ADULT SERVICES COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 8 June 2015

at 10.00 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Atkinson, Beck, Belcher, Loynes, Richardson, Tempest and Thomas

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 9 March 2015 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

No items.

7. **ITEMS FOR INFORMATION**

7.1 Waverley Allotment Group: Promoting Change, Transforming Lives Project Update – *Director of Child and Adult Services*

7.2 Provision of Information and Advice – *Director of Child and Adult Services*

7.3 Healthwatch Hartlepool Hospital Discharge Project: Action Plan – *Director of Child and Adult Services*

7.4 Care Homes – Verbal Update – *Director of Child and Adult Services*

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

ITEMS FOR INFORMATION

Date of next meeting – Monday 6 July 2015 at 10.00 am

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

9 March 2015

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Carl Richardson (In the Chair)

Councillors: Paul Beck, George Springer and Stephen Thomas

Also Present:
Frank Harrison, Years Ahead Forum
Members of the Public – Stella and Gordon Johnson and Evelyn Leck
Maureen Lockwood, Zoe Sherry - Healthwatch

Officers: Jill Harrison, Assistant Director, Adult Services
Jeanette Willis, Head of Strategic Commissioning
Neil Harrison, Head of Service, Adult Services
John Lovatt, Head of Service, Adult Services
Kerry Trenchard, Strategy and Performance Officer
Denise Wimpenny, Principal Democratic Services Officer

63. Apologies for Absence

Apologies for absence were submitted on behalf of Councillor Brenda Loynes and Ruby Marshall, Healthwatch.

64. Declarations of Interest

Councillor Thomas declared a personal interest in Minute 73 as an employee of Healthwatch.

65. Minutes of the meeting held on 9 February 2015

Received.

66. Matters Arising from the Minutes

In relation to Minute 61 – Hear My Voice – Inclusion North Event, 27 March 2015 – Verbal Update, the Chair reminded all those in attendance of the Inclusion North Event to be held on 27 March at 10.30 am until 1.00 pm in the Council Chamber of the Civic Centre.

67. Council Plan 2015/16 – Child and Adult Department Proposals (*Director of Child and Adult Services*)

Type of decision

Budget and Policy Framework

Purpose of report

To provide an opportunity for the Adult Services Committee to consider the Child and Adult Services Department's proposals for inclusion in the 2015/16 Council Plan that fell under the remit of the Committee.

Issue(s) for consideration

The Assistant Director, Adult Services reported on the proposals included in the 2015/16 Council Plan that fell under the remit of the Adult Services Committee. As in previous years detailed proposals were being considered by each of the Committees throughout February and March. A further report would be prepared for the Finance and Policy Committee on 23 March 2015 detailing the comments/ observations of each of the Committees along with a full draft of the 2015/16 Council Plan.

In support of the report, the Assistant Director provided a presentation which detailed the key challenges that Adult Services faced over the next year and beyond and how these would be addressed.

In response to a query regarding the support available to 16 year olds after leaving care, it was reported that issues of this type fell within the remit of Children's Services Committee. The Committee was provided with an update in relation to progress made to date on the new Independent Living Centre following a Member's request. It was noted that the development was on target for completion in 2016.

Clarification was sought regarding the latest position in terms of re-commissioning of low level support services and the timescales involved. Members were advised that as previously reported, it had not been possible to award a single contract covering low level services, day services and social inclusion for older people and those with dementia. Contracts for handyperson services, information and signposting and support for people with dementia had been awarded and work was ongoing with the preferred provider in relation to social inclusion for older people with a contract expected to be awarded during April.

Whilst Members welcomed the plans and policy direction for the future concerns were expressed regarding the lack of funding in Adult Services to deliver these services given the continuing financial pressures placed upon the Council and legislative changes contributing to these pressures.

Officers responded to further queries raised in relation to the actions.

Decision

That the proposals reported for inclusion in the Council Plan 2015/16 be supported and the comments of Members be utilised to formulate a response on behalf of the Committee for consideration by the Finance and Policy Committee.

68. Joint Mental Health Implementation Plan & Mental Health Update (*Director of Child and Adult Services*)

Type of decision

Non key decision

Purpose of report

To seek approval from the Adult Services Committee for the Joint Mental Health Implementation Plan.

To request that the Adult Services Committee refers the Joint Mental Health Implementation Plan to the Hartlepool Health and Wellbeing Board and Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) for approval and monitoring of the action plan.

To provide an update on a number of key reviews of mental health services

Issue(s) for consideration

It was reported that a number of key framework documents had been

produced in recent years that related to mental health services, details of which were provided. A Joint Mental Health Implementation Plan for 2015-18, attached at Appendix 1, was co-produced with the CCG and incorporated key national and local mental health outcomes. The action plan would be refreshed annually to demonstrate progress and reflect any changing national and local priorities. Information in relation to how the Plan had been developed was set out in the report.

It was noted that as part of Sector Led Improvement, all North East Councils had agreed to the LGA undertaking a Peer Challenge within adult social care over a three year period. Hartlepool's Peer Challenge had taken place in November 2014 and had focused on mental health services, the recommendations of which were included in the report. An action plan was being developed with Tees Esk and Wear Valley to address the recommendations and progress had already been made in a number of areas.

