Sunderland City Council

Memo

My ref: DN
Your ref:
Email: davidnoon@sunderland.gov.uk

From	E. Waugh	**Date**	31.08.11
Title	Head of Law and Governance	**Ext**	561 1008
Service	Commercial and Corporate Services		
Subject	**HEALTH AND WELL BEING SCRUTINY COMMITTEE –TUESDAY 6TH SEPTEMBER 2011**		
To	All Members and Officers of the Health and Well Being Scrutiny Committee		
Copied to			

I attach for your attention the report relating to the following item marked 'copy to follow' on the agenda for the above meeting of the Health and Well Being Scrutiny Committee.

8 Policy Review - Rehabilitation and Early Supported Discharge from, Hospital – Scene Setting Report.

Report of the Chief Executive

D.G. Noon.

for Head of Law and Governance

Sunderland City Council

Item No.8

HEALTH AND WELL-BEING SCRUTINY COMMITTEE **6th September 2011**

POLICY REVIEW: REHABILITATION AND EARLY SUPPORTED DISCHARGE FROM HOSPITAL – SCENE SETTING REPORT

JOINT REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING AND ADULT SERVICES AND SUNDERLAND TEACHIING PRIMARY CARE TRUST

1. Purpose of Report

1.1 For the Scrutiny Committee to receive detailed service information to begin its investigation of services in support of the rehabilitation and early supported discharge from hospital policy review.

2. Background

2.1 A key function of the Scrutiny Committee is to evaluate and review policy and make proposals to Cabinet for policy development.

2.2 At its meeting in July the Committee agreed to proceed with the review with the following aim: To establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings.

3. Current State

3.1 The Discharge Planning Process

3.1.1 Introduction

Many people admitted to hospital fear the experience of hospitalisation and of losing their autonomy: they want to return to living their previous lives as soon as possible and every effort should be made for this to become a reality (DH, 2003)[1].

Many patients discharged from hospital will have no identified needs and do not require ongoing care from either the NHS or from social care or any complex planning and delivery. Such discharge arrangements can be considered straightforward or what is referred to as a 'simple' discharge, occurring in approximately 80% of cases.

However, some patients will require further support, either on a short-term basis to support rehabilitation and recovery, or on a longer-term basis to meet ongoing care needs. These more 'complex' discharge arrangements are likely to be lower in number (approximately 20%) but will require effective planning and co-ordination by members of

[1] Department of Health. Discharge from Hospital: Pathways, Policy and Practice. 2003

the multi disciplinary team. This team often spans not only a range of professionals but also a number of different organisations, which adds an additional layer of complexity to the process.

Discharge is not an isolated event which occurs at the end of a patient's stay, but is part of a planning process which starts on admission, or sometimes even prior to admission as part of anticipatory care.

3.1.2 Discharge Policy

Locally, City Hospitals Sunderland and Northumberland, Tyne and Wear NHS Foundation Trusts, working with multi-agency partners have developed 'Hospital transfer and discharge' policies (see Appendix 1 and 2). Key principles for discharge planning as set out in these policies include:

- Discharge planning will commence prior to or on admission following a holistic assessment of needs and an individualised discharge care plan will be formulated.
- For acute hospital admissions, every patient will have a clear documented clinical management plan within 24 hours of admission which will be reviewed daily.
- For mental health admissions, a full MDT meeting will take place within 7 days (or earlier if appropriate) and care plan developed.
- For acute admissions, ongoing discharge needs will be clearly identified as either simple or complex for acute patients and the appropriate action taken.
- For mental health admissions, the service user's needs for immediate discharge and also successful reintegration into the community are considered and the care plan will make reference to support in the first week and subsequent 3 months.
- For acute admissions, an expected date of discharge will be identified within 24 hours of admission for simple discharges and 48 hours for complex discharges and reviewed on a daily basis.
- For mental health admissions, planning for discharge will take place at every review.
- Ward staff will have ownership for individual patient transfer and discharge arrangements.
- All patients and carers will be at the centre of the discharge process and will receive a copy of the discharge checklist or discharge care plan as appropriate.
- For acute admissions, primary and community care professionals will be invited to attend a case conference prior to discharge for those patients who have complex needs.
- For mental health admissions, there will be a care coordination review prior to discharge and primary, community and other relevant external agencies will be invited to attend, to review the service user's needs including assessment of risk and formulate a discharge plan.
- Identified equipment will be provided prior to discharge.

3.1.3 Discharge Numbers

The following tables show the number of discharges per annum from City Hospitals Sunderland and Northumberland, Tyne and Wear NHS Foundation Trusts.

City Hospitals Sunderland NHS Foundation Trust	
2010/ 11	All Discharges
	57735

Northumberland, Tyne and Wear NHS Foundation Trust		
2010/ 11	All Discharges	Sunderland TPCT Discharge
	644	540
Approximately 80% of discharges per annum are for adult mental health		

3.2 Services that Support Discharge

3.2.1 National context

Nationally the emphasis is to make care available, where safe to do so, outside hospital, closer to peoples' homes and tailored to the needs of the individual. This is supported in policy through 'Putting people first – transforming adult social care'[2](2007) and the national refresh of the intermediate care guidance 'DH Halfway home' (DH, 2009)[3].

Intermediate care

The Department of Health published its original Intermediate Care guidance in 2001[4] which was incorporated within the "National Service Framework (NSF) for Older People" 2001[5].

The original guidance described Intermediate Care as a range of integrated services to:

- *promote faster recovery from illness*
- *prevent unnecessary acute hospital admission*
- *prevent premature admission to long-term residential care*
- ***support timely discharge from hospital and maximise independent living.***

Since 2001, there have been numerous policy developments and considerable investment in the whole health and social care economy and in July 2009 the updated guidance, "Intermediate Care – Halfway Home"[6] was published. This informs local health and social care economies to ensure that:

- Intermediate Care is widely available to support a diverse range of service users to promote their independence in the community.

---

[2] HM Government. Putting People First - A shared vision and commitment to the transformation of Adult Social Care. 2007

[3] Department of Health. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities. 2009

[4] Department of Health. Intermediate Care Health service/local authority circular HSC 2001/001. 2001

[5] Department of Health. National Service Framework for Older People. 2001

[6] Department of Health. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities. 2009

- Lean thinking methodology is used to develop pathways which ensure timely transfers from acute settings.
- There is an effective alternative to avoidable hospital admissions.
- There is the widest access to Intermediate Care, underpinned by a collaborative approach
- Assessment and decision making of an individual's longer term care needs is undertaken outside of an acute setting, in a rehabilitative and re-enabling environment.
- The number of individuals requiring readmission to hospital is minimised.
- There is a reduction in the number of service users requiring formalised care.
- That assessment for, and delivery of Assistive Technology, is an integral part of Intermediate Care provision.

Intermediate Care is a function rather than a discreet service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with an identified health or social care related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services.

Reablement

Reablement is an 'approach' or 'philosophy' which aims to help people 'do things for themselves' rather than 'having things done for them'.

It is the use of timely and focused support to improve choice and quality of life, so that people maximize their independence by regaining skills and confidence.

Evidence shows that timely bursts of social care Reablement can either prevent hospital admission or post hospital transfer to long term care, or appropriately reduce the level of ongoing home care support required. Reablement complements intermediate care services and the benefits include maximised independence and minimised whole life cost of care.

The Department of Health's definition of Reablement[7] is:

'The use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can ***maximise their long term independence by enabling them to remain or return to live in their own homes within the community****. This approach focuses on re-abling people within their homes...so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.*

Homecare reablement complements the work of intermediate care services, focusing on skills for daily living. It is a key policy priority for health and social care, as one of a range

[7] Department of Health. Care Services Efficiency Delivery Team Reablement Toolkit. 2010

of reablement services that, through short term intervention, help people recover skills and confidence to live at home. Providing equipment for use at home is an important part of reablement.

Like all Intermediate Care Services, reablement aims to assist people at transitional points in their life and to help develop confidence and functioning. What might distinguish it from other models is that it tends to emphasise a "Social Model" by focusing on social interaction and daily living skills, and that it tends to be delivered by un-qualified (but well-trained) staff operating under the guidance and supervision of professional staff.

Rehabilitation

Rehabilitation is a global term for a range of interventions designed to support people through their recovery period to achieve their optimum function and independence. Such services can be accessed in both hospital and community settings and often staff providing rehabilitation work within **an in-reach / out-reach model facilitating a timely and supported discharge from hospital to home**.

'The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce' from the Kings Fund 2000[8].

However, rehabilitation is often a function of a number of services, not a service in its own right. These services are historically provided by secondary and tertiary health services, increasingly the independent health sector and, in recent years, primary health and social care through the intermediate care and reablement policy agendas. Physiotherapy, occupational and speech and language therapists, dietitians and podiatrists, general nurses and some specialist nurses are key professions aligned to rehabilitation services. There is frequently confusion around the terms intermediate care and reablement in the context of rehabilitation, nationally and locally.

The services are frequently commissioned in a variety of ways, resulting in a un coordinated range of programmes related to clinical, medically led specialties such as:

- cardiac rehabilitation
- pulmonary rehabilitation
- stroke rehabilitation
- brain injury
- neuro rehabilitation
- traumatic spinal injury
- chronic pain programmes

Rehabilitation is more than a single intervention or technique. It is a process requiring a range of models and approaches from within specific treatment regimes, to be applied in context for the individual and their environment. Treatment/care plans need to be

[8] Kings Fund. Trends in Rehabilitation Policy: a review of the literature. 1988

reviewed and modified by appropriate personnel, according to the stage of recovery, progress and any change in circumstances impacting on their ability to respond.

Effective rehabilitation requires active engagement and participation of the individual (and maybe their carer) both in setting their personal goals and in modifying their responses and behaviour to optimise their potential. Rehabilitation facilitates a positive change that is more than simple recovery but is dependent on the stage of recovery reached, previous lifestyle, age and co morbidities.

People requiring rehabilitation services may not return to their full health and well being status and need support to adapt to living with a new level of function and levels of impairment. Rehabilitation should support this period of adaptation and social integration but in recent years has frequently been limited due to many factors including the secondary health care drivers and time limited approaches that have focused on throughput rather than effective outcomes.

The complexity of rehabilitation is frequently misunderstood and opportunities to support people towards a more effective outcome, through access to psychological and emotional support, including contributions through the voluntary sector, is an area overlooked in many areas of rehabilitation.

Personalisation

The overall aim is to secure a shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer and delaying or avoiding the need for targeted services. Those who do need such help, however, should have maximum control over this, with the information, means (financial and practical) and confidence to make it a reality.
Think Local, Act Personal – Next Steps for Transforming Adult Social Care, November 2010[9]

"Think Local, Act Personal" provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. It proposes universal approaches designed for all including:

- promotion of health and wellbeing;
- hospital admission avoidance;
- public information including assured financial advice;
- assessment of social care needs on request;
- advice and support to choose and arrange suitable services;
- the availability of an adequate range and quality of provision in the market place;
- robust local community capacity;
- quality assurance and consumer feedback on care and support services.

[9] HM Government. Think Local, Act Personal - A sector-wide commitment to moving forward with personalization and community based support. 2010 http://www.thinklocalactpersonal.org.uk/

Plus targeted support for particular groups, including:

- crisis support;
- reablement / intermediate care;
- personal budget entitlement;
- care management and safeguarding;
- carer support.

There are specific elements within the report which focus on intermediate care and reablement. These are set out in the following paragraphs.

- **Supporting prevention and avoiding crisis admissions to hospital** and other high cost services by combining health and social care personal budgets, crisis support, equipment, adaptations, reablement and the better use of housing opportunities.
- **Promoting the delivery of a broader range of housing/accommodation** designed to offer more supportive living environments to people with care and support needs.
- **Supporting community capacity** so people make use of informal support from family, neighbours, volunteers, community enterprises and live-in support tenants.
- **Mobilising people's own resources, skills and assets** to meet their care and support needs, leaving public funding to cover those that cannot be met from such means.

Personal Budgets

All councils with responsibility for adult social services have been charged with the development of personalisation in their areas. To measure progress made by councils the Department of Health and ADASS focussed on National Indicator NI 130: Proportion of people with an ongoing care (i.e. personal) plan provided with self-directed support, by which this means people with a Personal Budget (whether this is taken as part of Direct Payment or a managed budget or a combination of both).

In relation to the proportion of people directing their own support the Department of Health set a target for councils to achieve 30% by April 2011. The Government intends that all eligible people will be in receipt of a personal budget by April 2013, with the majority managing this through a Direct Payment.

In Control has defined a set of principles that underpin self-directed support and help by giving clear examples of what this means in practice:

- **Right to independent living** - If someone has an impairment they should be able to get the support they need to live an independent life.
- **Right to a personal budget** - If someone needs ongoing support they should be able to decide how the money that pays for that support is used.

- **Right to self-determination** - If someone needs help to make decisions then decision-making should involve that person as much as possible and reflect that person's own interests and preferences.
- **Right to accessibility** - People must be able to understand the systems and rules to maximise the ability of the person to control their own support.
- **Right to flexible funding** - When someone is using their personal budget they should be free to spend their money in a way that best makes sense to them, without unnecessary restrictions.
- **Accountability principle** - The person with support needs and the government both have a responsibility to each other to explain their decisions and to share what they have learnt.
- **Capacity principle** - People with support needs, their families and their communities must not be assumed to be incapable of managing their support, learning new skills or making a contribution.

Personal Health Budgets

A personal health budget allows people to have more choice, flexibility and control over the health services and care they receive.

A pilot programme involving around half the primary care trusts in England is currently underway to test out personal health budgets in the NHS. The programme and its evaluation will explore who will benefit most from personal health budgets, and how the NHS can make them work.[10]

This is a very different way of managing health care, and we know there are many details to work through. That is why we are piloting personal health budgets, and evaluating the work that the pilot sites will do. The pilot programme will run for three years, until 2012.

Carers

On 25 November 2010, Care Services Minister Paul Burstow announced the Government cross department plan *Recognised, valued and supported: Next steps for the Carers Strategy*[11].

This built on the existing national strategy "*Carers at the heart of 21st century families and communities*[12] launched in 2008 with all party support. The new Government has confirmed its support for the principles contained in the previous national strategy and developed a new national action plan across all government departments. The Government notes that carers are by far the largest source of help for disabled and vulnerable people and as such embody the spirit of the 'Big Society'. Carers are

[10] http://www.personalhealthbudgets.dh.gov.uk/About/
[11] HM Government. Recognised, valued and supported: Next steps for the Carers Strategy. 2010
[12] HM Government. Carers at the heart of 21st century families and communities. 2008

therefore said to be particularly deserving of support from both national and local government.

The Government has reaffirmed support for the vision contained in the 2008 strategy, and in the new strategy sets out it's priorities for carers, identifying the actions they will take over the next four years to ensure the best possible outcomes for carers and those they support.

The new National Carers Strategy action plan contains a number of key measures including making available to the NHS an additional £400 million over the next four years to provide support carers to take breaks from their caring responsibilities, including young carers.

The commitment to carers' short breaks funding was further clarified when the Department of Health announced, in January 2011, a number of funding streams to enable NHS support for reablement and social care services. The overarching aims for these new funding streams were:

- to promote and enable better integrated working between health and social care systems, for the benefit of patients, service users and carers;
- to ensure that individuals are supported to regain and maintain their health and independence;

The carers funding is one of four funding streams announced by DH to support these outcomes.

3.2 Local Context

Intermediate Care, Reablement and Rehabilitation

Following the launch of the Intermediate Care guidance in 2001, Sunderland Council Health, Housing and Adult Services (HHAS) working in partnership with Sunderland Teaching Primary Care Trust (TPCT), City Hospitals Sunderland (CHS) and Northumberland, Tyne and Wear (NTW) NHS Foundation Trusts, established Farmborough Court Intermediate Care Service, providing 52 residential rehabilitation and reablement beds for older people including people with dementia. The service, which has access to community therapy and reablement, nurse practitioners, community psychiatric nurses and GP input during day time hours, continued to flourish throughout the proceeding years, and in 2004 won the '*Queen Mother's Award for Intermediate Care of Older People',* being recognised as one of the best services in the country.

Over the subsequent years, the services supporting individuals in the community and facilitating discharge from hospital, continued to develop and re-shape to meet increasing demand and the desire to support people to maintain independence and remain in their own homes for as long as possible.

A Health Needs Assessment (HNA) undertaken in 2008 followed by a whole systems stakeholder event, set out a vision for future rehabilitation pathways in Sunderland and developed a set of core principles for commissioning these services that would be 'seamless, accessible, evidence based, and shaped around the needs of individuals and families'.

During 2008-2010, significant redesign and development of intermediate care, reablement and rehabilitation pathways took place focusing on the critical gaps in services identified in the HNA, as well as piloting new approaches to care and support. New services include:

- *Intermediate Care at Home service* which aimed to facilitate timely discharge and promote independence through home based reablement (now the *Reablement at Home Service)*
- *Community Stroke Rehabilitation Service* providing specialist support and facilitating earlier discharge for stroke survivors
- *Interface Team* providing rapid assessment and intervention for patients attending A&E, AMU, Walk in Centre who are deemed medically fit and not requiring admission, to facilitate discharge and prevent unnecessary admission to secondary care
- *Intermediate Care Assessment and Rehabilitation Beds* – a new 24 bedded inpatient unit within Houghton PCC (opening March 2012), bringing together both medical and nursing care adopting a rehabilitative and reablement ethos to service delivery
- *Memory Protection Services* providing access to information, support and specialist diagnosis, followed by a range of interventions and ongoing care
- *Stroke Association Family Support Service* providing advice and support to stroke survivors and their carers during admission and post-discharge
- *Age Concern Hospital Discharge Service* providing support to people over 60, who are being discharged from hospital who do not have a formal care package to support their arrival home and start the reablement process.

There remain some gaps in condition-specific services to be addressed, such as increased access to neurological and pulmonary rehabilitation, however, stakeholders have identified that continuing to reform rehabilitation services along the lines of multiple individual disease pathways seems unsustainable. Such an approach is not only time consuming and costly, but also does not address the needs of individuals with multiple long term conditions and co-morbidities. Therefore joint working has commenced between health and social care colleagues to develop a more integrated model for intermediate care, reablement and rehabilitation for individuals with long term conditions and complex care needs.

The announcement of additional funding to PCTs in 10/11 and then for 11/12 and 12/13, to support the development of reablement services, post discharge support and prevent readmissions provided an opportunity to progress this work, piloting new services and beginning some preliminary integration of intermediate care services, however,

stakeholders also identified the potential for fragmentation and confusion for both service users and staff, as new services were developed.

A formative evaluation of the PCT reablement funded schemes in 10/11 (see Appendix 3), proposed exploration of increased integration and the feasibility of a single point of access / referral. Transforming these services into a single integrated service with a shared gateway generates opportunities for patients and could also release significant resources. Such an approach would entail generalist rehabilitation services to meet the needs of all patients with long term conditions and complex care needs, as well as some disease specific specialist elements.

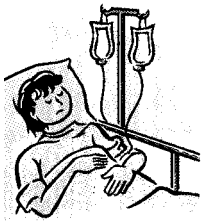
In light of the above developments and service evaluations, stakeholders in Sunderland acknowledged the need to develop a Sunderland wide Strategy for Intermediate Care and Reablement and therefore a Strategy Group has recently been established the aim of which is to provide senior leadership and strategic overview for the development and implementation of a Joint Intermediate Care and Reablement Strategy between the TPCT / Clinical Commissioning Group and Sunderland Council. The reporting structure of the group and terms of reference are shown in Appendix 4 and 5. A Project Coordinator has also been appointed to support this work. In a recent report to the Directors of Adult Social Services in the North East, it emerged that Sunderland were ahead of other areas in their work on strategy development (see Appendix 6).

A draft strategy is now in development and as part of that work we have begun a piece of work to scope intermediate care and reablement in Sunderland, developing an assessment criteria based on Intermediate Care Strategy objectives with the goal of identifying those services aligned with the primary goal of delivering intermediate care.

Whilst this scoping exercise is still underway, we have attached in Appendix 7 a matrix of the services that currently exist in Sunderland which could be considered part of the an intermediate care spectrum and as such have a key role in supporting discharge and promoting independence. This information clearly shows that there are a wealth of services available to facilitate timely discharge and provide both short and longer term community support for individuals, and also that there are considerable linkages between these services. However, it also reinforces the need for streamlined access, clear pathways and joint working between organisations to ensure that discharge pathways are smooth and timely and that opportunities to support independence are maximised for all individuals.

To demonstrate the way in which services work together in Sunderland to facilitate discharge, we have provided 4 case studies below.

Case Study A



Services involved pre-admission and whilst in hospital:
- Ward nursing and medical team
- Discharge Sister
- Depravation of liberty team
- Health Visitor
- Learning disability liaison nurse
- Speech and Language Therapy
- Community Matron for learning disabilities
- Hospital Social work team
- Housing options
- Tissue viability/vascular team
- Continence advisor
- Safeguarding team
- Continuing health Care Nurse Assessors
- Physiotherapy
- Occupational therapy
- Infection Control
- Psychotherapist
- Appliance team
- Dental hospital

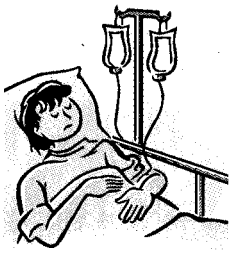
Age: 19

Service: Surgery

Discharge Issues:
- Learning difficulties
- Post partum septicaemia resulting in bilateral above knee amputation
- And dental decay
- Hair loss post scalp infection
- Depression/loss of image
- Relationship breakdown with boyfriend and custody issue of child
- ? Whether potential main carer has her best interests at heart
- Homeless after breakdown of relationship
- Poor motivation

Planned services post discharge:
- Rehabilitation centre
- Community Matron for learning disabilities
- Community learning disabilities team
- Community social work team
- Health visitor
- Speech and Language Therapy
- Community rehab team

Case Study B



Services involved pre-admission and whilst in hospital:
- Ward nursing and medical team
- Discharge Sister
- Speech and Language Therapy
- Occupational Therapy
- Physiotherapy
- Mental health Liason nurse
- Farmborough Court
- Relatives (care day)
- Hospital social work team
- Community social work team
- Telecare

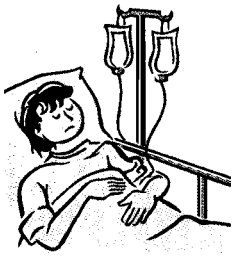
Age: 77

Service: Care of the Elderly

Discharge Issues:
- Frailty
- High falls risk
- Recent fracture neck of femur
- Chronic Obstructive Pulmonary Disorder
- Arthritis

Planned services post discharge:
- District nurse
- Community social worker
- Community care team
- Telecare
- Community matron
- Speech and Language Therapy

Case Study C



Age: 47

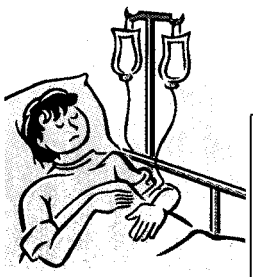
Service: General Medicine

Discharge Issues:
- Alcohol misuse leading to frequent admissions for sustained injuries
- Risk of falls
- Seizures
- Radial nerve palsy
- Cognitive impairment due to alcohol misuse

Services involved pre-admission and whilst in hospital:
- Ward nursing and medical team
- Discharge Sister
- Alcohol liaison nurse
- Safeguarding team
- Occupational Therapy
- Physiotherapy
- Hospital social work team
- Drug and alcohol social work team
- Police
- Probation officer
- Ambulance Service
- Interface team
- Housing options

Planned services post discharge:
- Community social worker
- Probation Officer
- Community care team
- Telecare
- Community alcohol addiction team

Case Study D



Age: 43

Service: General Medicine

Discharge Issues:
- Epileptic
- Insulin dependant diabetic
- Morbid obesity
- Immobility
- Pressure sores
- Sleep apnoea

Services involved pre-admission and whilst in hospital:
- Ward nursing and medical team
- Discharge Sister
- Dietician
- Partner
- Occupational Therapy
- Physiotherapy
- Hospital social work team
- Ambulance Service
- Housing options
- Telecare
- District nurse

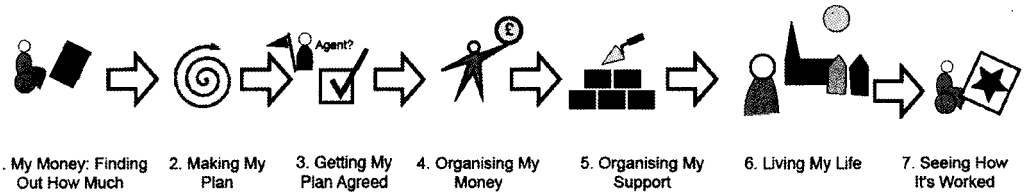
Planned services post discharge:
- Community social worker
- Community care team
- Telecare
- District nurse
- Community Dietician
- Community matron

The TPCT and HHAS are working to develop a set of measures relating to intermediate care and reablement. These measures, which incorporate both proposed national Department of Health NHS and Adult Social Care Outcome Frameworks measures, are based on a holistic view of the solutions available to individuals to move care closer to home and cover a number of different perspectives on performance including:

- Service Delivery – for example, the number of people using these solutions;
- Customer/Patient Outcomes – both professional and customer-defined outcomes;
- Cost-Effectiveness – costs and benefits of the solutions;
- Health/Social Care System Outcomes – for example, to what extent have the outcomes achieved by reablement or Intermediate Care made a difference to emergency admission/re-admission rates to hospital for specific conditions or admissions to Council-funded residential nursing care?

