HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 12 January 2015

at 9.30 a.m.

in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Brash, Richardson and Simmons.
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Gill Alexander
Representatives of Healthwatch (2). Margaret Wrenn and Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council (1) – Dave Stubbs
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Caroline Thurlbeck
Representative of Hartlepool Voluntary and Community Sector (1) – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust (1) – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster

Observer – Representative of the Audit and Governance Committee, Hartlepool Borough Council (1) – Councillor Springer.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

To confirm the minutes of the meeting held on 1 December 2014

4. **ITEMS FOR DECISION**

4.1 HealthWatch Hartlepool Hospital Discharge Investigation - *HealthWatch Hartlepool*

4.2 Health and Wellbeing Board Development Programme - *Director of Child and Adult Services, HBC; Director of Public Health, HBC; Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG*

4.3 Securing Quality In Health Services (SeQIHS) - *Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Project Director, NHS Darlington Clinical Commissioning Group on behalf of the Durham, Darlington and Tees CCGs*

5. **ITEMS FOR INFORMATION**

5.1 Obesity Conference Planning Update – *Verbal*

5.2 Improving Urgent Care Services in Hartlepool (*Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG) (to follow)*

6. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date of next meeting – 2 March 2015 at 9.30 a.m. at the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

1 December 2014

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

Councillor C Akers-Belcher, Leader of Council (In the Chair)

Prescribed Members:
Elected Member, Hartlepool Borough Council – Councillor Carl Richardson
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Schock and Alison Wilson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Representative of Healthwatch – Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council – Dave Stubbs
Representative of the NHS England, Ben Clark as substitute for Caroline Thurlbeck
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust – David Brown as substitute for Martin Barkley

Also in attendance:-
L Allison, J Gray, S Johnson, G Johnson and S Thomas, HealthWatch

Officers: Neil Harrison, Head of Service, Hartlepool Borough Council
Amanda Whitaker, Democratic Services Team, Hartlepool Borough Council

27. Apologies for Absence

Elected Member, Hartlepool Borough Council – Councillor Simmons
Representative of NHS England – Caroline Thurlbeck
Representative of Tees Esk and Wear Valley NHS Trust – Martin Barkley
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster
Representative of Audit and Governance Committee – Councillor Springer

28. Declarations of interest by Members

Councillor Christopher Akers-Belcher reiterated the declaration he had made at a previous meeting of the Board (minute 3 refers) that in accordance with the Council's Code of Conduct, he declared a personal interest as Manager for the Local HealthWatch, as a body exercising functions of a public nature, including responsibility for engaging in consultation exercises that could come before the Health and Wellbeing Board. He had advised that where such consultation takes place (or where there is any connection with his employer), as a matter of good corporate governance, he would ensure that he left the meeting for the consideration of such an item to ensure there was no assertion of any conflict of interest. Councillor Christopher Akers-Belcher informed the Board that he would, therefore, vacate the Chair during consideration of the item relating to HealthWatch Work Programme 2014/15.

29. Minutes

The minutes of the meeting held on 20 October 2014 were confirmed. There were no matters arising from the minutes.

With reference to minute 28, Councillor Christopher Akers-Belcher vacated the Chair for consideration of minute 30

Dr Schock In the Chair

30. HealthWatch Work Programme 2014/15 (*HealthWatch Hartlepool*)

Steve Thomas, HealthWatch Development Officer, presented HealthWatch Hartlepool's agreed work plan together with their Communication and Engagement proposal. The Board was informed of the background to the compilation of the work plan and salient issues were highlighted. With regard to the provision of Out of Hours Services in Hartlepool, the Board was informed that whilst it was considered that there had not been a deterioration of that service, there had also not been the improvements which had been anticipated. The Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group advised that the Clinical Commissioning Group shared some of the concerns which had been expressed. The Chief Officer provided details of improvements which had been made together with further improvements to be made arising from the future commissioning of an integrated service. It was noted that work undertaken by HealthWatch would inform that specification. The Chief Officer commented also on issues identified in relation to dementia in the context of General Practice and ongoing discussions with North East Ambulance Service particularly since the recent appointment of a new Chief Executive of the Ambulance Service. The HealthWatch Development Officer advised the Board that he was encouraged by the outcome of the Board's discussions. The Director of Public Health congratulated HealthWatch on their achievements the previous year and highlighted the work being undertaken by the Audit and Governance Committee on dementia particularly in the context of the opportunity for more research into lifestyle determinants.

Decision

The Board noted the HealthWatch Hartlepool work plan 2014/15.

Councillor Christopher Akers-Belcher In the Chair

31. Health Performance Framework Proposal (*Director of Child and Adult Services and Director of Public Health*)

The report sought endorsement of the proposed health performance framework, the key principles of which were set out in the report: It was aimed to develop a representative number of Performance Indicators into a framework that was understood and agreed by all partners. It would be based, therefore, on the outcomes of the Health & Wellbeing Strategy. The proposal also sought to ensure that the Performance Indicators provided a relevant and recent picture of the Borough and enabled the Board to react in a timely manner to areas of concern. Therefore it was proposed to have two levels of performance reporting as detailed in the report. The proposed Performance Indicators for inclusion in the reporting framework were set out by outcome in an appendix to the report.

It was proposed that trend and benchmarking information be provided annually where available as set out in report. The presentation of the information would build upon the variety of ways that health information is currently presented including that demonstrated in the Ward Health Profiles and north east health & wellbeing heat maps (appended to the report). There would also be an annual performance meeting when performance information and potential future priorities would be considered.

Decision

(i) The Health and Wellbeing Board endorsed the proposed health performance framework.
(ii) It was agreed that the Performance Indicators be reported to all Councillors on an annual basis by way of a Members' Seminar.

32. Joint Health and Social Care Learning Disability Annual Self Assessment Framework (*Director of Child and Adult Services*)

The report updated the Board on the results of the eighth annual learning disability performance and self assessment framework (SAF). The issues raised by the Hartlepool Learning Disability Partnership Board in completion of the SAF were highlighted to the Board. The Head of Service made a

presentation which highlighted issues arising from the document. The Board was informed of background information, core themes, identification of priorities and a summary of findings. The role of the board was highlighted with particular reference to the NHS England publication 'A practical guide for Health and Wellbeing Boards – leading local response to Winterbourne View' A copy of that publication was appended to the report together with the Quality Assurance report for Hartlepool. The Board discussed issues arising from the presentation and the Service Manager agreed to examine the viability of 'quality checkers' as a result of impending staff changes. In response to assurances sought from Board Members, the Service Manager referred to the significant progress which had been made including improved sharing of information with the Foundation Trust and enhanced robustness of data. Improvements referred to by the Service Manager were supported by the representative of Tees Esk and Wear Valley NHS Trust. Reference was made to the work in the mental health and learning disabilities workstream and the Board discussed the improvement in dementia diagnosis in GP registers.

Decision

(i) The Board noted the content of the report and the progress made;
(ii) The Board agreed the key priorities for improvement for 2014/15; and
(iii) The Board considered the challenges and constraints in respect of completion of the SAF for 2014/15 and considered how the process could be better supported.

33. Due North – Report of the Inquiry on Health Equity for the North (*Director of Public Health*)

The report introduced a presentation regarding Due North: the Report of the Independent Inquiry on Health Equity for the North which had been published on 15th September 2014. A presentation made by the Director of Public Health informed the Board that Due North was the report of an independent inquiry, commissioned by Public Health England. Its aim was to provide further evidence on the socio-economic determinants of health and additional insights into health inequalities for the North of England (covering the North East, North West and Yorkshire and the Humber regions). The report built on the Marmot Review and focused on the three themes of a fair start for children, the economy and welfare and democratic and community empowerment. The report provided additional evidence on what actions were needed to tackle the underlying determinants of health on the scale needed to make a difference. It also set out challenges to local areas, communities, businesses, councils, the health sector and national political leaders about potential actions they could deliver which could disrupt these persistent health inequalities. The report set out four high level recommendations, as follows:

- tackle poverty and economic inequality within the North and between the North of England and the rest of England
- promote healthy development in early childhood
- share power over resources across the North and increase the influence that the public has on how resources are used to improve the determinants of health
- strengthen the role of the health sector in promoting health equity

The Director of Public Health's presentation highlighted that the recommendations and underpinning supporting actions were aimed at policy makers and practitioners working within agencies in the North of England and secondly, to central government.

Board Members expressed disappointment that health inequalities continued to exist despite ongoing efforts of partner agencies to improve the situation. The Board highlighted that changes to the funding regime had resulted in reduced resources which had prevented further progress in narrowing the health inequality gap.

Decision

(i) The content of the presentation was noted and the Board considered how to work with organisations such as Public Health England to implement the recommendations.
(ii) The Board agreed that a response should be send to Public Health England which highlights action which has been taken and the implications of the funding regime which has prevented further progress being made.