The report also included feedback from a CQC Mental Health Act Monitoring Visit to Tees Esk and Wear Valley NHS Foundation Trust, details of the Crisis Care Concordat as well as details of the main changes to the Mental Health Act Revised Code of Practice.

Reference was made to the CQC's recommendations and it was confirmed that funding had been agreed to develop additional resources to support people self-presenting at Roseberry Park. Some concerns were raised regarding the number of 'at risk' individuals self presenting at night at Roseberry Park and the Head of Service highlighted some of the potential reasons for the increase. In response to a query regarding the number of individuals self presenting and utilising crisis services in Hartlepool, the Head of Service agreed to explore this issue at a future meeting regarding the Crisis Care Concordat.

Whilst the benefits of the strategy were welcomed, concern was expressed that there was limited input to the Mental Health Forum from users of mental health services or patients themselves and it was noted that a sub group had been established to address this. The Committee discussed at length the importance of crisis services and was keen to examine statistical evidence of how crisis services were currently being provided and patient experiences in Hartlepool over the last 18 months to determine whether the newly configured services had addressed the concerns raised at previous meetings in this regard. Emphasis was placed upon the need to continually monitor the level of resources to ensure needs were being met.

The Committee commented on the increase in mental health needs generally, the importance of prevention and adequate support being available to prevent mental health relapse and the need to provide adequate support for veterans suffering from severe post traumatic stress disorders. Feedback was requested from Tees Esk and Wear Valley NHS Foundation Trust as well as Council officers in terms of how successful the new crisis care arrangements had been. More detailed feedback from the recent Peer

Review and Care Quality Commission review was also requested for consideration at a future meeting of this Committee.

Decision

(i) That the Joint Mental Health Implementation Plan be approved.
(ii) That the Joint Mental Health Implementation Plan be referred to the Health and Wellbeing Board for approval and monitoring.
(iii) That the outcomes of recent reviews and actions taken to address the recommendations be noted.
(iv) That the revised Code of Practice for Mental Health be noted.
(v) That the comments of Members, as outlined above, be noted.
(vi) That feedback be provided to a future meeting of this Committee in relation to:-
a) a review of Section 136 suite and crisis care arrangements.
b) the recent Peer Review and Care Quality Commission Review.

69. Hartlepool Local Executive Group – Adult Safeguarding Statistics and Progress Report for the Period April – December 2014 (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To present the Hartlepool Local Executive Group (LEG) statistics covering the period from 1 April 2014 to 31 December 2014 and to share a summary of the progress made with the implementation of the Teeswide Safeguarding Adults Board (TSAB) strategic aims and objectives for the same period.

Issue(s) for consideration

The report provided background information in relation to adult safeguarding arrangements and the significant changes in the Care Act which would affect the protection of vulnerable adults. One of the key changes was the statutory requirement for a Safeguarding Adults Board. To support the work of this Board, Hartlepool had established a Local Executive Group.

In the reporting period 1 April 2014 to 31 December 2014 there were 310 alerts identifying possible cases of abuse of adults 86 of which met the safeguarding adults threshold guide and led to actual referrals. In the same reporting period last year there had been 247 alerts, 103 of which had led to referrals. Within the current reporting period 47% of referrals related to

people aged 65 and over with a physical disability. As in previous reporting periods, care homes continued to be the most common location of reported abuse, details of which were set out in the report.

The report provided background information in relation to the Deprivation of Liberty Safeguards as well as the trends for the period April 2013 to March 2014 where there had been 49 requests. Between April and December 2014 there had been 441 requests for authorisation.

In relation to safeguarding vulnerable adults there had been a number of developments in the first nine months of this reporting period, details of which were provided as outlined in the report.

In the discussion that followed presentation of the report, concerns were expressed in relation to the financial implications for the Local Authority as a result of the Supreme Court Judgement in relation to Deprivation of Liberty Safeguards in terms of both workload/staffing capacity and cost. The importance of closely monitoring this issue particularly the significant increase in the workload element was emphasised. The Head of Service responded to issues raised by the Committee in relation to the requirements and implications of the introduction of Deprivation of Liberty Safeguards. In response to a query as to whether all care homes in Hartlepool were compliant with the new Deprivation requirements it was confirmed there were two homes where work was being undertaken and it was anticipated that this should be completed by 31 March.

Decision

(i) That the contents of the report and comments of the Committee be noted.
(ii) That the implications of DOLS be closely monitored.

70. Implementation of the Care Act (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Adult Services Committee with an update on progress regarding implementation of the Care Act and the financial implications in 2015/16

Issue(s) for consideration

The report provided background information in relation to the Care Act and set out progress towards implementing the Care Act from April 2015. Regional and national support to implement the Care Act and information on the National Care Act Implementation Stocktake Programme was also included in the report. There had been three stocktakes across the year in May 2014, September 2014 and February 2015 which indicated that Hartlepool was making progress towards implementing the Care Act and demonstrating a significant level of confidence that the care reforms would be delivered within timescales. The main risks identified for Hartlepool in association with delivering the Care Act were the unknown levels of additional demand from carers and self funders, unknown additional workforce capacity and unknown total implementation costs.

