HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Thursday, 18th April, 2013**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meeting (Pages 1 - 14)

8. Health and Wellbeing Board (Pages 15 - 25)
   - Minutes of meeting held on 27th February, 2013
   - Verbal update from meeting held on 10th April, 2013

9. Rotherham Heart Town - Annual Report (Pages 26 - 41)

10. Hospital Discharge Arrangements (Pages 42 - 95)

11. Urgent Care Review - NHS Rotherham (Pages 96 - 106)

12. Residential Homes Scrutiny Review (Pages 107 - 120)

13. Date and Time of Next Meeting
    - Thursday, 13th June, 2013 at 9.30 a.m.

HEALTH SELECT COMMISSION
7th March, 2013

Present:- Councillor Steele (in the Chair); Councillors Barron, Beaumont, Beck, Dalton, Goulty, Hoddinott, Kaye and Wootton.

Apologies for absence:- Apologies were received from Doyle, Wyatt, Middleton and Roche.

58. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or press at the meeting.

60. COMMUNICATIONS

Councillor Hoddinott reported that the Secretary of State's Judicial Review into the proposed closure of the Children's Cardiac Surgical Hospital in Leeds had found that the consultation process was unfair and legally flawed.

61. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 1st February, 2013.

It was noted that the Childhood Obesity Review Group had not met as yet.

Resolved:- That the minutes of the previous meeting be agreed as a correct record.

62. HEALTH AND WELLBEING BOARD

It was noted that the minutes of this meeting would be submitted to the next meeting.

Councillor Hoddinott asked why Community Alcohol Partnerships had been commenced in Deprived Communities when most of the evidence suggested that it was those in employment that had issues with alcohol. Had the Board taken the evidence into account?

Dr. John Radford reported that 1 of the aims of the Partnerships was to reduce the supply of alcohol particularly to children under the age of 18 and hopefully see less violent behaviour in that cohort, less street drinking and also reduce street drinking in the older age groups where it was clear

that abuse was taking place. He agreed that the evidence base suggested that there was a significant hidden problem that Partnerships would not address.

63. CLINICAL COMMISSIONING GROUP

Chris Edwards, Chief Officer, NHS Rotherham/Rotherham Clinical Commissioning Group, gave the following powerpoint presentation:-

What do the changes mean for Rotherham?

- Rotherham Primary Care Trust/NHS Rotherham would be abolished in March, 2013
- There would be (at least) 6 new bodies in its place:-
  - Rotherham Clinical Commissioning Group – Expected to be authorised to formally start in April, 2013
  - RMBC – Public Health responsibilities transfer from NHS to RMBC in April, 2013
  - National Commissioning Board (NHSCB) – would cover all of South Yorkshire and Bassetlaw based at Oak House, Bramley. Includes GPs/Dentists/Pharmacists/Opticians contracts and specialist commissioning
  - HeathWatch – would be formed to promote the views of patients and Service users
  - NHS Property Services – all estates owned by NHS Rotherham e.g. health centres
  - Public Health England – Health Protection Agency would also lead on commissioning support to the Commissioning Board – specialist commissioning covering vaccination and immunisation

Funding

- NHS Rotherham £460M
  - RMBC Public Health = £14M
  - Rotherham Clinicial Commissioning Group - £330M
  - NHS Commissioning Board GPs/Dentists/Pharmacists = £116M

Who is CCG represented by?

- David Tooth, Chair, Long Term Conditions/Urgent Care
- Chris Edwards, Chief Officer
- Richard Cullen, Vice-Chair, Finance
- Ian Turner, Primary Care
- Phil Birks, Rotherham Foundation Trust
- Julie Kitlowski, Clinical Referrals and Pathways
- David Pokinghorn, Children and Young People
- Jason Page, Prescribing
- Russell Brynes, Mental Health, End of Life Care and Equality and Diversity
- David Plews, Medical Director, NHS Rotherham Metropolitan Borough Council

What Services will the CCG commission?

- Unplanned (unscheduled care)
- Planned (scheduled care)
- GP prescribed medication
- Mental Health and Learning Disability
- Children and Young People
  Policy decided that most of Children's Services would be commissioned by the CCG but School Nursing would remain the responsibility of the Council and Public Health. Health Visitors would come under the NHSCB for 2 years and then transfer. This was a risk area
- End of Life Care
- Transport services for patients
- Any qualified provider services
- Services jointly commissioned with RMBC
- Services the CCG commissions from GPs (small)

Financial Challenges

- Nationally the NHS had to save £20B
- Rotherham would have to save approximately £80M by 2014/15

Challenges for the CCG

- Overall the NHS spent approximately £2,000 per person
- Approximately ¾ of the £2,000 per head was the responsibility of the CCG
- Some areas which were very important for patients such as GP services and very specialised services were the responsibility of others (NHSCB or Public Health)
- Costs and demands for services were increasing faster than NHS spending
- Much of the balance of the spend was hard to change e.g. most of the money was spent on urgent hospital care
- There was a chicken and egg problem in that the CCG could not spend more on prevention until it decreased the cost of acute services

CCG Urgent Care Review

- A new Urgent Care Centre for Rotherham
  - Would be open 24/7
  - Purpose-built at Rotherham Foundation Trust Hospital
  - Staffed by experienced and specially trained nurses and GPs
  - Joined up with Accident and Emergency
- Re-investing money from the Walk-in Centre into Urgent Care
  - Urgent Care Services currently provided at the Walk-in Centre would transfer to the Urgent Care Centre
  - The Walk-in Centre would close (but not the building)
  - New NHS 111 service would provide advice and support for non-urgent care (to be launched on 19th March, 2013)

Next Steps
- Finalising proposals
- Continuing discussions with providers, patients and stakeholders
- 12 weeks public consultation starting in the Spring
- Recognition that for some the proposals would raise issues. They would be listened to and work with the local community to address them where possible
- Proposal to open the new Urgent Care Centre in Autumn 2014

Discussion ensued on the presentation with the following raised/clarified:-

- The Legislation governing CCGs recognised that the nursing voice had to be heard and that there should be a hospital doctor. Sue Casson was on the Governing Body representing nursing and a Dr. Ashurst from Bradford Hospital. Any suggestions of a forum that could be engaged would be useful

- There was no requirement in the national guidance to include a specialist health professional on the Governing Body

- The CCG Strategy was to decrease unscheduled hospital admissions. If Rotherham could reduce its number to the national average, the plan was to spend £5M more on Community Services to ensure patients received the appropriate services

- The move of the Walk-in Centre to the Hospital would cause logistical problems for visitors from a car parking/bus route point of view. Consideration would be given to accessibility

- The demolition of the former Mental Health block fronting the main road would provide additional car parking spaces

- A GP practice would remain at the Walk-in Centre for a period of time following its transfer to the Hospital

- There was an efficiency target for the whole health community of £80M over 4 years. A large proportion would be passed to the Rotherham Foundation Trust but the CCG still had to make significant savings. The CCG's annual commissioning plan, available on the website, detailed what it intended to do in terms of efficiencies

- The Health and Wellbeing Board, Healthwatch and Health Select Commission would be responsible for scrutinising the CCG

- Currently there were no plans to move any services outside of Rotherham. It was not a case of stopping delivery but delivering differently. All CCGs across the country shared the strategy that hospitals were expensive. Rotherham had a lot of people that went

into hospital unnecessarily and would receive better treatment outside of it. A big issue was follow-up out-patient appointments a large number of which could take place at GP practices.

- Conflict of interest – GPs were not involved in the decision making; they were involved in the discussion and working up of the business case but the decisions were made by the lay people and independents. This was in accordance with the national Policy

- The Department of Health was introducing Payment by Results not Rotherham CCG. It would be based on a national price rather than a local price for Mental Health Services. The Department of Health had tried to introduce it since 2005 but had struggled due to the difficulties in getting an average price due to the varieties of the client group. It was proposed that it be introduced in 12 months and run in shadow form as from 1st April, 2013, to understand whether it would be realistically possible and whether it was a far way of recompensing providers for providing those services. It would be about numbers going through the Service rather than outcomes. Rotherham CCG had in its contract additional payments on top of the tariff for improving quality

- Rotherham CCG had 2 lay members – 1 for governance (John Gomersall) and 1 for patient engagement (Sue Lockwood)

- The CCG Audit Chair met with the Council's Audit Chair. It was expected that the current arrangements would continue. Due diligence had been completed

Chris was thanked for his presentation.

Resolved:- (1) That the presentation be noted.

(2) That an item entitled "Walk-in Centre" be included on the next Select Commission agenda.

(3) That the Health Select Commission be provided with a copy of the Clinical Commissioning Group's annual commissioning plan for information.

64. ROTHERHAM FOUNDATION TRUST

The Chairman introduced Peter Lee, Chairman of Rotherham Foundation Trust Board, and Michael Morgan, Interim Chief Executive of Rotherham Foundation Trust.

Peter gave a brief resume of recent events at the Trust. As a result of the Nicholson challenge, the NHS had been required to save £20Bn across the country of which Rotherham's proportion was £50M over 3-4 years. It

was fair to say that the Board had not acted quickly enough in terms of recognising it had to make the savings.

As a result, the Trust had come to the attention of Monitor, the independent regulator of NHS Foundation Trusts, who assess the quality of service provided, financial stability and sustainability of a Trust. When examining the Trust's finances, the Trust had been downgraded to a 2 from a 3 as it had not achieved the required savings. They then examined the plans for the organisation and the way the organisation was moving forward and decided that they had concerns about the financial stability of the organisation. Monitor had declared the Trust to be "in significant breach" but decided not to exercise Intervention Powers as they were satisfied with the quality of care but not the financial recovery. A recovery plan had to reach them by 18th March together with monthly meetings and reports.

Work on the plan was underway and would be submitted in accordance with the deadline.

Michael stated that it was important to note that Rotherham was in a situation that was not unique to other Trusts within the UK. Included in the report to Monitor would be the first year very robust budget process together with years 2 and 3. Monitor had also requested a 3 year strategic plan to be submitted in September, 2013, looking at all the services throughout the Trust.

Michael had started in Rotherham on 1st December, 2012, to work on transformation issues but it had soon become clear that it was a turnaround company that was required. An interviewing process had commenced and Bolt Partners appointed. Michael had commenced in his new role at the beginning of February, 2013.

A question and answer session ensued with the following points raised/clarified:-

Financial Situation

- How had the Trust gotten into such deep financial troubles? Financial performance was flagged up as an issue in February, 2011. What has been done since then? Would the Trust be able to achieve the required savings? Could the Trust go "bust"?
  The Trust had always spent its income on its services which did not have a reserve fund. The impact of the required savings and the Trust not acting quickly enough in certain areas resulted in it finding itself in a position where it was spending the money it was not receiving as well as not making the efficiencies at a sufficient pace. The Trust had been in breach in 2010/11 because it had not achieved savings required then by Monitor. In the past funding had always appeared and the problems solved. In the new regime that had not happened. There had been a lot of effort to recover in ways which did not involve job losses and efficiencies tried but had not achieved the

required savings. Eventually the decision had been made that the Trust needed to look at immediate efficiencies and to look at the question of redundancies which had lead to the 90 days consultation with staff.

The Trust could go "bust" but it was not going to. The steps that were being taken involved, not only a realisation by the Board that the savings had to be achieved as part of the overall financial requirement, but also that it could save money by working/creating a different structure within the organisation. Huge efficiencies in terms of admissions, length of stay and the way in which patient pathways were designed all of which would achieve efficiencies and save money at the same time were being considered. The recovery programme would take 3 years but would not prejudice patient safety.

- Why would it work this time? What was different?
  In late 2012 it had become obvious that there was a need for a specific post of Turnround Director whose job it was to deliver the required savings. Tremendous headway had been made with every line of finance being challenged and contracts renegotiated. The work was being carried out in parallel to the delivery of services.

- Being mindful of the Mid-Staffs review, focussing on financial aspects could be at the expense of patient care. Was it correct that the Trust was not achieving its 2 week target on breast cancer at the moment?
  No that was not true. Since 15th September all targets for breast cancer had been met. It was believed that there were 4 patients in August that had symptomatic breast cancer. 1 of those individuals decided not enter into the 2 week field. The Trust had very low counts of symptomatic breast issues going through so the numbers would be hard to meet from the stand point of 85%.

  There are 2 ways to undertake turnarounds for hospitals. 1 was the slash and burn method and secondly the leadership style which was very inclusive and an encompassing style for the organisation to make the changes in a way that did not harm the quality or patient safety within the hospital. The company used a very inclusive management style and one that utilised the consultants and specialists within the hospital. The Trust's 11 Clinical Directors would be very important when the issue of staffing was considered. A past decision of the Trust was to close a Ward and had stopped hiring nurses because if 1 Ward was closing the nurses could be transferred. However, the company had quickly become aware that the hospital was short of nurses. 1 of the company's stipulations was that the Trust hire new nurses and, as a result, 60 nurses had been interviewed. 50 had been signed up to come to the Trust and over time there would be approximately 60-70 new nurses.

  The consultants and specialists' working methods had to be revised. They had met recently and committed to have a new rota in place by

18th March which allowed rounds to be made in the hospital and getting to patients that should be discharged quickly.

A further change that needed to be made was the Walk-in Clinic which would help the hospital reduce the amounts of funds it required and increase the efficiencies of the Trust. There were patients in the hospital that really did not need to be treated in an Acute Care setting and, once in hospital, was difficult to get them turned around quickly.

- How did it fit with the planned redundancies?
  The company approached redundancies and/or changing staffing patterns within a Trust was by not considering any areas that touched patients initially. It looked at areas of Corporate spend in the first instance and that was the area the plan to be submitted to Monitor was concentrating on. For example, Corporate spend at Rotherham was approximately £22M; other Trusts in the area and within the UK spent closer to £16M. The Clinical Directors had been asked to re-look at their areas and come up with a £5M reduction in Corporate spend. Estates (domestics, porters) was exempted as that was an area that touched patients directly.

- How many professional staff had taken voluntary redundancy? Were the 60 nurses new appointments or from within the organisation?
  They were new appointments. The redundancy 90 days consultation started in December, 2012 and finishes on 14th March, 2013.

- What were the numbers you are looking for in redundancies and from what areas? Had redundancy costs been budgeted for? Were the new nurses employed full-time on permanent contracts?
  The Trust had required 60 full-time equivalent nurses. The CCG had provided some additional funding for the Trust as it went through the recovery process. It was believed that there needed to be a slimmer executive group.

- The 3 year plan and progress would not be in a straight line. What interim measures were there to review and correct that process? How would you intervene when/if they dropped below the target?
  The organisation needed a very strong project planning process put in place. An inclusive strategic planning process, part of what Monitor was requesting, illustrating what needed to take place in the next 3 years as well as what was happening on an interim basis, had been pulled together. In the future the Trust would no longer receive funding on the number of patients but on the efficiency and care that was provided. It would mean a huge amount of change in the organisation had to happen and some by the Board.

- Would the nurses be newly qualified?
  They were qualified nurses. A problem had been identified at the Trust some time ago in that the nurses at Rotherham were banded at a very high level, higher than other Trusts in the area. However,

those nurses concerned would be pay-protected for 2 years and that change would probably need to be made to make it competitive with other Trusts.

- Monitor identified concerns that last time consultants came in, they improved the situation but 1 of the risks is that interim arrangements were not permanent. Does not change need to come from within and to ensure that that change was still happening 2-3 years down the line?
  The Interim Chief Executive's role was to look at the organisation and its culture. The process for changing the culture at the Trust had started. Almost daily staff forums were held from which information was gained on what exactly needed to be incorporated into the strategic planning process. Whilst ever a Trust was receiving funding and progressing everyone was happy and not a lot of problems; when a big change happened the weaknesses of the organisation came to the forefront. The plan was to institute a more inclusive management process. It was a leadership process from the top down.

  There was also an issue with the Trust having taken over Community Nursing 2 years ago. Acute Care and Community Nursing were 2 different entities and synergy was needed between the 2 so they could work together and ensure care to the patients in the right setting.

  The plan to be submitted to would be scrutinised by Monitor as well as external scrutiny to ensure that it was deliverable. There would then be monthly meetings with Monitor.

Electronic Patient Record System

- There had been reports in the media that the system was not working and costing a lot of money. How much was being spent on it? Was it being used elsewhere in the United Kingdom?
  There were such systems in the United Kingdom that were functioning but not the version of the system which was the latest version. The process had been commenced 4 years ago and at that time there had been engagement by physicians, clinicians, specialists and nurses to get the system in. There was then disengagement by the specialists, nurses and consultants. The system worked very well in most instances but the biggest problem was that, the way in which the system had been built, physicians were having to input the initial front end information themselves which was timeconsuming for them. The way in which the information was inputted by consultants and specialists had to be redesigned and it would then be a very robust and good system. Having an electronic system was very efficient for a Trust and a hospital.

  Approximately £20M had been spent on the system over the 4 years. There was a system which worked very well for Community Nursing, however, that was not a full blown Acute Care hospital EPR system

and probably would not work well for a full EPR system in a UK hospital. The Board had been requested to bring in outside independent help. That help had now been looking at the system and was to submit a plan to Monitor.

- If the system had been in for 4 years and was still not working correctly how much would it cost to put right?
  Although the system had been in for 4 years it had only actually been installed in June, 2012. The Trust had already purchased the hardware and infrastructure and everything was in place even the additional modules. There would not be a big cost as far as additional hardware and infrastructure were concerned; it would only be the cost of retraining of staff and redesigning the method of inputting the information.

  As it was the latest version there would be no upgrade for a while.

- What were the lessons learnt from this process and could it happen again?
  Some of the largest hospitals had had problems with such systems and had to reinstall. They were very difficult systems to install and to do so properly.

Patient Quality

- There was a very skilled Community workforce at the Trust and it was very important that the pathways of care were clear
  It was believed that the integration process was not working between Acute Care and Community. Since 4th February, 2013, the weekly meetings now included the leadership from Community together with executives of the Acute Care hospital. This had not happened previously. Until there was synergy between the 2, there would never be the efficiencies the hospital required to move forward.

- Were there cultural issues to be addressed in terms of perception of each other's view of the work that was done? Often it was thought that money would be saved by delivering care in the community but it was not necessarily so
  There were cultural issues to be addressed on both sides. Community was and currently still funded by grant i.e. not funded in the same way as the Trust so there were fundamental differences. The culture was also different in both organisations and that had to be synthesised. It was the intention that each of the executives and stakeholders within the Acute Trust and Community were together and worked through their strategic planning process. It would be a very intense process and really the only way to get to the cultural changes that needed to take place. It was also the only way you could reach the 2nd and 3rd year financials that needed to take place within the process.

- There was varied feedback about the care received from the hospital Even though the Trust had needed additional nurses the Wards were not short of nurses. The Trust had been bringing in nurses from outside agencies and using nurses within the organisation through their bank system. This, however, was a costly practice.

- How did the patient voice fit into the strategies?
  Michael reported that for years he had used "Dear Michael" which was a very easy way for employees, patients, consultants, specialists etc. to be able to write directly to him concerning their experience at the hospital. However, the NHS had introduced Friends and Family, a survey that had to be filled out by the patient. So as not to cause confusion, "Dear Michael" was to be available on the website.

The Chair thanked Peter and Michael for their attendance at the meeting.

Resolved:- (1) That the presentation be noted.

(2) That Peter Lee and Michael Morgan be invite to the 13th June meeting of the Health Select Commission.

65. SCRUTINY REVIEW - AUTISTIC SPECTRUM DISORDER

Deborah Fellowes, Scrutiny Manager, submitted the findings and recommendations of the Scrutiny Review of Autistic Spectrum Disorder in Rotherham.

The overall aim of the review was to achieve a better understanding of patterns of Autistic Spectrum Disorder (ASD) in Rotherham leading to the development of appropriate support and assistance to families affected by it. It had taken place in a climate of budget reductions and, therefore, also wanted to look at the potential for more effective use of existing resources.

The review had been structured around 4 objectives:-

- The reasons for the higher diagnosis rates
- Services required at diagnosis stage and after
- 16+ support and transition
- Budget implications.

The Key messages from the Review were as follows:-

- Early intervention and prevention work was key for children with ASD
- Mental Health needs of children and adults with ASD could arise because of the lack of support
- Lack of clarity about where the lead of support laid – Education, Health etc.

- It was difficult for many parents to make sense of all of the different agencies that were involved in the area of work
- There had been significant progress made with the area of work and this needed to continue with clear leadership and direction
- To ensure the best outcomes for children and young people with ASD, parental voice and influence was absolutely crucial
- All of the recommendations formed as part of the review were about more effective use of existing resources, achieving better value for money and becoming better organised in delivery of support. It was the view of the review group that there should not be a need for additional resources to implement the recommendations

Resolved:- (1) That the findings and recommendations set out in the report be endorsed.

(2) That the report be forwarded to the Overview and Scrutiny Management Board and Cabinet.

(3) That the Cabinet response to the Scrutiny Review recommendations be fed back to this Select Commission.

66. ROTHERHAM HEART TOWN - ANNUAL REPORT

This item was deferred due to the absence of the Cabinet Member for Health and Wellbeing.

67. EXCLUSION OF THE PRESS AND PUBLIC

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (as amended 2006 – information relates to finance and business affairs).

68. TRANSPORT AND LEARNING DISABILITY DAY SERVICE CATERING CONSULTATION

The Service Manager, Adult Community Services, submitted for information the final proposals for Transport and Catering arrangements for the Learning Disability Day Care Service based on the recent consultation with customers and carers.

Transport Provision
Extensive work had been undertaken with a number of officers who were aware of customers and carers' needs to review the change to current transport provision.

Catering Provision
At present the current in-house Day Service catering arrangements, delivered on site, were underutilised by customers and therefore not cost effective. Recent consultation had shown that customers were accepting of the choice of taking their own packed lunch or purchasing a meal from the café.

Discussion ensued on the proposals with the following points highlighted:-

- Approximately 30% of the clients were in receipt of the higher level Mobility Allowance

- Concerns raised at the consultations with regard to those who had learning difficulties and not able to feed themselves or have the ability to choose what they wanted to eat. There were a significant number with complex needs that needed support with feeding and that would not stop

- Some would need a bus buddy – consideration was to be given to this in the consultation

- Running alongside these proposals was a tendering exercise across Adult and Children Services with private providers. Work had been undertaken with Procurement who were conducting the tendering process and having discussions with private providers so they were well aware of the proposals

- £39.10 quoted in question 10 of the consultation questionnaire was the unit cost. It was a flat rate charge which was less than the lowest DLA rate. Clients were not financially assessed. If it was raised with the Service it would be looked at but not assessed as part of their care package cost

- Routes were being taken into consideration to ensure the length of time a client could possibly be on the transport was kept to a minimum

- There would still be cafes on site available for customers who wished to purchase snack items – it was the old dining rooms that were being closed – or there was the option of making their own meal

- People had the choice whether to attend a Day Centre. Some were taking the choice of taking their Direct Payment instead. Younger people found that Day Centres did not meet their needs. If there was a reduction in the number of people using day centres it would be seen by a rise in the number of Direct Payments. Then there would be a need to change the way in services were provided

Resolved:- That the report be noted.

69. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 18th April, 2013, commencing at 9.30 a.m.

HEALTH AND WELLBEING BOARD
27th February, 2013

Present:-
Members

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Helen Dabbs	RDaSH
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/ NHS Rotherham Metropolitan Borough Council
Brian Hughes	Director of Performance and Accountability, NHS Rotherham South Yorkshire and Bassetlaw
Shafiq Hussain	Voluntary Action Rotherham
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Michael Morgan	Interim Chief Executive, Rotherham Foundation Trust
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children, Young People and Families

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications and Marketing, RMBC
Dr. Nagpal Hoysal	Public Health Consultant
Joanna Saunders	Head of Health Improvement
Dawn Mitchell	Committee services, RMBC

Apologies for absence were received from Christine Bain, Karl Battersby, Martin Kimber, Gordon Laidlaw, Fiona Topliss, Janet Wheatley and Chrissy Wright.

S62. MINUTES OF PREVIOUS MEETING

Resolved:- (1) That the minutes be approved as a true record subject to the following clerical correction:-

S55(e)(Local Medical Committee)
"It was felt that there was GP representation on the Board through the CCG which could reflect the views of GPs as commissioners and not providers."

Arising from Minute No. S54(2) (Information Sharing Protocol), it was noted that RDaSH, NHS Rotherham and the CCG had signed off the Protocol. It was hoped it could be raised as an extra item at the Rotherham Foundation Trust Board meeting the following day.

(2) That the Overarching Information Sharing Protocol be placed on the Council's Risk Register.

Arising from Minute No. S60 (Rotherham HealthWatch), the Chair reported that 7 tenders had been opened and were currently being evaluated. It was hoped that the contract would be awarded to a successful tenderer, however, if that was not the case, there was a fallback position set out in the national guidance.

(Shafiq Hussain disclosed disclosable pecuniary interest in the above item.)

S63. COMMUNICATIONS

(1) Health and Wellbeing Board Work Plan

The Board noted the updated Work Plan illustrating the cycle of reporting up to October, 2013 when an evaluation would then take place.

(2) Health and Wellbeing Strategy Workstream Update

The Board noted a report setting out the progress on each of the workstreams. It was felt that future progress reports would benefit from inclusion of figures so the Board would be able to see what change had been achieved.

(3) Better Health for Women: A Summary Guide

The Board noted the above briefing which should be fed into the Joint Strategic Needs Assessment.

(4) Rotherham Carers' Charter

The Board noted the above which had been considered by the CCG and adopted by the Council.

It was reported that a multi-agency Steering Group had been established, meeting regularly, to progress the accompanying action plan and achieve the plan's objectives.

Discussion ensued on the forthcoming Bedroom Tax and the view that it ought to be included as it would affect carers and foster carers, cross referenced with the work taking place on Welfare Reform.

Resolved:- (a) That Bedroom Tax be included in the Joint Action Plan for Carers cross referenced with the work taking place on Welfare Reform.

(b) That the annual review of the Carers Plan be submitted to the Board.

(5) Conferences

The following conferences were noted:-

2nd Annual Health and Transport Conference: Remaining Healthy Through Sustainable Travel – Transport Planning Society – 10th April, 2013

Rotherham Health and Wellbeing Conference – 17th April, 2013

Health and Social Care Policy Forum and Q&A with Andy Burnham MP, Shadow Secretary for Health – Goole College – 7th March, 2013

S64. HEALTH AND WELLBEING BOARD COMMUNICATIONS PLAN

Tracy Holmes, Head of Corporate Communications and Marketing, submitted a draft Communications Framework.

The primary purpose of the Framework was to ensure effective, consistent and co-ordinated communications, marketing and social marketing activity to support the work of the Board. It set out how strategic and operational communications and marketing activity was undertaken by the range of organisations which contributed to the delivery of the outcomes through Rotherham's Health and Wellbeing Strategy as well as communications activity in support of, and on behalf of the Board itself.

The Framework would be supported by a plan of key actions which summarised the communications and marketing activities/campaigns in support of the work plans for each Priority area. It would be regularly reviewed and monitored by the Board but nominated lead agencies would individually or jointly be responsible for its delivery.

Resolved:- That the draft communications Framework be supported.

S65. ROTHERHAM FOUNDATION TRUST

Michael Morgan, Interim Chief Executive, Rotherham Foundation Trust, gave a verbal update on the Trust as follows:-

- The Trust had received notification from Monitor, the independent regulator of NHS foundation trusts, that it was in significant breach for both finance and Board governance. It had until 18th March, 2013, to provide a plan to Monitor. The proposed plan was to be considered by the Trust's Board on 28th February

- The plan would provide initial short term, 1 year, financial turnaround for the organisation. It would also include a 2 and 3 year financial turnaround

- There would then be a period between 18th March and 15th September, 2013, to provide Monitor with a 3 year strategic plan including the 2 and 3 year financial turnaround in much more detail as would be available for the 18th March deadline

- It was anticipated that the team would be in for 8-12 months. There not only needed to be a financial turnaround but also a cultural change that the team specialised in

- There were 2 ways to turn an organisation around – slash and burn or management style that provided for interaction between the various groups i.e. physicians, consultants, nurses etc. The latter enabled a real perspective of the organisational structure and found to provide a much longer term structure

- Outside independent specialists had been brought in to look at the Patient Record Information System. In the short time they had been there, reassurance had been given that they would probably be able to get the system to a point where there was much more functionality for the specialists and clinics where the majority of the problems were located

- The Ward closures had been put on hold for the present time as it had not been seen as an immediate priority. The new Clinical Director for Medicine had met with approximately 20 of the specialist consultants and unanimously arrived at a new work plan scheme for the organisation. The new scheme would become operational as from 18th March. This was a fundamental building block for the Trust and whereby it may be possible to close a Ward in the future

- If it could be helped areas of staffing that affected patients were never the first starting point. The proposed plan would start in the Executive Suite and Corporate overheads. It did not include Estates and certainly did not include Nursing. The 90 day consultation document issued on 14th December, which finished on 15th March, proposed some rebanding of Nursing and it may be that that would continue.

- The Board had approved the hiring of additional nurses – 50 nurses had signed a commitment to start at the Hospital

- There need to be synergy between the Community aspects of the Trust and the Acute Care side

Michael was thanked for his report.

Resolved:- That the Equality Impact Assessments carried out by the Trust be submitted to future Board meetings.

S66. ROBERT FRANCIS INQUIRY - MID-STAFFORDSHIRE NHS FOUNDATION TRUST

The Board considered a resume of the Francis Report – the independent inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust prompted by unusually high hospital mortality statistics.

Its recommendations and conclusions were many and far reaching with implications for commissioners and providers far beyond those of healthcare. The report found that the failures at the Trust were essentially failures of culture and systems and did not single out any 1 individual for blame.

Discussion ensued on the report with the following points highlighted/raised:-

- "Humanity" was missing from the Trust
- Each organisation of Rotherham's Board should report on what actions they were taking in respect of the Report
- A "mirror" should be held up to commissioners and scrutiny to ascertain that the same failures were not occurring
- The Report referred to some form of Annual Statement but it was not known what it would look like at the present time
- Interaction across organisations was fundamental

It was noted that there was to be a Seminar on the Francis Report on Thursday, 18th April, 2013, commencing at 11.30 a.m.

Resolved:- (1) That the findings of the Francis Report be acknowledged.

(2) That the Board ensures that all commissioning and provision of Healthcare in Rotherham follows the principles and recommendations laid out in the Report.

(3) That, as a minimum, all Rotherham healthcare providers, commissioners and Scrutiny submit evidence that supports their assurances that their organisation and practices were in line with all the Francis recommendations and, in particular, in relation to safe staffing levels and the prioritisation of patient safety ahead of financial pressure.

S67. PUBLIC HEALTH OUTCOMES FRAMEWORK: HIGH LEVEL OUTCOMES

Dr. John Radford, Director of Public Health, presented a report on the Public Health Outcome Framework which was designed to assist the Board in understanding how well it was improving and protecting Public Health.

The high level profile allowed the Board to review performance and consider its priorities for Health Services and to make decisions and plans to improve local people's health and reduce health inequalities. The profile presented a set of important health indicators that showed how Rotherham compared to the national and regional average.

The health profile for Rotherham 2012 illustrated:-

- higher than average under-75 death rate from cancer and coronary heart disease

- injuries and falls in the elderly remained higher than average

- preventable sight loss was higher than average

- access to diabetic retinopathy screening was worse than average

- child poverty, obesity levels in Year 6, pupil absence and 16-18 year old NEETS were of concern as they were all worse than average

- breastfeeding initiation and maintenance rates were worse than average

- emergency re-admissions remained higher than average

Resolved:- (1) That the Board regularly review progress against the Public Health, NHS, Adult Social Care and Children's Outcomes Frameworks.

(2) That the alignment of the current Joint Health and Wellbeing Strategy to address issues highlighted within the report be noted.

S68. PERFORMANCE MANAGEMENT FRAMEWORK

This was taken together with Minute No. 69.

S69. WORKSTREAM PROGRESS: HEALTHY LIFESTYLES, PREVENTION AND EARLY INTERVENTION

Dr. John Radford, Director of Public Health, and Dr. Nagpal Hoysal, Public Health Consultant, gave the following powerpoint presentation:-

Approaches
- Joint Health and Wellbeing Strategy
  Stages of Life Course
  Six Priority Outcomes
- Priority Measures
  Alcohol, Obesity, Tobacco, Dementia, NEETS, Affordable Warmth

Life Course Framework
- The Strategy set out a life course framework which had been adopted from the Marmot life course
- Life course: Early Intervention, Prevention and Behavioural Change

- Integral to the 6 Public Health programmes from Strategy
- System-based responsibility under the Health and Wellbeing Board

Healthy Lifestyles, Prevention and Early Intervention
- Outcome: people in Rotherham would be aware of health risks and be able to take up opportunities to adopt healthy lifestyles
- Outcome: Rotherham people would get help early to stay healthy and increase their independence

Communication
- QTV
- Campaigns – MCAT
- Web-based social media/mobile devices/engagement
- Every contact counts

Starting Well
- Children's Strategy
- Health Visitor 0-5 programme
- UNICEF Baby Friendly Initiative
- Troubled Families
- Family Nurse Partnership
- Imagination Library
- Specialist Midwifery

Developing Well
- Children's Strategy
- Looked after Children
- Healthy Schools
- Communication –website campaigns
- School Nurse Contract Revision
- Healthy Weight Framework
- NEETS system reporting framework

Living and Working Well
- Obesity – system reporting framework
- Alcohol – system reporting framework
- Smoking – system reporting framework
- NHS Healthcheck
- Communication – campaigns website development
- Workplace health

Ageing Well
- Affordable warmth – system reporting framework
- Dementia – system reporting framework
- Healthy Ageing
- NHS Healthchecks
- Flu vaccination

Healthy Lifestyles, Prevention and Early Intervention

- Delivery of a shift towards Prevention and Early Intervention and Healthy Lifestyles required a strong partnership approach
- The system-wide reporting framework proposed would enable the Board to hold the partners to account for their individual responsibilities

Discussion ensued on the presentation with the following issues raised/highlighted:-

- Considerable work had taken place in mapping the existing strategies against the Centre for Disease Control Framework for the 3 areas of Obesity, Smoking and Alcohol. Suggested targets would be submitted to the Board

- Linkages with the work of the Children's Board. Starting Well and Developing Well firmly sat within the Children's Board but should there be any issues e.g. partners, governance, they should be reported to the Health and Wellbeing Board

- Key issue of underage drinking – need more rigorous approach to the affordability of alcohol with suppliers, shops etc.

- Low level of referrals for weight issues – no real awareness of Obesity and the associated risks

- Restricting supply – measurable but currently not done. The Council did not have a planning and/or licensing policy restricting the availability of fast food

- Currently if someone was found drunk in Rotherham they were not required to attend a binge drinking course – could be part of an Attendance Order

- Relatively small number of targets across the 3 areas of Obesity, Smoking and Alcohol but all were measurable and quite challenging. If the focus was on a relatively small numbers of measures they would be achievable and make a difference

- How was the Public Health money going to be used to achieve the 6 Priorities?

- Discussion was still ongoing with regard to which Public Health services were contained within the Public Health funding allocation. A budget had not been set within the Council as yet. There would be significant investment in Alcohol, Obesity and Stop Smoking Services but as yet there had been no commitment requested from partners to contribute accordingly

Resolved:- (1) That the presentation be noted.

(2) That the targets and priorities for Public Health be submitted to the next meeting.

(3) That the information contained in the presentation be worked up into measurable proposals.

(4) That the relevant Steering Group consider the NEETS information further.

S70. PRIORITY MEASURE 2: OBESITY

Joanna Saunders, Head of Health Improvements, gave the following powerpoint presentation:-

Why is Obesity a priority?
- Public Health priority nationally and locally
- Can have serious health consequences and impacts on health and social care services
- Can be prevented and treated (NICE)
- Impacts on emotional wellbeing
- Impacts on the economy

What Does a Healthy Weight Framework look like?
- Children
  Tier 1 – Primary activity – School Nurse, GP, Health Visitor
  Tier 2 – MoreLife Clubs
  Tier 3 – Rotherham Institutes for Obesity
  Tier 4 – MoreLife Residential Camps

- Adults
  Tier 1 – Primary activity – GP, Health Visitor, Leisure Services
  Tier 2 – Reshape Rotherham
  Tier 3 – Rotherham Institute for Obesity
  Tier 4 – Specialist Obesity Service

What do we need to do?
- Raise public awareness
- Get more people to engage with services
- Skill people up to live healthier lives
- Make healthy choices the easy choices
- Get everyone to recognise their role and act
- Challenge cultural and “normal for Rotherham” behaviour

What are the current priorities?
- Raise the profile of whole population prevention activity
- Continue to provide a range of services for people who are already overweight or obese

- Maximise the resources already available – training, signposting and referral
- Agree our position on the impact of planning decisions, transport planning

Challenges
- Preventing and treating childhood overweight and obesity in the primary school aged population
- Whole family engagement
- Changing behaviour amongst those that most need to change
- Evidence of what really works
- Funding to support grassroots initiatives

What can the Health and Wellbeing Board do?
- Making Every Contact Count. Power of partners
- Recognition of the importance of health as a driver of deprivation
- Political leadership
- Collaborative commissioning

Health and Wellbeing Board Members commitment
- Commit to all staff doing e-learning on MECC and giving feedback on their performance in signposting and referring to services
- Introduce planning and licensing policy to restrict availability of fast food particularly near schools or in deprived communities and promoting use of green space
- A concentrated effort to address the issue in the primary school population

Discussion ensued on the presentation with the following issues highlighted:-

- Awareness was the big issue
- The message was getting across but people failed to recognise they had a problem
- Many did not have the skills or income to provide healthy food

Joanna was thanked for her presentation.

S71. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (contains information relating to the financial or business affairs of any person (including the Council)).

S72. FOOD FOR PEOPLE IN CRISIS PARTNERSHIP

The Chairman presented a brief report on the 12 VCF organisations in the Food for People in Crisis Partnership providing a range of different services.

The report set out the food parcels and cooked meals provided by each during the months of October and November, 2012.

Discussion was now required on how to progress the work in the future to meet the predicted demand.

Resolved:- That consideration be given to establishing a Steering Group to take this issue forward.

S73. DATE OF NEXT MEETING/FREQUENCY OF MEETINGS

Agreed:- That further meetings of the Health and Wellbeing Board for 2013 be held on Wednesdays, commencing at 1.00 p.m. in the Rotherham Town Hall as follows:-

10th April
8th May
12th June
10th July
25th September
23rd October
27th November
18th December
22nd January, 2014 (9.30 a.m.)
19th February
26th March
30th April

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH SELECT COMMISSION

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**18th April, 2013**
3.	**Title:**	**Annual report of the Rotherham Heart Town project 2012**
4.	**Directorate:**	**Public Health**

5. Summary:

Rotherham Heart Town is a 5-year partnership project with the British Heart Foundation (BHF) to raise awareness of the risks of cardiovascular disease, improve access to prevention and care services, identify where BHF services can add value

The accompanying annual report outlines the activity undertaken by the partnership and its constituent partners during 2012.

6. Recommendations:

That the report be noted.

7. Proposals and Details:

During the first year of the partnership activities have included:

- Establishing a steering group
- Establishing a fundraising branch
- Holding a large stakeholder event held
- Attending events to promote the partnership, raise awareness and funds
- Establishing the Circle of Hope One Day event
- Running schools and health professional education workshops
- Delivering Olympic Legacy events at two schools

8. Finance:

N/A

9. Risks and Uncertainties:

It appears that the standard fundraising target set for all Heart Towns and Cities, regardless of size and deprivation, may not be quite achieved in year one.

Changes in the health service structure means we need to review membership to ensure the CCG is represented in the future.

10. Policy and Performance Agenda Implications:

The Heart Town Partnership supports the delivery of many key local authority programmes, including public health, sports development and healthy schools outcomes, as well as those of the NHS.

11. Background Papers and Consultation:

N/A

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Rotherham Heart Town
Annual Report 2012

Contents

Introduction

Heart Towns and Cities is an initiative launched by the British Heart Foundation during its 50th Anniversary year with the aim of establishing 50 Heart Towns and Cities across the UK. Rotherham became a Heart Town in January 2012.

Becoming a heart town puts an increased focus on cardiovascular disease, increasing awareness of risk factors and improving health and wellbeing of the community. The initiative aims to bring communities together through local fundraising and volunteering as well as raising awareness of heart disease and offering residents a range of support services including schools initiatives, workplace programmes and health and lifestyle information resources.

This report summarises the progress made during our first year as a Heart Town and plans for the future of the five-year partnership.

Cardiovascular health in Rotherham

People living in Rotherham have poorer health than the England average, and there are high levels of deprivation in the borough, with around one third of the population living in the most deprived 20% of areas in England. Early deaths from heart disease have fallen, but are still worse than average.

Recently published data shows that most electoral wards in Rotherham have a higher than average risk of cardiovascular deaths, with several ranking among the worst 10 percent for cardiovascular mortality risk.

Levels of overweight and obesity, smoking and binge drinking are all higher than average in Rotherham, and these lifestyle factors all increase the risk of experiencing a cardiovascular event.

People from certain ethnic groups have a greater risk of developing heart disease, with South Asian men developing heart disease at a younger age and being more likely to have a heart attack. About 3.5% of Rotherham's population is from the South Asian community, less than the proportion in England but higher than our statistical neighbours (Manufacturing Towns).

Establishing Rotherham as a Heart Town

Rotherham launched its 5-year partnership with BHF to become a Heart Town in January 2012 at Rotherham Town Hall.

In order for the partnership to be effective, a steering group and a local BHF fundraising branch needed to be established.

The steering group held its first meeting in February 2012 and has continued to meet monthly throughout 2012. It comprises representatives from the statutory, voluntary and private sectors with an interest in the prevention and treatment of heart disease. The committee is responsible for overseeing the delivery of the project and the achievement of its action plan.

The fundraising branch was developed from the existing local group in South Rotherham and held its first meeting in February 2012. The branch meets at Rotherham College of Arts and Technology and a number of students can be found among its highly committed members.

To ensure that we engaged a wider range of stakeholders from the public, private and voluntary sectors we held a launch event in June 2012. Over 40 people attended the event, where the aims and objectives of the partnership were outlined and people affected by heart disease gave personal

accounts to highlight why the work is so necessary. Delegates were asked to give specific pledges of how they will engage with the project, how they can use the BHF prevention and care products and services to enhance their work and how they will support fundraising and volunteering activity. We will continue to follow-up on these pledges throughout 2013 as well as to further extend our network of engaged stakeholders.

Defibrillator Campaign

Defibrillators (also known as automated external defibrillators or AEDs) are used to give electric shocks in some cases when the heart has stopped. For every minute that passes without defibrillation chances of survival decrease by 14 per cent. Research shows that applying a controlled shock within five minutes of collapse provides the best possible chances of survival. No specific training is required to use the defibrillators as the machine will not allow a shock to be delivered if there isn't a need for one, and emergency call handlers can talk somebody through what to do if they need further support. The importance of having defibrillators easily accessible in the community cannot be underestimated.

Yorkshire Ambulance Service (YAS), working with the Heart Town Partnership, is leading a piece of work to identify where existing defibrillators are located in Rotherham and to identify key gaps in the coverage across the borough. With the assistance of the Rotherham Advertiser a call was put out for all organisations and businesses with a defibrillator to notify YAS so a comprehensive map could be established. This enables YAS staff receiving an emergency call to identify whether there is a machine close by that can help save a life.

We have identified some gaps in the coverage and are now beginning a phased programme working to close those gaps. Support from BHF and regional trust funds may help to fund some new machines.

Prevention and care activities

BHF Health Care and Innovations

The BHF Health Care and Innovation Programme (HCI) is continuing to offer a BHF support package to one BHF fully funded (until June 2014) Community Resuscitation Development Officer (CRDO); he is employed by Yorkshire Ambulance Service (YAS) and seconded into the Community Resilience team for the duration of the funding. His role it to develop a network of BHF affiliated school and community Heartstart schemes.

This support package provides access to a variety of formal and informal learning activities that is appropriate to each individual Healthcare Practitioner. The courses supported are those that can demonstrate their value and impact on prevention of disease, patient care and service delivery. The package offers access to:

- BHF conferences and events
- Healthcare conferences (national and regional)
- BHF branded clothing, business cards and badges

- Access to BHF courses
- Introduction to the BHF
- Access to a members only website and resources
- Networking opportunities

The BHF is also providing a CPD package to six Cardiac Rehab Nurses, six Heart Failure Nurses and one Arrhythmia Nurse in Rotherham.

BHF Heartstart

The BHF has provided grants to fund the manikins, training and resources to 59 schemes in Rotherham over the previous years and continues to support an affiliation package, which includes free annual public liability insurance and educational resources to each of these schemes.

BHF Heartstart is an initiative which teaches people what to do in a life-threatening emergency. It will enable participants to put the skills into practice to help save lives. The course is designed to follow the current Resuscitation Council (UK) guidelines.