34. Better Care Fund Update (*Director of Child and Adult Services and Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The report provided the Board with an update regarding the assurance process for the Better Care Fund (BCF) and the outcome for Hartlepool, as well as an update on progress in relation to implementation. It was noted that the outcome of the assurance process had been announced on 30 October 2014. Hartlepool's plan had been assessed as 'approved with support'. Work was underway to provide the additional evidence required in order to have the plan fully approved. This included further detail in relation to risk sharing and contingency arrangements, agreement of a patient experience metric and some additional detail demonstrating how the various elements of the plan contributed to the delivery of the agreed outcomes. An action plan had been drafted and information had been gathered and submitted to the Area Team

by the deadline of 28 November 2014.

Work had continued in parallel to the assurance process to ensure that the plan could be implemented from April 2015. A number of the developments in relation to low level support and improved dementia pathways had already been progressed. Further work has been undertaken in relation to the intermediate care element of the plan, including a range of clinical audits and a review of community nursing and the outcomes of this work would be considered in detail at a planned event on 27 November 2014 to further develop the model for an integrated intermediate care service. It was noted that there would be a further progress update provided to the Health & Wellbeing Board in January.

As a consequence of discussion at the meeting, the Board was informed of details of intermediate care and continuing care provision with particular reference to quality assurance issues and ongoing discussions with providers. The Board discussed issues associated with ensuring consistent quality of service. It was highlighted that carers required support and concerns were expressed regarding delays in accessing day care due to alleged delays in social care assessments. It was agreed that it was essential to ensure services were considered across the area to ensure community services were appropriate. It was suggested that a report be submitted to the Board addressing the range of care packages which were available.

Decision

The Board noted the outcome of the assurance process and the further work undertaken to implement the plan and agreed to receive further updates as detailed plans are developed.

35. The NHS Five Year Forward View (*Director of Public Health, Director of Child and Adult Services, Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group and Director of Operations and Delivery, NHS England*)

The representative of NHS England, Ben Clark introduced the document summarising the key issues in the NHS Five Year Forward View (5YFV) which had been published on 23rd October 2014. The document described the collective view of NHS England, Public Health England, Monitor, the NHS Trust Development Authority, the Care Quality Commission and Health Education England on why change in the NHS was needed, what that change might look like and how it could be achieved. The paper outlined the potential implications for the Durham, Darlington and Tees Area Team and the NHS organisations within that geographical footprint. The report covered issues relating to public health and prevention, greater patient control, new models of care, enabling work, the financial perspective and local implications.

The Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group, addressed the local context and referred to discussions earlier in the meeting. Board Members noted that it was intended that a report on development of scenario planning to be submitted to the next meeting of the Board. The Chair proposed that communication and engagement should be developed also by working with the Public Relations Officers.

Decision

The Board noted the content of the report.

Meeting concluded at 11.30 a.m.

CHAIR

HEALTH AND WELLBEING BOARD

12th January 2015

Report of: HealthWatch Hartlepool

Subject: HealthWatch Hartlepool Hospital Discharge Report - November 2014

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1. PURPOSE OF REPORT

1.1 To inform the Health & Wellbeing Board of HealthWatch Hartlepool's recent investigation into the effectiveness from the patient perspective of Discharge processes which are in place at North Tees and Hartlepool Hospitals.

2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The Hospital Discharge Project was included in the 2014 work programme of Healthwatch Hartlepool as a result of concerns which were raised with us by patients and partner organisations regarding a number of problematic discharge experiences, particularly in cases were a complex package of care and post discharge support was needed.

3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.

- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).
- This report will be made available to all partner organisations and will be available to the wider public through the Healthwatch Hartlepool web site.

4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board note the HealthWatch Hartlepool Discharge Report and that full consideration is given to recommendations contained within.

6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations are based on findings from our investigations and the feedback and comments we have received through patients, family members and carers who have recent experience of discharge from North Tees and Hartlepool Hospitals.

7. BACKGROUND PAPERS

7.1 Governance Framework and Communication & Engagement proposal

8. CONTACT OFFICER

Stephen Thomas - HealthWatch Development Officer
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

Healthwatch Hartlepool Hospital Discharge Investigation

November 2014

MISSION STATEMENT

"Healthwatch Hartlepool has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard."

Contents of the Report

1. Background

1.1 There are few issues in the area of Health and Social Care that have attracted as much attention as patient discharge from hospital. Hartlepool is no exception, and over recent times Healthwatch Hartlepool has been made aware of an increase in the number of issues regarding the discharge of patients from hospital to the community. From this flow of intelligence from patients, carers and partner organisations it is clear how important this issue is to all concerned and consequently Healthwatch Hartlepool made it central to its 2014 work programme.

1.2 Hospital discharge is the term used when a person leaves hospital once they are sufficiently well to do so and each year hundreds of thousands of patient discharges will occur from hospitals up and down the country.

1.3 Most discharge procedures (around 80%) are termed as "minimal" or "routine" and require only a small amount of follow up care. However, there is a second group of procedures which are referred to as "complex" and which require more specialised care packages once the patient has left the hospital. This can involve –

- An assessment of the person's needs, living environment and support network in order that ongoing health and social care needs can be met
- The involvement of community care services
- Intermediate care requirements
- Access to nursing or residential care provision
- Ongoing involvement of multiple health and social care agencies and professionals as well as local authorities and independent or community and voluntary sector organisations.

1.4 As discharge processes become increasingly complex the potential for problems and difficulties increases significantly and between October 2012 and September 2013 there were around 10,000 reports to NHS England through the National Reporting and Learning System (NRLS) of patient safety incidents relating to discharge. Failure of systems at point at point of discharge have in

some instances resulted in avoidable readmission to secondary care and in the most serious cases serious harm and sadly patient deaths.

1.5 Consequently hospital discharge is the subject of rigorous national guidelines which govern discharge procedures and which outline key steps which must be followed in order to ensure safe, timely and well planned discharge procedures. At the very heart of all such documentation is the need to ensure that a person centred approach which treats individual patients with dignity and respect is always in place. This enables diverse and unique needs to be central to individual care packages and best possible patient outcomes to be achieved.

1.6 As well as national guidance hospitals are required to have a transfer and discharge policy which outlines their individual approach and ethos. The North Tees and Hartlepool NHS Trust Inter Agency Admission, Transfer and Discharge Policy states –
"Safe to discharge/transfer is a decision that must be made by the multi-disciplinary team including carers, social workers, district nurses and Allied Healthcare Professionals (AHP's) caring for the individual patient by careful consideration of all the factors and involving patients and carers at all stages".

1.7 This statement is central to the manner in which Healthwatch Hartlepool has conducted its investigation of discharge processes and the direct experience of Hartlepool based patients at North Tees and Hartlepool hospitals. Members of Healthwatch Hartlepool have put considerable time and effort into developing their understanding of the whole discharge process and of the roles played at different stages by different organisations and service providers. Consequently, an enormous amount of information has been gathered but this report will focus primarily on the experience of patients and how effectively the system works for them

1.8 Finally, hospital discharge has been recognised as an area of concern nationally by Healthwatch England and in June 2014 a national Special Inquiry was launched into perceived unsafe discharge of patients from hospital, care and mental health settings. The specific focus of this national inquiry was on the experiences of frail and elderly people, people with mental health conditions and people who are homeless. Information gathered in this investigation is not specific to these groups but does cut across and include many common themes

which are relevant to the national investigation and our findings and recommendations will be shared with all interested parties.

2. Methodology

2.1 To start the process off Healthwatch Hartlepool held a workshop event on January 22nd 2014 to which all partners who are involved in hospital discharge procedures were invited. This included representatives from the North Tees and Hartlepool Hospital Trust, Hartlepool Borough Council, Healthwatch Stockton, Housing Hartlepool and a various community and voluntary sector organisations.

2.2 The workshop included presentations from Healthwatch Hartlepool, the Hospital Trust and Hartlepool Borough Council and concluded with table top workshop discussions which allowed participants to identify things they felt currently worked well and issues and problems that they had encountered with the manner in which discharge currently works. At the end of the session four key themes had been identified –

- The complexity of the discharge process
- Communication with patients and between agencies
- Post Discharge support
- Early interventions

2.3 With the exception of early interventions, which falls outside of the scope of this investigation, all of these area have proved to be central to the key findings which have been made.

