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**Healthwatch LLR Quarterly Meeting with CEO UHL NHS Trust**

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| **Gillian Adams** | **Vice Chair – Healthwatch Leicestershire** | **Chair of UHL Quarterly Meetings** |
| **Cherelle Farrell** | **Engagement Advisor - Healthwatch Leicestershire** | **Coordinator of Quarterly Meetings** |
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| **John Adler** | **Chief Executive** | **UHL NHS Trust Board** |
| **Mark Wightman** | **Director of Marketing & Communications** | **UHL NHS Trust Board** |

**Theme: Communication**

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| Question 1 | Healthwatch would like to ask how UHL plan to meet the standards outlined in the car-parking principles? |
| UHL Response | UHL provided the following response [(click here to read)](http://www.healthwatchleicestershire.co.uk/sites/www.healthwatchleicestershire.co.uk/files/healthwatch_november_nhs_car_parking_guidelines.pdf) |

**Background:** *‘NHS patient, visitor and staff car parking principles’*

* NHS organisations should work with their patients and staff, local authorities and public transport providers to make sure that users can get to the site (and park if necessary) as safely, conveniently and economically as possible
* Charges should be reasonable for the area.

**Source:**

<https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles/nhs-patient-visitor-and-staff-car-parking-principles>

*Issued by Department of Health 23rd August 2014*

**Theme: Communication**

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| Question 2 | a) How many patients is a consultant able to see in a week?  b) How are appointment-booking systems affected when consultants are absent? How many cancelled appointments, over any given period? |
| UHL Response | A typical substantive Consultant Neurologist would have 3 clinic sessions a week with each session having 8 patients this would be a combination of New and follow ups. So the total for the week would be 24 patients.  The epilepsy clinic is a multi-consultant clinic in which Dr Eames, Dr Farrell and I all participate assisted by one or two Specialist Registrars. The clinic would only be cancelled if all three responsible consultants were absent simultaneously, which is very rare. There is an obvious trade-off between the length of time patients wait for their appointment and the length of time they may be kept waiting in the clinic waiting room. If we try to reduce the former we risk overbooking the clinic and increasing the latter. However, as regards the epilepsy clinic we have taken the following measures to increase capacity:   1. Running the clinic as a multi-consultant clinic as above with each participating doctor taking the next patient in line rather than taking patients from an individual consultant’s list 2. Increasing the number of Specialist Registrars allocated to the epilepsy clinic from one to two and ensuring registrar presence in clinic by cross-cover 3. Increasing the number of available appointments in line with increased registrar availability 4. Developing a business case for the recruitment of two extra Epilepsy Specialist Nurses to work in the community   As regards my other clinics, those would be cancelled if I were not present.  All clinics run 42 weeks a year with consultants giving 6 weeks’ notice of leave |

**Background:** What is the booking system for appointments with the Outpatients Epilepsy Clinic & Neurology Department based at Leicester General Hospital given instances reported to Healthwatch where consultants are absent?

**Source:** Appointments with Dr Mark Lawden Clinic- are being booked despite the consultant not being there, patients report this to as miscommunication and waste of resources. Issues with the clinic being over booked, and patients have to wait long time to be seen.

**Theme: Communication**

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| Question 3 | a) What procedures do the PILS team use to vet their responses to patients before they respond to a complainant?  b) How can UHL ensure that a patient’s data is protected whilst making a complaint? |
| UHL Response | I would apologise if there has been any miscommunication from the PILS team to a patient. Having reviewed complaints received into the service in June 2014 for midwifery services I am unable to identify the particular case referred to but I would be very happy to investigate further if provided with more detail and to enable a personal apology to be offered.  There should be checks made on response letters by the individual manager signing off the response to ensure the response is both adequate in terms of detail as well as demographics and grammar/spelling and a check list is provided to assist them in doing so. The PILS team should therefore receive a response that is “fit for purpose” but they also check demographics to ensure the right response is going to the right patient.  In the 8 years that I have been managing complaints I am aware of 2 occasions when human error has meant that a letter has been sent to the wrong address (wrong house number put on letter). On both occasions we made immediate moves to successfully retrieve the letters before they had been opened. We were open and honest and informed the intended recipients of the error, with apologies.  In terms of emails the PILS team are instructed to request a delivery and read receipt so that we can be assured that correspondence is safely delivered. I hope that is helpful. |