Personalisation

Health, Housing and Adult Services Directorate Personalisation Service has introduced revised business processes and trained staff to implement a personalised approach through a simplified customer journey, in line with the In Control "7 Steps for Self-Directed Support".



The Personalisation Service is promoting access to universal services through closer working with the Customer Services Network where all contacts are triaged and signposted to the most appropriate services. The emphasis is to ensure our customers reach the service they need as quickly and easily as possible, and with the lowest level intervention needed for them to achieve the outcomes they are seeking.

The council's Vision for 2025 is to eliminate the need for admissions to residential and nursing care, and for all people to be enabled to live independently in their own home, in the community.

Personal Budgets

A publicity campaign has been developed to explain the role of reablement and personal budgets and to raise awareness of the advantages this approach brings.

A change in culture is required for practitioners, our partners and our customers for Personalisation to become meaningful for individuals. Most people are still receiving traditional services from their existing provider if this has been in place for some time. However, as we gain experience with new customers who are being assessed and

developing their support plans, we are increasingly seeing a wider range of solutions being used to achieve the outcomes people want.

The provider market place will need to adapt and develop rapidly if Sunderland is to reach the goal of all people directing their own support through a personal budget by 2013. New roles, such as Personal Assistants are developing, and many people are already planning their support much more flexibly, tailoring it to meet their own priorities and preferences.

Sunderland met the 30% target for NI 130, (Social Care clients receiving Self Directed Support), and exceeded it with a final outturn of 31.81%.

At the end of March 2010 the total number of people with a personal budget was 819. At the end of March 2011 this had risen to 2,154.

Personal Health Budgets

Sunderland TPCT have not applied for pilot status but are looking at how pilots are working to consider how we can implement locally. The nearest local pilot is NHS Hartlepool and Stockton-on-Tees for long term conditions.

Carers

There are more carers in Sunderland than the national average and more provide care for over 50 hours a week. According to the 2001 Census, Sunderland had a population of 280,807, of which, around 32,000 people reported themselves to be a carer. However, it is important to remember that many people do not consider themselves to be a carer, they are just looking after their mother, son, or best friend, getting on with it and doing what anyone else would in the same situation, therefore the true figure is likely to be higher. Carers in Sunderland save the economy £706.9 million per year -this is what it would cost the city if the care they provide had to be replaced (Valuing Carers 2011, Calculating the value of carers' support).

The Sunderland Carers Strategy *Recognising and Valuing Carers In Sunderland*[13] sets out a local vision and action plan for carers in Sunderland. The vision is to ensure that the immense contribution made by carers every day is recognised and valued by society, and that they are respected as an expert partner in the provision of support to the person they care for. Carers will be enabled to have a life outside of caring where they can contribute to the social, cultural and economic life of the city and to fulfill their aspirations for a full, healthy, safe and prosperous life.

The strategy has been developed by the Multi-Agency Carers Strategy Group which includes, carer support organisations and partners from across the city. It sets out areas

[13] Sunderland Council. Recognising and Valuing Carers in Sunderland: A multi-agency approach to supporting carers 2009 – 2025. 2009

for action that carers have identified as being important to them and that would enable them to have an ordinary life.

Supporting carers to effectively care should be a key element of ensuring that the reablement and intermediate care services provided for individuals by health and social care are successful. However, whilst intermediate care and reablement services have been developed locally for service users / patients the potential for providing services to carers needs to be fully explored.[14]

HHAS is in the process of developing a Carers Resource Allocation System (RAS), which will deliver personal budgets for carers, to enable them to access support and respite as flexibly as possible, and to enshrine the principle that they have needs in their own right. Although this is contingent on success in the testing of the model, it is anticipated that this will be fully operational by the spring 2012. The carers' RAS is building on existing experience from the Carers Breaks and Opportunities pilot, and we are confident that it will afford carers a good level of choice and control over the support they need to maintain their caring responsibilities and look after their own health and well-being

What have local people told us?

During 2009/10, a number of focus groups and 1-1 interviews took place with the public and carers working with Age Concern (now Age UK), Sunderland Carers Centre, Farmbrough Court, Sycamore Care Centre and City Hospitals Sunderland.

Due to the breadth of services that come under the heading of Intermediate Care, and its links with hospital discharge and wider community health and social care services, this led to a very varied content of discussion in the PPI work above and subsequently very diverse comments and views. However, key themes emerging can be summarised as:

- The need for person-centred care, focused on individual needs and promoting choice and control
- A social disability model which promotes independence and enablement not compensation
- Carers as partners in care, whose views, needs and expertise should be recognised and acted upon
- The need for good discharge planning and coordinated transfer of care
- Care at home if possible, but availability of alternatives to hospital if recuperation and rehabilitation is required

In September 2010, a 'Positive Ageing' conference was held by the TPCT, in conjunction with HHAS and Age UK. During the conference, more that 60 members of the public, users and carers participated in workshops on 'Staying Healthy for the Future', which

[14] http://www.sunderland.gov.uk/CHttpHandler.ashx?id=5713&p=0

included a question on support after illness. The comments most relevant to Intermediate Care, Reablement and Rehabilitation are provided below.

What have been your good experiences? Any ideas/thoughts on what else would have made a positive contribution after a period of ill health?

- *Quick access to health services*
- *Immediate post-op care*
- *24/7 Team*
- *Social services*
- *Equipment provided*
- *Good hospital after care*
- *Follow up rehabilitation*
- *GP to contact patient post discharge/ill health*
- *Phasing into normal routine*
- *More information should be given*
- *More respite facilities*
- *Longer hospital stay to recover or more access to intermediate care i.e. Farmbrough Court*
- *Single rooms in hospital*
- *Individualised care*
- *Care based on needs rather than statistics*
- *Blocks of intermediate care provided after which nothing else provided – individual goes back to where they started (very negative experience)*

3.3 Delayed Discharges

3.3.1 Definition of delayed discharge

A delayed discharge is defined by the Department of Health (2006) as:

'A delayed transfer of care from acute or non-acute (including PCT and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- *A clinical decision has been made that patient is ready for transfer AND*
- *A multi-disciplinary team decision has been made that patient is ready for transfer AND*
- *The patient is safe to discharge/transfer.'*[15]

The Community Care (Delayed Discharges) Act 2003[16] facilitates joint working and requires partners to identify the causes of delay, and implement the actions required to tackle delays within local systems.

[15] Department of Health. Weekly SITREPS – Definitions and Guidance, 18th December 2006
[16] Department of Health. Community Care (Delayed Discharges) Act. 2003

Delays in discharge are not just a local issue, and much work has been undertaken both regionally and nationally to understand the features of delays and consider the improvements required in discharge planning processes.

Regionally discussions undertaken by the North East Strategic Health Authority (SHA), with doctors and managers indicate that there are a significant number of patients who remain in hospital for significant periods of time after being deemed fit for discharge, because of processes and existing perverse incentives in the health and social care system which delay discharge to the most appropriate level of care.

Similar discussions with social care professionals indicate that there is a tendency for hospital clinicians to 'prescribe' residential or nursing care where in practice a period of reablement would support the patient to arguably be discharged sooner, to recover quickly and to maintain their independence. While meeting the clinical needs of a patient will be paramount within a hospital setting it should be noted that this is not always the best time to fully assess any long term social care needs.

The North East has historically had the highest levels of hospitalisation and care home admission in the country, however, in Sunderland there has been an explicit strategy to reverse this trend to improve the quality of life for patients and their families. This has led to increased scrutiny in the discharge process through the introduction of a panel process to oversee decision making with regard to long term care placements. The panel has typically agreed to around 7 placements per week, however, the number of individuals seeking a placement or being referred for a placement has tended to be higher than this, resulting in a bottleneck within the system while cases wait to be considered. The individuals 'who are waiting to go to panel' may wait in a variety of places:

- Their own home (Community)
- A hospital bed (NHS)
- Intermediate Care (NHS/LA)
- 'Short break'(temporary residential care –usually independent sector)
- Transitional bed (NHS funded independent sector)
- Their own home with support (community with home care/telecare)

Discussions are currently taking place regarding opportunities to streamline the panel process and also to increase access to accommodation to undertake the assessment outside of the hospital environment and ensure that an individual's opportunity for reablement and independence are maximised.

In addition, in July 2009, the National Framework for NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care[17] encouraged PCTs to avoid assessing for NHS CHC within the hospital setting as this may not reflect an individual's capacity to maximise

[17] Department of Health. National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care. 2009

their potential after further support. The Framework asked PCTs to consider whether further NHS-funded services to maximise the individual's potential should be provided and to defer assessing for NHS CHC until the person's long term future needs are clearer.

Assessment of eligibility for NHS CHC should take place before eligibility for Local Authority (LA) social care services is considered but should be after appropriate post-discharge NHS-funded support has been provided to maximise the individual's potential. Examples given of such interim services are therapy and/or rehabilitation, intermediate care or an interim package of support in an individual's own home or in a care home (such services are funded by PCTs under their overall powers under section 3 of the NHS Act 2006).

3.3.2 Delayed Discharge Numbers

NHS trusts (including foundation trusts) are required to report delayed discharges using a specific Department of Health SitRep system. This system collects data on the number of patients whose transfer is delayed, the number of bed days of delayed transfer and the number of reimbursable bed days. This can then be used to calculate a fee (a cost per day of delay) which can be requested from social services departments. In Sunderland the trust does not operate a reimbursement policy in this regard.

The number of bed days caused by delayed transfer is reported during a full month, however the number of individuals whose discharge has been delayed is reported as a snapshot. In order to avoid variations caused by, for example, weekend discharges, the monthly census day has been chosen as a Thursday. The data is collected by trusts and is sent to the Department of Health for collation.

The following 5 pages provide an analysis of delayed discharges in Sunderland and also compared to three other local authority areas in the North East region.

- Analysis of delays which are NHS related
- Analysis of delays which are LA related
- Analysis of reasons for delay NHS related
- Analysis of reasons for delay LA related
- Overall analysis of reasons for delay

It should be noted that the graphs provide actual numbers rather than rates of delays, and therefore you might expect to see an increase in number linked to population size. Also SitRep reporting changed from weekly to monthly in August 2010, hence the smoother trend lines between 2010 and 2011.

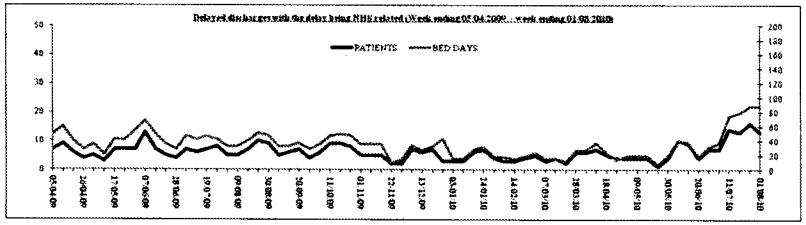
Reasons for delay are coded within the SitRep report as follows:

- Completion of assessment
- Public funding
- Further non acute NHS care (including intermediate care, rehabilitation etc)
- Awaiting residential care home placement

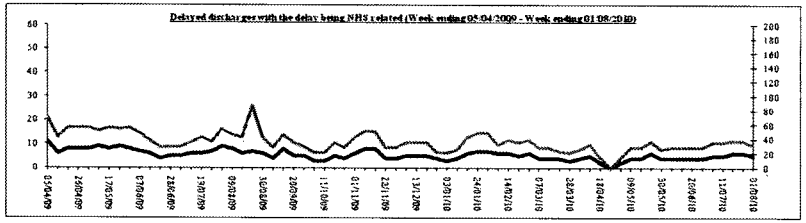
- Awaiting nursing home placement
- Care package in own home
- Community equipment / adaptations
- Patient or family choice
- Disputes
- Housing – patients not covered by NHS Community Care Act

DELAYED DISCHARGES WITH THE CAUSE BEING NHS REALTED (WEEK ENDING 05/04/2009 AND 01/08/2010) (WEEKLY)

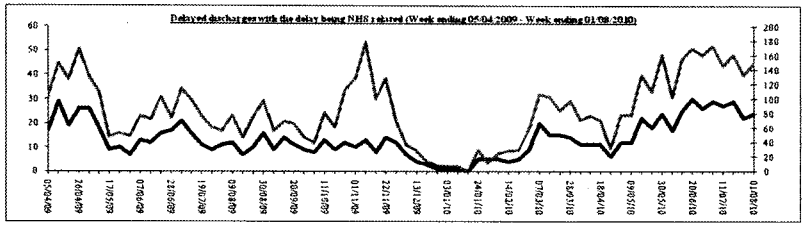
SUNDERLAND LOCAL AUTHORITY



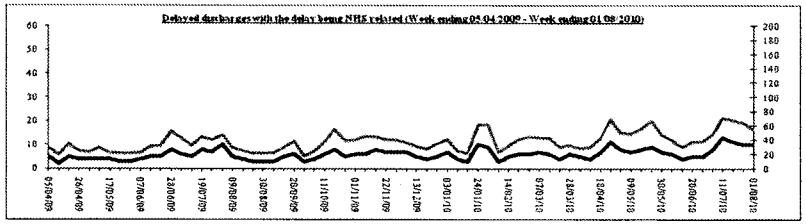
GATESHEAD LOCAL AUTHORITY



NEWCASTLE UPON TYNE LOCAL AUTHORITY

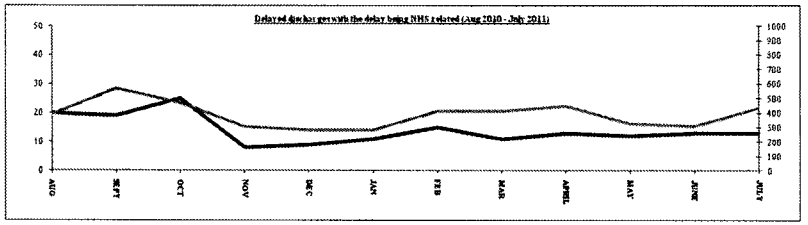


DURHAM LOCAL AUTHORITY

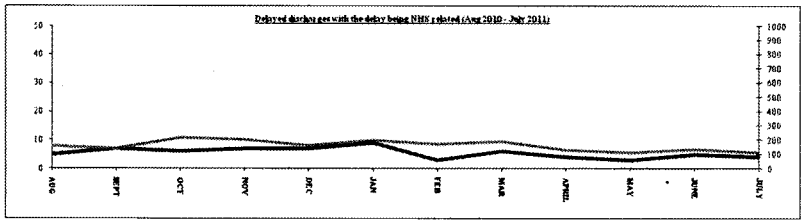


DELAYED DISCHARGES WITH THE CAUSE BEING NHS RELATED (AUG 2010 TO SEPT 11) (MONTHLY)

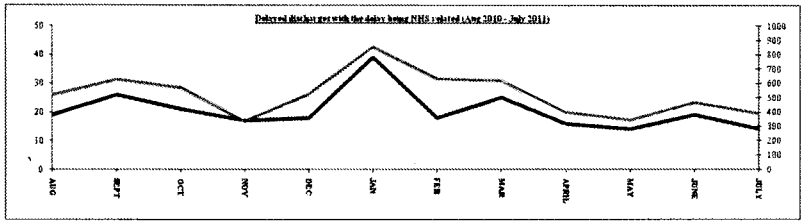
SUNDERLAND LOCAL AUTHORITY



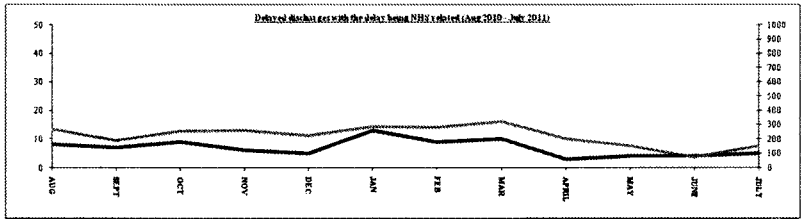
GATESHEAD LOCAL AUTHORITY



NEWCASTLE UPON TYNE LOCAL AUTHORITY



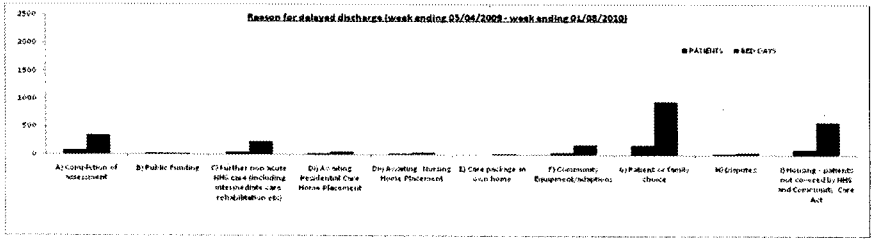
DURHAM LOCAL AUTHORITY

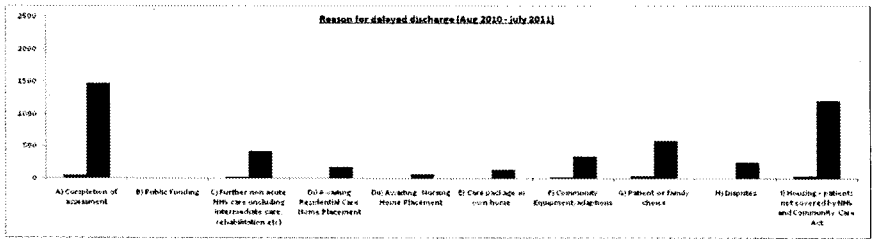


REASON FOR DELAYED DISCHARGES (WEEK ENDING 05/04/2009 - 01/08/2010) NHS

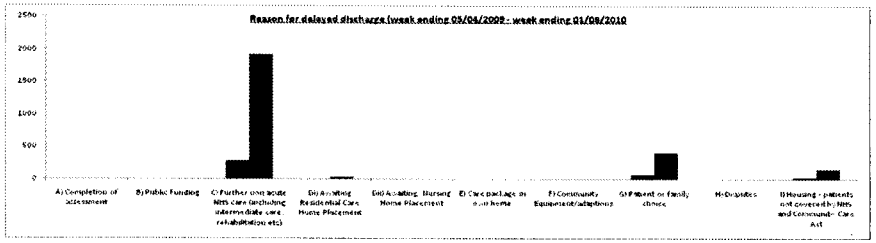
REASON FOR DELAYED DISCHARGES (AUG 2010 - SEPT 2011) MONTHLY NHS

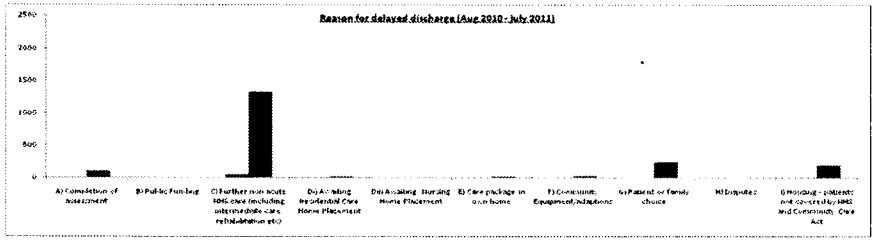
SUNDERLAND LOCAL AUTHORITY



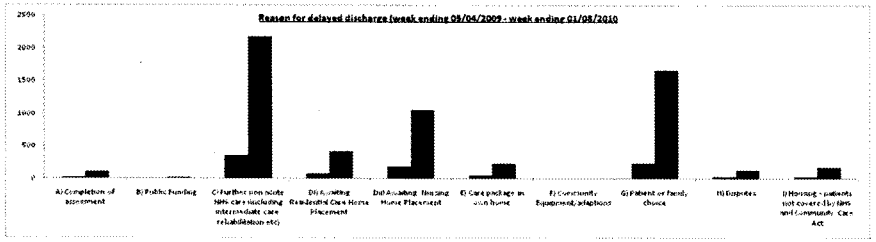


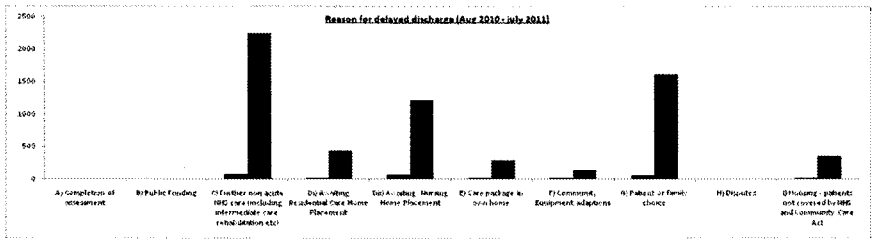
GATESHEAD LOCAL AUTHORITY



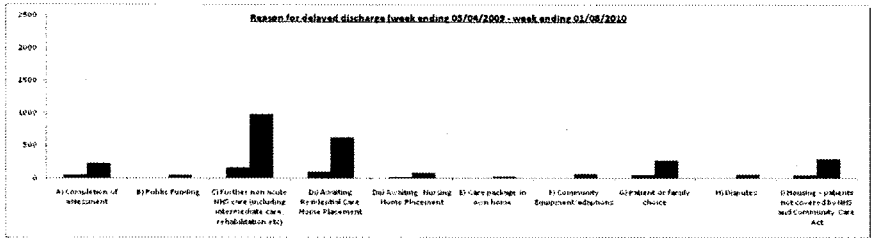


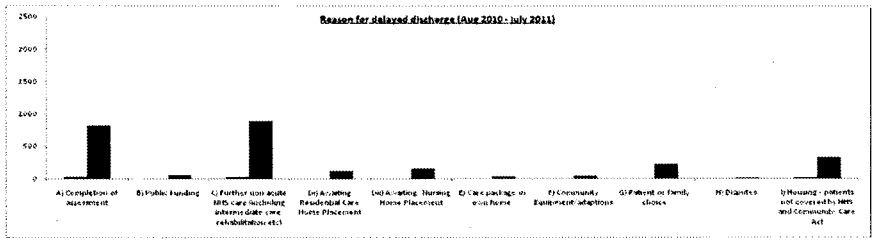
NEWCASTLE UPON TYNE LOCAL AUTHORITY





DURHAM LOCAL AUTHORITY

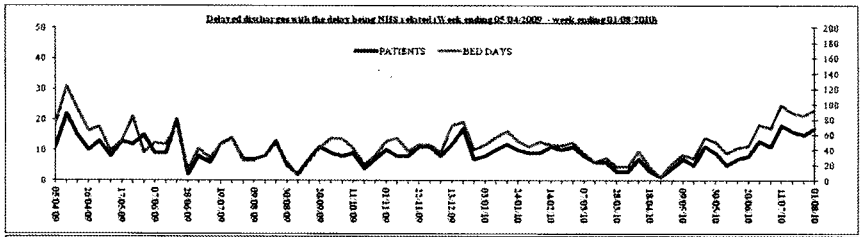


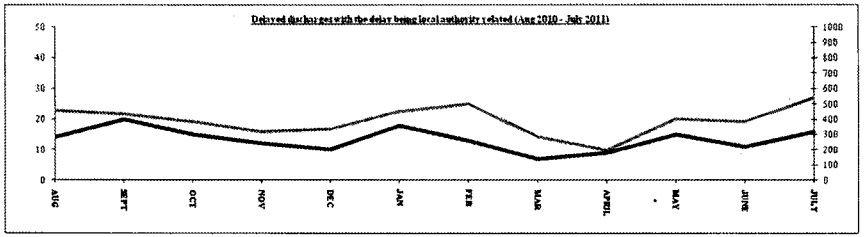


DELAYED DISCHARGES WITH THE CAUSE BEING LOCAL AUTHORITY REALTED (WEEK ENDING 05/04/2009 AND 01/08/2010) WEEKLY

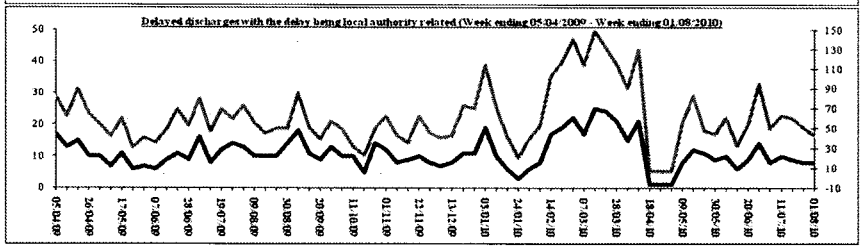
DELAYED DISCHARGES WITH THE CAUSE BEING LOCAL AUTHORITY REALTED (AUG 2010 - SEPT 2011) MONTHLY

