Scrutiny Investigation Report
From Hospital to Home

Investigation Members

Councillor Peter Read (Chairman)
Councillor Elin Walker Jones
Councillor Eryl Jones-Williams
Councillor Linda A. W. Jones
Councillor Ann Williams
Councillor Huw Edwards

Officers

Darren Griffiths and Janet Roberts	(Lead Officers)
Dafydd R. Bulman	(Support Officer)
Bethan Adams	(Member Support and Scrutiny Officer)
Lowri Haf Evans	(Member Support and Scrutiny Officer)

Gwynedd Council
Shirehall Street
Caernarfon
Gwynedd
LL55 1SH

The Report

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1. Executive Summary

Investigation Background

Concern regarding arrangements for discharging and transferring from hospital is the reason behind this scrutiny investigation. Members of the Services Scrutiny Committee had concerns regarding the suitability and effectiveness of these arrangements in Gwynedd. Their concerns were based on the experience expressed by some of their electors when they were discharged from hospital without the care support and the appropriate community and social networks in place to enable them to return home or to live in the community in some cases.

Investigation Brief

The aim of the investigation was to consider the following matters:

- The suitability and effectiveness of discharge arrangements in terms of ensuring the best outcomes for older patients, by identifying and highlighting good practice and fields in need of improvement.
- The suitability and effectiveness of collaboration arrangements between the Local Health Board and the Council in terms of assessing, planning and providing integrated and appropriate care for older patients who are discharged from hospital.
- The role of Third Sector organisations in terms of supporting older patients to return home or to live in the community.
- Identify examples of good practice from other areas and highlight the ones that could be adopted and put into practice in Gwynedd / North Wales.
- Draw up a series of improvement recommendations to be submitted to the Local Health Board, Gwynedd Council and Third Sector organisations in order to respond to the investigation's main findings and outcomes.

Recommendations

The Cabinet Member for matters relating to Care is asked to :

- Check whether or not the Discharge Protocol by Betsi Cadwaladr University Health Board (BCUHB) has been reviewed and is consistent with the operational arrangements of Gwynedd Council and partners in the community.
- Ask the Adults, Health and Well-being Service to collaborate with the Hywel Dda Health Board to agree on a hospital discharge protocol and on practical arrangements for its implementation.
- Review collaboration and communication arrangements between those teams that facilitate hospital discharges and transfers and those agencies offering support in the community in order to identify opportunities to improve the service for patients and look at good practice in other areas.
- Review the 7 day discharge and transfer service that has been temporarily offered at Ysbyty Gwynedd and consider any relevant matters when developing a similar service within the Intermediate Care Project in the same field.
- Report back to the Scrutiny Committee on the progress of the Intermediate Care Project which is equivalent to an expenditure of £1.3 million.
- Press for improvements to the Transfer Lounge making it a comfortable and purpose-built room that includes changing facilities and moving the disabled toilets closer to the Lounge for convenience.
- Ask BCUHB for an update on their schemes to implement 'More than Words'.
- Develop ways to compile data in terms of older patients' satisfaction on the discharge and transfer service in order to ensure that they have a voice in the process of developing the service further and improving the provision.

2. Investigation Background

2.1 The aim of any health and care service is to offer the right care, in the right place, at the right time. When the process of transferring a patient home or to another care placement is held back, it is evidently a subject of concern for the patient and their family but it is also a sign that the arrangements themselves do not work properly for the benefit of the patient or the organisation offering them.

2.2 Therefore, the discharging process is an essential part of care management in any health and social care organisation. Ensuring that there are proactive systems to support individuals, families and carers when arranging to discharge or transfer a patient to another placement, either to hospital or organisations within our communities, is essential and crucial.

2.3 The person who is transferred is not the only one who benefits when those arrangements work but also the family, carers and those organisations who offer care. The cost of a bed is high and demand is great and delaying a transfer is an additional financial cost on health organisations and is a poor use of scarce resources. This may also mean that another patient's care is delayed. In the same manner, support after a transfer is also important in order to avoid further admissions to hospital or an unnecessary dependency on services.

2.4 Each health organisation should have a policy or formal arrangements in place to plan the way patients are discharged from hospital. The main aim of these arrangements is to reduce the period of time that patients must spend at the hospital, to reduce the possibility that patients will return to hospital in an unplanned manner and to improve the way support services are coordinated and delivered to patients when they have returned home or to live in the community.

2.5 These arrangements are not the sole responsibility of a single body such as health, but a joint responsibility between health and social care and their partners in the community. These bodies' understanding of their responsibilities and the way they communicate and collaborate for the benefit of the patient is crucial to the success of any arrangements.

2.6 Concern regarding these arrangements is the reason behind this scrutiny investigation. Members of the Services Scrutiny Committee had concerns regarding

the suitability and effectiveness of these arrangements in Gwynedd. Their concerns were based on the experience expressed by some of their electors when they were discharged from hospital without the care support and the appropriate community and social networks in place to enable them to return home or to live in the community in some cases.

3. Purpose of the Investigation

3.1 Therefore, it was agreed that the purpose of this investigation was to consider how suitable and effective the arrangements of Betsi Cadwaladr University Health Board and its partners are to discharge older patients from hospital and to support them to return home or to live in the community.