2.4 Following the workshop it was decided that there was a need to get to know in some detail how discharge processes currently work. This initially involved meetings with key staff members at the hospital Trust and Local Authority and a wide range of relevant information and documentation was requested and gathered together. This was followed by a series of planned visits to key service delivery points which at the North Tees and Hartlepool Hospitals included –

- The Emergency Care Team
- The Discharge Liaison Team
- The Emergency Assessment Unit

- Bed Meeting/Duty Point Officer
- Accident and Emergency unit
- Continuing Health Care Team
- Short Stay Wards
- The Emergency Admissions Unit
- Orthopaedic Wards 42/43
- The Holdforth Unit

2.5 Visits were made to the Single Point of Access (SPA) and Community Integration assessment Team (CIAT). The SPA acts as a central hub through which information is gathered regarding patient's post discharge care and rehabilitative support requirements. This information comes from several sources, the main one being the hospitals, but also includes doctors, nurses and other allied staff. CIAT carries out standard single assessments and works very closely with various other teams including Falls, Rapid Response, Out of Hours District Nursing, West view Lodge Discharges and the Rehabilitation Day Unit at University Hospital Hartlepool. Support is provided at discharge and post discharge stages and their reports address physical, functional and social needs as well as mental health and financial assessments.

2.6 A visit was also made to the South Team District Nurses. This team deals with patients in the community for treatment and monitoring when they are ill at home or have been discharged from hospital. The SPA centre is the link between all services and acts as the main communication hub.

2.7 Visits were also made to Hartlepool Borough Council to discuss the role and input of social services into discharge processes. Councils play a key role in providing help and support to patients on their return home or it may be decided that a person needs to receive care in a care home. Services provided through the local authority can be means tested and individuals may be required to contribute to costs. The Community Care (Delayed Discharge) act 2003 is an important consideration in the role of the Local authority. This legislation seeks to ensure that patients do not stay in hospital longer than necessary. When the patient is ready for discharge the hospital must inform the Local authority if social service care is needed, at which point they must then assess the patient's needs and arrange any necessary services within a certain amount time. If it does not do so the act states that a fine must be paid to the hospital or relevant NHS body.

2.8 However, central to all of this has been input from patients and carers who have recently had experience of hospital discharge processes. Whilst developing an understanding of how this extremely complex process should work, the main thrust of this project has been to test real life experience against the understanding which has been developed around how things should work.

2.9 Patient experience has been gathered by means of questionnaires which were complete by patients in Hartlepool Hospital (Healthwatch Stockton undertook a similar exercise with patients in North Tees Hospital) and in the community after discharge. Two coffee morning events were also held at Laurel Gardens and Burbank Court and our thanks is extended to Housing Hartlepool for the support they gave us in facilitating these events. Questionnaires were also sent out to and completed by members of various community and health related organisations from across the town including –

- The Breathe Easy Group
- Epilepsy Outlook
- Voice For You
- Friends Of Sunflower
- Parkinson's Disease Group
- Arthritis Care Group
- Blind Welfare
- Hartlepool Deaf Centre
- Hartlepool Hearts group
- Hartlepool Carers
- Hartlepool Hospice
- M.E Support Group
- Stroke Support
- Healthy wellbeing Group
- Careline
- Carewatch
- 50 + forum
- Residential and nursing care homes in Hartlepool

2.10 The support of these groups and organisations was invaluable and we extend our thanks to them all.

2.11 Finally, meetings were also held with G.P practice managers and specific input was received from the North East Ambulance Service regarding transport issues and the Chair of the Local Professional Network of Pharmacists.

2.12 Our programme of research and information gathering was extensive and in depth and has given Healthwatch members a real insight into the complexity of hospital discharge procedures and subsequent care and rehabilitation procedures.

3. Findings

3.1 The first point to make regarding our findings is that in the vast majority of cases hospital discharge and subsequent care packages run smoothly and without any problems. Operational systems and procedures in hospital, community and local authority all appear to be thorough, robust and appropriate. Managers and staff who were encountered during our investigations were all thoroughly professional in their outlook and an ethos of care is present amongst all service providers that were visited.

"Efficient, competent and caring staff, gave me a feeling of confidence and safety"

3.2 Around 80% of patient discharges are simple or routine and of the remaining 20% only a very small number are problematic and of concern. However, hospital discharge can be an incredibly difficult and complex process and in order to function properly requires multi disciplinary inputs from a wide range of services from hospital, community and local authority. Effective communication is vital between and within these organisations and inevitably problems do occur. A minor communication problem can have enormous consequences for individual patients and the subsequent provision of timely and appropriate treatment and care.

"My experience was so bad that I contacted my family to arrange my discharge"

3.3 In all discharge guidance and policy documentation the importance of regular, effective communication with patients and their families and carers is highlighted as being central to good patient centre practice.

"Good communication is the way to ensure that your knowledge and clinical skills are used to best effect. Use language and terminology that are familiar to the patient and always check their understanding"
Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care – Department of Health

3.4 The North Tees and Hartlepool Hospital Trust policy document "Inter-agency Admission, Transfer and Discharge" regularly refers to the need for patients, their families and carers to be fully informed of and aware of discharge planning, arrangements and timings. Indeed, if this does not happen vital information regarding home and personal circumstances and subsequent care needs may be overlooked. It also contains a comprehensive package of paperwork which should be completed over the course of the patients stay within hospital and includes documentation particular to discharge planning and subsequent care requirements.

3.5 National guidance states that hospital discharge assessment should be carried out through a single assessment process. This is a government issue which enables health and social care staff to work together to provide co-ordinated and consistent services. Members of the multi-disciplinary team will work closely together to consider the patient's health and social care needs and should share assessment information in order to avoid duplication and delay. This should make the discharge process more structured particularly when the person has complex care requirements.

3.6 During the course of their visits to Hospitals Healthwatch members were impressed by the commitment and dedication of the discharge liaison team, ward based care co-ordinators and all other staff involved in the planning and management of discharge processes.

3.7 However, our research questionnaires showed a significant proportion of those who responded said that they felt they had not been fully consulted and informed about their discharge arrangements and subsequent care and support package.

"I was not given any advice about after care nor was I offered the option of a district nurse while my catheter was in place"

"We had to chase staff for discharge papers, no one came to make sure I was OK when I left"

"I was not consulted and have since complained to the hospital"

3.8 Some patients also reported that information had been provided, but because of short term memory problems could not recall the detail of the conversation and some went on to say that they had also *"lost"* their discharge letter or couldn't recall whether or not they had received one. One person also said that they had not been able to read forms and leaflets they had been given because of sensory loss and had not been offered any assistance.

3.9 Periods spent in hospital are stressful for patients, families and carers. Discharge processes and subsequent care and rehabilitation periods can be complex and frightening. Language used by staff to describe these things to patients may be unfamiliar and difficult to follow or to understand. Indeed, Healthwatch members have spent many days and weeks examining these processes and feel that they are still at the early stages of building a full understanding and awareness of how hospital discharge and subsequent care and support systems work.

3.10 During the time period of our investigation both the North Tees and Hartlepool Discharge Policy and Discharge leaflet were under review and we understand that updated versions will soon be available.

3.11 Defined procedural pathways are in place to assist in cases where patients are known to have dementia or a memory problem, but care must also be taken to ensure that all patients are fully aware of and involved in their discharge arrangements and the planning of their future care needs. Ward pressures can make this difficult, but there can never be any excuse for patients and their families not being central to decision making processes about future care and rehabilitation needs.

3.12 Around 40% of those completing the questionnaires reported that they had not been given specific information about who to contact and what to do if they were worried or concerned about their recuperation and ongoing care needs after discharge.

"I was told to go back (to hospital) if still in pain, but no information was given"

3.13 A small number of patients reported being given new medication which was not fully explained and some also reported that they had received an explanation but had not fully understood or because of memory problems could not fully recall what they had been told.
"Yes, but due to memory issues I didn't follow what was being said"
"X could have done with more detail about new medication and was upset he was noted as refusing to take it when in fact he was too ill"

3.14 Concerns over understanding of medication illustrated above led members to question the level of knowledge and understanding that many patients would have regarding the correct and appropriate usage of their medication post discharge and the levels and type of support that would be available to them.

3.15 Around 40% of patients reported that there had been a delay in their discharge with the most frequent time period being between 2 and 6 hours. The most common reasons given for delays were transport issues and waiting for medication to come from pharmacy.

"Medication should be ordered and available at time of discharge ".

"On several occasions I have had to wait up to 6 hours to leave hospital, very frustrating!"

3.16 A patient reported that in their opinion discharge had been unduly delayed due to their care package *"not being in Place"*, and another reported that there had been *"some confusion"* between the hospital and social services regarding their care package.

"I had a hip operation on Monday and could have been discharged on Friday but Hartlepool Social Services did not review me until Monday which aggrieved me and the nursing staff."

3.17 However, Hartlepool Borough Council have informed us that they have never been the subject of a Delayed Discharge Fine as per the requirements of the Community Care Act (2004).

3.18 During the course of our investigation we were informed that in line with national guidance North Tees and Hartlepool Hospital does now aim to discharge patients seven days a week. We were also informed that Stockton Social Services now operate a seven day discharge support model whereas Hartlepool still operate a five day pattern and that discharges requiring social care inputs therefore do not take place between 4pm on Friday afternoon and Monday morning.