The Heartstart course is free, provides practical hands-on learning and includes:

- assessing an unconscious patient
- performing cardiopulmonary resuscitation (CPR)
- dealing with choking
- serious bleeding

The Heart Town Steering group is inviting expressions of interest from people in the community and schools to take up the roles of either Heartstart training supervisor and/or Scheme Directors, who already have the pre requisite skills to support the growing number of schemes in Rotherham. This will help to sustain the schemes and BHF investment in Rotherham.

BHF Health at Work

The Health at Work programme has been promoted widely in Rotherham including an editorial in the Chamber of Commerce think tank magazine, to help businesses and workplaces promote better health and wellbeing. It's completely free and provides a range of benefits including:

- a welcome pack, including a Quick Guide to Health at Work
- monthly Health at Work e-newsletter
- free resources on physical activity, healthy eating and mental wellbeing
- tools and posters to download from our Health at Work website
- an online community where members can learn more by sharing experiences, ideas and tips

BHF Skipping workshop

Nineteen teachers and other participants attended the BHF Skipping workshop which was delivered to familiarise teachers with a range of skipping techniques, useful in PE and in the playground. The BHF Jump Rope for Heart resource was shown as a way of schools receiving free skipping equipment,

as well as raising funds for the school and BHF. Staff left learning about new ideas to help develop skipping techniques, as well as raised their awareness to the range of free resources available from the BHF to enhance skipping and get children active.

BHF Healthy Hearts in the Classroom

Sixteen teachers and other participants attended the BHF Healthy Hearts in the Classroom workshop. It was delivered to raise awareness of what is available from the British Heart Foundation to help make health education lessons come alive. It demonstrated how a range of resources can be used to inject new ideas into school lessons. It explored how creative projects can be set for a series of weeks as well as individual lessons and shared ideas about how these can be used to introduce fun learning experiences.

The workshop ran through a school day (including lunch time and after school club) looking at different subjects, such as science, learning to read and PSHE, and the resources supplied by the BHF.

BHF Healthy Hearts in the Community Workshop

Two free BHF half-day workshops were delivered in November to introduce participants to the BHF Healthy Heart and Chest Pain toolkits. The toolkits have been developed to help tutors and trainers get heart health messages across to those who need them most.

The Healthy Hearts workshop delivered practical sessions to showcase a range of techniques to engage community groups in healthy eating, physical activities and in understanding about heart disease. The toolkits offer readily available materials for practitioners to use when developing their own training sessions and the main purpose of the workshop was to illustrate the benefits and features of this BMA award winning resource and how to make best use of it.

The Toolkit include activities on the following topics

• How the heart works • What coronary heart disease is • Recognising the Symptoms of coronary heart disease and heart attack • Saving Lives Skills • Know the Risk factors • Introduction to Heart screening • Making Lifestyle changes • Controlling blood pressure	• Increasing physical activity levels of the population • Dealing with stress • Stopping smoking • Workplace Challengers • Preventing diabetes • Healthy eating • Losing weight, and maintaining a healthy weight

The chest pain kit workshop also included practical demonstrations to help trainers deliver the sessions easily and effectively.

The chest pain kit aims to:

- raise awareness of heart attack signs and symptoms

- encourage people to phone 999 immediately if they experience these symptoms or see the signs in other people
- help people overcome barriers to calling 999
- Using the kit couldn't be simpler. Everything you need is in one place - we've even provided some session guides to help you plan your training. We've made sure it's flexible - you can follow our step-by-step guides, or use the kit in a way that suits your own style and audience.

29 participants attended both workshops including:

- Public Health Promoters
- Health Trainers & Community Champions
- Health Educators
- Resuscitation and defibrillator officers, community first responders
- Sports and Leisure services staff
- Health Care Assistants
- Medical Practitioners

BHF Olympic Legacy project

Two Rotherham Schools (Thrybergh School & Sports College and Thornhill Primary) were identified for the BHF National Centre for Physical Activity & Health (BHFNC) to receive an Olympic assembly as part of a BHF Olympic Legacy project. The BHFNC delivered the assembly along with Nicola White, who is an ambassador for the BHF Flames programme and a member of the GB women's bronze medal-winning hockey team.

Left: Team GB's Nicola White visits Thornhill Primary

Below: at Thrybergh School

Both pictures: Sarah Matson @ Photography by Sarah Jane on behalf of the British Heart Foundation

BHF Publications and exhibits

Free access to a wide range of publications, including information for the public on prevention of heart disease and for people who are diagnosed with a heart condition has been offered to Rotherham. We hosted a stand at a range of events including a Paramedic Conference, the Rotherham Show and a Protected Learning Time event for GP Practices where resources for the public were promoted.

Fundraising and volunteering

The local BHF branch has been prominent in Rotherham throughout 2012 raising funds for the Mending Broken Hearts Appeal and BHF core funds, which support BHF provision such as cardiac nurses and equipment and educational materials. Regular bucket collections and stalls at Rotherham Show and Fair's Fayre led up to the major fundraising event of the Heart Town Partnership's first year, the Circle of Hope, which took place during World Heart Week.

The Circle of Hope kicked off in Clifton Park with a sponsored fun run/jog/walk. The High Sherriff set the participants off on a 1, 2 or 3 lap circuit of the park. For those people who prefer their physical activity to be team based, Rotherham United Community Sports Trust provided some 5-a-side sessions on their inflatable football pitch, and for the younger supporters there was a treasure hunt. The focus then moved onto the Rotherham leisure centres, where DC Leisure had organised sponsored swim-a-thons and splash-a-thons, and to the town centre, where Mr Hearty thanked all the local businesses who had supported the event. Over £3,000 has been raised to date and funds from the event are still coming in.

In addition to these large scale events organised by the local branch, other partners arranged wear red days, organised bake sales and other smaller scale fundraising activities during National Heart Month in February. In addition to a branch bucket collection at Rotherham United Football Club, these activities raised £1000 for the campaign. Core funds were also boosted with £800 raised through a fashion show organised by the community heart failure unit.

The local branch is also the focus for volunteers supporting the BHF and the Heart Town project. The branch has established close links with Rotherham College of Arts and Technology (RCAT) and a number of students have volunteered to support a range of events throughout the year. The next focus will be to establish a volunteer to provide a specific link with schools across the borough to support their access to BHF services and encourage participation in fundraising activity.

The future

This first year has predominantly been about establishing structures, engaging stakeholders and promoting Rotherham as a Heart Town. During 2013 we need to build upon these foundations to ensure that Rotherham's place as a Heart Town is truly embedded in the local consciousness. We will continue to work with partner organisations to identify and share best practice in cardiovascular prevention and care, but also to close any gaps in current provision.

We will deliver a campaign focused upon chest pain and when to call for help, as we know that in Rotherham too many people, particularly women, are not seeking help as quickly as they should.

We particularly want to focus on the engagement of local businesses during year two, whether that be through accessing training and resources, signing up for the Health at Work initiative, or supporting volunteering and fundraising activities.

We will further develop the links between the Heart Town Partnership and other heart health related events, such as No Smoking Day.

Finally, we want to continue to support and nurture our volunteers, who have played such a key role in the development of the Heart Town Partnership.

Rotherham Heart Town steering group members

During 2012 the following people were members of the Rotherham Heart Town steering group

- Cllr Ken Wyatt (Joint Chair)
- David Thomas (BHF branch member and Joint Chair)
- June Thomas (BHF branch chair)
- Joanne Ward (BHF patient representative)
- Dr John Radford, Rotherham Public Health
- Alison Iliff, Rotherham Public Health
- Malcolm Chiddey, Rotherham Public Health
- Fiona Topliss, NHS Rotherham
- Stephanie Dilnot, BHF
- Lauren Mallinson, BHF
- Cllr Christine Beaumont, RMBC
- Kay Denton Tarn, RMBC
- Chris Siddall, RMBC
- David Barker, RMBC
- Laura Brown, RMBC
- Michelle Tyler, RFT
- Katie Taylor, RFT
- Sarah Briggs, RFT
- David Smith, Yorkshire Ambulance Service NHS Trust
- Ian Cooke, Yorkshire Ambulance Service NHS Trust
- Emma Scott, Yorkshire Ambulance Service NHS Trust
- Alex Wilson, Rotherham United Community Sports Trust
- Claire Shaw, Groundwork Dearne Valley
- Dominic Beck, Barnsley and Rotherham Chamber of Commerce
- Julie Adamson, Voluntary Action Rotherham
- Nizz Sabir, Rotherham Council of Mosques
- Lisa Williams, DC Leisure
- Natalie Dunn, DC Leisure

Thank you

The Heart Town partnership would like to extend particular thanks to the following businesses and individuals for their support of the initiative during its first year:

- June and David Thomas and all the members of the Rotherham Fundraising Branch
- Brinsworth Academy of Engineering
- Rotherham Advertiser
- DC Leisure
- Tata Steel
- and all local businesses that have supported Heart Town fundraising activities

Appendix 1: Heart Town Agreement

HEART TOWN COMMUNITY PLEDGE

We agree to become a Heart Town for a period of five years (undertaking a yearly review), partnering the British Heart Foundation (BHF) to achieve shared goals which will enhance the Heart Town and stimulate wider community engagement in the fight against heart disease.

The BHF will provide the Heart Town with access to resources such as:

- **Heart Matters Magazine** – a free personalised membership club for anyone concerned about or affected by heart disease
- **Schools programmes and initiatives** – including Jump Rope, Dodgeball, Arties Olympics and an extensive range of materials tailored to the curriculum
- **The Artie Beat Club** – a free membership club for children
- **Health at Work initiative** – a range of packs for employers and workplaces focussing on Be Active, Eat Well, Think Well
- **Lifestyle and heart information** – a wide range of healthy lifestyle and health information booklets and resources

The BHF will nominate a representative to lead the Heart Town partnership together with town representatives.

The Heart Town will

- Adopt Heart Town Branding
- Create a **'HEART TOWN RIDE/WALK/RUN'** in the centre of town
- Support BHF work in schools, businesses and the community
- Support BHF fundraising and volunteering initiatives, including:
- **One Day** – unite the town for one day to fundraise for Mending Broken Hearts

and support our existing campaigns in the town:

- Red for Heart – be part of our major campaign in February for National Heart Month
- Hand on Heart – help nurture a community of volunteers in your town, with a special focus in June
- The BIG Donation – encourage the community to recycle and donate to our BHF shops in September

Heart Town name.....

Signed for Heart Town	**Signed for BHF**
Designation	**Designation**
DATE:	**DATE:**

Appendix 2: activities undertaken for the Heart Town partnership

- Steering group and local BHF fundraising branch established
- Web pages established on NHS Rotherham and RMBC websites
- Rotherham Heart Town logo developed
- Stakeholder event held
- Defibrillators mapped and action plan developed to close gaps in coverage
- Healthy Hearts Kit and Chest Pain Kit workshops delivered
- Skipping workshop and Healthy Hearts in the Classroom workshops delivered
- Olympic Legacy event at two Rotherham schools
- Regular promotional articles published in the Rotherham Advertiser
- Partnership promoted in RMBC Active Always brochure and at Mega Active events, in all Healthy Schools newsletters, in the Barnsley and Rotherham Chamber of Commerce newsletter *Think Tank* and DC Leisure newsletter

Heart Town partnership stands at:

- Rotherham Show
- Paramedic Conference
- Fair's Fayre
- Active Always event
- Primary Care Protected Learning Time

Fundraising activity:

- Circle of Hope – sponsored walk, splash-a-thons, swim-a-thons, 5-a-side football, treasure hunt and bucket collections
- Community Heart Failure Unit Fashion Show
- Cake Tombola at Fair's Fayre
- Fundraising raffle
- Bucket collection at Rotherham United during National Heart Month
- Partners held smaller fundraising events for National Heart Month, including wear red days, bake sales and coffee mornings

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**18th March 2013**
3.	**Title:**	**Discharge Arrangements from Hospital**
4.	**Directorate:**	**Rotherham NHS Foundation Trust**

5. Background Summary

5.1 The Rotherham NHS Foundation Trust has on average 70,000 patients admitted to the hospital per year. Whilst 38,000 patients are admitted for a planned elective procedure, 32,000 are admitted as an emergency.

5.2 The number of emergency admissions continues to rise year on year, and this year there is to date a 7.6% increase in emergency admissions this year compared to last year.

5.3 In addition, there is a significant increase in the number of frail elderly people being admitted to hospital. This patient group is very vulnerable and often have very complex care needs, which require very complex discharge planning arrangements.

5.4. It is also acknowledged that Rotherham as a health and social care community admits more patients with long-term conditions over and above the national averages and at any given time has patients in acute hospital beds that do not necessarily require that acute level of care.

5.5 Rotherham NHS Foundation Trust has and continues to work in close collaboration with partner agencies to explore and provide alternatives to admission to hospital and a number of new initiatives have been developed over recent years to provide alternatives to hospital admission i.e. Breathing Space, Intermediate Care, Community Hospital beds.

5.6 Due to the pressure and demand on hospital beds and the need to be able to accommodate the admission of acutely ill patients, it is important that the hospital can expedite discharge where the patient no longer needs to be in hospital.

5.7 Whilst it is important to discharge patients in a timely way, it is equally important that discharge is safe and that patients who have complex discharge needs have those needs carefully planned for and executed.

5.8 As a result, Rotherham NHS Foundation Trust has a comprehensive and detailed Discharge Policy (attached).

5.9 This Discharge Policy has recently been systematically reviewed and the current version is in its final draft format, having been consulted upon.

6. Reasons for Delayed Discharges

6.1 There will always be some patients who experience a delay to their discharge for a number of reasons:

- A complex home care package of support is required
- Equipment to support discharge is required
- Patient choice for those patients requiring 24- hour residential or nursing care
- Housing adaptations are required
- Re-housing is required
- Complex family dynamics
- Financial complexities

6.2 The Delayed Discharge Act clearly defines the criteria for reportable delayed discharges and Rotherham NHS Foundation Trust, working closely with RMBC Social Services, has a low rate of reportable delayed discharges. This is a reflection of the collaborative approach taken.

6.3 However, there are patients where this delay is not reportable, but is still a delay i.e. patients undergoing complex assessments.

6.4 All patients are entitled to have their ongoing needs assessed against Continuing Health criteria for Continuing Health Funding. This process can be lengthy and complex and the documentation associated with this process can be time-consuming and resource intensive.

6.5 Occasionally there can be a dispute between agencies, families, and healthcare providers in terms of what is required to facilitate a safe and appropriate discharge. This dispute process, whilst always resolved eventually, can add delays into the discharge process.

6.6 The attached Discharge Policy pulls together all of these potential complex issues, in order to ensure that any discharge or transfer of care is safe and effective, whilst keeping the patient/family needs at the centre of the decision-making process.

7. Conclusion and Recommendations

7.1 This report to view the discharge arrangements of Rotherham NHS Foundation Trust was requested, in order to provide reassurance to Rotherham Borough Council Members of the hospital's commitment to safe and timely discharge.

7.2 The attached comprehensive policy demonstrates the hospital's acknowledgement of the need to ensure that discharge is well planned,

adheres to legislation, takes a collaborative approach with partner agencies, and most importantly meets the needs of the patient and their family.

7.3 There will always be room for improvement in terms of greater co-ordination between partner and voluntary organisations for those patients with very complex needs.

7.4 The attached revised version of the policy is in a final draft format and is about to go through the RFT policy ratification process and, therefore, should members have comments or suggestions that they would wish to make, these would be welcomed.

8. Policy/Papers/Attachments

8.1 Rotherham NHS Foundation Trust Discharge Policy attached

Should there be any questions in relation to this summary report or the attached policy document, please contact:

Maxine Dennis, Interim Director of Patient and Service Utilisation. Ext 4486 or 01709 424486. E-mail Maxine.dennis@rothgen.nhs.uk

The Rotherham NHS
NHS Foundation Trust

Ref No: 32

DISCHARGE POLICY AND PROCEDURES

SECTION 1
PROCEDURAL INFORMATION

Version:	4d
Ratified by:	Trust Document Ratification Group
Date ratified:	
Title of originator/author:	Lead Nurse Care Management Team
Title of responsible committee/individual:	Lead Nurse Care Management Team Patient Safety Committee
Date issued:	
Review date:	
Target audience:	Trust Wide

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Document History Summary

Version	Date	Author	Status	Comment
1	October 2007	Claire Robinson	Ratified	
2	November 2009	Claire Newey	Ratified	Trust Ratification Group
3	October 2011	Patient Safety Lead Community Group Nurse	Ratified	Amended to reflect new structure and responsibilities
4a	February 2012	Claire Newey	Draft	
4b	April 2012	Claire Newey	Draft	
4c	October 2012	Claire Newey	Draft	Sent for consultation
4d	February 2013	Claire Newey	Draft	Comments incorporated from consultation process.

Section 1 Contents

Section 1 Appendices

Section 2 Contents

Section 2 Appendices

1. INTRODUCTION

The policy is designed to ensure that every patient discharged from the care of The Rotherham NHS Foundation Trust is discharged safely to the community with appropriate arrangements made for their continuing care, involving all the appropriate agencies at the correct stage.

2. PURPOSE & SCOPE

2.1 Purpose

The purpose of this policy is to ensure that the discharge process is patient focussed, and that relevant staff are aware of their responsibilities with regards to the discharge of patients.

2.2 Scope

The policy covers the discharge arrangements and documentation requirements for the following patient groups;

- Adults
- Children / Babies
- Another healthcare provider/community services
- Nursing/Residential homes
- With medicine/equipment
- Patients admitted for planned procedures and discharged on the same day.
- Patients admitted for investigation/treatment and discharged on the same day.

Special requirements for certain patient groups are contained within Appendix 1.

3. ROLES & RESPONSIBILITIES

Role	Responsibilities
Chief Executive	The Chief Executive is responsible for supporting this policy operationally and financially, in order to fulfil the purpose of this policy.
Chief Nurse	The Chief Nurse is responsible for ensuring that this policy is implemented into all parts of the Trust and for ensuring that the policy is reviewed and updated by the specified review dates.
Lead Nurse Care Management Team	Responsible to the Service Director. Responsible for the support of Matrons and Ward Managers in the Implementation, monitoring and auditing of the policy to ensure best practice.
Matrons/Lead Nurses	Matrons/Lead Nurses are responsible for

	ensuring that there are adequate resources, both staff and otherwise, to ensure this policy is adhered to, and for supporting their teams with the familiarisation of this policy and with any training that may be required.
Medical Staff	Responsible to the Chief Medical Officer, for ensuring compliance with this Policy, within their CSU/FU.
Nursing Staff	The named nurse or designated other (as recorded in the patients nursing notes) will act as the coordinator for all discharge arrangements.
Nursing staff on children's wards	The nurse will act as co-ordinator of all discharge arrangements, with responsibility for assessing, planning and liaising with patient, family, members of the MDT team and all other relevant agencies.
Moving and Handling Specialist	Where there are difficult or complex moving and handling issues the Moving and Handling team will support staff and offer advice regarding equipment and techniques. This will be in conjunction with the multi-disciplinary team. The Moving and Handling team can facilitate the communication with, and the sharing of relevant information with receiving health and social care providers on discharge.
Hospital Based Social Work Team	It is the responsibility of the Social Work Team Manager to ensure an assessment by the appropriate Social Worker/Social Services Officer is undertaken and completed in conjunction with the other members of the multi-disciplinary team and an appropriate discharge plan agreed, in accordance with the procedures and statutory time frame identified in the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy
All Staff	Every employee of the Trust involved in the transfer of patients, are responsible for ensuring that they have read, understood and are working in accordance with this policy.
Patient Safety Committee	Are responsible for monitoring this policy and escalating issues as appropriate.

4. PROCEDURAL INFORMATION

4.1.1 Initial Activities

Inpatients

Within 24hours of admission the registered nurse will gather detailed information regarding the patient's social circumstances, activities of daily living, packages of care and Allied Professionals input. This is documented within the health records discharge page. This information is communicated to all members of the multi-disciplinary team as required.

Preparing for discharge begins on admission by the admitting registered nurse. As soon as possible following admission the consultant or their deputy should discuss with the patient and /or family/carer/advocate, the likely outcome and length of stay, including giving a predicted discharge date that the patient is likely to be ready for leaving hospital. For patients being admitted as part of a planned process, wherever possible discharge planning will commence as part of a pre-admissions process.

A copy of Leaving Hospital Information Booklet should be given to the patient upon admission or pre-admission and completed throughout the patients' journey.

Where appropriate, and as part of an MDT assessment process, refer the patient for specialist assessments and treatment by other members of the multi-disciplinary team.

In cases of patients with mental health needs or dementia, medical staff may need to refer to the Mental Health Team to be involved in the discharge process.

Where it is suspected or known that patient has an infection please refer to the Policy for the Admission, Transfer and Discharge of Infected Patients.

4.2 During Patients Stay

4.2.1 Preparing for Discharge

On admission the registered nurse must:

- Discuss all aspects of discharge with the patient, family, relatives or carers as appropriate and with relevant consent.
- Record all information of actions, referrals and discussions in the health records.
- Access the services of an interpreter if required.
- Give the patient a Leaving Hospital leaflet.
- Advise patients of their overall treatment plan, and a description of what the milestones and criteria for safe discharge will be.
- Ascertain whether transport is required and what transport most suits the patients' needs. This must done utilising the Transport Criteria Form. A transport form will be completed and sent to the Care Management Team to be booked. Please refer to section 4.5.

- Inform the patient and relatives, carers or Nursing/Residential/IMC home of the date of discharge.
- Complete and send an assessment notification (a Section 2) to Social Services, OT and Physiotherapy where applicable. Followed when appropriate with a section 5.
- Liaise with external agencies where applicable e.g. Community Rehabilitation Team, Community Matrons.
- Ensure that the patient has appropriate clothing and footwear for discharge and weather conditions, and have the means in which to access their discharge address.
- Arrange a case conference (for complex discharges) involving all appropriate members of the MDT including patients and families/ carers/ advocates and community staff. A time and date for the case conference should be arranged within 48 hours of recognition of a need for the same.
- For enquiries relating to mattresses and cushions please contact the Tissue Viability Service.
- Complete a pressure relieving equipment form (Appendix 8) and fax to Pressure Relieving Equipment Co-ordinator on 3225
- For equipment REWS require 7 working days' notice so early requests are required.
- Fast track patients requiring equipment MUST be identified /highlighted on the form that it is a request for equipment relating to a fast track.
- For information regarding when equipment will be delivered the wards need to contact Rotherham Equipment Wheelchair Service (REWS) (3250) for delivery dates.
- Ascertain whether a waste collection is required and if so confirm with the Borough Council or District Nurse the type of collection required, so that appropriate arrangements can be made. Community waste collections by the Borough Council will automatically default to an 'Offensive' waste stream i.e. that waste that is not known or believed to be infectious/hazardous.
- Follow the local policy if additional equipment for use at home is required e.g. bedpans, bottles, traction equipment.
- All patients who are admitted to the Rotherham NHS Foundation Trust should expect to have discharge planning commenced within 24 hours of being admitted.

