time
- Medication should be supplied for seven days, unless the course is shorter
- Dressings, (including all materials, lotions, bandages etc. required incontinence products, and any other medical supplies required should be supplied at least for three days and in sufficient quantity to cover weekends and holiday periods.
- Discharge letter to GP/district nurse should advise regarding need for ongoing supply of dressings
- Patients/carers/relatives understanding of treatment and medication should be checked

5.3.6 Where applicable a DSS medical certificate should be supplied for the period the patient is expected to be unfit for work or two weeks, whichever is the shorter.

5.3.7 Hospital transport should only be provided where there is clinical need. Information on patient needs must be explained when transport is

ordered: e.g. stretcher, wheel chair, walking frame, two man lift etc.

5.3.8 Prior to discharge patient/carers/relatives should be given information on:-

- Ongoing care arrangements; Out Patient Appointment, further supplies medication, service visit to the home etc.
- Whom to contact in case of problems or emergencies
- Anticipated time of transport
- Package of care arranged
- Where applicable written information should be provided

5.3.9 The provider spell discharge summary should be completed and sent to GP with 24 hours of discharge and a copy given to the patient (see appendix D for information to be included).

5.3.10 When a patient is being transferred to another care environment a nursing transfer letter should be completed and accompany the patient on transfer (see appendix E for information to be included).

5.3.11 Care programme approach documentation should be given to the patient/relative/carer.

6. Monitoring/Audit

6.1.1 Monitoring/audit will take place through the Quality Partnerships Group.

6.1.2 Where applicable complaints will be harnessed to improve future practice.

6.1.3 Through compliance with the Health Authority requirement for regular census of delayed discharges.

Policy Produced by: The Quality Partnership Panel

Policy Produced: July 2000

Review Date: July 2001

For Review by: Quality Partnership Panel

Key Organisational contacts:
Portsmouth HealthCare NHS Trust: Lesley Humphrey, Quality manager
Portsmouth South East Hants Health Authority: Sue Damerell-Kewell, Quality Manager
Portsmouth Hospitals Trust: Ursula Ward, Nursing Director
Haslar: Barbara Smith, Quality Manager

APPENDIX A

INFORMATION TO BE INCLUDED IN THE REFERRAL LETTER

The referral letter should be legible and as a minimum contain the following information; where available.

- The patient's name and marital status
- Date of birth
- Address (with postcode) and telephone number
- NHS number - (if known)
- Identifying reference (if the patient has been seen by the hospital before)
- An outline of case history
- Treatment to date, including details of any medication or investigation
- An indication of what the general practitioner expects by way of response from the consultant
- Suggested diagnosis/reason for referral
- An indication of any special needs the patient may have
- Social factors which may influence inpatient care, discharge planning and management
- All available information affecting the patient's health which is likely to affect discharge needs and decisions.

APPENDIX B

JOINT HEALTH/SOCIAL SERVICES AGREEMENT HOSPITAL DISCHARGE ARRANGEMENTS

A Joint Community Care Agreement was produced by Hampshire County Council Social Services and Portsmouth and South East Hampshire Health Commission, in 1993 and is still in effect. This includes a Joint Policy for Hospital Discharge, copies of the full policy are held by Divisional General Managers. Key standards/requirements include:

Screening

- All patients will be screened at the earliest possible stage to establish if a referral to Social Services is necessary. Responsibility for ensuring this occurs rests with the Sister or Charge Nurse of the ward - although the screening may be done by other nursing, medical or paramedical staff and will draw upon existing knowledge of the patient from community staff.
- The patient must agree to a referral - unless the welfare of a child is concerned, or if there is doubt about the ability of the patient to make their own decisions.
- A referral to Social Services will be made in circumstances highlighted in para 4.4 of the main policy.
- Referrals should be on agreed forms and provide the information requested.

Assessment

- A Hospital based Social Worker will give an initial response to the referral, including meeting the patient within 2 working days.
- The assessment will normally be completed within 5 working days of referral.
- The completed assessment will include a health needs assessment. It is the responsibility of the doctor to complete this.
- The referral should indicate the estimated date of discharge and Social Workers will make every effort to prioritise their work to ensure assessment does not delay discharge.

