ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue: **Town Hall, Moorgate Street, Rotherham.**

Date: **Thursday, 10 September 2009**

Time: **10.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

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

3. Apologies for Absence and Communications.

4. Declarations of Interest.

5. Questions from members of the public and the press.

For Consideration

6. Right Patient, Right Place, Right Time (herewith) (Pages 1 - 51)
   10.00 am

7. Swine Flu Pandemic - Verbal Update by Steve Turnbull, Head of Public Health
   10.50 am

8. Cabinet Member for Health and Social Care - Priorities for the forthcoming Year - Verbal Presentation
   11.20 am

9. Forward Plan of Key Decisions - Adult Services (herewith) (Pages 52 - 53)
   11.35 am

10. Autism Alert Card - DVD
    11.50 am

For Information

11. Complaints Annual Report (herewith) (Pages 54 - 67)
12.00

12. Minutes of a meeting of the Adult Services and Health Scrutiny Panel held on 9th July, 2009 (herewith). (Pages 68 - 75)

13. Minutes of a meeting of the Cabinet Member for Adult Social Care and Health held on 6th July 2009, 20th July 2009 & 3rd August 2009 (herewith). (Pages 76 - 88)

Date of Next Meeting:-
Thursday, 1 October 2009

Membership:-

Chairman – Councillor Jack
Vice-Chairman – Barron
Councillors:- Blair, Clarke, Goulty, Hodgkiss, Hughes, Kirk, Turner, Wootton and F. Wright

Co-opted Members

Mrs. I. Samuels, Kingsley Jack (Speakability), Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Taiba Yasseen, (REMA), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Victoria Farnsworth (Speak Up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum), Mr. R. H. Noble (Rotherham Hard of Hearing Soc.) and Parish Councillor Mrs. P. Wade

Agenda Item 6

The Rotherham InterQual® Initiative

'Transforming patient care'

Carole Lavelle – Project Lead, RFT

Introduction

In 2004 South Yorkshire organisations undertook a spot audit of all patients occupying an acute bed using the InterQual® (McKesson) criteria. The aim was to evaluate whether the application of the criteria would have resulted in admission to an acute bed, or whether a less intense level of care could have been offered had it been available. In 2006 RFT signed up to the license for InterQual and a further pilot study was undertaken within the Care of the Elderly Unit which confirmed the previous findings.
The Rotherham NHS Foundation Trust (RFT), NHS Rotherham and Rotherham Metropolitan Borough Council (RMBC) have developed a strategy for the implementation of InterQual. All of the partner organisations have identified a requirement to develop local community based care with the primary aim of building an alternative to hospital based accommodation to support transition from illness to recovery and avoid unnecessary hospital admission. While beds are only one element in meeting individual needs for health care, an opportunity has arisen to introduce a whole health economy approach to the appropriateness of level of care as part of a strategic understanding as to the appropriateness of place of care, enabling the health economy to plan for the right number and types of accommodation and bed provision to meet the needs of the population of Rotherham.

InterQual criteria are a set of measurable, clinical indicators that reflect a patient's need for hospitalisation. They consider the level of illness of the patient and the services required, thus they service as the criteria for all acute hospital care, regardless of the location or size of the hospital. The criteria are grouped into body systems and include 3 sets of criteria for each body system:

- Intensity of Service;
- Severity of Illness; and
- Discharge Screens

Intensity of Service Level of Care Criteria is used to determine the appropriateness of admission, continued services and discharge across the continuum of care. Objective clinical indicators are used to determine the proper level of care, based on the patient's severity of illness and service requirements and to suggest an appropriate care setting.

InterQual criteria are intended to supplement and support clinical decision-making, ensuring the appropriateness of health care services, they are not intended to replace clinical judgement.

Quality and patient safety

The partnership organisations (RFT and NHS Rotherham) Service Development Strategy and Quality Improvement Strategies set out an intention to ensure that services delivered are of good quality and value for money. At the least the new InterQual approach to appropriateness of place of care will be deployed in a way that promotes patient safety and reduce errors occurring. Services will continue to be delivered using clinically effective methods and practices, and will aim to exceed patient expectations. A small qualitative study will be undertaken as part of the project in order to measure patient and carer expectations.

To ensure that patients are treated and managed effectively and efficiently, all patients will be cared for using the evidence based electronic tool for the main

admission conditions. To monitor the impact of this there will be an agreed suite of reports produced from the InterQual database for all recorded admissions and discharges that identifies through exceptions any contributing factors of any variance from plan.

Benefits

It is expected that the benefits of the implementation of InterQual are:

Health and social care system

- Reduced lengths of stay in hospital
- Reduced hospital readmission rates (to be monitored at 7,14,21 and 28 days)
- Reduced emergency admissions
- Patients length of stay in The Rotherham NHS Foundation Trust is in accordance with plan on admission – Predicted Date of Discharge
- Clinician satisfaction with InterQual
- Achievement of clinical outcomes for patients (both condition specific and generic measures- i.e. x% patients are discharged from the facility with their optimum BMI; without healthcare acquired infection ;) by ensuring patients are cared for in the most appropriate care setting.

Patients and carers

- Patient satisfaction achieved in terms of discharges
- Working in partnership with patients and carers to agree a plan of care on discharge
- Appropriateness of place of care (Retrospective Review)
- Reduction in treatment/discharge related complaints (PET)

The implementation of InterQual will provide the Commissioners and providers with clinically rich, evidence based criteria to support management of capacity and demand in terms of the required levels of care for the population of Rotherham.

Case Management

The intention behind the implementation of case management is that there will be a move away from a simple focus on the short term needs of the patient, towards an approach that focuses on developing a long term approach to case management. Evidence has shown that intensive, ongoing and personalised case management can improve the quality of life and outcomes for patients with longer term conditions, many of whom are unable to cope with day to day activities. The scale of the problem is illustrated by a Department of Health report that reveals, seventeen and a half million people in this country live with a long term condition such as asthma or diabetes (Dept of Health 2005).
Furthermore, a report from the healthcare information company Dr Foster revealed that around 493,000 people were admitted to hospital as emergencies at least 3 times in 2006. Indeed 1,494 patients had 3 or more non elective admissions to The Rotherham NHS Foundation Trust in 2007/2008.
Thus the introduction of case management is part of a Government initiative to take the lead on introducing policies and setting targets to improve the outcomes for people with long term conditions.

Ref No:

Discharge Policy and Procedures

Version:	2a
Ratified by:	
Date ratified:	
Name of originator/author:	Claire Newey Lead Nurse Care Management Team
Name of responsible committee/individual:	
Date issued:	
Review date:	
Target audience:	

Version	Date	Author	Status	Comment

The 10 Golden Rules of this Policy

1	**All staff must be aware of their roles and responsibilities regarding the discharge process (Section 3.1)**
2	**The patients best interests and wishes will remain central to plans being made for discharge, including being realistic about their discharge plans.**
3	**Discharge is to be commenced on admission and for elective admissions discharge planning will begin at the pre assessment phase of admission**
4	**Discharge is a multi disciplinary process that is continuous and occurs across 7 days a week**
5	**10am is the 'Golden Hour' for discharge**
6	**Communication is paramount between the patient, relatives / carers and all members of the MDT to facilitate an effective discharge. Where there are barriers to effective communication, specialist help will be sought.**
7	**Patients will be provided with information regarding their treatment in hospital, advice regarding future management and details of follow up arrangements and discharge documentation.**
8	**All patients are entitled to have their ongoing needs assessed against Continuing Health Care criteria for Continuing Health Care Funding**
9	**Effective partnership working and planning is imperative to ensure effective and safe management of transfer of patients to the community, and it is the responsibility of all members of the MDT to adopt this approach to discharge planning.**
10	**All consumables (ie TTO's) for the patient to be obtained 24hrs prior to discharge**

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1 INTRODUCTION

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

1.2 To ensure that discharge preparation is patient focussed, patients/families/carers and advocates will be encouraged to be involved at all levels within the discharge planning process, their roles and responsibilities will be clearly identified to them, and they will receive, where appropriate written confirmation of assessments and decisions made.

1.3 To ensure that relevant staff are aware of their responsibilities for preparing and providing appropriate documentation and information to accompany the patient on discharge. Detailed guidance is available in section 2 Discharge procedures of this policy.

2 PURPOSE

2.1 Before any patient is discharged, it is vital that arrangements are made to ensure that the patient experiences a smooth discharge/transfer from hospital, back to the community.

2.2 Comprehensive, patient centred approach that takes into account the needs of individual patients, their families and carers, and that maintains the privacy and dignity of the patient, must be undertaken in a systematic managed approach to discharge planning.

2.3 A plan that involves all relevant members of the Multi-disciplinary team in a standardised, high quality and equitable approach must be prepared and agreed for each individual patient including needs related to ethnic origin, language difficulties, sensory and physical impairment, and that encompasses the patients' needs, wherever the patient subsequently is discharged to.

2.4 Discharge planning itself must be viewed as part of the process of good patient care, rather than an isolated event, that must commence as soon as possible for each patient once they have been admitted to hospital.

2.5 Where patients have specialist needs in terms of their discharge plans or care, relevant guidelines have been developed and included as appendices to the discharge procedures document.

The principles of this policy will be followed by all members of staff within The Rotherham NHS Foundation Trust

2.6 The principles that follow in this Discharge Policy, and Discharge procedures section 2 of this policy and procedures document, are common to all patients being discharged from the Rotherham NHS Foundation Trust, over the full 24 hour period, 7 days a week. Specific out of hour requirements are identified within the discharge procedures section and where more specific requirements are identified, these can be found within the appendices.

2.7 Any discharges from the Acute Trust will also follow relevant protection guidelines including The South Yorkshire Child Protection and Safeguarding Adults Guidelines.

2.8 We aim to give the patient, family/Carers/Advocates information to support help them through the process of discharge planning and preparation for discharge. This includes the provision of the Patient information booklet, ' Leaving Hospital' to assist patients' and families/carers/advocates in their understanding and encourage them to take an active part in the discharge planning process.

2.9 To make good choices, people need to understand the consequences of decisions regarding discharge plans and take some responsibility for them. So the Policy aims to promote a culture of choice that entails responsible, supported decision-making, even in situations where choices may be very limited.

2.10 The aim of this policy is also to ensure that The Rotherham NHS Foundation Trust has an up to date Discharge Policy, and Discharge Procedures document, that has been agreed with all agencies in the Health and Social Care Community.

3 DUTIES

3.1 Duties within the Organisation

3.1.1 Chief Executive

The Executive Team is responsible for supporting this policy operationally and financially, in order to fulfil the purpose of this policy.

3.1.2 Chief of Performance and Standards-Chief Nurse

The Chief Nurse is responsible 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.

3.1.3 Lead Nurse Care Management Team

Responsible to the Deputy Chief of Quality & Standards / Deputy Chief Nurse. Responsible for the support of Matrons and Ward Managers in the Implementation, monitoring and auditing of the policy to ensure best practice.

3.1.4 Divisional Patient Service and Standards Managers (DPSSM)

The Divisional Managers 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.

DPSSM's will be responsible for the development of specific local guidelines in conjunction with the requirements of this policy, for patients identified as having potentially high risk transfer needs or as dictated by clinical condition. DPSSM's will be responsible for identifying the above patient groups within their division in conjunction with the CSU's / Matrons and ensuring that local guidelines are developed, implemented and monitored and where required entered on to local risk registers.

3.1.5 Medical Staff

Responsible to the Medical Director, for ensuring compliance to this Policy, within their Division.

- Medical staff - for clear management plans, Predicted Discharge Dates, ensuring timely completion of take home medication prescriptions/General Practitioner letters and communicating effectively with patients/families/carers/advocates.

- The consultant or their deputy should discuss with the patient and /or family/carer/advocate, the likely outcome and length of stay, including giving an predicted discharge date the patient is likely to be ready for leaving hospital (Discharge standard 1, appendix 1)

- 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, e.g. Psychiatrist for Mental Health advice.

- Once all medical treatment has been completed, the Consultant and /or their medical staff should liaise with the MDT delivering care to the patient to identify that the patient is medically fit and safe to transfer to the chosen discharge pathway, and clearly identify this in the patients' medical notes.

- In cases of patients with mental health needs or dementia, Medical staff may need to refer to Psychiatrists for discharging advice.

- 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.

- The discharge summary must be completed prior to the patient's discharge by the medical staff, as identified in discharge standard 9 (appendix 1). If there are likely to be particular medical difficulties the GP must be contacted by phone or urgent letter.

- Particular care must be taken when discharging patients in the evening, at weekends or bank holidays when the services they require may be difficult to organise. In such instances, an early request for GP, local authority or community based nursing is most important.

- It is the responsibility of the medical staff to provide sick notes, if more than 1 week away from work is required (med 3).

- Following the death of a patient in hospital, the GP must be notified in writing within 48 hours. A notification death proforma should be used for this purpose.

Paediatric Consultants

Please refer to the Paediatric Bed Management Policy and escort guidance tools, for further guidance regarding responsibilities of both Consultant and paediatric Middle grade staff.

3.1.6 (i) Nursing Staff

- The named nurse or designated other (as recorded in the patients nursing notes) will act as the coordinator of all discharge arrangements. They have responsibility for assessment, planning and liaison with the patient/carer/advocate and all other members of the MDT or other agencies. On medicine for the elderly the ward based Discharge Facilitators will take lead for this responsibility for coordinating the discharge process.