Medical staff must:

- Identify a predicted date of discharge.
- Provide a comprehensive medical management plan and clearly document this in the patient's health records.

4.2.2 Management of medicines Pre discharge

Medicines for patients to take home must be prescribed as soon as possible prior to discharge, giving a minimum of 24 hours notice in advance of the proposed time and date of discharge. If a District Nurse is required to administer these medications a signed notification by the medical staff is required.

It is anticipated that the discharge process will plan so that all prescriptions can be dispensed within the normal pharmacy opening times.

- **Process for Multi Dose Systems (MDS) dispensing via LloydsPharmacy**

  - MDS items (and any other TTO items for the same patient) are to be prescribed on a LloydsPharmacy prescription pad. The pads will be provided to wards by TRFT pharmacy. More than one sheet can be used if required.
  - Please allow for a 24 hour turnaround on MDS as these items are time consuming to produce
  - Prescription passed by ward to TRFT pharmacy clinical team.
  - TRFT clinical team clinically check the prescription, check MDS criteria has been met, check date and time of discharge and whether home delivery will be needed.
  - TRFT clinical team pass the prescription and delivery instructions to Lloyds.
  - Lloyds dispense. If for home delivery, Lloyds deliver home as per delivery instructions. If not for home delivery, Lloyds inform TRFT wards that MDS is complete.
  - Lloyds staff send completed MDS to dispensary where they will be placed in relevant wards pigeon hole in TRFT dispensary.
  - Ward staff collect from pigeon hole.

4.3 Patient wishing to leave against medical advice

If a patient wishes to take his/her own discharge, medical staff must be informed by nursing staff caring for the patient and appropriate action taken by both the medical and nursing staff to ensure the patient has the relevant information to make an informed decision.

The nurse in charge of the ward or the member of medical staff who has seen the patient, must ask the patient to sign a self-discharge form and a copy retained in the patients' medical notes. Full details must be documented in the medical and nursing records, dated and signed. If the patient will not sign, this must be clearly documented in the patients' notes.

If appropriate the patient must be provided with medication, dressings and equipment that they require, by the ward nursing staff.

Complete a Datix of the incident.

Usual measures will be taken to inform community services and the patients GP by telephone or letter.

In the event that it is suspected a patient may lack capacity to make an informed decision, consideration must be given to the need for a capacity assessment to be undertaken. In the case of a patient who is showing clear evidence that they may lack capacity, and who is refusing to remain on the ward to wait for an assessment by the mental health team a decision will need to be made as to whether or not the patient meets the criteria for detention under a section 5/2 of the 1983 Mental Health Act.

In hours inform the relevant Matron covering that area.
Out of hours inform the 221 bleep holder of any concerns and any plan of action that has been instigated.

Complete a Datix of the incident.

In the event of the patient taking a self discharge whilst on a home visit, the Nurse caring for the patient must refer to: Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge.

4.4 Day of Discharge

4.4.1 Patients who are admitted and spend more than 24 hours within the Trust:

The Registered Nurse must:

- Inform the Patient Flow Support Worker of pending and actual discharges for the day.
- For patients being referred to District Nurse on discharge, referrals must be sent via the Strata referral pathway. At weekends and bank holidays referrals to District Nurses must be made via Yorkshire Ambulance Service, who will forward information to District Nurse team. NB. Community staff do not have access to health centres at weekends and Bank holidays. For patients who require first District Nurse visit from the evening or night service - referral Information must be faxed direct to 01709 336787.
- Ensure that transport is in place and arrangements for access visit is made if applicable.
- The nurse coordinating the patients discharge must liaise with the MDT regarding appliances and/or equipment that require transportation to the patient's discharge destination.

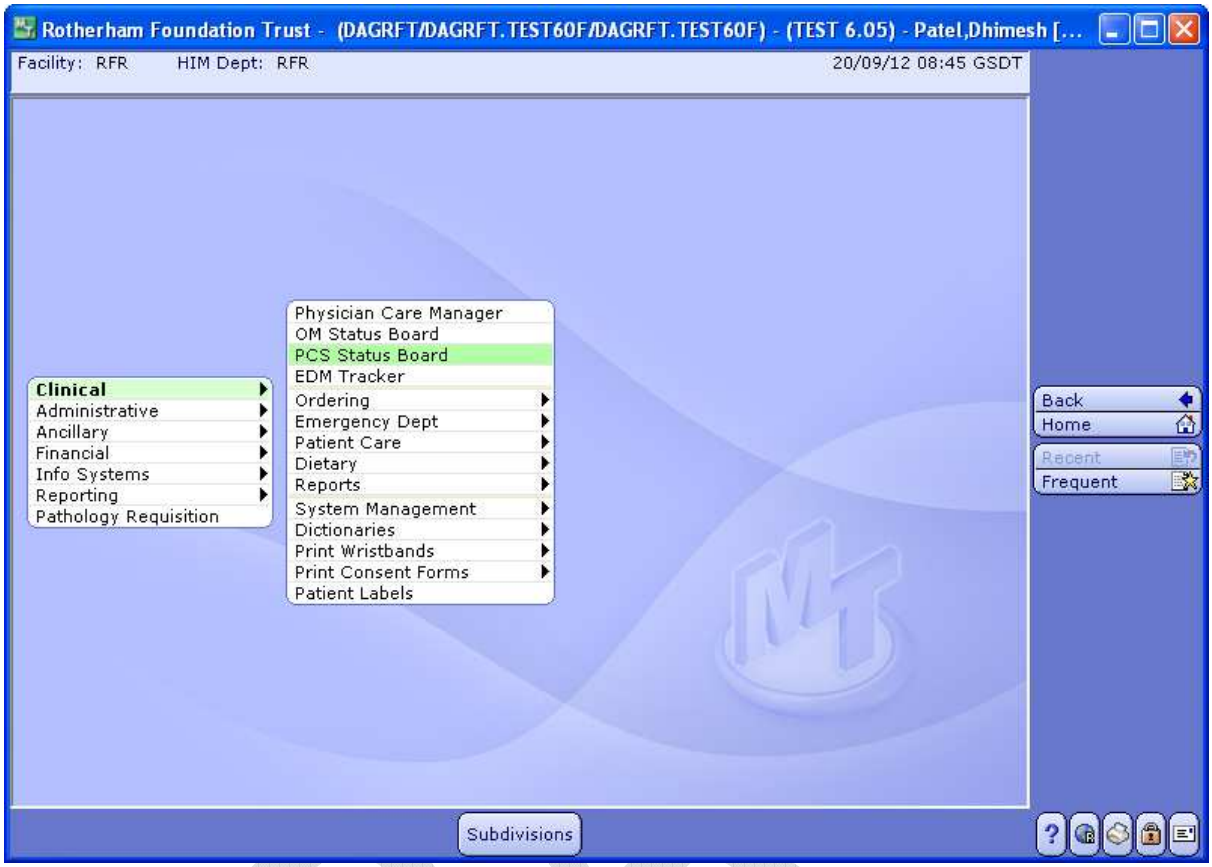
- Check that the discharge arrangements are complete and that the discharge care plan is complete on discharge.
- Confirm the discharge address and ensure basic provisions and amenities are available.
- Confirm with the patient and relatives, carers or Nursing/Residential/IMC home that the discharge is taking place.
- Provide the patient with the a computer generated discharge summary which includes reason for admission, treatment given, TTO's dispensed and any follow up appointments required.
- Give any condition specific information leaflets to the patient and carer/ family/ advocate and discuss these prior to the patients discharge.
- Document the discharge and discussions in the patient's health records.
- Provide education to the patient and relatives /carers regarding take home medications. Sufficient dressings are provided for a minimum of 48 hours and longer if discharge occurs at weekends and bank holidays.
- Ensure that continence products are supplied.
- Ensure that all elements of the discharge letter is completed prior to discharge.
- Ensure that the discharge summary is available and sent to the patient's general practitioner.
- Provide the patients sickness notification for up to 1 week if applicable. The type of sickness notification and the period of time given are to be recorded in the discharge summary letter at all times (if sickness notification is not given this should also be recorded).

Medical staff must:

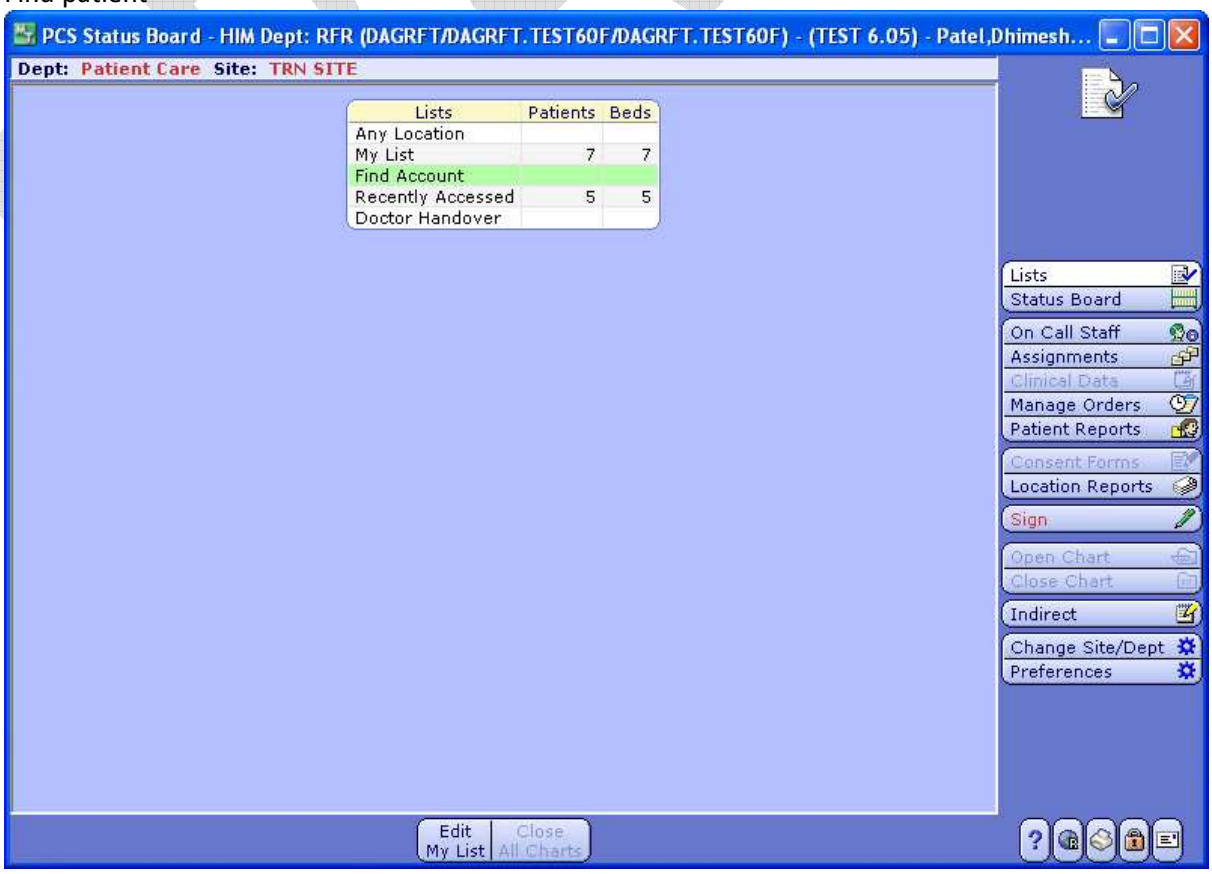
- Ensure the medical element of the discharge plan and discharge letter is completed in a timely manner.
- Forward a copy of the discharge letter to the relevant MDT members within two working days of discharge.
- Provide statement of fitness to work, if more than one week away from work is required.
- The ward must discharge the patient from the bed board as soon as the patient leaves the ward.