The Committee was referred to the financial implications of implementing the Care Act, as set out in the report. Nationally, funding of £420m would be provided for implementing the Care Act in 2015/16. The confirmed revenue allocations for Hartlepool Borough Council for 2015/16 were £754,000, a breakdown of which was included in the report. In addition, as part of the Social Care Capital Grant allocation, £279,000 had been allocated for Hartlepool in 2015/16. Funding remained an extremely complex area and it was not yet possible to give an indication as to whether the additional funding allocated would meet the anticipated additional demand and costs. For 2015/16 planning purposes it was currently anticipated that the changes would be budget neutral. The financial impacts would need to be monitored on an ongoing basis.

In support of the report the Assistant Director provided a detailed and comprehensive presentation on the Care Act and the Wellbeing Principle which included the aims of the Care Act, what the Act was trying to achieve, Framework of the Act, Definition of the Wellbeing Principle, Wellbeing Care and Support, new responsibilities of local authorities towards all local people, what this meant for people needing care and support, what this meant for carers as well as the implications for the Council.

The Assistant Director responded to queries raised in relation to the changes to care and support as a result of the Care Act. Clarification was provided on the care cap arrangements and assessment process as a result of the Care Act. It was noted that consultation on the Care Act funding reforms, to be implemented from 1 April 2016, was currently underway and would end on 30 March. Regulations relating to this second phase of implementation were expected to be issued in October 2015.

Decision

(i) That progress to date in relation to implementation of the Care Act from April 2015 be noted.
(ii) That funding allocations to support Care Act implementation be noted.
(iii) That further reports be received throughout 2015/16.

71. Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17 (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Adult Services Committee with an update on implementation of 'Moving Forward together – The Vision for Adult Services in Hartlepool 2014-17'

Issue(s) for consideration

The Assistant Director, Adult Services, presented the report which provided the background to the vision for Adult Services in Hartlepool following approval by the Committee in July 2014. The overall aim was for people to stay healthy and actively involved in their communities for longer thereby delaying or avoiding the need for targeted services.

An action plan for 2014/15, attached as an appendix to the report, provided the framework for the detailed work required to deliver the vision and included an update on progress. In terms of the next steps, an action plan for 2015/16 would be developed based on the priorities identified in Appendix 2.

Following presentation of the report the Assistant Director responded to issues raised in relation to step up/step down services which aimed to prevent avoidable hospital admissions and to support people following discharge from hospital.

Decision

The Committee noted progress made to implement the vision for Adult Services and noted that a further update would be received in March 2016.

72. Support for People with Dementia in Hartlepool (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Adult Services Committee with a further update regarding support for people with dementia in Hartlepool, following a report in August 2014.

Issue(s) for consideration

The report provided background information to the National Dementia Strategy and the support available for people in Hartlepool living with dementia. Details of national developments around dementia, how Hartlepool had addressed the National Strategy as well as the process for raising awareness of dementia in Hartlepool was provided, as set out in the report.

It was reported that a Steering Group had been established to deliver the Working to Build a Dementia Friendly Hartlepool Project, bringing together a large range of local organisations to actively look at Hartlepool becoming accredited as a Dementia Friendly Community. An action plan, attached at Appendix 3, had been developed and was regularly updated. Members were referred to the process in terms of engagement with the wider community, as detailed in the report.

The Chair, on behalf of the Committee, took the opportunity to thank Steve Thomas, Modernisation Lead for Older People, who would shortly be retiring from the authority, for his hard work and contribution to the developments in relation to support for people with dementia and their carers.

Decision

(i) That the developments in relation to support for people with dementia and their carers be noted and further reports be received as appropriate.
(ii) That all Council Members be invited to pledge their support for the Working to Build a Dementia Friendly Hartlepool Project.

73. Update on Domiciliary Care Services in Response to Recommendations by Healthwatch Hartlepool (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

The Healthwatch Hartlepool investigation into domiciliary care services made several recommendations. The report provided the Adult Services Committee with an update regarding how the recommendations were being addressed.

Issue(s) for consideration

The Head of Strategic Commissioning updated the Committee on progress made in relation to the Healthwatch recommendations following their investigation into domiciliary care. The report set out progress made on implementing each individual recommendation.

Following the investigation into domiciliary care services, a desktop review of the requirements of the Unison Ethical Care Charter had been undertaken by the Council. This had not been a formal review but would form part of the renegotiation of contracts which would take place in the spring of 2016.

A Healthwatch Member was pleased to note the progress made to date and emphasised the importance of closely monitoring the recommendations.

With regard to the Unison Ethical Care Charter which aimed to ensure employees of organisations were properly remunerated and protected whilst carrying out their employment, a Member spoke in support of the Charter and whilst acknowledging that both providers were already meeting some of the requirements of the Charter was keen to see this issue placed high on the authority's agenda to implement the recommendations in full. Concerns were reiterated in relation to levels of pay of care workers and views were expressed that 15 minute visits should be kept to a minimum, the reasons for which were shared with the Committee.