**Background:** In June 2014 a patient submitted an official complaint about the midwifery service at Leicester General Hospital. Patient received a response that thanked them for an email sent in February 2014 and congratulated on the birth of a baby in January 2014 at the Leicester Royal Infirmary. The patient had in fact had a baby at the General in September 2013 and did not send a letter in February.

**Source:** Patient contacted Patient Information and Liaison Service (PILS) to highlight the mistake, using the name and direct dial number found on letter. The individual on the phone stated the response letter had not come from them.

Patient is concerned that PILS do not check the details of their responses accurately and that they are replying to the wrong patients regarding a complaint.

**Theme: Communication**

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| Question 4 | Does the Trust have a policy in place when it comes to presenting staff ID and engaging with patients? |
| UHL Response | As stated in our Security and Uniform and Dress Code policies all staff have a personal responsibility to wear the correct identification badge(s) at all times for security reasons and should expect to be challenged if their identification badge is not visible. We have also recently introduced new magnetic name badges, which clearly state the employees name and role which staff are expected to wear.  Part of the Quality Commitment is about patients knowing their named nurse and named doctor and this should be above each of the beds. We will also be introducing ‘hello, my name is….’ as part of this. |

**Background:** Concern raised regarding Acute Neurology Services at LRI. Patient was admitted to LRI- Ward 24 September 2014, stayed for 10 days and during that time had interactions with a number of medical staff, from nurses to doctors.

**Source:** Patient found it very distressing when staff came to talk to patient and they do not introduce themselves properly; do not say what role they are, no name, or relevant information. Patient feels it’s very impersonal and reported sometimes you can’t even see their ID badge.

**Theme: Communication**

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| Question 5 | Could UHL provide an update to what is currently in place to ensure shorter waiting times for pre-booked appointments at the Ophthalmology Clinic? |
| UHL Response | The service has reviewed the clinics templates and is putting in place appropriate time spaces to assist with clinics running to time. In addition the medical staff and support staff capacity has been increased to reduce the overall waiting time. |

**Background:** A number of people have raised concerns regarding Ophthalmology Clinic at the LRI over long waiting times for pre-booked and arranged appointments at outpatient clinics (approx. 3hrs long). A similar question was asked at the UHL Quarterly Our Quarterly Meeting April 2013, your response was briefly as follows;

* UHL have adopted changes in the administrative processes and started work to understand the clinic templates with regards to the number of patients UHL need to see in a particular clinic
* Looking at our Doctor availability and how changes to the rota will support some of the necessary changes required. In time, over the year, we will have had the opportunity to review all sub specialty Ophthalmology clinics with a view of ensuring the correct capacity is available and the necessary clinics provided

We wish to introduce a triage system to ensure each patient is seen in the correct clinic first time. This is a high volume specialty and we need to make the outpatient process run much smoother for patients who attend regularly or as a short-term visitor to service

**Source:** Patients believe that having a good management system, something in place that allows the flow of appointments should be priority.

Patients are making comments: *‘What is currently in place is not working and needs to be addressed’*, *‘if you are planning to go to the clinic, you are better to take a picnic- you will spend a half of day there’* and *‘Consultants are never on time’*.