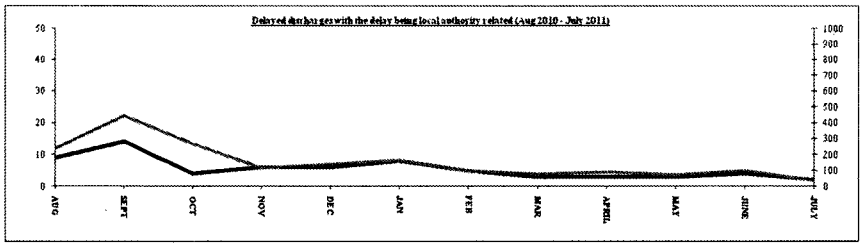
SUNDERLAND LOCAL AUTHORITY



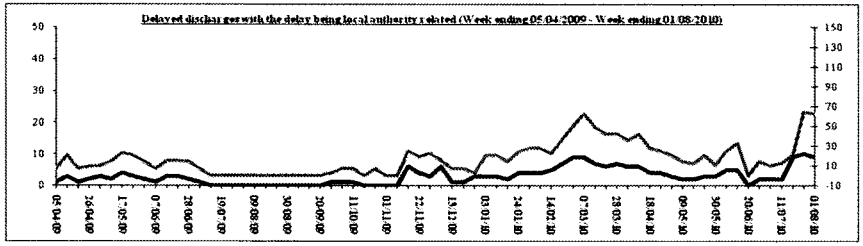


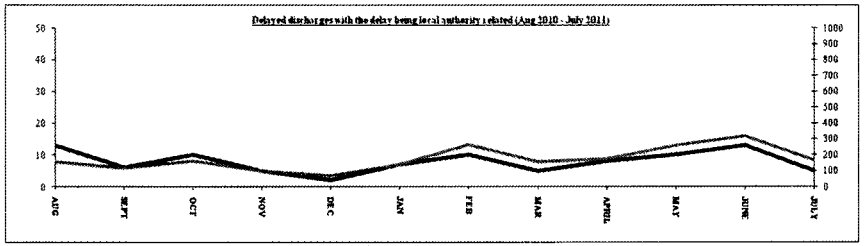
GATESHEAD LOCAL AUTHORITY



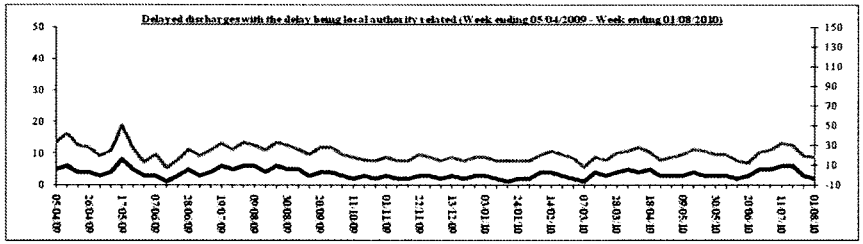


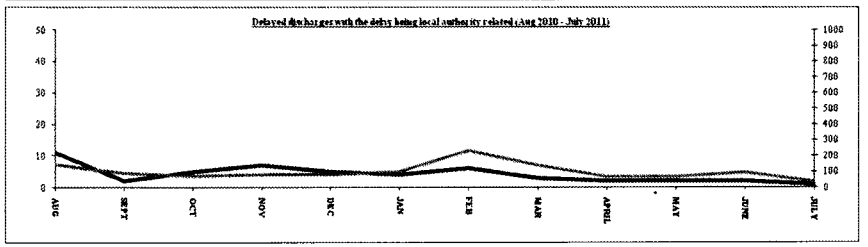
NEWCASTLE UPON TYNE LOCAL AUTHORITY





DURHAM LOCAL AUTHORITY

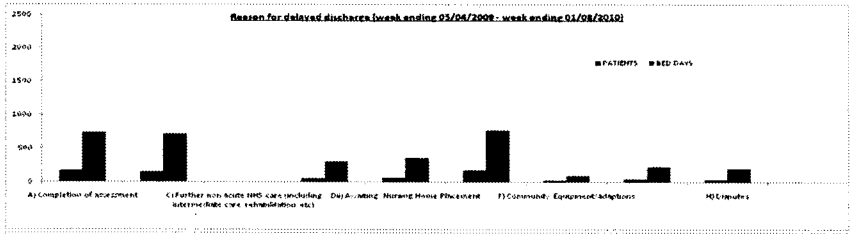


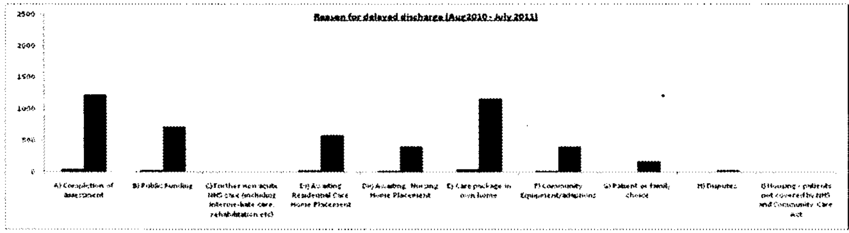


REASON FOR DELAYED DISCHARGE (WEEK ENDING 05/04/2009 AND 01/08/2010) LOCAL AUTHORITY RELATED

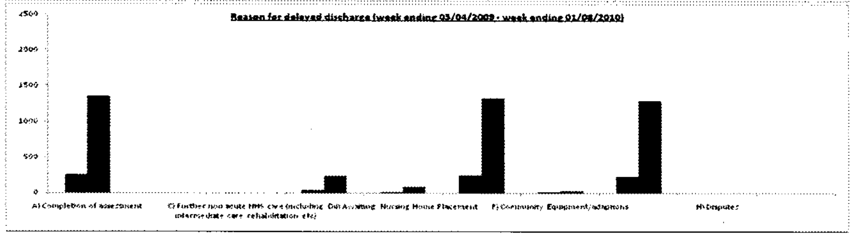
REASON FOR DELAYED DISCHARGES (AUG 2010 - JULY 2011) LOCAL AUTHORITY RELATED

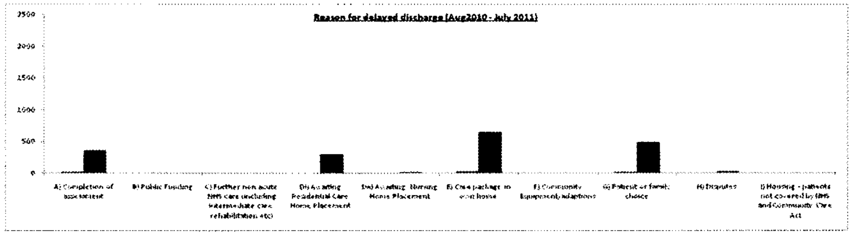
SUNDERLAND LOCAL AUTHORITY



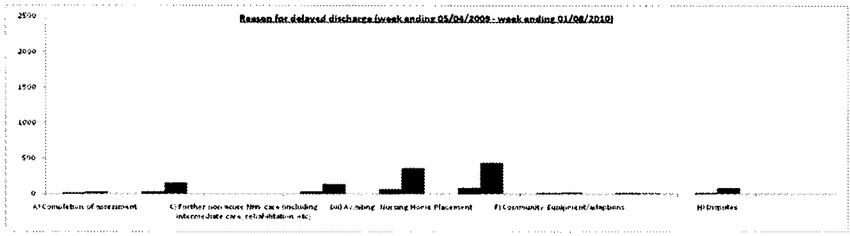


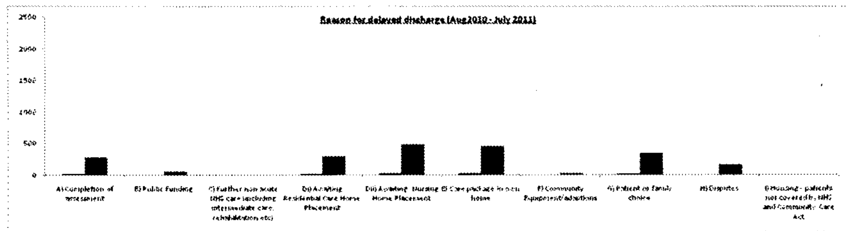
GATESHEAD LOCAL AUTHOIRTY



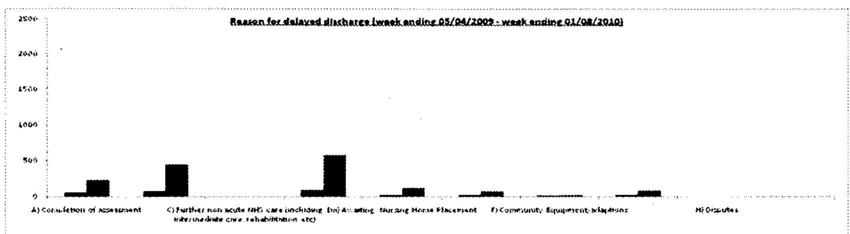


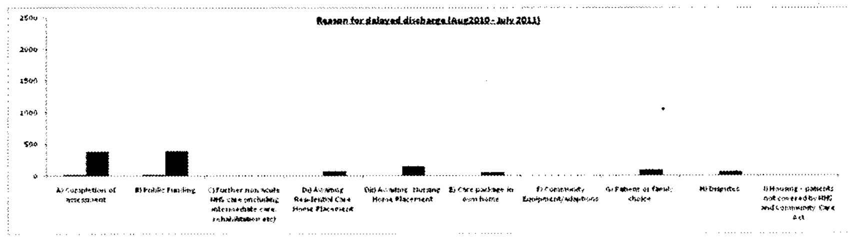
NEWCASTLE UPON TYNE LOCAL AUTHORITY



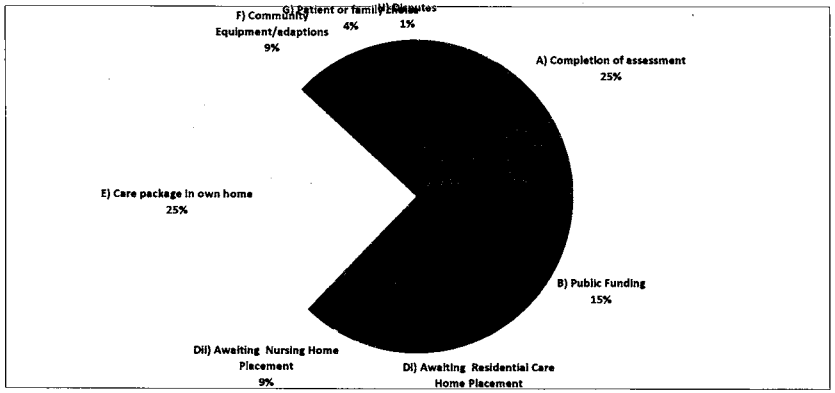


DURHAM LOCAL AUTHORITY

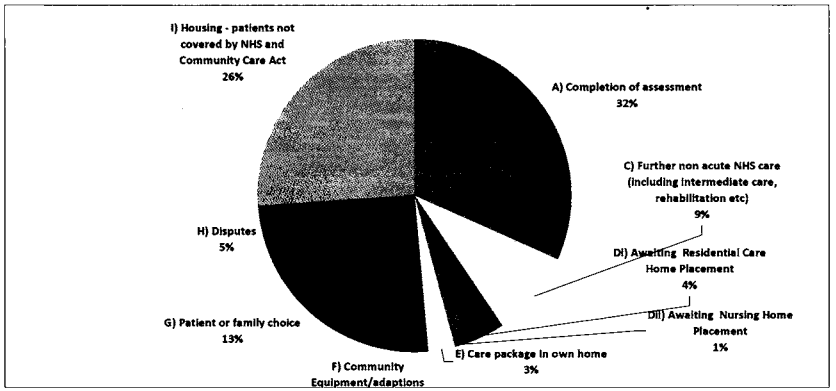




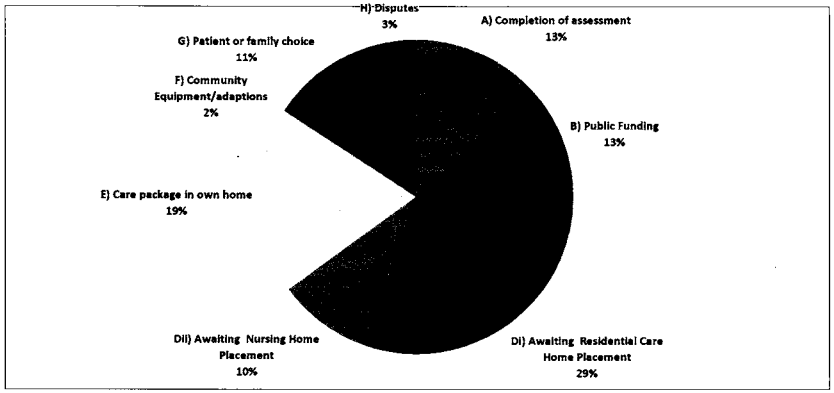
Sunderland delayed discharges Aug 2010 - Sept 2011 local authority related



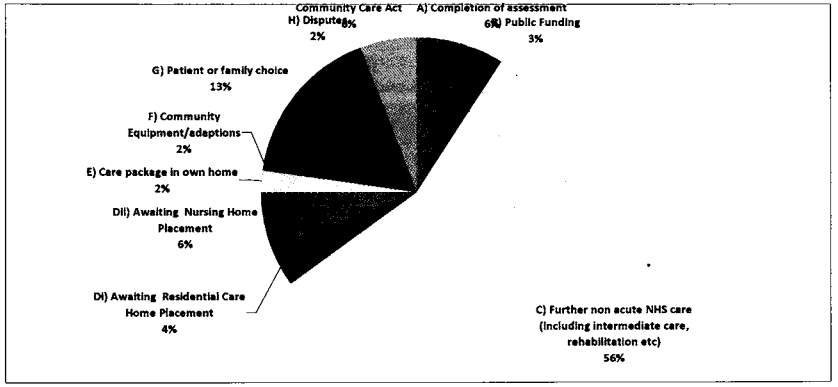
Sunderland delayed discharges Aug 2010 - Sept 2011 NHS related



Regional delayed discharges Aug 2010 - Sept 2011 local authority related



Regional delayed discharges Aug 2010 - Sept 2011 NHS related



The following table provides a 12 month analysis of delayed discharges at City Hospitals Sunderland by PCT of residence and whether attributable to NHS or LA delay.

PCT of residence	NHS	SOC	BOTH	Grand Total
Gateshead		1		1
South tyneside	7	1		8
Sunderland	**117**	**223**	**67**	**407**
County durham	19	20	4	43
Newcastle		1		1
Gloucestershire	2			2
Grand Total	145	246	71	462

462 delays out of almost 58,000 discharges in 12 months is a very small figure, however the table below provides an overview of the bed days lost related to those delays, which is 6111. In most cases the reasons for the delay will be complex and the number of organisations involved will be many.

Month	LOST BED DAYS			
	NHS	SOC	BOTH	Total
TOTAL	2386	2762	963	6111

When reviewing the local, regional or national picture regarding delayed discharges, there are a number of reasons to suggest that this data does not represent a true picture of delayed discharges in the system:

- The complexity of the processes for discharging patients, and the lack of aligned incentives for the timely discharge of patients, make it almost inevitable that there will be very significant delays.
- A mini review by the North East SHA of some of the data collection processes used within trusts in the North East shows wide variation in the approaches taken within and between trusts. This includes variation in approach (produced bottom up at each MDT meeting or collated by a telephone ring round to each ward by the corporate information team) and completeness of reporting (all trusts and departments or just care of the elderly units).
- Anecdotes suggest that many trusts are making little use of the right to fine local authority social care departments (apparently because of difficulties getting local authorities to agree to pay the fines because of disputes as to whether cases meet the criteria) and therefore the trusts find little added value in completing the SitRep data return.
- As indicated above there appears to be wide variation in the understanding of what counts as a delayed discharge.
- Published research (Godden et al, 2007[18]) has also identified concerns around the quality of the SitRep data. These included questions concerning the timing of when the delay actually starts in different

[18] Economic and Social research Council. Discussion Paper Series. No 0703: Can We Tell if Government Policies Are Working? Interpreting Government Data on Delayed Discharges from Hospitals. Godden at al. May 2007

hospitals, differences in the way data is collected and the potential for inefficient data collection systems to make the hospital look more efficient than it actually is. The configuration of beds within a hospital could also lead to patients being moved to intermediate beds rather than being discharged and not, therefore, being recorded as a delayed discharge. The complexity of the system for accurately capturing the required data could lead to misclassification or underreporting of delays.

In a paper prepared by the North East SHA in July 2011, they identified two main areas that they believe require further attention in order to establish the reality of delays. These are:

- data collection arrangements
- the definition and identification of patients experiencing a delay in their discharge or transfer arrangements.

These issues will be raised nationally with the NHS Operations Board.

However, the SHA have also identified a number of factors that they believe may provide optimism towards joint working to address the challenges behind delays in discharge, which are:

- The significant productivity challenges that both the NHS and local authorities face throughout the current comprehensive spending review period and beyond which are creating a burning platform for working differently.
- The direction of health and social care reforms including the transfer of public health responsibilities from PCTs to local authorities and the introduction of health and well being boards, which are giving a far greater role for local authorities in health and healthcare.
- The impact of reablement and other social care funding which is flowing through the NHS to local authorities in a significant way from 2011/12 onwards.
- The very strong emphasis on integration that has come through in PCT cluster integrated plans and emerging clinical commissioning group pathfinder plans.

3.3.3 Improvement Work

Multi-agency Hospital Discharge RPIW

In March 2010, as part of the reform of Urgent Care agenda in Sunderland, it was suggested that NHS SOTW be asked to lead a multi-agency RPIW focusing on the hospital discharge process for patients with social care needs. This was a very large RPIW, involving 20 team members from a wide range of disciplines and across three provider organisations:

- City Hospitals Sunderland Foundation Trust
- Sunderland Health Housing and Adult Services
- Sunderland PCT/NHS South of Tyne and Wear.

The RPIW was sponsored by senior leaders from within each organisation.

The scope of the RPIW was identified as the reduction of overall lead time for the hospital discharge process for patients with social care needs on three Care of the Elderly wards at the Royal Hospital in Sunderland. The boundaries set for the week were safeguarding of adults, ensuring safe discharges and no increase in cost.

The current state value stream map showed the many steps in the process from admission and identification of social care needs through to social care package in place and subsequent discharge. A number of quality defects and potential kaizen opportunities were identified during the initial data gathering phase and mapping the current state, including waiting, re work and over processing. For example:

- Lack of understanding of "why refer" to Social Care leading to inappropriate referrals
- No social work in MDT
- Over processing SAP → SWIFT
- Re work ringing wards due to inappropriate and incomplete referrals
- No set response times for Social Work allocation
- Fragmented discharge pathways
- Significant hospital re-admission

Many ideas for improvement were generated which were collated into 4 themes. These themes along with the key outputs are outlined below. Further information can be found in Appendix 8.

Referral process
Our solution was to develop a pull system for referrals, to be known as the Pow Wow. This Forum brings together multi- professionals to make timely decisions about referrals required to enable a safe and appropriate discharge after consideration of all the exit routes.

MDT working
Our solution was to consider alternative methods of achieving positive communication and improving Multi-Disciplinary working and developing a protocol pathway to pull relevant people through the system.

Patient experience
Our solution was to simplify and standardise the information currently available, producing a single patient file and create a visual control with built in mistake proofing. This is used by patients, carers, relatives and professionals and ensures that relevant information is conveyed in a timely and understandable manner to all involved in the patients' pathway.

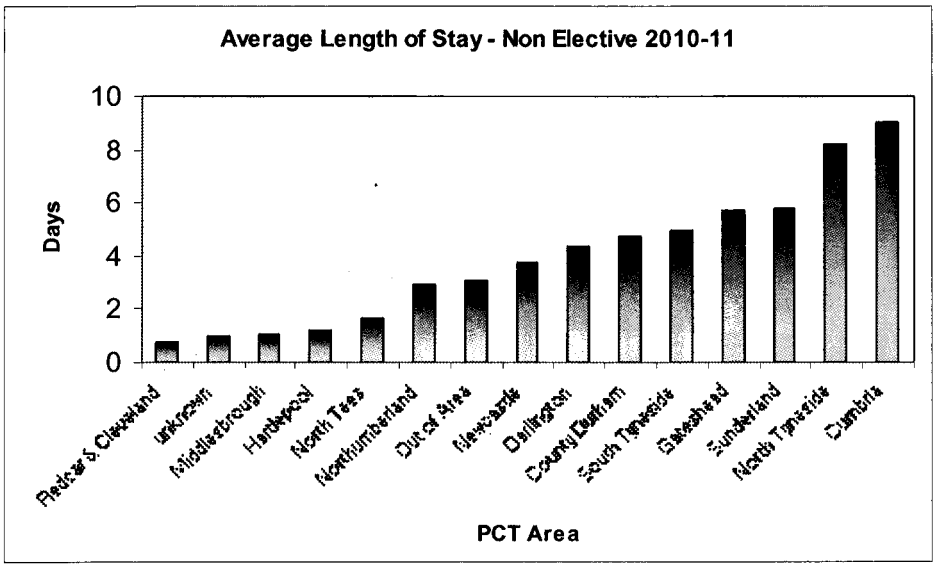
Assessment and discharge
Our solution was to develop a revised discharge pathway, including roles and responsibilities to create a more efficient and effective process and a plan around how to make this happen.

City Hospitals Sunderland Project to Improve Patient Flow

During 2010/11, CHS have undertaken a significant amount of improvement work looking at internal trust processes to improve within the hospital. For example introduction of daily ward rounds including weekends across the hospital. in Spring 2011, CHS undertook a project to improve patient flow and eliminate bed batching. The aim was to implement a "pull" system for admissions onto the base wards by implementing a ward culture of declaring beds to the bed managers as soon as the bed becomes vacant and then reutilising the bed within 1 hour. In addition the trust aimed to increase the utilisation of the discharge lounge to take at least 400 admissions per month by changing utilisation to be obligatory not optional part of the patient's journey in terms of discharge.

The results were an increased usage of the discharge lounge and increase flow through the hospital, however, the full 'pull' system can not yet be fully monitored until an electronic bed state is achieved. Work is ongoing to address this.

The following graph shows an analysis of average lengths of stay for non-elective patients within CHS during 2010/11. Whilst significant progress has been made, the figures show that Sunderland remains in the top quartile as compared to other localities. There are many internal and external factors that may impact on length of stay, with delayed discharges being one such external factor.



Multi-agency Delayed Discharge Project

In February 2011, Sunderland Health Housing and Adult Services and NHS SOTW Commissioners established a multi-agency 'Delayed Discharge Project' to:

- review current discharge pathways and map the current state
- identify bottlenecks and the main causes of delays
- propose solutions and pathways to address these issues.

Three key areas were identified which it was felt were the greatest cause of delays:

- lack of streamlined pathways to reablement
- limited access to transitional 'step down/forward' accommodation
- pathways that did not meet the needs of older people with mental health problems.

Three workshops were held on these topics and resulting actions were collated into a Project Newspaper (see Appendix 9).

Key actions for 11/12 include:

- Development of a joint strategy for intermediate care and reablement
- Develop a shared gateway to intermediate care and reablement with common ownership / standard criteria for referral and assessment
- Develop a compact for working collaboratively to facilitate patient pathways across the statutory and non-statutory sector
- Agree a standard set of performance and outcome metrics for all providers of intermediate care and reablement
- Review access to services out of core hours
- Review steps in discharge process including panel process
- Increase focus on mental health within pathways as well as physical health needs

- Review accommodation options and address gaps in service to meet need
- Explore reablement for carers
- Increase capacity and skills in the community around nutrition, hydration, continence, medication support
- Explore Care Navigator role to support individuals with complex needs through their journey from admission and post discharge

The actions from the Newspaper have been allocated to three multi-agency groups taking forward implementation of an 'Intermediate Care and Reablement Strategy' for Sunderland. This includes a senior Strategy Group, with two working groups for 'Reablement and Accommodation' and 'Delayed Discharge'. The Project Overview and Action Plans for these groups can be found in Appendix 9a/9b/9c, and Terms of reference can be found in Appendix 10 and 11.

The aim of the Delayed Discharge Working Group, is to take a strategic overview of the hospital discharge process and ensure that agencies work together to minimise delayed transfers of care for the benefit of patients. Key tasks include:

- To establish a set of multi-agency principles for ways of working in relation to delayed transfers of care
- To receive and analyse intelligence in relation to delayed discharges, draw out key themes
- To agree a set of metrics for delayed discharge, set targets for improvement in 11/12 and monitor progress towards targets.
- Deliver the actions arising from the Delayed Discharge Workshop Newspaper
- For areas in which progress towards targets is not being made, undertake a rapid review to determine the reasons for delays in the system, and identify the strategies and solutions that are required to minimise delays
- Make recommendations to the Sunderland Intermediate Care and Reablement Strategy Group regarding how each of the agencies involved could contribute to improvements to the system and ensure each organisation maximises outcomes and efficiency.

4. Conclusion

4.1 This report includes comprehensive and detailed information to launch the investigation by members. The key aspects of this detailed information will be highlighted for members at the meeting.