3.2 In order to achieve this, the investigation addressed the following matters:

- The suitability and effectiveness of discharge arrangements in terms of ensuring the best outcomes for older patients, by identifying and highlighting good practice and fields in need of improvement.
- The suitability and effectiveness of collaboration arrangements between the Local Health Board and the Council in terms of assessing, planning and providing integrated and appropriate care for older patients who are discharged from hospital.
- The role of Third Sector organisations in terms of supporting older patients to return home or to live in the community.
- Identify examples of good practice from other areas and highlight the ones that could be adopted and put into practice in Gwynedd / North Wales.
- Draw up a series of improvement recommendations to be submitted to the Local Health Board, Gwynedd Council and Third Sector organisations in order to respond to the investigation's main findings and outcomes.

3.3 The abovementioned purpose was relatively broad, however in practical terms the main focus of the investigation was the discharge patients form Ysbyty Gwynedd as the majority of Gwynedd residents currently go there to receive treatment.

However, when undertaking that work some other matters became evident and reference is made to them in this Report.

4. Methodology and main activity of the Scrutiny Investigation

4.1 An attempt was made to consult extensively with the main partners in this field to gather and collect information about the arrangements and the behaviour including:

i. Senior Site Manager (Betsi Cadwaladr University Health Board)
ii. Senior Business Manager (Social Services)
iii. Service Manager (Gwynedd Social Services)
iv. Hospital Discharge Multi-disciplinary Team (Ysbyty Gwynedd)
v. Ysbyty Gwynedd Social Workers Team and Arfon Area Manager (Gwynedd Social Services)
vi. Mantell Gwynedd Health and Social Care Facilitator
vii. Sample of 14 Service Users and Patients in four sessions across Gwynedd (Appendix 3)

4.2 During the investigation, officers from Third Sector organisations were invited to meet the Scrutiny Committee to discuss their contribution to the arrangements and the community support that is now available in Gwynedd. Unfortunately, they could not be present and the timetable for completing the investigation did not allow for rearranging the meeting. This was a disappointment to members of the Investigation.

4.3 Three sessions were arranged to discuss the discharge arrangements, namely:

i. A presentation and a question and answer session on the arrangements and collaboration between the Betsi Cadwaladr University Health Board and the Gwynedd Council Adults, Health and Well-being Service.
ii. Meeting with Ysbyty Gwynedd and Gwynedd Council operational teams to discuss the implementation of the transfer arrangements with an opportunity to see specific facilities including the Transfer

Lounge. The new pilot arrangements were also outlined during this meeting.

iii. A presentation by Mantell Gwynedd's Health and Social Care Facilitator on the services available by the Third Sector to support individuals once they have been discharged and are back in the community.

See Appendix 4 for notes on these meetings.

4.4 To support the investigation, good practice in other hospitals and recognised good practice guidelines were examined (Appendix 1).

4.5 Four sessions were arranged across Gwynedd either at the Council for Older People or the Forums for Older People to discuss older people's own experiences of being discharged from hospital (Appendix 3).

4.6 In order to identify any consistent trends, consideration was given to the complaints list for the Health Board and the Adults, Health and Well-being Service which was also based on discharge arrangements.

5. Findings in accordance with the Scrutiny Investigation Brief

5.1 Discharge Policy and Arrangements
Findings The Betsi Cadwaladr University Health Board has a detailed policy, namely the Discharge Protocol, which according to the information in the document is to be reviewed in March 2014. It is a detailed policy based on the current arrangements and reflects recognised good practices. Social Services in north Wales' local authorities have also committed to this policy. Some patients in South Meirionnydd use health services by the Hywel Dda Health Board and this mainly at Ysbyty Bronglais, Aberystwyth. When discussing discharge arrangements with officers from the Board in question, it became apparent that the Board currently has no agreed policy in place.

Source of Evidence

- BCUHB Discharge Protocol
- Research into good practice – Appendix 4
- Discussion with officers from the Hywel Dda Health Board

Recommendations to the Cabinet Member for Care

- Check whether or not the Discharge Protocol by Betsi Cadwaladr University Health Board (BCUHB) has been reviewed and is consistent with the operational arrangements of Gwynedd Council and partners in the community
- Ask the Adults, Health and Well-being Service to collaborate with the Hywel Dda Health Board to agree on a hospital discharge protocol and on practical arrangements for its implementation.

5.2 Collaboration and Communication

Findings

The proof of any protocol or procedure is in its implementation. When speaking with older people at the forums, it became very apparent that they had very little criticism of the hospital discharge arrangements.

Research on good practice clearly shows the importance of clear communication when attempting to ensure a discharge procedure or smooth transfer from one care location to another or back home. Including the patient and their family in every discussion is paramount but the communication between workers from different agencies is as important in order to ensure collaboration and integrated working in the patient's interests.

It became apparent in the evidence sessions that there was close collaboration between multi-disciplinary officers from Ysbyty Gwynedd, including social workers and community care and health workers.

Nevertheless, examples were seen where the communication and collaboration did not work as well. In one case, the lack of communication between the Discharge Team and Social Services regarding a multi-disciplinary meeting had led to postponing the meeting as the Social Workers Team had not been informed in good time of the need to attend. The family submitted a complaint about this.

Good practice suggests that joint-locating the Discharge Team and the Social Workers Team increases collaboration for the benefit of the patient and ensures the best service for the individual. The Wiston Hospital in the Wirral has successfully adopted this procedure and in other hospitals in England, the same manager manages both teams again in order to improve communication and collaboration for the benefit of the patient.

Again, when speaking with older people about their experiences, some concern was expressed about the time one had to wait for medication before being discharged. Some had been waiting for over 4 hours. One said, "9 out of 10 times time they know you are being discharged the day before, why can't they get everything done before hand?"

In another case, arrangements were made for a district nurse to visit patients after they had undergone orthopaedic surgery in the Hospital. Nevertheless, they had to make alternative arrangements to see the nurse at the local surgery as the message had not been communicated to the district nurse.