How to discharge patients from Meditech

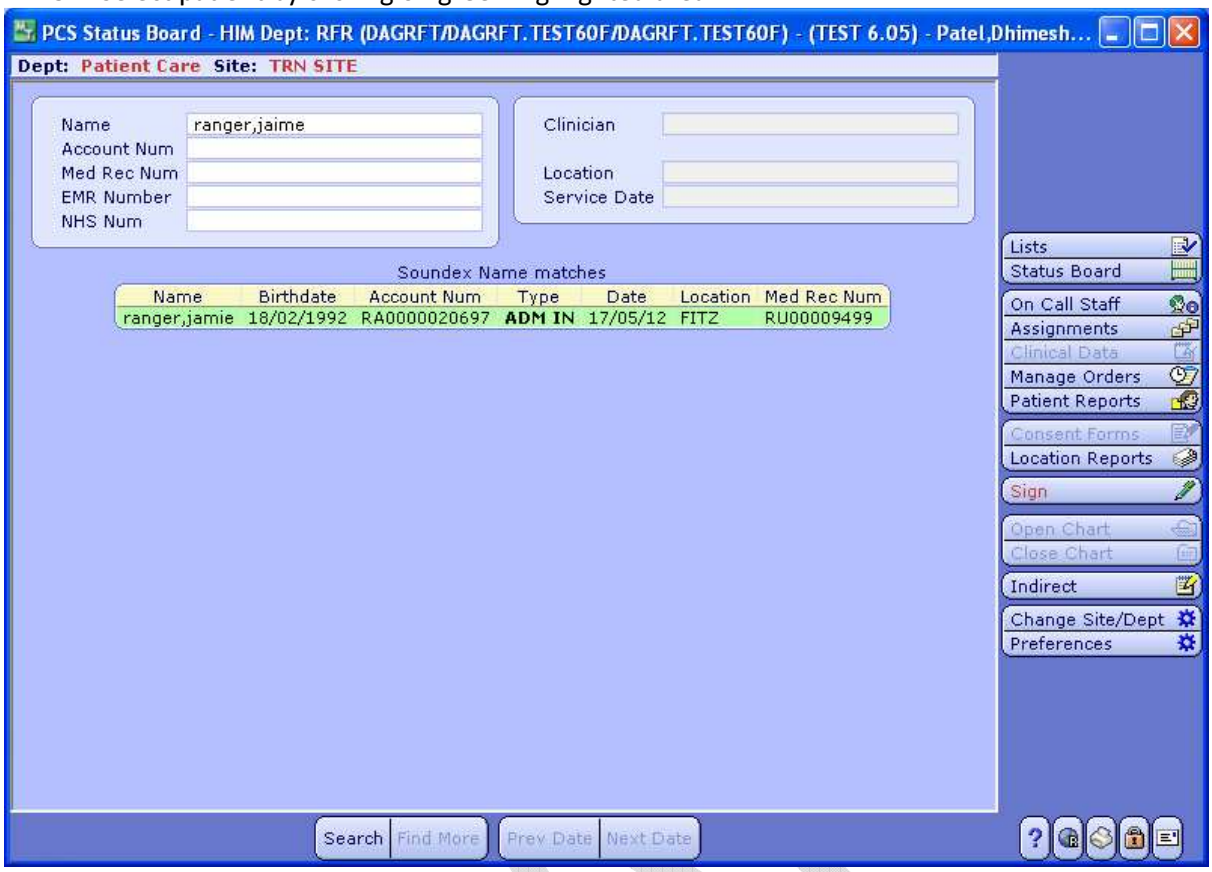
1. Clinical - PCS



2. Find patient

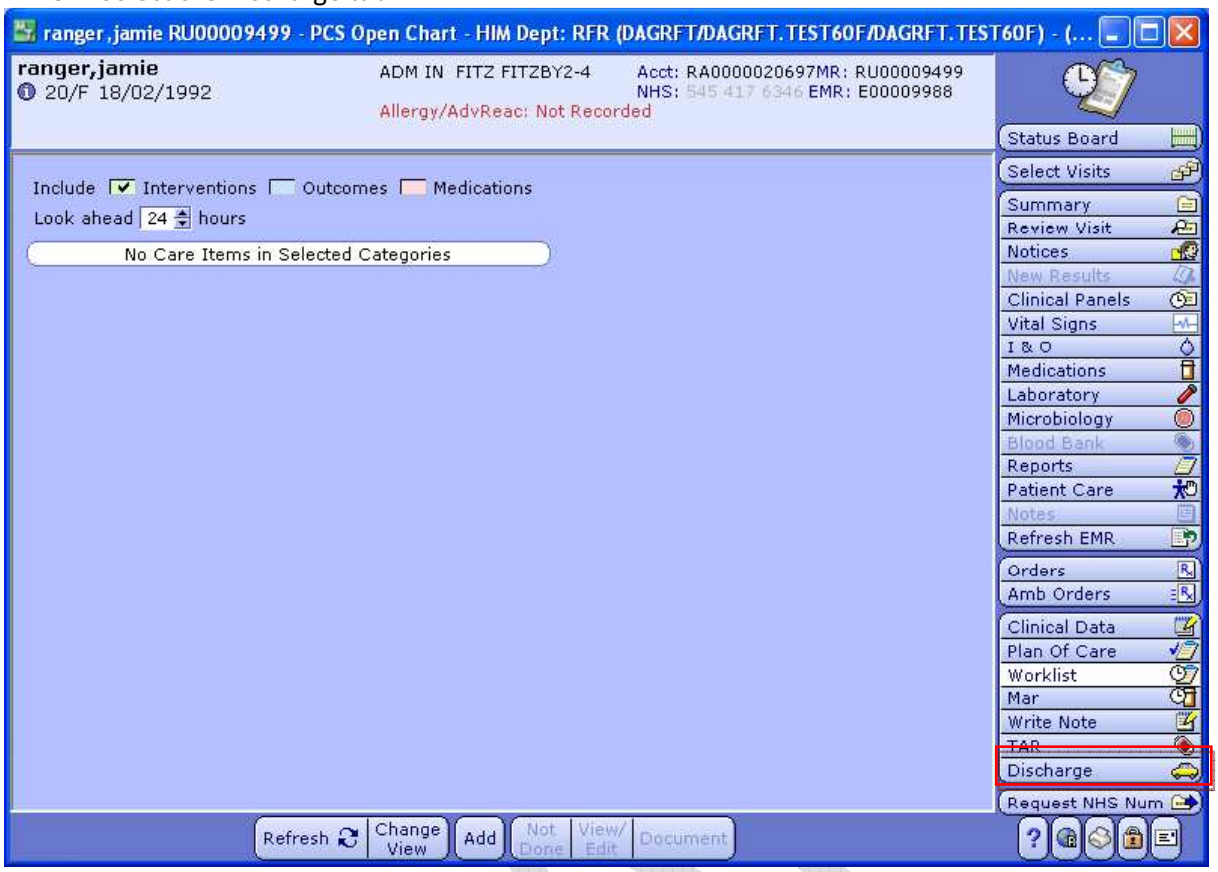


3. Select patient by clicking on green highlighted area

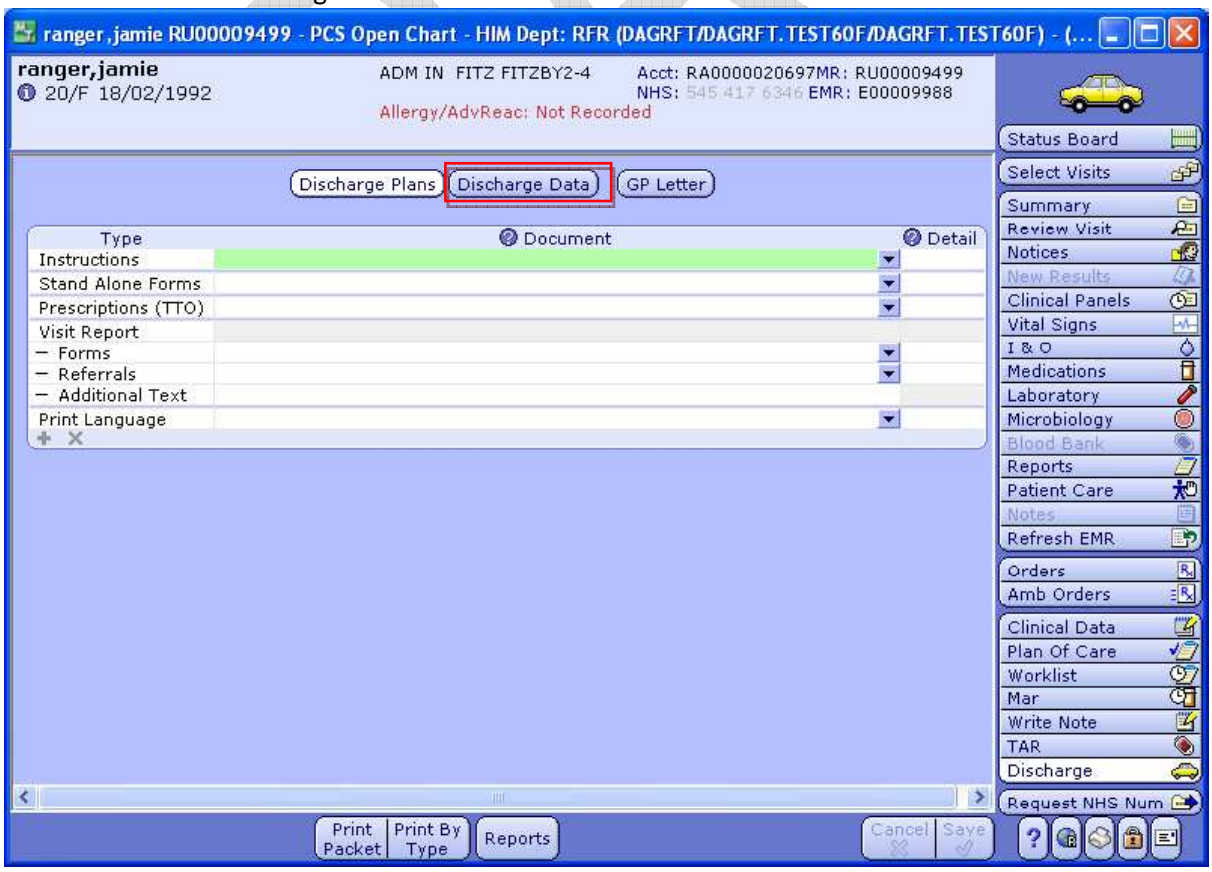


4. Open Chart (either by clicking left if name or Open Chart)

5. Select the Discharge tab

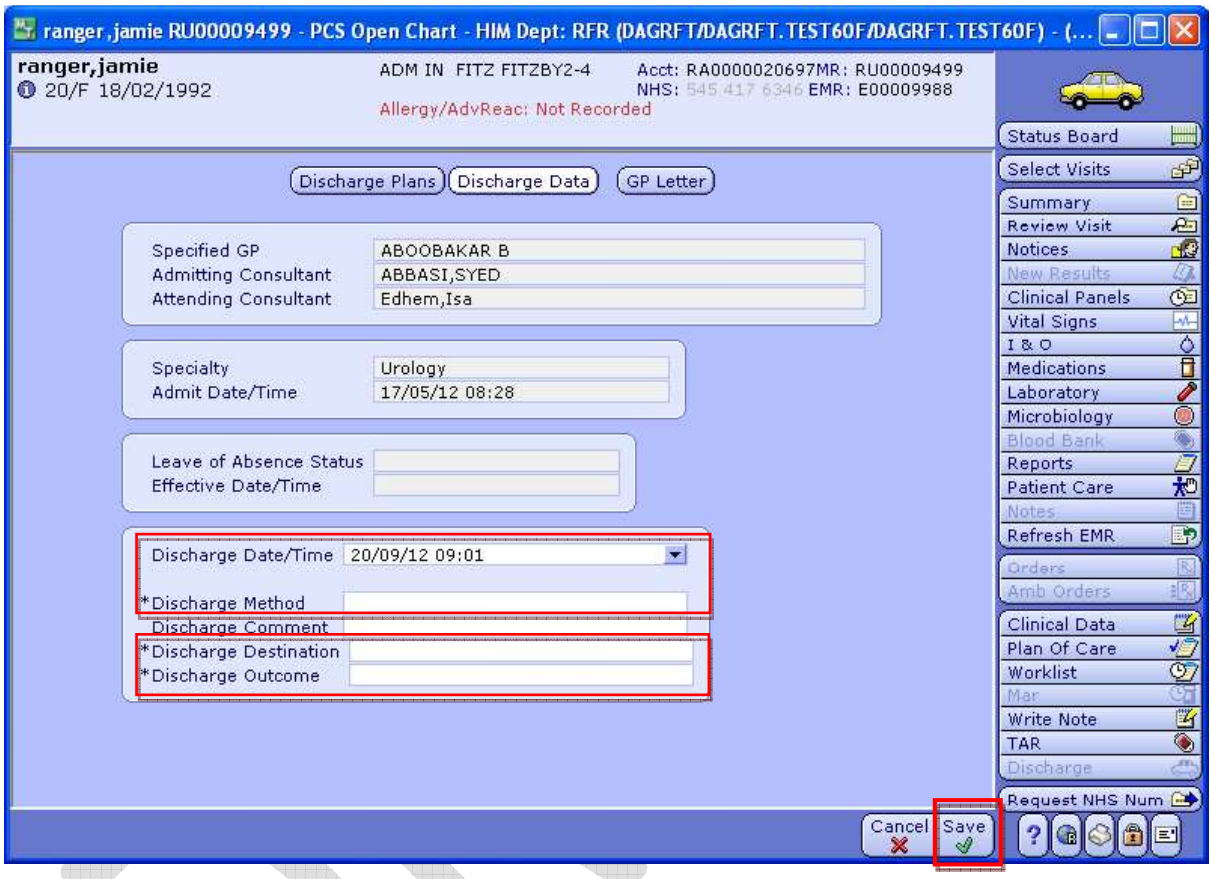


6. Select the Discharge Data tab



7. Enter data into the four fields
   NB. For *Discharge Outcome choose one of 3 options:
   - Exit – Diagnostic Admission
   - Exit – No Treatment Given
   - Exit – Treatment Admission

Then click Save



- The **ward must not** move the patient within the ward to the 'Sent on Leave' beds or chairs and discharge them from there once the discharge process has been complete

- **How to complete the discharge letter after the patient has been discharged-** access the correct patient's account (which will be in DIS IN status) and check that the TTO medications and IP Discharge Summary (Doctor) have been completed by the doctor first and is in signed status. **Only then** should the registered nurse open the IP Discharge GP letter **(retro)** which will pull in data from the doctor's letter.

- **For more training support please refer to the training packages found on the Intranet.**

4.4.2 Patients Admitted and Discharged within 24 hours

Patients are given a copy of their 24 hour discharge summary and any new medications required with instructions for use as per Trust policy. Outpatient's appointment cards will also be given on discharge if required. A copy of the discharge summary will be sent to the GP.

4.4.3 Medicine supplies on Discharge

Medicines will only be dispensed or issued for discharge against a valid prescription written by a prescriber employed by the Trust. Written information must be given indicating medication prescribed, dosage, route and timing. Medical staff must ensure the time of PRN or specifically timed drugs are indicated on the discharge summary.

MDS' (NOMAD's) will require 24 hours turnaround. (See 4.2.2)

A 28 day supply will normally be dispensed for long term medicines. Analgesics will be supplied as a single pack unless intended for long term use and drugs such as antibiotics or steroids will be provided for the length of any course intended.

Those wards undertaking medicines management services may have their inpatients provided with original packs of medicines labelled in a manner suitable for discharge. These medicines will be assessed by a member of the pharmacy staff for suitability and accuracy and be issued as part of the discharge process.

All medicines issued on discharge will be accurately and appropriately labelled with full instructions for patients/carers to use. Under no circumstances will medicines that are not labelled be given to patients.

The nurse designated to care for the patient must obtain medication, (including any food/fluid thickeners or dietary supplements) and dressings prior to discharge.

The Registered Nurse must ensure that all take home medications are discussed with the patient and/or carer including times, doses and side effects.

Good practice dictates that medications are given to the patient upon discharge. When this is not possible contact the Care Management Team to discuss the use of the discharge crew to deliver the medications and only in exceptional circumstances should a taxi be used.

For more information please refer to The Trust's Medicines Management Policy.

4.4.4 Out of Hours Discharge

Where discharge cannot be facilitated prior to 9pm, the 221 must be notified for authorisation for the discharge to occur.

Particular care must be taken when discharging patients in the evening, at weekends or bank holidays and inclement weather as services they require may be difficult to organise. Therefore pre-planning for weekend and bank holiday discharges is essential to ensure the safety of the patient.

Ensure that all the relevant information/appointments is given to the patient prior to discharge.

The Registered Nurse documents all interactions/outcomes in the patient's health records.

4.4.5 Day-Case patients

All patients scheduled via the elective surgical pathway will have a pre-operative assessment prior to their admission for surgery. Patients will be issued the 'You and Your Anaesthetic' booklet to advise them of the precautions to be taken before and after anaesthetic, and this must be documented in the patients notes.

- **For Surgical Day Cases:**
    - Patients who meet the day surgery guidelines will be discharged via the nurse led discharge protocol following the written/verbal instructions given by the surgeon/anaesthetist in the operation notes/ward round.
    - Any patient who does not meet the day surgery guidelines pre-operatively must be reviewed by a Surgeon or Anaesthetist prior to discharge with a written instruction given that they are fit for discharge.
    - Nurses will complete the discharge documentation within the DSC Care Plan and issue a discharge letter to the patient containing all pertinent discharge and follow up information as instructed by the Surgeon and any other Clinical Colleagues..
    - If patients do not meet the nurse led discharge criteria and is deemed fit for discharge this must be documented by the attending Doctor within the patient's notes.
    - If patients are not fit for same day discharge then a request is to be made to the Patient Flow Team for an inpatient bed. A transfer document accompanies the patient to the ward and a copy of this is retained by DSC. This can be initiated by the nurse or doctor.

- Patients transferred to an inpatient ward must be transferred with all discharge documentation, appointments, prescribed TTO's and any necessary dressings.
- A contact number for in and out of hours must be given to the patient, in case they have any concerns or queries after discharge by the nurse coordinating the patients' discharge.
- Discharge information should be given to the patient with an accompanying responsible adult, who has private transport to take the patient home.

A record of patients discharge letter is to be placed in the patient notes. A copy of the discharge letter is to be forwarded to the patients GP from DSc Reception

For Medical Day Cases:

- Nurses complete discharge documentation within the patients Nursing Records.
- Medical notes of discharged patients remain in the ward clerk office until a discharge letter is completed. The discharge letter is forwarded to the patients GP.

4.4.6 Patients refusing to leave a hospital bed

Patients do not have the right to occupy a hospital bed when they have been assessed as no longer requiring acute inpatient care, and appropriate discharge Package of Care/Equipment is either identified or is actually in place.

If a patient refuses to leave hospital on the planned date of discharge, then the nurse coordinating discharge must contact the Site 221 bleep holder out of hours and the Matron or Business and Service Manager in hours, who will take appropriate action.

4.5 Booking Transport for Patients

Eligibility is based upon clinical and not social care needs, the aim being to ensure non-urgent Patient Transport Services are patient focused by being more responsive to patient and service needs, whilst improving the efficiency and effecting cost improvements.

Where appropriate the named nurse or designated other will encourage patients to make their own arrangements. Advice on suitable forms of transport may be required.

Where patients or carers family/carers/Next of Kin request transport home, it is the responsibility of all Rotherham NHS Foundation Trust staff to advise the patient that an assessment will need to be made utlising specific criteria, to assess eligibility for transport, and clearly document this in the patient's

notes. A patient's eligibility/ requirements for transport must be assessed by a Health Care professional. Appendix 4 Ascertaining Eligibility for Patient Transport Services (PTS)

For patient's assessed as needing transport home whether from wards or Outpatient departments, the Named Nurse or designated other holds the responsibility for ensuring that the request is made.

From 08:00 – 21:00 hours Monday – Friday

Complete a patient transport request form (found on all wards or an electronic copy can be obtained from the Care Management Team 4373), taking the form to the Care Management Team Office A1/A2 to make a request.

For Outpatients contact 7323 with patient details and type of transport requested.

From 10:00 – 19:00 hours Saturday / Sunday and Bank Holidays

Complete a patient transport request form (found on all wards or an electronic copy can be obtained from the Care Management Team), taking the form to the Care Management Team Office A1/A2 to make a request.

Any patient that is on the Liverpool Care Pathway will be booked to travel alone unless an escort or family member is required. If so please make sure that this is communicated when booking transport to ensure that appropriate provisions are made.

Please note: Any patient that is to be discharged after 9pm needs to be in discussion with and authorisation for discharge obtained from the 221 bleep holder.

Patient's luggage will be taken i.e. 1 bag and 1 frame with the patient (frames need to be booked on the transport at time of request. Any excess luggage will need to be taken by other means, which must be arranged by the ward, and wherever possible with families/carers/advocates.

The named nurse or designated other must ensure that the patient is clothed appropriately for their journey and weather conditions.

Please refer to Appendix 6 – Inter Facility Transfer Algorithm and Guidance.

4.6 Delays in Discharge

When a patient is medically stable and deemed by the MDT as safe to transfer from acute care, but is unable to transfer due to waits for provision of services, equipment or suitable accommodation then this patient is determined as a delayed discharge.

A delay in discharge will be determined by the MDT and reported on the weekly Delayed Discharge sheets by qualified ward nursing staff. Discharge delays should be reported to the Lead Nurse Care Management Team or designated other.

Delays in discharge will also be documented in the patient's health records by the registered nurse and in the health records by the medical team.

The Care Management Team will collate and disseminate this information via the monthly SITREP.

If the Neighbourhood and Adult Services have been involved in discharge planning assessment notification 3 (if withdrawing request) or 5 will be sent, as appropriate in accordance with the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

Discharge

The process where the patient transfers from hospital care to the appropriate care setting. This may be associated with the end of treatment or may involve home care (either self care or provided by community staff.)

5.2 Abbreviations

A&E	Accident and Emergency
ADL	Activities of Daily Living
CHC	Continuing Health Care
CRT	Community Rehabilitation Team
CSU	Clinical Service Units
CTR	Central Treatment Room
DF	Discharge Facilitator
DIS	Discharge
DSN	Discharge Specialist Nurse
DST	Decision Support Tool
FU	Foundation Unit
GP	General Practitioner
HCP	Health Care Professional
IMC	Intermediate Care
IP	Inpatient
MDS	Multi-Dose Systems

MDT	Multi-Disciplinary Team
NAS	Neighbourhood and Adults Services (Social Services Care)
NHS	National Health Service
OPD	Outpatients Department
OT	Occupational Therapy
PEG	Percutaneous Endoscopic Gastrostomy
PRN	Pro Re Nata (when required)
REWS	Rotherham Equipment and Wheelchair Service
RN	Registered Nurse
SW	Social Worker
TRFT	The Rotherham NHS Foundation Trust
TTO	To Take Out
YAS	Yorkshire Ambulance Service

6. REFERENCES

- Discharge of patients from hospital HC(89)5 and LAC(89)7
- Achieving a timely simple discharge from Hospital (3573)
- Discharge from Hospital: pathway, process and practice (30473)
- Community Care Act, (Delayed Discharges) 2003
- National service Framework Continuing Health Care 2004
- NHS Responsibilities for Meeting Continuing Health Care Needs. HSG(95)8/LAC(95)5
- Independence, choice and risk: a guide to best practice in supported decision making. DOH. May 2007
- Mental Health Act (1983)

7. ASSOCIATED DOCUMENTATION

- The Rotherham NHS Foundation Trust Leaving Hospital Information booklet
- The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

- Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge
- The Rotherham NHS Foundation Trust Safeguarding Policy
- The Rotherham NHS Foundation Paediatric Bed Management Policy
- The Rotherham NHS Foundation Policy for the Admission, Transfer and Discharge of Infected Patients
- The Rotherham NHS Foundation Medicines Management Policy
- The Rotherham NHS Foundation Transport Criteria
- Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge.

APPENDIX 1

SPECIAL REQUIREMENTS

Occupational Therapists

Any patient experiencing difficulty with personal and/or domestic function needs to be referred to the Occupational Therapist.

A Referral must be made via STRATA by the nurse caring for the patient or designated other, to Therapy Services as soon as the need is identified.
In the interim, a verbal referral will be accepted and action taken if appropriate.

The Occupational Therapist (OT) will:

- Assess the patient in hours within 24 hours and initiate an appropriate treatment plan to ensure satisfactory and timely arrangements are made for the continuing care of the patient on discharge.
- Discuss and determine with the patient, if a home visit assessment is necessary as part of the discharge plan.
- Organise and coordinate the visit, after which a written report will be provided for in the patient's health records detailing action taken and any recommendations. The visit will normally include the patient and/or carer, two members of the Occupational Therapy staff and any appropriate hospital/community based member of the MDT.
- Issue a report and recommendations which must be discussed by the MDT and appropriate action agreed and implemented.
- Discuss with the patient and or carer any onward referral, which is deemed appropriate. This discussion must include details of the service referred to, how the patient will be contacted, likely timescales for treatment and how to contact the service if the patient has any concerns or feels that the timescale has been exceeded.
- Ensure that where patients are being referred to out of area services such as Intermediate Care; a comprehensive discharge summary accompanies the patient, including details of present functional status, rehabilitation to date and intended goals of further rehabilitation.
- Advise of equipment required/ordered and being used. If specific training is required for equipment e.g. PEG feeding this will be arranged prior to discharge by the named nurse or designated other. Any equipment/minor adaptations needed for discharge must be ordered as soon as the need is identified especially if the patient lives outside the Rotherham MBC boundary. The patient and/or their carer will be informed of this.
- Instruct the patient and/or carer in the safe use of equipment. Written instructions will be issued by the provider of the equipment. This includes details of reporting any defects and how to return the equipment when no longer needed.
- Discuss details of discharge arrangements with the patient and/or carer and other members of the MDT and record on the discharge care plan.

Physiotherapists

On admission the ward staff must identify if the patient has been experiencing problems with their cardio-respiratory status, mobility or function at home, which would necessitate referral to Physiotherapy

A Referral must be made via STRATA by the nurse caring for the patient or designated other, to Therapy Services as soon as the need is identified. In the interim, a verbal referral will be accepted and action taken if appropriate.

If the patient is identified as being medically stable the Physiotherapist should be consulted as regards their on-going rehabilitation needs.

The Physiotherapist will:

- Ensure that if the patient requires a period of further rehabilitation this is discussed with the MDT as to the most appropriate service provider.
- Organise the provision of equipment required for discharge e.g. mobility aids, compressors etc.
- Inform ward staff of equipment required for discharge in order that the appropriate transport arrangements can be made by the named nurse or designated other. This will also include educating the patient and/or carer on the appropriate use of the equipment, where to report problems and where to return the equipment when no longer required, and provide written information where appropriate.
- Discuss details of the discharge plan with the patient and the MDT and record on the discharge care plan. Details of the referrals made will be documented in the Physiotherapy notes or copies of the referrals attached to the Physiotherapy notes.
- Discuss with the patient and or carer any onward referral, which is deemed appropriate. This discussion must include details of the service referred to, how the patient will be contacted, likely timescales for treatment and how to contact the service if the patient has any concerns or feels that the timescale has been exceeded.
- Ensure that where a patient is being referred to out of area services such as intermediate care; a comprehensive discharge summary accompanies the patient, including details of present mobility status, rehabilitation to date and intended goals of further rehabilitation.

Social Worker

If it is likely that the patient will require community care services on discharge, once the patient has been identified as fit to commence discharge planning, a section 2 assessment notification of the social work team should be made by named nurse/designated other. Refer to TRFT discharge planning and reimbursement policy.

The Social Worker/Social Services Officer will:

- Liaise with other members of the Social Services Department already involved with the patient's case. On completion of the appropriate assessments and when agreed by the Consultant and the MDT that the patient is medically stable and safe to transfer in accordance with The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy, the patient

will be transferred from an acute bed into the appropriate environment with the relevant support services.
- Discuss the details of the discharge arrangements with the patient and/or carer and other members of the multi-disciplinary team and record this in the nursing record.

Patients discharged with a Subcutaneous Syringe

As soon as it is known that a patient is to be discharged with a hospital MS26(Green fronted) syringe driver
The registered nurse will ascertain the area to which the person is being discharged to

- Immediately prior to discharge from hospital ensure the syringe driver is running as per prescription instruction in other words on time not fast nor slow. Any problems replace the syringe driver with one from the library and return the other one to the equipment library to be serviced. A Datix will then be completed.
- Prior to leaving the hospital the lock box will be removed and the original plastic sleeve put in its place correctly, as community staff will not have keys to access the syringe
- Ensure contact is made with the district nursing service in order to alert them that this patient is going home with a syringe driver so that the local syringe driver can be commenced and the hospital one is returned to the equipment library
- Ask the medical team to contact the patients General Practitioner in order for a home prescription form to be completed in order for the District Nurse to transfer over to the syringe driver that is used for that area We would advise that a copy of the TTO form is faxed to the General Practitioner These forms are not kept in the hospital and a syringe driver chart is not recognised in the community
- The General Practitioner can also notify the Out of Hours Service regarding the patients condition treatment and the usage of the syringe driver should problems occur out of normal hours or the weekend
- As part of the discharge medication supplied to the patient to take home ensure that there is sufficient medication for the syringe driver and prn medication If the patient is on the end of life care pathway ensure there is sufficient injectable medication for the syringe driver and prn medication , this is to include opioid analgesia/ anti agitation /antiemetic/ antisecretory plus either water for injection or normal saline dependent on the dilutent used in the syringe driver. Ensure sufficient quantity of medication as some of these will not be readily stocked by the local pharmacist
- Advise the family that the District Nurse will be coming in to check on the syringe driver and change it on a daily basis. The District Nurse will leave their contact details once they have been. A copy of their number can be given to the families prior to discharge from the discharge liaison nurses covering that area
- Advise the family if there are any problems with the syringe driver or symptom control or medication they are to contact their General Practitioner or District Nurse

- Ensure the ambulance service are aware that the patient is going with a syringe driver and the medication being supplied with the patient as a paramedic ambulance crew may be required The ambulance team will also require the original DNARCPR form to go with the patient
- Ensure the patient is known to the hospital palliative care team ext 7180 in order to arrange community palliative care services
- If patient is going home on the Liverpool care pathway and with /or without a syringe driver ensure that the instructions on Page 22 Appendix 2 are followed

Patients who are being discharged from hospital who are receiving intravenous therapy

- Equipment required will vary depending upon the patient's needs and the type of vascular access device in use. The Vascular Access Team can help obtain the equipment from the list below if ward staff require assistance.
- The supply of equipment relates to the short to medium term treatments for patients whom remain under the care of a hospital consultant. This guidance does not include the supply of equipment for patients on long-term intravenous therapy for whom the day-to-day responsibility of their care remains with the GP.
- The equipment list below is for advice only. The exact equipment required will depend upon individual requirements.

Item	Notes
Yellow/Black heavy duty clinical waste bag	Usually one
Wound care pack	Number required will depend upon prescription
Alaris **solution** sets	For short term infusions
Alaris **pump** sets	For continuous infusions
Chloraprep 3ml	For weekly dressing change
Tegaderm 1650	Change weekly
Cavilon/Sorbaderm 3ml	Required at weekly dressing change
Biopatch	Required at weekly dressing change
Statlock (PICC's only)	Required at weekly dressing change
Standard needlefree	Weekly change required
Positive pressure needlefree (Midlines only)	Weekly change required
Sharps container 1L/5L	Usually one
10ml syringes	Number required will depend upon prescription
20ml syringes	Number required will depend upon prescription
23g blue needles	Number required will depend upon prescription
Clinell **green** swabs	Number required will depend upon prescription
10ml Prefilled saline flush	Number required will depend upon prescription
IV medication and appropriate diluent	As per prescription

- The number of items supplied will mirror the prescribed intervention e.g. if TDS drug administration is prescribed then three wound care packs per day will be supplied. The number of 'days' of equipment supplied will be either the number of days to the next outpatient appointment/vascular access team review or end of therapy (whichever is sooner).
- Once community Intravenous therapy has been agreed, the patient/family/carer should be offered relevant information both verbal and written regarding the care of their intravenous therapy. Peripheral cannula, midline and PICC patient information leaflets are available.
- Medical staff must ensure that the discharge letter indicates the type and length of Intravenous therapy treatment and follow-up arrangements to be sent to GP and community Fast Response Nursing Team.
- A 'new' drug kardex must be written for the community nursing team and the TTO's supplied.
- The nurse caring for the patient must contact Vascular Access Team telephone 7545 so that they may insert an appropriate vascular access device as soon as possible to prevent delay in discharge. The Vascular Access Team can also provide assistance with the discharge process and continuing support if required following the patient's discharge. If unavailable, the ward staff should liaise with the District Nursing Service and Fast Response Nursing Team as appropriate.
- If required the community nurse must obtain electronic infusion devices from the equipment library and a loan receipt completed. It is the community nurses responsibility to ensure they are trained to use the equipment and return the equipment, in a clean condition, to Biomedical Engineering, Level A, The Rotherham Hospital Foundation Trust.
- Outpatient follow up must be arranged prior to discharge by the team responsible for patient discharge. The Vascular Access Team are also available for advice if required.