Decision

(i) That the current position in relation to domiciliary care and comments of Members be noted.
(ii) It was noted that domiciliary care contracts were due to be

renegotiated in Spring 2016.

74. Winter Update (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Adult Services Committee with an update on the management of winter pressures.

Issue(s) for consideration

It was reported that for a number of years, health and social care agencies had worked together to plan for increased activity and pressure over the winter months. This was currently undertaken through a Systems Resilience Group. It had been well publicised in the national media that health providers had experienced unprecedented levels of pressure over the winter months in 2014/15. In North Tees and Hartlepool Foundation Trust, there had been up to 52 additional beds open over the winter months to manage the additional demand and bed occupancy had consistently been above the recommended national average of 85%.

The Council had received additional funding of £70,000 linked to the Systems Resilience Plan to fund additional rehabilitation beds at West View Lodge and to commission additional domiciliary care capacity over weekends. There had been a 40% increase in hospital discharge referrals compared to the same period last winter which had created pressures for social care staff. Throughout the winter period to date, despite the huge increase in hospital discharge referrals, there had not been a delayed discharge that was due to a delay in a social care assessment or a social care package being in place. Activity in relation to care home admissions for the winter months was currently being analysed. An initial review of the data indicated that care home admissions for 2014/15 would be lower than in previous years. It was reported that there had been an announcement at the end of January 2015 that all local authorities would receive a one off ring-fenced 'Helping People Home' Grant, details of which were provided. The allocation for Hartlepool was £75,000.

Decision

That the current position in relation to winter pressures be noted.

75. Chair's Closing Remarks

Prior to closing the meeting the Chair stated that this was the last meeting of the Committee prior to the Council Elections and took the opportunity to thank all attendees for their contributions over the last year.

The meeting concluded at 12.45 pm

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 18 MARCH 2015

ADULT SERVICES COMMITTEE

8 June 2015

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Child & Adult Services

Subject: WAVERLEY ALLOTMENT GROUP: PROMOTING CHANGE, TRANSFORMING LIVES PROJECT UPDATE

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to update members on behalf of the Waverley Allotment Group (WAG) Promoting Change, Transforming Lives Project and to inform members of recent success at the National Gardening Against the Odds awards and the Best of Hartlepool Awards.

3. BACKGROUND

3.1 The Waverley Terrace Allotment Project was set up in 2007 by the WAG: a group of adults with a range of mental, social and physical disabilities. The project was originally developed by the Council's Adult Services Team and service users with support from a range of local partners including Hartlepool MIND, DISC, Nacro, Kirklevington HMP and Hartlepool College of Further Education.

3.2 The Waverley Terrace Allotment offers 3.5 acres of arable land in the Rift House Area of Hartlepool for the cultivation of fruit and vegetables, refurbishment of furniture and creation of a range of seasonal items including Christmas wreaths. The produce is then sold to the local community with any profit going into continuing delivery of the project. The allotment offers a venue for therapeutic and employment support to disabled adults and/or those with a mental health problem.

3.3 There has been considerable progress since the site opened due to the efforts of service users, staff members and partners culminating in the project being praised by Disability Rights UK. However, there is still work to do, with staffing and infrastructure improvements needed to further develop the site.

3.4 Over the past six months, the Council's Adult Services, Economic Regeneration and Building Control Teams have been working closely together to consider how the Waverley Allotment site can be transformed into a financially sustainable enterprise. As part of this work, a feasibility study has already been produced which sets out key elements such as:

- Options Analysis;
- Ten Key Implementation Actions;
- SWOT Analysis.

3.5 The feasibility study identifies that the Waverley Terrace Allotment Project requires a dedicated Business Co-ordinator who will be responsible for the strategic management and sustainability of the facility as well as a Volunteer Co-ordinator who will be responsible for the day to day management of the site.

3.6 The Council has held favourable meetings with the Chief Executives of Disability Rights UK and the Association for Real Change as well as representatives from the Big Lottery Fund who welcomed the Council submitting a funding application.

4. BIG LOTTERY FUND PROJECT PROPOSAL

4.1 On behalf of the WAG, the Council submitted a Big Lottery Fund Reaching Communities Application to support the development of the Promoting Change, Transforming Lives Project.

4.2 The project incorporates three key elements: -

- **Therapeutic Services:** The project will build on the current offer and provide a safe environment where service users who are unlikely or unable to engage in employment can still lead positive lives and be involved in horticulture which will help them with life-skills, raise their aspirations and prevent social isolation. At present, a number of service users from disability day services access the site as part of their therapeutic support.

- **Employment and Training Services:** The site will provide work experience and placements, and high quality training for service users to develop relevant employability skills to assist them to progress into sustained employment. The site will be used as a pathway for individuals to build their confidence and when they are ready for progressing into mainstream employment, they will be supported by dedicated Employment Link Workers who will help users to identify their chosen career options and link them to local employers. In addition, local training providers are keen to use the facilities for delivery of horticultural Apprenticeships and Traineeships and a test pilot is currently underway with Springboard to assist young people with emotional and social problems to learn key employability skills.