Concern was also expressed about the awareness of staff and residents of the various projects or support services available within our communities. These could be a means to make discharge and transfer take place more smoothly and offer very practical support to keep people in their communities and avoid unnecessary admissions to hospital or any other care organisation. It is known that the Red Cross have an arrangement in some areas to take patients home and ensure that they have their essential groceries waiting for them.

Source of Evidence

- Evidence from Complaints
- Evidence session
- Research into good practice (Appendix 1 and 4)
- Evidence from the Mantell Gwynedd Health and Social Care Facilitator
- sector
- Engagement session with Patients/users (Appendix 3)

Recommendations to the Cabinet Member for Care

- Review collaboration and communication arrangements between those teams that facilitate hospital discharges and transfers and those agencies offering support in the community in order to identify opportunities to improve the service for patients and look at good practice in other areas.

5.3 7 Days a Week Discharges

Findings

One suggestion of good practice in this field is to ensure hospital discharge arrangements over 7 days a week, rather than a procedure that is based on five day practice. Such arrangements enable a patient to go home immediately when they are ready rather than having to wait over the weekend in some cases to arrange care packages. In complex cases that require very careful planning, it is a much more effective method of working. In order to successfully implement an arrangement of this kind, all agencies are required to

collaborate and agree to offer their services 7 days a week also.

Research shows that 7 day discharges are an effective way of securing a balance with hospital beds and gives users the flexibility to be discharged on time, including during weekends. Good practice highlights that it is important for individuals to go home as soon as possible as remaining in hospital increases the risk of infection, loss of independence and inappropriate use of resources.

A 7 day service was trialled at Ysbyty Gwynedd over a five month period, however; the service ended in May 2014. The multi-disciplinary team included Social Workers, an Occupational Therapist, a Physiotherapist and Discharge Coordinator who worked over the weekend to offer the service.

The temporary service was not comprehensive as new care packages or changes to care packages were not available over the weekend. Similarly, equipment from 3rd Sector organisations was not available to enable weekend discharges. Nevertheless, workers were able to plan ahead and ensure that a patient was released early on the Monday under the new procedure. However, this pilot demonstrated the potential of operating such an arrangement for patients and their families and what needed to be considered should such an arrangement be implemented. The staff certainly saw its advantages.

Offering a service such as the one outlined above has been included within Gwynedd's grant for the Intermediate Care Grant which equates to spending £1.3 million in revenue on integrated services. An outline of the Project has been developed during this Scrutiny Investigation.

The proposal, which includes multi agency partners, is eager to fund, develop and test new service models that secure sustainability for the future and better outcomes for older people. Amongst the benefits noted in the bid are:

- Transformation Team
- Improving Communication
- Weekend Capacity
- Improved discharge arrangements and discharge support
- Access to providing equipment and adaptations in a timely manner

Scrutinising the Intermediate Care Project Board's work programme will be key to the Scrutiny Committee in order to secure the best possible benefits in this field for older people.

On a more practical matter, members of the Scrutiny Committee were invited to Ysbyty Gwynedd to meet the staff in question and to visit the Transfer Lounge, which is a crucial part of the provision.

Source of Evidence

- Research into good practice (Appendix 1 and 4)

- Evidence session (Appendix 4)

Recommendations to the Cabinet Member for Care

- Review the discharge and transfer service that has been temporarily offered at Ysbyty Gwynedd and consider any relevant matter when developing a similar service within the Intermediate Care Project in the same field.
- Review the discharge and transfer service that has been temporarily offered at Ysbyty Gwynedd and consider any relevant matter when developing a similar service within the Intermediate Care Project in the same field.
- Press for improvements to the Transfer Lounge making it a comfortable and purpose-built room that includes changing facilities and moving the disabled toilets closer to the Lounge for convenience.

5.4 More than Words

Findings

Reference has already been made to the need to ensure clear communication with users and patients and in this context in order for them to understand what is happening and for them to be part of the discharge and transfer process.

Securing bilingual services for bilingual people has been included within the Welsh Government's directives on respect and dignity for patients.

The aim of the Welsh Government's 'More than Words' is to strengthen Welsh language services among the health and social care frontline. Although the availability of Welsh language services was not within this Scrutiny Investigation's terms of reference, concern was expressed that if Welsh language services were available in some cases and a desire for more clarity regarding BCUHB's ability to provide such services in a period of time where the patient has to travel further to receive services.

Additionally, four vulnerable groups have been identified where offering Welsh language / bilingual services is a matter of clinical priority, namely older people, children and young people, people with learning disabilities and people with mental health difficulties due to the nature of their needs. Research shows that even those who are fluent in both languages often feel more comfortable speaking Welsh with a nurse or social worker, particularly in an unfamiliar setting or in an emergency.

Recommendations to the Cabinet Member for Care

- Ask BCUHB for an update on their schemes to implement 'More than Words'

5.5 Gathering patient opinion
Findings It was quite a difficult task to gather the opinions of older patients on Ysbyty Gwynedd's discharge and transfer arrangements. When questioned at sessions, it is fair to note that the majority of older people praised the hospital discharge and transfer service. However, it also became apparent that older people were reluctant to find fault in any arrangement made for them. Those people who were willing to voice their complaints were few and far between. However, feedback must be gathered from those customers who use the service and observations must be collected, be it praise or criticism, in order to improve any service.
Source of Evidence • Evidence session (Appendix 4) • Engagement session (Appendix 3)
Recommendations to the Cabinet Member for Care • Develop ways to compile data in terms of older patients' satisfaction on the discharge and transfer service in order to ensure that they have a voice in the process of developing the best service for them.