- Plans for discharge must be commenced on admission. For patients admitted via an elective pathway – discharge planning may happen as part of pre – assessment process/clinics/OPD.

- The discharge planning process must include an assessment of whether the patient will require referral to other members of the MDT using assessment notifications, section 2, (Appendix 6).

- When patients are admitted from Care Homes, the Care Home staff must be consulted as part of the MDT assessment of patient needs process, and encouraged where appropriate to be involved in the discharge planning process, including being invited to attend Case Conferences etc.

- Following early assessment of the patients' potential discharge needs, a Continuing Care assessment must be offered to the patient by the Nursing staff usually with 48 hours from admission (Discharge standard 4), and utilising the appropriate Continuing Care Paperwork.

- For complex discharges the Named Nurse or designated other holds the responsibility for arranging a case conference involving all appropriate members of the MDT including patients/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. (As identified in the discharge process flow chart appendix 2)

- If the patient requires a specialist mattress Central Treatment Room (CTR) should be contacted to assess needs. They require a minimum of 3 days for assessment and arrangement for delivery of specialist equipment.

- All decisions about the discharge plan will be discussed with the patient/ families/carers/advocates before being finalised, and all conversations clearly documented in the patients nursing notes.

- When the predicted date for discharge is identified by the Medical staff – this must also be identified within the nursing notes.

- Once the definite date of discharge is identified, the nurse must confirm this with the MDT, the patient and the family/carer/advocate. The date must also be recorded in the patients nursing notes.

- Restarts for home care services must be carried out in accordance with the Rotherham NHS Foundation Trust Community Care Delayed Discharge and Reimbursement Policy.

- Referrals for community nursing services must be made 24 hours prior to discharge (appendix 11) by the Named Nurse or designated other.

- The nurse designated to care for the patient has responsibility for checking that discharge arrangements are complete and that the discharge care plan will be completed on the day of discharge and a copy given to the patient.

- 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

- The nurse designated to care for the patient must obtain medication, (including any food/fluid thickeners or dietary supplements) and dressings prior to discharge and ensure that the patient/family/carer/advocate understands their use. Where appropriate, written explanations must also be given to the patient.

- Sufficient dressings should be provided for a minimum of 48 hours and longer at weekends and bank holidays.

- Where education and training is required instructions and advice should be given verbally and in writing. Specialist help should be obtained where

required and it is the responsibility of the Specialist giving the advice to document this clearly in patients' notes.

- The nurse or designated other must ensure that transport arrangements are made for the patients journey from hospital, and that the patient can gain access to their discharge destination.

- The nurse must ensure that outpatient appointments and transport as necessary are made, discussing details with patient/family/carer/advocate ensuring appointment cards are given prior to discharge.

- The nurse or designated other must check with the patient whether they require monies that have been deposited with the Treasurers Department to be repaid in cash up to the value of £100. If the documentation has been correctly filled in the department will be able to arrange same day reimbursement. . (Appendix withdrawal slip)

- Any problems in the discharge process must be reported to the appropriate MDT member and documented clearly in the patients nursing notes. Discharge delays should be reported to the Lead Nurse Care Management Team or designated other.

- If NAS have been involved in discharge planning assessment notification 3 or 5 will be sent, as appropriate in accordance with the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy (Appendix 6)

- Any condition specific information leaflets, will be given to the patient/carer/family/advocate and discussed prior to the patients discharge by the named nurse or designated other.

- The nurse responsible for planning the discharge must 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.

3.1.6 (ii) Patients discharged from Healthcare for Older People

- Ward based Discharge Facilitators act as lead for all discharge arrangements within Elderly Medicine wards including liaison with patients, carers, members of the MDT and all other agencies.

- Discharge Specialist Nurses have a strategic role in regard to discharge planning acting as resource/advisor to ensure safe timely discharge for all patients, including offering support and advice to Discharge facilitators and ward staff.

- Plans for discharge are commenced on admission. Safe timely discharges are ensured through liaison and effective cross boundary working between secondary and primary settings.

- The Discharge Facilitator will take the Lead role in the continuing care process, case conferences and MDT meetings, however in their absence the responsibility lies with the nurses caring for the patient.

- Discharge facilitators and in their absence ward nurses will liaise and co-ordinate with all other agencies to ensure discharge planning is comprehensive including Nomad systems, home oxygen, sub-cut fluids etc.

3.1.6 (iii) Patients being discharged to a Nursing or Residential Home

- Once discharge planning has commenced (usually within 48 hours from admissions), if the patient has been a resident in a 24 hour care home prior to admission, the named nurse or designated other will invite the care home manager to reassess patients 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 instigate a re-assessment process, including a Continuing Care assessment, and sending a section 2 to Social Services team as identified in the Discharge Planning and Reimbursement Policy (appendix 6)

- Occupational Therapists or Physiotherapists will 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.

- Discharges to Nursing and Residential care homes from In-patient beds, excluding the Emergency admission Unit, 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 (please see Discharge Standard 9, appendix 1)

- 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.

- The named nurse or designated other will provide dressings/appliances to the patient sufficient for treatment for a minimum of 48hours (extra will be required for weekends and bank holidays)

- The Named nurse or designated other will inform the care home of details of appointments made including the date and time, transport booked and escorts required.

- The Named Nurse or designated other will send written discharge information to care home including any written instructions appropriate to patients condition and treatment e.g. pressure sore discharge form.

- Written information to be sent from A&E on treatment given in the department and treatment needed, will given to nursing home staff

- In the case of patients returning to residential homes who require Nursing care, they must be referred to the community nursing service.

3.1.6 (iv) Responsibilities of the ward 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. This must be supervised by the deputy ward manger co-ordinating the ward.

- Plans for discharge must be commenced on admission. Discharge planning meetings should be convened and held wherever appropriate, as per the Trust safeguarding policy.

- The nurse will liaise as appropriate with the paediatric community nursing team, Health Visitor, School Nurse or Specialist Nurse and complete the relevant referral form.

- If the patient requires additional equipment at home such as bedpans, bottles, traction equipment, local policy will be followed in obtaining it.

- All decisions about the discharge plan will be confirmed with patient and or carer after being finalised.

- The actual date of the discharge will be agreed with the patient and or carer as well as the MDT as soon as possible and appropriate, and recorded in the MDR.

- The nurse has the responsibility for checking that the discharge arrangements are complete and that the discharge care plan in the MDR is complete at discharge

- The member of medical staff that discharges the patient must complete a written discharge plan and discharge letter. Ideally this should be shared with the patient and or parent/carer and a copy given to them. A copy of the discharge letter should be forwarded to relevant MDT members within two working days of discharge.

- The nurse will obtain medication /dressings required prior to discharge. They will provide verbal and written information re drug use and storage to patient and or carer as required. Sufficient dressing should be provided to last 48 hours and longer if discharged over a bank holiday/ weekend.

- The nurse will liaise with the dietician to ensure sufficient supplies of special infant milk at discharge. The above rules should apply when being discharged over weekends. The paediatric dietician usually arranges further supplies through the GP practice.

- The nurse will ensure transport arrangements are made as required for the patient journey from hospital to home as required.

- The nurse will arrange OPD appointments as required and discuss details with patient and or family as appropriate.
  (For discharges from SCBU please refer to appendix 13)

- The nurse will give the parent/care condition specific written information according to the child's continuing care needs

- The nurse will give the parent or care written and verbal information re open access to the ward following discharge.

3.1.6.(v) Nursing responsibilities on the day of discharge

- On discharge a full nursing assessment of the patient's condition must be made and recorded in the nursing records.

- If there is any cause for concern regarding the patients' medical condition, the named nurse or designated other must report this to the Consultants team.

- Any concerns regarding discharge planning for older people, must be reported to the Discharge Facilitator or Care Management team or member of the MDT as appropriate.

- The named nurse or designated other must ensure that the patient must be clothed appropriately for their journey.

- The discharge address must be confirmed by the nurse, ensuring basic provisions and amenities are available, and ensure the patient has access to their discharge destination.

- 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 named nurse or designated other must check that all items for discharge are available and that the patient and family/carer understands their use, including prescribed medications.

- The nurse must return valuables and other property to the patient and obtain a receipt.

- The nurse must advise the patient/family/carer where they can obtain advice or help once they leave hospital.

- The nurse must check that the discharge care plan is completed.

- It is the responsibility of the named nurse or designated other to ensure that all documentation to accompany the patient is available and given to the patient. Relatives/carers/advocates, before the patient leaves the ward.

- The discharge letters must be completed by medical and nursing staff, and given to the patient family/carer/advocate in order to ensure that they are fully aware of the treatment received and the post discharge arrangements made. If information needs to be given by ward staff direct to a District Nurse at base point this can be done by fax or via YAS, ensuring any administration instructions are signed by a physician.

- When the discharge summary is completed the Medical staff must give this to the ward clerk to be sent to the patient's general practitioner, and the Named Nurse or designated other will clarify that this has occurred prior to the patients discharge.

- Should the discharge be postponed or cancelled, the nurse caring for the patient must inform all concerned parties and make a record of the details in the patients care record. If appropriate send assessment notification section 3. (See Appendix)

- It is the nurse's responsibility to provide the patients sickness notification for up to 1 week (if applicable - med 10). 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).

3.1.6 (vi) Responsibilities of nursing and medical staff when patients wish to take their own discharge 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 persuade them to stay.

- If this fails 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.

- 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 be suffering from a mental disorder, consideration must be given to the need for a mental health assessment to be undertaken. In the case of a patient who is showing clear evidence that they may be suffering from a mental disorder, 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.

3.1.7 Occupational Therapy

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

- Referrals must be faxed by the nurse caring for the patient or designated other, to the Occupational Therapy Department as soon as the need is identified utilising a section 2, (appendix). In the interim, a verbal referral will be accepted and action taken if appropriate.

- The Occupational Therapist (OT) will assess the patient within 1 working day and initiate an appropriate treatment plan to ensure satisfactory and timely arrangements are made for the continuing care of the patient on discharge.

- The Occupational Therapist will discuss and determine with the patient, if a home visit assessment is necessary as part of the discharge plan. The Occupational Therapist is responsible for organising and coordinating the visit, after which a written report will be provided for the medical notes 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.

- The report and recommendations must be discussed by the MDT and appropriate action agreed and implemented.

- The Occupational Therapist must 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.

- Where patients are being referred to out of area services such as intermediate care the Occupational Therapist must ensure that a comprehensive discharge summary accompanies the patient, including details of present functional status, rehabilitation to date and intended goals of further rehabilitation.

- 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.

- When equipment is issued, the patient and/or carer will be instructed in their safe use by Therapy staff. 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.

- Details of discharge arrangements will be discussed with the patient and/or carer and other members of the MDT and recorded on the discharge care plan by the OT.

- In the event of the patient taking a self discharge whilst on the home visit, the Nurse caring for the patient must refer to: Occupational Therapy Home Assessments: Procedure in the Event of Self-Discharge. (Appendix 16)

3.1.7 (ii) Physiotherapy

- 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 (appendix 15)

- If the patient is identified as being medically stable the Physiotherapist should be consulted as regards their ongoing rehabilitation needs. If the patient requires a period of further rehabilitation the Physiotherapist has responsibility for ensuring that this is discussed with the MDT as to the most appropriate service provider.

- The Physiotherapist is responsible for organising the provision of equipment required for discharge e.g. mobility aids, compressors etc, the Physiotherapist is responsible for informing 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.

- Physiotherapy specific details of the discharge plan will be discussed with the patient and the MDT and recorded by the Physiotherapist 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.

- The Physiotherapist must 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.

- Where patients are being referred to out of area services such as intermediate care the Physiotherapist must ensure that a comprehensive discharge summary accompanies the patient, including details of present mobility status, rehabilitation to date and intended goals of further rehabilitation.

3.1.7 (iii) Speech and Language Therapy

Patients identified, as having swallowing difficulties must have a dysphagia screen completed where appropriate and a referral made to Speech and language Therapy. If this assessment is required to facilitate safe discharge this should be identified on the referral form.

3.1.7 (iv) Responsibilities of the Moving and Handling Specialist

- On admission patients requiring specialist moving and handling interventions, or patients identified as being Bariatric, must be referred to the Moving and Handling Specialist (MHS) on extension 4314.

- It is the responsibility of all staff to refer to and utilise the Bariatric guidelines (Appendix), when planning for or caring for Bariatric patients.

- The MHS will provide a detailed assessment of the patient and make recommendations with respect to equipment required on admission.

- The MHS will liaise with the Occupational Therapists in order to perform an access visit to the patients' home to ensure relevant manual handling equipment is suitable for the home environment.

- The visit will normally include a relative of the patient and/or carer and any appropriate hospital/community based members of the MDT.

- The assessment and recommendations of the MHS will be discussed with the MDT and appropriate action agreed and implemented.

- Where the patient requires follow up manual handling assessments the MHS will be responsible for this.

- The Occupational Therapist will be responsible for ordering equipment required for discharge.

- Details of the discharge arrangements will be discussed with the patient and/or carers and other members of the MDT and recorded on the discharge checklist.

- The MHS or key trainer will provide any training requirements for carers or family prior to discharge.

- Where patients require specific moving and handling to facilitate safe discharge out of hospital, the MHS will accompany the patient on discharge.