- **Commercial Services:** The development of a commercial facility is critical in supporting the overall project objectives. The commercial aspect of the project will be non-profit based and all income generated will be used to expand the services provided. A business plan and feasibility study has already been produced which shows how the project can realistically be self-sustainable within five years as long as initial Big Lottery funding can be secured to fund a Business Co-ordinator and Volunteer Co-ordinator within this timeframe. The business plan provides a comprehensive ten point action plan and when implemented will enable the business to be viable and grow.

4.3 This will build on the partnership work between the Economic Regeneration and Adult Services Team which has allowed the Adult Services Employment Link Team to operate within Economic Regeneration since April 2012 through a Service Level Agreement. During this time, the number of adults with a learning disability and/or difficulty in employment has increased to 17%, which is more than double the national average.

5. FUNDING

5.1 The overall cost of the project will be £475,000 over five years (2015 – 2020), with £400,000 of funding being requested from the Big Lottery Fund Reaching Communities Programme and a £75,000 in-kind contribution from the Council. The project costs are based on: -

- 1 x Business Co-ordinator employed for 5 years @ £35,000 per annum = £175,000.
- 1 x Volunteer Co-ordinator employed for 5 years @ £28,000 per annum = £140,000.
- Capital Infrastructure improvements to the site such as polytunnels, machinery and a welfare unit as well as additional revenue costs = £85,000.
- In-kind staff contribution from Hartlepool Borough Council for the delivery of the project = £75,000.

6. TIMESCALES

6.1 The Big Lottery Fund Reaching Communities Programme issues an open call for applications with requests able to be submitted at any time and there is a two stage application process:

- A Stage One application form was submitted and a response has been received confirming that the bid has been approved to move on to Stage Two.

- A Stage Two application has been submitted providing further information about the project. A response is expected within four months.

7. AWARD NOTIFICATIONS

7.1 On 22 April 2015 WAG members were invited to an Award Ceremony in London where they had been shortlisted for the '*Gardening Against the Odds Award*, which is Sponsored by The Conservation Foundation and the Sunday Telegraph. The awards are open to individual gardeners and community groups all over the country and celebrate people who garden in the face of physical, mental and environmental odds and make their own lives and the lives of others brighter, better and more fun through their efforts to create beautiful garden spaces.

7.2 The Waverley Terrace Allotment Project was shortlisted along with seventeen other projects and the judging panel for the Award included the conservationist David Bellamy, actress Susan Hampshire and the Duchess of Northumberland.

7.3 The project was the overall winner of the national Gardening Against the Odds award and was described by the judging panel as "*a shining beacon of success*". As part of the judging process, members of the public were invited to vote on line for the project they felt deserved some recognition and as well as achieving the award from the judges, the project also received the highest number of public votes.

7.4 The Waverley Terrace Allotment Project will now be followed throughout the year by the Conservation Foundation and also the Sunday Telegraph in order to assess the impact of the award and to ensure that the success of the project is shared with the wider public.

7.5 At the time of writing this report notification, had been received that the project had also been nominated for the Hartlepool Mail Best of Hartlepool Award in the Green Champion category.

8. LEGAL, FINANCIAL AND STAFFING IMPLICATIONS

8.1 There are currently no legal, financial or staffing implications. If the Big Lottery funding application is successful an additional report will be submitted to Adult Services Committee detailing all of the implications in the delivery of this project.

9. SECTION 17 OF THE CRIME AND DISORDER ACT 1998 CONSIDERATIONS

9.1 This project will positively contributed to Section 17 by improving employment routes for vulnerable groups. It will also provide early intervention and support for individuals who may have been identified as high risk of offending.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 This project will support vulnerable groups of people, regardless of their background, to achieve their aspirational goals. There will be a particular focus on some priority groups including:

- Adults with learning difficulties and/or disabilities;
- Adults with autism;
- Adults with mental health problems;
- Elderly people at risk of social isolation;
- Young people with specific learning difficulties and/or disabilities, and;
- Young people with mental health issues.

11. CONTRIBUTION TO OTHER COUNCIL PROJECTS AND PERFORMANCE INDICATORS

11.1 If successful this project will benefit other Council employment initiatives, such as Think Families, Think Communities. The initiative will also contribute towards achievement of the following key indicators: -

- Improving the Overall Employment Rate;
- Reducing the Unemployment Rate, and;
- Increasing the Number of Adults with Learning Disabilities in Employment.

12. RECOMMENDATIONS

12.1 It is recommended that members of the Adult Services committee note the contents of this report.

12.2 A further report will be submitted to Adult Services Committee once a decision has been made on the Council's Big Lottery funding application.

13. REASONS FOR RECOMMENDATIONS

13.1 This funding will provide the Council with an opportunity to: -

- Develop additional resources to support adults with a physical disability, learning disability, autism or mental health problem;
- Improve the employability skills and employment opportunities of vulnerable adults, and;
- Transform the Waverley Terrace Allotment Project into a sustainable community enterprise.