6. Reporting back to the Services Scrutiny Committee

6.1 The report is submitted for consideration by the Cabinet Member for Care. The investigation members are eager for the Scrutiny Committee to receive a report back by the Cabinet Member on his response to the recommendations in due course.

APPENDIX 1

Background Documents

AGE UK (2014) Factsheets 37 – Hospital discharge arrangements. London

BETSI CADWALADR UNIVERSITY HEALTH BOARD 2012, Discharge Protocol. Bangor

CARERS UK (2012) Coming out of hospital.

CHRISTIE NHS FOUNDATION TRUST (2011) Discharge and Transfer Policy.

DEPARTMENT OF HEALTH (2010) Ready to Go? Planning the discharge and the transfer of patients from hospital and intermediate care, London

DEPARTMENT OF HEALTH (2003) Discharge from Hospital: pathway, Process and practice. London

HALTON AND ST HELENS (2009) Admission & Discharge Policy, Newton Community Hospital

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (2012) Hospital Discharge Policy.

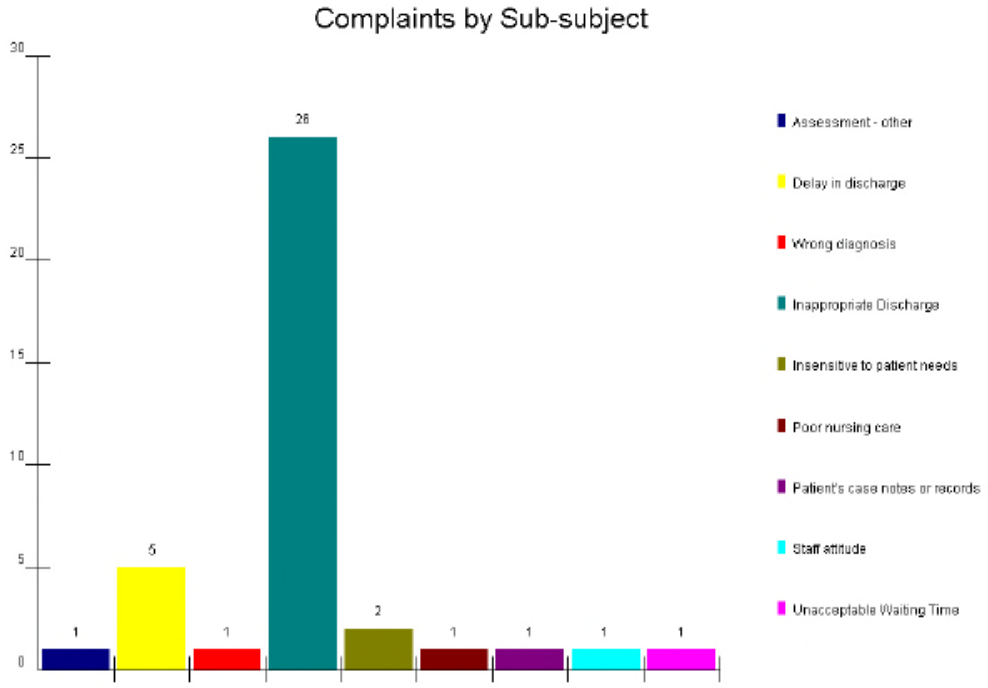
NHS (2004) Achieving Timely "simple" discharge from Hospital. London

ST HELENS COUNCIL (2012) Enhanced Integrated Hospital Discharge Team and Community Care Project.

APPENDIX 2

01st April 2013 – 31st March 2014

There have been a total of 39 concerns recorded for the time period.



Concerns by Type	
Formal	18
On The Spot	19
OTS upgraded to Formal Complaint	2
Totals:	39

Concerns by Subject	Access, Appointment, Admission, Transfer, Discharge
Delay in discharge	7
Inappropriate Discharge	32
Totals:	39

APPENDIX 2

Concerns by Sub-subject and Unit

	Ysbyty Gwynedd - Acute	Ysbyty Cefni Hospital	Ysbyty Penrhos Stanley	YG Mental Health - Hergest Unit, Ysbyty Gwynedd	GP Out of Hours Service	Total
Assessment - other	0	0	0	0	1	1
Delay in discharge	5	0	0	0	0	5
Wrong diagnosis	1	0	0	0	0	1
Inappropriate Discharge	23	1	1	1	0	26
Insensitive to patient needs	2	0	0	0	0	2
Poor nursing care	1	0	0	0	0	1
Patient's case notes or records	1	0	0	0	0	1
Staff attitude	1	0	0	0	0	1
Unacceptable Waiting Time	1	0	0	0	0	1
Totals:	35	1	1	1	1	39

APPENDIX 3

A presentation was given in the Area Forum meetings of Age Cymru and the Gwynedd Older People's Council giving individuals who had been in hospital an opportunity to come to us at the end of the session.

Two questions were asked:

1. *What was your experience of being discharged from hospital?*
2. *How can we help to improve your experience of the process of being discharged from hospital next time?*

They had highlighted that it was very important to discuss positive and negative opinions in order to identify improvements but also to look at good practice.

This was the response within these sessions:

Session	Number at the Session	Response to the Investigation
Gwynedd Older People Forum	25	5
AGE Forum Arfon	14	2
AGE Forum Dwyfor	20	2
AGE Forum Meirionnydd	21	5
Total	**80**	**14**

APPENDIX 4 – Evidence session

Services Scrutiny Committee

Scrutiny Investigation Group – Care (From Hospital to Home), 6 February, 2014

Present

Councillors: Peter Read (Chairman), Huw Edwards, Eryl Jones-Williams and Ann Williams.