5. Background Papers

Health & Well-Being Scrutiny Committee reports June and July 2011

Contact Officers: Jean Carter, Deputy Director, Health, Housing and Adult Services
Ailsa Nokes, Strategic Lead for Long Term Conditions, NHS South of Tyne and Wear

APPENDICES INDEX

APPENDIX 1

City Hospitals Sunderland NHS
NHS Foundation Trust

Hospital Transfer & Discharge Policy "Transfer of Care"

Document Reference	
Document Status	
Target Audience	
Date Ratified	
Ratified By	
Release Date	
Review Date	
Sponsor	Director of Nursing & Quality

Version Control

Version	Release	Author	Update comments
1.0		Lynn Tallintire, Senior Nurse – Patient Access	
2.0	September 2008	Lynn Tallintire, Lead Matron – Patient Access	
3.0	July 2011	Anna Hargrave, DGM Lynn Tallintire, Matron PAT Susan Martin, Complex Discharge Sister	

Contents

1 Introduction

Many people admitted to hospital fear the experience of hospitalisation and of losing their autonomy: they want to return to living their previous lives as soon as possible and every effort should be made for this to become a reality (DH, 2003). Acute hospitals should only be used for the delivery of services that cannot be provided as effectively elsewhere in the health service, social care or housing system (DH, 2003).

Discharge is not an isolated event which occurs at the end of a patient's stay but is a process (DH, 2003) which for the majority of patients is often referred to a 'simple' occurring in approximately 80% of cases whereby the patient has no identified needs or their needs do not require complex planning and delivery. For the remaining 20% their needs will be more complex requiring effective management by members of the multi disciplinary team (DH, 2004).

2 Purpose and Scope

This policy underwrites good practice guidelines for all patient groups which are patient, carer and family focused and endorses partnership and collaborative working among the various professions, disciplines and agencies involved. This unified approach will promote choice and independence (Putting People First, DH, 2007).

The transfer and discharge process requires each individual patient to be formally assessed and any identified needs clearly documented, acted upon and completed within an agreed timeframe. An inadequate plan for discharge is unacceptable and so it is vital to identify any complexities early in the patient journey to ensure that any complications are foreseen and overcome. During this process both the patient/carer will play an integral role and will be kept fully informed of any developments regarding their planned programme of care. The provision of personalised care is required to be tailor made to the needs of patients and agreed with them and their carers (Lord Darzi, 2008). It is a statutory requirement of the NHS and Community Care Act (1990) that the decision to discharge someone cannot be made on solely clinical grounds and for those patients requiring a social assessment or reassessment the decision to discharge will be made with Social Services. This policy sets out the procedures for patient discharge within City Hospitals Sunderland (CHS) and those who require referral to healthcare organisations outside of CHS (discharge process appendix 1a).

- This policy provides a systematic approach to the safe transfer and discharge arrangements of all patients across the Trust irrespective of speciality. Discharges can be defined as:

    - Simple Discharge Adult
    - Simple Discharge Paediatric
    - Complex Discharge Adult

- Complex Discharge Paediatric

This policy must be read in conjunction with the following policies and documents:

- CHS Bed Management Policy 2011
- CHS Bed Escalation Policy 2011
- CHS Policy for the Management and Transfer of Patients with a known or suspected Infection/Colonization 2011
- CHS Infection Control Clostridium Difficile Policy 2007
- CHS Informed Consent Policy 2010
- The Mental Capacity Act (DH) 2005
- E discharge operational procedure 2011
- Adult safeguarding procedure (DH)2009

3 Duties

3.1 Board of Directors

The Board of Directors is responsible for ensuring that there is a robust system of Corporate Governance within the organisation. This includes having a systematic process for the development, authorisation and management of policies.

3.2 Chief Executive

The Chief Executive has ultimate responsibility for the safe, effective and timely transfer and discharge for all patients across the organisation. However this responsibility will be delegated to the Director of Nursing and Midwifery.

3.3 Director of nursing

The Director of Nursing is responsible for liaising with external agencies to facilitate safe discharge.

3.4 Divisional General Manager/Directorate Manager/Duty Manager

The Directorate Manager works closely with the Patient Access Team to ensure that day to day capacity is available for the individual speciality and to identify trends which are causing a blockage to the patient's journey.

3.5 The General Practitioner (GP)

If a patient is admitted to hospital via their GP they are required to provide the hospital with a detailed history of events leading up to the patient's admission including a full medication history and associated information in line with Royal College Guidelines. Information should also be provided regarding any circumstances, which may impact on patient's care and subsequent discharge plan.

3.6 The Hospital Consultant and Medical Team

Each Consultant is responsible for the overall care of a patient while in hospital. They will at the earliest appropriate opportunity, identify with the patient and carer

the outcome of their assessment and provide them with an anticipated date of discharge. In most cases this will be identified at the first ward round following admission and will be documented within patients' medical records. The estimated date of discharge will be used as a reference point to inform timescales associated with Multi-Disciplinary Team (MDT) assessment and planning in preparation for the patient's discharge. Any tests or investigations that are not urgent are required to be identified and undertaken as an out-patient. It is the responsibility of the consultant to determine when a patient is medically stable for discharge either by direct contact with the patient or documenting clear and concise parameters in the medical records to support nurse led discharge. Medical staff must:

- Ensure that all admissions/transfers, including those from clinics and other hospitals are directed to the Bed Manager.
- Be aware that non-urgent admissions/transfers may be delayed during a period of amber, red or black alert, and it may be appropriate to explore alternatives to admission e.g. rapid access to the next available clinic.
- Collaborate with the ward nursing team to identify patients who are appropriate to be "boarded" to other specialities daily.
- Work with the nursing teams to ensure that on every ward, there is a minimum of two planned morning discharges.
- Along with the Social Work Team share responsibility for assessing the patients' mental capacity regarding their discharge and preferred place of care.
- An assessment of patients physical and mental health needs is undertaken where young children are in the home.
- Ensuring that the GP is informed, by telephone, of the need for an urgent visit post discharge.
- Ensure that the discharge prescription is prepared in advance of the discharge date, on wards that medicine management is not in place, and reviewing medications where medicine management is in place. Where possible this should be the day before discharge to ensure medication is in place prior to transfer to the discharge lounge.
- Ensure that when the decision to discharge/transfer the patient is made, the appropriate medical documentation is completed immediately; including the GP e-discharge letter is completed at each individual patient's bed side and received by the GP within 24 hours.
- Provide patients with appropriate fit notes to cover the length of time they should refrain from work.
- Inform the GP, within 24 hours, if the patient dies in hospital.
- Provide documentation/communication regarding the patient's medical management plan when they are transferred to another hospital or organisation.
- Organise additional ward rounds during periods of black alert.
- Fast tracking patients in Accident and Emergency (A&E) as appropriate.

3.7 Bed Managers

Are responsible for:

- The daily management of patient flow into and out of the hospital.
- Keeping an accurate record of all patients waiting for admission and transfer.
- Co-ordinating the process when boarding patients.
- Co-ordinating the transfer of discharged patients from the wards to the discharge lounge.
- Liaising with patients/relatives who refuse to go to the discharge lounge.

3.8 Matron

The Matron will provide support and advice to ward staff when they experience difficulty in identifying patients suitable for boarding/transfer.
The specialist activity role will be to ensure consideration of patient safety, patient experience, HCAI and MSA issues.

3.9 Ward Manager or Designated Deputy

The Ward Manager has responsibility for ensuring that effective transfer and discharge planning processes and practices operate within the ward. This responsibility will designate to individual qualified members of the nursing team leading and managing that individual patient's care, utilising a multi disciplinary team approach. The ward manager is responsible for ensuring that:

- All patients have a holistic assessment of needs completed including a social history irrespective of their speciality.
- Risk assessments are completed and actioned according to Government and Trust Policy.
- All patients, on those wards trained in EDD, have a realistic estimated date of discharge recorded and that this is reviewed at least daily.
- All relevant members of the MDT are involved as appropriate at the relevant time. This is to be done via ward "powwows" where established.
- All patients have a personal, documented discharge plan activated on HISS on which ongoing care arrangements are recorded. This will be monitored and evaluated throughout the patients stay in hospital.
- Discharge arrangements to be completed by no later than 10:00 am on the day of discharge, and the patient is transferred to the discharge lounge to await transport.
- Staff will inform the bed manager in real time of all admissions/transfers/ discharges including those from clinics and other hospitals.
- Staff understand that at times they will be expected to take boarders into an appropriate bay on their ward following an infection control risk assessment.
- The nursing team must work proactively with the medical team to identify patients who are appropriate for boarding daily.
- A full nurse handover will be given and documented when transferring a patient to another ward or hospital Discharge Planning & Resource File.
- The nursing team informs the patient, family/carers of any plans for transfer/ discharge to another ward/hospital/place of care.

- The nursing team will declare beds, complete documentation and admit in real-time so that bed availability statistics are accurate and up to date.

3.10 Named/Responsible Nurse

The named/responsible nurse must:

- Ensure that a nursing assessment is undertaken to identify the patients care needs on discharge. This will include an assessment of their physical, mental and social circumstances.
- Attend medical staff ward rounds and request and record estimated date of discharge and confirm the date that that patient is medically safe to transfer/discharge.
- Identify those patients suitable for Early Supported Discharge.
- Update "Progress Towards Discharge Boards" and the electronic patient record Discharge Planning & Resource File
- Ensure that the patient and carers are at the centre of care and are involved in discharge plans early in the patients stay. (Achieving Timely Discharge DH 2004). This includes ensuring that the patient and or carer are aware of their responsibility to raise concerns about discharge early in the admission and also that they are responsible for providing transport for discharge unless there is a clinical need for ambulance. They must reinforce the aim for morning discharge and that the patient will be transferred to the discharge lounge whilst awaiting transport.
- Ensure that all patients discharge is personalised via discharge planning pathway in their electronic record. Discharge Planning & Resource File
- Co-ordinate and proactively manage patient care from admission to discharge ensuring that the estimated date of discharge is reinforced and reviewed with all involved in the patients discharge planning so that the patient is discharged when they are deemed medically fit for transfer/ discharge.
- Ensure that all patients with high care needs are screened against the continuing health care checklist criteria once all assessments are completed.
- Arrange and attend case meetings to discuss and agree discharge plans.
- Ensure that all patients no longer requiring acute care are highlighted to the discharge sister so that delayed discharges are minimised and the patient is transferred to the appropriate setting.
- Ensure that relevant information regarding infection control precautions are communicated to the GP and Community Nursing Services.
- Ensure that "not for attempted cardiopulmonary resuscitation orders" are communicated with the ambulance service and GP. A copy of the NFACPR form must be faxed to the ambulance service as part of the ambulance booking process.
- Identify training needs with the ward manager to agree an action plan.
- Declare vacated beds to the bed manager in real time.
- Ensure that the declared vacated bed is prepared for the next admission within an hour of the decision to discharge.

- Individual patients are given written instructions regarding any aftercare which is required and any advice given is recorded on the CHS preparing for discharge leaflet Discharge Planning & Resource File
- Consideration to be given to convening a multi-agency pre-discharge meeting when concerns are identified about a child

The discharging nurse will also provide/arrange:

- A supply of medication which has been checked against the discharge letter and the drug prescription.
- Seven days supply of dressings if required (this is related only to the timing of the dressing changes e.g. three dressings will be provided if the wound requires to be redressed twice a week).
- Any equipment required e.g. hospital bed, pressure relieving mattress, cushion, oxygen, mobility aids etc.
- If the patient is transferring to another ward within/outside of the Trust, the Nurse is responsible for completing the transfer of care document. Discharge Planning & Resource File
- It is essential that an assessment of parents physical and mental health needs is undertaken where young children are in the home and that any concerns raised are addressed and the home environment is assessed as being safe.

- If a child is admitted to hospital and staff have either child care or child protection concerns it is the nurses' responsibility to contact Childrens Services within 1 day of admission to agree a formal written plan before the individual child can be discharged from hospital. Where it is believed that a child will remain in hospital longer than 3 months and they are currently under the care of the local authority, the same department must be contacted to undertake an assessment concerning their legal responsibilities as stated in the Children's Act 1989.

3.11a Complex Discharge Sister

The Complex Discharge Sister role is to work with the health, social and voluntary teams to facilitate the safe discharge of patients with complex care or social needs. They deal with patients from age 16 with a wide range of illnesses and conditions. The role involves:

- Ensuring that the discharge policy is adhered to and patients are given choice where appropriate.
- Predicting discharges on a daily basis.
- Facilitating palliative care discharges for those patients wishing to go home to die.
- Liaising with the MDT to facilitate the discharge/transfer of patients to a care home in a timely manner.
- Raising awareness of resources available to facilitate safe, effective and timely discharge.
- Anticipating and monitoring delayed discharges: working closely with therapists and the hospital social work team to agree Situation report

(SITREP) reportable delays and record these on a secure database and produce reports as requested.

- Reinforcing the requirement that all patients have a realistic agreed estimated date of discharge which is reviewed daily.
- Monitoring length of stay within their area and assisting staff in identifying reasons for delays in investigations, assessments, provision of equipment and services.
- Speaking with relatives to identify and attempt to resolve concerns and issues relating to discharge.
- Liaising with others involved in the patients discharge including Independent Mental Capacity Advocate (IMCA), Social Workers, Therapists, and Care Home Staff to ensure a smooth transition from acute care.
- Attending case meetings for those patients with complex needs and providing expert advice and support staff in completing recommended actions.
- Facilitating the development of daily "powwows" which bring together the health and social team involved in the patients care to agree referrals and identify priorities.
- Facilitating the development and delivery of training so that nursing staff are informed of latest practice in relation to discharge and the resources available.
- Investigating complaints and incidents in relation to complex discharges.
- Ensuring that all patients aged 18 years and over who have three or more unplanned admissions/attendances in A&E in a 12-month period are referred to the community matron.
- Working closely with the ward staff and nurse assessors to ensure that continuing health care funding is agreed to facilitate fast-track discharge for end of life patients.
- Co-ordinating discharge audits in their area of responsibility.

3.11b Discharge Staff Nurse

The Discharge Staff Nurse provides day to day support to ward staff via daily visits with the aim of minimising delayed discharges and ensuring that the complex discharge sister is involved as appropriate. The role involves:

- Attending ward "powwows" to support staff in making referrals to the appropriate resource at the appropriate times.
- Ensuring that referral documentation is complete and appropriate and that records are maintained of all referrals to intermediate/transitional care teams.
- Reinforcing the requirement that all patients have a realistic agreed estimated date of discharge which is reviewed on a daily basis.
- Investigating complaints and incidents in relation to simple discharge.
- Ensuring that all patients aged 18 years and over who have three or more unplanned admissions/attendances in A&E in a 12-month period are referred to the Community Matron.
- Following completion of the discharge letter by a member of the medical team the master copy is to be faxed to the GP on the day of discharge by

the Ward Clerk. If the Ward Clerk is absent the discharging nurse is required to undertake this role.

3.12 Ward Clerk
Following completion of the discharge letter by a member of the medical team the master copy is to be faxed to the GP on the day of discharge by the Ward Clerk. If the Ward Clerk is absent the discharging nurse is required to undertake this role.

3.13 Patients
Each patient will be fully aware of the circumstances relating to their stay in hospital and be able to give informed consent regarding any treatment and aftercare. Where patients cannot represent themselves, the next of kin, carer, relative or an independent mental capacity advocate (IMCA) must be involved. Their role is to represent the patient's interest and to challenge any decision that does not appear to be in the best interests of the patient (Ministry of Justice, 2005). Wherever possible, the views of children will be taken into account and respected.

3.14 Carers
With the patient's agreement, relatives and carers will be fully involved in the transfer and discharge process. The role of the carer will be acknowledged and recorded regarding their contribution to the discharge plan. It should not be assumed that a person's carer will necessary be able to or want to continue with their caring role. Patients and their carers may have different needs and aspirations. Carers have a right to their own assessment and to any services they may need to support them in their caring role which may be conducted post discharge. It is also important to remember that young people may also be providing a major part of a patients care (DH, 2010).

Many patients and carers are becoming expert in managing long term chronic conditions and often providing care that is equivalent to that provided by a registered nurse. In such circumstances home care arrangements can be set up quickly once the patient is clinically stable and safe for transfer (DH, 2010).

3.15 Pharmacy
Following notification of a pending discharge and/or provision of a correct prescription from non medicine management wards, pharmacy staff will ensure that drugs are available at the appropriate time and that they are provided in a suitable, accurately and clearly labelled container. They aim to do this within two hours of receipt of the request. Where possible requests should be identified on the preceding working day to allow resolution of any outstanding queries and so arrangements can be made for the discharge medication to be completed prior to transfer to the discharge lounge. Drugs should be supplied for a minimum of 14 days (average 28 days) unless they are required for longer.

Patients who are within formal step up/ step down schemes will have arrangements with the medicines management team to ensure a minimum of 28 days is available unless clinically inappropriate.

If the patient uses a NOMAD/ dosette system, the medication must be reviewed, the discharge medication finalised and confirmed and the NOMAD requested at least 48 hours before the anticipated estimated date of discharge (EDD) to minimise the risk of delay. Any patient identified with medication adherence issue will be referred to primary care who will agree an appropriate action plan post discharge with the GP.

3.16 Nutrition and Dietetic Service

If the patient is known to them, the dietetic service will be informed of the patients anticipated discharge date so as to arrange follow up services and appointments. When it has been established that a patient requires to be fed enterally at home the nutrition and dietetic service require two days notice prior to the actual date of discharge to ensure the appropriate equipment can be put in place. If the patient is to be discharged on supplements these also need to be prescribed and dispensed at the point of discharge.

3.17 Physiotherapy

Physiotherapists provide members of the multi disciplinary team with invaluable information regarding patients' progress and level of support a patient will require on discharge to function at home. The physiotherapist may order appropriate aids and equipment to support discharge if indicated and may perform home assessment visits with other agencies prior to a patients discharge to ensure risk is minimised. Physiotherapists also provide an educational role as well as providing specialist advice not only to the patient, family/carers but to all members of the MDT.

3.18 Occupational Therapy

Occupational Therapy intervention is a process of collaboration and negotiation between the therapist and patient in which the patient is assisted to identify problems and goals and to find effective ways of dealing with them. Occupational Therapists work with individual patients to undertake assessment and treatment designed to facilitate safety and independence within the areas of self maintenance, productivity and leisure. For example this may include being able to wash and dress independently or prepare a meal, undertake housework or use public transport.

Assessment and treatment will be discussed with the patient and an individual action plan agreed. A number of patients will require assessment at home; this may be undertaken with or without the patient being present whilst they are still an in-patient or some patients will be followed up at home on discharge. Decisions around the need for, and type of home visit undertaken will be identified by the occupational therapist who will base this decision on the needs of the individual patient and on the associated risk assessment of the situation.

3.19 Mental Health Liaison Nurse

The mental health liaison nurse is able to:

- Undertake comprehensive mental health assessment whilst the patient is in a ward setting.
- Offer advice and support to patient, carers and staff during the hospital admission, signposting them to appropriate agencies.
- Facilitate referral to mental health services if required.
- Assist with the appropriate transfers to other inpatient areas.
- Work with the MDT to facilitate timely discharge.

3.20 Hospital Social Work Team

It is a requirement of the NHS and Community Care Act 1990 that care managers are involved in the discharge planning of all patients where the need for their support has been identified.

- As a normal part of the social services assessment, social services will involve the service user and their carer where appropriate in the planning of the discharge and in discussions in respect of any identified social care needs.
- The Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 acknowledge the important role carers play and the need to help them maintain their own health and well being. The 2000 Act gave carers the right to have their own needs assessed via the carer's assessment and social services have to listen to carers, record their views and take their assessed needs into account when deciding, in association with the multi-disciplinary team, what services to provide to the patient.
- Assessment will be completed within the required Sunderland Social Services standards and to comply with the Community Care (Delayed Discharges) Act.

3.21 Children's Services

- Referrals regarding services for disabled children will be made by completing the Common Assessment Framework form (CAF) which is available on the intranet under "family care". CHSnet Intranet This should be faxed to the Services for Disabled Children Team. A telephone call can be used to support this. Referrals can be made by a health or social care professional or parent.

- Child protection referrals will be made in accordance with Sunderland Safeguarding Children Board procedures and CHS Child Protection Policy.

- A verbal referral must be made to the duty social worker and followed up in writing on the same working day using a safeguarding concern form. CHSnet Intranet

3.22 Community Based Services

The NHS and Community Care Act places a duty on Community Based Services (CBS) to assess all people who require publicly funded community care.

Referrals will be made to CBS when a patient requires 'social care' in order to be discharged safely. This may be provided in the person's own home or in arranging 24 hour care in either a residential or nursing home care setting. Assessments should not be undertaken in a hospital environment but in a designated transitional bed where the patient may be transferred following resolution of a period of acute illness. Discharge Planning and resource File

3.23a Care Packages
Care providers do not receive a retainer for care packages and therefore it is likely that the care package will be cancelled immediately the patient is admitted to hospital. An agreed date and time for restart must be agreed prior to discharge.

3.23b Assessment/Re-assessment of Needs
Where assessment or reassessment is required a referral to the social work team should be made when the patient is medically stable to participate in assessment and all other therapy, and medical assessments are complete. The agreed plan of care must be clearly recorded in the patient's discharge summary.

3.24 The Ambulance Service
The Ambulance Service is responsible for providing transport for patients who are medically unfit to travel by any other means. Bookings for discharge will be requested through the e-booking system by 11:00am on the day prior discharge (or in advance of this). If the patient needs to be home by a specific time for carers, the nurse must specify this on the booking. Patients and their relatives must be informed that there may be a significant wait for transport. If the discharge is cancelled, the ambulance liaison officer must be informed.

Nursing staff must ensure that patients and relatives are aware that ambulance will only be booked for those who are unable to travel by car for medical reasons and those patients awaiting transport must be transferred to the discharge lounge unless they meet the exclusion criteria. (See CHS Bed Management Policy 2011).

3.25 Community Nursing Team
The District Nursing Service provides a high quality service that is patient centred and delivered within the patient's own home. The service is predominantly for housebound patients, but it is also provided to patients whose nursing needs are better met in their own home, such as residential care homes. Other patients receive care at home according to their assessed clinical need.

The District Nursing Service operates to provide both planned and unplanned nursing intervention/care for people with acute/chronic/palliative conditions. The service is predominantly used by adults, but in some cases can be accessed for children with nursing needs.

It is a proactive service which aims to empower patients and their carers and to promote health and independence whenever possible through self care. This aim will be achieved through partnership working with patients and their carers, with

other agencies and professionals and by using the best available evidence to guide and inform clinical practice.

When planning discharges timely and effective communication between professionals is essential.

If a patient has an identified nursing need post discharge requiring intervention from the district nursing service the appropriate referral documentation will be completed by the named/responsible nurse/midwife. This referral will be confirmed with a telephone call to the appropriate district nurse triage contact telephone number. The patient must not be discharged until the service or requested equipment has been confirmed as being in place.

If the discharge is classified as being complex a case conference will be arranged and an agreed action plan formulated. The district nurse may have additional information about the patient home circumstances which will promote a timely discharge.

3.26 Paediatric Specialist and Community Nursing Teams
Children are referred to the service if they have a nursing need that requires some intervention within the home following admission to hospital, or if they have a long term nursing need due to a chronic condition. The specialist nurses support and advise children and families with specific illnesses and conditions.

Many professionals, including ward staff and paediatricians, can make referrals to the nurses. Referrals should be made via the appropriate referral form which should be supported with a telephone call. The community services are available during office hours, although the staff may work earlier and later to meet the needs of the child and families they will be visiting. The Team will provide 24-hour end of life support.

3.27 Community Matron
The overarching aim of the Community Matron is to combine a clinical role with case management methods and to orchestrate and improve the care for those adult patients with complex long-term conditions. With proactive care planning the Community Matron will ensure that patients and their families receive the best possible care, avoiding unnecessary hospital admissions/attendances and keeping necessary hospital stays as brief as possible. Referrals will be made for patients who are 'high-intensity' service users, with three or more previous admissions within the past twelve months, who could potentially have a complex discharge, and would benefit from a case-management approach to their care. The community matron will be invited to attend case meetings to plan discharge for complex patients.

3.28 Community Care Nurse Assessors
If the NHS Funded Care Team receives an NHS Checklist indicating the need for full consideration of Continuing Health Care (CHC), they will, within approximately 28 days of acceptance of the referral, convene a full multi

disciplinary team meeting to look at assessed needs and apply the eligibility criteria for NHS Continuing Healthcare funding.

The recommendations from the multi disciplinary team are then presented by the nurse co coordinator to the Primary Care Trust Commissioners who will make the final decision and funding required.

All patients have a right to be assessed for Continuing Health Care. Patients demonstrating high level health needs must have a CHC checklist completed. If the triggers are met, the Nurse Assessors will co-ordinate an MDT within 4 weeks of discharge. They will inform the patient next of kin (NOK) of the outcome of the MDT meeting and how to appeal if they disagree with the outcome.