3.19 One patient who completed the questionnaire reported that they felt that they had been discharged before they were medically fit

"I felt they needed the bed"

Another commented on the heavy demand for beds-
"Three or four people had been in each bed by the time I was discharged"

Several patients also commented on the pressure that they considered staff to be under.

"They were absolutely rushed off their feet"

3.20 Overall, Healthwatch members were impressed with the way in which the SPA and CIAT operations function. Both came in to being as part of the remodelling of community based services which happened two years ago as part of the Community Renaissance process. However members did feel that at times having to send all messages via the SPA can slow down responses. Though it was never the intention to reduce communication between professionals and consequently impact upon the timely delivery of patient care, on some occasions, due to current operational procedures this does happen.

3.21 Concerns were raised by patients regarding transport issues. On some occasions transport arrangements had been disrupted due to other delays in the discharge process and volunteer drivers had been used to take patients home. Wherever possible medically appropriate patients are encouraged to make their own transport arrangements. If this is not possible, PTS (Patient Transport Services) may be organised through NEAS (North East Ambulance Service) and only in exceptional services will transport be provided in an ambulance. NEAS do

not provide transport services after 7pm. Discharges of a complex nature, in which care packages are required by the patient should not happen after 5pm.

3.22 Discussions with Housing Hartlepool raised concerns that in the previous year there have been several occasions in which residents have been discharged back to sheltered and extra care accommodation without the prior knowledge of either wardens or care managers. This was of some concern to members as some years earlier they had worked with Housing Hartlepool staff and the Hospital Trust in developing a pilot discharge card. The card would be give contain details of the Housing Hartlepool Contact Centre telephone number and would allow the Hospital to enable the hospital to notify them of the discharge arrangements thus enabling care packages to be reinstated for the returning resident.

3.23 During the course of the investigation Hartlepool Borough Council became aware that there had been a number of inappropriate discharges from hospital back into care homes. In response to this the Council has developed a protocol and flow chart which clearly outlines the process which should have been followed prior to discharge including multilink team inputs and hospital assessments and expected contact with the specific care home.

3.24 Concerns were also raised during the course of the investigation regarding a lack of nursing care beds in Hartlepool resulting in patient being unable to be discharged into an appropriate nursing facility of their choice. This is clearly an unacceptable situation and as well as resulting in *"bed blocking"* can impact significantly on recuperation and expose the patient to hospital infection risks for unnecessarily long periods of time.

3.25 Finally, members noted with some concern that many NHS I.T systems are not compatible and that this can have a significant impact on the smooth flow of vital patient information between different service providers at critical times in the discharge and subsequent care and recovery of patients

4. Conclusions

4.1 Overall members were impressed with the discharge and subsequent care and support provision. A real desire to provide excellent care and support was evident from all managers and staff who we met during the course of this

project. However given the complex nature of the process it is not surprising that some concerns did come to light which can be covered under the general headings of complexity, communication and post discharge support which came out of our initial workshop event in January.

4.2 The discharge process can in some instances be extremely complex and involve inputs from numerous health and social care service provider organisations and consequently we believe that on some occasions the patient experience of transfer from hospital care to social care, whether it be in their own home or within a care home can be problematic and confusing. Efforts have been made to integrate pathways and services but there is still much to be done. Financial constraints on both health and social care budgets have been a driving factor towards greater integration and closer working but excellent patient experience must always be at the very heart of any service delivery model.

4.3 The level of I.T systems integration is still quite low and this can have a detrimental impact on the flow of information between different organisations, particularly in complex cases in which there is a need for complex care packages to be fully in place as well as G.P and pharmacy inputs.

4.4 Financial considerations are undoubtedly an important factor in measuring effectiveness of service delivery and performance but is only one consideration amongst many. For example Hartlepool Borough Council quite rightly points to the fact that they have not incurred delayed discharge fines. We acknowledge that much progress has been made in making the patient transition pathway from acute to social care a more seamless experience but more work is needed to further reconcile and integrate pathways and information sharing.

4.5 The potential of the Better Care Fund to assist with pathways integration and service development needs to be explored fully and there must be recognition of the importance of getting discharge processes right in reducing avoidable admissions and re-admissions.

4.6 It is noted with some concern that during the course of the investigation instances of problematic discharge to care and sheltered/extra care housing settings have continued to occur. The Inappropriate Discharge Protocol developed by Hartlepool Borough Council for use by care and nursing homes is a valuable tool but we are disappointed that the Discharge Card initiative which

was piloted by Housing Hartlepool over two years ago has not been adopted. We were also extremely concerned that instances were reported by Housing Hartlepool in which residents with significant care needs were brought home after 5pm.

4.7 Discharge procedures and pathways are the subject of an extensive paper trail of forms and paperwork. However, there was a strong indication from some patients and carers that they feel they have not been fully involved in decision making about their treatment and subsequent social care pathway development. Consequently some leave hospital unclear about their medication and other ongoing aspects of care. There are clear systems in place which should ensure that this does not happen and we have uncovered no evidence to suggest that procedures are not being rigorously followed. However, for some patients, and in particular those with short term memory problems and sensory loss these safeguards and checks appear not to be working. Similar concerns apply to a reported lack of knowledge and awareness of who to contact if patients experience difficulties with care package after discharge.

4.8 Some significant delays to discharge have resulted from a shortage of nursing care beds in Hartlepool and resulted in occasional *"bed blocking"*. This is an unacceptable state of affairs both for the patient and hospitals concerned.

4.9 Delays on the day of discharge are far more common and the most frequent cause appears to be medication not being available to collect. Patients can find themselves waiting up to four hours for their medication which causes personal inconvenience but also impacts upon transport and personal care arrangements.

4.10 Lack of clarity and understanding of medicines as mentioned above is a particular worry, and nationally it is estimated that between thirty and seventy percent of patients have either an error or an unintentional change to their medicines when their care is transferred between acute and primary settings.
(PSNC – Responding to the special Inquiry into Post Discharge Care – July 2014)

4.11 The SPA and CIAT functions appear to be working well although some minor communication and access problems have been reported, and in particular COPD patients have reported difficulties in accessing timely specialist support since its introduction.

4.12 Transport should always be made available to patients where necessary and discussion about day of discharge transport arrangements should happen as early as possible in the discharge planning process. Relatives, care homes, nursing homes and sheltered and extra care housing providers must be informed of dates and times of discharge in advance.

5. Recommendations

5.1 Post discharge care and support pathways are complex, fragmented and confusing. There is an urgent need to review existing processes with a view to consolidation and simplification.

5.2 Work should also be undertaken in order to ensure that communication and cross service working is maximised across all aspects of the discharge pathway and to ensure seamless, timely, problem free patient transition. This needs to include improving the compatibility of I.T systems and wherever possible the sharing of patient information and care records in order to maximise the potential for continuity of patient care.

5.3 The Better Care Fund should be a primary driver for developments of this nature and should be used as a vehicle to instigate improved continuity during discharge and subsequent patient reablement and ongoing care and support provision.

5.4 Wherever possible, hospital discharge should be a seven days a week process and all agencies should aim to make this a safe and viable reality.

5.5 Pre discharge discussions with patients, carers and family members must be started at the earliest possible opportunity, and should be conducted in plain, simple jargon free language.

5.6 Patient and carer/family member understanding of the contents of discharge summary letters must always be thoroughly checked in order to ensure understanding of future care, treatment, transport home requirements and medication arrangements prior to actual discharge. Also, clear information regarding services or organisations to contact if they are not happy, want to make a complaint or need further help and support post discharge should be provided by the named Discharge Co-ordinator.

5.7 Consideration should be given to developing an enhanced level of discharge support to patients who have difficulties planning for and anticipating their future needs without help. It is important to acknowledge that time and skill is needed to consult with all parties including patient, family and carers.

5.8 Under no circumstances should a patient with a complex package of care and complex care needs be discharged back home or into a care facility after 5pm.

5.9 A review of day of discharge dispensing should be conducted with a view to reducing the delays patients experience waiting for medication to arrive. This should involve all aspects of this process including the part played on the wards by Doctors and Consultants and the potential for prescribing minor medication via a named communication with patient consent.

5.10 There is the potential for enhanced support from community pharmacies. By identifying those patients who could benefit from specialised advice and support on the most appropriate use and benefits of their medicines post discharge .Also the development of enhanced IT systems which would facilitate sharing of patient summary care information.

5.11 A full review of current and future nursing beds should be conducted by the Hartlepool and Stockton CCG and appropriate commissioning arrangements put in place in order to meet needs.

5.12 Consideration must be given to ensuring that providers of extra care and sheltered housing are always informed when residents are being discharged and the "discharge card" suggested by Housing Hartlepool should be revisited.