Investigating Officers: - Darren Griffiths (Strategic Planning Manager), Meilys Heulfryn Smith (Senior Business Manager – Social Services), Bethan Adams and Lowri Haf Evans (Member Support and Scrutiny Officers).

Others invited:- Eleri Evans (Senior Clinical Site Manager, Betsi Cadwaladr University Health Board), Glenda Lloyd Evans (Service Manager, Gwynedd Council), Ellen George (Area Manager, Arfon 18+ Team, Adult Services, Gwynedd Council) and Bridgitte Williams (Gwynedd and Anglesey Social Workers Team, Ysbyty Gwynedd).

1. APOLOGIES

Apologies were received from Councillors Elin Walker Jones and Linda A. W. Jones.

2. NOTES ON THE MEETING OF 22 JANUARY 2014

The notes of the previous meeting of the Scrutiny Investigation Group were accepted as a true record.

3. PRESENTATIONS AND A QUESTION AND ANSWER SESSION

Eleri Evans, Glenda Lloyd Evans, Ellen George and Bridgitte Williams were welcomed and thanked for agreeing to meet members of the Scrutiny Investigation.

Everyone introduced themselves.

The context and purpose of the Investigation was set out by the Strategic Planning Manager.

The following provided presentations and members were given an opportunity to ask questions:-

(i) Ellen George, Area Manager, Arfon 18 + Team, Adults Services, Gwynedd Council

The following main points were made:

- That the team was responsible for individuals over eighteen years old, including individuals with disabilities and those suffering from dementia;
- That her team worked in the community with individuals known to the Council;

- That the team included Occupational Therapists, Social Workers and Enablement Workers.
- That the Enablement Workers were responsible for returning individuals to the community and providing assistance for Carers of the individuals.
- That the team operated a demand management procedure.

In response to a question by a member regarding what she wished to change in the current system, she noted that there was collaboration / communication happening between the Council and Betsi Cadwaladr University Health Board (BCUHB) at lower levels of the managerial hierarchy but there was a need to strengthen the relationship. She added that there was pressure on BCUHB to release beds and on the Council not to take individuals into the Social Services system unless there was a real need.

A member expressed his concern that individuals were discharged from hospital when no prior warning had been given to carers of the individuals of the time when they would be returning home. In response, Ellen George noted that the team arranged a time for assessing the service needed for individuals who were unable to do everything for themselves. She added that they worked under time restrictions and attempted to satisfy the needs of individuals.

Glenda Lloyd Evans added that families or neighbours ensured that individuals arrived home to a warm house and that there was food in the house but with the most vulnerable individuals it was anticipated that a conversation would be held in the hospital to discuss the situation. She noted that the Red Cross also provided support for individuals in the Arfon area but there was a real need for the provision throughout Gwynedd.

In response to an enquiry regarding who was responsible for deciding which individuals would be sent to the Lleu Unit in Penygroes, which was part of the Enablement Scheme, Ellen George noted that there was room for up to six persons in the Unit and the decision on who was eligible for the provision was made by a Social Worker and the Manager of the Home. She added that the aim of the Enablement Scheme was to make arrangements to enable individuals to return home or as a result of an assessment, for them to receive a placement in a home. She noted that the aim was care in the community.

(ii) Glenda Lloyd Evans, Service Manager, Gwynedd Council

She noted that the focus was to try to get people home but intermediate care provision was available for individuals. She reported that there were three beds in the residential home of Cerrig yr Afon in Felinheli for the provision and there was spot purchase of beds in private residential homes when there was a demand for the

provision in Dwyfor and Meirionnydd. A member noted that he was glad of the use made of beds in private residential/nursing homes.

The speaker reported that there was an Extra Care Scheme in the Meirionnydd area and BCUHB intended to extend the provision to Arfon and Dwyfor in due course. She noted that there was collaboration between Gwynedd Council and BCUHB to improve the provision to enable individuals to live at home.

In response to a question from a member regarding what she would wish to change in the current system, she noted that a regional statement of intent had been prepared following the Welsh Government's wish to introduce a complex needs service. She emphasised that it would be crucial for the proposed County Forum to be effective by prioritising clearly and setting the agenda.

In response to an observation by a member, she explained that £50 million of one-off funding had been given by the Welsh Government for providing an intermediate care service across Wales with an allocation per region. Work was underway to plan how best to use the funding.

(iii) Eleri Evans, Senior Clinical Site Manager, Betsi Cadwaladr University Health Board

She noted that she and her team were responsible for hospital admissions, beds and discharging patients from hospital and providing assistance to staff of the Accidents and Emergency Unit and providing assistance on the wards if there were staffing issues.

She noted that collaboration between her team and the Ysbyty Gwynedd Social Services Team had improved.

She noted that patients were not discharged from hospital until it was safe to do so. Glenda Lloyd Evans added that there was increasing pressure on beds and on staff in hospitals to discharge patients as soon as possible but if the Social Services team disagreed with the medical opinion or if arrangements were not in place for patients to be discharged safely, then they questioned the decision. She added that nurses on the wards also questioned some decisions.

In response to a question from a member regarding what she would wish to change in the current system, she noted that Ysbyty Glan Clwyd would be losing 60 beds and this would add to the increasing pressure on beds and she was concerned that there was no back-up plan.

A member noted that the root of the problem was the lack of beds in hospitals and it was a matter for the principal officers of Gwynedd Council to highlight to BCUHB officers that the arrangements were not working and that this was unacceptable. She

added that problems arose because some individuals were unwilling to ask for assistance or that they were unaware of the Enablement Scheme.

