MINUTES OF A MEETING OF THE JOINT DELAYED DISCHARGES TASK AND FINISH GROUP HELD AT COUNTY HALL, CHELMSFORD ON 20 MAY 2010 AT 10AM

Membership comprises Members of the Community Wellbeing and Older People Policy and Scrutiny Committee (CWOP P&SC) and the Health Overview and Scrutiny Committee (HOSC)

*	W J C Dick (Chairman)		Mrs M Miller
	L Dangerfield	*	Mrs J Reeves
*	M Garnett	*	Mrs M J Webster (part)

* Present

Officers in attendance were:

Robert Fox	-	Governance Officer
Graham Hughes	-	Committee Officer
Jennifer Maude	-	Executive Support Officer

Also in attendance:

Charles Novis	-	Essex and Southend LINk

1. Apologies and Substitution Notices

The Committee Officer reported apologies from Councillor M Miller.

2. Declarations of Interest

There were no declarations of interest reported.

3. NHS West Essex and NHS Mid Essex Update

Graham Ramsay, Chief Executive, Mid-Essex Hospital Services NHS Trust, John Tobin, Divisional Manager, Emergency Care, Broomfield Hospital, and Tracy Porter, Commissioner NHS Mid- Essex, were in attendance at this meeting to discuss health delays in hospitals within their area, determining the reasons behind the delays and the action needed to eradicate them.

Councillor Dick opened the meeting and confirmed that the Task and Finish Group's remit was to look at hospital delayed discharges particularly beyond seven days. Statistics had shown higher delayed discharge figures in the Mid-Essex area than other areas in Essex and Members were concerned that such delayed discharges did not adversely impact on other services, particularly delaying urgent operations, nor exacerbate the risk of patients becoming institutionalised.

Mr Ramsay advised that a PFI new build at Broomfield Hospital would be handed over in August and be fully operational in October providing more social care beds. New models of care were being looked at including reducing the unnecessary emergency admittance for the elderly who otherwise could be institutionalised once admitted and who would be better placed in alternative care arrangements through community pathways. Mr Tobin added that executive and senior management focus had increased across all health partnerships to address the issue but that numbers remained higher than was thought necessary. Very few appointments for operations were cancelled as a result of the delayed discharges.

Mr Tobin confirmed the high level of bed occupancy at present was due to an increase in emergency admissions the previous week particularly in the age profile of 85+. Winter peaks for admissions were expected and an extra intermediate care ward could be opened to relieve the pressure. Mr Ramsay advised that the Hospital trust were slightly unusual compared to other hospital Trusts in that they did have extra wards that could be opened to deal with peak periods of demand for beds although this could incur extra staffing costs to administer the wards.

NHS Mid Essex reported that as a result of increasing delays during the last year a strategic group had been formed to work with health and social care partners through the coming summer to develop a robust plan and to ensure systems were put in place to support patient discharge and to reduce the numbers of delays. Mr Ramsay advised that the various funding mechanisms for hospital trusts and PCT's were not helpful to co-ordinate actions but that the economic environment would add further pressure on the parties to be more joined-up in their thinking and working practices going forward so as to judge social versus health responsibility. However there were good existing relationships between Social Care and the PCT. As a result of the winter 2008/9 peak the PCT and Social care and the Hospital Trust had met regularly to go through delayed discharges generally and appropriate care and to ensure that the process moved patients through appropriately and as fast as possible.

Mr Tobin confirmed that the opportunity existed to treat some elderly persons at home, if appropriate processes were in place, and various initiatives already were underway to support this including community matrons to manage long-term patients, extra support for GPs to avoid unnecessary hospital admissions, intravenous operations undertaken in the community, and further attention given to arrangements for end-of-life care.

Members questioned whether pressure on beds could lead to premature decisions being made on discharges. Mr Ramsay advised that the opposite was true and that the hospital often was too slow to complete a discharge and that they were working on planning for discharge at the time of admittance with a treatment plan and estimated discharge date.

Mr Tobin advised that one of the key assessments the hospital had to make was when a patient no longer had acute medical needs but was not necessarily ready to go home and that it was up to their partnership with PCT colleagues to resolve an alternative community pathway; currently Social Care and community services were not necessarily set-up for this assessment and resolution. The hospital trust were looking at ways to facilitate improvements to the discharge process particularly to intermediate/interim care locations in a cost effective manner. It was explained that Adult Social Care already did use interim placements and step down beds while patients were waiting for care home spaces or funding and these decisions were taken with relevant family members. The health partnerships worked together to manage family expectations and address issues and concerns to try and minimise any further delays.

The PCT were increasing the use of on-the-spot purchasing of interim beds at various residential homes and Members agreed that it was better to incur cost in this manner, and it would be a more suitable environment for the patient, rather than incurring extra hospital ward costs.

The representative from The Essex and Southend Local Involvement Network (LINk) present at the meeting advised that wherever possible relatives could do with information on anticipated future care needs on the day of admittance and not a few days before discharge so that early advice and arrangements could be instigated. However, this was not always possible although MEHT had developed a patient information pack as a result of an integrated workshop the previous year. LINk felt the use of sheltered housing as an interim placement should be encouraged and explained to the patient in a positive manner to relieve pressure on hospitals. Furthermore LINk were actively encouraging health and Social Care partnerships to look at the use of social landlords with warden (or similar) presence on site. In particular, legislation on mental capacity had helped with discussions with family members and the final decision making process.

Members queried whether there was a high incidence of re-admittance from particular care homes and whether this could be related to staffing levels at these homes. MEHT would advise on this.

Statistics

Members questioned whether each set of statistics reported for patient admittances and delayed discharges included those patients remaining from the previous reporting period or whether they were new cases. MEHT agreed that they would look into whether the reporting statistics could be made clearer.

There were issues with the way in which delays were compiled and reported. An example was given of the incidence of the Norovirus where wards needed to be isolated or closed and patients could not be discharged and would then appear on

the delayed discharge figures. Members queried whether this should have been included in the statistics without, at least an explanatory note.

Conclusion of evidence

Mr Ramsay advised that in the Netherlands acute hospitals ran their own social care homes and that some benefit could be seen in integrated care pathways for acute and social care bed placements. Members discussed the practicalities of shared budgets and the example of Hammersmith and Fulham Borough Council that had pooled its health and social care budgets with mixed results.

In conclusion Mr Tobin confirmed that he felt the position was improving as a result of social care team changes, increased management focus from the hospital trust and health and social care partners. Undoubtedly, more work was required and MEHT would be working closely with the PCT on this. Members were encouraged that there had been recent progress on the matter of delayed discharges and requested that they be kept informed of further developments and progress. They concluded that the MEHT statistics were not necessarily showing the complete picture.

The representatives of the MEHTand PCT then left the meeting.

It was suggested that the next step for the review would be to receive:

- Evidence from the Essex and Southend LINk on delayed discharge case studies with patient views, as appropriate, to be taken to reflect the concerns of the public.

It was **Agreed** that:

1. A representative from LINks be invited to attend a future meeting of the Group to give evidence on their case study findings.
2. A review of the commissioning of residential social care was a separate issue outside the current remit of the Task and Finish Group.
3. Further spot purchasing of interim social care beds by PCTs should be encouraged if proven to be more cost effective.

4. Date of Next Meeting

The Group agreed to hold the next meeting in around six weeks from the date of this meeting.

The meeting closed at 11.29am.