**Theme: Communication**

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| Question 6 | a) When changes are made to appointment and communication formats do UHL consult patients Liason Officers regarding potential changes?  b) Do UHL offer alternative formats for appointment letters for visually impaired patients like; large print, alternative colour fonts? Is there anything that can be done to assist eye clinic patients with these access concerns? |
| UHL Response | The outpatient letters have been reviewed and amended so they are easier to read and have minimal information on them.  We are going to roll this out in a phased way. The letters will start to be available from November 2014.  They are due to change in ophthalmology in February 2015. Large print and Braille letters will also be available.  Regarding Braille we are going to trial a new system that will hopefully be able to automatically generate a Braille letter to those patients that have notified us that they need them. This is being tested at the moment.  In terms of the appointment cards our Equality Manager is going to follow this up with Ophthalmology. |

**Background:** Eye Clinic Liaison Officer (ECLO) reported several patients have expressed concerns at the use by Hinckley hospital of new appointment cards which measure only the same size as a credit card but contain the same amount of required information (i.e Name, Hospital number, clinic name, appointment date/time, Hospital contact number). These are very difficult for anyone with good sight to read, let alone someone with visual problems. Previous appointment cards were postcard sized and much more user/patient friendly. No warning or explanation was given for the change and patients have expressed concerns about missing appointments due to not being able to read the card or losing the card, as it is so small.

**Source:** This question was also presented at the LPT Quarterly meeting on 16th October 2014 who currently believes LPT still utilise post-card size appointment cards in this clinic. Secondly despite several attempts, appointment letters are still not offered to visually impaired patients in alternative formats other than the standard NHS very small grey on white print.

**Theme: Documentation**

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| Question 7 | What process is followed to ensure any allergy concern/ needs are addressed before a patient’s planned procedure at hospital? |
| UHL Response | All endoscopy units now have latex free gloves onsite for patients with latex allergy.  We rely on the referring clinicians indicating on the referral forms if a patient has an allergy – this will then alert the administrative staff to ensure that the patient is booked is on the list and make sure the nursing teams are aware.  Some patients are pre-assessed prior to their admission (either face to face or over the telephone) with a member of the nursing team – this appointment also gives us the opportunity to identify if there are any allergies/ symptoms that we need to be aware of – we are planning to role out pre-assessment across all sites. |

**Background:** Patient is allergic to latex, which can be found in patient’s consultation notes. This information had not been considered prior to patient attending the planned procedure and they had not prepared non-latex gloves. This caused a significant delay in the patient having the procedure and a excessive number of car park charges for having to attend 3 hospitals in a day.

**Source:** A patient reported to Healthwatch that they had a planned procedure for an endoscopy at Glenfield hospital. Glenfield Hospital was unable to provide the procedure due to only having latex gloves and no alternative gloves were available on site. Patient was then sent to LRI where again, no alternative gloves were available.

**Theme: Documentation**

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| Question 8 | 1. Why are LRI consultants not accepting referrals from Specsavers? 2. Why are opticians no longer referring to GPs? 3. Has the Ophthalmology department not considered utilizing local hospitals for consultations (ie. Melton Mowbray Hospital Eye clinic)? |
| UHL Response | Referrals can be received directly from SpecSavers.  SpecSavers are also able to refer directly for Cataract patients.  I am not sure why opticians are no longer referring to GP’s this will need answered by the CCG’s.  Ophthalmology clinics take place in all community hospital locations except for Ashby and Lutterworth, the service is working with the Alliance to increase the number of clinics starting with ocular plastics. |

**Background:** In May 2014 when patient last attended Specsaver’s for Optician appointment they were informed their Cataracts had clouded over. Specsavers referred patient to the LRI for laser treatment to correct the eye, which was at 6.15pm 18th August at the Ophthalmology department. Patient attended and saw a consultant who stated that only a consultation was planned because opticians have been making inaccurate referrals and LRI want to make sure the diagnosis is correct.

**Source:** The consultant stated surgery is necessary but that patient would have to come back to LRI in October for the procedure. Patient had been prepared to have operation and feels frustrated that there is a further wait and that they do not acknowledge Opticians diagnosis.

