HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES of the meeting of the Housing & Social Care Scrutiny Panel held on Friday, 28 March 2014 at 12.00 pm in the executive meeting room, floor 3 of The Guildhall, Portsmouth.

Present

Councillor Phil Smith (in the Chair)

Councillors Steven Wylie
Margaret Adair
Michael Andrewes
Lee Mason
Mike Park

15. Apologies for absence (AI 1)

There were no apologies.

16. Declaration of Members' Interests (AI 2)

There were no declarations.

17. Minutes of the meeting held on 18 February and 24 February 2014 (AI 3)

(TAKE IN MINUTES)

The minutes of the Housing and Social Care Scrutiny Panel meetings held on 18 and 24 February 2014 were agreed as a correct record and signed by the chair.

18. Review: Hospital Discharge Arrangements (AI 4)

Mike Quinn, the Managing Director of Medicine for the Clinical Services Centre at QA Hospital

Mike Quinn explained that there are 105,000 discharges a year which are managed through the hospital. 80% of these discharges are classed as 'simple', with the remainder being categorised as 'complex'. There is a cohort in the middle which requires more focus and attention. An example of a simple discharge would be a patient who has an arranged procedure and is in hospital for a few hours for that procedure. An example of a complex discharge is when a patient is admitted following 'an event' and has more than likely come through the emergency department.

Prior to the pressure period before Christmas the Integrated Discharge Bureau ('IDB') used to meet twice a week, now they meet daily. Mike Quinn chairs these meetings and community partners from Hampshire and Portsmouth also attend the meetings. The IDB discuss the discharge and care package of the more complex cases, which tend to have a complicated discharge planner. Often social services recommend a referral whilst on the ward. It is at the IDB that the patients other needs often become identified. For example, whilst admitted a patient could become homeless. A delayed discharge is often non-health related and these cases are discussed daily at the IDB meetings. The bed stock needs to be utilised for 'acute' care. The hospital look to discharge a patient once the healthcare plan is complete and we can ensure a safe discharge. The hospital does not want to leave any patient feeling vulnerable. Working with our partners is key and our relationship with Portsmouth is very positive.

The following information was given in response to questions from members of the panel;

- When a patient is in hospital, this offers a period of respite and it is often at this point that the carer feels they cannot cope. This is not recognised prior to the patient admission and so is not planned for. Families/carers feel that they cannot cope when the patient is discharged. The hospital would identify this as 'potentially complex' and would involve social services.

  Marie Edwards gave an example of this where social services have recommended a patient be discharged to Grove House as an interim arrangement but the family are adamant that the best place for the patient is here in hospital. A whole care package is available for the patient at Grove House but the family are blocking the discharge. The acute care has finished and the family want the patient to go home but not via another route. The family are advised that this is a step down opportunity to give the family more time to look at the next care step.

- Families do not see that they are 'bed blocking' and feel that it is their right to say no to a discharge. It is about managing expectation, first at ward level by nurses and doctors, and then this being enforced by other partners of the 'managing discharge team' ('MDT').

  Mike Quinn reiterated that it is important that all of the clinical groups are working towards one document plan within the patients' notes. This is managed by the MDT on their white board rounds, at ward level, who look at the whole care package. All patients have a named consultant and any decision made by that consultant can be challenged as to its reasonableness.

- In response to a question regarding the times of the day, or evening, that patients are discharged, Mike Quinn said he would be horrified to know that patients have been discharged unsafely. Hospital transport is available up to 2100 hours and we do work with the family regarding the most appropriate time of the day for a patient discharge. 60% of our discharges occur after 3pm and this is mainly due to family need.

- In response to a question regarding that some of the care agencies do not know how to feedback information into the hospital, Marie Edwards explained that patient care providers should know how to feed information back. If Agency's have a wasted visit or an agency goes out to see a patient recently discharged, we need to know. We have met with PHT to look at moving these processes in alignment. There is now a much more co-ordinated approach for all.

- Mike Quinn explained that there is currently a big focus on patient experience and PHT have appointed a role of Corporate Nurse (CN) who will lead on this issue. Friends and family, and patients, are encouraged to provide feedback on the website, through PALS and the PHT meet with nursing home managers on a regular basis, where patient experience feedback is encouraged. Marie Edwards mentioned that she has met, and will continue to meet with the CN to look at sharing the issues logs and to look at any recurring themes. She felt that there is now a real sense that things are moving forward.