14. CONTACT OFFICERS

Neil Harrison
Head of Service (Adult Services)

Level 4 Civic Centre
Hartlepool, TS24 8AY
Tel: (01429) 523751
E-mail: neil.harrison_1@hartlepool.gov.uk

Chris Horn
Team Manager - Provider Services
Centre for Independant Living
1 Havelock Street
Hartlepool
TS24 7TL
Tel: (01429) 851371
E-mail: chris.horn@hartlepool.gov.uk
Scott Campbell
Performance Officer – Economic Regeneration Team
Hartlepool Enterprise Centre
Brougham Terrace
Hartlepool
TS24 8EY
Tel: (01429) 284306
E-mail: scott.campbell@hartlepool.gov.uk

ADULT SERVICES COMMITTEE

8 June 2015

Report of: Director of Child & Adult Services

Subject: PROVISION OF INFORMATION & ADVICE

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide members of the Adult Services Committee with an update in relation to provision of Information and Advice and the work that has been undertaken to ensure that Adult Services comply with the new requirements within the Care Act.

3. BACKGROUND

3.1 It has been recognised for some time that provision of information and advice is essential to enable people to access services and make informed choices.

3.2 The Care Act introduced new duties regarding provision of information and advice and from April 2015, councils are required to ensure that there is comprehensive information and advice about care and support services in their area.

3.3 It is recognised by Adult Services in Hartlepool that good quality, accessible information and advice services are critical to managing demand, meeting people's needs and joining up the range of services available locally.

3.4 Current users of Adult Services and carers are asked through regular surveys about accessing information about local services. The most recent survey results indicate that 81.7% of people surveyed in Hartlepool reported that they found it easy to access information. This is higher than the England average of 74.7% and the North East average of 78.9%.

3.5 While current survey responses are very positive, the Care Act introduces a requirement for Information and Advice to be provided to the whole population rather than being targeted at existing users of service and their

carers, and this requires further work to be undertaken by councils to develop and promote services.

4. HARTLEPOOL NOW

4.1 Hartlepool Now was originally developed as an information and advice resource in 2009. People who accessed the site were positive about the approach and the information available, but it was difficult to keep the site up to date due to limited staffing resources and difficult to engage providers in updating their information and keeping the site fresh and engaging.

4.2 Linked to implementation of the Care Act, the Hartlepool Now site has been completely redeveloped and re-launched with a new provider, more up to date technologies, refined search features and a more user friendly, interactive approach.

4.3 The site is live and can be accessed at www.hartlepoolnow.co.uk. A demonstration of the site will be provided.

4.4 The site aims to provide information and advice to all residents of Hartlepool, covering a broad remit from traditional care and support services (such as information regarding care homes) to local activities (e.g. tea dances) and low level services that support people in their own homes (such as luncheon clubs and handyperson services). Through ensuring that the site is kept up to date, it is hoped that some people will become regular visitors while others may access the site on a one off basis when looking for a specific piece of information.

4.5 It is recognised that online services are not accessible by all residents, so the Hartlepool Now site is only part of the solution. People will also be able to access Information and Advice through factsheets and printed information downloaded by frontline staff from Hartlepool Now. There is also an information and signposting service commissioned from Hartlepool Voluntary Development Agency (HVDA) which can be accessed by telephone or face to face, information and advice for carers commissioned from Hartlepool Carers and a service currently being commissioned to provide Information and Advice for people with autism.

5. FUNDING

5.1 As reported previously to Adult Services Committee, the Council received a one off allocation of £125,000 in 2014/15 to support implementation of the Care Act. As agreed by the Committee, £40,000 from this allocation has been used to develop and commission the new Hartlepool Now site as a public facing information and advice service. In addition to this one off cost, a new post focused on information and advice has been created within the Development Team. This will ensure that there is a resource in place on an ongoing basis to maintain the site and work with providers to make it a vibrant and engaging site and the post will also support development of

information and advice in other formats for people who do not choose to use web based services.

6. NEXT STEPS

6.1 There is further work required to develop the site over time. Residential and non residential providers who are commissioned by Adult Services will be required under their contracts to keep the site up to date regarding their services. Other providers will be encouraged to use the site to promote the services they offer, as well as promoting any regular activities or one off events.

6.2 A low level equipment self assessment module is being developed to add to the site. This will provide an opportunity for people to complete a short online self assessment, the results of which will lead to the identification of relevant equipment to meet an identified need with details of local providers will be available to enable. This element of the service will be available from July 2015.

6.4 In addition, a three year project is currently being commissioned that will provide supported access to information and advice. The project will build on a tablet loan project that demonstrates the potential of technology for people with a disability.

7. EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 This project will support vulnerable groups of people, regardless of their background, to access information and advice. There will be a particular focus on priority groups including:

- Adults with learning difficulties and/or disabilities;
- Adults with autism;
- Adults with mental health problems;
- Elderly people;

8. RECOMMENDATIONS

8.1 It is recommended that members of the Adult Services Committee note the contents of this report and promote the Hartlepool Now site with residents and local communities as a means to access information and advice.