**Theme: Documentation**

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| Question 9 | How are A&E hospital staff teams made aware that a patient is on End Of Life care? |
| UHL Response | This question raises a number of issues including   * Meaning of the term ‘end of life care’ * Documentation and communication of decisions that somebody is approaching the end of their life * Discussions and planning about future care, including what to do (or not do) in anticipated emergencies/urgent situations –for example about particular treatments and whether or not they should be give.   Currently the process of alerting A&E staff relies on the patient/ family bringing with them a record of discussions that have been had with them and clinical staff (e.g. their GP) about treatments and preferences for ‘end of life care’  The nationally accepted definition of ‘end of life’ is when somebody is likely to be in the last year or so of life. This means that some patients who are having ‘end of life care’ may be in the last few days of their life, whereas others may have a prognosis of many months or longer.  The appropriate treatments for patients, including those at the end of their life, depends upon a number of factors including the person’s preferences, the clinical situation at the time and the overall prognosis. For example whether the person has days, weeks, months or potentially longer is likely to influence which treatments are or aren’t appropriate. When assessing a patient who is ‘having end of life care, clinical staff should take this into account but the fact the prognosis could vary from days to a year or so means that it is unlikely that just letting A&E staff know that somebody is having ‘end of life care’ would enable them to make safe or appropriate decisions about that person’s care.  Staff who work in A&E, admissions units, out of hours services (GPs and nurses) and the ambulance service, may all need to make urgent decisions about people who are recognised as approaching the end of their life. A number of initiatives are in place or being further developed in order to help these staff know what to do when the encounter an ‘end of life’ patient and to try to ensure that care that is given is tailored, when possible, to the needs and preferences of the patient and their family. This includes recognising the patients as end of life and recording this on the GP practice palliative care/ end of life care register and offering the patient the opportunity to complete a Personalised Care Plan: Deciding Right. At present, although hospital staff can make this recommendation, the process is led by the GP.  Unfortunately, the GP practice palliative care register is not routinely available to other staff, for example those in A&E. There is a task group from the Leicester, Leicestershire and Rutland End of Life Care Group looking at whether an electronic system can be implemented to record patients who are recognised as being ‘end of life’ as well as recording information about plans have been made about their care (anticipatory or advance care planning). The number of different clinical systems locally, competing pressures and the need to identify a process that could work to alert clinical staff to plans for patients with other health problems but who aren’t end of life), means that progressing an electronic solution is complex. An electronic solution is unlikely to be ready in the near future but trying to find a solution to this is likely to be an important part of future Better Care Together work.  At present, the recommended process for alerting staff that somebody is ‘end of life’ and what to do is via creation of a handheld record. The process starts when it is identified that a person could be approaching the end of their life and the doctor/ nurse explains this. The person should then be offered the opportunity to consider their preferences for future care –this often happens over a series of visits because people often need time to assimilate and consider these difficult decisions. Clinical staff will usually discuss what sort of things may happen to them in the future and help identify their preferences and priorities. Sometimes this is specifically about treatments, and sometimes it is about other things –such which family members they want involved in discussions about care if they can’t express their wishes. It may (but does not have to) include decisions about resuscitation and preferences for place of death. Following discussions, for patients who are ‘end of life’ the information is documented in a ‘Personalised Care Plan: Deciding Right”. This is printed off and given to the patient –or the family if the person does not have capacity. It is recommended that they keep it in a green wallet and often this is place in a green (medication) bag. The person (patient) and their family are advised to let people know about its existence and to take it with them when something happens e.g. when the attend A&E or a clinic appointment. The hospital have seen increasing numbers of these over recent months and work is underway to ensure that frontline staff, such as those who work on admissions and A&E, are aware of these documents and how to interpret them. |

**Background:** A patient lived in residential home and one night had a fall. An ambulance was called and the patient was taken to A&E. The family of the patient was contacted by the residential home staff and told to make their way to LRI. Family explained to the Doctor treating the patient that the patient was on End of Life care and should not be treated, as the Doctor did not know this they were reluctant to stop treatment.