Discharge from Special Care Baby Unit (SCBU)

- Babies should be fully examined at discharge and findings recorded in the patient's health records and the Red Book (Personal Child Health Record).
- If the discharge is planned for the weekend, examinations must be undertaken on Friday to reduce weekend workload.
- Discharge summaries are completed for all patients admitted to SCBU. These are normally done by the middle grade but the straightforward discharges may be delegated to the SHOs. Please take special care over drug dosages, formulations, inhaler devices, etc. (your letter may be used for repeat prescribing in primary care).
- The discharge letter must be completed on Badger. A hard copy is retained in the case notes and copies sent to GP, Health Visitor, Community Children's Nurse, Child health and Obstetrician
- One copy is given to parents at discharge. Nursing staff on SCBU must go through it with parents before they take their baby home.
- Parents of Babies below 32 weeks gestation should be asked to consent to the PANDA 2 year follow up prior to discharge.

- Wherever possible follow up appointments should be made prior to discharge as per the routine follow up schedule for neonates or in accordance with consultant instructions.
- Ensure that parents receive and understand all relevant condition specific and general baby care information prior to discharge.
- Ensure that the parents have been offered all relevant parent-craft information and practical demonstrations prior to discharge.
- If the baby has continuing care needs e.g. nasogastric feeds or long term oxygen therapy, ensure that all relevant equipment has been issued to parents and that parents are competent to provide ongoing care with the support of a community healthcare professional. Ensure that parents receive written information re replacement equipment and monitoring of the baby's condition post discharge.

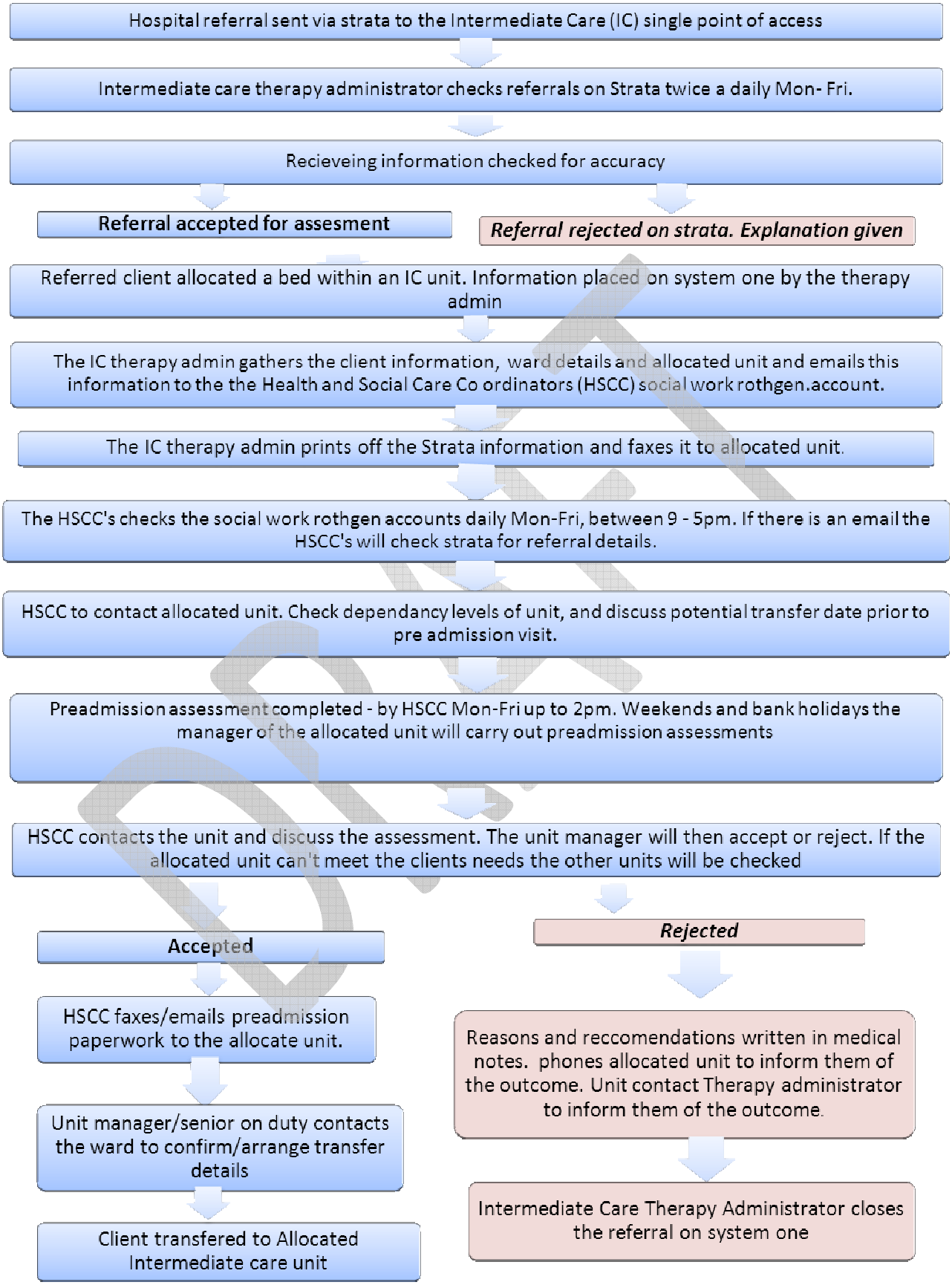
Discharge to other Healthcare settings

- **Where a Patient was Resident in a Nursing and Residential Care Homes On Admission**
    - Discharges to Nursing and Residential Care Homes from In-patient beds, excluding the Emergency Admission Units, are generally planned 24 hours in advance of the discharge date, therefore medications to take home, and discharge summaries should be completed and prepared at least the day before the actual discharge.
    - Once discharge planning has commenced, the named nurse or designated other will invite the care home manager to reassess the patient's condition and needs prior to discharge, to establish if their condition or care needs have changed.
    - When the care home manager comes to assess the patient, if they believe they can no longer deliver care to meet the patients needs and refuses to accept the patient for transfer back to the home, the named nurse or designated other must instigate a re-assessment process, including a CHC checklist.
- **Discharging to Nursing/Residential Home**
    - The RN will ensure that appropriate transport has been requested.
    - The RN will inform the patient and relatives, and Nursing/Residential home of the date of discharge. If the patient is transferring to a Care Home or Intermediate Care bed, the nurse coordinating the discharge must call the home to confirm final arrangements.
    - The RN will provide information to the patient, and Nursing /Residential home, regarding take home medications.
    - The RN will ensure the correct amount of take home medications are obtained before discharge.

- The RN will provide the patient with a discharge letter and any other relevant appointments or information.
- The RN will document the discharge and discussions in the nursing records.

- **Consideration of Intermediate Care Facilities as the discharge pathway**
  - Once discharge planning has commenced; the MDT will assess for and agree a need for on-going rehabilitation, i.e. have potential to regain or adapt function within a 6-week period, be medically stable and safe to transfer.
  - The MDT involved in caring for the patient, will identify the appropriate Intermediate Care pathway that is required for the patient to follow, i.e. Residential, Community or Day Services.
  - Once Intermediate Care is identified as the chosen discharge pathway; all members of the MDT will complete their relevant section on the Intermediate Care multi-disciplinary referral form (for Community Rehabilitation Team or Day Rehabilitation referrals) and STRATA for an Intermediate Care bed.
  - The last member of the MDT to complete the referral will ensure that the form is sent via STRATA as appropriate. Staff can communicate directly with the IMC team if it is felt necessary, via telephone: 01709 423970.
  - The MDT will identify which member of the team will be responsible for explaining IMC rehabilitation to the patient and carer/relative, and will document all conversations in the patients' health records.
  - Once the referral has been received for an Intermediate Care bed; the preadmission assessment will be carried out by a Health and Social Care Coordinator (HSCC) to look at the dependency levels of the patient referred and the availability of a bed to meet that need.
  - The HSCC will coordinate the discharge arrangements in conjunction with the ward and the allocated unit.
  - Whilst Intermediate Care will try to accommodate patient preferences as regards to which unit they would like to be discharged to, this may not always be possible.
  - Patients discharged to IMC must have 28 days medication and necessary dressings and/or equipment, with them on discharge.
  - For further information regarding an Intermediate Care bed referral please see the Intermediate Care Referral Process document.

○ Intermediate Care Referral Process for The Rotherham Hospital



- **Patients being discharged from ward and outpatients departments to Community Nursing Service**

  - On admission to hospital/hospice, if the patient is known to a District Nurse, a Strata referral must be completed and sent to the appropriate District Nurse, by the nurse coordinating the patient's discharge. This information may help discharge process.

  - At referral, clearly identified nursing needs are to be stated, using referral Criteria required by the Community Nursing Services. Patient's name, home address, address being discharged to, date of birth, home telephone number, general practitioner, next of kin contact, and NHS number. Details of diagnosis and treatment required must be completed on the referral form.

  - The named nurse on the ward or designated other must advise any other agencies involved. The RN/DSN/DF will liaise with external agencies where applicable e.g Community Rehabilitation Team, Community Matrons.

  - The named nurse on the ward or designated other must advise regarding equipment ordered and in use.

  - District Nurse referral paperwork for medication requiring administration by a District Nurse, the RN or designated other must enclose clearly written instructions signed by medical staff, as part of the

  - Nursing staff should ensure that dressings, catheter bags including leg bags, and any other equipment required by the District Nurse accompany the patient home. District Nurses (DN) do not carry spare equipment, dressings, tape etc.

  - The MDT must invite community nurses /community matrons to a home visit assessment if they are being asked to visit after discharge.

  - If a discharge is deemed to be complex, either because of patient's condition or equipment used as part of the patient's assessment for discharge, the community nurse /matron should be invited to the ward prior to the patient's discharge to familiarise themselves with patient's needs, by the named nurse or designated other.

  - The nurse coordinating the patient's discharge must give the patient their discharge letter and any other appropriate documentation or written instructions appropriate to patient's condition and treatment, explaining reason for District Nurse input.

  - The patient should be informed that they will be contacted by the District Nursing Service to arrange the date and time of their visit.

  - For discharge of patients requiring treatment/assessment by the district nursing team, the named nurse or designated other must refer as soon as the discharge date is known.

- For patients being referred to a District Nurse on discharge, referrals should be sent via the Strata referral pathway. At weekends and bank holidays referrals to a District Nurses should be made via YAS, who will forward information to District Nurse team. NB. Community staff do not have access to health centres at weekends and Bank holidays. For patients who require a first District Nurse visit from the evening or night service - referral Information must be faxed direct to 01709 336787.
- Referrals for community nursing services must be made 24 hours prior to discharge by the Named Nurse or designated other. The District Nurse should have a request for treatment made via the Strata pathway. For unexpected discharges (less than 24 hours notice) the DN can be contacted by Ambulance Control on 0845 1219993 to inform them of referral and request they bleep the relevant District Nurse.
- All relevant information regarding the patient's on-going care arrangements must be given to the patient in writing on the day of discharge by the nurse Named Nurse or designated other to the patient, relatives /carers/ advocates. The patient's and their relatives/carers/advocates must be advised to give this written information to the community nurse on their first visit to their home.
- It must be made clear to ambulant patient's not requiring a District Nurse visit to contact the Practice Nurse for follow up treatment if required. Only housebound patients will be visited by a District Nurse.

- **Community Rehab Team (CRT)**
  - CRT will be organised by Therapy staff prior to the day of discharge.
  - If involved the SW team will be informed of the provision of CRT by Nursing Staff and if appropriate a section 3 issued to SW.
  - The procedure for discharge will follow as per instructions for 'Day of Discharge'.

- **Patients Discharged back to Own Home**

  The RN must:
  - Inform the patient and relatives of the date of discharge
  - Where appropriate inform any existing home care providers at least 24 hours before the patients pending date of discharge. This is the responsibility of the nurse and not the patient/relative/carer even if they offer to do so.
  - Where appropriate ensure that basic provisions / amenities will be available on discharge.
  - Obtain the relevant amount of take home medication 24hrs prior to discharge.

- Ensure the discharge documentation is completed and given to the patient upon discharge.
- Ensure that the patient is properly clothed for discharge and weather appropriate.

CHCS Providers Contact Details

APPENDIX 2

Provider Name and Branch Office Address	Branch Manager(s)	Out of Hours Telephone Number	Contract Quality Assurance Officer	Area /Business Manager
360 Healthcare Suite 6 Dinnington Business Centre Outgang Lane Dinnington Rotherham S25 3QX Fax: 01709 263361	Mandy Walker mandy@360healthcare.co.uk Tel: 01709 263360	07714 771200	Maxine Dulcamara	David Johnson david@360healthcare.co.uk Mob: 07931 365 647
Ark Homecare Office 34-35 Bradmarsh Business Park Rotherham S60 1BY Fax: 0845 034 2281	Theresa Hooker theresahooker@arkhealth.co.uk Tel: 08450 342280 Claire Wright, Co-ordinator clairewright@arkhealth.co.uk Debra Berry, Field Care Supervisor debraberry@arkhealth.co.uk	08450 342280	Maxine Dulcamara	Leanne Watson Leanne.watson@Arkhealth.co.uk Mob: 079205448277
Care UK 29 President Buildings President Way Saville Street East Sheffield S4 7UQ	Amanda Howe amanda.howe@careuk.com Tel: 0114 2798228	Tel: 0114 2798228	John Lingard	Beverley Sims Manley Beverley.sims-manley@careuk.com Mobile: 07880853416
Carewatch 27 Moorgate Crofts Business Centre South Grove Rotherham S60 2EN	Angie Kay akay@carewatch.co.uk Tel: 01709 331134 Tel: 07881 845165	01709 331134	Maxine Dulcamara	Bev Peters bpeters@carewatch.co.uk Mob: 07889166748
Comfort Call Unit B7 Taylor's Court Taylor's Close Rawmarsh Rotherham S62 6NU	Debbie Fletcher debbiefletcher@comfortcall.co.uk rotherham@comfortcall.co.uk Tel: 01709 529661	07912 597829	Maxine Dulcamara	Jonathan Lees jonathanlees@comfortcall.co.uk Mob: 07702887255

Crossroads Care Rotherham (Carers Service) Unit H, The Point Bradmarsh Rotherham South Yorkshire S60 1BP Fax No: 01709 389518	Liz Bent liz@crossroadsrotherham.co.uk rotherhamxroads@btclick.com Tel: 01709 389516 Tel: 01709 360272 Helen Cryan helen@crossroadsrotherham.co.uk	07527 925067 07711 697387	John Lingard	Liz Bent liz@crossroadsrotherham.co.uk
Direct Health Unit C 14 Taylor's Court Taylor's Close Rawmarsh Rotherham S62 6NU	Emma Povey emma.povey@direct-health.co.uk Tel: 01709 710243	01709 710243 0114 2798228	Maxine Dulcamara	Judith Proctor Judith.proctor@direct-health.co.uk
Domus Healthcare Unit A07 Ground Floor Magna 34 Business Park Temple Road Rotherham S60 1FG Fax: 01904 720008	Keith Boland KeithB@domushealthcare.com Tel: 07595 567557 Tel: 01709 363797 tracyw@domushealthcare.com	07860 503359	John Lingard	Andrea Jetten AndreaJ@domushealthcare.com Mob: 07850 044424
Housing 21 Unit 19 President Park President Way Saville Street East Sheffield S4 7UQ	Gerri Kelly – Care Manager geraldine.kelly@housing21.co.uk Tel: 07799 715678 Tel: 03031 231291 Bianca Murtag – Registered Manager	07799 715678 03031 231291	Maxine Dulcamara	Gary Kent Gary.kent@HOUSING21.co.uk Tel: 03007901145
Mears Unit 1 Claire Court Rawmarsh Road Rotherham South Yorkshire S60 1RU	Bev Green bev.green@mearsgroup.co.uk Tel: 07771 645600 Tel: 01709 722420	07787 156989	John Lingard	Leigh Tudour Leigh.tudor@mearsgroup.co.uk Mob:

SAGA Suite 2, Floor 2, Building 1 Hawke Street Industrial Estate Hawke Street Sheffield S9 2SU	Julie Wales julie.wales@saga.co.uk Tel: 01142 613003 Deborah Scott – Co-ordinator deborah.scott@saga.co.uk	07909 894754	Maxine Dulcamara	Lisa Hillman Lisa.hillman@saga.co.uk
Sevacare A4 Taylor's Court Freshfield House Parkgate Rotherham S62 6NU Fax: 01709 710497	Janet Senior janet.senior@sevacare.org.uk Tel: 07891 335522 Tel: 01709 523635	01709 523635	John Lingard	Debbie Dennis debbie.dennis@sevacare.org.uk T: 01902 625088 M: 07807104665
TLC Homecare A3 Taylor's Court Freshfield House Parkgate Rotherham S62 6NU	Lynne Smallwood lynne.smallwood@tlc-homecare.co.uk Tel: 07889 002361 Tel: 01709 524364	07794 219485	John Lingard	Leanne Archbold Leanne.archbold@warrencare.co.uk Mob: 07530282422
Voyage Unit 18 Moorgate Croft Business Centre Alma Road Rotherham S60 2DH	Hayley Odemis Hayleyodemis@voyagecare.com Denise McClure Denisemcclure@voyagecare.com Tel ; 01709 331242	Hayley 07793 616697 Denise 07793 616633	John Lingard	Yetwo Li yetwoli@voyagecare.com

APPENDIX 3

Responsibility of all RFT staff to complete Continuing Health Care Assessments

- All Patients or their families/carers/advocates have the right to an assessment of their health care needs against Continuing Health Care criteria, and may request a Continuing Care Assessment (Rotherham Hospital Discharge Planning and Reimbursement Policy: A Partnership Agreement.)
- Therefore patients may refuse a discharge option until this process is completed in accordance with the criteria.
- The eligibility criteria for Continuing Health Care operates in conjunction with the assessment for the Registered Nursing Care Contribution (also known as NHS Funded or Free Nursing Care), and both will be complementary to the Fair Access to Care Services (FACS) eligibility criteria operating within the Local Authority.
- The decision for eligibility will be taken by the multi-disciplinary professionals involved in the individuals care and their identified needs will considered against Continuing Health Care checklist criteria.
- Following the request for a Continuing Health Care Assessment, the multi-disciplinary team will complete the Decision Support Tool and will liaise with the patient and family/carer/ advocate ensuring that necessary information is made available for a full and comprehensive assessment.
- A summary of the reviewed assessment made against the Continuing Health Care eligibility criteria will be completed and discussed with the patient/family/carer/ advocate who can apply in writing for a copy of this document.
- In the event that the MDT identifies that the patient may meet the criteria for Continuing Health Care eligibility or joint eligibility with Social Services, then the Decision Support Tool document must be completed with the MDT recommendation, and faxed to the Primary Care Trust Continuing Health Care Panel fax number 01709 308826 for review and confirmation of Continuing Health Care eligibility at the appropriate
- A CHC information leaflet will be given to the patient and family/carer/ advocate which explain the CHC process including that of formal disputes, reviews and eligibility criteria.
- If the CHC ratification is not in agreement with the MDT recommendation then the MDT should meet to discuss the additional evidence/information requested by CHC. If there is no further evidence available the MDT will evoke a formal dispute process and write to CHC stating areas of disagreement. If further evidence is available this will be included in the DST and sent for CHC consideration.
- If the patient or family/carer/ advocate consider their health needs have not been correctly assessed they should be advised to follow the CHC dispute process. This is described in the decision letter sent from CHC.

APPENDIX 4

Ascertaining Eligibility for Patient Transport Services (PTS)

Opening statement:
NHS transport is an expensive resource and it is important that all alternatives are explored to enable patients to travel to or from a healthcare location by their own means, rather than using PTS. It is only provided if the patient's medical condition prevents them safely using other travel options to get to or from their appointment. Previous use of PTS isn't a guarantee that the patient will be eligible in future.

Question 1
Is the patient travelling to or from an NHS healthcare provider for NHS care?

No → **The Patient is not eligible for NHS Transport For this Journey**

Yes

Question 2
Can the patient use their own transport to safely get to/from their appointment?

Yes → **The Patient is not eligible for NHS Transport For this Journey**

No

Question 3
Can the patient travel safely to/from their appointment with a friend or relative?

If the friend or relative is not available at the date & time of the appointment it may be possible to re-arrange it.

Yes → **The Patient is not eligible for NHS Transport For this Journey**

No

Question 4
Can the patient safely access and use other forms of transport - public transport, taxis – to get to/from their appointment, without detriment to their medical condition. Options may be available for wheelchairs.

Yes → **The Patient is not eligible for NHS Transport For this Journey**

But if cost is an issue, they may be eligible for help with travel costs through the Healthcare Travel Costs Scheme.

Alternatively they may be able to access other forms of community transport.

No

Question 5
Does the patient have a medical condition which affects their mobility and means they cannot use non-NHS transport or do they need the facilities available on a PTS ambulance and/or a the help of a PTS Crew in order to travel safely?

Yes → **The Patient is eligible for NHS Transport For this Journey**

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No

Pag

sion.

Guidance Information

Guideline Information

Question 1

A Healthcare provider could be community, secondary or tertiary care based.

Question 2

Consideration needs to be given to the following:-

- How the patient normally gets out & about.
- The effect of treatment or diagnostics which the patient may be subjected to at the Healthcare provider and which may affect their ability to transport themselves.
- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.

Question 3

Consideration needs to be given to the following:-

- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.

Question 4

Consideration needs to be given to the following:-

- Any effect of treatment or diagnostics which the patient may be subjected to at the Healthcare provider.
- The frequency of journeys the patient has to make in a short time period, for example, if more than 3 return journeys per week.
- The complexity of the journey, if for example the patient needs to make more than one change of vehicle.
- Access to and from transport.

Question 5

Examples will be:-

- The need to utilise on-board oxygen.
- The requirement for a stretcher, carry chair, ambulance service wheelchair or bariatric vehicle.

APPENDIX 5

Ascertaining Eligibility for an Escort

Opening statement:
Once a patient's eligibility has been established, it is equally important that any request for an Escort is properly assessed to avoid inappropriate use of PTS resources.

Previous approval for an Escort isn't a guarantee that a patient will be eligible in future. In the event that the patient is admitted, it is the responsibility of the escort to make their own way home.

Question 1
Is the patient under 16 years of age?