3.29 Intermediate Care Services
A range of services have been developed to assist the prevention of admission and the safe, effective and timely discharge from hospital for those patients who have rehabilitation needs for time limited period of up to 6 weeks. Discharge Planning & resource File

3.30 Voluntary Services
The Health and Social Care Community, which includes voluntary organisations works in an agreed partnership, to provide services for people following discharge. Some voluntary organisations work independently of that partnership process, to provide care and support to individuals following their discharge from hospital.

For further information, please contact either Sunderland Council for Voluntary Service or the Patient Advice and Liaison Service on `who will be able to signpost individuals and their families to organisations and support groups. Age UK have representatives based in the hospital Discharge Lounge.

3.31 Specialised Patient Services
In addition to the range of staff and services indicated above significant patient groups, such as children, adult and elderly mental health and maternity, all have specific staff undertaking similar but distinctive services and tasks which can be used as a specialist resource in relation to discharge planning. Discharge Planning & resource File

3.32 Health Records
The timely completion of Health Records and communications between professionals are essential for good practice and are crucial to this process. Filing systems and retrieval will be uncomplicated and accessible, reflecting good practice guidelines. Case notes will be legible, informative and up to date.

4 Definitions

A Medical/Surgical/Orthopaedic Boarder
A patient residing on a ward outside their admitting speciality.

Estimated Date of Discharge
Based on the expected time required for tests and interventions to be completed and the time it is likely to take the patient to be clinically stable and ready for discharge (DH, 2010) Discharge Planning & Resource File

Homeless Person
A person is homeless if there is no accommodation that they entitled to occupy or they have accommodation but it is not reasonable of them to continue to occupy this accommodation (Housing Act 1996).

NHS Continuing Healthcare
A package of care arranged and funded solely by the health service for a person aged 18 and over to meet physical or mental health needs which have arisen as a result of illness (Delayed Discharges (Continuing Care) Directions 2009). Discharge Planning & resource File

Residential Care
24 hour care which is provided in a care facility for those patients who are no longer able to cope at home with their day to day activities. Discharge Planning & Resource File

SBAR: (Situation, Background, Assessment, Recommendations)
An acronym which is used as a standardised framework to communicate vital information in a clear and concise manner from one healthcare professional to another.

Nursing Care
24 hour care which is provided in a care facility for those patients who require nursing care on a daily basis due to illness or disability. Discharge Planning & resource File

5 Main Body of the Policy

5.1 Key Principles of Discharge Planning

- Discharge planning will commence prior to or on admission following a holistic assessment of needs and an individualised discharge care plan will be formulated.
- Every patient will have a clear documented clinical management plan within 24 hours of admission which will be reviewed daily.
- Ongoing discharge needs will be clearly identified as either simple or complex and the appropriate action taken.
- An expected date of discharge will be identified within 24 hours of admission for simple discharges and 48 hours for complex discharges and reviewed on a daily basis.
- Ward staff will have ownership at for individual patient transfer and discharge arrangements.

- All patients and carers will be at the centre of the discharge process.
- Discharge planning will occur seven days a week and morning discharges promoted on a daily basis.
- Primary Care professionals will be invited to attend a case conference prior to discharge for those patients who have complex needs.
- Identified equipment will be provided prior to discharge.

5.2 Pre-Assessment

Prior to patient being admitted to hospital for elective surgery a comprehensive pre assessment will be undertaken in order to identify any potential discharge needs post discharge and any appropriate referrals initiated at this time. Complex patients will be referred to the Complex Discharge Sister. This proactive approach to discharge planning will ensure each individual patient will be provided with an anticipated discharge date and the necessary equipment and/or services provided on discharge.

5.3 Process for Transfer In or Out of Hours

Patients' will only be transferred between 07:00 – 22:00 hours with the exception of those patients being transferred based on clinical need or from assessment units such as Coronary Care, Critical Care or Accident and Emergency to a base ward. It is only in exceptional circumstances that the transfer of patients will occur outside of these times including protected meal times. All transfers out of hours that are not for clinical need will be discussed with the Night Matron first to determine if the move can wait until the next morning. Any patients transferred out of hours will be discussed at the morning handover report to the Chief Matron.

5.4 Process for Transfer or Boarding Patients within CHS

When a patient is being transferred from one clinical area to another within the organisation, it is vital that the patient is placed according to clinical need, paying particular attention to the issues related to infection control and privacy and dignity.

The boarding of patients will be avoided as far as possible; however there are times when such activity becomes a necessary part of managing emergency admissions and maintaining a supply of appropriate beds. The decision to board will be coordinated by the Bed Manager and discussed at the Bed Meetings held daily.

Prior to a patient being transferred across wards in times of variation in demand and capacity, the transfer must be discussed and explained to the patient, relatives and carers. Patients will only be subjected to one move during their hospital episode which this is not directly related to their clinical management plan.

The Named Nurse / Responsible Nurse will coordinate the process by:

- Explaining the need for the move to the patient and next of kin in an appropriate manner.
- Providing the receiving ward with a verbal handover of care.
- Completing the written transfer checklist to go with the patient Discharge Planning & resource File

Patients who are suitable to board are those who are medically stable and are ready for discharge.

Patients who are **not** suitable to board are those with: (Boarding Criteria Appendix 3)

- Any degree of cognitive impairment
- Any patient with complex needs
- Any patients who are at risk of falls
- Any patient who is medically unstable
- Any patient with an EWS of 3 or above
- Any patient who has already been boarded
- Any medical patient with MRSA will not be transferred to a surgical ward

It is acknowledged that they may be times when no patients meet this criterion; under these circumstances the clinical team will be expected to make the decision based on their professional judgement to identify patients to transfer.

When a patient is being transferred from the Critical Care Department to a base ward, a Critical Care Transfer Report will be completed on HISS.
It is the responsibility of the nurse in charge/deputy to establish if an escort is required based on the patients clinical and nursing needs.

5.5 Process for Transferring Outside CHS

When the patient is being transferred to another hospital for further clinical management, Medical staff will provide the receiving hospital with an updated medical condition and treatment management plan.

The Named Nurse will coordinate the process by:

- Explaining the need for the move to the patient and next of kin in an appropriate manner.
- Providing the receiving care facility with a verbal handover of care.
- Completing the appropriate written transfer information to with the patient.
- Providing a patient with a supply of drugs which have been checked against their current drug prescription.

Separate arrangements exist for Children services. It is essential that a Paediatric Collaborative Transfer Document is completed when a child is being transferred to another hospital using the SBAR format, in particular safeguarding issues must be considered and concerns communicated to the relevant professionals. (See CHS Discharge Planning Resource File for document).

5.6 Process for Transfer to a Residential/Nursing Home

When a patient is being transferred to a residential or nursing home the discharging nursing is required to complete a transfer document Discharge Planning & Resource File. This is supplementary to the standard discharge letter completed by medical staff and must accompany the patient on transfer. Any follow up appointments or arrangements must be made and sent with the patient. A comprehensive verbal handover must take place prior to transfer using the SBAR format. It is the responsibility of the NHS to provide the necessary equipment required for patients residing in residential care but for nursing care it is the responsibility of the individual home.

If a patient is planned to return to residential care, a Care Manager from the home must reassess them to ensure that their needs have not changed.

5.7 Direction on Choice

Discharge or transfer from hospital is frequently delayed when a patient's preferred accommodation is not available. Although it is reasonable for a person to exercise their choice, at a time in their lives when they are vulnerable the patient cannot expect to remain in hospital until their home of choice becomes available. It is to be expected that a person will move from an acute hospital bed into an interim placement or home with a comprehensive package of care to support them at home as long as the proposed interim arrangements meets the identified needs of the patient.

It is extremely important that consistent messages and information are given to both patient and carers by all members of the multi disciplinary team about the expected length of stay in hospital and the need to move into more appropriate care when they are ready to do so.

5.8 Process for Discharge Out of Hours

Pro-active discharge planning is promoted across the Trust and morning discharges are encouraged. However if a discharge has been arranged for after 5 pm it is the discharging nurses responsibility to ensure that all people involved in the patients ongoing care are aware of this prior to discharge.

5.9 Guidelines relating to Patients Leave from Hospital for Significant Family Events

In exceptional circumstances it may be necessary to arrange a period of temporary leave from hospital for an in-patient to attend a significant family event for example a funeral of a close relative or a wedding. This would occur if a patient was unable to be discharged due to the nature of their condition and needed to remain in hospital for continuing treatment. In this situation it is necessary to complete the checklist Discharge planning & Resource file to ensure that in such circumstances arrangements are in place to support the patient and their carers whilst on temporary leave.

5.10 Patient or Carer Disagreeing with the Discharge Plan

When disagreements occur in relation to the patients discharge plan it is essential that concerns are raised at ward level with the ward manager. The Complex Discharge Sister will be able to provide support and guidance and assist in gaining resolution. Additional support can be obtained from the Patient Advice and Liaison Service (PALS). Each ward should also have information leaflets available relating to raising concerns and complaints to the Trust.

5.11 Patients Wishing to take their own Discharge

Sometimes patients wish to exercise their right to take their own discharge against the advice and expressed opinion of the medical team. (Self Discharge Appendix 4).

5.12 Discharging Patients who are Homeless

Homeless people, especially rough sleepers or those with a chaotic lifestyle, may have poorer health than the rest of the community. People living in temporary or insecure accommodation may have difficulty accessing primary care. Once admitted they present a complex medical and social history (DCLG, 2006). For many people who are homeless, living in temporary accommodation or seeking asylum, admission to hospital may present itself as an opportunity to deal with any underlying medical, social, mental health problems and to address accommodation needs.

The Homeless flow chart outlines procedure for simple discharges to no fixed abode. (Homeless flow chart appendix 2) For more cases, where there are ongoing nursing needs, the Complex Discharge Sister will need to be involved. Discharge Planning & Resource File

5.13 Discharge Documentation

- All patients must receive a copy of a completed discharge checklist, which is dated and signed by the nurse responsible for discharge. Discharge Planning & Resource File
- All patients must be provided with a list of their medications on discharge and any approved literature related to their ongoing care or condition.
- Where known, they will be informed of follow up appointments in writing.
- All patients must receive a copy of the CHS "Preparing for Discharge" leaflet. Discharge Planning & Resource File

5.14 Infection Prevention and Control (IPC)

The term Health Care Associated Infection (HCAI) encompasses any infectious agent acquired as a consequence of a person's treatment by the NHS or which is acquired by a health care worker in the course of their NHS duties. The prevention and control of HCAIs is a high priority for all parts of the NHS. Effective prevention and control of HCAIs has to be embedded into everyday practice and applied consistently by everyone (The Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Health Care Associated Infections). All infection control policies are available on all wards and departments in hard copy and electronically via CHS intranet.

If a member of staff is in any doubt regarding the placement of patients with a known or suspected infection they should refer to the control of infection manual or contact the IPC department for advice. The medical microbiologist can be contacted via the hospital switchboard and an emergency out of hour's infection prevention control nursing service is also available, whereby the on call infection prevention and control matron can be contacted via switchboard.

6 Monitoring Compliance/Effectiveness of the Policy

6.1 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

6.2 Monitoring Compliance and Effectiveness of the Policy

Monitoring of the effectiveness and implementation of transfer and discharge procedures including documentation requirements across the organisation will be the responsibility of the Matron for Patient Access, Complex Discharge Sister with Ward Managers being responsible for the collection of the required evidence.

- The Nursing Team on each ward will collect a sample of transfer and discharge documentation for every month of the year:

    1. Discharge. One copy of complex and one copy of a simple discharge checklists.
    2. Transfer. Copies of documentation accompanying the patient when they are transferred to care home, another hospital or to another ward within the Trust.

The Discharge Nurse Team will collect the information form the wards and compile a monthly audit. This will then feed into quarterly and ultimately annual Trust wide audit.

Monthly audits will be presented at Operational Management Group. An annual report will be presented to the Operational Committee.

Other audits will be undertaken according to changes in service provision and in light of national guidance.

The Discharge Nurse Team will collect and agree, with social services, weekly statistics regarding delayed transfers of care and use these to identify trends. This will assist in multi-agency action planning

7 Dissemination, Implementation and Training

The Discharge Team are responsible for training across the organisation.

7.1 Training

- Preceptorship Programme
- Development Days for Ward managers and their deputies

This is in addition to informal discussions at ward level between the ward manager and member of the nursing team.

8 Consultation, Review and Approval/Ratification

8.1 Consultation and Review

This policy has been devised by adopting a collaborative approach using a multi professional and multi agency focus regarding the transfer and discharge arrangements for all patients across the organisation. The views and opinions of the professionals, both internal and external to the organisation, have been sought and this policy has been devised based on their expert knowledge, experience, and the relevant legislation and supporting guidance documents.

8.2 Implementation of the Policy (including raising awareness)

This policy will be embedded across the organisation following its ratification. The Hospital Discharge Team together with the Practice Development Team, Matrons and Ward Managers will reinforce the policy in conjunction with their day to day clinical practices.

9 References

Achieving timely simple discharges from hospital (DH, 2004)
Children's Act (1989)
Children's Act (2004)
Community Care (Delayed Discharges) Act 2003
Delayed Discharges (Continuing Care) Directions 2009
Delayed Discharges (Continuing Care) Directions 2007
Discharge from Hospital: Pathways, Policy and Practice (DH 2003)
Discharge from NHS in-patient care of people with continuing health care needs
Hospital Discharge Work Book (1994)
Mental Capacity Act (2005)
NHS and Community Care Act (1990)
Patients Charter Standards (DH 1995)
Ready To Go – No delays (DH, 2010)
Safeguarding Vulnerable Adults (DH 2009)

10 Associated Documentation

OP Pre Assessment
OP 21 Point of Discharge
OP 33 Bed Management and Escalation Policy
OP 39 Health Records
Guidelines for In Utero/ Ex Utero Transfer of Sunderland Patients to Other Units 2004
Guidelines for Transfer of a Baby from Delivery Suite to Neonatal Intensive Care Unit 2011

Appendix 1a

City Hospitals Sunderland NHS
NHS Foundation Trust

DISCHARGE PROCESS

Clear medical management plan identified by medical staff

↓

Holistic assessment of needs completed on admission by qualified nurse

↓

Estimated discharge date identified and reviewed daily by medical staff

↓

Appropriate referrals completed by multi disciplinary team according to identified need

↓

Simple Discharge

No ongoing needs identified

OR

Low level intervention required
Rehabilitation
Meals on Wheels
Small packages of care

Timescale:

5 days from initial referral

Complex Discharge

Continuing Health Care

24 hour care in the community

Home of Choice

Large packages of care (3 / 4 visits per day requiring 2 carers) with equipment (hoist / bed)

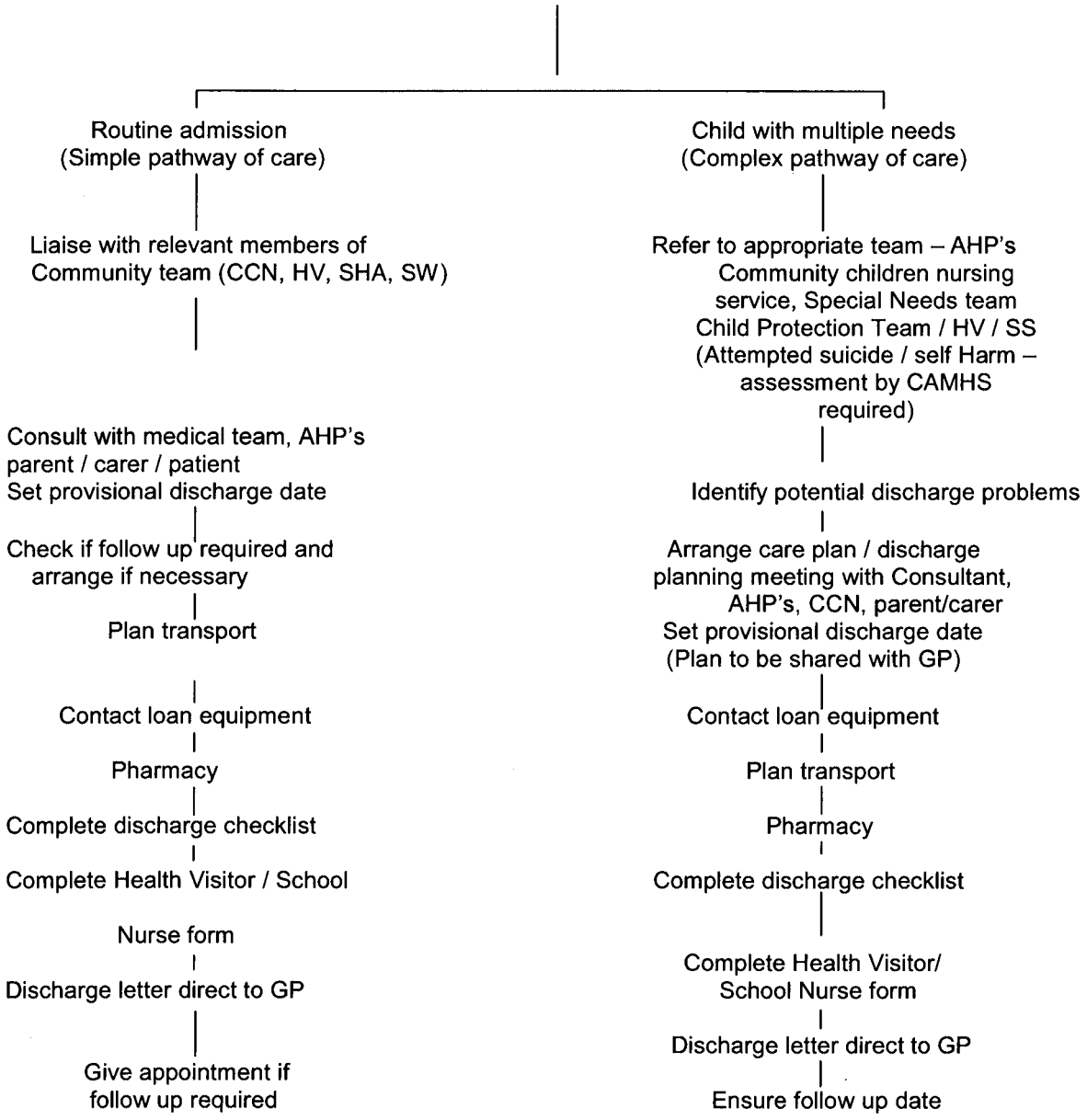
Timescale:

28 days from initial referral

Appendix 1b

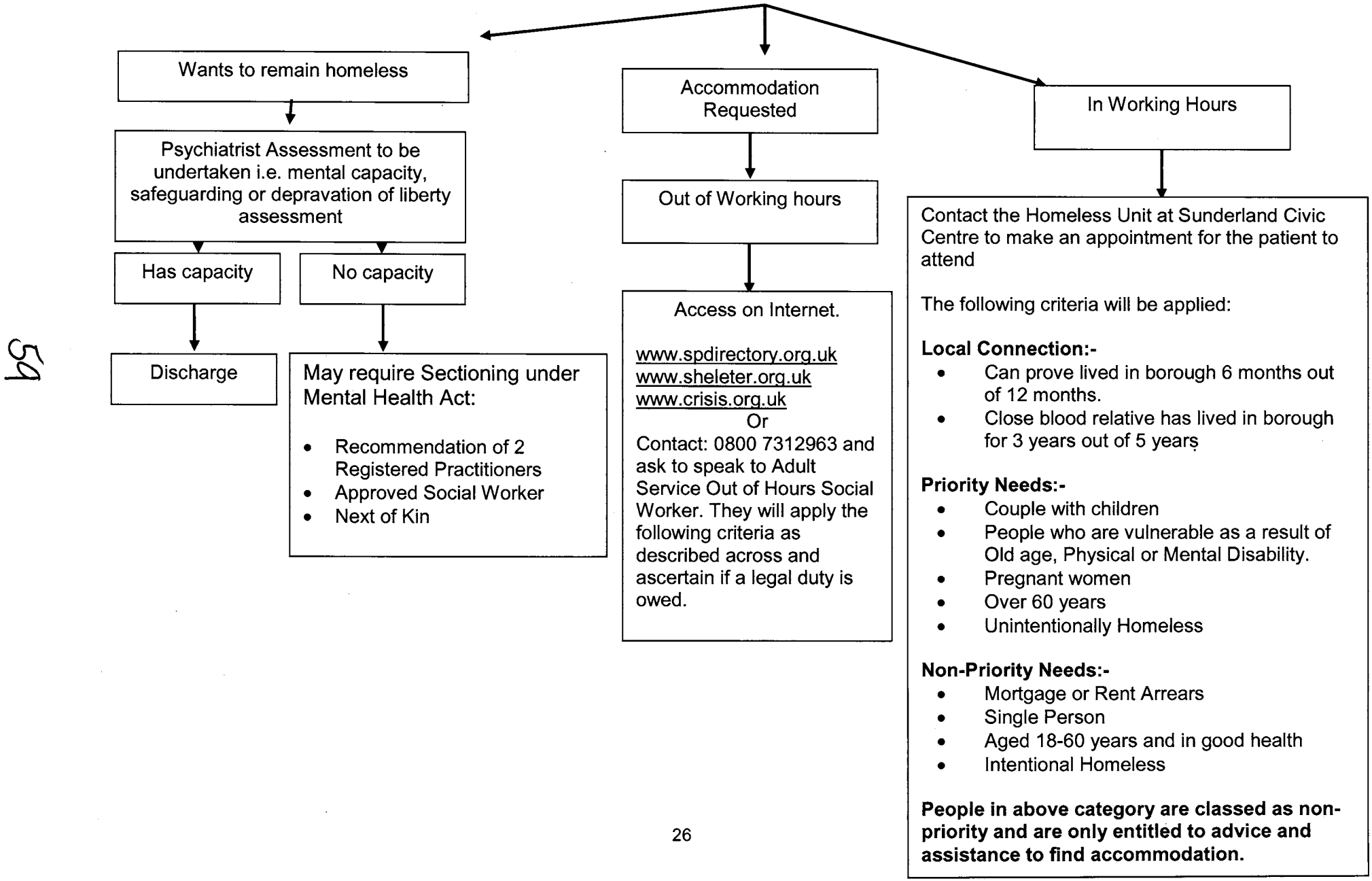
CHILDRENS SERVICES DISCHARGE PROCEDURE

Named nurse admits child and completes holistic assessment on admission.
Parental/carer involvement initiated at time of admission.



Appendix 2

HOMELESS PATHWAY



Appendix 3

City Hospitals Sunderland NHS
NHS Foundation Trust

DIVISION OF MEDICINE

TOOL TO AID DECISION ON WHETHER THE PATIENT IS APPROPRIATE TO BOARD

	Patients suitable for boarding include: ➢ Medically stable i.e. awaiting social services
Amber	**Patients not clearly fitting into red or green category** ➢ Patients must not be boarded unless the nurse in charge has reviewed the EWS and medical notes and ensured that the patient does not have any red criteria. ➢ Nurse transferring must document date and time of transfer and Consultants name and destination ward in medical notes. ➢ Receiving ward to document date and time received.
	These patients must not be boarded from the ward unless: ➢ Discussed with the patient's consultant on weekdays 9:00am – 5:00pm. ➢ Discussed with the Consultant On Call at evenings and weekends if the Consultant is on site or the On Call Registrar. **Do not board if:** ➢ EWS score > 5 in any category or physiological triggers or diagnostic triggers present. ➢ Terminally ill, those with a new diagnosis of malignancy or those with undergoing investigations likely to lead to a diagnosis of malignancy. ➢ Cardiac patients requiring telemetry, those with established cardiac failure during which diuretic does are being established, and those who are within 72hrs of acute infarction. ➢ Neurological Glasgow coma scale < 15 and patients with acute delirium. ➢ Rheumatological – patients admitted with acute vasculitis or multi system diseases. ➢ Infections – any patient with an infectious disease, MRSA positive patients and those with diarrhoea awaiting results of stool C+S. ➢ Confused wandering patients at high risk of falls.

Appendix 4

City Hospitals Sunderland NHS
NHS Foundation Trust

PATIENTS TAKING OWN DISCHARGE AGAINST MEDICAL ADVICE

When a patient is determined to discharge his or herself against medical advice the nurse must inform a member of the Medical Team and try to dissuade the patient.

- It is the responsibility of the medical staff to discuss with the patient the reasons why they wish to self-discharge. In addition, if they are homeless consider unrecognised or inadequately managed alcohol or drug dependence anxiety about losing accommodation; or ongoing or unrecognised mental health problems. The outcomes of this discussion should be documented in the medical records.

- It is the responsibility of medical staff to document the decision-making process and further actions related to the patient in the patients' medical records. Any further follow up plans should be recorded with clear timeframes identified.

If the patient insists on self discharging:

- They must be asked to sign a "Leaving Against Medical Advice" note.

- The signed form must be filed in the patients medical notes.

- They must be made aware that out of hours take home medication may not be available and they need to visit their own GP.

- If the patient refuses to sign the note, the nurse must document this in the patients medical notes with the reason why they refused to sign.

- The patient's family/next of kin must be advised of the intent to self discharge, and where appropriate, involved in discussions to prevent the discharge.