**Theme: Performance**

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| Question 10 | a) What is the latest performance figures for pre and post handover between EMAS and LRI staff?  b) How is UHL progressing with meeting its target? |
| UHL Response | Latest figures for September are that 106 crews (out of 5186 per month) waited over 60 mins. However we believe this information is incorrect and are working with EMAS and CCGs to improve the data accuracy and actual turnaround time. |

**Background:** At the July 2014 EMAS quarterly meeting Paul Sinclair (at the time) Director of Operations discussed that ambulance response times are falling short of national targets. The hand over between EMAS and A+E should total 30 minutes; 15 minutes for ‘pre’, which is UHL patient admissions, and 15 minutes for ‘post’, which refers to the clear down time for EMAS to prepare for next patient. UHL are currently taking 21 minutes for pre-handover which means the EMAS post-handover is reduced to 9 minutes to be able to meet target 30minute target.

**Source:** Concern has been raised with Healthwatch to what is being done to reduce the length of handover times in A+E and consequently the time ambulances wait outside with new admission patients.

**Theme: Emotional Wellbeing**

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| Question 11 | Whilst appreciating that nursing staff are busy, is there an understanding that patients with Dementia need to have some company/ stimulation? If so, how are UHL implementing this? |
| UHL Response | We know meaningful activity can improve the well-being of people with dementia as well as promoting a closer working relationship with their carers. In September 2013, UHL appointed three Meaningful Activity Facilitators using part charitable funds and CQUIN monies. They are an additional support for older people’s wards at the Leicester Royal Infirmary to help improve the well-being of people with dementia and their carers.  To date they have supported over 730 patients with dementia through reminiscence, music therapy, arts and crafts, afternoon tea events, mealtime socialising, along with many other activities, whilst being in hospital. This was achieved on patient 1-1 basis or as part of a group activity.  In addition, the Meaningful Activity Service has;   * Involved 308 carers with activities * Supported patients through procedures such as x-rays, scans, blood taking, personal care and infection prevention * Assisted or prompted with their nutritional intake. * Have been involved in training and recruiting Forget-Me-Not Volunteers   This year we are in the process of appointing a further 5 facilitators to enable us to expand the Meaningful Activity Service across more wards within the Trust to support people with dementia.  NB: UHL currently are the only trust who has implemented this service. |

**Background:** Dementia patient was put in a side room and left with no company or stimulation for long periods of time, becoming quiet and withdrawn. One doctor acknowledged this and so when on duty would have dementia patient sit by the nurses’ station for stimulation, which made patient much happier.

**Theme: Nutrition**

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| Question 12 | Healthwatch would like to ask if you could explain to our members what plans UHL have to meet the better food standards? |
| UHL Response | Interserve are to introduce new information systems to help individuals assess nutritional and calorific data on the daily menu choices. Details are expected back from Interserve by Friday the 31st of October  Steamplicity Patient Feeding is a nationally utilised system with strong ethical and sustainable components.  Further reviews are needed. Restaurant menus  Choice of 3 fish dishes daily  Menus reviewed every 6 months to reflect seasonal produce  All areas have tap water available  All potatoes, rice and vegetables are cooked without Salt  Currently 3 fruit choices per meal on menu  Half of tea and coffee should be Fair Trade  This is not currently a requirement of the existing agreement. As such currently 0% of patient tea and coffee is fair-trade. However we offer both Soho and Starbucks Brands within our staff and visitor restaurants. Starbucks Coffee is ethically sourced in accordance with Coffee and Farmer Equity Practices and all Soho Coffee is Fair Trade. 100% of retail coffee is ethically sourced, with approximately 50% Fair Trade.  Patient tea and coffee specifications under the contract will need to be considered further. |

**Background:** *‘New rules to serve up better food for NHS patients and staff'*

Key requirements:

* Hospitals should screen patients for malnutrition and patients should have a food plan
* Hospitals must take steps to ensure patients get the help they need to eat and drink, including initiatives such as protected meal times where appropriate
* Hospital canteens must promote healthy diets for staff and visitors – the food offered will need to comply with government recommendations on salt, saturated fats and sugar