3.1.7 (v) Responsibilities of the Hospital Based Social Work Team

- A referral to Social Work team, to be made by the named nurse or designated other, in accordance with the Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy. Utilising a section 2. *(*where there is a need for assessment once the patient has been identified as fit to commence discharge planning)

- The Social Worker/Social Services Officer will liaise with other members of the Social Services Department already involved with the patient's case.

- It is the responsibility or the Social Work Team 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 plan agreed, according to the timelines identified in the accordance with Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

- Following assessment – when it is 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, utilising a section 5 after which the patient will be transferred from an acute bed into the appropriate environment with the relevant support services

- Details of the discharge arrangements will be discussed with the patient and/or carer and other members of the multi-disciplinary team and will be recorded in the nursing record, by the Social Work team.

3.1.8 Responsibilities of the Multi-Disciplinary Team when Intermediate Care Facilities are being considered as the Discharge Pathway

- Once discharge planning has commenced, the multi-disciplinary team will assess for and agree a need for ongoing rehabilitation, i.e. have potential to regain or adapt function within a 6-week period, this may be identified as part of a pre-assessment clinic process.

- The multi-disciplinary team 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 identified as the chosen discharge pathway, all members of the MDT will complete their relevant section on the multi-disciplinary form for Intermediate Care referring to the information required on the multi-disciplinary check list within 24 hours of the form being commenced, ensuring the objectives of Intermediate care are clearly identified.

- The last member of the MDT to complete the referral forms will ensure that the forms are faxed direct to the IMC home coordinating IMC referrals, and communicate directly with the IMC team if it is felt necessary via telephone contact. Currently this is Netherfield Court Intermediate Care Home, on telephone number 01709 336792 and fax number 01709 336790.

- 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' notes.

- The MDT will agree a discharge date; and where appropriate admission to Intermediate Care. This will include a Pre-admission assessment by a representative from the residential Intermediate /Care Unit. (as this will depend

on the availability of vacancies within Intermediate Care, as patients are only assessed by IMC once a vacancy has been identified)

- Once the patient is declared medically stable and safe to transfer, discharge to Intermediate Care will take place. Any Delays to this process will be identified as such as in accordance with The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

- Whilst we will try to accommodate patient preferences as regards to where they would like to be discharged to, this may not always be possible.

3.1.9 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 towards this policy.

3.2 Consultation and Communication with Stakeholders

Insert a description of the consultation process in regard to the development of this policy – who was consulted with

3.3 Approval of the document

This policy has been approved by

3.4 Ratification of the document

This policy has been ratified by the Trust Ratification Group

.4 DEFINITIONS AND ABBREVIATIONS

4.1 Definitions

List and describe the meaning of the terms used in the context of the document if considered necessary.

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

4.2 Abbreviations

List and explain any abbreviations utilised within the document

A&E - Accident and Emergency
CSU - Clinical Service Units
DPSSM - Divisional Patients Services and Standards Manager
HCP - Health care Professional
MDT - Multi-Disciplinary Team
NAS - Neighbourhood and Adults Services (Social Services Care)
NHS - National Health Service
OPD - Outpatients Department
OT - Occupational Therapy
YAS - Yorkshire Ambulance Service

5 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

This policy has been assessed using the Trust Equality and Impact Assessment Tool (appendix 23 and no adverse impact was found.

6 REVIEW AND REVISION ARRANGEMENTS

This policy will be reviewed by the Lead Nurse, Care Management Team every three years unless such changes occur as to require an earlier review

NB *The cover sheet must contain the approval and review dates.*

7. PROCEDURAL INFORMATION –

- **Medicine supplies on Discharge**
- **Patients refusing to leave a hospital bed**
- **Patients being discharged with a subcutaneous syringe driver**
- **Patients who are being discharged from hospital who are receiving intravenous therapy**
- **Responsibility of Medical and Nursing staff in caring for Day- Case patients**
- **Nurses responsibility for booking transport for the patients**
- **Patients being discharged to a Nursing or Residential Home**
- **Patients being discharged from ward and outpatients departments to Community Nursing Service**
- **Responsibility of all RFT staff to complete Continuing Health Care Assessments**

8 DISSEMINATION AND IMPLEMENTATION

8.1 Dissemination

Where you have put implementation this is really dissemination

8.2 Implementation

All wards will receive a copy of the Policy and Procedures document.

Each ward Manager or individual designated to act on Ward Manager's behalf, will be asked to sign a register to indicate they have received the Policy.

A copy of the Policy will also be given to designated colleagues within the Rotherham Primary Care Trust and Local Authority Social Services Department (please see distribution list in appendix 21)

The Policy will be posted on the Trust Intranet in the document management section, ratified documents, policies and procedures.

9 MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THE POLICY

9.1 Process for Monitoring Compliance and Effectiveness

- This process is designed to review the effectiveness of the discharge procedure and ensure effective action is action is taken to implement the required changes necessary to improve services for the patient and families/carers/advocates.

- Each Clinical Service Unit Management team will identify their percentage of adherence to the discharge standards (appendix 1) to their Divisional Management Team and DPSSM.

- Each Clinical Service Unit will self assess twice yearly, utilising the audit tool in appendix 5.

- Audit results and reports, will be shared in each Clinical Service Unit, where action plans will be developed to address areas of poor performance or adherence to policy. These shared with Divisional Patient Services and Standards Managers to provide evidence of monitoring of adherence to the policy, and to ensure areas of poor performance are addressed.

- Yearly, each Specialty will seek peer review utilising the above audit tool, and each speciality will develop action plans that will be presented to Divisional Board and then to Hospital Management Board for approval to resolve any issues or areas of poor adherence.

- Failures and issues relating to the Discharge Process will include Discharge Exception and Serious Untoward Incident reports

- Complaints regarding discharge will be monitored through the Trust Complaints Procedures. DPSSM's will complete trends analysis of all complaints and ensure the development of local action plans to resolve these.

- A meeting will be chaired by the Lead Nurse Care Management Team or designated other, with representation from each division, to ensure that Delayed Transfers of Care are being monitored each week, and action plans developed for each patient experiencing a delayed transfer from hospital, that will include the responsibility for actions to resolve the delay wherever possible.

- Delayed Transfers of care will be declared each week by the Lead Nurse Care Management Team, or designated other.

- A report will be prepared by the Lead Nurse Care Management Team or designated other for Divisional General Managers, Business and Service Managers, 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 and Divisions

9.2 Standards/Key Performance Indicators

10 REFERENCES

11 ASSOCIATED POLICIES/PROCEDURES/DOCUMENTATION etc

Provide details of any supporting/linked policies/procedural documents

- 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
- The Rotherham NHS Foundation Trust Leaving Hospital Information booklet
- The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.
- 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
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- Independence, choice and risk: a guide to best practice in supported decision making. DOH. May 2007
- The Rotherham NHS Foundation Trust Leaving Hospital Information booklet
- The Rotherham NHS Foundation Trust Discharge Planning and Reimbursement Policy.

Appendix 1

EFFECTIVE DISCHARGE ARRANGEMENTS

1. INITIAL ACTIVITIES

- Within 24hrs the staff nurse detailed information regarding social circumstances, ADL's, packages of care and Allied Professionals input.
- This is documented within the nursing records and discharge page.
- This information is communicated to the Discharge Specialist Nurses, Discharge Facilitators and members of the MDT as required.

DURING PATIENTS STAY – PREPARING FOR DISCHARGE

- Preparing for discharge begins on admission by the admitting staff nurse
- The staff nurse will discuss all aspects of discharge with the patient, family, relatives or carers as appropriate and with relevant consent.
- The staff nurse / DSN/ DF will liaise with external agencies where applicable i.e. Community Rehabilitation Team, Community Matrons.
- The staff nurse will complete and send an assessment notification (Section 2) to Social Services, OT and Physiotherapy where applicable.
- All information of actions, referrals and discussions are made in the nursing records.
- Medical staff will identify a predicted date of discharge and provide a comprehensive medical management plan clearly documented in the patients medical notes.
- The staff nurse will ascertain whether transport is required and what transport most suits the patients' needs. This transport is then booked before the day of discharge.
- The staff nurse will inform the patient, relatives, carers or Nursing/Residential/IMC home of the date of discharge.
- The staff nurse will ensure that the patient has appropriate clothing and footwear for discharge and have the means in which to access their discharge address.

DAY OF DISCHARGE

- The staff nurse will ensure all agreed services in place
- The SN will ensure that transport is in place.
- The staff nurse will inform the patient, relatives, carers or Nursing/Residential/IMC home of the date of discharge.

- The SN will provide education to the patient, relatives, carers regarding take home medications.
- The SN will provide the patient with a discharge letter and any other relevant appointments or information
- The SN will document the discharge and discussions in the nursing kardex.
- The nurse in charge will inform the Patient Flow Support Worker of pending and actual discharges for the day.

DELAY 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.
- Delays in discharge will also be documented in the patients nursing records by the SN and in the medical records by the medical team.
- The Care Management Team will collate and disseminate this information via the weekly SITREP.

OUT OF HOURS DISCHARGE

- Patients who are seen in A&E or CDU 'out of hours' and do not require admission-
- Where applicable the SN will provide the patient with relevant information ie Head Injury leaflets, Care of Sutures leaflet.
- Take home medication if required is dispensed from the department or the patient is given an FP10 to collect the medication from an external pharmacy.
- Outpatients appointments are given where necessary ie fracture clinic
- The SN documents all interactions/outcomes in the patients A&E notes.
- Patients admitted to the Medical Admission Unit and discharged 'out of hours' – where applicable information leaflets given ie Warfarin information books, DVT books.
- Where able TTO's will be dispensed from the ward area, if not possible the patient is requested to return to the ward the following day.
- Outpatient or follow up appointments are given where necessary.
- The SN will document all interactions / outcomes in the patients nursing notes,

DISCHARGE REQUIREMENTS SPECIFIC TO EACH PATIENT GROUP

Surgical Day Cases

- Day Surgery Centre (DSC) offer and run a Nurse Led Discharge Service. Although some Consultants do return to review patients before discharge.
- Patients are seen post operatively by the operating surgeon who will document specific instructions pertaining to the discharge requirements on the operation sheet.
- Nurses only discharge a patient when all the discharge criteria have been fulfilled.
- Nurses complete discharge documentation within the DSC Care Plan.
- A record of patients discharged from DSC is maintained in the DSC reception from which a discharge letter is initiated. The discharge letter is forwarded to the patients GP.
- If patients do not meet the discharge criteria a request is 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.

Medical Day Cases

- The Planned Investigation Unit (PIU) offers and runs a Nurse Led Discharge Service. Although some Consultants do return to review patients before discharge.
- Patients are seen pre procedure by the medical team responsible for the planned investigation and they will document specific instructions pertaining to the discharge requirements in the patients' notes.
- Nurses only discharge a patient when all the discharge criteria have been fulfilled.
- Nurses complete discharge documentation within the patients Nursing Records.
- Medical notes of discharged patients remain in the PIU ward clerk office until a discharge letter is completed. The discharge letter is forwarded to the patients GP.
- If patients do not meet the discharge criteria they remain on the PIU unit and are reviewed by medical teams daily until ready for discharge. On days when PIU closes at 16.00 a request is made to the Patient Flow Team by 10.00 for an inpatient bed.
- The patient is transferred to the ward with his nursing and medical records and transferred from the PIU bed-state to that of the receiving wards.

Discharging to Nursing/Residential Home

- The SN will ensure that transport is in place.
- The staff nurse will inform the patient, relatives, and Nursing/Residential home of the date of discharge.
- The SN will provide information to the patient, and Nursing /Residential home, regarding take home medications.
- The SN will provide the patient with a discharge letter and any other relevant appointments or information.
- The SN will document the discharge and discussions in the nursing records.
- The nurse in charge will inform the Patient Flow Support Worker of pending and actual discharges for the day.

To Community Services

Community Rehab Team (CRT)

- CRT will be organised by Therapy staff prior to 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'

Intermediate Care (IMC)

- When discharging patients to IMC Nursing Staff will follow the plan as per instructions for 'Day of Discharge'
  It should be remembered that;
- Patients discharged to IMC must have TTO's and discharge letters with them on discharge.
  They **cannot** be sent later by delivery service.
- Unless previously agreed with the receiving IMC home patients should arrive by 12.00.

District Nursing Service

- When discharging patients with involvement from the District Nursing Team the procedure for discharge will follow as per instructions for 'Day of Discharge'
- 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 do not carry spare equipment, dressings tape ect.
- The District Nurse should have a request for treatment faxed to the DN office at least 24 working hours prior to discharge.

- A detailed letter should be sent home with the patient confirming the plan of treatment by the DN.
- For unexpected discharges the DN can be contacted by Ambulance Control. If this is necessary the ward nurse should ring Ambulance Control ask for the DN service giving the patients name, DoB, address, GP, and a brief description of the intervention needed from the DN.
- A detailed letter should accompany the patient.