In response to the observation, Glenda Lloyd Evans noted that a Social Worker funded from the Intermediate Care Fund was working in Ysbyty Gwynedd for four hours on Saturdays and Sundays. She added that it was proposed to have one Social Worker to serve Dwyfor and Meirionnydd in the same way over weekends.

(iii) Bridgitte Williams, Gwynedd and Anglesey Social Workers Team Leader Ysbyty Gwynedd

The following main points were made:

- A joint team between Gwynedd Council and Anglesey Council had been established for three years;
- The team dealt with new cases as well as open cases in the community where a specific Social Worker had not been allocated;
- The team included one Team Leader's post, 2½ Social Workers' posts, one temporary Social Worker's post and two Care Assessors' posts;
- The permission of the patient was required prior to receiving the referral;
- The team assessed the needs of patients when they were ready to leave the hospital and they decided whether patients needed statutory support or support from the Third Sector;
- There was a close relationship between the team and the Red Cross and Carers Outreach;
- They collaborated closely with Eleri Evans's team;
- That a recent development had been the establishment of an Assessment, Discharge and Transfer Team;
- That it was proposed to integrate the discharge team and the Social Services team as one team and BCUHB was looking for a location;

In response to a question by a member regarding what she would wish to change in the current system, she noted that there was a need to build on the collaboration which was already happening.

A member enquired how important the Welsh language was in terms of discharging patients from hospital. In response she noted that everyone within the team was bilingual.

In response to an observation regarding the lack of provision in community hospitals, Glenda Lloyd Evans noted that following the closure of Uned Meirion, the Council was

working with BCUHB to commission a bed in a private home in the Dwyfor area which specialised in dementia.

Glenda Lloyd Evans noted that a meeting had been held with Dr Bill Whitehead, BCUHB Community Clinical Director, regarding the role of community hospitals and the possibility for individuals to stay for a period in a nursing home prior to returning home. Eleri Evans added that such a scheme operated successfully in Conwy.

Regarding the lack of a Welsh language provision to assess individuals for dementia, Ellen George noted that there were difficulties when individuals were only comfortable in communicating through the medium of the Welsh language.

The Senior Business Manager – Social Services reported that work was in the pipeline to assess whether the Council's contracts complied with the strategic framework 'More Than Words'. She noted that if the language expectations in the contracts were insufficiently robust and did not comply then an action plan would be established to respond to the shortcomings.

Eleri Evans explained the main considerations when discharging patients from hospital:

- A nurse ensured that someone was available to fetch the patient;
- Ensure that it was possible for the patient to return home safely;
- Was a referral to Social Services needed?
- Ensure that tablets had been ordered;
- If there was a problem regarding transport home then the Welsh Ambulance Service NHS Trust had to be contacted;

Regarding problems which arose with transport home it was noted that problems arose when no transport had been booked from the Welsh Ambulance NHS Trust sufficiently early.

In response to an observation regarding problems with receiving tablets in a timely manner prior to the patient returning home, Eleri Evans noted that the situation was improving and that the Pharmacists visited the wards in the morning and at midday every day to arrange tablets.

Everyone was thanked for their contributions and those invited were asked to convey the gratitude of the members to their staff for the work which was being done.

The meeting commenced at 2.05pm and concluded at 3.40pm.

Services Scrutiny Committee

NOTES of the Scrutiny Investigation Group – Care (From Hospital to Home), 25 March 2014

Present

Councillors: Peter Read (Chairman), Huw Edwards, Linda A. W. Jones and Ann Williams.

Investigating Officers: - Janet Roberts (Senior Delivery and Support Manager), Bethan Adams and Lowri Haf Evans (Member Support and Scrutiny Officers).

Others invited:- Eleri Evans (Senior Clinical Site Manager, Betsi Cadwaladr University Health Board), Ceri Pritchard (Occupational Therapist, Betsi Cadwaladr University Health Board), Yvonne Moules Roberts (Social Worker, Gwynedd and Anglesey Social Workers Team, Ysbyty Gwynedd), Stuart Whittle (Qualified Learning Disability Nurse) and Sarah Williams (Discharge Coordinator, Betsi Cadwaladr University Health Board).

1. WELCOME

Eleri Evans, Ceri Pritchard, Yvonne Moules Roberts, Stuart Whittle and Sarah Williams were welcomed and thanked for agreeing to meet members of the Scrutiny Investigation.

Everyone introduced themselves.

2. APOLOGIES

Apologies were received from Councillors Elin Walker Jones and Eryl Jones-Williams.

3. NOTES ON THE MEETING OF 6 FEBRUARY 2014

The notes of the previous meeting of the Scrutiny Investigation Group were accepted as a true record.

4. PRESENTATION ON THE ASSESSMENT, DISCHARGE AND TRANSFER TEAM

A brief presentation was given by Sarah Williams on the Assessment, Discharge and Transfer Team at Ysbyty Gwynedd.

It was noted that the team which included the Discharge Coordinators, Social Workers, Gogarth, Aran and Beuno ward Nurses along with Occupational Therapists had been established in October 2013.

She noted that she led the team, with three members of staff and one social worker working additional hours on weekends from 10am to 2pm.

She added that more staff were needed in the long term in order for the team to succeed.

Eleri Evans noted that the additional funding received to enable the service provision on the weekends would cease at the end of March 2014.

It was explained that the staff would go around patients who had been designated on the Clinical Vulnerability Scale with a vulnerability scale of between 4 and 6 in order to seek to discharge the patients safely within five days.