Food must be sourced in a sustainable way so that it is healthy, good for individuals and for our food industry

**Source**: The new standards will require hospitals to provide:

* Fish twice a week
* Seasonal produce
* Tap water
* Cooked rice, potatoes and vegetables without salt
* Half of all desserts should be fruit
* Half of tea and coffee should be Fair Trade

[**https://www.gov.uk/government/news/new-rules-to-serve-up-better-food-for-nhs-patients-and-staff**](https://www.gov.uk/government/news/new-rules-to-serve-up-better-food-for-nhs-patients-and-staff)

**Theme: Nutrition**

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| Question 13 | Patient spouse asks what is the policy regarding meals for Dementia / Alzheimer’s patients; are relatives and carers able to make meal choices for patients? |
| UHL Response | There is no set policy, relatives and carers are able to make menu choices for patients. Menus are available on the ward for carers and relatives to select appropriate meals and Housekeepers do communicate their choice to the ward hostesses. The new patient profile will include a section for carers and relatives to share dietary needs and preferences. Carers are able to support their relative at meal times should they wish to. Sign posting behind patients bed spaces is available where required to highlight where patients will need assistance at mealtimes. Meal time volunteer assistants provide additional support and receive training in the meal time needs of patients with dementia. Nutrition is also reflected in Category A dementia staff training. The UHL dementia implementation plan incorporates nutrition as part of a workstream action. |

**Background:** A patient was suffering from Dementia at a stage that the patient was unable to recognise their spouse. Whilst patient was in hospital spouse found that food the patient didn’t like / couldn't eat as patient didn't have dentures, was being provided. When ward staff were asked why staff said told patient had chosen it. Spouse tried to explain that patient was not capable of knowing what they were choosing.

**Theme: Promoting Health**

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| Question 14 | a) A Healthwatch member reported that at the LRI Balmoral Entrance it reads that when people are standing on NHS grounds "it is illegal to smoke on this property", NHS grounds constitute ‘outside’ so is it illegal to smoke on the property?  b) NHS NICE say smoking costs the NHS 2.7 billion pound a year for treatment of smoking related diseases. What has UHL put in place to prevent smoking on their sites? |
| UHL Response | The message on the tanoy is used as a deterrent (actually says “it’s against the law” – and there is currently no law preventing people smoking on NHS properties).  It is obvious that the deterrent is not working and that we need something more robust to prevent smoking at our hospital entrances and move smokers to the designated smoking shelters or off-site.  Unfortunately to police this efficiently would cost the Trust money in hiring additional security staff.  We do support our staff to challenge visitors and patients smoking in areas where they shouldn’t, but many staff do not feel confident or comfortable to do so.  In the past, we have tried to implement a complete smoking ban across our hospitals for all staff, visitors and patients. However, following a great deal of negative feedback from the public and patients about this decision, we relented and introduced discreet smoking shelters for visitors and patients to use on site. Our staff are still banned from smoking on site.   We realise that these designated smoking areas often are not used as they should be and therefore still trying to overcome the issues we face with the public smoking outside building entrances and windows.  We also offer support for patients to quit smoking via MECC (Making Every Contact Count) and local smoking cessation services.  Smoking on NHS properties is a difficult issue to address and we welcome any constructive feedback and support from the public, and Healthwatch, as to ways we can move forward to eliminated unwanted smoking and its associated waste from our sites. |

**Background:** Healthwatch have received a number of questions and concerns regarding smoking outside hospitals from two very different perspectives.