Appendix 2

Documentation To Accompany the Patient Upon Discharge

24hr Discharge

- For those patients who are admitted and discharged within 24 hours will be given a copy of their 24 hour discharge summary, and a copy will be posted to the GP. They will be provided with any new medications required with instructions for use as per Trust policy.
- If a District Nurse is required ward staff will arrange this by telephone and provide a written referral letter with instruction for care to go home with the patient. Also provided if necessary will be any equipment / dressings that may be required to fulfil the treatment requested.
- Outpatients appointment cards will also be given on discharge if required

Adult Discharges

- For those patients who are admitted and spend more than 24 hours within the Trust upon discharge will be given;
    1. A computer generated discharge summary which includes reason for admission, treatment given, TTO's dispensed and any follow up appointments required.
    2. Also included is a nursing summary of care and ongoing care required. This letter is then faxed to the District Nurses (Where necessary) requesting a visit. Depending upon the treatment required a specific date / timeline may be needed and this information will be given to the patient within the nursing summary.
    3. When necessary a Discharge Summary of Wound Care will be given by the Central Treatment Room for continuity of care by themselves, District Nurse or care home staff where applicable.
    4. Any follow up required as an out patient will be given to the patient on a separate appointment card.
    5. If a home care package is required, social services provide written Information detailing the plan of care.

Documentation given to Patients being discharged with a subcutaneous syringe driver

- A Photocopy top copy of the prescription sheet with the medication to be used in the syringe driver for use by the community nursing service.

- The Nurse coordinating the discharge must give the patient/carer an information letter explaining the use of the syringe driver and the use of other analgesia for breakthrough pain.

    - A computer generated discharge summary which includes reason for admission, treatment given, TTO's dispensed and any follow up appointments required.

    - Also included is a nursing summary of care and ongoing care required. This letter is then faxed to the District Nurses (Where necessary) requesting a visit. Depending upon the treatment required a specific date / timeline may be needed and this information will be given to the patient within the nursing summary.

    - When necessary a Discharge Summary of Wound Care will be given by the Central Treatment Room for continuity of care by the District Nurse or care home staff where applicable. (Copies of this are also held by CTR and within the patients medical notes.) Wards are encouraged to also give the patient a photocopy of their wound care plan.

    - Any follow up required as an out patient will be given to the patient on a separate appointment card.

    - If a home care package is required, social services provide written Information detailing the plan of care.

Documentation given to Patients who are being discharged from hospital who are receiving intravenous therapy

- A computer generated discharge summary which includes reason for admission, treatment given and TTO's dispensed. 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.
- 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.
- A 'new' drug kardex must be written for the community nursing team and given to the patient on discharge
- Outpatient and/or Vascular Access Team follow up to be arranged prior to discharge by the team responsible for patient discharge.

DISCHARGE FROM SCBU

Babies should be fully examined at discharge and findings recorded in the case notes and the Red Book (Personal Child Health Record)
If the discharge is planned for the weekend, please do the examinations on Friday to cut down weekend work

Discharge summaries are done for all patients admitted to SCBU. These are normally done by the middle grade but they may delegate some of the straightforward discharges to SHOs. Currently this is done by completing the discharge proforma during the SCBU stay, which is then typed. One copy is given to parents at discharge. Nursing staff on SCBU go through it with parents before they go home.

Discharge Documentation

- Parents receive a copy of the letter so please use plain, jargon-free language wherever possible.
- Please take special care over drug dosages, formulations, inhaler devices, etc., (your letter may be used for repeat prescribing in primary care).
- Aim to complete the discharge letter in time for the baby's discharge

Appendix 3

Patient, family and carer expectations of the Discharge process

- To define criteria for success, the following points need to be addressed in order to ensure the best quality of care through the discharge process:-
- All patients who are admitted to Rotherham NHS Foundation Trust should expect to have discharge planning commenced as soon as they are medically stable, and usually within 48 hours.
- For patients being admitted as part of a planned process, wherever possible discharge planning will commence as part of a pre-admissions process
- All patients/families/carers/advocates will be given a forecast of when it is likely that they will be medically fit and safe to transfer home – or predicted discharge date. This date will be given usually within 48 hours of being admitted.
- All patients will be advised of the overall treatment plan, and a description of what the milestones and criteria for safe discharge will be.
- Have access to the services of an interpreter when required.
- All patients/families/carers/advocates will have discharge planning discussed with them.
- The patients/families/carers/advocates will be given information support throughout the discharge process.
- All patients will receive throughout their admission, appropriate and timely assessments in terms of their Health and Social Care needs as set out in the discharge procedures document.
- All patients will be advised that confidentiality through the discharge planning process will occur, and that only pertinent information will be discussed with members of the MDT. This is to ensure effective and appropriate communication is maintained.
- All patients will have discharge plans in place ready for when they are medically fit and safe to transfer to the chosen discharge pathway.
- Appropriate community services will be informed of the planned discharge plan, by way of discharge summaries and letters to GP's or District Nurses etc.

Appendix 4

PROCEDURAL INFORMATION

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.

- Prescriptions for discharge must be written in advance of the patient being informed of their discharge, and at least 24 hours in advance of the proposed time and date. A 28 day supply will normally be dispensed except where the treatment is a limited course e.g. antibiotics or steroids.

- 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.

- It is anticipated that the discharge process will plan so that all prescriptions can be dispensed within the normal pharmacy opening times. The on-call pharmacist will not provide this service out of hours. In exceptional circumstances, where the discharge has not been planned, there are guidelines for medical staff to dispense limited supplies.

- To supply Monitored Dosage Systems (MDS) e.g. Nomads for discharge, a copy of the discharge prescription signed by a prescriber is required which is faxed to the GP requesting that they provide prescriptions; this usually requires 2 working days. The Community Pharmacist who is to supply the MDS is contacted and a copy of the prescription faxed to them. The delivery date for the MDS must be arranged in order for the discharge date to be set.

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.

PATIENTS BEING DISCHARGED WITH A SUBCUTANEOUS SYRINGE DRIVER

- As soon as it is known that a patient is to be discharged with a syringe driver in situ, the community nursing service must be contacted by the nurse co-ordinating the patients care and discharge, and wherever possible at least 48 hours in advance of the patients discharge. Photocopy the drug prescription chart with the medication to be used in the syringe driver.

- Syringe drivers within the Trust are Graseby MS26 (green fronted) which administers a drug at a 24 hour rate. The community use the Graseby MS16 (blue fronted) which administers drugs at an hourly rate.

- When a patient is discharged with a hospital syringe driver the district nurse will visit at home to change the syringe driver to a Graseby MS16 and then be responsible for returning the hospital syringe driver to the equipment library department at the hospital.

- When a patient is admitted from the community with a Graseby MS16 it should be replaced on admission with a Hospital Graseby MS26 machine straight away. The MS16 can be returned to the equipment library to be sent back to community.

- All equipment taken or returned to the equipment library must be identifiable to the patient that is to use or has used it.

- Immediately prior to the patient leaving hospital the nurse co-ordinating the discharge must ensure the syringe driver is working correctly. The nurse must check the equipment is running at the correct speed and that the patient has the correct medication in adequate supply as well as the correct diluents for when it is due to be renewed.

- Any problems whilst the patient is under the care of the Trust advice may be sought from the Palliative care team. Out of hours please contact the Hospice 24 hour professionals helpline; (01709) 308905.

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

- 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.
- The nurse caring for the patient must contact Vascular Access Team telephone 7545 so that they may insert an appropriate vascular access device, provide assistance with the discharge process and continuing support following the patient's discharge. If unavailable, the ward staff should liaise with Fast Response Nursing Team.
- 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.
- Equipment required will vary depending upon the patient's needs and the type of vascular access device in use. The Vascular Access Team will usually obtain the equipment from the list below, however, when busy or otherwise engaged ward staff may also need to complete this task.
- 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 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).
- A 'new' drug kardex must be written for the community nursing team and the TTO's supplied.
- 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, Rotherham General Hospital.

- Outpatient and/or Vascular Access Team follow up to be arranged prior to discharge by the team responsible for patient discharge.

- The equipment list below is for advice only. The exact equipment required will depend upon individual requirements.

Item	~~Notes~~
Yellow 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 3ml	Required at weekly dressing change
Biopatch	Required at weekly dressing change
Statlock	Required at weekly dressing change
Standard needlefree	Weekly change required
Positive pressure needlefree	Weekly change required
Sharps container 11L	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

Responsibility of Medical and Nursing staff in caring for Day- Case patients

- Arrangements for discharge must be discussed at the initial consultation in Out Patients Department (OPD), an explanatory leaflet must be given to the patient at this stage by the nurse in OPD, to inform them of the necessity of an escort to take them home and warning against driving.

- Where appropriate dressings sufficient for a 48hour period, or longer in the case of bank holidays, must be provided by the nurse coordinating the patients' discharge.

- If other community agencies are required to facilitate a safe discharge and provide after care, this must be arranged at pre assessment clinic i.e. District Nurses, Social Services, Transport etc.

- If the patient is to undergo anaesthetic, they should be given a letter entitled "Instructions for General Anaesthesia" to advise them of the precautions to be taken before and after anaesthetic, and this must be documented in the patients notes.

- A contact number must be given to the patient, in case they have any concerns or queries after discharge by the nurse coordinating the patients' discharge.

- All discussions with the patient and carers/families must be clearly documented in the patients nursing notes

Nurses responsibility for booking transport for the 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.

- It is the responsibility of all staff employed by the Rotherham NHS Foundation Trust to adhere to the above principle.

- 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 for transport is defined in appendix ?? and the criteria must be applied by a Health Care professional.

- 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 –17:00 hours Monday – Friday

- Contacting Ambulance desk on 4485 to make request

OR

- Completing ambulance carbonated request forms (found on all wards), taking the form to the Ambulance Desk to make a request. One copy is then returned to ward and placed in patients care records and one is retained in the ambulance department.

From 17:00 – 08:00 hours and from Friday – Monday

- Request an ambulance via telephone number: 0845 1219993.

Same day discharge requests must only be made when the patients are ready to be discharged, i.e. tablets, doctors letters completed. Take home medicines can be delivered by Take home medicines delivery service if the patient is being discharged via ambulance.

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

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

- On admission to hospital/hospice, if the patient is known to the District Nurse, a Transfer/Admission Form must be completed and faxed/sent to 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 (Appendix). Give patient's name, home address, address being discharged to, date of birth, home telephone number, general practitioner, next of kin contact, and if possible NHS number. Details of diagnosis and treatment required.

- The named nurse on the ward or designated other must advise any other agencies involved.

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

- Any medication requiring administration by District Nurse, the named nurse or designated other must enclose clearly written instructions signed by medical staff, as part of the District Nurse referral paperwork.

- The MDT must invite community nurses on to home visit assessments if he/she is being asked to visit after discharge.

- If a complex discharge, either because of patient's condition or equipment used as part of the patient's assessment for discharge, the community nurse to 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.

- 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 District Nurse on discharge, referrals to be faxed to District Nurse base in area between the hours of 10am - 3pm Monday to Friday . Referrals outside of these hours, at weekends and bank holidays to District Nurses to be made via YAS, who will forward information to District Nurse team. NB. Community staff does 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.

- If patients are being discharged, and are being referred to District Nurse with less than 24 hours notice, then nursing staff must call ambulance control on 0845 1219993 to inform them of referral and request they bleep the relevant District Nurse. The Discharge information must also be faxed to the District Nurse base in the area the patients lives.

- All relevant information regarding the patient's ongoing 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 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 District Nurse visit to contact the Practice Nurse for follow up treatment. Only housebound patients will be visited by the District Nurse.

Appendix 5

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 (Appendix)

- 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 be applied to the Continuing Health Care checklist criteria the decision support tool and/or the fast track tool. (Appendix 6[1])

- An identified staff member (decided by the MDT) applying the Continuing Health care Criteria, will be responsible for confirming the patient's /families/carers /advocate's views and that they have the necessary information in writing /appropriate format regarding the continuing health care eligibility criteria, the review panel process and contact points for independent advocacy services.

- The same identified staff member is also responsible for advising the appropriate consultant, nursing / business and service manager for the Directorate and the members of the multi-disciplinary team involved with the care of this patient.

- Following the request for a Continuing Health Care Assessment, the multi-disciplinary team will meet no later than one week of the patient / family/carer/ advocate announcing their recommendations.

- A summary of the reviewed assessment made against the Continuing Health Care eligibility criteria will be completed and a copy given to the patient / family/carer/ advocate).

[1] Not circulated with this document, but available from Delia Watts, Scrutiny Adviser (delia.watts@rotherham.gov.uk) on request

- In the event that the MDT identifies that the patient may meet the criteria for Continuing Health care funding or a joint funding 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 level at the next panel meeting.

- If the patient/relative/advocate consider their health care needs have not been correctly assessed against the Continuing Health Care eligibility criteria, the NHS medical practitioner / representative will facilitate the patient/ relative/advocate to make a formal request to the primary care trusts designated officer to review the application in accordance with the Continuing Care Policy.

APPENDIX 6 - Not circulated with this document, but available from Delia Watts, Scrutiny Adviser (delia.watts@rotherham.gov.uk) on request

Equality Impact Assessment – Initial Assessment Form
APPENDIX 7

Document Name: _____ Date of assessment July 2009

Lead Officer: _____ Department: _____

❑ Function	√ Policy	❑ Procedure	❑ Strategy	❑ other, please state
Please provide details of the main aims, objectives and intended outcomes/benefits of the work.				

The following will help you to check if this policy is sensitive to people of different age, ethnicity, gender, disability, religious
help you to identify improvements required to ensure that the policy is compliant with equality legislation.