6. Acknowledgements

Healthwatch Hartlepool would like to thank all of the organisations and individuals who have provided information and completed questionnaires over the course of this investigation. We also wish to thank our volunteers for the countless hours they have spent gathering the information that is contained within this report. Your efforts are greatly appreciated.

Stephen Thomas
Healthwatch Development Officer

7. References

7.1 Inter Agency Admission, Transfer and Discharge Policy
(North Tees and Hartlepool NHS Trust)

7.2 Protocol for Hospital Discharge
(Hartlepool Borough Council)

7.3 Hospital Discharge
(Alzheimer's Society)

7.4 Effective Approaches in Urgent and Emergency Care
Paper 3 – Whole System Priorities for the Discharge of Frail Older People from Hospital Care
(NHS)

7.5 Moving Patient Medicines Safely – Guidance on Discharge and Transfer Planning
(NHS)

7.6 Ready to Go – Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care Settings
(Department of Health)

7.7 Essential Information for Agencies Providing Services to Support Safe Hospital Discharge
(Hospital to Home Fact Sheets)

7.8 Contributions Community Pharmacies Can Make to into Hospital Discharge
(PSCN)

7.9 Achieving Timely Simple Discharge from Hospital – A Toolkit for Multi - Disciplinary Teams
NHS

7.10 Discharge Planning – Service Improvement Tools
(NHS)

Appendix 1

Hospital Discharge Questionnaire – Post Discharge

1) When You Were Admitted to Hospital Was It –

Planned	14
Emergency	10

Comments

"Kept waiting for four hours on trolley in corridor on admission but staff good"
"Waited three hours in assessment"
"Care in A&E was really good. When I was moved to ward it was dreadful. " I am on oxygen and suffer from panic attacks. Asked for a move to smaller room but was refused. I felt ignored".
"Well looked after, professional staff"

2) Did Discussions Take Place With You, Family or Carers regarding Your Discharge?

Yes	16
No	4
No Response	4

Comments

"Waited in Discharge Lounge so long nurse brought lunch"
"No discussion but I did get a follow up appointment"
"I was just told I was going home. I was sent to discharge without any oxygen and was 20 minutes without it"
"On admission" (x3)
"On day of discharge" (x3)
"Before I was admitted" (x2)

3) When Planning Your Discharge Were You Asked About –

	Y	**N**
Transport	14	4
Medication	16	4

Discharge Letter/Plan	14	6
Anyone Home To Meet You	19	2
Social Services	7	6

Comments

"Because I waited so long for medicines I couldn't book a taxi so a volunteer driver took me home"

"Had to wait four hours in Discharge lounge for tablets"

4) If Care was Offered Was It?

Rapid Response	6
Occupational therapist	8
Care Worker	7

5) Were You Given Details of Who To Contact If Worried on Return Home

Yes	13
No	5

6) How Do You Feel About The Overall Experience?

"Mams discharge was a farce as nurses were trying to override her G.P. The ward was understaffed and I have seen cleaner back yards. Some staff were amazing, others didn't want to be there"

" Staff really helpful and friendly"

"Very satisfied" (x3)

"Not good"

"Felt like a number and they wanted the bed"

"Told I was being discharged at 10am but had to wait until 3pm.

"I had cancer removed from face and still not happy about it. I have had no follow up"

"The wait for medication is excessive. Two hours for two tablets, and they were only pain killers!"

Appendix 2

Post Hospital Discharge Questionnaire - North Tees Responses

1) How Long Was Your Stay?

Less than 1 week	21
1 – 2 weeks	14
2 – 3 weeks	10
More than 3 weeks	10

2) Were You Assessed on Admission?

Yes	46
No	2
Don't Know	3
No Response	4

Comments

"I was put in a cubicle which was unlit because of a defective light. A doctor attempted to obtain a blood sample a few times which resulted in bruising to my arms. A nurse tried to insert a catheter but couldn't. Another doctor tried but couldn't and finally a third doctor managed with the help of an i-phone torch.

"I was examined on arrival by two doctors who could not find a reason for my pain"

"The staff in the Assessment Unit were excellent"

"Efficient, competent and caring, giving a feeling of confidence and safety"

"Staff were well organise, efficient and friendly"

"Excellent care"

"Long wait for assessment"

"A&E was excellent, wonderful staff"

"Rubbish"

3) When Were You Told About Your Discharge?

1 Hour Before Discharge	1
Day of Discharge	25
Day Before	8
2 Days Before	1

3 days before	3
1 Week Before	1
Day of Admission	1
Yes	6
When I Recovered	1
Not Sure	1
No Response	7

Comments

"The Sister in charge thought I was to stay but the Doctor had discharged me. My notes had gone missing so my family enquired about the delay and consequently I was discharged".

"I was told but suffer memory loss and cognition problems so didn't understand"

"I was told at half past midnight"

"I was told three days before discharge"

"Although I knew of discharge all day, I was kept waiting for four hours for medication"

"My family arrange my discharge"

Were Your Family and Carers Also Told?

Yes	32
No	6
I Told them	6
Don't Know	2
No Response	9

Comments

"My wife did not know about my discharge until she rang the ward to see how I was"

"My experience was so bad that I asked my family to arrange my discharge"

"I felt overwhelmed by the information given"

"Everything fully discussed"

"Care Watch informed day before.

4) Were you Consulted About Plans For Care or Support at Home?

Yes	28
No	15
Don't Know	2
Not Applicable	2
No Response	8

Comments

"I was not given any advice about after care nor was I offered the option of a district nurse whilst my catheter was in place"

" I was not consulted and have since complained to the hospital by letter"

"X said he could not remember what had been said but was comfortable as he was aware Care Watch would restart on his return home"

"Wife says she was told he would be discharged to respite care due to challenging behaviour"

"Yes but situation more complex than questions asked"

"Not consulted, told!"

Were You Happy with The Support Offered?

Yes	28
No	17
Don't Know	2
No Response	8

Comments

"I was not given any advice about after care nor was I offered the option of a District Nurse while my catheter was in place"

"We had to chase staff for discharge papers, no one came to make sure I was ok when I left"

"If I didn't have my family to help I would have been concerned as I live on my own with a child"

"I would have felt stronger if I'd had a few more days to recover"

5) Were You Given Details of Who to Contact if Worried When You Returned Home?

Yes	28
No	19
No Response	8

Comments

"I was told I would be sent an appointment through the post. To date nothing has arrived.

"X's daughter was informed of who to contact"

"Ring 999"

"Nobody spoke to me about my situation at home except paramedic"

"See GP"

"Not by hospital staff, but Stroke association have been fantastic"

"Told to go back to hospital if still in pain"

"I was told that I would be sent an appointment through the post"

"I phoned Ward 30 few days after discharge and was told in matter of fact way nothing could be done"

6) Were You Consulted about Your Care Plan and Did You Receive a Copy?

Yes	23
No	16
Don't Know	3
Not Applicable	5
No Response	8

Comments

"Consulted but not given a copy"

"Not on this occasion but have been in the past"

"X was unsure about what she had been told about care plan or if she had received a copy"
"Discharge letter given with details of medication and treatment"
"Completed care plan with nurse"
"Only after I had started on it"
"Told visit GP about HRT"

7) Did You Get Medication on Discharge and Was it Explained to You?

Yes	40
No	3
Not Applicable	6
No Response	6

Comments

"Fully explained new medication"
"Yes week supply of antibiotics in case of infection"
"Given medication but not explained" x 5
"Yes it was explained but briefly"
"Yes but due to memory issues didn't follow what was being said"
"Had to wait four hours for medication to arrive"

Did You Have Your Old Medication Returned to You?

Yes	29
No	3
Had None	12
No Response	11

8) Was There Any Delay in Your Discharge?

Yes	21
No	27
Don't Know	1
No Response	6

Comments

"Walked to nursing station and booked taxi, no help offered"
"Four hour delay, paperwork and medication"
"Four hour medication delay"
"Four hour wait for prescription"
"Had to chase paperwork and long wait for medication"
"Had to chase paperwork"
"Long wait for ambulance"
"My discharge was changed from Wednesday to Saturday due to medication problem"
"Long wait for medication"(x4)
"Five hour wait for transport"
"Long wait for discharge letter"
"All went smoothly apart from long wait for medication"
"Two day delay"
"The waiting time for medication was exhausting for the patient and those waiting to take the patient home"
"Had a bad experience, short staffed, didn't leave till after 9pm"
"had hip operation on Monday and could have been discharged on Friday but Hartlepool Social Services did not review me till Monday which aggrieved me and the nursing staff as I was well enough to go home"

9) **How do you Feel about Your Overall Discharge Experience?**

"Dissatisfied, it was not the hospital's fault but social services"
"On several occasions I have had to wait up to six hours to leave hospital"
"All staff should listen to carers, wanted to send him home after three hours, stayed two weeks and was found to have infection and three medical problems"
"Each patient is an individual, staff must read pre-assessment notes and listen"
"Speak to patients when entering wards, introduce self and remind where at when patient has memory problems"
"Very unhappy, no explanation was given as to why I was moved to West View Lodge or what it meant. I was frightened and confused as I knew it was a care home."

