HILLINGDON
LONDON

Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

Wednesday 14 December 2016
Meeting held at Committee Room 6- Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Wayne Bridges (Chairman),Jane Palmer (Vice-Chairman), Shehryar Ahmad-Wallana, Peter Davis, Beulah East, Tony Eginton and Peter Money. **Apologies for Absence:** Councillors Teji Barnes, Becky Haggar and Co-opted Member, Mary O'Connor. **Officers:** Gary Collier (Health & Social Care Integration Manager), Nina Durnford (Head of Social Work, Adult Social Care Services), Dr Steve Hajioff (Director of Public Health) and Khalid Ahmed (Democratic Services Manager). **Also Present:** Kim Cox (Borough Director, Central North West London NHS Foundation Trust), Claire Eves (Head of Adult Services, Central North West London NHS Foundation Trust), Graham Hawkes (Chief Executive Officer, Healthwatch Hillingdon), Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group), Vanessa Saunders (Deputy Director of Nursing, Hillingdon Hospital), Dr. Julie Vowles (Consultant Geriatrician, Hillingdon Hospital) and Julie Wright (Director of Integrated Care, Hillingdon Hospital).	
31.	**MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2016** Agreed as an accurate record.	
32.	**TO CONFIRM THAT ALL ITEMS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT ANY ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** It was confirmed that all items on the agenda would be considered in public.	
33.	**MAJOR REVIEW - HOSPITAL DISCHARGES** For this witness session, the Committee was provided with the perspective on hospital discharges from patients (Healthwatch) and from Hillingdon Hospital and Central North West London NHS Foundation Trust. **Healthwatch Hillingdon** Graham Hawkes, Chief Executive Officer of Healthwatch attended the meeting and provided Members with a summary of the recent review which had been carried out by the	**Action By:**

	organisation into hospital discharges from Hillingdon Hospital. The project aimed to gain an understanding of the discharge process from the perspective of the patient. It looked at what went well, and what did not go well. The project focussed on adults over the age of 65 and their experiences of being discharged from Hillingdon Hospital. The methodology of the review was split into three stages. Stage 1 involved 172 patients being interviewed and completing a survey on 17 different wards at the Hospital. Dependent on the condition of the patient, patient's advocates completed the survey. Stage 2 involved interviewing patients 30 days after being discharged, in which they were asked for their experience of the discharge process and whether their post discharge care had been adequate. 52 discharged patients/advocates completed the second survey. At Stage 3, Healthwatch met with over 20 organisations who commissioned, or provided care services within hospital and the community for the over 65s in Hillingdon. This stage helped the review to identify and understand the processes and procedures involved in hospital discharges, and the factors, barriers and enablers which contributed to providing patients with a safe transfer from hospital to being cared for, out in the community. The Committee was informed that generally the results showed that the over 65s had expressed an overwhelming feeling of pride in the NHS and hospital discharges. However, it was found that staff were working under intense pressure and that care could not always be delivered to the required standard. The review's findings were summarised into three categories: • Communication and Information Communication between patients / carers and health professionals and the information provided, was sometimes poor. Reference was made to patients being unable to speak to doctors, patients not remembering what had been told to them, patients not knowing which medicines to take, who was coming to see them at home and how to arrange a private care home placement or a care package. Discussion took place on how this could be improved and whilst it was acknowledged that hospitals were very busy, it was suggested that providing clear written information for patients / carers, would improve communication and improve	**Action By:**

	outcomes for patients. Details of the review's recommendations were reported which included updating the Trust's "Working Together" booklet, to include a Patient Journey booklet which provided information for patients / carers. • Process and Procedures There was a marked difference in the discharge procedures on each ward which meant there were discrepancies on how patients were treated in terms of being prescribed medication and how transport was processed. Examples were given on how some patients had been left many hours without hot food and refreshments, either in the discharge lounge, in their beds or in the ward's day room. The recommendation of the review would be to standardise as far as possible the discharge process across all wards. A standardised process would help both staff and patients and improve the quality of care to patients. • Closer Integration and Joined up Working Reference was made to the perception from patients that organisations did not appear to communicate well with each other or work closely enough. Examples of these were assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings etc. It was important that all organisations were aware of each other's services and that the effectiveness of the Joint Discharge team was maximised to its fullest. A possible solution could be a single point of access for discharge which would provide an information hub for professionals and provide integrated care for the patient. **Hillingdon Hospital** The following witnesses from Hillingdon Hospital attended the meeting Vanessa Saunders (Deputy Director of Nursing), Dr. Julie Vowles (Consultant Geriatrician) and Julie Wright (Director of Integrated Care). The context to the situation was provided which was that for the over 65s age group, the average length of stay in Hillingdon Hospital had increased when compared to 2015/16. The Committee was informed that a Discharge Task Force Programme had been implemented which was a dedicated “task force” group which would be focusing on improvement	**Action By:**