Assessment of possible adverse impact against any group				
Does your policy contain any statements, conditions or requirements which may exclude people from using the procedure who would otherwise meet the criteria under the grounds of:		Response		If yes, please state why and the evider
		Yes	No	
1	Age?			
2	Gender (Male, Female and Transsexual)?			
3	Disability (Learning Difficulties/Physical or Sensory Disability)?			
4	Race or Ethnicity?			
5	Religious, Spiritual Belief?			
6	Sexual Orientation?			

SCHEDULE OF DECISIONS

KEY DECISIONS TO BE MADE BY THE CABINET MEMBER, STRATEGIC DIRECTOR AND DIRECTORS FOR NEIGHBOURHOODS AND ADULT SERVICES

Strategic Director: Tom Cray
Representations to: The Strategic Director for Neighbourhoods, Rotherham Borough Council, Neighbourhood Services, Norfolk House, Walker Place, Rotherham S65 1HX.

KEY DECISIONS BETWEEN 1 September 2009 and 30 November 2009					
Matter subject of key decision	**Proposed date of key decision**	**Proposed consultees**	**Method of consultation**	**Steps for making and date by which representations must be received**	**Documents to be considered by decision-maker and date expected to be available***
September, 2009					
Extra Care Housing petition update	September	Cabinet Member for Health and Social Care	Report		Report
Performance	14th September	Cabinet Member for Health and Social Care	Report		Report
Adult Social Care Self Assessment	14th September	Cabinet Member for Health and Social Care	Report		Report
Scheme of Delegations	14th September	Cabinet Member for Health and Social Care	Report		Report
Budget	14th September	Cabinet Member for Health and Social Care	Report		Report
Serious Case	14th September	Cabinet Member for	Report		Report

KEY DECISIONS BETWEEN 1 September 2009 and 30 November 2009					
Matter subject of key decision	**Proposed date of key decision**	**Proposed consultees**	**Method of consultation**	**Steps for making and date by which representations must be received**	**Documents to be considered by decision-maker and date expected to be available***
Review – Child T and Future SCR Arrangements		Health and Social Care			
CQC Inspection Action Plan	28th September	Cabinet Member for Health and Social Care	Report / Plan		Report / Plan
October, 2009					
November, 2009					
Advocacy Strategy	9th November	Cabinet Member for Health and Social Care	Report / Strategy		Report / Strategy
Brokerage	9th November	Cabinet Member for Health and Social Care	Report		Report
Day Care Opportunities	9th November	Cabinet Member for Health and Social Care	Report		Report
Transforming Community Services	9th November	Cabinet Member for Health and Social Care	Report		Report
Prevention Strategy	9th November	Cabinet Member for Health and Social Care	Report / Strategy		Report / Strategy
Performance	9th November	Cabinet Member for Health and Social Care	Report		Report

Adult Services Annual Report Summary 2008/09

Complaint Performance
Improvements in performance with respect to responding to complaints within timescales continues. 98% of stage 1 complaints and 100% of stage 2 complaints were responded to within the statutory timescales. This compares to 94% in respect of Stage 1 for last year and maintaining the 100% performance in relation to Stage 2 complaints.

Complaint Satisfaction
All customers are sent a satisfaction survey following the response to their complaints. The figures are collated for the Directorate as a whole and satisfaction increased in the number of people satisfied with the outcome of their complaint, how the complaint was handled and being kept informed of the progress of their complaint. Over all 73% of customers were satisfied with the outcome of their complaints which has increased form 66% for the same period last year. Satisfaction with being kept informed of the progress of the investigation and time taken to respond also increased from 72% to 77%. The number of customers expressing confidence in using the process again also increased form 90% to 96%

Learning from Complaints - Recognition and 5 examples

Customer Complained That	We Have
The response to a complaint was late because of delays caused by Health Service staff not replying to requests for information	Reviewed and agreed a Joint Protocol for handling complaints relating to both Adult Social Care and Health Service Complaints
A homecare package was terminated without warning by an independent provider	Amended procedures to ensure customers are informed immediately of any risks to the continuation of an existing service
They found contacting Assessment Direct difficult	A separate phone line has been set up for customers not currently known to the Adult Services
They were not consulted regarding the reconfiguration of a service they had previously used	Changed the consultation process to ensure previous customers are invited to consultation events in addition to current users
That suitable arrangements were not in place to cover redundancy costs in respect of Personal Assistants providing care for a recently deceased customer on Direct Payments	Reviewed or processes to ensure such costs are covered in future

Personalisation of Complaints
Since January 2009 the complaints process across the whole of NAS has fully incorporated the principles of personalisation. The implications of this are that managers investigating and responding to complaints maintain contact with the customer throughout the process and agrees with the customer the outcomes

that are being sought to resolve the issues raised. The figures above indicate that satisfaction with the complaints process continues to rise and the biggest improvement being in the number of customers expressing satisfaction with the outcome of their complaint. One of the key aims of personalising the complaints process is to increase the number of successful outcomes for customers and early signs that this is happening are encouraging.

Annual Report

April 2008 to March 2009

Adult Services Complaints

Rotherham Metropolitan Borough Council

Where Everyone Matters

Executive Summary

This report provides information about complaints made between 1 April 2008 and 31 March 2009 under the complaints and representations procedures established through the Local Authority Social Services Complaints (England) Regulations, 2006. The Complaints process primarily contributes to Outcome 4 (Increased Choice and Control**)** with links to Outcome 5 (Freedom from Discrimination and Harassment) of the new Outcomes Framework for Social Services. Details are given on the performance in responding within the deadlines contained in these to Complaints submitted under these procedures. Separate figures are kept for Adult Services because complaints regarding Community Care are covered by statutory regulations which are separate form the process covered by the corporate complaints process

Over the last 12 months the total number of complaints received has reduced from 228 to 209 (46%)**.** A centralised system of recording complaints has been implemented to ensure that performance in handling complaints is consistent across all directorates. Details of each customer, each contact they make (interaction) and each complaint point are recorded. 125 (159 in 2006/07) customers submitted complaints.

Overall 94% of all complaints were responded to within the statutory timescales, compared to 88% (2006/07) and from 72% (2005/06). This is an improvement on last years figure with a significant improvement in responding to Stage 2 complaints, none of which were responded to out of timescales. This performance is the best in the Council for services who have received more than 10 complaints. The overall percentage was slightly reduced by delays in the setting up the hearings of Stage 3 complaints within timescales due to a number of unavoidable factors. These are detailed later in this report along with measures to be taken to improve performance in this area.

The merger of the Adult Social Services and Neighbourhoods Programme Areas into the Neighbourhoods and Adult Services Directorate was completed in April 2008. The complaints function is now fully integrated and works to an established customer defined service standard. This has led to a number of significant progress being made in terms of improving performance by:-

- Improving the timeliness of responses to customers
- Improving the quality of responses
- Learning from Complaints to identify service improvements, recognised nationally by Cabinet Office.
- Strengthening our performance management of complaints with monthly reports being presented to DMT.
- Improving satisfaction of the complaint management process
- Promoting and increasing accessibility of the complaints procedure through the development of the internet, information packs and campaigns in our reception areas.
- Training in complaint handling which has been delivered to all M2 managers in Adult Services.
- Meeting the new Government Customer Service Excellence Standard, one of the first organisations in the country.

Performance in 2008/09

Stage 1

At Stage 1, 114 people made and received responses to 164 complaints compared to 121 people having 183 complaints considered the previous year. Overall there has been a reduction of 6% in the number of customers making complaints and a 10% reduction in the number of complaints submitted.

100% of complaints were acknowledged within 2 working days.

98% of complainants received a response within the statutory timescales which compares to 94% the previous year. This continues the annual trend of improvement in performance in 2005/06 when the number of Stage 1 Complaints responded to within timescale was 72%. Three complaints were not responded to within the statutory timescales because the customer requested a delay in the investigation following a bereavement.

Table 1 Services receiving the highest number of complaints

Service Area	Percentage
Locality Team Older People	21%
Community Occupational Therapy	5%
Community Mental Health Community Team	11%
Client Services / Interviewing Offices	14%
Business Unit	14%

The highest number of complaints relate to services provided by the Locality Teams (Older People) 21%. Older people however make up the vast majority of people seeking or receiving services. Compared to last year there have been significant increases in the proportion of complaints regarding the Business Unit, Community Mental Health Services and Interviewing Officers. Eighteen of the 41 complaints regarding these services however were submitted by 2 customers. There was a significant increase in the number of customer complaining about not being awarded Blue Parking Badges during the first half of the year. The volume of complaints regarding this service have now reduced significantly since a new appeal system was introduced in December.

There has also been a significant reduction in the number of complaints received about Community Occupational Therapy services since the introduction of the Assessment Direct service which is reducing the demand for assessments by assisting customers locate alternative services where this is appropriate.

Table 2 Category of Complaints

Category	Percentage
Quality	26%
Action of Staff	40%

Delay	8%
Lack of Service	8%
Other	4%
Cost	4%
Lack of Information	10%

At 40% of the total, Quality of Service was the biggest single issue people complained about and represented an increase of 20 complaints compared to the same period last year. However 18 of these complaints were submitted by 2 customers. There were significant reductions in the number of complaints received regarding the Quality of service (down 12) Delay (down 10) and Refusal of service (none recorded this year compared to 13 last year)

During the year the complaints team has been supporting managers to, wherever possible seek resolutions with customers expressing dissatisfaction before they escalate into complaints. Of the complaints that were registered at Stage 1, 44% were upheld this year compared to 42% the previous year. The total number of complaints however was fewer and the total number of complaint upheld was actually down by 5 when compared to the previous year.

The first phase of complaints training for frontline managers has now been completed and over 90% of managers have completed the course. Further courses to train those who have not attended will be completed by the end of September and a programme of f=refresher training will be completed. This will cover new statutory complaints processes introduced for Social Care complaints in April 2009. The training will also emphasise the personalisation of the complaints process introduced in January 2009 across the whole directorate

Over the past 12 months we have improved performance in a number of areas – we have doubled the number of assessments carried out and improved waiting times with an average time now being 1 week and as a result have removed all backlogs. We have also trebled the number of annual reviews carried out. These actions and improvements have had a major impact on reducing the number of complaints.

Table 3 – Complaint Decisions

Team	**Upheld or Part Upheld**	**Percentage**
Mental Health Community Support	17	89%
Disability Community Support	13	48%
Intermediate Care Fast Response Team	2	18%
Disability COT	3	38%
Business Unit	0	0%
Other	13	65%
Client Services Blue Badge	16	73%
Hospital Team	2	25%
Locality Elderly	6	18%
Total	**72**	**44%**

Stage 2

Between April 1st 2008 and March 31st 2009 11 customers received responses to 30 Stage 2 complaints. Although the number of customers escalating complaints to Stage 2 increased by 3 compared to the previous year, the number of complaints points investigated reduced significantly from 45 to 30. This maintains the trend of recent years and compares to 11 customers receiving responses to 70 Stage 2 complaints for the year 2006/07. All customers receiving responses to Stage 2 complaints during the year received their reply within the required timescales, again maintaining last years performance.

The average response time for the period was 48 working days which is well within the 65 working days statutory timescale. This compares with an average of 50 working days for the previous year.

Table 4 Outcomes of Stage 2 Complaints

Category	Total	Percentage of Total	Upheld/Part Upheld	Percentage	Percentage of all complaints
Action Of Staff	12	40%	5	42%	17%
Quality	11	37%	4	36%	13%
Other	2	7%	2	100%	7%
Lack of Information	5	17%	2	40%	7%
Total	30	100%	13	43%	43%

In all complaints (Stage 1, 2 and 3) customers receive an apology for the issues that gave rise to their feeling the need to complain.

At Stage 2, 43% of the complaints were either upheld or part upheld, a reduction of 21% compared to last year and the total number of complaints progressing to Stage 2 has decreased. A total of 13 complaints were upheld or partly upheld this year compared to 29 complaints last year and 45 the year prior to that. This represents a significant reduction (36%) compared to last years figure.

Under statutory regulations Social Care complaints need to be investigated by a person independent of the service being complained about. In Rotherham, external consultants are used because it has been found to be more cost effective. They produce a report considered by a senior manager (the Adjudicating Officer) who sends a response with a copy of the Investigating Officer's report to the complainant.

Stage 3

Three people had 4 complaints considered at Stage 3. Under the Statutory guidelines Panels are supposed to be convened within 30 days of the Complaints Manager receiving a request to go to Stage 3. A further 5 working days are then allowed for the Panel to inform the complainant of their decision. A further 15 working days are then allowed for a final response

to be sent form the Strategic Director. Therefore a total of 57 calendar days is allowed from receipt of the request to go to Stage 3 to the final response being sent from the authority

Under statutory regulations, the panel must consist of two people not employed by the authority, the Investigating Officer and the Adjudicating Officer. Two of the Panel meetings were not arranged within the required 30 day timescale. This however is an improvement on the previous year where none of the panel meetings were arranged within the required timescales. The reasons for delay in arranging 2 of the panel meetings were:-

- the customer was offered two meeting dates within the timescales asked for the meeting to be delayed due to holiday commitments.
- the earliest available date was 10 days late due to delays caused by the Christmas break

The statutory regulations governing Adult Social Care complaints changed in April 2009 and the requirement to have complaints considered by an independent panel no longer exists. Please see section on new procedures for further details.

