Health Scrutiny Panel – Patient Transport Scrutiny Review

1. Following a clinical decision to discharge, how are Social Care kept aware about patients requiring Social Care input?

Social Care are informed of the need for assessment via the notification process linked to the Delayed Discharge process.

Part A informs the department a patient is in hospital
Part B informs us of the need for assessment
Part C gives an approximate discharge date, minimum notification must be 72 hours.
Part D is sometimes sent giving us a further 24hours to work with the MDT to achieve an appropriate discharge.

Although work is allocated throughout the day the discharge process is reliant on a number of components.

Continuing Health Care must be considered for all patients, triggers completed by ward staff and sent to the PCT.

If the patient does not need full consideration for CHC the social worker will request reports that may be necessary to progress discharge from other professionals, working with the family i.e.: SALT, OT, Physiotherapy, CPN. The social worker will meet with family/carers or it may be necessary to consult an IMCA under the Mental Capacity Act.

If the Continuing Health Care triggers are met the same reports are requested along with a nursing assessment. A meeting is held to consider the reports and complete the Decision Support Tool. Once the DST is complete the case is presented to the Community Care Panel for consideration for;

a) Support at home
b) Support in either a residential, nursing or specialist setting.

Funding arrangements are then clarified.

Patients on the end of life pathway can be fast tracked through this process.

Patients who do not meet eligability for CHC may be discharged home from hospital with a support package; intermediate care either residential or community based, or residential care in respite, short stay or interim basis.

2. Does Social Care have an input into the appropriateness of a mode of transport following discharge?

Social Care does not have input into the appropriateness of the mode of transport. There are occasions when patients are not discharged home when expected and we are not informed.

3. How is a care package prepared and finalised when it relates to a person being discharged?

When all assessments are complete the most appropriate support package or placement is agreed with the patient/family/carer. A care plan is compiled and a service is commissioned. Discharge plans are agreed with the nurse, patient and carer. In Middlesbrough the Rapid Response Service can facilitate a speedy discharge if a patient needs a package of care. The service is flexible and reliable, covering seven days. This service can also cover end of life care.

4. Is Social Care notified when a patient requiring social care has arrived following the use of patient transport?

Very often the department is not notified by the trust/ward staff when a patient in receipt of service is admitted to hospital. We are not notified when they arrive home with a package of support organised by a social worker.

5. When a patient is coming from residential care home or the intermediate care center to attend an outpatient appointment, does social care have an input into the arranging of patient transport?

Intermediate care or a care home rings patient transport. They give details, such as a two-man ambulance may be needed if a wheelchair is used when a patient is unable to transfer.

If staffing allows, both MICC and independent facilities, a carer may be sent to hospital with the patient. When outpatient clinics run late patients need to report to reception to let them know they need return transport. Patients may sit and wait a while if not aware of the process.

6. Does Social Care have any general views with reference to Patient Transport it would like to bring to the attention of the panel?

Social Work staff are concerned that patients have to wait in the discharge lounge sometimes all day for discharge. Wards can't give accurate times for discharge, making it difficult to set up support in the home. Families can find co-ordination of support difficult, medication is sometimes not ready and follows in a taxi.

For regular users of patient transport any change to the usual patterns i.e.; if patient is going to respite care or day care following treatment or vise-versa can cause problems.

Social workers are of the opinion that there is not enough information in GP Surgeries related to modes of transport for hospital appointments/admissions.