Yes → **The Patient is eligible for an Escort**

No

Question 2
Is the patient's condition such that they require the constant attention of a Healthcare Professional throughout the journey to provide clinical input and/or safe transfer and which cannot be provided by PTS staff?

Yes → **The Patient is eligible for an Escort**

No

Question 3
Is the patient a vulnerable adult (ie clinical confusions/dementia, learning difficulties, certain mental health problems) requiring the particular skills/support of someone known to them during the journey to ensure the wellbeing of the patient and others on the vehicle?

Yes → **The Patient is eligible for an Escort**

No → **The Patient is not eligible for an Escort**

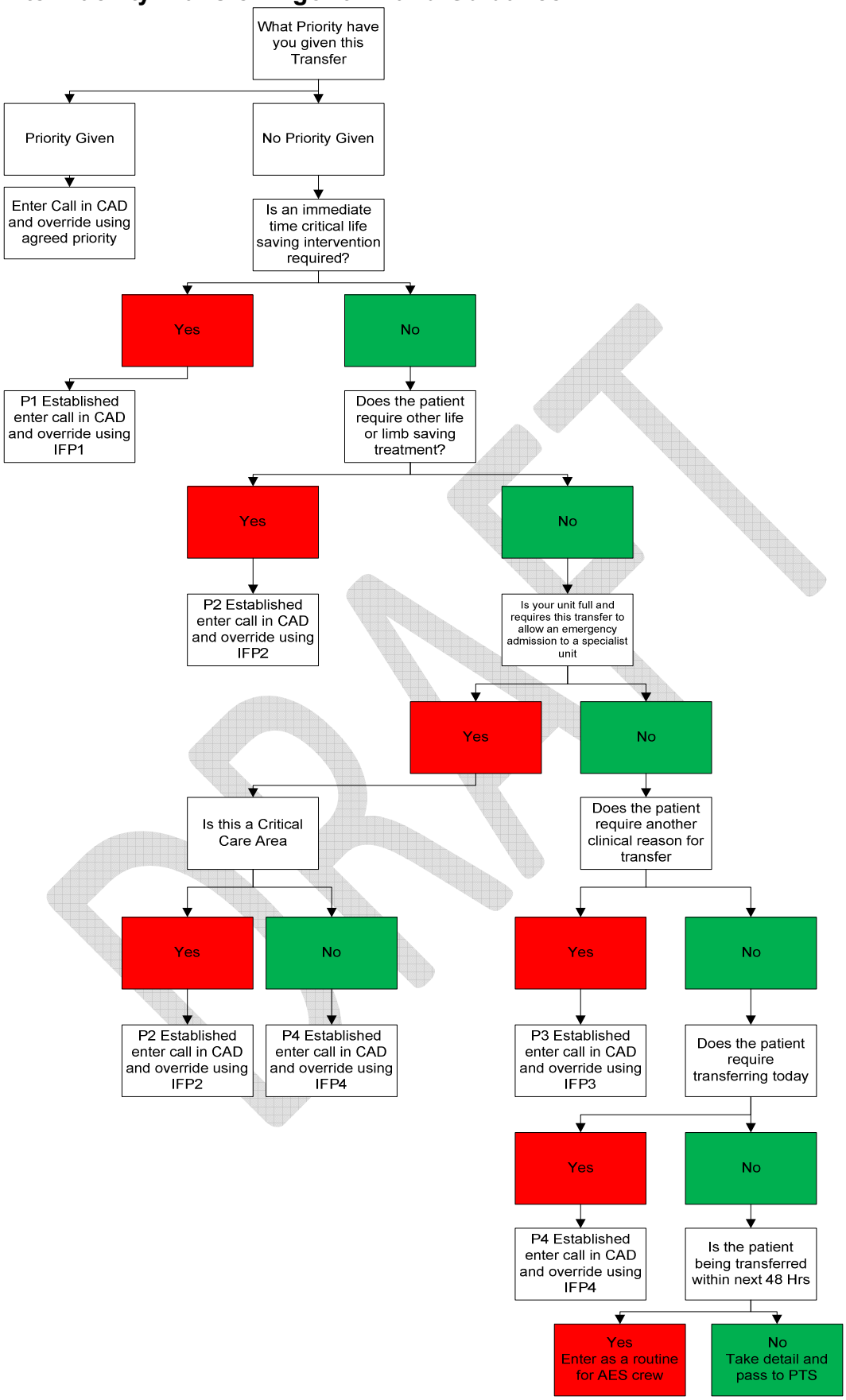
Question 3 Guidance

There may be cases where an Escort is not specifically required during the actual journey, but is necessary whilst the patient is at the Healthcare location to provide support. In such cases the Escort should travel independently to the Healthcare location.

Sometimes Escorts are not able to travel on their own and such cases will be considered on an exception basis provided that it is in the best interest of the patient.

Inter Facility Transfer Algorithm and Guidance

APPENDIX 6



P1	R1 Call - 8 minute Response
P2	G4 Call - 1 Hour Response (Upgrade to G2 if response > 60 Minutes)
Retrieval	Treat as usual through Embrace or P1-P4
P3	Urgent Call - up to 4 hours Response (with 30 minute warning of arrival)
P4	Routine call - up to 8 hours Response (where contracted)
Routine	Suitable for AES crew

Inter-facility Transfer Questions

1. What Hospital ward or department are we collecting the patient from? – Ensure correct ward / department is entered from hospital table and refrain from using General as an option

2. Where are taking the patient to?

3. What is the condition/diagnosis of the patient?

4. What is the patients name and date of birth?

5. Is this a ***Critical Care Transfer***?

If Yes

   a. Tag on system as CRIT
   b. Advise doctor must accompany the patient
   c. Ask if the patient will be transferred on a Critical Care Trolley

6. Is the patient connected to specialist equipment which cannot be disconnected for the journey or is likely to require clinical intervention en-route?
   a. Yes **Advise that suitably qualified staff must accompany the patient**
   b. No

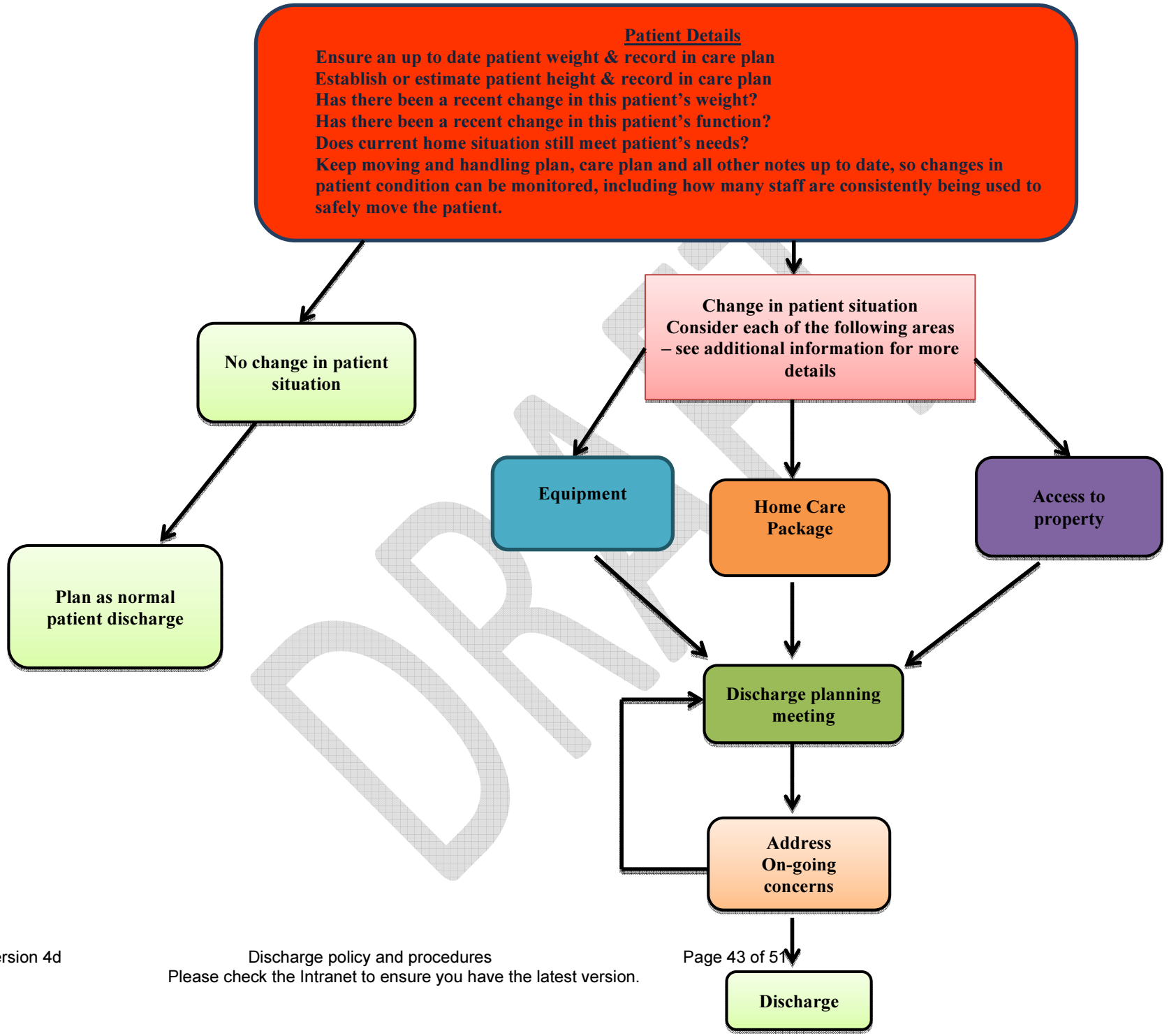
7. Does the patient have a current Do Not Attempt Resuscitation (DNAR) Order in place?

   a. Yes **Advise crew of DNAR**

   If DNAR in place can you make sure it is available for the crew to see.

   b. No

APPENDIX 7: BARIATRIC PATIENT



Equipment

Specialist assessments may be required prior to discharge of some bariatric patients by: - therapists, moving and handling, transport, tissue viability, district nurse teams.
Refer to OT who will ensure that the equipment being used at home is adequate or if further equipment needs to be ordered. An assessment will be made of the home environment to check space, lifting heights, flooring,

Bed

If a bariatric bed is needed on discharge home – contact Moving & Handling Team for availability of beds and the suitability of available beds for your patient. Beds generally are available in standard (approx. 3ft), 3ft 6 and 4ft widths.
Establish which type of bed is available for D/C. A trial of the bed maybe required – Speak with Therapists and Moving & Handling Team.
Can bed be delivered into property? Contact REWS to complete their own assessment

Mattress

Request a mattress assessment. Liaise with Tissue Viability and Moving & Handling Team to establish an appropriate mattress and that it is compatible with bed.

Bed Rails

Most bed rails on community beds are not designed to be pulled on by the patient. If patient requires bed rails for safety reasons ensure can be rolled without using rails to pull on. There is limited availability of pull handles for bariatric beds, but they cannot be used in conjunction with bed rails. Liaise with Therapists/ M & H/ REWS

Hoist & Slings

Usual checks and assessments are made. Extra consideration needs to be given to safe working loads of equipment, whether sling can be easily inserted or removed or if a specialist sling is required?

Other equipment

Liaise with Therapists regarding any additional equipment that may be required such as commodes, walking aids, etc. Therapists will

Home Care Package

Establish if new or existing care package is required.
Check how many staff are assisting to move and care for patient on the ward. Is this consistent?
If more than 2 carers are required – start DST **as soon as possible**
Once care provider is established ensure they are familiar with any special instructions/ equipment, and have been given all appropriate information.
If informal carers/family are helping with care ensure this is appropriate and they have had appropriate instruction – liaise with therapists and Moving & Handling Team.

Access to Property

Consider how patient will be taken home - Ambulance/relatives/own
Check whether the property has steps/stairs or difficult access?
Check if patient will be able to get into property, will they need help?
Check if OT needs to complete environmental assessment?
Is stair assessment required?
Ask if property suitable for wheelchair or stretcher access
Liaise with Patient Transport - They may need to risk assess property; give them min 72 hour's notice.
Once in property consider how patient will be transferred onto bed etc.

Discharge Planning Meeting

Arrange a MDT meeting in advance of discharge. Consider inviting: -
Nursing staff, OT, Physio, District Nurses, Discharge Nurses, Moving & Handling, Tissue Viability Nurses, Patient Transport, Home Care, Social Workers, Community OT, patient, patient's family, and any other relevant parties.

APPENDIX 8

The Rotherham NHS
NHS Foundation Trust

REQUEST FOR PRESSURE RELIEVING EQUIPMENT

Ward…….. **Tel Ex**…… **Planned discharge date**……..

Discharge destination……..…….. …….**Tel**….....

Next of kin/person dealing with discharge…….……**Tel**……

Name of Occupational Therapist……..……**Tel**……

Patient diagnosis…….

Weight…… **Waterlow**…. **Pressure ulcers** - Yes/No **Site and grade**……..……**Hours in bed** 19-24 □ 13-18 □ 6-12 □

Type of bed frame to be used at home: Single □ Double □ Double shared □ ¾ bed □ Hospital □ Delivery date for hospital bed……

Mattress currently in use: Foam □ Standard dynamic overlay □ Dynamic replacement □ Dynamic therapy □

Cushion currently in use: Propad □ Flo-tech Plus □ Flo-tech Solution □ Dynamic □ Other □

Continence: Catheterised □ Incontinent urine □ Incontinent faeces □ Stoma bag □ Continent □

Care package: Single handler □ Double handlers □ Night visits □ No. of visits …… daily District Nurse to visit: Yes/No Date arranged……..

Any other information……
……..

……
……

……
……

Equipment requested: Standard foam mattress □ Standard dynamic □ Dynamic replacement □ Dynamic therapy □ Cushion □

Referred by…… Designation…….……
Tel…… Date…….....

When this form is complete, fax to Tissue Viability Office NHS Rotherham on 3255

For advice on equipment delivery on discharge call the Equipment Coordinator on 3250

DISCHARGE POLICY AND PROCEDURES

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Management Team
Business and Service Managers
Clinical Directors
Matrons
Group Nurses
Quality Governance Team

9. APPROVAL OF THE DOCUMENT

This document will be/was approved by:

Patient Safety Committee

10. RATIFICATION OF THE DOCUMENT

This policy will be/has been ratified by Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as to require an earlier review.

The Lead Nurse, Care Management Team is responsible for the review of this document.

13. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
Quality Governance Team via polices email	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform Quality Governance Team if a revision and which document it

				replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.
Communication Team (documents ratified by the document ratification group)	Quality Governance Team	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments /Matrons	Author	Meeting/ Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.
All staff within area of management	Heads of Departments /Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

14. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Completion of Continuing Healthcare	Workshops for authors Support via email and telephone	Upload blank document templates to the intranet	Quality Governance Team	Ongoing
Approval Process/form	Workshops/ meetings with	Upload blank approval form to		Within 3 months of publication of

	approving committees	the intranet		revised policy

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF, THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Audit/Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Discharge Requirements for all patients	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
Information to be given to the receiving healthcare professional and how this is recorded	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
Information to be given to the patient when they are discharged and how this is recorded	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee
How a patient's	Audit	CSU's/Care	Twice yearly	Relevant	Patient

medicines are managed on discharge		Management Team in conjunction with the relevant Ward Managers and Matrons		CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Safety Committee
Process for discharge out of hours.	Audit	CSU's/Care Management Team in conjunction with the relevant Ward Managers and Matrons	Twice yearly	Relevant CSU's, Matrons and Ward Managers identified themes/issues escalated to Patient Safety Committee	Patient Safety Committee

A report will be prepared by the Lead Nurse Care Management Team or designated other for Business and Service Managers and Performance Managers regarding the number of **Delayed Discharges** areas and reasons for delay, so that trends can be monitored locally, and actions to resolve can be developed within CSU's/FU's.

15.2 Standards/Key Performance Indicators (KPIs)

- Reduction in delayed discharges
- Reduction in outlying patients
- Reduction in time of 'boarding out' for patient's in A&E

Section 2
Appendix 1

The Rotherham NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name: _____ Date/Period of Document: _____

Lead Officer: _____ Directorate: _____ Reviewing Officers: _____

❑ Function	❑ Policy	❑ Procedure	❑ Strategy	❑ Joint Document, with whom?
Describe the main aim, objectives and intended outcomes of the above:				

*You must assess **each** of the 9 areas separately and consider how your policy may affect people's human rights.*

1. Assessment of possible adverse impact against any minority group				
How could the policy have a **significant** negative impact on equality in relation to each area?		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	**Age**?			
2	**Sex** (Male and Female?			
3	**Disability** (Learning Difficulties/Physical or Sensory Disability)?			
4	**Race** or Ethnicity?			
5	**Religion and Belief**?			
6	**Sexual Orientation** (gay, lesbian or heterosexual)?			
7	**Pregnancy and Maternity**?			
8	**Gender Reassignment** (The process of transitioning from one gender to another)?			
9	**Marriage and Civil Partnership**?			

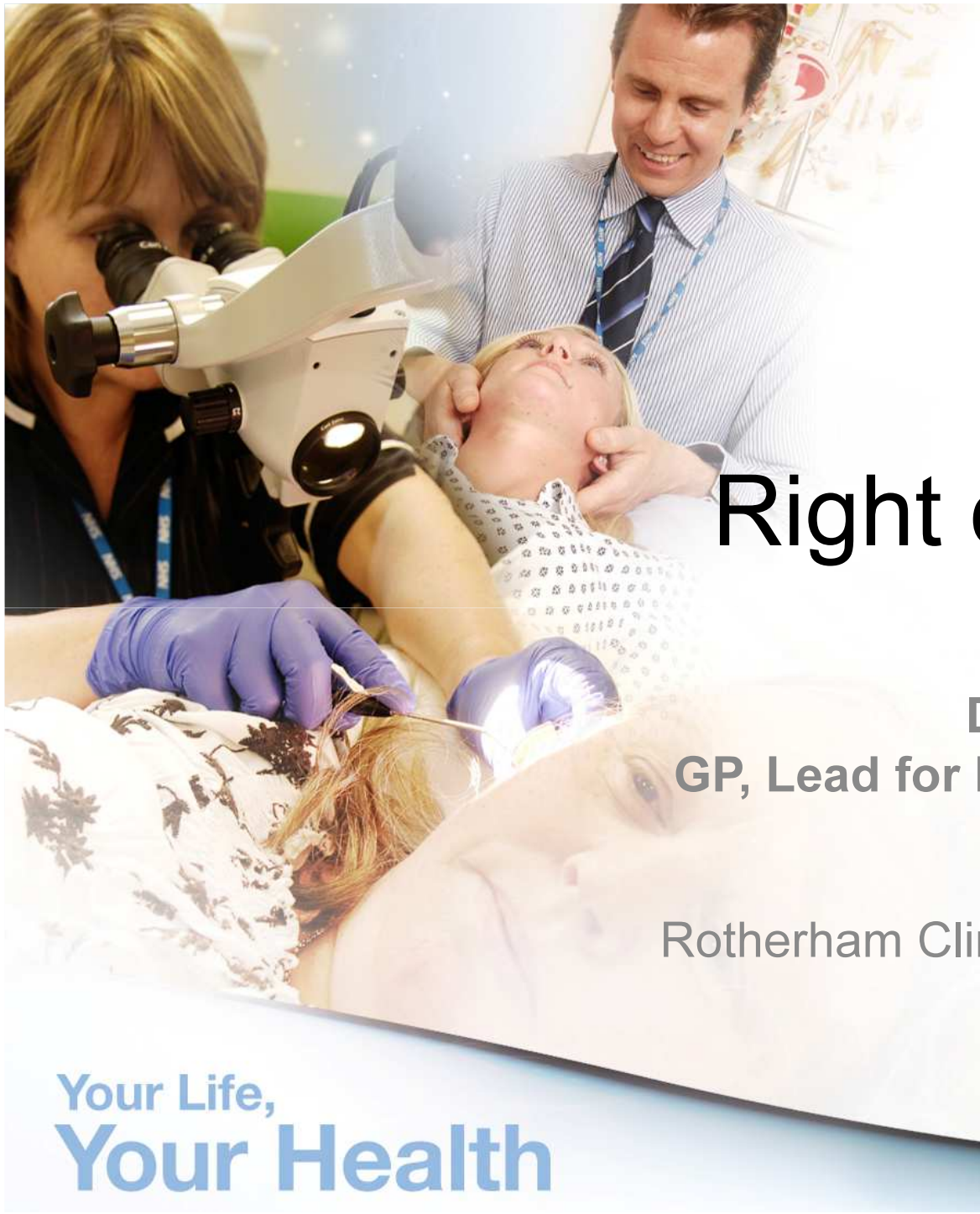
You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community of group? **Yes/No**
- Will any group be **excluded** because of the policy? **Yes/No**
- Will the policy have a negative impact on **community relations**? **Yes/No**

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment

2. Positive impact:				
Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	Promote **equal opportunities**			
2	Get rid of **discrimination**			
3	Get rid of **harassment**			
4	Promote **good community relations**			
5	Promote **positive attitudes** towards disabled people			
6	Encourage **participation** by disabled people			
7	Consider **more favourable treatment** of disabled people			
8	Promote and protect **human rights**			

3. Summary On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?						
Positive	*Please rate, by circling, the level of impact*					**Negative**
HIGH	**MEDIUM**	**LOW**	**NIL**	**LOW**	**MEDIUM**	**HIGH**
Date assessment completed:	Is a full equality impact assessment required?		❑ Yes (documentation on the intranet)		❑ No	



NHS
Rotherham
Clinical Commissioning Group

Right care, first time

Dr Ian Turner
GP, Lead for Primary Care Quality and Efficiency

Rotherham Clinical Commissioning Group

Your Life,
Your Health

Recap on our proposals

NHS
Rotherham
Clinical Commissioning Group

Our proposals are:

- Right care, first time
  - everything for urgent care, in one place
- Quality of care
  - bringing together primary care skills with the skills and facilities of Accident and Emergency
- Sustainable for the future
  - re-investing in urgent care will make the whole NHS in Rotherham work better

Your Life,
Your Health

By urgent care we mean

NHS Rotherham Clinical Commissioning Group

- Treatment/advice for minor injuries or illnesses, which cannot wait
  - Broken bones
  - Burns/scalds
  - Infections
  - Sprains
  - Wounds

Your Life, Your Health

Why re-invest in urgent care?