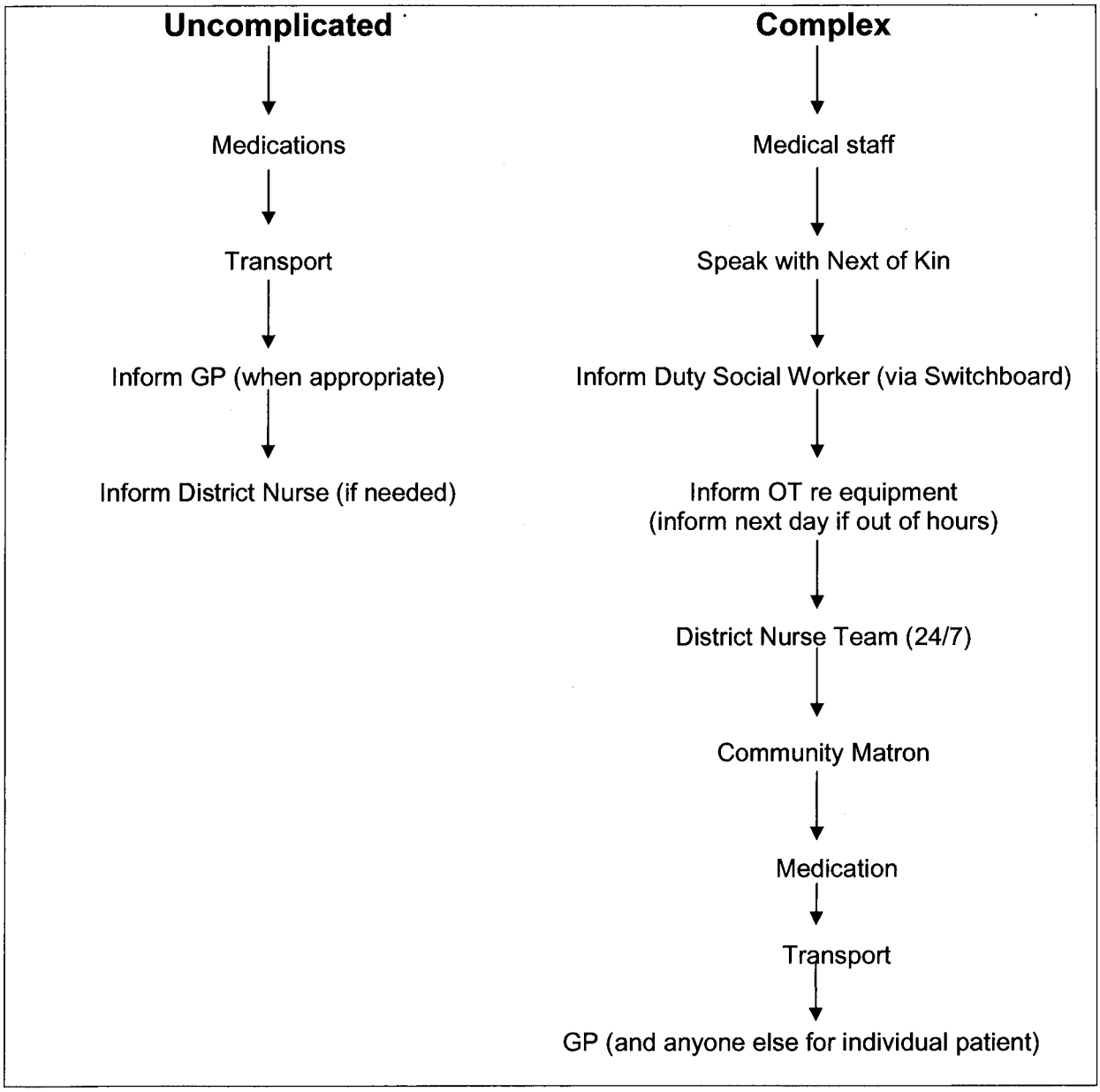
- When a patient has made a decision to self-discharge, the patients GP should be contacted as soon as possible (Before 12 mid-day the next day if overnight).

- The nursing staff should ensure that the patient has adequate transport arrangements.

- The nursing staff should ensure that any arrangements for necessary after care are made.

- This may involve contacting the Discharge Nurse, Social Services Department or the District Nursing Service.

PATIENTS TAKING DISCHARGE AGAINST MEDICAL ADVICE



DISCHARGED AGAINST MEDICAL ADVICE (STICKERS FOR NOTES)

I,.....

Hereby take the entire responsibility attached to the taking of my discharge

(or the removal of.....)

From the.....Hospital

Against the advice and expressed opinion of the Medical Officer to the contrary.

Witness .....

Designation.....

(medical or nursing staff)

Name of medical on-call notified.....

Bleep number.....Time notified.....

APPENDIX 2a

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Document Title	Care Co-ordination (Incorporating Care Programme Approach (CPA)) Policy		
Reference Number	NTW(C)20		
Lead Officer	Executive Director of Nursing and Operations		
Author(s) (name and designation)	Liz Bowman – Care Coordination Development / Training		
Ratified by	Quality and Performance Committee		
Date ratified	November 2010		
Implementation Date	November 2010		
Date by which policy to be embedded	November 2010		
Review Date	November 2013		
Version number	V03.2		
Change Control	**Date**	**Version**	**Reason**
	Nov 10	V03	New version
	Jan 11	V03.1	Inclusion of CC-CPA-PGN-07-Chaplaincy
	Mar 11	V03.2	Inclusion of CC-CPA-PGN09 - Psychotherapy

This policy supersedes the following documents:

Reference Number	Title
NTW(C)20-Version 03.1	Care Co-ordination (Incorporating Care Programme Approach) Policy

Care Co-ordination (Incorporating Care Programme Approach (CPA))

Standard Appendices – attached to policy document		
A	Equality Impact Assessment tool	25
B	Communication and Training check list & Needs Analysis	28
C	Audit/Monitoring Tool	30
D	Policy Notification Record Sheet	31

Appendices – listed separately to policy	
1	Possible strategies for professionals responding to service users who want to withhold consent to share "need to know" information from other professionals
2	Possible strategies for professionals when service users exercise their right to withhold consent to share "need to know" Information with Carers
3	Information Sharing
4	Northumberland Tyne and Wear NHS Trust minimum approved tools to record the outcome of the assessment of risk
5	Core Service Contact Details
6	Keeping Children Safe Assessment

Practice Guidance Notes (listed separate to policy				
PGN No:	**Title**	**Version**	**Issue Date**	**Review date**
CC-CPA-PGN-01	Practice Guidance Adults (Adult directorate Forensic Mental health and Specified Specialist services)	V01 - Issue 3	Nov 10	Nov 13
CC-CPA-PGN-02	Practice Guidance Older People's (OP) Directorate	V01 - Issue 4	Nov 10	Nov 13
CC-CPA PGN-03	Practice Guidance Learning Disability (LD) Services	V02 - Issue 1	Apr 11	Apr 14
CC-CPA-PGN-04				
CC-CPA-PGN-05				
CC-CPA-PGN-06	Learning Disabilities Directorate – Admissions (within LD only)	V01 – Issue 4	Jan 11	Jun 11
CC-CPA-PGN-06.1	Learning Disabilities Directorate – Management of Epilepsy (within LD only)	V01 – Issue 2	Mar 11	May 11
CC-CPA-PGN-07	Chaplaincy	V01 – Issue 1	Jan 11	Jan 12
CC-CPA-PGN-08	Self Discharge against medical/.clinical advice - Draft			
CC-CPA-PGN-09	Application of CC Standards within sub speciality assessment – Psychotherapy Service (Sunderland)	V01 – Issue 1	Mar 11	Mar 12

1 INTRODUCTION

1.1. Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) and its partner agencies of Gateshead Social Services, North Tyneside Adult Services, Newcastle Social Services, Northumberland Care Trust, South Tyneside Social Services and Sunderland Health Housing and Adult Services are committed to the principle that all service users referred to secondary mental health and learning disability services should have access to high quality, evidence-based mental health services.

1.2. The approach of each organisation to individuals' care and support puts that individual at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. Each organisation and its staff recognise the individual as a person first and service user second. This approach is underpinned by shared Values and Principles and is encompassed by the term Care co-ordination.

1.3. Care co-ordination ensures that the requirements of the National Service Framework for Mental Health (September 1999) and the Department of Health guidance Refocusing the Care Programme Approach and Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach are met by mental health and learning disability services within the Trust and their partner agencies.

1.4. Statement of Values and Principles

- Assessment and Care planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have with the aim of optimising mental and physical health and well-being.
- Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinions to deliver valued, appropriate, equitable and co-ordinated care.

2. PURPOSE

2.1 This policy sets out the principles and framework for assessment and care planning for adults receiving mental health or learning disability services within the Trust and its partner agencies here there is shared care or section 75 partnership agreements.

68

2.2 It includes the requirements of C(90)23/LASSL(90)11 "Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach (1999)" and DOH guidance Refocusing CPA(2008) ensuring that the requirements of the National Service Framework for Mental Health Standard 4 is met and contributes to Standard 6.

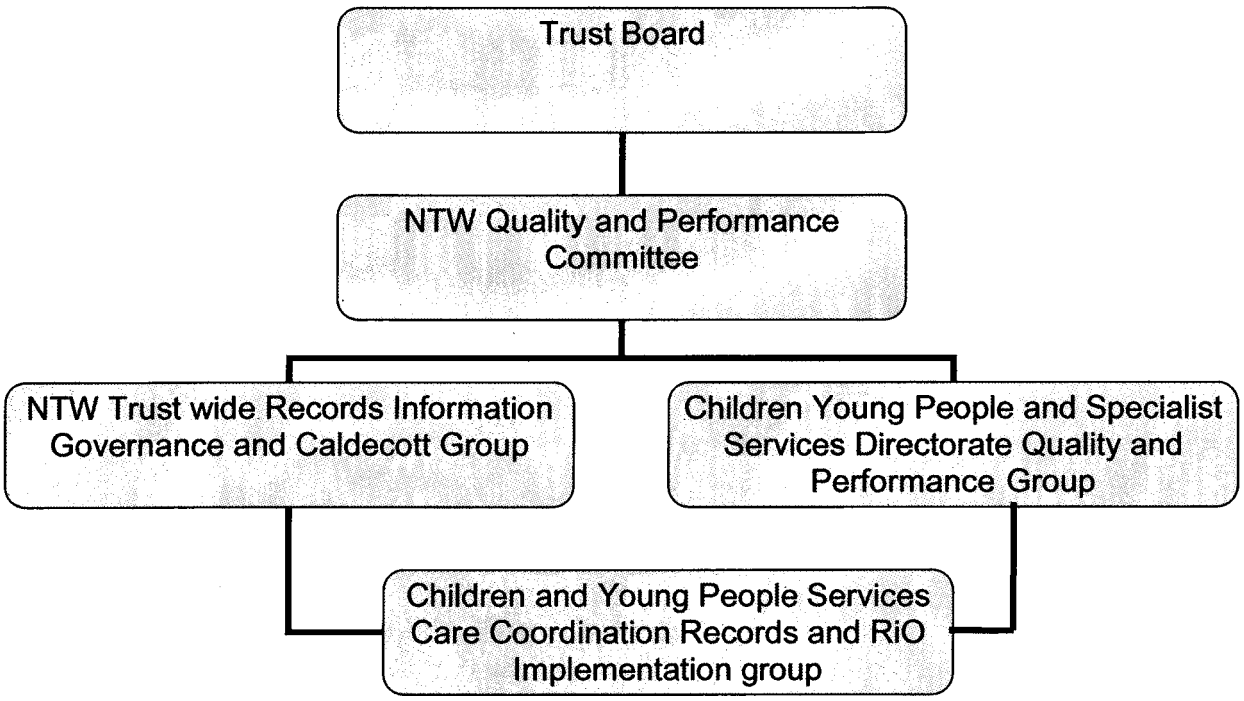
2.3 This policy will be supported by practice guidance which will detail the information sharing arrangements and interagency arrangements including recording requirements between the Trust directorates and the local authority partners it works with to deliver services for individuals.

3 DUTIES

3.1 The Chief Executive on behalf of the Trust retains ultimate accountability for the health, safety and welfare of all service users, carers, staff and visitors; however key tasks and responsibilities will be delegated to individuals in accordance with the content of this policy

3.2 Directors and all managers at all levels are responsible for ensuring the policy and relevant practice guidance is applied consistently and appropriately in their area of responsibility

3.3 The corporate governance arrangements relevant to this policy are shown in the diagram below



3.4 Each Directorate's Care Coordination, Records and RiO group are responsible for agreeing the tools to support risk assessment and clinical recording including on the electronic care record within the directorate and ensuing that the agreed tools and the process for use are reflected in this policy.

3.5 The Care co-ordination Development / Training lead has responsibility for the Trust wide implementation, development and expansion of care co-ordination standards to incorporate new legislation, standards, targets and professional practice requirements through policy development and the provision of expert professional advice to senior managers, service users, carers, managers and colleagues liaising with other agencies as appropriate each directorate

3.6 All staff are responsible for ensuring they meet their professional standards of recording within their organisations / directorates documentation and for applying this policy and relevant practice guidance in their practice with service users and their families.

3.7 A consultant psychiatrist (or associate specialist) should always be involved in the care of all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan

4 ASSESSMENT AND CONSENT TO SHARE INFORMATION.

4.1 Assessment and planning should aim to meet the service user's needs and choices and not just focus on what professionals and services can offer. It should address a person's aspirations and strengths as well as their needs and difficulties. Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services.

4.2 The person undertaking the assessment should explain to the service user that their family, friend or an advocate can support them through the whole assessment if they so wish.

4.3 Everyone referred to secondary mental health and learning disability services should receive an assessment of their needs, with assessment of mental health and risk as an integral component.

4.4 Each organisation's assessment framework must enable an initial assessment of health and social care needs and risk to identify the individual's needs and where they may be met. This will include an assessment of social care needs including enabling of identification of Fair Access to Care Services eligibility criteria (including Direct Payments / Individualised budgets).

4.5 The assessment framework will also enable consideration, as appropriate to the individual, of psychiatric, psychological and social functioning, including:

- Impact of medication;
- Risk to the individual and others,
- Needs arising from co-morbidity;
- Personal circumstances including family and carers;
- Housing needs;
- Financial circumstances and capability;
- Employment, education and training needs;
- Physical health needs;

- Equality and diversity issues including faith and culture;
- Social inclusion and social contact and independence.

4.6 The service user can only benefit from well co-ordinated assessment and planning if there are clear lines of communication between professionals and agencies. There will be times when it will be necessary to share information about the service user with other professionals and agencies. The service user's consent to disclose information will be routinely sought as part of the assessment process in compliance with the requirements of the DOH Confidentiality NHS Code of Practice 2003and the Data Protection Act 1998

4.7 Consent to seek and share Information should be discussed agreed with the individual and recorded as part of the initial assessment whenever possible or as soon as is practicable and should be revisited:

- When indicated by the service user
- Where information/circumstances demonstrate that the service user has different wishes to those previously recorded
- During care planning process.
- When mental capacity status changes.

4.8 Some service users may not have the capacity to consent, or be able to understand the implications of sharing information. If concerns about the service user's capacity to consent arise, a decision will be made by the "decision maker" following an assessment of capacity with clear reference to the Mental Capacity Act best interest checklist.

4.9 Assessment of capacity should involve discussion with relevant members of any multi disciplinary team, carers and/or advocates and will be clearly recorded in the service user's record.

4.10 There may be occasions when it is deemed necessary to share information without consent in accordance with Trust Policy, common law and the Data Protection Act 1998 as appropriate. For example; in circumstances where disclosure is felt to be justified in the public interest; e.g. to protect the service user or someone else from harm. This must be explained to the service user, including what information must be shared and with whom, and an appropriate entry made in the record.

4.11 The outcome of the initial and any subsequent assessment should be communicated to the individual (in a way that they will understand) and to the referrer promptly.

4.12 If it is agreed that the person's needs are best met by a secondary mental health service, a care plan should be devised and agreed with the service user and, where appropriate, their carer.

5 CARE PLANNING AND REVIEW FOR SERVICE USERS WHO DO NOT HAVE ENHANCED NEEDS

5.1 Where a service user has straightforward needs, is able to be self-directed in

their own care, with some support if necessary, and has **contact with only one organisation** but more than one professional then an appropriate professional in that organisation will be the person responsible for facilitating their care and will be the **lead professional**

5.2 Where a service user has straightforward needs, is able to be self-directed in their own care, with some support if necessary and has **contact with more than one organisation** the **lead professional will come from one of the statutory services**

5.3 Where a service user has straightforward needs, is able to be self-directed in their own care, with some support if necessary and has **contact with only one professional that person will always be the lead professional**

6 RESPONSIBILITIES OF THE LEAD PROFESSIONAL

6.1 The lead professional will ensure that:

- The service user's previous consent to seek and share information is discussed and updated as needed.
- In partnership with the service user and any other significant care provider, including carers, develop a clear understanding of how care and treatment will be carried out, by whom, taking into consideration any existing Advance Statement or advance decision to refuse treatment.
- The agreed care and treatment (care plan) is recorded as required by their organisation. Trust staff can record using a clinical letter that meets the standards set out in the practice guidance relevant to the lead professional's directorate.
- Provide advice and signposting to the service user to enable them to access other agencies/support to meet their needs, facilitating referrals if needed
- A central record of care is maintained as required by their organisation.
- A copy of the current care plan is always offered to the service user
- The service user is offered copies of letters as outlined in the Trust's policy, NTW(O)22 - Sharing letters with service users policy
- A copy of the current care plan is sent to the person's General Practitioner (GP) and any other significant care provider, including carers, if appropriate.
- Ensure that the care plan and risk assessment is subject to on-going review as required, involving the service user and any other significant care provider, including carers
- In partnership with the service user and any other significant care provider, including carers, consider at each review whether a service user's needs have changed, and if there is need for intensive care co-ordination support.
- HoNOS (Health of the National Outcome Scale) ratings will be completed at significant points of change within the care pathway and at any event, at least once a year as part of the formal review process. This requirement will be implemented in a staged approach linked to the implementation of the electronic patient record (RiO) and SARN17

- Documenting the review as required by the lead professional's organisation. Trust staff can record using a clinical letter that meets the standards set out in the practice guidance relevant to the lead professional's directorate.

6.2 The role of **Lead professional** can be undertaken by Medical staff and Qualified Nurses, Qualified Social Workers, and Qualified Allied Health professionals who are suitably experienced and skilled, under appropriate supervision, to be able to assess service users

7 CARE PLANNING AND REVIEW FOR SERVICE USERS WITH ENHANCED NEEDS (Care Programme Approach - CPA)

7.1 Where a service user has more complex needs and characteristics, as outlined below, then enhanced Care co-ordination incorporating the requirements of CPA will be the framework used to deliver continuous care for vulnerable people who may require intensive intervention or long term support.

- **Severe mental disorder** with high degree of **clinical complexity**
- Current or potential **risks** including suicide, self harm, harm to others, relapse history, self neglect, non-concordance, vulnerable adult, adult/child protection
- Current or significant history of **severe distress/instability or disengagement**
- Non-physical **co-morbidity** e.g. substance/alcohol misuse, learning disability
- **Multiple service provision** from different agencies
- Currently/recently **detained under Mental Health (MH) Act, or referred to crisis/home treatment team**
- Significant **reliance on carer/s, or has own caring responsibilities**
- Disadvantage or difficulty as a result of:
  - **parenting** responsibilities;
  - **physical health** problems/disability;
  - **unsettled accommodation;**
  - **employment** issues;
  - significant **impairment of function** when mentally ill;
  - **ethnicity, sexuality or gender** issues

7.2 The list is not exhaustive and there is not a minimum or critical number of items on the list that should indicate the need for enhanced Care Co-ordination. Professional experience, training and judgement should be used in using this list to evaluate which service users will need this support.

7.3 All service users subject to Supervised Community Treatment (SCT), or subject to Guardianship under the (MH) Act (section 7) status should be supported by enhanced care co-ordination (CPA) and the requirements set out in each organisation's policies. A care coordinator will be identified; this may or may not be the responsible clinician.

7.4 Service users with enhanced needs **can expect**:

- To have a Care Coordinator
- To have access to health and social care services through one systematic assessment of their health and social care needs.
- That the Care Coordinator, through discussion and negotiation with them and others, will ensure that a comprehensive, formal written Care Plan is developed and agreed taking into consideration any Advance Statement or advance decision to refuse treatment
- Their Care Plan to be clear and easy to understand and include outcomes that they have determined
- That any disagreement they have with any part of the Care Plan will be recorded on that Care plan
- To know who their Care Coordinator is and what role that person will play in their treatment and care
- To have the role of their carers recognised, and actively supported
- To have information on how risks will be assessed and managed
- To have clear crisis arrangements agreed in their Care Plan
- To know who is doing what and when, to have this clearly stated in their Care Plan, including their comments, and be offered a copy
- To be offered copies of letters as outlined in the Trust's policy - NTW(O)22 Sharing letters with services users
- To have the Care Plan reviewed regularly and changed if necessary with their active involvement, including being informed of their right to request a care co-ordination review at any time
- To have access 24 hours and 7 days per week to information and services
- To have access to information in a way they can understand in an accessible format appropriate to their needs, including information about their condition and/or treatment, the risks of the treatment and information about available alternatives

7.5 **Care Planning**

7.5.1 For service users lacking mental capacity, any potential Deprivation of Liberty (Mental Capacity Act - MCA) should be considered when planning care. Should the care plan amount to a deprivation rather than a restriction, then authorisation, in the person's best interests, must be sought from the appropriate supervising authority.

7.5.2 The care plan will identify the service user's needs, the resources, and actions by individual members of the care team, including the service user and carer and any Lasting Power of Attorney (LPA) or court appointed deputy (as appropriate) to meet those needs.

7.5.3 Where the care plan includes medication it will identify the prescriber, where medication is obtained from, instructions for administration and how

monitoring will be undertaken. The service user will be offered information about the medication including benefits and side effects.

7.5.4 Service users must always receive a copy of their care plan unless they have explicitly stated that they do not wish to receive a copy. Where there are difficulties in ensuring understanding, the Care Coordinator will explore alternative means and accessible formats (pictorial, Braille) to ensure service user or carer understand the content of the care plan.

7.5.5 If it is identified that there could be an increased risk for the service user to receive a copy of their care plan, a clinical decision must be made not to offer a copy of the Care Plan and this decision recorded in the service user's health record and on the care plan.

7.5.6 Copies of the care plan should be given to the service user's GP and any other significant care provider, including carers, if appropriate.

7.5.7 Care plans should routinely include arrangements for setting out, measuring and reviewing specific outcomes. An outcome focus can help to improve understanding of the impact of services on the lives of people who use them; give assurance that treatments and care provided are producing results; and ensure that outcomes related to treatment, care and support are monitored on an on-going basis.

7.5.8 The desired outcomes should be explicitly agreed with the service user and carer(s) at the beginning of the care process and include service user defined outcomes so that the plan is personalised to the service user.

7.5.9 Care plans should routinely include a crisis plan and where appropriate a risk management plan incorporating trigger factors/relapse indicators specific to the service user. The crisis plan should clearly specify the respective responsibilities of all members of the care team including the service user in response to increasing levels of risk.

7.5.10 If there is doubt about the service user's capacity to consent in relation to any aspect of care or treatment, as recorded on the care plan, an assessment of capacity in relation to that aspect of treatment should be completed and recorded in the health record. The "Decision maker" in relation to each / any specific aspect of the care plan must weigh up all the information in order to determine what decision is in the person's best interests.

7.5.11 Where a significant decision is being considered in relation to a patient without capacity a formal assessment of capacity should be completed in line with Trust or relevant Local Authority Policy on the Mental Capacity Act

7.5.12 Where a Welfare Lasting Power of Attorney is in place the attorney needs to be consulted on all matters relating to the person's care and treatment. Unless the Welfare LPA specifies limits to the attorney's authority the attorney will have the authority to make personal welfare decisions and refuse treatment (except life-sustaining treatment unless the LPA specifies this) on the person's (donor's) behalf. Any Advance Decision or Statement should also be taken into consideration.

7.6 **Review**

7.6.1 The review of a care plan must be regarded as an ongoing process and will be undertaken by the Care Coordinator involving the service user, any identified carer and all those professionals involved in an individual's treatment or care.

7.6.2 As a minimum a formal review will take place once a year. This formal review will usually involve a meeting of all concerned in a setting where the service user feels comfortable.

7.6.3 It is expected that for service users with enhanced needs, HoNOS (Health of the National Outcome Scale) ratings will be completed at significant points of change within the care pathway and at any event, at least once a year as part of the formal review process. This requirement will be implemented in a staged approach linked to the implementation of the electronic patient record (RiO) and Summary of Assessments of Risk and Need (SARN)17.

7.6.4 If a full multidisciplinary meeting will prevent service user's participation this will be documented and the review will be undertaken by the Care Coordinator meeting with the service user and any identified carer, with other members of the care team contributing to the process through the Care Coordinator through the provision of written reports.

