TRAFFIC, ENVIRONMENT & COMMUNITY SAFETY SCRUTINY PANEL

MINUTES OF A MEETING of the Traffic, Environment & Community Safety Scrutiny Panel held on 16 February 2011 at 3.00pm in Meeting Room 2, Third Floor, Portsmouth Guildhall.

(NB These minutes should be read in conjunction with the agenda for the meeting, which can be found at www.portsmouth.gov.uk).

Present

Councillors
Caroline Scott (Chair)
Mike Blake
Lynne Stagg

In attendance

Maria Purse, Emergency Pathway Manager, Portsmouth Hospitals NHS Trust
Allison Stratford, Associate Director of Communications &Engagement, Portsmouth Hospitals NHS Trust
Dawn Egerton, Senior Manager, Adult Social Care, PCC
Anthony Quinn, Senior Local Democracy Officer

6 Apologies for absence (AI 1)

Apologies had been received from Councillor Frank Jonas, Nichola Martin, Senior Discharge Nurse Portsmouth Hospitals NHS Trust, Judy Hillier, Solent Healthcare, Portsmouth Local Involvement Network

7 Declarations of interest (AI 2)

There were no declarations of interest.

8 Minutes of previous meetings (AI 3)

RESOLVED that the minutes of the TECS meeting of 26 January 2011 be agreed as a correct record.

9 Patient Discharge from QA Hospital and St James's Hospital (AI 4)

The panel continued their review into, "patient discharge from QA Hospital and St James's Hospital and welcomed the representatives that have attended today's meeting.

The chair expressed concerns regarding the level of abbreviations within the documents that had been submitted to the panel ahead of the meeting and sought clarity regarding their meaning.

The panel received a presentation from the Emergency Pathway Manager from Portsmouth Hospitals NHS Trust.

[TAKE IN PRESENTATION]

The panel heard that effective discharge planning occurs either at the point of entry to the hospital, or prior to admission, during out-patient appointments and were informed of the distinction between simple and complex discharge from hospital. Around 80% of discharge from hospital are classed as simple and require very little involvement for the patient to be sent home safely. Conversely, where there are complex discharges, there can potentially be a lot of clinical input. It is ultimately the decision of the senior clinician when a patient is deemed to be “medically fit” to leave or “medically stable”. The decision to apply any changes to the Expected Discharge Date (EDD) can only be sanctioned by the senior clinician with input from all involved in the care and welfare of the patient. It is possible for patients who are deemed “medically stable”, to still be receiving treatment when they are deemed eligible to go home.

There is an Integrated Discharge Bureau (IDB) at QA Hospital, which is mirrored on the model in use in Southampton. The benefits of the IDB are that it brings together the professionals involved in the patient’s ongoing care to discuss the discharge options and progress to ensure they do not stay in hospital longer than is medically necessary, as this can be detrimental to the recovery process. This type of intervention has always been in place, although it is now on a much more formal basis.

The panel heard how ongoing funding arrangements for patients can be a barrier to discharge and that this can sometimes slow down the process. There are funding panels operated by Social Care that sit on Tuesdays and Fridays to agree funding requests. There are occasions when decisions regarding funding can be taken out with the panel meetings by a senior manager within Social Care. Some of the barriers identified where funding can’t be agreed relate to complex histories or family dynamics. Other obstacles to effective discharge apply to managers from private residential homes not attending QA to carry out care assessments in a timely manner. This is particularly pertinent on Friday’s, where there appears reluctance by private residential homes to accept patients. The level of family engagement can also slow down the discharge process, particularly where the family are seeking an appropriate care home for their relative.

There are enablement beds and assessment beds within the Portsmouth health system, however, there is high demand for these services and limited availability. The use of assessment beds enables patients and their families to make decisions about future care needs in a more relaxed environment than an acute hospital ward.

Improvements in the pharmacy department at QA have helped to reduce waiting times in the discharge lounge following the installation of a robot to pick drugs, coupled with electronic prescribing. This is complemented by ward based dispensing, where medication can be issued on the ward and the

patient discharged direct from the ward.

Patient transport can be a cause of delayed discharge, however, QA seeks to make best use of the limited resources by grouping (where appropriate) patients who live in a similar locality and sending them home together. Whilst this efficiency is cost effective and saves money for the hospital, it should be noted that there is no legal requirement for the Trust to provide such patient transport.