- In response to a question regarding what the outcome is if a particular nursing home cannot accommodate a discharged patient, Marie Edwards explained that options would be provided for a suitable alternative vacancy but it is often the case that the family will insist on waiting for the home of their choice to become available. We then try to encourage an interim move but again this often takes a lot of persuasion. It is appreciated that this is often a difficult decision for the family to make but there is an expectation from families, which needs to be managed. Often homes will not accept patients if they cannot accommodate their particular needs even if there is room available. Nursing Home staff will come to assess the patient whilst in hospital but quite often the patient does not receive the reasons as to why they have not been accepted at the particular home of their choice. Mike Quinn added that if there are staff shortages at the nursing homes, then they are unable to turn up to assess a patient. This non-assessment has a knock-on effect and means they have to stay another night in hospital when it is not necessary and the patient is ready for discharge. There are arrangements in place where groups of home care staff come out to make an assessment. The question has been raised as to why the PHT cannot make assessments, particularly when the patient has been agreed ready for discharge. However the Care Quality Commission must undertake the assessment of care.

  Mike Quinn reiterated that the weekly IDB meetings, has improved the flow of patients through the hospital and the relationship between Portsmouth adult social care and the PHT has hugely improved. There is room for improvement but the healthy relationship means there is an appetite for improving, to iron out 'the niggles' and to strive for perfection.

  Mike Quinn gave an example of a patient who lived in a raised apartment, was admitted to hospital and following treatment needed a wheelchair. He was assessed as physically fit to leave the hospital but needed ground floor accommodation. During the patients stay in hospital, his accommodation had been let out by his father and therefore was deemed to be homeless. Eventually the patient took himself to Portsmouth housing office.

Marie Edwards explained that we do need to have a couple of adapted disabled properties, preferably ground floor, available for incidents like this. Portsmouth does have Grove House and Longdean Lodge for interim care but more independent interim accommodation is needed.

- In response to a question asking whether PHT can discharge patients to St James' Hospital or to a rehabilitation clinic, Mike Quinn explained that patients can be transferred directly to St James'. However, patients are often in beds here with mental health issues who need to be assessed. We often have to provide security as they are unpredictable. Medically they have been addressed but mentally they are 'not fit' to be discharged.

- In response to a question relating to when a patient is discharged to a Portsmouth owned home and whether the PHT are satisfied that Portsmouth are getting these sorted, Mike Quinn explained that the PRRT works well and that the community nurses do come into the daily meetings. The CN team then assess the number of visits required.

- In response to a question relating to adaptations causing discharge delay, Mike Quinn explained that patient needs are identified as early on as possible and what equipment we think would be of benefit to the patient on discharge. The PHT do discharge patients to Longdean and the Grove if patients are waiting for equipment or adaptions.

- In response to a question relating to when patients are discharged to a local authority sheltered home at the weekend and is it assumed that they have support, Mike Quinn explained that PHT would never assume as our aim is for a 'safe' discharge. If a weekend discharge were planned PHT would look at the support available to the patient.

- Asked how the PHT manage quality and successful discharge, Mike Quinn explained that the patient receives on-going support and care. The patient is monitored through re-admittance. PHT have failed if the patient is re-admitted within 28 days. PHT do not receive any payment for a re-admittance.

- In response to a question relating to support for a discharged patient in terms of shopping etc, Mike Quinn explained that the Red Cross are situated within the hospital and supply equipment. Marie Edwards also explained that an initiative started four months ago, DAD worker ('day after discharge'). DAD follows patients who have come through the social care route to see if all has gone well with the discharge, checking milk etc and support is in place. The workload for a DAD worker is roughly 4-5 patients a day. Social care workers are based in the hospital until 2000 hours daily now. Mike Quinn also added that the hospital now has a supply of tracksuits because if patients are admitted during the night in their nightwear and are then ready for discharge the following day, we can get them out of the bed and into the discharge lounge. PHT are working towards 24-7, 7 day working. We now employ a registrar for three hours on a Saturday and Sunday. The registrar is able to discharge patients. Weekends are often the ideal time for patient discharge as the family are around and able to offer support.

19. Date of next meeting (AI 5)

It was agreed that the next meeting would be arranged in consultation with the chair and the panel members.

The meeting concluded at 1.45 pm.

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Councillor Phil Smith
Chair of the Housing and Social Care Scrutiny Panel