The Panel supported the Adjudicating Officers responses regarding 2 complaints from 1 customer. However, the Panel in supporting the Adjudicating Officer in respect of a complaint that was upheld believed that the desired outcome of cancelling £1,000 of outstanding care charges should be accepted to reflect the time and trouble the customer had taken to raise the complaint. The Adjudicating Officer did originally not support this particular outcome.

One complaint not upheld by the Adjudicating Officer regarding the classification of a property transfer as a deliberate attempt to avoid paying care charges was overturned. Fees already paid by the customer have now been reimbursed and the local authority has now accepted the funding of the care package.

The Panel overturned by a majority decision the Adjudicating Officers recommendation to uphold a decision not to award a Blue Parking Badge in respect of a child with Autistic Spectrum Disorder. However Cabinet member did not accept the Panel's recommendation and the original decision not to award the Blue Parking Badge was confirmed.

Local Government Ombudsman

Three enquiries were received from the Local Government Ombudsman and all were responded to within the required timescales. This is a significant improvement on the previous year when 2 responses failed to meet the required timescales.

The results of these enquiries were:-

1. Local Settlement
2. The Ombudsman did not uphold the customer's complaint
3. The Ombudsman closed the enquiry

Customer Satisfaction of Complaint Handling

Over the past 12 months we have tested satisfaction on with every person who has made a complaint. All customers receive a satisfaction questionnaire within 6 weeks of receiving a response to their complaint. Twenty three per cent of customers have returned the survey.. The surveys sent now include more specific questions regarding how complaints are handled than in previous years and include questions what outcomes they wanted. While this makes making direct comparisons with last year difficult The following results have emerged:-

- 90% of customers expressed satisfaction with one or more aspects of how their complaints were handled.
- 92% of customers stated that if dissatisfied in future they would use the complaints process again. This is up 2% compared to the previous year.
- 77% were satisfied with the time taken for a response to be sent
- 62% expressed satisfaction with the thoroughness of the investigation.

The survey highlighted that only a minority stated they were asked what outcome they wanted and ensuring this proportion increases significantly will be priority for the complaints team over the next 12 months.

Learning from Complaints

Learning from Complaints discussions with accountable manager to promptly identify service improvements and changes in current practice now take place in respect of all complaints responded to. This approach has been recognised nationally and is part of the Cabinet Office Front Office Shared Service (FOSS) Developing Customer Insight report – May 2008 as best practice. We are also corporately leading the way in ensuring complaints lead to real improvements in services for customers.

Table 5 A Sample of Learning from complaints

Customer Complaint	Issue/Recommendation	Action
The Direct Debit for care costs was taken form their account when they were in respite care	The customer was required to pay for care not received and then apply for a re imbursement	Customers are now all offered the option of a Swipe card as an alternative to setting up a Direct Debit
The availability of Community Based Services in Woodsetts was limited	The Commissioning Team negotiated additional service from existing providers	Availability of community based services made evenly available across the borough
That Interviewing Officers did not fully account for the needs of an autistic child when making a decision regarding a Blue Parking Badge for an autistic child	To have the decision re considered the customer needed to submit a formal complaint	An appeals system has now been put in place to review decisions regarding Blue Parking Badges

Customer Complaint	Issue/Recommendation	Action
That information given by a member of staff regarding Benefits had jeopardised a customers claim for benefit	The knowledge the worker had of the subject was out of date	Knowledge of benefit issues now monitored as part of the PDR and Supervision process and refresher training on benefits organized for staff
A female customer complained that the Social Worker discussed a number of highly personal issues in front of several people in an assessment review meeting	The issues discussed needed to be raised. However the customer had not been informed of the issues likely to be discussed in the meeting	Social Workers now ensure customers are aware of what issues will be discussed prior to the commencement of Assessment meetings
The way that they had been informed of the withdrawal of the meals on wheels service	The service was withdrawn as part of an eligibility review under FACS but the possibility of a service being withdrawn had not been mentioned in the previous care review.	All customers are informed at review meetings of any likely reductions to service if their eligibility is likely to change and identifying alternatives is part of the review plan
A customer complained about the arrangements for funding redundancy costs in respect of Direct payments paid to Personal Assistants who had cared for his recently deceased wife	The funding was not available to pay the redundancy costs	The issue was referred to the Director and this situation has now changed
A Blue Badge application was refused because the customer made an error on the form	The form was processed without being checked	Staff now offer to check the form with the customer before processing the application
A customer was not happy when the reasons for the refusal of a Blue Badge application were given in a public reception area	Issues relating to the customer were discussed in a public arena	Customers are now offered the opportunity to discuss such issues in a private room
A customer who had previously withdrawn her daughter from a day centre for people with learning disabled services was not complained that she was not included in consultation when the service was reconfigured.	The customer felt that as someone dissatisfied with a previous service, she would be in a good position to comment on improvements that could be made to the reconfigured service	Past and potential customers to be involved in consultations relating to changes in provision within Learning Disability Services in addition to current service users.
A tenant at Grafton House was unable to access the alarm when he fell out of	This led to a delay in medical attention being sought	The alarm system has been enhanced to ensure that tenants can easily access the

Customer Complaint	Issue/Recommendation	Action
bed		system if they have a fall
A number of customers complained about difficulty in getting through to Assessment Direct	Delays were being caused because customers with open enquiries were given the same telephone number as those seeking referral for the first time	A new number was established for existing customers
A number of customers complained when carers turned up late	There are situations where a carer is unavoidably delayed and could not make contact with the next customer on the list	Carers have now been issues with mobile phones
The response to a complaint was delayed due to lack of clarity over who was responsible for 2 of the 5 issues being complained about.	The lead manager did not contact the customer until the due date for a response	Under the personalisation process introduced in January 2009 the lead manager will discuss with the customer who will deal with issues and agree a timescale for a response Under new regulations implemented in April 2009 regarding the handling of Social Care and health Service complaints, an amended protocol has been agreed to ensure all agencies are working to the same timescales in responding to complaints
The suspension of a care package while a new provider was identified.	The customer had not been told that there was a likelihood that the provider would cease offering the service because the contract team did not want to unnecessarily alarm the customer. Following the receipt of the complaint it was recognised that this was a mistake and that the customer was not involved in planning alternatives while a new provider was identified	The policy on how customers are informed of possible risks to continuation of a service has changed. Customers are now immediately informed and consulted on the most appropriate contingency plan

Finance

Expenditure

There are additional ongoing costs attached to not delivering an effective complaints service for the Department, particularly not effectively resolving complaints at Stage 1.

Table 6

Stage 2 Independent Investigating Officers	£12,507
Stage 3 Review Panellists	£1,356

The costs of Investigation at Stage 2 and Stage 3 have increased this year. However £1,400 of the expenditure was in respect of a Stage 2 complaint submitted in March 2008. The costs of Stage 3 panels also increased because in order to ensure that panel's were held within the required timescales, additional costs were incurred in ensuring an independent member in addition to an independent chair person would be available.

Under new procedures implemented in response to the Making Experience Count White Paper (please see below) there will be considerably more flexibility in how complaints not resolved at the first attempt are progressed. This should dramatically reduce the need to engage external Investigating Officers and therefore expenditure should also reduce significantly. The new procedures also no longer require an independent panel to consider Stage 3 complaints further reducing anticipated expenditure next year.

Compensation

In respect of Stage complaints upheld the following compensation was agreed:-

- £150 in respect of delays to an assessment being completed
- £150 in respect of delays in oraganising a care package when an existing service broke down.
- The reimbursement of £340 in respect of fees charged in respect of care organised for a customer without full consultation with the family.
- £300 in respect of time, trouble and distress caused by delays to responding to a stage 1 complaint

In addition to the above, Stage 3 panel meetings upheld a number of complaints not upheld at Stage 2. This resulted in the following compensation being awarded:-

- A decision not to pursue £1,500 in respect of fees charged for homecare services
- Reimbursement of contributions for residential fees paid over a period of 2 years in due to the transfer of a property wrongly being classed as a deliberate attempt to avoid paying residential fees.

New Developments

Since January 2009 the complaints process has been amended to incorporate the principles of personalisation. The main features of this change are:-

- When complaints are registered, the outcomes being sought by the customer are immediately recorded

- Managers are committed to discussing the details of the complaint with the customer within 2 days of receiving the complaint documents.

- Managers are encouraged to maintain contact with customers while investigating complaints

- Agreement regarding how and when the response to a complaint will be sent is now made with all customers. Nevertheless current timescales for responding to complaints remain unchanged.

- The emphasis on complaint handling is to seek resolution with the customer and to agree an action plan on how the issues will be dealt with.

Since April 2009 new procedures have been implemented to reflect requirements laid out in the Making Experience Count White Paper. The implications of this are detailed below:-

- The progression of complaints not resolved by first line managers will now be more fluid. Because a formal statement with agreed outcomes will have been made at the first stage it will not be necessary to agree a new statement if further consideration is needed. This will ensure that any further investigation can commence immediately. There will also be more flexibility in trying to resolve complaints not immediately resolved within the service area. This will significantly reduce the requirement for people not familiar with the service being complained about to investigate complaints.

- While consideration by cabinet member for difficult complaints is still an option, the convening of a Sage 3 panel is no longer required. This will enable consideration of complaints to progress more rapidly than was the case previously

- Expectations regarding the response to complaints within the previous timescales remain and it is expected that 95% of complaints will be satisfactorily be resolved this way. However, in cases where further consideration is needed, it is anticipated that the process will be less time consuming. Under the previous regulations, it could take up to 22 weeks to take a complaint through all 3 stages. Under the new process, it is expected that no customer should wait more than 13 weeks to receive a final response to a complaint.

- The new complaints process covers both Adult Social Care and Health Service complaints. The previous protocols for handling complaints covering both organisations have been amended to reflect the new obligations each organisation has in responding to complaints within required timescales and in consulting with customers regarding how complaints will be dealt with.

2009/10 Improvement Actions

The merger of the former Neighbourhood and Adult Social Services Programme Areas has continued to improve performance in handling complaints and ensure feedback is used to improve the quality of service that customers receive. Since January 2009 the complaints process has been amended to fully incorporate the principles of Personalisation. During the next 12 months the following improvements will be made:-

- Maintain the improvement in performance in terms of responding to complaints
- Tracking performance in complaint handling across the whole Directorate will continue to further improve performance.
- Improve performance in responding to Freedom of Information and Subject Access requests
- Ensure that the outcomes customers are seeking form complaints are always recorded at the outset.
- Ensure that managers investigating complaints always discuss and agree an action plan with the customer within 2 days of receiving the complaint
- Ensure that the new combined Adult Social Care and Health Service complaints process reduces the maximum time a customer will wait before all stages of the complaints process are completed.
- Improve and enhance the recording of comments and concerns and ensuring learning issues are captured form all feedback and not just formal complaints.
- The successful training in complaint handling to first line managers in Adult Services will be completed. Complaints staff will deliver refresher training to all first line managers to ensure all are aware of new responsibilities related to personalisation of the complaints process

ADULT SERVICES AND HEALTH SCRUTINY PANEL
9th July, 2009

Present:- Councillor Jack (in the Chair); Councillors Barron, Blair, Clarke, Goulty, Hughes, Turner, Wootton and F. Wright.

Also in attendance were Mrs. I. Samuels, Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum) and Mr. R. H. Noble (Rotherham Hard of Hearing Soc.).

Apologies for absence were received from Mr K Jack, Mrs A Clough, Mr J Evans and Ms V Farnsworth.

15. COMMUNICATIONS.

Councillor Jim Richardson commented on the lack of consultation relating to developments at Swallownest Court that would include a psychiatric intensive care unit. Residents in the area had been extremely unhappy and were holding the Parish Council responsible. He felt that Rotherham Council should have made more effort to consult with residents and keep them informed.

Councillor Jack confirmed that a meeting was taking place about Swallownest Court on Monday 13th July 2009 at Aston Comprehensive at 7.00 pm which everyone was invited to attend.

16. DECLARATIONS OF INTEREST.

Irene Samuels declared an interest in item 6 “Emergency (999) Services – Performance in Rotherham”, as her son in law had recently taken up post with the ambulance service.

George Hewitt declared an interest in the item 10 “Voluntary and Community Sector Review as he was a member of the Rotherham Carers Forum.

17. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS.

There were no members of the public and press present at the meeting.

18. EMERGENCY ('999') SERVICES - PERFORMANCE IN ROTHERHAM

Martyn Pritchard, Chief Executive, Yorkshire Ambulance Service and Andy Buck, Chief Executive, NHS Rotherham gave a presentation on the Emergency 999 Services performance in Rotherham.