	and transformation. This would undertake a forensic investigation of the discharge process for every ward at the hospital. The Committee was informed that the task force consisted of 5 individuals, who were mainly drawn internally. Data was collected over 9 weeks and the hospital held a clinical summit reviewing the findings. The key actions which were agreed to take forward were:- • Appointing patient flow coordinators to help with communication • The implementation of a Red to Green system • Patient involvement in discharge Reference was made to the trial which had taken place on Fleming ward which involved the engagement of patients in managing their own discharge. One of the initiatives involved patients wearing their own clothes. This had a positive outcome with research showing that patients wearing their own clothes spent an average of 0.75 days less in hospital than patients wearing hospital clothes. Work had been taking place with wards to place patient's estimated discharge dates on "About me" notice boards. Overall the results had been positive. Reference was made to the SAFER and Red to Green schemes, which were two national tools which had been introduced to improve the flow of discharges. SAFER consisted of a **Senior Review** which was where all patients would receive a consultant review before midday. **All** Patients would have an expected discharge date which would be based on the medical suitability for discharge status agreed by clinical teams. **F** - **Flow of patients** would commence at the earliest opportunity (by 10am) from assessment units to inpatient wards. **E** – **Early discharge, 33%** of the hospital's patients would be discharged from base inpatient wards before midday. Medication to be taken home for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so. **R** – **Review**, A weekly systematic review of patients with extended lengths of stay would take place to identify the issues	**Action By:**

	and actions required to facilitate discharge. This would be led by clinical leaders and be supported by operational managers who would help remove constraints that lead to unnecessary patient delays. Details of the Red to Green scheme were reported which was a scheme used to signify progress on patient treatment and eventually discharge. A red day was what every patient started off on. Green days were when patients received interventions which supported pathways of care through to discharge, a day when all that was planned or had been requested, had taken place on the day it had been requested, which resulted in a positive experience for the patient. In addition a green day was when a patient received care, which could only be delivered in hospital. The Committee was informed that the following improvements would be made to the Discharge work stream: • Redrafting of the hospital's Working Together leaflet to encompass all the above mentioned suggestions. • The development of written information for patients and carers in relation to NHS Continuing Healthcare Assessments. • The continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of medication to take home and the format of Multi-Disciplinary Meetings to aid discharge planning. • The development of an in-house survey to capture patient and carer feedback and satisfaction scores following discharge. Particular mention was made of the improvements needed in relation to communication at patient's bed meetings, the introduction of virtual Multi-Disciplinary Meetings for Mt Vernon wards, the introduction of ward based medication to take home and therapy communication. The Committee was informed that both the hospital and Healthwatch were working together and sharing information and ideas on improving the discharge process. This was welcomed. **Central North West London (CNWL) NHS Foundation Trust** The following witnesses from CNWL attended the meeting Kim Cox, Borough Director and Claire Eves, Head of Adult Services. The Committee was informed that the needs of people with mental health issues were catered for by Liaison Psychiatry	**Action By:**

	who saw patients who presented themselves at A & E. with symptoms ranging from self-harm, suicidal ideation to psychotic symptoms. Patients were assessed and sign posted to other services. Patients were also seen in general hospital wards where again they were assessed, staff were advised and help was given with the discharge plan if their mental health needs dictated it. The Clinical Health Psychology service helped patients who were having serious difficulty coping with an illness or a disability, which impacted on their lives. Reference was made to the Rapid Response Team (RRT) who provided a rapid response 7 days a week in A & E. Assessments were made of patients to facilitate their discharge home. Specifically in relation to patients over the age of 65, RRT Clinicians attended wards to assess patients and if suitable for discharge, they were discharged under the care of RRT. The Committee was provided with details of the Homesafe scheme which was commissioned to help facilitate early supported discharge, which included people aged 65 years and over. Through this service, patients had access to therapy, nursing and/or care support, including a night sitting service. Areas which had been identified to improve discharges were: • Better information sharing through IT. Sharing information would avoid duplication of assessments. It was important that the service had information of other health issues of patients they were treating with mental health issues • The development of 15 Care Connection Teams • Reviewing and improving the current Rapid Response Service • The establishing of a single point of access • Better integration of intermediate care services **Discussion** Recognition was made of the requirement for a single point of access for discharge which would improve the communication to the patient / carer. The Committee was reassured that this was already being put in place across North West London and would greatly improve the process of discharge. It was acknowledged that joint and closer working would improve the process and maximise the use of resources and avoid duplication. Members acknowledged that hospitals were very busy places and health professionals had heavy and involved workloads, but the suggested improvements would	**Action By:**

