Sunderland City Council

Health and Wellbeing Scrutiny Committee
23rd November 2011 Committee Room 1
Policy Review: Hospital Discharge
Evidence from Service Users / Carers

Notes of meeting held on: 23rd November 2011

Present: Cllr Peter Walker (Chair), Cllr Christine Shattock (Vice Chair), Cllr Fiona Miller, Cllr Diane Snowdon, Cllr Jill Fletcher, Cllr Neville Padgett, John Dean (Links), Ralph Price (Links), Eibhlin Inglesby (Carers Centre) Victoria Brown (Age UK),

In attendance: Karen Brown (Sunderland City Council), Helen Wardropper (Sunderland City Council), Christine Swain (Links), Janet Butler (Links)

Apologies: Cllr Norma Wright, Cllr Anne Hall, Cllr Bob Frances, Cllr Paul Maddison, Ernie Thompson (Action on Dementia Sunderland)

		Action
1.	**Welcome, introductions and apologies** Cllr Walker requested everyone gave a brief introduction of themselves. Apologies were from Ernie Thompson, (Action on Dementia Sunderland)	**A** Action on Dementia evidence to be re-scheduled
2.	**Age UK** Victoria Brown (VB) gave an overview of the Age UK discharge services. Age UK provide services to people over the age of 65 without an assessment. Patients are accessed from the Sunderland Royal discharge lounge. Age UK provide patient support from this base and services can include a variety of support including assessment for risks, trips and falls. Questions raised included the relationship established with the re-enablement team (would the gap be filled if Age UK weren't providing this service), requests for equipment, after hour's admissions and liaison with the discharge team at the hospital. Temporary ramps, medication, home access, assessment process for discharge, currently eligibility age for services, discharge lounge usability. Sunderland Eye Infirmary was cited as an example of very good practice. VB responded to all questions raised explaining that a good relationship exists with the re-ablement team but that referral processes could be improved. There are people receiving no support or advice on leaving hospital who could communicate individual information to Age UK who could pick up more people. After hours admissions are often more complex due to availability of services at that time. Depending on when a person is discharged, can't put care package in place e.g. Friday. Medication was often a cause for delays as pharmacy delays and doctor sign off time are a factor. Some people go home with no information. Families were not always involved in the discharge process. Discharge lounge within the hospital could be an area for improvement with private space for assessment. If all services worked	**A** See facilities at Grindon Mews **A** Report from Links on discharge lounge

	together effectively the system exists for effective discharge but everyone has to interface for it to work. In summary, priorities for improvement were given as follows: • Hospital discharge lounge needs to be fit for purpose • Integration of all services working together effectively. • Communication centred around the person and between services to have early alerts to patient needs.	
3.	**Parkinson's UK** Olwen Pollinger from Parkinson's UK explained that the charity is centrally funded and managed. Services for hospital discharge have improved considerable over recent years however there were still areas for improvement. Once patients with Parkinson's are in hospital they will stay longer than most because of medication needs. There are an average of 20 patients in Sunderland Royal Hospital. There is only one nurse in SRH with level of expertise for Parkinson's. Ideally patients would move from A&E to specialist unit. Intermediate Care (Farnborough Court) is not used enough. Awareness is not there. Staff seem to be very cautious about pursuing a nursing level of care. Hospice facilities won't take patients too soon. High dependency day care would give security of health care and carer relief, whether it be intermediate (6-8 wks) or extra care housing. Re-admission can be caused by carer breakdown and specialist community support would help avoid this. Rehabilitation services are not strong enough to support people in community and avoid re-admission. There are two community matrons in Sunderland with understanding of neurology. They do act as consultants to other community matrons but this could be strengthened. In recent months they have encouraged users to share their stories as a way for improvement for services in liaison with the hospital. A major issue was highlighted as there being no outreach facility, lack of prompt medication and no cover on evenings and weekends. The provision of temporary ramps seemed to be uncertain Priorities for improvement were given as follows: • Respite day care with carers being more supported to reduce re-admissions • Parkinson's Nurse within the Community working across teams and working to care homes (Hartlepool have tried this model) • Enhanced palliative / respite day service • Training in Parkinson's to health professionals to compensate for staff turnover	

4.	**Stroke Association (North East Region)** Louise Hedley and Brenda Walker gave a presentation and history on the Stroke Association. Families are offered an Information Pack as part of the Pathway. This, and the subsequent follow up, is seen as a good practice model. Community stroke teams are involved with patients for up to 12 weeks. The Hospital currently does not have a discharge information pack and could do more to share information with the voluntary sector. A joint discharge package was suggested which gives contacts for all services Questions were raised regarding children who have a stroke, delays in service provision and discharge procedures. Funding and joint working issues need to be addressed. Use of personalised budgets for accessing a specialism is an issue as the pathway doesn't allow for budgets to be used. Priorities for improvement were given as follows: • Funding – how services fit around Direct Payments / Personalised Budgets. Councils moving away from block contracts • More risk assessment • Advice on discharge (it can take months to send notes to GPs)	**A** Information packs available on request
5.	**Sunderland Carers Centre** Eileen Inglesby introduced three carers who had attended to give evidence and case study examples.	
6.	**Case Study 1** The carer of a 62 year old man who was admitted to hospital to have major surgery expressed concerns about neglect whilst in hospital and the discharge procedure. Following surgery the patient was unable to feed himself. Nursing staff placed food out of reach of the patient. The carer gave instance of where she was called to go into the hospital to assist after he had soiled himself and then vomited and had not been cleaned. On discharge there was no care plan or assistance given which led to complications receiving follow up services from GP. Equipment had to be borrowed from friends and neighbours.	
7.	**Case Study 2** Carer accompanied elderly mother, who had multiple health problems into hospital after she had been admitted with a chest infection. Carer expressed concerns after being advised by the medical team that a 'do not resuscitate' instruction should be authorised by the family. The patient made a slight recovery two days later and was discharged. The patient now resides in palliative care but on discharge no assistance was made available regarding personal care or care plans. No information was passed to the GP to help with care in the community.	

8.	**Case Study 3** Carer of male with multiple health problems expressed concerns after he had been frequently admitted, discharged and re-admitted within very short time periods. This included being discharged when he was booked in for a procedure the following day. The patient deteriorated while being transferred to the discharge lounge and had to be moved back. Concerns were expressed over nurses relaying information that was incorrect to the patient in that the wife had said she did not want him to come home. This caused great upset for the family. The same carer gave an example of her mother being admitted to the hospital and having difficulty with weekend discharges and delays etc.	
9.	Priorities for improvement were given as : • Three cases where no discharge had occurred as such • Assessment on whether person can cope at home. Criteria is not individualised, just a tick box exercise. The 'Continuing Care Assessment' has been in operation for some time and hardly anyone meets the criteria. • Carers centre never get referrals from hospital. Could provide more help if got referrals. • Communication with carers/care staff on date of discharge and involvement of families in assessment • Follow up appointments	