“Staff told me that they would find out why I hadn’t been discharged but did not bother to come back to tell me”

“I could have done with more information about stroke and what to do at home”

“X was not given enough information about new medication and was upset that he was noted as refusing to take it when actually he felt too ill”

“Felt level of care at North Tees was poor, don’t want to go there again”

“No continuity of care”

“Care from student nurses not very good, also mainly male nurses”

Appendix 3

Post Hospital Discharge Questionnaire - Hartlepool Responses

1) How Long Was Your Stay?

Less than 1 week	8
1 – 2 weeks	3
2 – 3 weeks	2
More than 3 weeks	0

2) Were You Assessed on Admission?

Yes	12
No	0
Don't Know	0
No Response	1

Comments

"Very thorough pre-op assessment"

"Doctors and nurses made every effort to ease may concerns"

"Excellent standard of care"

3) When Were You Told About Your Discharge?

On Admission	4
After Surgery	1
Day Before	2
Discharged Myself	1

Day of Discharge	3
Yes	2

Comments
"Given a lot of information when admitted"

Were Your Family and Carers Also Told?

Yes	7
No	3
No Response	3

4) Were you Consulted About Plans For Care or Support at Home?

Yes	10
No	1
No Response	2

Were You Happy with The Support Offered?

Yes	9
No	2
No Response	2

5) Were You Given Details of Who to Contact if Worried When You Returned Home?

Yes	9
No	2
No Response	2

Comments
"Had a name and number to ring in case of problems"

6) Were You Consulted about Your Care Plan and Did You Receive a Copy?

Yes	9
No	2
No Response	2

Comments

"Received a discharge letter with diagnosis on and full explanation of what found and treatment"

"Could not understand the details of what had been done and wasn't explained

7) Did You Get Medication on Discharge and Was it Explained to You?

Yes	10
No	1
No Response	3

Comments

"I was told the medication I already had was stronger than that prescribed"

Did You Have Your Old Medication Returned to You?

Yes	8
No	1
Had None	2
No Response	2

8) Was There Any Delay in Your Discharge?

Yes	1
No	10
No Response	2

Comments

"Only slight delay due to medication.

How do you Feel about Your Overall Discharge Experience?

"Fairly straight forward, staff worked really hard to prepare people for leaving hospital"

"Excellent service from start to finish"

"I felt there was a lack of support".

"Quite happy with discharge and given advice regarding post operation exercises"

"Some confusion between staff, social services and patients"

"I thought the staff worked well together and were professional"

"Staff were considerate and caring and took time to explain details and ensure I was happy"

"The food was awful"

"There should be someone to read the information I was given. Due to my sight loss I was unable to read and choose from the menu"

HEALTH AND WELLBEING BOARD

12 January 2015

Report of: Director of Child & Adult Services, HBC; Director of Public Health, HBC; Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG

Subject: Health and Wellbeing Board Development Programme

1. PURPOSE OF REPORT

1.1 To consider a proposed approach to developing the role of the Hartlepool Health and Wellbeing Board in providing strong leadership in relation to the urgent strategic challenges facing the local health and care system across the town.

2. BACKGROUND

2.1 Legislative Content

2.1.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) as statutory committees for all upper tier local authorities to act as a forum for key leaders from the local health and care system to jointly work to:

- Improve the health and wellbeing of the people of their area
- Reduce health inequalities, and
- Promote the integration of services (see section 197-199 of 2012 Act).

2.1.2 The Government's 2010 White Paper *Equity and Excellence: Liberating the NHS* said that Health and Wellbeing Boards would take on the function of joining up the commissioning of local NHS Services, Social Care and health improvement … [and] allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda (page 34).

2.1.3 Health and Wellbeing Boards are responsible for carrying out Joint Strategic Needs Assessments (JSNAs) to identify the current and future health needs of the local community. In so doing Health and Wellbeing Boards must involve local Healthwatch and in the process and engage with wider local

stakeholders. Based on their findings they must develop a Joint Health and Wellbeing Strategy (JHWS) and set out joint priorities for local commissioning. CCGs are also required to include relevant HWBs in the preparation of their Commissioning Plans and when making significant revisions. Health and Wellbeing Boards can refer CCG Plans to NHS England if they do not think the JHWS is being taken into proper account of by the CCG or the Local Authority.

2.2 **Recent Debate on Health and Wellbeing Boards**

In October 2013 the Kings Fund published its report *Health and Wellbeing Boards: One Year On* to explore how Health and Wellbeing Boards were functioning. The conclusions of the report were:

- Local Authorities have shown strong leadership in establishing Boards
- The highest priorities in health and wellbeing strategies of most Boards concern public health and health inequalities; but there is little sign as yet that boards have begun to grapple with the strategic challenges facing their local health and care systems. Unless they do there is a real danger they will become a side show rather than providing system leadership.

2.3 **Current Context**

In October 2014 the NHS published the *Five Year Forward View* which sets out some of the fundamental challenges facing the health and care System in relation to wider health inequalities, variations in standards of care and funding pressures. The report sets out a case for:

- A radical upgrade in prevention and public health:
- Breaking down barriers between primary and acute care, physical and mental health, and health and social care;
- A more diverse system with new models of health and social care that will require innovative partnerships with local communities, health service providers, local authorities and employers.
- New models of urgent and emergency care services;
- New models of hospital services to provide high quality specialist services and more locally based hospital services.

Importantly the Five Year Forward View emphasises the importance of local leadership in driving forward effective joint commissioning between the NHS and local government as being critical to driving the transformation that will be required. It is timely to review the function and role of the Hartlepool Health and Wellbeing Board and in this context develop a strategic plan for the next five years.

2.4 **Hartlepool Context**

2.4.1 The Hartlepool Health and Wellbeing Board comprises the most senior leaders of the health and wellbeing system across Hartlepool. Hartlepool's Healthwatch is an active member of the Board and the Board has facilitated wider community engagement in considering health and wellbeing priorities.

2.4.2 In keeping with Health and Wellbeing Boards nationally the Hartlepool Board has primarily been focused on the prevention and public health agenda; reflecting the significant health inequalities across Hartlepool. The Board has also had oversight of the Better Care Fund and the Hartlepool Better Childhood Programme as important steps in achieving greater integration across health, care and education services.

2.4.3 However, in addition to the current focus of the Health and Wellbeing Board there are significant strategic challenges across the town in relation to:

- Growing demand arising from an increasing older and frail population, increasing mental health needs, high levels of obesity and smoking, substance misuse and long term conditions.
- The development of new models of intermediate care to support people within their communities, and to support discharge from hospital.
- The future of acute hospital and GP services and the emergency and urgent care model for Hartlepool.
- The need for a radical re-shaping of preventative and targeted public health services to change life limiting behaviours and support greater self care.

3. Moving Forward: A Health and Wellbeing Board Development Programme

3.1 It is clear that the important challenges we face will require the Health and Wellbeing Board to provide strong local leadership that has ownership of and can effectively influence health and social care commissioning. It is, therefore, timely to develop a better shared understanding of the challenges we face and identify the joint strategic priorities we need to address through effective partnership working and integrated models of delivery.

3.2 **A Proposed Approach**

It is, therefore, proposed to commission a Health and Wellbeing Board development programme with the overall aim of developing a new and innovative plan for the town which sets a clear strategic direction for shaping new models of service delivery that will respond to the strategic challenges facing our health and care system.

3.3 This will involve:

3.3.1 Developing a shared understanding of the strategic challenges we will need to address over the next five years taking into account of:

- Hartlepool's JSNA
- Findings and issues identified through consultation and engagement including Healthwatch
- Current and projected service pressures
- Existing local authority and NHS commissioning priorities and plans.

3.3.2 Using scenario planning methodology developing and appraising options and models for responding to the challenges we face and agreeing priorities and principles for shaping future service provision in the context of diminishing resources.

3.3.3 Strengthening the Board's system leadership capacity to deliver the required level of service transformation by:

- Developing a shared understanding of how effective partnership and alliances are established and maintained.
- Removing barriers to effective partnership working
- Developing the right leadership culture and behaviours at every level across the Health and Wellbeing system
- Strengthening the correct approach to engaging the public and stakeholders
- Improving public and stakeholder engagement in shaping health and wellbeing board priorities

3.3.4 Establishing a streamlined programme management, governance and joint commissioning framework for delivering the necessary change.

3.4. **Health and Wellbeing Board Summit**

3.4.1 To commence the Health and Wellbeing Board Development programme it is proposed to hold a summit early in 2015 involving:

- Health and Wellbeing Board Members
- Representatives of the senior leadership teams of partner agencies.