Arrangements at time of discharge

- There will usually be at least 2 working days between the receipt of a request for service and the actual delivery of the service.
- The person who co-ordinated the care plan for discharge shall be responsible for reviewing the arrangement within 3 weeks of the patient beginning to use them.

Disputes

- The exception is that local managers will be expected to resolve any disputes that may arise. However in exceptional circumstances the situation may be referred to the Deputy Director or Social Services / Trust Chief Executive.

Monitoring Arrangements

At ward level continuous monitoring of any discharge delays (ie. where delay in excess of 10 working days occurs) should occur. This will be internally reported monthly and reviewed quarterly by the Trust/Health Commission and Social Service

THIS AGREEMENT NEEDS TO BE REVIEWED DURING 2000/2001

APPENDIX C

INFORMATION TO BE INCLUDED IN DISCHARGE PLAN OR CHECKLIST, AS APPROPRIATE

- Patient I.D.
- Named nurse
- Planned date of discharge
- Actual date of discharge
- Discharge destination
- Referral to Occupational Therapy; needed/made
- Referral to physiotherapy; needed/made
- Referral to S.A.L.T.
- Referral to Social Services; needed/made
- Referral to community nurse (CPR/HV/DN); needed/made
- Transport arrangements; needed/made
- Written/verbal advice to patient/carer/relatives on treatment/aftercare
- Discharge date discussed/agreed with patient/carer/relatives
- Equipment needed/in situ
- Aftercare arrangements needed/made
- Aftercare arrangements in place
- Clothes/keys etc. available
- Nursing transfer form needed/completed
- Spell discharge summary completed/copy given to patient
- Medication TTO's dressings, medical products etc. prescribed/issued to patient/carer/relative
- Patient/carer/relatives knowledge/skills checked
- Personal property returned
- Medical certificate issued
- Out Patient Department appointment needed/made
- Contact names/telephone numbers provided

All entries should be signed and dated

APPENDIX D

THE SPELL DISCHARGE SUMMARY PREPARED ON DISCHARGE, SHOULD CONTAIN THE FOLLOWING INFORMATION AS A MINIMUM

- The patients name
- Date of birth
- Address (with postcode) and telephone number
- NHS number
- Hospital reference number
- Consultant's name, speciality and ward
- Date of admission and discharge
- Discharge diagnosis; key investigations/findings; treatments
- Medication details to include ALL drug names, dosage and course length
- Follow up plan (including specific requests for primary health care team action, OPD arranged, OT, Physio, day hospital, specialist referral etc.)
- Whether elective or emergency admission
- No abbreviations, unless understandable by the patient
- Contact person

The information on the discharge summary must be clear, understandable and unambiguous.

(taken from Portsmouth & South East Hampshire Health Authority Quality Requirements for 1999/2000)

APPENDIX E

NURSING TRANSFER LETTER

On transfer of care, a Nursing Transfer Letter should accompany the patient, which includes as a minimum:

- Name
- Address (or visiting address) including postcode and telephone number
- Date of birth
- Name of GP
- Next of kin (with telephone number)
- Diagnosis
- Information given to patient/carer/relative regarding diagnosis/prognosis and understanding of condition
- Treatment/intervention required
- Named nurse contact number
- Social Worker contact number
- Summary of care/treatment in hospital
- Date of discharge
- Other services involved
- Waterloo and/or Barthel score where appropriate

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY
REDUCING THE CERVICAL SCREENING RECALL INTERVAL

In late 1998 the NHS cervical screening programme recommended that the recall interval for cervical smear testing should be reduced from the maximum of 5 to a maximum of 4 1/2 years. At that time it was noted that Health Authorities using the Exeter Call and Recall system were unable to recall patients for smear tests at other than full year intervals. As a consequence we were unable to take any action. In late 1999 a software upgrade was developed to allow health authorities to call at 4 ½ year intervals.

There has been discussion at the District Cervical Screening Working Group as to how this change may best be implemented. Informal contact has also been made with the Health Authority on the Island. As they have a 3 year screening interval they have no specific concerns on this issue. If the health authority approves the change to a 4 ½ year recall interval, the working group will arrange for prior publicity to be sent to general practitioners through their PCGs. However there are a number of issues that will arise in 4 ½ years time as a consequence of this change that both Health Authority and PCGs should note.