The presentation drew specific attention to:-

- Yorkshire Ambulance Service (YAS), a regional service – in Facts

and Figures
- Where the YAS fit with the rest of the NHS
- Working across the region's Partnerships
- Key Measures
- Progress made in 2008
- Clinical Performance Indicators (CPIs)
- Response Times for YAS
- Resources and Investment
- Response times for Rotherham
- Paramedic Practitioner Scheme
- Next Steps
    - What we are doing now
    - How we can work together

A question and answer session ensued and the following issues were discussed:-

- How many hoax calls were made to the Ambulance Service. It was confirmed that there were very few hoax calls, but there were calls which were not true emergencies and could better be dealt with by another service.
- Was the 8 minute response time target, an average time? Confirmation was given that the minimum 8 minute response time had to be met 75% of the time in order to meet the target.
- Did the response refer to a medical person responding within 8 minutes or was it simply that a vehicle arrived within this time? It was confirmed that this would include response by a Community First Responder or a paramedic.
- A query was raised as to whether the Category A 8 minute target which had been achieved by Rotherham was sustainable. Confirmation was given that with more staff, better communication technology and more staff "off station on standby" it was achievable to sustain this target.
- What caused YAS to have registration conditions imposed on it, with respect to managing infection, and had the problem now been resolved? There were two major issues which caused this, one of which was that the trust was implementing infection control practices, but was not recording them adequately. The other was uncertainty about whether voluntary car drivers and St Johns Ambulance were part of the scheme. However the former had since been addressed and guidance had now been issued which clarified that these vehicles were excluded, so the Trust had now been able to declare itself fully compliant and had had its registration conditions lifted.
- Does the commissioning process meet the requirements of 'World Class Commissioning'? 2-3 years ago it was not fit for purpose but work has been undertaken with the 12 PCTs resulting in significant improvements, so that it was now working towards meeting the 'world class' criteria.

- Does NHS Rotherham get value for money for its 999 services? It was believed that the investment made by the 12 PCTs was justified and they were confident that value for money would be obtained once the contract was meeting all its clinical indicators and response targets.

- Why were YAS consistently underachieving on the Cat B, 19 minute target, both across the YAS area and in Rotherham? Cat A calls had always taken priority which had impacted on the target for Cat B. Steps were now being taken to address this issue eg trialling a paramedic practitioner scheme in Rotherham. However, as there was no medical reason for having a 19 minute target, the Government was planning to replace this indicator with a new one from April 2010.
- Would patients be taken to the best hospital for their condition, in an emergency, or would they be taken to the nearest hospital to them at the time? If there was time a patient would always be taken to the hospital that specialised with their condition. However if the situation was that the condition was life threatening then they would be taken to the nearest hospital to be stablised.

Members thanked Martyn and Andy for their presentation.

Resolved:- That the performance against the Patient Transport contract for Rotherham be considered at a future meeting.

19. NOMINATIONS

Resolved:- That this item (Nomination to the Rotherham Women's Refuge) be referred back to the Cabinet Member for Health and Social Care.

20. MINISTRY OF FOOD - IMPACT TO DATE - PRESENTATION BY LISA TAYLOR, MINISTRY OF FOOD MANAGER

Lisa Taylor, Ministry of Food Manager gave a Powerpoint presentation on the Ministry of Food – Impact to Date.

The presentation drew specific attention to:-

- What is the Ministry of Food?
- Why bring Ministry of Food back?
- What does Ministry of Food Centre do?
- What is "Pass it on"?
- What are the benefits of coming to the Ministry of Food?

- Events which have taken place
- Classes
- Measures taken
- News – Ministry of Food goes from strength to strength.

A question and answer session ensued and the following issues were discussed:-

- Where was the current source of funding? This was mainly from the Government and regional grants and did not include any mainstream Council funding.
- When would the first formal evaluation report be available? It was expected that this would be produced during August and would be available for circulation to the Panel in September.

- It was felt that although children accepted that healthy food was good for them, they still preferred to eat pizza and burgers. What could be done to change their perception and sustain healthy eating? Children were being offered healthier options of the food they liked which was proving successful. The impact of the courses would be monitored after 6 months and 12 months and reviewed to ensure sustainability.
- There appeared to be little effort made to involve ethnic groups in the ministry of food. Was anything being undertaken to address this? Guest chefs were being invited to come along and demonstrate healthy Asian and Chinese food in the very near future.
- What was the monthly cost of running the project, and when would the current funding run out? The cost was £10,500 per month and the current funding would last until September 2011.

Members thanked Lisa for her presentation.

21. INNOVATIONS TEAM

Tom Sweetman, Innovation Manager gave a Powerpoint presentation about the work of the Innovations Team.

The presentation drew specific attention to:-

- Who the Innovations Team are
- What the Innovations Team are
    - Formed in January 2008
    - Hand-picked – alternative to Project Managers and Consultants
    - Part of Neighbourhoods and Adult Services
    - Transformation services and processes
    - Deliver efficiencies

    - Change Management
    - Raise profile of services
    - Customer focussed consultation
    - Operate across all directorates
- Why the Innovations Team exist
    - To deliver change and efficiencies across the Council
    - Bespoke team
    - Making changes to frontline services
    - Working with customers
    - Holding Visioning Events
    - Better processes – shortened waiting times
    - Focus on customers
- Updates by each member of the Innovations Team about the work they were currently involved in

A question and answer session ensued and the following issues were discussed:-

- Members of the panel were impressed by the enthusiasm of the team and the work that they were doing. As a customer how could contact be made with the team? It was confirmed that there was a single Assessment Direct number now available to make it easier for customers to make contact about any issue.
- What were the main projects being undertaken at present, what were the priorities for the coming year and what actually dictates the work programme? It was confirmed that the Service Plan launch would dictate what work was undertaken by the team.
- Concerns were raised that the team appeared to be very laden down with ongoing work, and the question was asked whether there were enough resources to sustain the good work being undertaken. Confirmation was given that when a project was started, officers in the relevant programme area would also engage in the work being undertaken.

Members thanked Tom and his team for their presentation.

22. VOLUNTARY AND COMMUNITY SECTOR REVIEWS

Tim Gollins, Strategic Commissioning Manager presented the submitted report which summarised the contract review process for the voluntary and community contracts held by Neighbourhoods and Adult Services.

The services identified at Appendix 1 were all contracted on a block basis

which meant that the council purchased the service on behalf of the customer who was there offered a place. This mechanism for customers accessing services was not personalised and in some instances needed to be changed. This was a recommendation made in the cases of Sense Supported Living, Age Concern Handyperson Service and Crossroads Sitting Contract.

A second set of contracts needed their service specifications tightening to be outcome led, after which a tendering exercise could deliver better value for money. These were Age Concerns Advocacy, the Carers Forum, Alzheimer's Support Group and RNIB Information Service.

The Sense contract required full renewal cost and volume purchase basis because of the essential function the service performed, the RNID communication service was also essential and needed to be re-contracted, whilst the RNID equipment services needed to be reorganised as demand and complexity meant the current specification and operating model required updating. This would be done in partnership which RNID over the next year, resulting in a revised service that could be tendered.

A key factor in the review was strategic relevance of the services in light of personalisation in particular and the approach to deciding this was led by a set of working priorities. Over the next six months these working priorities would be revised and replaced by a comprehensive strategic commissioning approach. This approach was being developed in partnership with the Voluntary Sector led by Voluntary Action Rotherham.

A question and answer session ensued and the following issued were discussed:-

- In the initial summary "being more outcome focussed" was mentioned. Members queried what was meant by this. It was confirmed that with personalisation customers were given a budget to purchase service which suited them and their circumstances rather than being directed to a specified service.
- What would happen to the contracts which were to end in September 2009? Was it possible for funding to be given over a longer term to allow voluntary groups time to make more long term plans? It was anticipated that future contracts would be tendered for 3 years.
- Concerns were raised about direct payments and how some old people may struggle to cope. Confirmation was given that support services would be available to all old people should they require it.

23. LINK ANNUAL REPORT

Consideration was given to the LINk Annual Report.

Resolved:- That the content of the report be noted.

24. EXPERT PATIENT PROGRAMME COURSE INFORMATION

Consideration was given to information received in respect of the "Expert Patient Programme" courses.

Resolved:- That the information be noted.

25. THE SUPPORTING PEOPLE (SP) PROGRAMME

Consideration was given to the submitted report in respect of the Supporting People (SP) Programme.

As part of the 2008/09 Local Government Finance Settlement, Ministers announced changes to the funding of the SP grant.

Summary of changes:-

- For 2009/10 the SP programme grant would be paid as an unringfenced named grant. Lifting the current ringfence from the grant meant paying funds to local areas without the current grant conditions.
- In 2010/11 the grant would be paid as part of the Area Based Grant. This meant the funding would be delivered in one single payment made to council's each month.

The report outlined the potential changes to the programme resulting from the two major changes identified above.

Recommendations were made by Supporting People Commissioners on how these changes should be managed.

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

(2) That from April 2009 there was a seamless transition to the governance arrangements for the Area Based Grant.

(3) That the currently established commissioning structures for Supporting People were maintained until March 2010 to deliver the 2008-13 Supporting People Strategy.

26. MINUTES OF A MEETING OF THE ADULT SERVICES AND HEALTH SCRUTINY PANEL HELD ON 4TH JUNE, 2009

Resolved:- That the minutes of the meeting of the Panel held on 4th June, 2009 be approved as a correct record for signature by the Chair.

27. MINUTES OF A MEETING OF THE CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH HELD ON 27TH APRIL 2009, 8TH JUNE 2009 AND 22ND JUNE 2009

Resolved:- That the minutes of the meetings of the Cabinet Member for Health and Social Care held on 27th April 2009, 8th June 2009 and 22nd June 2009 be received and noted.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
6th July, 2009

Present:- Councillor Doyle (in the Chair); Councillors Barron, Gosling and P. A. Russell.

16. MINUTES OF THE PREVIOUS MEETING HELD ON 22ND JUNE, 2009

Resolved:- That the minutes of the meeting held on 22nd June, 2009 be approved as a correct record.

17. ACCOMMODATION FOR OLDER PEOPLE IN ROTHERHAM

This item was withdrawn from the agenda.

18. ADULT SERVICES REVENUE BUDGET MONITORING REPORT 2009/10

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2010 based on actual income and expenditure to the end of May 2009.

The approved net revenue budget for Adult Services for 2009/10 is £72.9m which included additional funding for demographic and existing budget pressures together with a number of new investments and efficiency savings identified through the 2009/10 budget setting process.

The first budget monitoring report showed some underlying pressures of £256,000, however management actions were currently being identified to mitigate these budget pressures.

The latest year end forecast showed there were potential underlying budget pressures on Direct Payments, within Physical and Sensory Disabilities and Older People's Services due to increased numbers. These were being monitored closely. Additional one-off expenditure was being incurred in respect of security costs for the former residential care homes prior to transferring to the Council's property bank. Other budget pressures were due to delays in the implementation of budget savings agreed as part of the budget setting process for 2009/10 in respect of laundry and meals on wheels.

These pressures had been reduced by additional income from continuing health care funding from Health for placements within Learning Disability Services. Savings within independent residential care due to an increase in the number of discharges, further savings on the reconfiguration of extra care housing and slippage in recruitment to a number of new posts where additional funding was agreed within the budget process. Further

management actions were being identified within the Directorate to contain expenditure within the approved budget.

To ease the financial pressures within the service all vacancies continued to require the approval of the Service Directors. Budget meetings with Service Directors and managers had been arranged on a monthly basis to monitor financial performance against approved budget and consider potential options for managing expenditure within budget.

A question and answer session ensued and following issues were raised:-

- When was Rothwel Grange to be de-commissioned? It was confirmed that this would happen in December 2009 unless 10 vacancies can be established at Davies Court before then.
- What steps were being taken to ensure that there wasn't another overspend as had happened in previous years. It was confirmed that monthly performance clinics had been arranged in order to monitor the situation. Problems had arisen the previous year due to the delays in implementing shifting the balance.
- Members asked for a breakdown cost analysis in respect of quality of care. Confirmation was given that there would be a similar exercise undertaken in respect of quality of care as had been done for home from home. Once this work had commenced it was agreed that a report would be brought to a future meeting.
- A request was made for an update report in relation to Meals on Wheels to the next meeting.

Resolved:- (1) That the latest financial projection against budget for the year based on actual income and expenditure to the end of May 2009 be noted.

(2) That a report be presented to the next meeting in respect of the up to date position for Meals on Wheels.

19. 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 1 of Part 1 of Schedule 12A to the Local Government Act 1972, as amended.

20. HIGHFIELDS: DECISION ON CONTRACT

Tim Gollins, Acting Strategic Commissioning Manager presented the submitted report which detailed the recent history of Highfields and

described the current position. The Cabinet Member was asked to decide whether to continue the current contract, or alternatively, to terminate it in accordance with contract clause 13.5 (m).

Resolved:- (1) That the decision of the Care Quality Commission not to pursue actions against the owner be noted.

(2) That the decision of the police not to take any action against the owner by noted.

(3) That the contract with the owner be terminated.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
20th July, 2009

Present:- Councillor Doyle (in the Chair); Councillors Barron, Gosling, Jack, P Russell and S Walker.

21. MINUTES OF THE PREVIOUS MEETING HELD ON 6TH JULY, 2009

Resolved:- That the minutes of the meeting held on 6th July, 2009 be approved as a correct record.

22. MENTAL CAPACITY ACT 2005: DEPRIVATION OF LIBERTY SAFEGUARDS, S.75 PARTNERSHIP AGREEMENT FOR THE JOINT SUPERVISORY BODY

Shona McFarlane, Director of Health and Wellbeing presented the submitted report which informed Members about the formation of a S75 agreement to support the Joint Supervisory Body that had been developed in partnership with NHS Rotherham under the Deprivation of Liberty Safeguards.

The Deprivation of Liberty Safeguards had been introduced through the Mental Capacity Act 2005.