3.4.2 The issues that need to be considered are complex and it is proposed that the initial session should take place over a two day period assisted by external facilitators.

3.4.3 The initial summit will identify the key areas that need to be progressed over a six month period through follow up one day workshops.

3.4.4 The Health and Wellbeing Board Joint Commissioning Executive will take responsibility for commissioning the development programme and the follow up workshops.

4. Financial Implications

The cost of the programme will be met jointly from within existing Local Authority and CCG budgets and will relate primarily to the cost of independent facilitators and venue costs.

5. Risk Implications

One of the most significant risks associated with the integration of clinical and public health and social care relates to the failure of agencies to fully co-operate in the planning and delivery of new models of working and to share risk within the context of diminishing resources. The successful implementation of the programme will assist in mitigating this risk.

6. Communication and Engagement

The scenario planning and option appraisal undertaken as part of the development programme will take account of the views of stakeholders that have emerged through previous consultations and the recommendations arising from the Healthwatch work programme.

7. Recommendations

It is recommended that :

- The Health and Wellbeing Board agree to the proposal to take forward a Board Development Programme and to participate in the summit and follow up workshops.
- As part of the development programme to consider the effectiveness of the current approach to engaging the public and stakeholders.

8. Information

Equity and Excellence: Liberating the NHS - 2010
Health and Wellbeing Boards: One Year On
Five Year Forward View

11. CONTACT OFFICERS

Gill Alexander
Director
Child and Adult Services
Tel: (01429) 523914
Email: gill.alexander@hartlepool.gov.uk

Ali Wilson
Chief Officer
NHS Hartlepool and Stockton-on-Tees CCG
Tel: (01642) 745037
Email: awilson18@nhs.net

Louise Wallace
Director
Public Health
Tel: (01429) 284030
Email: Louise.wallace@hartlepool.gov.uk

HEALTH AND WELLBEING BOARD

12 JANUARY 2015

Report of: Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Project Director, NHS Darlington Clinical Commissioning Group on behalf of the Durham, Darlington and Tees CCGs

Subject: SECURING QUALITY IN HEALTH SERVICES PROJECT

1. PURPOSE OF REPORT

1.1 The purpose of the attached briefing is to inform stakeholders about progress in relation to the 'Securing Quality in Health Services' project that is underway across the County Durham, Darlington and the Tees region to deliver high quality acute hospital services.

2. BACKGROUND

2.1 Over the next ten years, both commissioners and providers of acute services face a range of challenges that threaten their long term sustainability. These include an ageing population, a rise in the number of people with long-term conditions, lifestyle risk factors in the young and greater public expectations of NHS provision. All this must be set against rising costs and constrained financial resources. While our local hospital trusts consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness, we know we can do better.

2.2 The **securing quality in health services project** was initiated by primary care trusts and has now become the responsibility of the five clinical commissioning groups, working together with the local hospital foundation trusts, in the County Durham, Darlington and Tees region. We are also in discussion with the neighbouring Hambleton, Richmondshire and Whitby CCG.

2.3 This project is being delivered in three Phases. Phase one aimed to establish a consensus in relation to the key clinical quality standards that should be commissioned in acute hospitals. Phase two worked with individual organisations to update the assessment of where we are in terms of meeting the clinical quality standards now and where we will be by April

2015. It also included an assessment of the implications of meeting the standards and where there are challenges to this across the system. Phase three will focus on how organisations and services might work together in the future to deliver the standards and identify a model of care across the Durham, Darlington and Tees area that will maximise our ability to meet the standards within the resources available.

2.4 The first phase of the project was reported to the Health and Wellbeing Board in August 2013.

3. PROPOSALS

3.1 The project has continued to develop since then and the latest position is presented today. It provides the outcome of phase two which included a feasibility study to inform commissioning intentions for 2014/15 and beyond. This included a review of the workforce implications; an investigation of affordability set against potential future financial allocations; a consideration of the overall achievability of planned milestones; and an assessment of the associated risks.

3.2 Proposals for Phase three of the project are included in the report.

4. LOCAL IMPLICATIONS

4.1 This is a significant and challenging project that is intended to develop proposals for the configuration of sustainable acute services across Durham, Darlington and Tees. Phase three is a key phase of the project where engagement with local people to understand their views is critical.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board are requested to receive the report and consider how they wish to continue to engage with the project as it develops.

6. REASONS FOR RECOMMENDATIONS

6.1 This is a significant project, the outcome of which could have potential implications for local and sub-regional services. The Health and Wellbeing Board will wish to take the opportunity given their statutory responsibilities to be involved in the consideration of the strategic challenges facing health and care systems.

7. BACKGROUND PAPERS

NHS Planning guidance: Everyone Counts
NHS England Five Year Forward View

Project report and feasibility analysis available from http://www.darlingtonccg.nhs.uk/county-durham-and-tees-valley-acute-services-quality-legacy-project/

8. CONTACT OFFICER

Ali Wilson
Chief Officer
NHS Hartlepool and Stockton-on-Tees CCG
Tel: (01642) 745037
Email: awilson18@nhs.net

Rosemary Grainger
Project Director
NHS Darlington CCG
Tel: 07837893214 or 01325 746 239
Email: Rosemary.granger@nhs.net

The following briefing has been issued on behalf of the following organisations:

NHS Darlington Clinical Commissioning Group
NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group
NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group
NHS North Durham Clinical Commissioning Group
NHS South Tees Clinical Commissioning Group

Briefing: Securing Quality in Health Services (SeQIHS)

Introduction

Over the next ten years, both commissioners and providers of acute services face a range of challenges that threaten their long term sustainability. These include an ageing population, a rise in the number of people with long-term conditions, lifestyle risk factors in the young and greater public expectations of NHS provision. All this must be set against rising costs and constrained financial resources. Recently, patients, the public and staff were invited take part in local and national discussions about the future of the NHS through the 'A Call to Action' initiative.

While our local hospital trusts consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness, we know we can do better.

The purpose of this briefing is to inform stakeholders about a significant project that is underway across the County Durham, Darlington and the Tees region to deliver high quality acute hospital services.

The **securing quality in health services project** was initiated by primary care trusts and has now become the responsibility of the five clinical commissioning groups, working together with the local hospital foundation trusts, in the County Durham, Darlington and Tees region. We are also in discussion with the neighbouring Hambleton, Richmondshire and Whitby CCG.

Why do we need to change?

There is growing evidence that patient outcomes could be improved by increasing the number of hours that senior doctors are available in hospital wards to make decisions about the assessment and treatment of patients.

There is also a need to reduce the time taken to assess, diagnose and treat acutely ill patients. A number of the clinical quality standards agreed during the project would address this.

Taking into account the number of people currently training to work as health professionals in the region and the age profile of existing staff, we are likely to experience staff shortages in the medium to long term unless we take action.

NHS England planning guidance 'Everyone Counts' identifies the following six characteristics of a high quality, sustainable health and care system and we need to build these into our planning:

- a completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- wider primary care, provided at scale
- a modern model of integrated care
- access to the highest quality urgent and emergency care.
- a step-change in the productivity of elective care
- specialised services concentrated in centres of excellence

Overview of the project

This project is being delivered in three Phases. Phase one aimed to establish a consensus in relation to the key clinical quality standards that should be commissioned in acute hospitals. Phase two worked with individual organisations to update the assessment of where we are in terms of meeting the clinical quality standards now and where we will be by April 2015. It also included an assessment of the implications of meeting the standards and where there are challenges to this across the system. Phase three will focus on how organisations and services might work together in the future to deliver the standards and identify a model of care across the

Durham, Darlington and Tees area that will maximise our ability to meet the standards within the resources available.

Phase one

During Phase one, the following were undertaken :

- a clinical quality assessment that considered national best practices, barriers and enablers
- an economic assessment, taking into account the local financial environment
- a workforce assessment that identified any constraints in relation to the achievement of agreed quality standards.

Phase two

During Phase two, clinical and other professional staff helped identify what the best possible care should look like in our hospitals and how we could go about delivering this, given increasing demand for services and the likely financial and workforce challenges ahead.

Between June 2013 and January 2014 an external feasibility study was a carried out which considered the implications of implementing the new standards across the Durham, Darlington and Tees region.

The outcome of the feasibility study helped to inform CCGs as they developed their commissioning plans and contracting intentions for the 2014/15 financial year and onwards and to ensure that the focus on sustainable, high-quality care remains the key driver for all organisations commissioning or providing secondary care for the patients in the region .

The feasibility analysis was designed to provide an independent assessment at each hospital site of the timetable for implementing the clinical standards. This included a review of the workforce implications; an investigation of affordability set against potential future financial allocations; a consideration of the overall achievability of planned milestones; and an assessment of the associated risks.