The impact on laboratory workload

1. Shortening the recall interval will at worst double the workload in the laboratory in 4 ½ years time for a period of 6 months. At present the laboratory is working close to capacity and a large increase in workload will be difficult to accommodate.

2. Shortening the recall interval will lead to a permanent increase in throughput at the laboratory of approximately 11% per year once the system is fully implemented.

However it is anticipated that some of the extra workload will be dissipated over the coming 4 ½ years as some women may have smears for other reasons before their normal recall date. The laboratory will also have sufficient time to plan how best to manage this increased workload and additional staff will need to be recruited.

The impact on primary care workload

3. GPs will at worst receive a doubling of requests for smear tests for a six month period in 4 ½ years. As described above some of this extra workload will be dissipated before this happens and almost 10% of women attend family planning clinics for smear tests.

4. There will also be an 11% increase in the number of smears taken in primary care each year. However this change will only result in a permanent increase of about 10-15 additional smear tests per GP list per year.

- The time period and method of calculating target payments for GPs will remain unchanged so some GP practices may in fact find it easier to meet their targets for payment.

Proposed actions

1. The commissioners of the service will work with the laboratory to minimise any financial consequences of the temporary and permanent increase in workload. Several years hence the trust will need to develop a business case to reflect the increasing level of costs incurred by increasing the throughput of the service.

- Opportunities for closer collaboration between the Island and Portsmouth pathology and cytology laboratories should be explored as part of this work.

2. The cervical screening working group supports a proposal to introduce a pre-printed cervical smear test form to primary care during the coming year. This will lead to an improvement in the quality and accuracy of some of the administrative aspects of the cervical screening programme and may marginally reduce workload. It also has potential to reduce the administrative workload in practices. A pilot is to be undertaken with one practice. Further information will be provided to the CEB about this once arrangements are clear.

Recommendation

The district cervical screening working group recommends that the health authority approve a reduction in the cervical smear recall interval from 5 to 4 ½ years from October 1st 2000.

Dr Nicholas Hicks
Consultant in Public Health

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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Review of the Portsmouth and South East Hampshire Health Improvement Programme 2000/2001

1 Introduction

The focus for Health Improvement Programme (HImP) development has shifted away from a district level towards localities based on Primary Care Group (PCG) boundaries. Each PCG will develop their locality HImP by the end of March 2001. The existing district HImP will continue but will adopt a more strategic role in relation to these locality HImPs.

This paper clarifies the role of the district HImP and suggests the key priorities it could contain. This paper does not deal with locality HImPs as their development has been taken on by Primary Care Groups with support from the Health Authority.

By the end of March 2001 there should be:

- A district-wide HImP for Portsmouth and South East Hampshire
- Locality HImPs for Portsmouth City, East Hampshire, Fareham and Gosport (which should include health plans for the two local prisons HMP Kingston and HMP Haslar)
- A HImP for the Isle of Wight

2 The Role of the District Health Improvement Programme

The existing HImP for Portsmouth and South East Hampshire will continue to set the broad strategic framework for the NHS and partners within the district. It will become less detailed as locality HImPs develop and it will contain national targets and priorities for organisations within the district interpreted, where possible, to a district level.

Although the district HImP should set the main priorities to be dealt with by PCGs during the delivery of their locality HImPs, it should also take into account any priorities for health improvement identified by the local PCGs.

3 Priorities for the District HImP 2001-2004

At this stage it is recommended that the district HImP addresses the following priorities:

- **Mental Health**
  The existing objective for Mental Health to be reviewed in the light of NSF (Mental Health) delivery plans.

- **Coronary Heart Disease**
  The existing objectives to be reviewed in the light of the NSF (CHD) delivery plan.

- **Modernising NHS Services and Waiting Lists**
  Existing targets and actions to be updated to reflect the plans from the Whole Systems Group and National Plan.

- **Learning Disabilities**
  The results of the recent strategic review of Learning Disabilities services should be integrated into the HImP, under Promoting Independence.

- **Older People**
  This should be added as a 'new' priority in preparation for the forthcoming NSF (Older People), integrated into the existing Promoting Independence section.

- **Teenage Pregnancy**
  Priorities set by the national and local strategies for tackling teenage pregnancy should be included in the HImP in the Reducing Inequalities section.

- **NHS National Plan**
  The implications of this may need to be reflected in the district HImP.