NHS Rotherham Clinical Commissioning Group

- To improve the quality of care
  - bringing together the skills of primary care and Accident and Emergency in one place
- Because the current system is confusing
  - patients with urgent care needs often don't know where to go, or may access several services before they get the care they need
- To ensure the NHS in Rotherham is sustainable for the future
  - more and more patients will need urgent care

Your Life, Your Health

A new Urgent Care Centre

NHS Rotherham Clinical Commissioning Group

- A new Urgent Care Centre for Rotherham
  - Open 24/7
  - Purpose-built at Rotherham Foundation Trust Hospital
  - Staffed by experienced and specially trained nurses and GPs
  - Joined-up with Accident and Emergency
- Reinvesting money from the Walk-in Centre into urgent care
  - Urgent care services currently provided at the Walk-in Centre will transfer to the Urgent Care Centre
  - The Walk-in Centre will close (but not the building)
  - New NHS 111 service will provide advice and support for non urgent care

Your Life, Your Health

How we developed our proposals

NHS Rotherham Clinical Commissioning Group

- Our proposals are based on:
  - best clinical practice
  - a review by local GPs
  - an assessment of local needs and all of the alternatives
  - discussions with the clinical teams from the Walk-in Centre and A&E
  - Discussions with local councillors, MPs and other stakeholders
  - the views of patients and local people

Your Life, Your Health

Where we are today

NHS
Rotherham
Clinical Commissioning Group

- We hope that Rotherham Metropolitan Borough Council will support our proposals and help us to improve urgent care for local people
- We recognise, that for some, the proposals will raise issues. We have already had feedback on some of the main concerns – and we will continue to listen and work to address these over the coming months

Your Life,
Your Health

What people are asking about our plans

NHS Rotherham Clinical Commissioning Group

- Does closing the Walk-in Centre affect other services at the same location?
  - No. All of the other NHS and community services will remain on site, including family planning/sexual health services, GP surgery and clinics
- Will public transport be an issue?
  - There are already comprehensive public transport services to the hospital and we will consider how these might be improved with the transport providers and the Trust
- Will car parking be an issue?
  - We are discussing this with the Trust; there are already plans for the development of car parking facilities at the hospital

Your Life, Your Health

Next stage: Public consultation

NHS Rotherham Clinical Commissioning Group

- Full 12 week consultation
- 6 May to 26 July
- Combination of online, traditional, social and media channels
- Working through local networks of voluntary, community and patient groups
- 4 public meetings

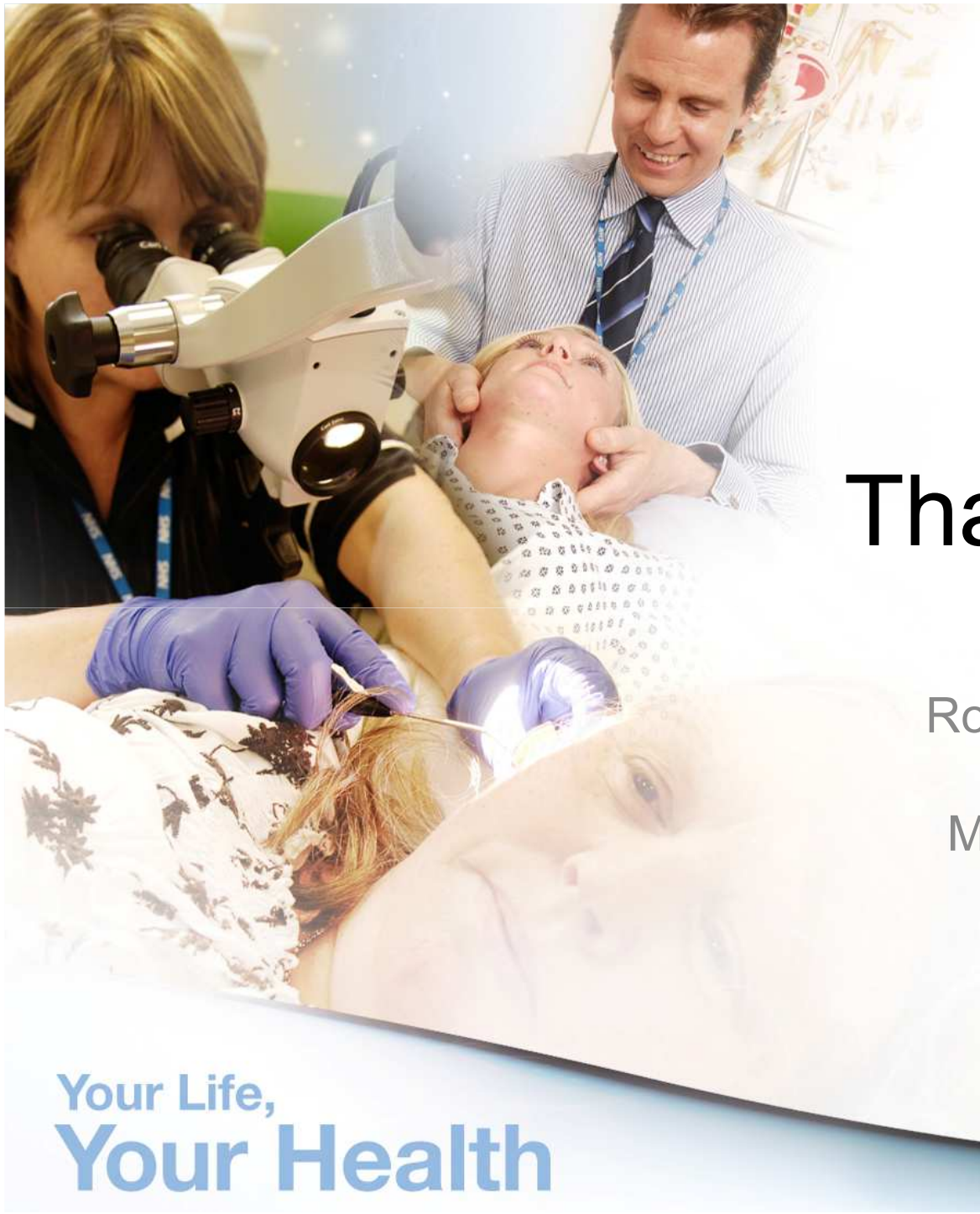
Your Life, Your Health

NHS
Rotherham
Clinical Commissioning Group

Thank you for listening

COMMENTS AND QUESTIONS

Your Life,
Your Health



NHS
Rotherham
Clinical Commissioning Group

Thank You

Rotherham CCG
Oak House
Moorhead way
Bramley
Rotherham

Your Life,
Your Health

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**18th April 2013**
3.	**Title:**	**Scrutiny Review of RMBC Residential Homes**
4.	**Directorate:**	**Resources**

5. Summary

This report sets out the findings and recommendations of the scrutiny review of RMBC Residential Homes. The draft review report is attached as Appendix 1 for consideration by the Health Select Commission.

6. Recommendations

That the Health Select Commission:

- **Endorse the findings and recommendations of the report and make any amendments as necessary**
- **Agree for the report to be forwarded to the Overview and Scrutiny Management Board and then Cabinet**
- **Request that the Cabinet response to the recommendations be fed back to the Health Select Commission**

7. Proposals and Details

This review was identified in the work programme for 2012/13 and was prioritiised by both Scrutiny Members and the Cabinet Member for Adult Social Care. In light of the budget pressures being faced by the Council and the need to identify further budget cuts it was felt that an independent view on the future of the homes was required. It took place, alongside a financial review, commissioned by Neighbourhoods and Adults Services management, and delivered by Price Waterhouse Cooper. It was intended that the Scrutiny review would add value to the work carried out by PWC and to allow a wider range of discussion to take place about the future of the homes.

The overall aim of the review was to achieve an understanding of value for money, outcomes and quality of service provision and in particular, the potential impact of budget cuts on this. The review would make recommendations to the Executive to be considered alongside the process of setting and reviewing the budget for 2013/14.

It would also aim to support the achievement of the following Council priorities from the Corporate Plan:

- Ensuring care and protection are available for those people who need it most
- Helping to create safe and healthy communities.

The review is reported under the five sub headings; staffing, catering and entertainment, buildings and maintenance, costs and comparisons and options for the future. Each of these sections of the review has its own recommendations. There are 10 recommendations in total, listed below.

1. That RMBC corporately agrees to review the terms and conditions of the staff to address issues of out of hours enhancements and sickness absence payments.

2. That Human Resources and NAS Management consider urgently whether the permanent recruitment freeze could be lifted for the two homes, enabling them to take more control of some of the staffing costs.

3. That the hard work and commitment of the staff and managers of both homes be recognised and the achievements made in enhancing the dignity of residents.

4. To provide the opportunity for the teams to explore this further and to generate independent income for the homes to enhance the experience for residents and to ensure that quality of provision is maintained as far as possible. This might also include some independent management of procurement for food and catering items.

5. That further work is done with the procurement team of the Council to look at value for money in the current contractual arrangements and a review of how the food budgets are spent is carried out in conjunction with the managers of the homes.

6. That consideration is given to the extent to which the handyman service or another internal employee could be trained to carry out some of the maintenance services

that are currently causing the homes to go over their repairs and maintenance budgets.

7. That the same review contained within recommendation 5 for food procurement is carried out regard to procurement of cleaning, repairs and maintenance services

8. Cabinet do not cut staff hours per resident below 25 as it is felt this will be to the detriment of the quality of the service provided.

9. That Cabinet re-consider the proposal to reduce the number of managers within the homes, as this is likely to result in re-deployment and payment protection costs which could outweigh the savings being made.

10. That the Council looks at alternative ways to manage the capital costs and borrowing associated with this, which potential remove the burden from the revenue budgets of the homes.

8. Finance

The review recommendations will need to be considered in the context of the agreed budget for 2013/14

9. Risks and Uncertainties

The review group considered at length the risks around reducing costs and the potential impact on quality. This potential "trade off" between cost savings and quality was at the heart of the review.

10. Contact

Deborah Fellowes
Scrutiny Manager

Ext 22769
Deborah.fellowes@rotherham.gov.uk

Rotherham Metropolitan Borough Council

Scrutiny review: RMBC Residential Homes

Review of the Health Select Commission

September – December 2012

CONTENTS

Executive Summary

The aim of the review:

The review group was made up of the following members:

- Cllr Brian Steele (Chair)
- Cllr Dominic Beck
- Robert Parkin (co-optee, Speak-up)
- Cllr Colin Barron
- Cllr Christine Beaumont

Summary of findings and recommendations

The overall aim of the review was to achieve an understanding of value for money, outcomes and quality of service provision and in particular, the potential impact of budget cuts on this. The review would make recommendations to the Executive to be considered alongside the process of setting and reviewing the budget for 2013/14.

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10. That the Council looks at alternative ways to manage the capital costs and borrowing associated with this, which potential remove the burden from the revenue budgets of the homes.

1. Why members wanted to undertake this review?

This review was identified in the work programme for 2012/13 and was prioritiised by both Scrutiny Members and the Cabinet Member for Adult Social Care. In light of the budget pressures being faced by the Council and the need to identify further budget cuts it was felt that an independent view on the future of the homes was required. It took place, alongside a financial review, commissioned by Neighbourhoods and Adults Services management, and delivered by Price Waterhouse Cooper. The aim of the Scrutiny review was to add value to the work carried out by PWC and to allow a wider range of discussion to take place about the future of the homes.

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It would also aim to support the achievement of the following Council priorities from the Corporate Plan:

- Ensuring care and protection are available for those people who need it most
- Helping to create safe and healthy communities.

2. Terms of reference

The work of the review group was split into two distinct pieces of work:

1. To understand the workings of the residential homes set in the context of Adult Social Care delivery, funding and regulations. This involved spending a full afternoon with the managers and staff of both homes.
2. To receive a summary of the work completed by PWC and the main recommendations regarding the future of the homes.

These two pieces of work were brought together in a final meeting of the review group to pull together their own recommendations.

The review has been provided with support and evidence by a number of officers for Neighbourhoods and Adult Services and these were as follows:

Tom Cray – Strategic Director
Shona McFarlane – Director of Health and Wellbeing
Ros Brown – Service Manager
Lynn Todd – Manager, Davies Court
Lisa Sykes – Manager, Lord Hardy Court
Doug Parkes – Business Manager
Sarah Turner and Paula Woodward – Team Leaders, Lord Hardy Court
Sue Severns and Denise Smith – Team Leaders, Davies Court
Vanessa Barlow – Senior Care Assistant, Davies Court

Juliette Seargent and Denise Gelthorpe, Care Assistants, Davies Court

The review also included visits to two independent homes in the Borough, to allow review group members to benchmark the two Council run homes under review.

In total the review group met 5 times and the notes of these meeting are available as background documents to this report.

3. Background

At the first meeting of the review group, members were provided with the background information and context within which the two homes operate. This is summarised as follows:

- All residential homes are assessed as part of the Home from Home scheme and are graded bronze to gold. Both Davies Court and Lord Hardy Court are currently graded silver
- Each home has 60 beds
- Of these 30 beds are designated for people who have a mental health problem (Elderly and Mentally Ill EMI), 15 are residential and 15 are intermediate care or fast response beds. The latter category is provided in partnership with NHS Rotherham and part funded through intermediate care pooled budgets and NHS reablement grant.
- All EMI beds are fully occupied
- The intermediate care beds have an occupancy rate of 80% which is the highest ever and length of stays is 16 days which is good performance
- People living at home after 91 days from discharge from intermediate care is at 89.53%, a best ever performance achieved.
- The homes were new build and were designed to allow the consolidation of residents from a number of older buildings into the new ones. The old homes were then transferred to Asset Management. Some of the old homes have since been sold and the Council benefited from the capital receipt.
- Because of the design of the buildings and the accommodation of larger numbers of residents, there has been an increase in the staffing levels from those originally planned, particularly for night shifts.
- The remaining homes that have not been sold sit within the Council's property bank and ongoing costs i.e. security, are met by corporate budgets.
- The independent sector has higher vacancy rates and the Council homes continue to be very popular with regular enquiries. Waiting lists are not kept.

4. Residential Homes.

4.1 Staffing.

Members of the review group were provided with the staffing structures and the working patterns of the staff. It was recognised from very early on that the homes would always struggle to remain competitive in terms of costs with the independent sector because of the terms and conditions of the staff, employed by the Council. Members felt strongly from the outset that the need to reduce costs

within the two homes should not result in a deterioration of the quality of the service provided. They were keen to look at value for money and to assess the quality of the provision as well as their financial viability. It was viewed that the review needed to make recommendations about achieving the right balance between these two things.

It was noted that the majority of the costs of the homes were related to staffing costs. It was also noted that staffing costs were higher than originally planned for the two homes because the buildings required higher numbers of staff. The staffing levels had been increased within 6 months of the homes opening. As staff are paid time and one third for night duties staffing costs increased.

It was also noted that sickness levels in Davies Court are high. This issue was explored by the review group at the session they held with staff. Staff discussed this openly and honestly with the group. As a result the following issues were concluded:

- For a number of reasons, including vacancy rates and annual leave, staff will regularly find themselves working longer hours than they are contracted for (e.g. someone on a 16 hours per week contract, could be working up to a 30 hour week
- Since annual leave and sickness are calculated on average hours worked, the result will be that staff will have an entitlement to more annual leave, but importantly, higher levels of sick pay. Night duty enhancements are also paid when on sickness absence.
- This has resulted in an “incentive” for sickness absence.

Staff were concerned that the combination of vacancies, annual leave entitlements and sickness absence have created significant staff shortages. At the time of the review, Davies Court had 10 vacancies. Managers were concerned that they have little control over these costs.

It was noted that a review of terms and conditions was required but that this was something that needed to be negotiated with Unions at a corporate level.

Members of the review group, however, noted that the high quality of care provided in the homes is largely down to the staff. Staff were proud to work for the Council and were extremely committed to driving up quality standards for their residents. Members therefore felt very strongly that although staffing costs did need to be controlled more, that this was not at the expense of the high quality of care provided by the staff. Members also noted that the management style of the two managers was inclusive and that they demonstrated strong leadership.

Recommendation 1.
That RMBC corporately agrees to review the terms and conditions of staff to address issues of out of hours enhancements and sickness absence payments.

Recommendation 2.
That Human Resources and NAS Management consider urgently whether the permanent recruitment freeze could be lifted for the two homes, enabling them to

take more control of some of the staffing costs. Also that they review the average hours offered on part time contracts for staff in the homes.

4.2 Catering and entertainment.

Members noted that there is a very clear policy within the homes that the food and entertainment provision is a key element of maintaining the dignity of residents. For example within the dining room napkins, linen table cloths and background music are provided. For residents who have to have soft or pureed meals they are moulded which means that in appearance terms the food looks the same as the real thing. This means the food is at a higher cost and this is not provided in most independent sector homes.

Similarly the entertainment and activities programme provided for the residents is of a high quality, and as such attracts visitors to learn about how it is provided, for example GPs, managers of independent homes. It is the view of the managers and staff that they are providing a flagship service which others could learn from.

It was noted that none of the mainstream budgets for the homes is being spent on entertainments and activities. They have a shop, café and hairdressing/beauty salon on site and this generates income that is used to fund activities. All of the services are provided at very low cost. This source of income for the homes is totally independent and is therefore an element of the homes' finances that the managers have complete control over. It is used to enhance the "dignity" experience for residents. All of the decorating, much of the furniture and soft furnishings were purchased through this budget and members of the review group noted that these were all of a very high standard.

In addition to this, the managers and staff have worked hard to strengthen links with the local communities and partners, for example the local church and police. Lord Hardy Court have set up Friends of Lord Hardy Court group and they were successful in gaining £10,000 lottery funding last year.

The review group also noted that in procurement terms, the Yorkshire purchasing organisation contract may not be offering the best value for money. It is designed to achieve economies of scale but the staff did not feel that this was being reflected in their budgets. It was noted that the changing arrangements with RBT may well change these procurement arrangements in the coming months.

Recommendation 3.

That the hard work and commitment of the staff and managers of both homes be recognised and the achievements made in enhancing the dignity of residents.

Recommendation 4

To provide the opportunity for the teams to explore this further and to generate independent income, at no additional cost to the Council, for the homes to enhance the experience for residents and to ensure that quality of provision is maintained as far as possible. This might also include some independent management of procurement for food and catering items.

Recommendation 5.

That further work is done with the procurement team of the Council to look at value for money in the current contractual arrangements and a review of how the food budgets are spent is carried out in conjunction with the managers of the homes.

4.3 Buildings and maintenance.

The review group heard from a number of witnesses about some of the problems that had been experienced with the design of the new buildings. The buildings themselves have the "wow" factor but are expensive to maintain. Decoration costs for the wooden exterior, the service charge for the maintenance of the green roof, cleaning of the high rise windows and the sprinkler system weekly servicing costs were all excluded from the original budgets. Staff suggested that it may be cheaper to train someone internally to carry out these tasks. In addition to this the grounds maintenance has been costing £5k per year for each home. It was noted, however, that this may decrease now that a handyman had been taken on for each home.

The review group were also made aware of concerns about costs associated with maintenance contracts and the fact that staff would prefer to be involved in the process for awarding them.

Recommendation 6

That consideration is given to the extent to which the handyman service or another internal employee could be trained to carry out some of the maintenance services that are currently causing the homes to go over their repairs and maintenance budgets..

Recommendation 7

That the same review contained within recommendation 5 for food procurement is carried out regard to procurement of cleaning, repairs and maintenance services. .

4.4 Costs and comparisons

The review group were presented with the findings of the information prepared by Price Waterhouse Cooper, on behalf of Neighbourhoods and Adults Services. The unit cost per resident week is much higher in both of the residential homes, compared to the independent sector.

When the overall budgets of the homes are broken down, by far the largest area of spend is staffing; approximately three quarters of the budget. The rest is split between capital charges, supplies and services and premises.

The conclusion drawn from the work by PWC about the costings of Lord Hardy Court and Davies Court was that although they are highly valued by customers and are fully compliant with external inspections, the current model is expensive and uncompetitive compared with the independent sector. The main areas of higher comparative spend are as follows:

- Pay and conditions of service
- Staff to customer ratios
- Management and supervisory levels
- Occupancy levels
- Procurement charges

As a result of the findings of PWC, Cabinet have considered as part its budget process for 2013/14 a package of savings for the homes which totals £870,000. This is likely to be achieved by changing the management structure, reductions to the staff to customer ratios and looking at changing arrangements to sick pay provisions. These proposals do not bring the homes in line with industry averages, but are proposed to strike a balance between cutting costs without undermining the quality of the service being provided. The reducing staff ratios will result in the number of staff hours per resident being reduced from 30 to 23. It was the view of the review group that this cut is too harsh.

As part of the review, the members visited some independent sector homes by way of comparison. Whilst on these visits they asked questions about staff ratios, costs, term and conditions etc as well as making general observations about facilities on offer and general cleanliness. The visits reaffirmed for the review group that the quality of provision and cleanliness of both Lord Hardy Court and Davies Court was of a considerably higher standard by comparison, although this also varied amongst the independent homes visited. They also noted that the staff ratios did not appear to be much different to those offered in Lord Hardy Court and Davies Court. The main area of difference was that of the staff terms and conditions, most notably the absence of any kind of pay supplement for anti social hours.

Another area of cost that the review group were concerned about was that of the outstanding costs of capital borrowing on the building of the two homes. They received evidence that the original capital costs of the buildings were under estimated and additional borrowing was required as a result of this. The capital raised from the sale of the old homes was used to offset the build costs, but a mortgage was required to plug the gap. The payment of these capital costs creates an additional pressure on the ability of the homes to break even. It also serves to limit the future options for the homes. The independent sector would be unlikely to take on the buildings because of this and if the homes were to close entirely the Council would still be required to pay this debt. The review group were concerned that this additional pressure on the budgets of the homes was not really fair and that other ways to account for this debt should be considered..

Recommendation 8

That Cabinet do not cut staff hours per resident below 25 as it is felt this will be to the detriment of the quality of the service provided.

Recommendation 9

That Cabinet re-consider the proposal to reduce the number of managers within the homes, as this is likely to result in re-deployment and payment protection costs which could outweigh the savings being made.

Recommendation 10

That the Council looks at alternative ways to manage the capital costs and borrowing associated with this, which potential remove the burden from the revenue budgets of the homes.

4.5 Future monitoring

The action plan for the implementation of the recommendations that are accepted should be reported to the Health Select Commission on a six monthly basis for monitoring purposes.

5. Background Papers

Notes of Meeting: held on 26th September 2012

Notes of Meeting: held on 26th October 2012

Notes of Meeting: held on 2nd November 2012

Notes of Meeting: held on 14th December 2012

6. Thanks

Thanks go to all of the witnesses who gave their time and support to the review process.

The review group would like in particular to thank the staff and residents of all the homes visited during the review.

Thanks are also extended to Shona McFarlane and Ros Brown, who provided valued support to most of the review group meetings.

For further information about this report, please contact

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