9. REASONS FOR RECOMMENDATIONS

9.1 There is a requirement within the Care Act to provide comprehensive information and advice to the local population and it is an important means of supporting people to stay independent, build links within their local communities and make informed decisions about their care and support needs.

10. CONTACT OFFICERS

Jill Harrison
Assistant Director - Adult Services
Level 4, Civic Centre
Hartlepool, TS24 8AY
Tel: (01429) 523911
E-mail: jill.harrison@hartlepool.gov.uk

Leigh Keeble
Development Manager
Child & Adult Services
Level 4, Civic Centre
Hartlepool, TS24 8AY
Tel: (01429) 284292
E-mail: leigh.keeble@hartlepool.gov.uk

ADULT SERVICES COMMITTEE

8 June 2015

Report of: Director of Child & Adult Services

Subject: HEALTHWATCH HARTLEPOOL HOSPITAL DISCHARGE PROJECT: ACTION PLAN

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to update members of the Adult Service Committee in relation to Healthwatch Hartlepool's recent Hospital Discharge Project, and action that is being taken in response to the recommendations made.

3. BACKGROUND

3.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool.

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

3.3 The Hospital Discharge Project was undertaken during 2014 and involved visits to key services and teams, interviews with staff and gathering of feedback from people who have experience of hospital discharge along with their families / carers. A report summarising the process and findings was presented to Hartlepool's Health & Wellbeing Board on 12 January 2015 (copy attached at **Appendix 1**). Work has been undertaken following that meeting involving Adult Services within the Council and hospital discharge leads within North Tees & Hartlepool NHS Foundation Trust to develop an action plan that responds to the recommendations made.

4. RESPONSE TO RECOMMENDATIONS

4.1 The HealthWatch Hartlepool report made twelve recommendations (which can be found on pages 16 and 17 of **Appendix 1**).

4.2 The Action Plan attached at **Appendix 2** lists those recommendations and outlines action being taken in order to address each recommendation.

4.3 It should be noted that a lot of the issues raised in relation to hospital discharges are reflected in Hartlepool's Better Care Fund plan, which aims to create more integrated services, improve sharing of information, enhance seven day working and increase support for people in their own homes to either prevent hospital admission or support reablement following a hospital discharge.

5. RECOMMENDATIONS

5.1 It is recommended that members of the Adult Services Committee note the recommendations made as a result of Healthwatch Hartlepool's recent Hospital Discharge Project, and endorse the actions being taken to address those recommendations, noting also the links to the Better Care Fund plan.

6. REASONS FOR RECOMMENDATIONS

6.1 Improving the hospital discharge process could potentially deliver significant benefits linked to the Better Care Fund outcomes, including a reduction in readmissions following a hospital stay, reduced duplication through integrated working and a better experience for people using services and their families / carers.

7. CONTACT OFFICER

Jill Harrison
Assistant Director - Adult Services
Level 4 Civic Centre
Hartlepool, TS24 8AY
Tel: (01429) 523911
E-mail: jill.harrison@hartlepool.gov.uk

7.3
APPENDIX 1

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"

HEALTHWATCH HARTLEPOOL HOSPITAL DISCHARGE PROJECT – ACTION PLAN

Recommendation	Action	Lead Officer(s)	Project Review Date
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.	Linked to Better Care Fund developments an outline model for Early Intervention and Intermediate Care has been agreed. The model will include a focus upon discharge and care and support pathways in order to simplify existing processes with an initial focus on patients known to health and social care and subsequently those who are unknown prior to hospitalisation. The Trust will work in partnership with the LA and CCG colleagues in support of the BCF work. In addition NTHFT will focus on its communication with patients, families and carers as a defining principle of future work around the development of more effective discharge plan and process.	**HBC** J. Lovatt **NT&H NHS FT** N. D'Northwood J. Driver D. Blackwood **CCG** P. Swindale	October 2015
2. Work should 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 continuity of patient care.	Work is underway to consider options relating to IT support using 'cloud' technology to improve information sharing and access to case records. A team is being developed that will provide intensive support in the ward area focused on embedding a more robust communication process between patients, family, carer, staff and external organisations. The aim is to empower patients, family and carers to monitor and challenge the standards of their own discharge, becoming an equal partner in the process. In addition under the 'Transfer of Care' project	**HBC** J. Willis **NT&H NHS FT** – N D'Northwood J. Driver P. Dean D. Blackwood **CCG** - P. Swindale	October 2015

	community pharmacists will be linked to consenting patients via secure electronic link (using PharmOutcomes) to provide further support and information, answer any questions which may have occurred to the patient following discharge. NTHFT will explore with the LA the information required to support patients post discharge with a view to develop a more robust communication mechanism.		
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.	The BCF is recognised as the primary driver for making any necessary improvements in operational systems at the interface between health and social care and systems and processes are in situ to ensure discussions take place about the way forward. The Trust will work in partnership with the LA and CCG colleagues in support of the BCF work.	**HBC** J. Harrison **NT&H NHS FT** N. D'Northwood **CCG** P. Swindale	October 2015
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.	Once the model is finalised, opportunities will be explored to facilitate a seven day a week discharge, where possible. Prior to the introduction of this development assurance will be required regarding patient safety, patient well-being, financial viability, and associated risks and these will be key determinants to the successful implementation, as will ensuring that statutory accountabilities are adhered to. The Trust is currently redefining the strategy and model around discharge in order to facilitate more effective seven day discharge. This is being done within the context of the development of the broader outline model and the integration of	**HBC -** J. Harrison J. Lovatt **NT&H NHS FT** N D'Northwood Emma Roberts Fiona McEvoy DrD Dwarakanath Darren Smith **CCG** P. Swindale	October 2015