7.6.5 A review will be undertaken in the event of a sudden relapse or following any major change in the service user's circumstances including significant changes to risk or if significant concerns are expressed by carers / family/significant others.

7.6.6 Every formal review should consider whether a service user's needs have changed, moving towards self-directed support will be the natural progression and the need for enhanced Care Co-ordination support may end.

8 RISK ASSESSMENT AND MANAGEMENT

8.1 Risk assessment is a dynamic and ongoing process in the provision of care and treatment to all service users. It is a multi disciplinary responsibility and the outcome of risk assessment should be formally documented using the minimum approved tool and recording required by each organisation **(see Appendix 4).**

8.2 Risk assessment is a multi disciplinary responsibility. A consultant psychiatrist (or associate specialist) should be directly involved in formulating risk assessment(s) and management plan(s) for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

8.2.1 This involvement should be whenever risk assessment is required and should be formally documented using the minimum approved tool and recording required by each organisation.

Risk assessment is required:

- As part of initial assessment / ongoing assessment / reassessment
- When admitting and discharging from hospital and as part of planning and agreeing leave.
- As part of community or inpatient care co-ordination or MDT reviews
- When there are major changes to presentation / personal circumstances or following an incident
- When alerted by Carers
- When transferring service users to other teams/service providers
- When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

8.3 Practice guidance details the Trust's approved minimum risk assessment tools for each directorate.

8.4 Risk management plans are an integral part of the Care Plan that will be developed when the level of risk is significant, serious, or serious and imminent.

9 IN-PATIENT ADMISSION AND DISCHARGES

9.1 Prior to or on admission the referring person, as a minimum, must supply the admitting ward with a copy of the assessment and risk assessment that led to the admission. If the service user is compulsorily admitted, this will comprise relevant section papers and assessments including the Approved Mental Health Profession (AMHP) assessment.

9.2 If the service user is already known to secondary mental health or learning disability services the Lead Professional / Care Coordinator will provide the ward, prior to or on admission or on the first working day following notification of admission, with the unified health record or if this is not practicable as a minimum:

- The most recent assessment
- The most recent risk assessment **including any keeping children safe assessment(s)**
- The current care plan and any risk management plan

9.3 On admission or at least within 24 hours of admission, service users should have a basic physical examination as outlined in the Trust's policy NTW(C)29 - Standards for physical health examination. If a service user refuses assessment of their physical condition a more detailed assessment should be offered as soon as practicable.

9.4 Each in-patient admission, regardless of time elapsed, is a separate episode. A full assessment of need including risk assessment will be undertaken for each episode of care.

9.5 If the service user is not admitted under the Mental Health Act and they do not have capacity to consent to the admission a formal assessment of capacity in

relation to the admission, recorded on the Trusts MC1 form must be completed as this covers the legal framework for the admission

9.6 The first Multi-disciplinary / care co-ordination review must be held within 7 days of the admission. The multi disciplinary Team (MDT)/ care co-ordination review, including the consultant, will complete and document a full review of the patient's care needs resulting in a plan of care and where appropriate; referrals to other agencies/services.

9.7 For service users lacking mental capacity, any potential Deprivation of Liberty (MCA) should be considered when planning care. Should the care plan amount to a deprivation rather than a restriction, then authorisation, in the person's best interests must be sought from the appropriate supervising authority

9.8 Whether the service user's needs are such that they have enhanced needs will be agreed and clearly recorded at the first patient review. All service users admitted to an adult acute ward will have enhanced needs and have a Care Coordinator.

9.9 If the service user is known to the service and has a Care Coordinator, this arrangement will be confirmed at this review.

9.10 For those service users with enhanced needs who are new to the service, or who have been previously supported by a Lead professional, the Care Coordinator will be arranged at the review via liaison arrangements with community services or from within the inpatient reviewing team. This is to ensure that identified needs and arrangements that may take some time to put in place are initiated early.

9.11 All service user's will have a pre-discharge meeting involving the service user carers and/or advocates as appropriate, who in partnership with the multi-disciplinary team, including the Care Coordinator or Lead Professional, community staff and other relevant external agencies, will review the service users needs including reassessment of risk and formulate a discharge care plan a copy of which should be offered to the service user and any carer as appropriate.

9.12 For all service users a discharge care plan will identify the service user's needs for their immediate discharge and successful reintegration into the community. The care plan will make particular reference to their immediate needs, support in the first week of discharge and the subsequent 3 months.

9.13 A consultant psychiatrist (or associate specialist) should be directly involved in formulating the discharge risk assessment and management plan for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable)

9.14 For service users with enhanced needs the care plan will **also** include:

- Financial issues (if appropriate)
- Medication changes including who is the prescriber, where medication is obtained from, instructions for administration, how monitoring will be undertaken and where appropriate Depot clinic/ Clozaril clinic, follow-up.

The service user will be offered information about the medication including benefits and side effects.

- Out-patient appointments
- Social requirements
- A Risk Management Plan that recognises and builds on protective factors
- A crisis plan
- 7 day follow up and action to be taken if the service user does not attend
- Explicit information relating to services provided under Section 117 (where applicable)
- Statement on best interest if any aspect of the care plan concerns client without capacity in relation to that area of intervention
- If a Service user is being discharged under supervised community treatment order the requirements set out in the Trust's policy NTW(C)47-Supervised Community Treatment must also be met

10 CARE COORDINATOR ROLES AND RESPONSIBILITIES

10.1 Consent **must** always be sought from a professional prior to them being identified as a Care Coordinator. Under no circumstances must any professional be stated as Care Coordinator without negotiation and agreement.

10.2 The role of the Care Coordinator should usually be taken by the person who is best placed to oversee care management and resource allocation and can be of any discipline depending on capability and capacity.

10.3 The Care Coordinator will have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the organisation of origin.

10.4 However, it is not the intention that the Care Coordinator is necessarily the person that delivers the majority of care. There will be times when this is appropriate, but other times when the therapeutic input may be provided by a number of others, particularly where more specialist interventions are required.

10.5 For people who have had damaging experiences of sexual abuse or violence, choice of gender of the Care Coordinator may be a crucial factor in establishing trust and a therapeutic relationship.

10.6 The Care Coordinator will:

- Ensure the service user's involvement in the process of decision-making.
- Ensure where appropriate, any carer's involvement in the process of decision- making.
- Ensure that, where in place, an Independent Mental Capacity Advocate or an attorney through a Lasting Power of Attorney (LPA), Independent

Mental Health Act Advocate (IMHA) or personal representative where involved is fully involved in the process of decision making.

- Promote, build and maintain relationships with others involved in the service user's care.
- Act as the "acknowledged" name for contact by all agencies relevant to the service user's care.
- Ensure that a comprehensive, formal written care plan including risk and crisis plan care plan is developed and agreed and that responses to crisis situations during working hours and outside of working hours are included. The level of response should be appropriate to the degree of crisis.
- Ensure that any Advance Statement or advance decisions are considered and recorded as part of the Care planning process
- Consult and seek appropriate advice if any aspect of the care plan proposes significant restrictions of liberty to ensure that such restrictions do not constitute "deprivation of liberty"
- Monitor the agreed care plan and record progress.
- Ensure appropriate review of the service user's care plan
- Provide support and care, taking positive action in the event of a service user disengaging from services.
- Work with in-patient services to ensure that prior to discharge a joint review takes place.
- Ensure the service user's GP and staff identified in the care plan are informed within one working day of the service user being admitted to hospital. Where appropriate it may be necessary to ensure that there is support for the service user to register with a GP
- Ensure the provision of follow-up and assertive outreach where this is available should the service user disengage from services.
- Ensure whenever possible any change of Care Coordinator should be agreed through the care co-ordination review process. This will ensure there is an effective hand-over of information to the new Care Coordinator.
- Where a service user plans to move area the Care Coordinator must liaise with the appropriate professionals in the receiving care team to ensure that the service user's care is transferred effectively.
- Ensure Carers are supported and offered an assessment of their needs

10.7 **The Care Coordinator may fulfil these responsibilities through effective, agreed and appropriate delegation to other members of the care team. Such delegation will be recorded in the clinical record or on the care plan or review documentation as appropriate to when delegation occurs.**

10.8 The role of Care Coordinator can be undertaken by Medical staff (except Senior House Officers) and Qualified Nurses, Qualified Social Workers, and Qualified Allied Health professionals who are suitably experienced and skilled, under appropriate supervision, to be able to assess service users

11 RESPONSIBILITIES OF MEMBERS OF THE CARE TEAM

11.1 All professionals whether employed in the statutory or voluntary sector, and any carers, have a responsibility to:

- deliver agreed interventions,
- undertake their own dynamic and ongoing risk assessment
- contribute to the overall assessment of risk through sharing of their professional assessment
- communicate with the Care Coordinator regarding
- their assessment of risk
- their role in the care plan and progress of associated service delivery.

11.2 This is particularly important following any major change in the circumstances of the service user or should service delivery cease or no longer seems appropriate

12 LEGISLATIVE FRAMEWORK

12.1 The policy and practice guidance incorporates the key aspects of the Mental Capacity Act 2005 including the statutory principles.

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
- Before the act is done, or the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

12.2 Assessment care planning and review within this policy framework for service users detained under the Mental Health Act 2007 will also be guided by the List of Guiding Principles in the new Code of Practice

- **Purpose:** Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.
- **Least restriction:** People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

- **Respect:** People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

- **Participation:** Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

- **Effectiveness, efficiency and equity:** People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

13 INVOLVING CARERS

13.1 The Care Coordinator is responsible for ensuring all carers who provide 'substantial care on a regular basis' are offered an assessment of their needs. (The Carer and Disabled Children's Act 2000). Where applicable their own care plan will be developed. This can be at the time of the service user's initial assessment, review or any other appropriate point. The assessment may be carried out by the Care Coordinator, a carer development worker or support worker or another member of staff involved in the development of the service user's care plan.

13.2 Carer's assessment and care plans will be recorded using appropriate locality documentation; it may be practical to combine a service user and carer care plan rather than developing separate documents. Carer's needs should be reviewed regularly and carer's care plans will be reviewed at least annually.

13.3 Relatives and carers often know a great deal about the service user's life, interests and abilities as well as having personal experience of the service user's illness. Some family carers will have a significant responsibility to support, protect and keep in touch with someone who cannot manage alone because of their mental health and/or learning disability and /or complex needs. It is important to include carers in the care planning process whenever possible.

13.4 Concern expressed from carers should be taken very seriously and should lead to the Care Coordinator considering the need to initiate a review

13.5 Carers should be fully involved in the aftercare of service users if they wish to

be and so far as is practicable on an equal footing with professionals. Information shared by professionals must also be shared with the carer, subject to the service user's consent.

13.6 If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment, staff must ensure that this is clearly and sensitively communicated to the carer and recorded in the service user's notes.

13.7 In the absence of consent, there may be exceptional circumstances in which disclosure of information and contact with involved carers can be justified in the public interest, for example, if someone has a history of violence.

13.8 Disclosure of information/sharing of information with carers based on public interest may involve weighing that interest against the duty of care in that particular set of circumstances. The balance can be delicate and it may be necessary to take legal advice. If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment – staff must ensure that this is clearly communicated to the carers and relatives and recorded in the service user's notes. It is anticipated that such cases will be relatively few and the expectation is that the majority of carers will be involved.

14 YOUNG CARERS

14.1 Young carers are children and young people under the age of 18 whose lives are restricted by the need to take responsibility for the care of a person who is affected by mental ill health and/or learning disabilities.

14.2 Where a young carer is involved in the care of an adult with mental health problems and/or a learning disability, the professionals involved have a responsibility to make an assessment of the family circumstances and the needs of the child/young person and, where appropriate, refer them to Social Services. Support services can be provided for young carers to enable them to maintain their usual activities outside of the caring role.

14.3 In addition, health professionals need to be aware of children's needs for access to a range of information, both regarding the nature of the mental health problem and/or learning disability and what services and support are available to them.

15 CHILDREN

15.1 When assessing and providing services to an adult with mental health problems and/or a learning disability, professionals must be alert to the needs of children for whom the adult has parental or caring responsibilities, or with whom the adult has substantial contact to ensure that the children have adequate support and protection. A child is defined as someone under 18.

15.2 All assessments must inquire about the children in the adult's family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact, even if there appears to be no immediate concern of significant harm.

15.3 Assessment must include the collection of all relevant information (the minimum being identified in relevant practice guidance / documentation) and areas of need perceived by the service user in relation to the child should also be identified and documented. Health and social care professionals must consider the needs of both the adult and the child, but the welfare of the child is always paramount.

15.4 Staff have a responsibility to contribute to the assessment of all children and families in need, not just those in need of protection and reference should **always** be made to the Trust's policy, NTW(C)04 – Safeguarding Children and Local Authority Safeguarding Children Policy as well as the local safeguarding children procedures. Staff working with families where there are children should normally have undertaken Level A, children's safeguarding training.

16 SAFEGUARDING ADULTS

16.1 Every member of staff has a responsibility to protect vulnerable adults from abuse, regardless of the setting in which the care takes place.

16.2 If any member of the care team has any concerns about the health or wellbeing of any vulnerable adult they must report this to their line manager immediately, or if the line manager is suspected of being involved tell his/her line manager.

16.3 It is the line manager's responsibility to take appropriate action as required by the Trust's policy NTW(C)24 - Safeguarding Vulnerable Adults and Local Authority Safeguarding Adults Policies.

17 PUBLIC PROTECTION

17.1 Every member of staff has a responsibility under MAPPA to protect the public from serous harm arising from the mental health of their service users, regardless of the setting in which the care takes place.

17.2 If any member of the care team has any concerns about the risk to the public they must report this to their line manager immediately, and discuss the need for referral to the police or probation via the single point of contact (SPOC) for their service area.

17.3 It is the line manager's responsibility to take appropriate action as required by the Trust's policy NTW(C)25 - MAPPA (Multi Agency Public Protection Arrangements - including non MAPPA)

18 COMMUNITY AND CRIMINAL JUSTICE COLLABORATION

18.1 CPA (Enhanced Care co-ordination) is applicable regardless of setting; therefore, it is particularly important that effective links are made with the Criminal Justice System.

18.2 Where an individual was cared for within the framework of CPA immediately before entering the criminal justice system, links must be maintained between the individual's Care Coordinator and the prison mental health services to ensure continuity of treatment until formal transfer of care and to help enable early and sound discharge planning on release from prison.

19 SERVICE USERS WHO MOVE WITHIN NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

19.1 Where service users move from one area / service to another within the Trust, there is the potential for interruption in the continuity of care and treatment. When a service user moves area Section 117 responsibility remains with the Local Authority where they were ordinarily residing, however, legal advice may be needed in particularly complex cases around issues such as ordinary residence, funding responsibility and Section 117 responsibility.

19.2 Trust locality Core Services teams can provide information to enable Care Coordinators to establish the appropriate team / service that covers the area the service user is to / has moved to.

19.3 Planned Moves

19.3.1 The decision to transfer responsibility for the care of a service user should take place within the care co-ordination review process involving the service user, unless exceptional circumstances prevent this.

19.3.2 Appropriate representative(s) of the receiving service should be invited to contribute to the review by attending a review meeting or by other means if that is not possible, e.g. the proposed Lead professional or Care Coordinator, Responsible clinician.

19.3.3 This must be supported by effective communication and detailed information must be made available to the appropriate professionals in the receiving team/service prior to the review. As a minimum this information must comprise of copies of the most recent

- Assessment
- Risk Assessment
- Care plan including crisis plan and where appropriate risk management plan

19.3.4 The review should consider and document the impact of the service user's transfer on risk issues and jointly complete a new risk assessment if appropriate. This should be recorded using the receiving team/service risk tool.

19.3.5 An agreed timescale for implementing the transfer should be drawn up between the current and receiving service to enable

- The receiving team/service to identify the new Lead Professional or Care Coordinator who then accepts responsibilities for the service user at the agreed time
- Appropriate services to be set up by the receiving team/service, in consultation with the service user and other service providers, to meet needs before the transfer takes place.

19.3.6 When transfer of care has been completed, and is between Trust services the transferring service's current unified health record (UHR) should be provided as soon as possible.

19.4 Unplanned Moves

19.4.1 Some service users will move in an unplanned way, where this is very local, and the original Lead Professional / Care Coordinator is aware of this they should continue working with that service user until formal handover arrangements, described above, can take place.

19.4.2 Where the move is at some distance and it would be impracticable for the Lead professional / Care Coordinator to do this, then detailed information should be sent immediately to the new team / service and discussion should take place between the teams at the earliest opportunity to enable formal handover to take place. The minimum information requirement is copies of the most recent

- Assessment
- New Address
- Risk Assessment
- Care plan including crisis plan and where appropriate risk management plan
- Summary of most recent contacts with the service user

19.4.3 Where the move is between Trust services the transferring service's current UHR should be provided as soon as possible.

19.4.4 If the role of lead professional / Care Coordinator is to be undertaken by a member of staff from a partner organisation the minimum information requirement is copies of the most recent

- Assessment
- New Address
- HoNOS Assessment
- Risk Assessment
- Care plan including crisis plan and where appropriate risk management plan
- Summary of most recent contacts with the service user

20 SERVICE USER'S WHO MOVE OUTSIDE OR INTO NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

20.1 Where service users plan move out of area Section 117 responsibility remains with the Local Authority where they were ordinarily residing, however, legal advice may be needed in particularly complex cases around issues such as ordinary residence, funding responsibility and Section 117 responsibility.

20.2 If a service user is moving outside of the geographic area covered by Trust, locality Core Services team / Sunderland CPA team (Appendix 5) can support the Lead professional / Care Coordinators to establish the appropriate team / service that covers the area the service user is to / has moved to.

20.3 The Lead professional / Care Coordinator should make contact with team / service that covers the area the service user is to / has moved to and arrange a formal hand over. If practicable this should be undertaken, though review meeting attended by a representative of the receiving team. Where the move is at some distance or has been unplanned discussion should take place between the teams at the earliest opportunity to enable formal hand over.

20.4 Whatever methodology is used the handover must be supported by effective communication and detailed information must be made available to the appropriate professionals in the receiving team/service. As a minimum this information must comprise of copies of the most recent

- Assessment
- Risk Assessment
- Care plan including crisis plan and where appropriate risk management plan
- Summary of most recent contacts with the service user
- New Address

20.5 If a service user is moving into the area covered by Trust the expectations are that the out of area Lead professional / Care Coordinator should make contact with the Trust team / service that covers the area the service user is to / has moved to and arrange a formal hand over.

21 SERVICE USERS WHO GO MISSING

21.1 If a service user disengages from services and is missing the care team should follow the Trust's policy NTW(C)03 - Absent without Leave and Missing Patient.

21.2 If the risk assessment of a service user missing from their home indicates risk to self or others, members of the care team and any relevant carers or family members should formulate a plan of action. When contact is lost and concern is high, and staff agree that a missing person alert needs to be circulated the locality Core services Team will help determine the appropriate communication route to follow based on information given. The locality Core services Team will also send out the missing person alert. This can be at a local level or regional or national level via the Care Programme Approach Association (CPAA.) If necessary, the locality Core services Team will seek guidance from Caldicott Guardian.

22 CONSULTATION AND COMMUNICATION WITH STAKEHOILDERS

22.1 The consultation of this policy has been carried out in line with Section 7 within the Trust's policy NTW(O)01 – Development and Management of Procedural Documents and the relevant process of each Local Authority.

23 APPROVAL OF DOCUMENT

23.1 This policy has been approved by the Quality and Performance Committee, which is a sub-group of the Trust Board and will be reviewed November 2013, unless by exception, i.e. due to change in legislation or standards etc. Each Partner organisation is responsible for the policy approval within its own procedures.

24 DEFINITIONS OF TERMS USED

- AMHP Approved Mental Health Professional
- CPA Care Programme Approach
- CPAA Care Programme Approach Association
- DOH Department of Health
- GP General Practitioner
- HoNOS Health of the Nation Outcome Scale
- IMHA Independent Mental Health Act Advocate
- LA Local Authority
- LPA Lasting Power of Attorney
- MAPPA Multi-agency public protection arrangements
- MCA Mental Capacity Act
- MDT Multi Disciplinary Team
- MH Mental Health
- SARN Summary of Assessments of Risk and Need
- SCT Supervised Community Treatment
- SPOC Single Point of Contact
- UHR Unified Health Record
- The Trust – Northumberland, Tyne and Wear NHS Foundation Trust

25 POLICY ADMINISTRATIVE PROCESS

25.1 The development, consultation and dissemination of this policy have been undertaken in accordance with the Trust's policy, NTW(O)01 Development and Management of Procedural Documents and in conjunction with the Trust's policy administration process and the relevant process of each Local Authority

25.2 It has been circulated within the Chief Executive's Bulletin via a link to the Clinical and Nursing policy bulletin and is available on the Trust Intranet site and also from the Trust policy administration. Each Local Authority is responsible for appropriate internal distribution and access.

25.3 Archiving of this policy will be in accordance with the Trust's policy NTW(O)01 Development and Management of Procedural Documents and the relevant process of each Local Authority

26 EQUALITY AND DIVERSITY ASSESSMENT (Appendix A – Impact Assessment Form)

26.1 In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner

27 TRAINING (Appendix B – Training Checklist and Needs Analysis)

27.1 Training on the Care co-ordination / CPA principals and processes, incorporating risk assessment will be provided for all those involved in providing care co-ordination to service users and is part of induction training for all disciplines.

27.2 It will be priority training for all clinical mental health and learning disability staff who assume the role of Care Coordinator or Lead Professional

27.3 Training will also be provided for those staff who contribute to risk assessment and implement risk management / care co-ordination / CPA care-plans e.g. support workers, unqualified nurses

27.4 Refresher sessions will be provided to staff who have previously completed this training to update them on changes associated with the new policy

27.5 It is the responsibility of both managers and staff to ensure that appropriate levels of training are undertaken and that attendance is verified and recorded. Levels of training are identified in the training needs analysis (see Appendix B) and are included within the Essential Training Guide which forms part of NTW(HR)09 – Joint Development and Review Policy, Practice Guidance Notes

27.6 The implementation of the national training programme for care coordinators will enable individual training needs analysis for care coordinators and refresher / update training being delivered though specific modules via e learning or face to face training courses.

28 EMBEDDING

28.1 Taking into consideration all the implications associated with this policy, it is considered that a target date of 12 months post implementation is achievable for the contents to be embedded within the organisation.

28.2 This will be supported by policy awareness sessions delivered via team meetings and book in courses.

287.3 This will be monitored by the Quality and Performance Committee during the review process. If at any stage there is an indication that the target date cannot be met, then the Quality and Performance Committee will consider the implementation of an action plan.

29 MONITORING AND COMPLIANCE

29.1 This policy will be audited using the Statements in Appendix C, using the Quality Monitoring Tool process and analysis of training statistics. Outcomes being reported to the Care Co-ordination Steering group which reports to Quality and Performance Committee.

29.2 It is important that the policy and associated practice guidance develops to continually reflect the needs of service users and carers and is updated to take account of experience in practice, changes in organisational policy,

legislation and recognised good practice. It will be the joint responsibility of the Trust and associated partners, to ensure that this happens.

30 STANDARDS / KEY PERFORMANCE INDICATORS

- NHS Litigation Authority Risk Management Standards 2.7 and 4.10

31 FAIR BLAME

31.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

32 ASSOCIATED DOCUMENTATION

- NTW(C)03 Absence without Leave and Missing Patient Policy
- NTW(C)04 Safeguarding Children policy & associated LA guidance
- NTW(C)05 Consent Policy
- NTW(C)07 Promoting Engagement with Service users including difficult to engage and non compliant
- NTW(C)12 Advanced Decisions and Statements Policy
- NTW(C)19 Observation policy
- NTW(C)24 Safeguarding Adults policy & associated LA guidance
- NTW(C)34 Mental Capacity Act Policy
- NTW(C)47 Supervised Community Treatment
- NTW(O)01 Development and Management of Procedural Documents
- NTW(O)11 Child Visiting Policy
- NTW(O)22 Sharing Letters with Patients Policy
- NTW(O)25 MAPPA (Multi Agency Public Protection Arrangements)
- NTW(HR)09 Joint Development & Review and Practice Guidance Notes

33 REFERENCES

- Department of Health (2008) Refocusing the Care Programme Approach
- Department for Constitutional Affairs Mental Capacity Act 2005 Code of Practice
- Mental Health Act 1983 Code of Practice TSO, 2008
- **Social Care Institute for Excellence** (2009) Guide 30 Think child, think parent, think family: a guide to parental mental health and child welfare

- **Department of Health & Social Care Institute for Excellence CARE PROGRAMME APPROACH (CPA) BRIEFING: Parents with mental health problems and their children April 2008**

- NHS Executive/SSI (1999) Effective Care Co-ordination in Mental Health Services (modernising the care programme approach)

- NHS Executive (1999) National Service Framework for Mental Health Modern Standards and Service Models

- The Department of Health's (HC(90) 23/LASSL(90)11)

- NHS & Community Care Act HSG 94 27

- HSF(95)56: Building Bridges – A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people

- CI(99)3: Still Building Bridges: The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach and Care Management

- Department of Health. January 2006. Briefing Paper. Sharing mental health information with Carers: pointers to good practice for service providers.