- **Locality HImP priorities**
  Priorities for health improvement which have been agreed at a local/PCG level should be included in the district HImP, possibly as appendices if appropriate. Gosport HImP should incorporate the evolving prison HImP for Haslar Detention Centre. Portsmouth City HImP should incorporate HMP Kingston's HImP.

In addition to the changes highlighted above, the following priorities are already in the district HImP and should be rolled forward into the district HImP for 2001-2004:

- Reducing Inequalities (including a Teenage Pregnancy section)
- Cancers
- Accidents
- Asthma
- Perinatal Mortality
- Promoting Independence (integrating an Older People's section)
- Developing Primary Care
- Provision of healthcare for residents of Gosport and South Fareham

In order to co-ordinate the revision of the district HImP, lead people from the Portsmouth and South East Hampshire Health Authority have been identified for each section of the HImP. These lead people are listed in **Attachment One**.

4 A Note on Inequalities

It is becoming increasingly important that the inequality agenda is recognised in all objectives for health improvement. Although the district HImP usefully identifies key determinants of health inequalities, and sets out objectives for these in its existing Reducing Health Inequalities section, it is recommended that EACH HImP priority highlights key health inequalities and sets out specific targets to tackle these.

This work was begun in the district HImP 2000-2003. For example, inequality targets for reducing smoking prevalence in wards where the highest rates have been recorded were set as part of the Coronary Heart Disease section.

5 A Note on the Isle of Wight

In the light of the planned 'integration' of the Portsmouth and South East Hampshire and Isle of Wight Health Authorities, it will be important to ensure that the existing Isle of Wight Health Improvement Programme is linked to the Portsmouth and South East Hampshire Health Improvement Programme.

It is recommended that the Isle of Wight HImP be defined as a 'locality HImP' and, as such, its priorities are included in the final Portsmouth and South East Hampshire HImP. The planning and delivery process for the Isle of Wight HImP in 2000/2001 will thus continue as agreed between partners on the Island but will have established links to the Portsmouth and South East Hampshire HImP prior to the integration.

6 Time-scales

In summary the key timescales for HImP development in 2000/2001 are:

- Locality HImP priorities identified by PCGs **by 31st August** and presented to district HImP Steering Group (14th September)
- District HImP review begins on **14th September** taking locality priorities into account
- Locality HImPs draw up implementation plans for each priority they have identified – these submitted to Health Authority **by 17th November**
- Health Authority lead people co-ordinate review of their HImP section in line with the recommendations given in this paper – review completed **by 24th November**
- First draft HImP, including locality HImPs, submitted to Regional Office **by end of November 2000**
- HImPs finalised between December and **31st March 2001**; this may involve final amendments in the light of feedback received, newly issued national guidance or agreements on resourcing

7 Recommendations

- The priorities for the district HImP identified by this paper are endorsed by the Portsmouth and South East Hampshire Health Improvement Programme Steering Group
- Inequality objectives and/or targets are included, and highlighted, for each HImP priority

Innes Richens
Health Improvement Programme Manager
Monday, 14 August 2000
h/innesr/planning/2000.2001/District HImP Priorities 2001.doc

Attachment One

Portsmouth and South East Hampshire Health Authority

Lead People for Review of HImP Sections: 2000/2001

HImP Section	**Lead Person**
Overall Co-ordination, Linkage to Isle of Wight HImP	Joanna Kerr
Mental Health	Dr Elizabeth Jorge Max Millet
Coronary Heart Disease	Dr Elizabeth Jorge Dr John Hughes
Modernising NHS Services and Waiting Lists	Mark Wagstaff
Learning Disabilities	Dr Elizabeth Jorge Elspeth Harding
Older People	Brendan Ward
Teenage Pregnancy	Dr Elizabeth Jorge Sarah Wild
Reducing Inequalities	Dr Elizabeth Jorge
Cancers	Dr Nicholas Hicks
Accidents	Dr Noreen Kickham
Asthma	Dr Paul Edmondson-Jones
Perinatal Mortality	Dr Nicholas Hicks
Promoting Independence	Brendan Ward
Developing Primary Care	Dr Paul Edmondson-Jones
Provision of Healthcare for Residents of Gosport and South Fareham	Penny Humphris
Other Agendas:	
Workforce Planning	Peter King Kathryn Rowles
Patient Involvement	Mary Stratford
Information Technology	John Jo-Campbell

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PERFORMANCE FUND – CASH LIMIT ADDITIONS
SUMMARY AS AT 31 MAY 2000

Introduction

The following pages summarise the local position and future targets for achieving the Performance Fund payments. These payments are the local allocations of the £60m NHS Performance Fund announced in March 2000 to provide financial incentives or reward for good performance.