In response to a question by the Senior Delivery and Support Manager in relation to receiving the clients' observations, Eleri Evans noted that the Gwynedd and Anglesey Social Workers Team Leader contacted patients as part of assessing the work of the Assessment, Discharge and Transfer Team.

It was emphasised that a 'What Matters Conversation' was held with the patient and their family soon after the patient was admitted to hospital. In response to an observation by a member, it was noted that the discharge options included intermediate care, nearby hospitals, community hospital, residential home or home.

In response to a question by the Senior Delivery and Support Manager in relation to the 'What Matters Conversation', Sarah Williams noted that this was a general chat with the patient.

In response to an observation by a member relating to comparing the obstacles involved with discharging patients to the homes of Cartrefi Cymunedol Gwynedd as opposed to private homes that required adaptations, Sarah Williams noted that there was no difference in terms of providing home care or providing commodes. She added that should adaptations to the home be required, such as handrails, that the individual would be referred for intermediate care or to an Occupational Therapist.

In response to a member's question regarding the availability of profiling beds for the patients' homes, Ceri Pritchard noted that the referral was made to the District Nurse where it was decided whether or not this provision was needed, but that it was not possible to refer to the District Nurse on weekends and that a bed would be hired from a company.

Yvonne Moules Roberts noted that private agencies were able to commence care services from anew on the weekends for individuals; however the Social Worker could only prepare documentation for the individuals.

Before the meeting, members had visited the Transfer Lounge for individuals who were leaving the hospital. A member noted that the lounge resembled a ward and that a comfortable and purpose made room was required along with changing facilities.

5. QUESTION AND ANSWER SESSION

Those invited to the meeting were given an opportunity to make observations and for the members to ask questions.

Stuart Whittle noted that he was a Qualified Learning Disabilities Nurse. He had undertaken a six month study of admissions arrangements, length of stay and discharge arrangements in September 2012. He added that his presence as a Qualified Learning Disability Nurse facilitated the process. He noted that the arrangements for the discharge of individuals with learning disabilities were not very problematic as there were already care arrangements in place in most cases.

In response to a member's observation regarding individuals with learning disabilities who required twenty four hour care, Sarah Williams noted that it would be possible to discuss with the ward nurses whether there was a need for someone to stay with the patient. It was added that the arrangements had improved compared with 18 months ago.

In response to a further observation by a member that the standard visiting hours of two hours a day in relation to patients with learning disabilities or dementia were insufficient, Sarah Williams noted that the ward staff were willing to discuss a patient's specific needs and to reach an understanding on visiting arrangements. Eleri Evans added that the specified visiting hours ensured that the patients could rest and should there be any special circumstances that they could talk to the charge nurse on the ward.

It was noted that there were Qualified Learning Disabilities Nurses present at Wrexham Hospital, Glan Clwyd Hospital and Ysbyty Gwynedd. It was added that Stuart's presence alleviated the concerns of patients with learning disabilities and made them feel more comfortable.

Sarah Williams emphasised that more support was needed in the community to enable patients to return home as soon as possible in the interest of the individual along with the need to free up beds.

Stuart Whittle noted that there was a lack of provision in the community for young people who needed nursing care and that this was causing bed-blocking.

Ceri Pritchard noted that the Care and Repair company held weekly sessions at Ysbyty Glan Clwyd to answer individuals' questions and it would be beneficial for this to take place at Ysbyty Gwynedd.

In response to a member's observations, Sarah Williams noted that should a patient insist on returning home that the rapid response team would be called in. It was added that if a patient had the mental capacity they could not be prevented from going home. It was noted that there were a high number of cases where a patient had

been admitted back to hospital within a few hours of going home contrary to medical opinion.

A member referred to a scheme at Chesterfield Royal where patients were discharged with a food parcel. The staff were of the opinion that this was a good idea. Yvonne Moules Roberts noted that the Red Cross had offered this provision in the past and they had a 'Home from Hospital Scheme' which provided patients with support in returning home in the Arfon area.

Sarah Williams noted that when individuals were prepared to return home they were provided with a list for shopping and care services etc.

It was noted that a pharmacy provision was now available throughout the week and this was a significant improvement. Reference was made to the Ambulance Service at weekends, it was noted that the provision was good on a Saturday however there were problems on Sundays.

In terms of ambulance provision Eleri Evans noted that it should be ensured that sufficient notice was provided to the services and if no transport was available by the service they would contact the Red Cross to provide transport in the Arfon Area.

In response to a question from a member regarding what he would wish to change about the existing procedure, Stuart Whittle noted that he had been asking to establish a means to identify individuals' needs in a data base, and this would benefit hospitals and GPs.

A member noted that care workers had a digital device which contained information such as the location of keys, details of the GP and details of any disability. The member added there should be a link to this information for hospital use.

Yvonne Moules Roberts reported that the Social Workers Team at the Hospital included a Team Leader, 2 ½ Social Worker posts, 1 temporary Social Worker and two Care Assessors' posts. She noted that the Betsi Cadwaladr University Health Board had funded an additional temporary Social Worker post for working on the weekends from 10am to 2pm. It was noted that the post holder was to finish soon and they had asked the team to volunteer to work on the weekends. It was unlikely that any volunteers would step forward therefore it was assumed that a rota system would be developed in future. It was added that unlike the other staff at the hospital, the Social Workers did not receive enhanced pay for working weekends.

In response to a question from a member regarding what she wished to change about the existing procedure, Sarah Williams noted that it would be beneficial if everyone worked seven days a week, being able to commence new packages on the weekends,

longer working hours on the weekends and the need for more beds in residential homes.