The safeguards ensure that a deprivation of a person's liberty could only take place when it was in their best interest and authorised by the Supervisory Body. The Safeguards also gave legal protection to the relevant person, including the right to:-

- An independent representative to act on their behalf
- The support of an Independent Mental Capacity Advocate (IMCA)
- Have their Deprivation of Liberty reviewed and monitored on a regular basis
- Challenge the Deprivation of Liberty through the Court of Protection

The new statute in relation to the Deprivation of Liberty Safeguards (DoLS) came into force on 1st April, 2009.

Supervisory bodies are responsible for overseeing the DoLS process at a local level and it is their role to commission and co-ordinate the assessment process and appoint assessors.

Local Authorities and PCT's that enter into formal s75 partnerships are able to carry out any of their functions on each other's behalf. This means, for example, that an assessor who was employed by the Local Authority may be covered by the indemnity/insurance of the PCT where they undertook the assessment on behalf of the PCT and vice versa.

A number of multi agency training sessions had been commissioned

specifically around the Deprivation of Liberty Safeguards and 2 sessions had been provided specifically for 'managing authorities'. An appointment had been made to the newly created, joint funded post of 'Safeguarding Adults and Mental Capacity Act Training and Development Manager'. It was envisaged that a comprehensive training would be developed through a multi-agency working group.

The report detailed the number of authorisation requests which had been received and these were comparable with other Local Authorities in the region.

A question and answer session ensued and the following issues were discussed:-

- What timescales had been set and whether these were being met? Confirmation was given that initially in April the timescales were to undertake an assessment within 42 days, but this had been reduced to 21 days with effect from May. It was confidently felt that with the structures which were in place, that this timescale could be met.
- A discussion took place around what measures were in place to support people with Alzheimers Disease. It was felt that it was brought on in some people as a result of loneliness and that measures should be put in place to prevent this. The Director of Health and Wellbeing agreed with this and confirmed that structures were being developed which would address this, which included working closely with the Alzeimers Society. A comment was made that most people did not know what assistance was available and it was agreed that more emphasis was required on raising awareness of the help that was available.
- A comment was made that Patients Panels were a good way of communicating to members of the public, but not all surgeries had them. Members asked for this to be looked into and an explanation sought. It was agreed that the Director for Partnerships and Commissioning communicate with NHS Rotherham via the Joint Commissioning Partnership and report back to members.

Resolved:- (1) That the S75 agreement for a Joint Supervisory Body be approved.

(2) That it be noted that this report be presented to the Adults Planning Board.

23. NEIGHBOURHOOD CENTRES REVIEW UPDATE

The Director of Independent Living submitted a progress report on the above review detailing the findings to date, emerging proposals and recommendation relating to future use.

The review findings to date highlighted that the use of the centres,

revenue expenditure and investment required in each centre varied significantly. Initial findings and recommendations relating to each of the centres were provided in an overview which was attached as Appendix 1 of the report submitted, the details included:-

- Centre location
- Ward
- The facilities available within each centre
- Condition of the centre
- Service requirements/usage
- Risks
- Rental income, expenditure and the payback period
- Costs to improve to ensure 'fit for purpose' and DDA compliance
- Initial community comments/concerns/aspirations
- Other community facilities located within the neighbourhood

63% of all Ward Members, or at least 1 Ward member within each Ward, had attended meetings with the Neighbourhood Centres Manager and Neighbourhood Investment Services to discuss and develop initial recommendations and assess the potential impact of the review findings for each Centre within their Ward. The issues raised included:-

- The importance of the Centres in preventing isolation and social exclusion
- Loss of laundry as some bungalows could not accommodate independent washing facilities: in addition reduction of Borough-wide Laundry Service
- Further loss of services for aged persons following changes to Meals of Wheels Service, Laundry Service etc.
- The rental income exceeded the expenditure on the majority of centres and no visible or recent investment or ringfencing of monies was apparent
- Misuse of Centres by Council and 2010 Ltd. operatives
- The need to explore the potential to opt out of the charge and service
- Support for increased use e.g. NHS locality based services and Safer Neighbourhood Teams
- Sensitive letting of void flats and accommodation attached to Centres

Based upon the identified use, investment requirements, revenue expenditure and proximity to other communal facilities, initial recommendations were as follows:-

- 46 Centres (79%) to be retained and their use maximised – they would be programmed for essential repairs and improvements as per the indicative 15 year investment programme attached at Appendix 2
- 5 Centres (9%) needed further investigation to determine options for alternative use -

- 7 Centres (12%) required more detailed consultation to inform recommendations due to the potential for decommissioning – consultation to take place in July.

A question and answer session ensued and the following issues were discussed:-

- A comment was made that the neighbourhood centres played a big part in the community and it would be tragic if they were to be closed. It was agreed that some were used more than others but it would be more beneficial to encourage usage of those currently not being used than to close them.
- It was noted that a lot of the neighbourhood centres belonged to the residents and as such was included in their rent. It should therefore be taken into consideration when offering the facility out to members of the public who were not resident. A suggestion was made that the rent be reduced accordingly.

- When was the final review expected? It was anticipated that a report outlining the findings would be presented to the Cabinet Member for Housing and Neighbourhoods in September.

Resolved:- That the content of the report be noted.

24. NATIONAL HOME COUNCIL CONFERENCE - 6TH OCTOBER, 2009

Consideration was given to attendance at the National Home Council Conference in London on 6th October 2009. The Cabinet Member was asked to agree attendance for a member and a nomination was sought.

Resolved:- (1) That the Cabinet Member agree to attendance for one Member at the above conference;

(2) That Councillor Frank Hodgkiss be nominated to attend.

25. HOME FROM HOME

Chrissy Wright, Director of Partnerships and Commissioning presented the submitted report in respect of Home from Home.

Home from Home was a new and innovative way of raising standards in contracted residential and nursing care homes in Rotherham. The framework increased the quantity of the assessments on any single home from one year to three. Previously there had been one assessment from a contract and review officer, but this was now supplemented with an assessment from customers, led by the service quality team and another by NHS Rotherham of the quality of health care provided in the home.

Since the last report, a further 20 homes had been assessed and a

current list of ratings awarded was appended to the report.

A question and answer session ensued and the following issues were discussed:-

- A query was raised about the ratings and whether there was a clear explanation on the website to assist members of the public to understand them.
- Concern was raised that the rating for Broom Lane Care Home had gone from excellent to good and the question was asked as to why this had happened. The Director of Commissioning and Partnerships agreed to look into this and report back to members.

Resolved:- That the details of the progress on Home from Home be received.

26. EXCLUSION OF 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 items of business on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs indicated below of Part I of Schedule 12A to the Local Government Act 1972.

27. SOCIAL SERVICES COMPLAINTS PANEL

Consideration was given to a report in respect of the decision and recommendations made by the Adult Social Services (Complaints) Review Panel for Mr J A

Resolved:- That the decisions of the Complaints Panel and the reasons for the decisions, outlined in the letter of response dated 3rd July 2009 to the complainant be received.

(Exempt under Paragraph 2 of the Act – information which is likely to reveal the identity of individuals)

28. SOCIAL SERVICES COMPLAINTS PANEL

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Resolved:- That the decisions of the Complaints Panel and the reasons for the decisions, outlined in the letter of response dated 3rd July 2009 to the complainant be received.

(Exempt under Paragraph 2 of the Act – information which is likely to reveal the identity of individuals)

Councillor Jack expressed an interest in this item as she had been a member of the Panel who had made the decision.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
3rd August, 2009

Present:- Councillor Doyle (in the Chair); Councillors Gosling, Jack and Walker.

An apology was received from Councillor P A Russell.

29. PETITION - MEALS ON WHEELS AND LAUNDRY SERVICE

Consideration was given to a petition which had been submitted in respect of the Meals on Wheels and Laundry Services in Rotherham.

Resolved:- That the petitioners be advised:-

1. The suggestion to ask Jamie Oliver to review the quality of the meals provided would not affect the decision that members needed to make about extending choice and changing the way in which meals were provided in the future.

2. The council were still in a consultation phase in relation to the laundry service.

3. The council was determined to ensure that it continued to provide services of the highest quality within the resources available.

30. COMMUNITY MEALS PROVISION

Tom Cray, Strategic Director for Neighbourhoods and Adult Services presented the submitted report in relation to Community Meals Provision.

A report had been previously presented to the Cabinet Member for Adult Social Care and Health in November 2008, which outlined three potential options for the future development of the Meals on Wheels Service. Following this the Council then made a decision on 4th March 2009 to adopt one of the options presented, as part of the budget setting process. The option chosen was to provide the meals in a different way, to increase choice, quality and value for money for customers and to cease directly providing a meals on wheels service.

An extensive consultation process had since taken place with staff, customers, trades unions and human resources representatives over a period of four months. It had included:

- A questionnaire to ascertain Meals on Wheels customers' views on the proposal.
- Four letters had been sent to customers, including one from the Leader of the Council and the Cabinet Member for Adult Social Care and Health to reassure them that they would continue to receive a meals service.

- Consultation Café – a highly successful event attended by 12 providers and over 100 members of the public in which a wide range of meals were made available for people to sample.

- Community based events were held, one of which was held in Bakersfield Court, which provided a further opportunity to sample some of the meals on offer.
- A voucher was sent to every customer to enable them to sample the meals available, free of charge in their own home.
- Individual assessments of need were undertaken on almost all customers to date, with the rest to be completed within the next three weeks.

The re-assessment process commenced in April 2009 and was due for completion at the end of July. At the start of the process there were 502 people receiving the Meals on Wheels service, and the feedback from customers about the change was positive with over 262 people already having made the change to the new providers at their own request. There were currently 240 people receiving the traditional meals on wheels service with around 20 people changing each week following assessment. Customers had been offered the choice to transfer to the new arrangements or to stay with the in-house meals on wheels service, and some had chosen to stay with the traditional meals on wheels service until it was no longer available. Some concern had been expressed by customers about the reliability of the new providers and the quality of the food, and the innovations team had been monitoring the outcomes for customers.

Since the beginning of July, those customers who had made the change to the alternative providers had been contacted to find out what they felt about the new arrangements. It was pleasing to note that there had only been one complaint from a single customer, and the rest were delighted with the results.

40% of customers had said that the new service was the same as the old one, and 60% had said they felt their choice and their meal had improved. Some people had not even noticed the change which was a measure of the quality of the alternative providers. It had been anticipated that the new meals would offer choice and quality, with most costing less than those provided by the traditional meals on wheels and this had been proven.

It was noted that since 1st April 2008 when the charge for meals increased from £3.20 to 4.30, there had been a reduction of 12% in up take. This had been further impacted by the new arrangements for Day Services. The meals on wheels service used to provide up to 133 meals per week to day centres in the local community but this had ceased as all day centres had now been relocated to Copeland Lodge and Charnwood Day Care provision where freshly prepared meals were provided on site by staff.

The Meals on Wheels service continued to operate from one kitchen at Bailey House, but some staff had already been re-deployed on a temporary basis to other locations within Health and Wellbeing. The Meals on Wheels delivery staff had had routes re-aligned to reflect a reduction in the number of meals to create some efficiencies and a number of staff had sought alternative employment outside of the Council.

There were initially 41 staff affected in the Meals on Wheels Service, four of whom had already been deployed and a further six were attending interview this week.

There were currently 39 posts available for redeployment but it was noted that these opportunities needed to be made available to other staff affected including those from the laundry service and Rothwel Grange. At present there were 70 staff at risk from across NAS but this number was reducing on a weekly basis as suitable posts were obtained.

Staff had received further information in relation to other vacancies but there had been very little take up, as these did not match staff's current working patterns, which were varied.

Staff had been informed and consulted with throughout this process. There had been meetings with senior managers and a staff newsletter had been distributed at the end of May providing staff with an update. In addition 1:1 meetings had been held with all staff affected, and these meetings had been held with trades union representatives, where applicable, and Human Resource Managers. These meetings had provided senior managers with an opportunity to complete a list of all staff skills, views and requirements and had given staff an opportunity to look at the options that may be available to them.

Staff had raised concerns about re-deployment within the Council and whether there were sufficient vacancies, and others had expressed an interest in redundancy should this be an option.

Details of the redundancy costs associated with staff was appended to the report and this calculated the entire cost of redundancy for all staff but was provided for information only. There were a full range of options being sought to avoid redundancy

- Redeployment to existing vacancies
- Taster opportunities to enable staff to experience new roles

Transitional Arrangements – Customers

As previously identified, a number of customers were now aware that there may be a change in the service they receive and had chosen to remain with the existing service until a decision was made about the future of the in-house service. In the event of the decision being made to

cease providing the service in-house, each of these customers would be visited and provided with the support that they needed to change to one of the existing alternative providers. Again there would be a follow up check to ensure that the new services were meeting their needs. It was anticipated, given the smooth transition that other customers had made, that there would not be any difficulties with this.

Resolved:- (1) That the new arrangements be fully implemented from 30th September, 2009

(2) That customers be notified of an end date for the in-house meals on wheels service and information be provided to support a transition to the new providers.

(3) That the proposal to provide a better service to customers be approved.

31. 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 items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972.

32. ROTHERHAM CARERS CENTRE

Chrissy Wright, Director of Commissioning and Partnerships presented the submitted report in respect of the Rotherham Carers Centre.

The scope of the Carers centre would include, but would not be restricted to, the hosting of a carers forum, advice, information, open access, drop-in and a carers register. The premises and funding had been identified and the support services were to be commissioned from the independent sector.

Resolved:- It be agreed that the Rotherham Carers Centre be delivered as set out and achieved within the identified timelines.