Allocations

The allocation available for Portsmouth and South East Hampshire is £640k, payable in four equal amounts on

1 June 2000
1 September 2000
1 December 2000
1 February 2001

Criteria

Payment is contingent upon the achievement of targets set out over three criteria:

- waiting lists
- financial position
- winter planning

It should be noted that payments are withheld unless all targets are achieved across all three criteria. There is opportunity for the Health Authority to claw back previously withheld payments where performance improves in subsequent periods. However, there is explicitly no intention by the NHS Executive to release previously withheld payments on the final cash limit allocation date where there is consistent underperformance through the year.

Current position

The targets for the first payment on 1 June **have not been achieved**. Performance against each of the criteria is summarised below and set out in more detail in the following pages.

		Targets achieved	Targets not achieved	Overall
Criteria 1	**Waiting lists**	3	1	Not achieved
Criteria 2	**Financial position**	1	0	Achieved
Criteria 3	**Winter pressures**	3	0	Achieved
	Overall			**Not achieved**

1 JUNE 2000 PAYMENT

	Target	Actual Performance
Criteria set 1		
• Inpatient waiting lists	➢ Credible agreed profiles ➢ Inpatient/daycase waits within 2% or 100 above April profile i.e. below 10,099 ➢ No 18 month waits during the period	➢ Achieved ➢ Not achieved. April waiting list position 10,336 i.e. 4.4% (435) above profile ➢ Achieved
• Outpatient waiting lists	➢ Credible agreed profiles	➢ Achieved **Overall: Not achieved**
Criteria set 2		
• I&E position	➢ Credible agreed financial plan	➢ Achieved **Overall: Achieved**
Criteria set 3		
• Winter planning	➢ Approval from MET and SERO on local winter planning arrangements	➢ Achieved
• Cancelled operations	-	
• Delayed discharges	-	
• Trolley waits	➢ Green or amber status at PHT and Haslar during April i.e. i) no more than 25 patients waiting over 12 hours and ii) no over 24 hour trolley waits	➢ Achieved ➢ Achieved **Overall: Achieved**

Actions in place

Waiting lists

- Identified as high priority target by partner organisations for 2000/2001
- Restructuring of local groups underway to address whole systems
- Recovery plan being developed

1 SEPTEMBER 2000 PAYMENT – Current position

	Target	Actual Performance As at 15 June 2000
Criteria set 1		
• Inpatient waiting lists	➢ Inpatient/daycase waits within 2% or 100 above July profile i.e. below 9,447 ➢ No 18 month waits during the period	➢ Waits at 31 May 2000 will be available on the 19th June. (PHT weekly reports demonstrate a reduction of 600 since the end of April)
• Outpatient waiting lists	➢ Outpatient waits within 2% or 50 above June profile i.e. below 5,383 (over 13 week waits following GP referral)	➢ Waits at 31 May 2000 will be available on the 19th June.
Criteria set 2		
• I&E position	➢ Q1 forecast position within either i) 0.1% of the HAs cash limit of £372,648k i.e. £372,648k, or ii) 0.1% of NHS Trust turnover i.e. £tba. (whichever is the greater)	➢ Q1 Forecast position will be available at start of July, currently expected to be break-even. ➢ Tba.
Criteria set 3		
• Winter planning	➢ MET risk assessment of final winter plans not above "medium"	➢ Not yet known
• Cancelled operations	-	
• Delayed discharges	-	
• Trolley waits	➢ Green or amber status at PHT and Haslar during May, June and July i.e. i) no more than 25 patients waiting over 12 hours and ii) no over 24 hour trolley waits	➢ Green during May ➢ Green during May

Risk areas

Waiting Lists

Waiting lists for the Health Economy are profiled to drop 300 by the end of May and a further 300 by the end of June. Considerable risks still exist for achieving the end of July target, but significant progress has been made.