Yvonne Moules Roberts noted that a re-enablement unit in south Gwynedd could assist to enable individuals to be discharged sooner.

Ceri Pritchard noted that a seven day working week would be beneficial but that it would have a harmful effect on staff. She added that they needed more support in the community as the nurses often had to use their own discretion to identify that an individual needed support when they were discharged from hospital.

In response to a question from a member regarding the number of people with learning disabilities who had been referred to Stuart Whittle, he noted that 22 individuals had been referred to him in January and that they would send the information for the year to the member.

Stuart Whittle noted that staff recognised in the current economic climate that it was not possible to have additional staffing resources. He added that everyone was under pressure at work but that he was in regular contact with community workers and that the collaboration was successful.

Everyone was thanked for their contribution.

The meeting commenced at 3.00pm and concluded at 4.15pm.

Services Scrutiny Committee

NOTES of the Scrutiny Investigation Group – Care (From Hospital to Home), 10 April 2014

Present

Councillors: Peter Read (Chairman), Huw Edwards, Eryl Jones-Williams and Ann Williams.

Officers of the Investigation:- Janet Roberts (Senior Delivery and Support Manager), Dafydd Bulman (Corporate Policy and Commissioning Manager), Bethan Adams and Lowri Haf Evans (Member Support and Scrutiny Officers).

Others invited:- Sioned Larsen (Health and Social Care Facilitator, Mantell Gwynedd).

1. WELCOME

Sioned Larsen was welcomed and thanked for agreeing to meet the members of the Scrutiny Investigation.

The members expressed their disappointment that there were no representatives from the Red Cross or the North Wales Advocacy Service present. A member noted that the organisations should be contacted to ask for a written report regarding their provision. The member added that they should note in the correspondence to Red Cross, the members' concerns that the service was not available throughout Gwynedd.

2. APOLOGIES

Apologies for absence were received from Councillors Elin Walker Jones and Linda A. W. Jones.

3. QUESTION AND ANSWER SESSION

Sioned Larsen explained that Mantell Gwynedd was an umbrella body for third sector organisations.

She noted that Red Cross offered a service for people returning from hospital, where individuals were supported for up to six weeks after coming home from hospital, and shopping and collecting prescriptions were a part of their provision.

In response to a question from a member, she noted that Crossroads North Wales offered respite care across the age range. She added that Betsi Cadwaladr University Health Board had commissioned Crossroads to undertake a pilot project of short-term respite care for carers.

A member referred to the Ffrindia' scheme and noted that individuals thought the service was valuable. The member noted that the Ffrindia' scheme was funded by the Big Lottery Fund and that Mantell Gwynedd, Age Cymru Gwynedd a Môn and the Carers' Outreach Service worked in partnership.

With regard to the advocacy service, she noted that a number of companies such as the North Wales Advocacy Service and Age Cymru provided support for individuals to express themselves.

In response to a member's observation in relation to support for individuals after the provision under the Enablement Scheme had ended, she noted that the Ffrindia' scheme was an option and that Age Cymru Gwynedd a Môn had Age Well Centres in Bala, Cricieth, Dolgellau and Nefyn.

She added that there were gaps in the provision in some areas in Gwynedd and that there were difficulties recruiting in the south of the County.

In response to a member's question with regard to how individuals came to know about the services that were available, she noted that individuals were referred

through the Advice and Assessment Centre, with 300 out of 900 individuals being referred to third sector organisations.

She added that some Social Workers were not aware of which individuals were suitable to be referred.

A member enquired in relation to the Ffrindia' Scheme whether the same volunteer was allowed to remain with the individual if he/she developed dementia, and she noted that this depended on the individual's needs.

She noted that the aim of such schemes was to enable individuals to be independent. A member referred to an individual who had developed confidence after using the Ffrindia' Scheme.

A member noted the need to communicate information to individuals about the services that were available. In response, she noted that the services were marketed continuously and that there was close collaboration between the third sector organisations, Social Workers and nurses in community hospitals. She added that perhaps individuals did not take notice of the services available until they needed support.

She noted that the Citizens' Advice Bureau used Mantell Gwynedd's mobile unit to go out to the communities to advise the individuals about the services that were available.

She noted that Llinos Parry had been appointed recently and that she would be working over Gwynedd, Conwy and Anglesey raising awareness amongst Social Workers of the services and training available.

Sioned Larsen was thanked for her contribution.

4. NEXT STEPS

A discussion ensued and the members noted what they had learned to date as follows:

- There was support available but it was not consistent over the whole of Gwynedd;
- Support from third sector organisations depended on funding from the Big Lottery Fund and not mainstream funding;
- A number of schemes existed which varied slightly;
- It was difficult to market services and individuals only looked for information when they needed it;

- A singe point of contact was important;
- A list of the services available and in which areas was needed;
- Collaboration was extremely important;
- Social Workers at Ysbyty Gwynedd needed to be able to start new care packages on weekends;
- Arrangements were needed in place to notify the family or home carer when an individual was returning home later than expected.

In relation to gathering users' opinions, the Senior Delivery and Support Manager suggested that members could try to find one story each from the individuals who had been through the process of being discharged from hospital.

A member noted that in his role as Carers' Champion, he had witnessed examples where individuals had been discharged from hospital without there being an enablement plan or a care package in place.

It was reported that Age Cymru Gwynedd a Môn were holding area forums and that examples could be obtained from the individuals who attended. It was added that examples could also be obtained at the next meeting of the Older People Council.

RESOLVED to aim to hold the next meeting of the Investigation in mid-May after the Older People Council meeting.

The meeting commenced at 2.00pm and concluded at 3.15pm.