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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HOUSING & SOCIAL CARE SCRUTINY PANEL

WEDNESDAY, 11 DECEMBER 2013 AT 1.30 PM

THE EXECUTIVE MEETING ROOM, THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Lucy Wingham 02392 834662
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Membership

Councillor Sandra Stockdale (Chair)
Councillor Steven Wylie (Vice-Chair)
Councillor Margaret Adair
Councillor Michael Andrewes
Councillor Lee Mason
Councillor Mike Park

Standing Deputies

Councillor Phil Smith
Councillor Caroline Scott
Councillor April Windebank
Councillor Steve Wemyss

(NB This Agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Apologies for Absence

2 Declaration of Members' Interests

3 Minutes of Previous Meeting

The minutes of the panel's meeting held on 7 November 2013 will follow.

4 Matters Arising from previous minutes (Pages 1 - 8)

i) Information circulated by Tim Hodgetts and Claire Budden in response to issues raised by Alison Croucher's presentation on sheltered housing
ii) Alison Croucher has provided anonymised accounts provided by sheltered housing residents

5 Review: Hospital Discharge Arrangements

Elaine Bastable, Housing Options Manager to speak about the local authority's housing allocations implications.

6 Date of next meeting

A provisional date of Thursday 30 January to be considered for a morning meeting with hospital representatives.

3 December 2013

Appendix 1 - Accounts of hospital discharges back to PCC Sheltered Housing schemes that went well and hospital discharges that could have gone better

Summary of events	**Outcome & Residents / Scheme Manager comments**
X arrived home in the evening on the 10/04/13. The family had told us when they went to see X that night X had a fall. We went to see X in the morning; X was upset and could not stand. X wanted to go to the toilet we helped X onto the commode but it was a struggle, we made X a cup of tea and toast and phoned the GP. The GP phoned X and spoke to her friend to say that she would not be coming out to see X. I phoned the GP up and said that GP needs to come out and could they see staff. GP phoned me and advised that they were taking X back into Hospital. X was relieved to go back into hospital. X became very ill then sadly passed away.	I would question why X was discharged home without support and care set up and in place to support X's discharge.
X came home on 18-6-2013 at 4.30pm, we were notified about that X was coming home and X was told by the ward sister that X would have a carer that evening and a morning and evening call starting the next day. X didn't have a carer that night, I phoned the next day, was told PRRT should have seen her, I phoned them, they knew nothing about it. I called the hospital again they said they would make the referral. There were no visits at all on the 19-6-2013, I phoned again on the 20-6-2013 and told ASC that X was extremely distressed about what was happening. Care started later that day. Scheme staff helped X until the care started.	This was very frustrating as I felt I was being pushed from pillar to post and all I wanted was to get X the care she had been promised on discharge.

X had a very successful discharge from hospital. A Social Worker rang to say X would be home on the 25th February 2013 about tea-time. It enabled us to ring the meal provider, the community nurses to dress X's leg and X's care agency. Family were informed and a friend was going to visit to check on X. As X had suffered a stroke X was sent home with a thickener for food/drink. Family were also able to buy a liquidizer and suitable foods and we were aware of X's needs because the Social Worker had briefed us.We were also informed that X would receive care 4x a day and what that consisted of and 3x week the Stroke Team would visit.	Good communication and involving scheme staff allowed this to be a very smooth, efficient discharge and our resident received excellent care from all involved.
Admitted to hospital on 20.06.13 and was discharged on 26.06.13. I rang the hospital (ward E3) and advised staff that X had no family support and that they needed to contact me to let me know when X would be discharged so that I could ensure that I was in the scheme and get any shopping, meds etc that X may need and arrange frequent visits to ensure that X was ok. I was not advised of X discharge and it was by luck that I saw X in the building. X had no food in the flat and could not walk far at all. I took X to the shops in a wheelchair as X could not have got to the shops unassisted and visited frequently until X recovered.	If I had not have seen X, X would have been at home without food, a drink or visits to ensure X's wellbeing. This may have resulted in X being readmitted from either falling or dehydration. The hospital should have contacted me as requested.
3/1/13 Admitted to hospital via ambulance and treated for lung infection, discharged 29/1/13 and arrived home at 7pm with family. O.T visited X's flat prior to his discharge, PRRT in place for his return to help with poor mobility.	Everyone arrived as they should and the transition was a good one for our resident.

Discharged on 07/08/12 - Home at 14:30X broke upper arm falling out of bed on 06/08/12, X was sent home by ambulance car without any checks on home situation or prior warning to scheme staff.X had no chair to sit in as X had only moved in to the scheme on the day X broke arm, X was upset and confused.We had no idea what if any care had been arranged until staff contacted the Hospital.	It would have been helpful if Hospital staff or O/T had spoken to scheme staff to find out the home situation and advised us of arrangements for care package prior to discharge.
X was admitted with heart and lung problems on 15/03/13 X was sent home in a Taxi on a walking frame, the driver dropped X's bag outside the main door and left X, X had no key to get in. No info was given to scheme staff prior to discharge, no home situation check and no care package arranged. Seven days later X fell and broke collar bone in four places.	It would have been helpful if Hospital staff or O/T had spoken to scheme staff to find out the home situation and advised us of arrangements for care package prior to discharge.
18.5.13 Admitted to hospital via ambulance, 19.5.13 sent home with PRRT in place to support. First visit from PRRT on the 19th resulted in X being taken back into hospital as they felt X couldn't cope in own home at that time. No rehab placement was available so X was taken back to QA, before being transferred to Spinnaker ward at St Marys shortly after. We were called by the discharge nurse 5.6.13 to tell us X would be home the following afternoon, X actually arrived home around 15:30 7.6.13. PRRT was put in place but was cancelled by X as they were coming to get X up but arriving between 10/11am, by which time X had got up, been out and back again.	X felt that had a rehab placement been offered before the first discharge X wouldn't have had to be re admitted to hospital.