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| Question 15 | Would John Adler see UHL working with a third party to set up the social enterprise? |
| UHL Response | There is significant interest in government circles (in fact cross-party) in the potential benefits of mutualisation within the NHS.  There are already many examples of this in community health and social care services but not in the acute sector.  This has resulted in the establishment of a ‘Mutuals in Health Pathfinder Programme’ to help further explores the potential and issues and identify solution to practical barriers.  UHL has been selected as a pathfinder along with a further 8 NHS organisations; the government has established the Pathfinder Programme as the mutual approach has not been tried in the acute sector.  We would emphasise that this is intended to help further explore the potential and the issues involved and does not commit us to following any particular course.  So no decisions to go down this route have been made.  As part of the programme, we will be provided with bespoke technical, legal and consultancy support and our contract value has been agreed at £120,000 in meeting our support requirements to successfully deliver the main elements of the programme.  Contracts will be awarded and commence with a kick off meeting in January 2015, following which there will then be a three month intensive period of work which will conclude by 31 March 2015.  A report will be produced, based on the conclusions and lessons learnt from the Pathfinders and will make recommendations to the Government by May 2015. |

**Background:** Following on from UHL John Adler’s comments in the Leicester Mercury in July regarding UHL taking part in a pilot looking at becoming a social enterprise.

An example of this is Circle, which is a Private organisation which runs Hitchingbrooke NHS trust through a social enterprise. They have been in partnership since 2012 and have had a number of issues during those 2 years.

**Source:** <http://www.leicestermercury.co.uk/Mutual-benefits-hospitals-shake/story-21936760-detail/story.html>

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| Question 16 | Can UHL clarify who is responsible for providing clear information on discharge and aftercare to a patient and when does this communication takes place during the discharge process? |
| UHL Response | It is the responsibility of all members of the multidisciplinary team to ensure patients their families and carers are consulted and regularly updated about discharge planning from admission (or preadmission when patients are attending pre-assessment clinics prior to admission); throughout inpatient stay.  It is the responsibility of the Consultant to ensure that the patient is fully aware of their diagnosis, treatment and aftercare. On the day of discharge the doctor responsible for discharge will provide the patient with a copy of their discharge letter which will be sent to their GP, containing the following information:   * The reason for admission * Main diagnosis * Past medical history * Inpatient management including events; operations; clinical risk factors * Key investigations * Healthcare related infections * Medical certificate * Information for patient / carer/ future plans * Follow up dates (outpatients) * Dementia screen * Drug allergy status * Action requested by GP * Medication given on discharge and changes to routine medication-patients requiring injections to be administered by the district nurse will be given an authorisation letter with details of the name, dose and administration route of the drugs required.   It is the responsibility of the nurse who is discharging the patient to ensure they are fully aware of their on-going care needs following discharge. If the patient is referred to community services they will providing the patient with a copy of their transfer letter which will provide the following information:   * Reason for admission/diagnosis * Transfer address * Next of kin * Mobility-Falls risk assessment/ transfers * Skin care-waterlow score/pressure sores/ wounds/ wound care * Personal care- e.g. assistance with washing and dressing * Nutritional information- special diet/ malnutrition score/Weight * Continence care-catheter * Bowel care * Behavioural problems * Equipment ordered/ required * Symptoms to look for and where to summon help * CHC funding * Details of package of care   There are various leaflets available for patients for specific conditions or aftercare e.g. wound care leaflet, instructions for caring for your fracture-the leaflet will either be given to the patient by the discharging nurse or by the specific specialist nurse caring for the patient.  The Allied Health Professionals (OT, physio, speech & language therapist) will provide holistic functional patient assessment and consider equipment, adaptations and/or goals for rehabilitation, to enable the patient to return to their baseline. They will liaise with patients, their carers, families and multidisciplinary teams within UHL and externally to enable the needs of the patient to be met.  If the patient who raised this question would like to speak to us in person about their experience we would be very happy to do so. |

**Background:** When UHL were last asked questions regarding discharge April 2014. UHL responded that discussions have started to look at the needs of patients who are being discharged from ITU/HDU and how best the specialist nurses can support this transition and indeed any further discharge arrangements.

**Source:** A patient spoke of their experience regarding being discharged from General Hospital after an operation but not being provided with any information regarding follow up care. Patient was not advised to see a nurse or GP but did so after persistent pain for two weeks subsequently the patient feels that the internal bleeding was missed because no care information was provided.