The discharge lounge has separate male and female sections to protect patient's dignity and is equipped with facilities for making hot and cold drinks, together with better access for families. Not all patients need to be discharged from the discharge lounge. The hospital deals with an average of 150 discharges per day, excluding day surgery cases.

There are on average 120 patients (10% QA bed stock) who are classed as medically stable, that have their discharge delayed due to waiting on something to take place in order for them to be discharged from the acute hospital environment.

The panel thanked the Emergency Pathway Manager for the presentation.

The panel then heard from a Senior Manager from Portsmouth City Council Social Care department, who had previously submitted responses to questions raised by the panel at their last meeting.

[TAKE IN RESPONSE]

The panel heard that it was often availability of appropriate provision, or the need for modification of the patient's home that prevented timely discharge of patients as opposed to actual funding issues. The panel were informed that legislation under section 2 of Community Care (Delayed Discharge) Act 2003, requires the Local Authority (LA) to assess the patient within 72 hours, however, the LA currently rejects about 40% of section 2 notifications due to the patient having an extended expected discharge date, or the referrals being inappropriate for a social work assessment. When the LA is served with a section 5 notice, they have 24 hrs (up to 48) to discharge the patient. Both the section 2 & 5 notices can be served at the same time if the patient has been admitted for less than 24 hours, and a breach of section 5 will result in a fine for the LA for contributing to Delayed Transfer of Care (DTOC). The DTOC data is always based on figures from midnight on Thursdays. There have been £3,500 of fines in total for this year and since 2nd August 2010, there have been only £500 in reimbursable fines paid, which equates to 5 delays for PCC. During this period, there have been 51 joint delays which could be the result of a combination of factors, and 82 delays directly attributed to PHT.

The panel heard examples of delays caused by factors outside the influence of QA and the LA, including; waiting for installation of door sensors, awaiting delivery of special air mattress, out of area family looking for out of area care home at weekends. In these examples, everything was being done to get the

patients future care needs catered for and discharged from hospital.

Differences in professional opinion about who should take responsibility for areas of care following discharge, such as a patient who requires a medication prompt to enable them to remain well; can cause conflict between health and social care professionals. This could be alleviated by having a shared funding pot that dealt with the patient's needs on a holistic basis. The panel were advised that patients may be discharged from an acute hospital setting to a community or home environment and receive primary care services, commissioned by the local Primary Care Trust.

The panel were informed that there needs to be joint commitments to discharge. Whilst members of staff already have the freedom to discharge patients, there appears a reluctance to do so. The panel heard that Hampshire (PCT) are funding Community Matrons to work with wards to get patient's home earlier to prevent extended stays in hospital, whilst PCC and PCT are using their additional DoH funds to facilitate earlier discharges for 'simple' patients' discharges (eg those without the need for a full social work assessment) through new reenablement workers into domiciliary agencies and care or nursing home beds, with assessment and therapeutic input in the community. Also there is work ongoing to support and facilitate CHC discharges in a different way by admitting patients into assessment beds from QA, but this requires more discussions to ensure all agencies involved are able to accommodate these changes to minimise any disruptions to other services or systems.

The panel heard that work already ongoing to tighten contracts, and changing market forces e.g. the opening of Harry Sotnik Nursing home, and more extra care housing stock, would improve the delay process currently being experienced within the private sector.

There is a meeting being set up between QA and Social Care to ensure checks are in place to prevent errors and increase learning for staff involved in the discharge process, as it was acknowledged that there has been some increase in safeguarding concerns around poor discharges.

The panel thanked the Senior Social Care Manager for her presentation.

RESOLVED that;

1. **The Senior Local Democracy Officer to compile an A-Z list of the abbreviations used and circulate to all panel members**
2. **The presentation given by QA Hospital and response to questions from Solent Healthcare be circulated to all panel members**
3. **Panel members submit any unanswered questions to the Senior Local Democracy Officer for inclusion in the draft report**
4. **A draft report of this stage 1 review be brought to the next meeting, for ratification and submission to Health Overview & Scrutiny Panel**

10 Date of next meetings (AI 5)

Thursday 10th March 2011 at 3 pm, Executive Meeting Room, Guildhall

The meeting closed at 4.30 pm

Chair…………………………………………………………………………

AQ 17/02/11