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Apologies from Tim Hogetts & Claire Budden who will be attending the 'Health and Social Care Partnership (HaSP) Stakeholder Event - An event to consider the announcement to create an Integration and Transformation Fund'

Tim has added below some context as to what this event is about so that the panel can understand its importance and also how it links so well to discharges from hospital and the services provided in the community.

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice.

In 'Integrated care and support: our shared commitment' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

Whilst the ITF does not come into full effect until 2015/16 it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2 2015/16, which must be in place by March 2014. .

The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years.

There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in The NHS belongs to the people: a call to action1. This process will support the development of the shared vision for services, with the ITF providing part of the

investment to achieve it.
The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Comments in response to presentation by Sheltered Housing Manager

Following the presentation by Alison Croucher (referred to below as SH for Sheltered Housing) at the previous meeting Tim Hodgetts and Claire Budden (referred to as ASC for Adult Social Care) have submitted the following responses to this evidence:

SH evidence : Scheme Managers and their teams providing the Sheltered Housing service to residents do not always play the role we would like them to play and should play in the hospital discharge process.
As part of the hospital discharge process we would like to see the knowledge and experience of scheme staff drawn on in a timely way to ensure the best possible outcome for residents being discharged from hospital and to reduce waste in both time and money to all services involved.

ASC response: It would be extremely useful to have Scheme staff involved in the discharge process and more often than not they are contacted. However, the demand and capacity of PHT does mean that clients can be referred, assessed and discharged within a very short period. When the Hospital Social Work team contact Scheme managers for support, they are not always available to respond the same day, the next day or over the weekend. This is not an appropriate reason to delay discharge and would occur a discharge delay fine for PCC at £100 a day. PCC have not been fined for any delayed discharge for the last 3 years under the current process. There is also a cohort of clients that are discharged directly from the Emergency Department, Medical Assessment Unit, day units and wards that have not been referred and are unknown to the Social Workers. These clients are reliant to the discharging nurse to contact Scheme Managers.

SH Evidence : Scheme staff in all categories should play a key role in the hospital discharge process as they have a level of knowledge that the hospital discharge team will not have and are in the majority of cases the most appropriate resource to pull when a resident is to be discharged as -

- They know each resident and how they live i.e. what they will be returning home to, do they choose to live in poor conditions? Are they reclusive and likely to refuse care set up by the hospital team? Will they have keys to get in, food, is the heating on, will they key electricity etc. when they return home?

ASC Response: The hospital will contact scheme managers when they are involved in a case. To improve communication and sharing of resource, it would be useful for scheme managers to write a admission summary for the client to take with them when admitted to QA. This way the information is there immediately and can be used to avoid admission where possible as well as support discharge. In the more complex cases, it would certainly be useful for the scheme manager to

attend the ward and be part of the discharge process in a timely way. (this could be same day or within 24 hours).

SH

- Due to regular contact and the relationships built, scheme staff often have good knowledge of each residents personal circumstances i.e. be able to give an honest account of the residents support network - residents will often say that scheme staff will do it all or friends/family will help just to be able to get home, often this is not the case.

ASC: Response as above.

SH:

- Scheme staff know how their scheme is run and the services provided within - it is often assumed by others that Sheltered Housing staff can provide 'personal care' and are on site 24 hours a day in all 3 categories, or there is little or no knowledge by others of the services we provide.

ASC: There are regular training sessions for all PHT staff regarding discharge services within ASDC and Community Providers. It would be extremely useful for a nominated Scheme Manager to attend and present at these regular workshops so all staff involved in discharges are educated regarding the services that can be provided.

SH: They can pull together all of this knowledge a to advise whether the residents home is the best place for them to be discharged to given their care and support needs following discharge.

ASC: Response as above. Also to add that a discharge destination is a multi-disciplinary decision, taking into account all professional opinions. Where the client has capacity, these professional opinions are communicated with the client so that they can make an informed decision.

SH: This is how we would like it to be, however Scheme Managers are frequently overlooked as part of the hospital discharge process and then have to go to great lengths to arrange care, get shopping, charge meter keys, arrange medication etc. very quickly to ensure the safety and well-being of that resident when they just arrive home with no fore warning.

ASC: For all clients that are discharged without an appropriate service being commenced, there is a system wide approach to reporting risk and incidents to PHT. These are then investigated and any responses and actions shared with those involved. As above not all clients discharged are known to the Hospital Social Work Team and as a result it is crucial these risks and incidents are reported.

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