	services around more effective discharge. The Trust is undertaking a Rapid Process Improvement Workshop with end date of September 2015, as part of the 'breaking the cycle' report from the DH.		
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.	The hospital discharge policy and related procedure(s) including information provided to patients, carers and family members will confirm that discussions relating to discharge will commence at the earliest possible opportunity. The development and implementation of a care transition team as previously mentioned will ensure that 2 way communication between the patients, carers and families is commenced at the earliest opportunity, embedding a culture of effective partnerships to deliver a patient centred discharge plan and in a way that is easily understandable.	**NT&H NHS FT** N D'Northwood J. Driver D. Blackwood J. Taran Patient Rep	October 2015
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 organisation 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.	The hospital discharge policy and related procedure(s), including information provided to patients, carers and family members will confirm that the contents of discharge summary letters will be checked as outlined and the information will include providing advice about who to contact if an individual is dissatisfied. This action will be monitored by the Discharge Steering Group, chaired by NTH NHS FT and attended by HBC and SBC. The development and implementation of a care transition team as previously mentioned will ensure that 2 way communication between the patients, carers and families is commenced at the	**HBC** J. Lovatt **NT&H NHS FT** N D'Northwood J. Driver D. Blackwood J. Taran Patient Rep	October 2015

	earliest opportunity, embedding a culture of effective partnerships to deliver a patient centred discharge plan and in a way that is easily understandable. The Trust is currently initiating a monthly audit of the DP1 Patient Discharge Plans to ensure that all the necessary information and support has been provided to the patient and that it has been recorded. The Trust is also exploring the application of a patient discharge passport to facilitate early support or advice following discharge if required.		
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.	The outline model takes into account all the circumstances of an individual at the point of admission through to discharge back into the community. The Trust will work in partnership with the LA and CCG colleagues in support of the BCF work. In addition NTHFT will focus upon it's communication with patients, families and carers as a defining principle of future work around the development of more effective discharge plan and process.	**HBC** J. Lovatt **NT&H NHS FT** N. D'Northwood	October 2015
8. Under no circumstances should a patient with a complex package of care and complex needs be discharged back home or into a care facility after 5pm.	If the model is implemented and effectively monitored patients with complex needs shouldn't be discharged after 5pm unless appropriate arrangements are in place and the associated risks are identified and effectively managed. The newly revised and ratified NTHFT discharge policy supports a more proactive approach to discharge planning therefore aiming to safely discharge patients before 5.00pm.	**HBC** J. Lovatt J. Willis **NT&H NHS FT** N. D'Northwood J. Driver D. Blackwood J.Taran Patient Rep	October 2015

	This proactive approach will be embedded through the development and application of a new discharge model and practical support that will be provided by the care transition team, empowering patients, families and carers to become an equal partner in the discharge planning process.	**CCG** P. Swindale	
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.	Work is currently being undertaken to establish the delays encountered in relation to receipt of medication prior to discharge. This information will provide a foundation for the improvement and development of systems and processes around medication. In addition the care transition team will also ensure that activities relating to medication are carried out in a more proactive manner.	**NT&H NHS FT** N. D'Northwood J. Driver D. Blackwood J.Taran Patient Rep P. Dean	October 2015
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.	Pharmacy is about to implement a service in which patients will be referred on discharge to their community pharmacist for further services. All suitable patients who consent for referral will be referred by secure electronic link (using PharmOutcomes) to the community pharmacy of their choice. The community pharmacist will contact the patient within 3 working days of referral to offer a consultation and provide further support and information.	**CCG** ? **NT&H NHSFT** P. Dean	October 2015
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 met needs.	A review of nursing home capacity for Hartlepool has commenced with strategic partner agencies working together to discuss challenges, identify potential future requirements for nursing care capacity and agree a way forward, which will include engaging with the market.	**HBC** J. Harrison **CCG** K. Hawkins	October 2015
12. Consideration must be given to ensuring that	Following implementation of the agreed model, a	**HBC** J. Lovatt	October 2015

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.	task and finish group will be established focused specifically on Extra Care and Sheltered Housing facilities to maximise community resources and consider preventative initiatives as well as discharge arrangements. This will include revisiting the proposal for a Discharge Card. NTHFT will work with the LA in reviewing the implementation of the "discharge Card". However it is anticipated that where any communication is required like that mentioned then this activity will become routine practice supported by the newly implemented discharge policy, care transitions team and development of a new discharge model.	J. Willis **NT&H NHS FT** N. D'Northwood **CCG** P. Swindale	