The key findings from the feasibility analysis

- both providers and commissioners are committed to achieving the clinical standards agreed in Phase one.
- there is a strong alignment of the proposed clinical quality standards identified by the project and those highlighted by Sir Bruce's Keogh's Forum on NHS Services, Seven Days a Week.

- appropriate monitoring mechanisms will need to be established to ensure confidence in the delivery of agreed clinical quality standards.
- there has been some progress towards the achievement of the agreed clinical standards since completion of Phase one. However trusts are unlikely to be able to deliver the required quality standards in seven key areas without further resources and/or a more system-wide approach (see below).
- the financial challenge for NHS and local authority partners has increased significantly since Phase one of the work was completed.

The analysis concluded that trusts would be unable to deliver the required quality improvements without a significant additional funding or a change of approach in the following areas:

- providing extended access to diagnostic services both out of hours and at weekends
- providing extended access to other support services such as physiotherapy, pharmacy and social services both out of hours and at weekends
- access to interventional radiology is currently extremely limited at all providers. Arrangements for out of hours cover and on-call need to be developed
- workforce to provide 10 WTE on each level of middle grade medical rotas (impacting upon acute paediatrics, maternity and neonatal services, acute surgery and Acute medicine services)
- trusts are close to achieving the 98 hours consultant cover at all maternity units within the region. However they are a long way from achieving the 168 hours best practice and clinical ambition agreed by the clinical advisory group
- the majority of the agreed end of life care standards are not going to be met by two of the trusts.
- the volume of neonatology services across the area means all providers fail to meet occupancy and staffing standards.
- the workforce assessment in Phase one identified that the current configuration of acute neonatal, maternity and paediatrics services was unsustainable in the medium to long-term, and that a reduced number of sites should be considered.

Phase Three

The SeQIHS Project Board, which comprises NHS and local authority organisations from across the Durham, Darlington and Tees region, have confirmed their commit-

ment to work together to continue to improve services and identify how the required clinical quality standards can be delivered within the available resources. All parties acknowledge that this could result in significant changes to the provision of services.

This next stage of the project must be informed by a range of national and local initiatives including the Keogh report on urgent and emergency care, developments around integrated care, specialised services commissioning, seven day working, and the five-year plans of local CCGs. The following service areas are included in the scope of the project:

- Acute Surgery;
- Acute Medicine;
- Intensive Care;
- Acute Paediatrics, Maternity and Neonatology;
- End of Life Care; and
- Urgent & Emergency Care (added in phase 2 following the publication of the Keogh report on urgent and emergency care)

Following the completion of the FA, the basis for moving forward was agreed as four sites [Middlesbrough, Hartlepool\Stockton, Darlington & Durham] across Durham & Tees Valley together with Friarage Hospital, Northallerton, all delivering a range of inpatient, outpatient, diagnostic and urgent care services.

It was also agreed that critical to consideration of any proposals to change the pattern of service delivery will be the need to reach agreement on the balance between quality, access and affordability.

With the publication of the Five Year Forward View from NHS England in October and the need to ensure the work of the project dovetails with local NHS and social care plans, we are also bringing together information on how each local health community is responding to the changing needs of the population in regards to the development of primary and community care services and how each local health and social care economy is responding to the need to better integrate services

To progress these discussions and to further develop the case for change and a service model for the area, a clinical leadership group has been established. The group is made up of senior clinicians from the three Foundation Trusts and the CCGs and Healthwatch colleagues, and is chaired by the chair of the Northern Clinical Senate who is independent of the organisations involved in the project.

The purpose of the Clinical Leadership Group is to provide clinical leadership, advice and challenge to the project. The group will make recommendations as to the future model of care for Durham, Darlington and Tees, for approval by the project board.

To date, there has been significant engagement with partners, Health and Wellbeing Boards and Overview and Scrutiny Groups. In the next phase of this work, the Board has acknowledged the need to incorporate wider involvement of the public and patients.

To this end we have commissioned independent research which will be carried out with the public to gain an understanding of what local people feel is important about hospital services, gauge levels of understanding of the balance that has to be achieved between quality, access and affordability and gauge levels of understanding about the need for change in the NHS generally.

We are also working with Healthwatch colleagues to obtain their advice about the further development of our engagement with local people.

If you would like any more information about this project please contact:

Rosemary Granger

Project Director

NHS Darlington Clinical Commissioning Group Dr Piper House King Street Darlington DL3 6JL

rosemary.granger@nhs.net

Tel: 07837893214 or 01325 746 239

If you would like to read the full project report and the report of the feasibility analysis, you can find them online at http://www.darlingtonccg.nhs.uk/county-durham-and-tees-valley-acute-services-quality-legacy-project/

November 2014

HEALTH AND WELLBEING BOARD

12 JANUARY 2015

Report of: Ali Wilson, Chief Officer, NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Subject: IMPROVING URGENT CARE SERVICES IN HARTLEPOOL

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1. PURPOSE OF REPORT

1.1 The purpose of this paper is to provide the Health and Wellbeing Board members with an update as to how the Clinical Commissioning Group (CCG) working with the Health and Wellbeing Board intends to deliver plans for a community based integrated urgent care service as described in the Clear and Credible Plan Refresh 2014/15 – 2018/19 (Our 5 year strategy) to ensure delivery of our agreed joint vision.

2. BACKGROUND

2.1 Our aim is to simplify the navigation of urgent care services – improve the understanding about accessing care out of hours or in an emergency, and to provide care at locations which provide necessary education to support people to look after themselves. In order to meet our aims we have reviewed our existing points of access for urgent care. The community based urgent care health services in Hartlepool (and Stockton-on-Tees) is supported by a range of providers, from different locations and with separate contracts including; primary care, GP out of hours, healthy living pharmacies, Minor Injuries Unit, 111 telephone advice and GP led Alternative Provider of Medical Services (APMS) Walk in Centres.

2.2 The APMS Walk in Centre contracts were originally agreed to run for a period of 5 years and are due to expire by the end of March 2016. In line with the NHS England policy entitled 'Managing the end of time limited contracts for primary medical services', this has provided the CCG with the opportunity to review existing services, with a view to better integrating urgent care services. This work will need to commence early in 2015 to enable services to be procured and operational by April 2016.

3. PROPOSALS

3.1 As the Health and Wellbeing Board are aware a number of engagement events have been undertaken across Hartlepool (and Stockton-on-Tees) where there was a clear message from the public, patients and partners stating that the current model for community based urgent care services is not easily navigated, there is a lack of understanding of the difference in providers and service provision across venues. It was clear from the engagement analysis and listening to concerns of the public, partners and our GP members that we need to ensure that future services must be easily understood, are accessible and are easily navigated. We are now in a position with current contracts that we are able to work with our communities and partners to put in place an improved model for community based urgent care services to make it easier for local people to get the right treatment at the right location at the right times.

3.2 Building upon the joint vision developed between the Health and Wellbeing partners the expectation is to commission and develop a simple, accessible, high quality service, managing patients at the point they present in a sensitive and person-centred approach, yet robust and resilient way. This is with a view to reducing the need for urgent care with the better management of long term conditions with primary and secondary prevention as a focus.

3.3 The urgent care model must provide the highest standard and quality of care based on nationally and locally agreed outcomes. The urgent care model has primary care at the heart of the service; GP's must have ownership accountability and lead the urgent care agenda. Urgent care provision must be aligned to changes within primary care, taking into account changes in the National GP contract as well as the emerging changes that will be informed by national and local pilots for extending GP access as it is clear the strategy and future model of care cannot be delivered in isolation of primary care.

3.4 Our long term strategic aim will be to provide local people with a fully integrated, 24/7, seamless urgent care service across Hartlepool (and Stockton-on-Tees). A simple vision is, for those people with urgent but non-life threatening needs, to be able to access clinically appropriate, highly responsive, effective and personalised services, outside of a hospital environment when clinically appropriate. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.

3.5 The CCG is committed to continuing engagement with partners and the residents of Hartlepool to inform the service specification and to take this forward we are developing a communication and engagement plan which will support the continued involvement and engagement of patients and partners.

4. RECOMMENDATIONS

4.1 Health and Wellbeing Board members are requested to note the update.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure that Health and Wellbeing Board members are kept appraised of progress and actions undertaken in order to deliver our agreed joint vision. Future updates will be shared with members to ensure they are kept appraised and in advance of any planned engagement activities being undertaken to ensure a joint approach.

6. BACKGROUND PAPERS

CCG Clear and Credible Plan -
http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST_CCG_5_YEAR_PLAN_FINAL_INTERNAL_WEB-15-August.pdf

7. CONTACT OFFICER

Karen Hawkins
Head of Commissioning and Delivery
NHS Hartlepool and Stockton-on-Tees CCG
01642 745126

Paul Parsons
Communication and Engagement Manager
NECs (on behalf of HaST CCG)
07776498260