	ultimately improve the discharge experience for patients. Discussion took place on the funding for social care and the difficulties in terms of recruitment, but the Committee was informed that authorities were introducing new schemes to attract and fill vacant posts. The Committee were provided with demographic information for the Borough which indicated that there were an increasing number of older people living in the Borough. With people living longer the incidences of people with dementia was on the increase, which was impacting on social and health care. This was likely to increase with Projecting Older People Population Information projections suggesting that the number of people with dementia was likely to increase by 14% to 3,133 between 2015 and 2020 and by 25% to 3,606 in the period between 2020 and 2025. This would be a challenge for the provision of health and social care services. A cause for the delay in discharge was because of the changing demographics of the population and some of the complex care needs of patients. The Committee noted that the diversity of Hillingdon's population needed to be taken into consideration and that certain ethnic groups were sometimes reluctant to come forward. The witnesses were thanked for the information they had provided the review. **RESOLVED –** 1. **That the witnesses be thanked for the information they had presented and the evidence be used as part of the review.** 2. **That for the next meeting of the Committee, officers be asked to summarise the evidence received during the review to enable suggested recommendations to be made.**	**Action By:** **Khalid Ahmed / Gary Collier**
34.	**UPDATE ON STROKE PREVENTION REVIEW** Members were provided with a progress report on the Committee's Stroke Prevention review. The Committee noted the information which had been provided in the report on the work which was being carried out by other public health authorities. It was noted that Hillingdon was ahead of other authorities in terms of initiatives for stroke prevention.	

		Action By:
	The Director of Public Health reported that for staff within Hillingdon, there were a number of initiatives which were used. There was a weight management programme, smoking cessations sessions and health checks. Reference was made to the possibility atrial fibrillation detection, and self-help health checks being made available for staff. The targeting of staff could be an opportunity for the Council to promote stroke prevention to the wider population of the Borough. Reference was made to the visit to Hillingdon Hospital's Stroke Unit by Councillor East who provided the Committee with a report on her findings. The Committee thanked her for the information provided. Discussion took place on suggested recommendations for the review and officers were asked to take forward the following suggestions, and include them in the final report for the review: 1. That Officers be requested to develop the universal wellbeing offer to prevent stroke and for this to include smoking cessation, physical activity and health - (Primarily with the Wellbeing Team) 2. That Officers be requested to develop a campaign on stroke risk and stroke prevention using multiple channels which is sensitive and appropriate. 3. That the Council, working in partnership with the Hillingdon CCG, be requested to promote and develop health checks as a vehicle for identifying residents at an increased risk of stroke. **RESOLVED –** **1. That officers be asked to update the previously circulated draft final report with the information above, and submit the report to the next meeting of the Committee for approval.**	**Steve Hajioff / Khalid Ahmed**
35.	**FORWARD PLAN** The Committee asked that a report on the Integrated Sexual Reproductive Health Services be brought to a future meeting of the Committee Noted.	**Khalid Ahmed**

36.	**WORK PROGRAMME** Members noted that the Chairman of the Adult Safeguarding Board would be invited to attend the Committee's meeting on 21 February 2017 to present the Board's Annual Report. Discussion took place on possible review topics for the Committee and the following areas were raised: • The Welfare Benefit Reforms and the Changes being Implemented, eg the new benefits cap? • Home Ownership in the Borough - the success of it. • Right to Buy Scheme. • Asylum seeking children in the Borough. • Loneliness. The Chairman of the Committee agreed to discuss the potential review topics with officers and at the next meeting of the Committee, a presentation would be given on the preferred option. Noted.	**Action By:** **Khalid Ahmed**
	Meeting commenced at 7.00pm and closed at 8.40pm **Next meeting: 18 January 2017 at 7.00pm**	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Khalid Ahmed on 01895 250833. These minutes are circulated to Councillors, Officers, the Press and Members of the Public.