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Appendix A

Equality and Diversity Impact Assessment Screening Tool

Names of Individuals involved in Review	Date of Initial Screening	Review Date	Service Area / Directorate
Liz Bowman	Aug 2007	Dec 2008	
Chris Rowlands	Dec 2008 – V02	Dec 2011	
	Nov 10- V03	Nov 13	
Policy or Service to be Assessed: **Care Coordination including Care Programme Approach – V03**		Is this a new or existing Policy or Service?	Existing ✔

Describe the aims, objectives or purposes of the Policy or Service	This policy sets out the principles and framework for assessment and care planning for adults receiving mental health or learning disability services within the Trust and its partner agencies where there is shared care or section 75 partnership agreements
Are there any associated objectives of the Policy or Service? If so what are they?	NTW (C) 03 Absence with out Leave and Missing Patient NTW (C) 04 Safeguarding Children policy & associated LA guidance NTW (C) 05 Consent and Examination To Treatment NTW (C) 07 Promoting Engagement with Service users including difficult to engage and non-compliant NTW (C) 12 Advanced Decisions and Statements NTW (C) 19 Observation NTW (O) 22 Sharing Letters with Patients NTW (C) 24 Safeguarding Adults & associated LA Guidance NTW (O) 25 MAPPA (Multi Agency Public Protection Arrangements) NTW (C) 34 Mental Capacity Act NTW (C) 47 Supervised Community Treatment
Does the policy unlawfully discriminate against equality target groups?	No
Does the policy promote equality of opportunity for equality target groups?	Yes integral to care co-ordination
Does the policy or service promote good relations between different groups within the community, based on mutual understanding and respect?	Yes

Equality and Diversity Impact Assessment Screening Tool

Which equality target groups of the population do you think will be affected by this policy or function?

Equality Target Group	What positive and negative impacts do you think there may be for each equality target group(s)?
Black and Minority Ethnic People (including gypsy/travellers, refugees and asylum seekers) **BME**	Positive the policy takes account of all possible access needs.
Women and Men **WM**	Sensitive to gender requirements
People in Religious/Faith groups **RF**	Needs are addressed through care co-ordination
Disabled People **DP**	Needs are addressed through care co-ordination
Older People **OP**	NA
Children **C**	NA
Young People **YP**	NA
Lesbian Gay Bisexual and Transgender People **LGBT**	Needs are addressed through care co-ordination
People involved in the criminal justice system **CJS**	Needs are addressed through care co-ordination
Staff **S**	Clear guidelines for staff to follow in implementation.
Any other group(s) **AOG**	

Equality and Diversity Impact Assessment Screening Tool

Screening Tool Checklist: Summary Sheet	
Positive Impacts (Note the code of groups affected) All groups positive	**Negative Impacts** (Note the code of groups affected)
Additional Information and Evidence Required	
Recommendations Monitor for impact during policy review	

From the outcome of the Screening, have negative impacts been identified for race or other equality groups?

Yes ☐ **No** ☑

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager's signature: Chris Rowlands **Date:** November 2010

Should any advice be required in respect of answering the above questions contact:

Equality and Diversity Officer
01670 394 848

Appendix B

Communication and Training check list

It is the responsibility of Governance Committees to ensure a full review of any training implications has been undertaken prior to the ratification of any policy.

What is the change in knowledge or skills required to achieve the differences that this policy has been designed to deliver for the organisation?	Understanding of only one level of care co-ordination; criteria of inclusion; differential recording requirements across pathways of care
Are the communication/training needs required to deliver the changes necessary by law, by national/local standards?	National and local standards
For which staff groups is the communication/training need required?	Clinical staff in all Directorates - see Training Needs Analysis – Appendix B
What levels of understanding are required e.g. awareness of policy, understanding of new responsibilities/skills?	Awareness of new policy; understanding of responsibilities; new recording requirements & documentation as indicated in practice guidance ; risk assessment skills and new recording tool for Adult Services south of Tyne
What means of delivery would be most appropriate e.g. team briefs, management cascade, e-bulletin etc?	Management cascade and e-bulletin to be used to facilitate delivery of policy awareness update to be delivered through team based sessions including new Risk assessment recording tool for Adult Services South of Tyne. Programme of Clinical Risk and Care Co-ordination Training incorporating directorate relevant practice guidance delivered through tailored book in courses and team based sessions for clinical staff who have not previously attended. E learning to be developed. Flow charts in policy practice guidance notes for easy reference.

Should any advice be required in respect of answering the above questions contact:
Individual Development -Tel: 0191 223 2309

Appendix B - continued

Training Needs Analysis

Staff/Professional Groups	Type Of Training	Duration of Training	Frequency of Training
All registered staff Apart from those that work in Addictions and Neuro rehabilitation but including those that work in Neuro psychiatry	Care Co-ordination and Clinical Risk	1 day	Once
All registered staff who have completed the initial one day Care Co-ordination and Clinical Risk Course.	Care Co-ordination and Clinical Risk update **OR** Care co-ordination update + Suicide prevention advanced course **OR** Care co-ordination update + Suicide prevention update (if advanced course completed)	2 hours 1 hour I day 1 hour ½ day	Completion of one of these options every 3 years
All non registered staff who participate in the care co- ordination process as a member of the care team This will exclude those that work in Addictions and Neuro rehabilitation but including staff that work in Neuro psychiatry	Care Co-ordination and Clinical Risk	½ day	Once
All non registered staff who participate in the care co- ordination process as a member of the care team	Care Co-ordination and Clinical Risk update **OR** Care co-ordination update + Suicide prevention Foundation	2 hours 1 hour ½ day	Completion of one of these options every 3 years

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Appendix C

Audit / Monitoring Tool .

Statement

The Trust will work towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance regular audits must be carried out. Policy authors are encouraged to attach audit tools to all policies. Audits will need to question the systems in place as outlined in the policy. It is suggested that between five and eight measurable standard statements be listed, which can then be audited in practice and across the Trust.

NTW(C)20 Care Coordination, including Care Programme Approach			
Standard Statement		**Yes**	**No**
Statement 1	Staff attend Clinical Risk and Care Co-ordination training		
Statement 2	A risk assessment is completed as part of assessments		
Statement 3	Risk assessment has been reviewed and reflects current needs		
Statement 4	A care plan has been developed with the involvement of the service user and their family ./ carer (if appropriate)		
Statement 5	Care plan has been reviewed and reflects current needs		
Statement 6	Joint review of the care plan and risk involving inpatient and community staff prior to discharge from hospital		
Statement 7	Evidence of a hospital discharge care plan		

The author(s) of each policy to complete the audit/monitoring template and ensure that the results are taken into consideration by the appropriate committee at each review date.

Appendix D

Policy notification record sheet

Policy number	NTW(C)20
Policy title	Care Coordination/Care Programme Approach
Date issued	Mar 11 - inclusion of PGN-09-Psychotherapy
Date of implementation	March 2011
Directorate/Service/Ward/Department	
Received by	
Date received	
Date placed in policy file	

I have read the above policy and understand its contents.

Name (print)	Signature	Designation	Service/Ward/Dept.	Date

This form is to be kept up to date at all times to act as a clear record that all relevant staff have received notification of the existence of the above policy, that they have read it and understood its contents. Form to be retained in the policy file in front of the policy specified.

Policies and policy index lists are available via Trust Intranet. Index lists are continually updated and current lists should be retained in the front of policy files.

APPENDIX 26

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Care Co-ordination /care Programme Approach Policy Adult Practice Guidance Note			
Issue 2 – Feb 09 **Issue 2 Oct 09** **Issue 3 – April 10** **Issue 4 – Nov 10**	**Planned review** Feb 2010 **extended to Nov 13**	**Responsible officer** **Liz Bowman**	**CC-CPA-PGN-01** Part of NTW(C) 20 CC/CPA Policy

CONTENTS

Appendices – listed separate to practice guidance note	
Appendix 1	Registration
Appendix 2	Assessment
Appendix 3	Consent
Appendix 4	Standards for Clinical Letters
Appendix 5	Care Plan
Appendix 5a	Care Plan – Acute Ward
Appendix 6	FACE Risk Profile
Appendix 7	FACE risk – Forensics
Appendix 8	Review
Appendix 9	Deregistration
Appendix 10	Keeping Children Safe Assessment

Adult Practice Guidance to be read in conjunction with NTW (C)20

This practice guidance relates to adults receiving mental health services within Northumberland, Tyne and Wear NHS Foundation Trust. It applies to staff within:

- Adult directorate including Social Workers in the integrated mental health teams in Northumberland and North Tyneside.
- Speciality services, but not including Neuro-rehabilitation and Neuro behavioural wards who will have a specific practice guidance note
- Forensic Mental Health services

It will be supplemented with specific information sharing guidance for localities that do not have integrated mental health teams with the local authority.

1 ASSESSMENT AND CONSENT TO SHARE INFORMATION (Appendix 2&3)

1.1 All service users referred to secondary mental health services will have their demographic information recorded on the electronic care record RiO. Where a team does not have Direct RiO access page one of the Care co-ordination registration document **(Appendix 1**) will be used. This form is designed to be used as the service user's information pages of a paper record.

1.2 All service users referred to secondary mental health services will have an initial assessment of their mental health needs using the Care co-ordination assessment framework (**Appendix 2).**

1.3 As a minimum this will always include:

- Reason for referral.
- Advocacy needs.
- Service Users account of their current problems, needs and mental health issues.
- Service Users expectations and wants from the service.
- Mental state (at interview).
- Mental health history.
- Cultural or faith needs.
- Assessment of social circumstances including enabling of identification of Fair Access to Care Services eligibility criteria (including Direct Payments / Individualised budgets) and information gathering about children in the family.
- Risk assessment; the outcome being recorded as a minimum requirement using the appropriate FACE risk profile. A consultant psychiatrist (or associate specialist) must attend the review and be directly involved in formulating risk assessment(s) and management plan(s) (including multi-agency planning via the safeguarding process where applicable) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan.
- Mental Capacity/ Best Interest determination in relation to proposed future action

1.4 The assessment will be recorded using the Care Co-ordination assessment document, Psychological Therapy letter with assessment headings. or the equivalent section of the electronic care record. This provides the framework to support professional assessment practice and recording within the standards required by Care Programme Approach (CPA), the National Service Framework (NSF) and professional bodies.

1.5 The prompts included are designed to illustrate the issues that might be considered in each area of the assessment but are not intended to be used as a checklist or exclude additional assessment components or relevant information.

1.6 Whether other sections of the assessment framework will be used at initial assessment will be a clinical judgement informed by the referral information, the service user's needs and the assessment process.

1.7 When assessing and providing services to an adult with mental health problems, professionals must be alert to the needs of children for whom the adult has parental or caring responsibilities, or with whom the adult has substantial contact to ensure that the children have adequate support and protection. A child is defined as someone under 18.

1.8 All assessments must inquire about the children in the adult's family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact, even if there appears to be no immediate concern of significant harm. Health professionals must consider the needs of both the adult and the child, but the welfare of the child is always paramount.

1.9 Staff have a responsibility to contribute to the assessment of all children and families in need, not just those in need of protection and reference should **always** be made to Trust's policy NTW(C)04 Safeguarding Children and local safeguarding children procedures.

1.10 Consent to seek and Share Information should be discussed agreed with the individual as part of the initial assessment. This will be recorded on page one the consent to share information form **(Appendix 3)** or the equivalent section of the electronic care record.

1.11 if the individuals assessed needs are to be met by secondary mental health services and an initial care plan should be agreed with the service user and recorded in the further action section of the assessment.

1.12 The outcome of the initial assessment should be communicated promptly in writing to the individual (in a way they will understand), to the referrer and the individuals GP.

1.13 If the service user's needs are not to be met by secondary services and the individual is provided with appropriate advice and / or signposting this information / advice should be included in the assessment outcome letter.

1.14 If it is **clear** from the initial assessment that the service user has more straight forward needs and does not meet the criteria of enhanced needs a **lead professional** will be identified. The **lead professional** will develop the initial care plan with the service user, and others as appropriate, to ensure there is a shared understanding of how care and treatment will be carried out, by whom and when.

1.15 Consent to share information should be revisited as part of the care planning process and documented on the relevant section of the consent form

1.16 This **care plan** can be recorded in the form of a clinical letter which meets the directorates' standards **(Appendix 4)** or using the directorates' care plan document if this enables clarity for the service user. Whatever format is used the service user must **always** be offered a copy of this care plan unless doing

so would constitute a significant risk to the service user or others and a copy sent to the General Practitioner (GP) and any others who are part of the care team

1.17 The service user will be registered on the electronic care record as "not on CPA" with the lead professional registered as a care co-ordinator until the updating of the system enables this to change. This registration will **not** confer the responsibilities of a care co-ordinator onto the lead professional. Where a team does not have access to do this directly onto the electronic care record the appropriate pages of the Care co-ordination registration document (**Appendix 1**) will be used.

1.18 If there is any uncertainty about the complexity of needs then the assessor must undertake further assessment of health and social care needs using the Care Co-ordination assessment framework involving other professionals and any specialist assessments as required enabling a clear decision to be made

1.19 Where the initial assessment is indicative that the service user has enhanced needs (CPA) the assessor will ensure that the initial assessment is developed into a comprehensive assessment of health and social care needs completing the Care Co-ordination assessment document (or the equivalent sections of the electronic care record) which meets the requirements of CPA. They will also update the initial risk assessment the outcome being recorded as a minimum using the appropriate FACE risk profile. The comprehensive assessment and risk assessment outcomes and formulation will be used to agree the appropriate professional to be the care co-ordinator

1.20 Other professional / specialist assessment / risk assessment tools will be used as appropriate to the service users needs.

1.21 Decisions following assessment cannot be made collectively by team meetings. This responsibility rests with the professional carrying out the assessment. They should seek support and advice from their supervisor if necessary. However team meetings are essential to good team practice in supporting colleagues and in guiding and informing practice. Team members have a responsibility to give sound advice, particularly where there are risk issues

1.22 Once a service user has received an assessment, or part of the assessment process where two or more sessions are required, the service assumes some responsibility for that person. In practice, this means that the assessing clinician needs to put in place care arrangements that meet any urgent clinical needs. This responsibility does not mean that the service user will necessarily be offered longer-term services by a team, but is designed to ensure that service users do not fall into gaps between services at transition points and is of particular importance when presenting risks are substantial or high.

2 REGISTRATION (Appendix 1)

2.1 For service users with enhanced needs the care co-ordinator will ensure that the service user is registered on the electronic care record as being on enhanced level care co-ordination. Where a team does not have access to do

this directly onto the electronic care record appropriate pages of the Care co-ordination registration document **(Appendix 1)** will be used.

2.2 For service users who do not have enhanced needs the lead professional will ensure that the service user is registered on the electronic care record with the lead professional registered as a care co-ordinator until the updating of the system enables this to change. This registration will not confer the responsibilities of a care co-ordinator on the lead professional.

3 CARE PLANNING FOR SERVICE USERS WITH ENHANCED NEEDS (Appendix 5)

3.1 The care co-ordinator, through discussion and negotiation with the service user and others, will ensure that a comprehensive, formal written care plan is developed and agreed. Referrals to another area of services within the Trust should be accompanied by a copy of the assessment documentation

3.2 Consent to share information should be revisited as part of the care planning process and documented on the relevant section of the consent form **(Appendix 3)** or the equivalent section of the electronic care record.

3.3 The care plan will identify the service user's needs, the resources, and actions by individual members of the care team, including the service user and carer and any Lasting Power of Attorney (LPA) (as appropriate) to meet those needs. The care plan will have a recovery, socially inclusive and outcome focus, these outcomes being identified by the service user and the team. The care plan will also include a crisis plan. Responses to crisis situations during working hours and outside of working hours must be included.

3.4 The crisis plan should incorporate trigger factors/relapse indicators specific to the service user and record the agreed the respective responsibilities of all members of the care team. This should include the service user e.g. increase their use of established coping skills; the family (with their agreement) and the community e.g. support lines.

3.5 Care planning on acute wards will incorporate observation and leave as appropriate and be recorded using the acute in patient care plan (**Appendix 5a)**

3.6 In the community and inpatient settings service users must **always** be offered a copy of their care plan unless doing so would constitute a significant risk to the service users or others.

3.7 Service user led documents such as an Advance Statement; a Wellness and Recovery Action Plan (WRAP) or a Bi-polar action plan can inform or even be used to fully formulate the crisis plan. Crisis responses from statutory services should be increase in a graded sense in relation to the risk.

4 RISK ASSESSMENT AND MANAGEMENT (Appendix 6, 7 & 10)

4.1 Risk assessment is a dynamic and ongoing process in the provision of care and treatment to all service users. It is a multi disciplinary responsibility and the outcome of risk assessment should be formally documented using the minimum approved FACE risk profile tool.

4.2 A consultant psychiatrist (or associate specialist) should be directly involved in formulating risk assessment(s) and management plan(s) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

4.3 This involvement should be whenever risk assessment is required and should be formally documented (as a minimum) on the FACE risk profile tool and through completion of the Keeping Children Safe Assessment (Appendix 10)

4.4 Risk assessment is required:

- As part of initial assessment (documented as a minimum on a FACE risk profile) / ongoing assessment / reassessment
- When admitting and discharging from hospital (documented as a minimum on a FACE risk profile risk) and as part of planning and agreeing leave.
- As part of review considerations. If there is no change to the risk indicators / level of risk recorded on the FACE risk profile then this profile remains current providing there is clear recording of no change via the review record i.e. the clinical letter (Appendix 4) or the care co-ordination review form.
- When there are major changes to presentation / personal circumstances or following an incident
- When alerted by Carers
- When transferring service users to other teams/service providers
- When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

4.5 Risk management plans are an integral part of the Care Plan and will be developed when the level of risk is significant, serious, or serious and imminent {FACE risk profile ratings scale 2,3, or 4}

4.6 The management of risk issues that are rated 1 do not require a specific risk management plan and should be covered by the Care Plan and appropriate crisis plan.

4.7 The risk management plan will be recorded by an agreed member of the care team using the' care plan document **(Appendix 5)**

5 RISK ASSESSMENT AND MANAGEMENT IN FORENSIC SERVICES

5.1 The Forensic service adopts the use of HCR20 as a required additional risk assessment tool to supplement/support the use of FACE Forensics (**Appendix 7**) within the Care Co-ordination process.

5.2 HCR20 is utilised and completed as part of all service users' initial assessments undertaken by Forensic Service and repeated as a minimum on an annual basis by the clinical team.

5.3 That risk assessment, including HCR20 is reviewed and if needed updated by the clinical team if the service user is to be transferred or discharged.

5.4 That all members of the Multi Disciplinary Team (MDT) contribute to the completion of HCR but it is signed off by the service user's consultant/psychologist

6 REVIEW (Appendix 8)

6.1 For all service users their Care Plan must be subject to ongoing monitoring and review but should be reviewed formally in line with the risk management plan, and planned review dates.

6.2 If a service user's care had been reviewed through MAPPA or Safeguarding Vulnerable adult's processes then a separate care co-ordination review should only be held if there is a clear need or if requested by the service user or Carer

6.3 Frequency of Reviews should be determined by the needs of the service users but should be **at least** once a year. A consultant psychiatrist (or associate specialist) must attend the review and be directly involved in formulating risk assessment(s) and management plan(s) (including multi-agency planning via the safeguarding process where applicable) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan.

6.4 For service users who do not have enhanced each review will involve the service user, any identified carer and any professionals involved in an individual's treatment or care including any involved from a multi agency perspective e.g. due to a child protection plan being in place. As a minimum, this would be the social worker working with the child/ family from children's services.

6.5 The review will:

- Review progress of Care Plan against the agreed outcomes
- Review current assessment of risk including where appropriate keeping children safe assessment
- Review any crisis and risk management plan
- **Consider if any changes in the service user's presenting needs and/or risks are now of a level of** complexity and characteristics, to require enhanced Care co-ordination to be the framework used to deliver a continuity of care.
- Agree any changes to the care plan (if required)
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Consider the impact of care plan changes

- On Carer / need for a carers assessment
- Service users capacity to consent to the care plan

6.6 The review can be recorded in the form of a clinical letter which meets the directorate's standards (Appendix 4) which will also constitute the new care plan. The Care co-ordination review document (**Appendix 8)** can be used if this enables clarity for the service user.

6.7 Whatever format is used the service user must be offered a copy of the review record and a copy sent to the GP and any others who are part of the care team

6.8 At each service users care co-ordination review, where there is carer involvement:

- Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision.

- Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review.

6.9 **For Service Users with enhanced needs** the monitoring of a care plan must be regarded as an ongoing process.

6.10 Informal reviews will be undertaken and documented using the Care co-ordination review form by the Care Co-ordinator involving the service user, any identified carer and all those professionals involved in an individual's treatment or care. This would include any professionals involved from a multi agency perspective e.g. due to a child protection plan being in place as a minimum this would be the social worker working with the child/ family from children's services. The frequency of these reviews will be determined by the service users needs.

6.11 The minimum requirement is that a formal review will take place **at least** once a year

6.12 This formal review will usually involve a meeting of all concerned including the those involved from a multi agency perspective e.g. due to a child protection plan, as a minimum this would be the social worker working with the child/ family from children's services being in place.

- The review should take place in a setting where the service user feels comfortable and will:

- Agree a chair (this will usually be the care co-ordinator)
- Agree a scribe to complete the documentation (Care Co-ordination review form Appendix 8). The scribe will check completed form with the service user and care co-ordinator for accuracy and if agreed obtain the service user and care co-ordinator's signature.
- Review progress of Care Plan against the agreed outcomes

- Review current assessment of risk including where appropriate keeping children safe assessment
- Review crisis and risk management plan

6.13 **Consider if any changes in the service user's presenting needs and/or risks are now of a level of** complexity, to no longer require enhanced Care co-ordination to be the framework used to deliver a continuity of care.

- Agree any changes to the care plan (if required)
- Consider the impact of care plan changes
    - On Carer / need for a carers assessment
    - Service users capacity to consent to the care plan
    - On any potential deprivation of liberty
- Agree who will record the new care plan
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Agree who will undertake the recording of new risk assessment (if required)
- Agree who will undertake the record new crisis and risk management plan (if required)
- If the service user has an advance statement and / or advance decision Review if this still reflects their wishes / views.
- Agree action to be taken (if any)
- **Date and Time of next meeting** agreed and documented

6.14 The care co-ordinator will be responsible for ensuring that a record of the review is made. Where a team does not have access to do this directly onto the appropriate section of the electronic care record the directorate review document will be used (Appendix 8) and sent to the appropriate core services office. A copy of the review record will be distributed by the Care Coordinator to the service user, GP and all those participating in the review process.

6.15 At each service users care co-ordination review, where there is carer involvement:

- Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision
- Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review

6.16 If the service user care plan is to be revised, and incorporates services/interventions being implemented as a result of carers needs

identified at assessment, carers should have the opportunity to identify if the revised care plan still meets their assessed needs.

6.17 There may be circumstances where it is inappropriate to review carer's issues within the service user's review. In such circumstances within 2 weeks of the service users review the carer(s) should have the opportunity to discuss the implications of the review on their role with the Care co-ordinator. This should provide the opportunity for

- Carers who have declined a carer's assessment to revisit that decision;
- Carers who have a separate care plan to identify whether they feel there is a need for a review
- Those carers whose support is incorporated in the service user's care plan to identify if the revised care plan still meets there assessed needs.

7 DISCHARGE PLANNING

7.1 Where a review is considering discharge from either a service or an inpatient ward an associated risk assessment must be completed.

7.2 If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made.

7.3 A consultant psychiatrist (or associate specialist) should be directly involved in formulating the discharge risk assessment and management plan for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable)

8 RISK HISTORY (Appendix 9)

8.1 If a service user is new to service the risk history form or the equivalent section of the electronic care record should be used to document all risk events, which occur following the initial risk assessment (as recorded on the FACE risk profile) throughout the service user's pathway of care

8.2 If a service user has been in service previously and is re referred, records including the previously completed risk history forms and equivalent section of the electronic care record should be used to inform the new risk assessment.

8.3 If the service user's previous contact with services was prior to the use of risk history forms the historical records must be accessed to determine if there are any risk events in the previous records to inform the initial assessment of risk. The risk history form or the equivalent section of the electronic care record should be used to document all risk events, which occur following the initial risk assessment.

8.4 The risk profile can be added to by any member of the care team and is a document that **must** be transferred to each new volume of notes

9 RESPONSIBILITIES OF THE LEAD PROFESSIONAL

9.1 The lead professional will ensure that

- The service user's previous consent to seek and share information is discussed and updated as needed.
- In partnership with the service user and any other significant care provider, including carers, develop a clear understanding of how care and treatment will be carried out, by whom, taking into consideration any existing advanced statement or advance decision to refuse treatment.
- The agreed care and treatment (care plan) is recorded using a clinical letter which meets the directorates' standards (Appendix 4) or using the Care co-ordination care plan document (Appendix 5) if this enables clarity for the service user.
- Provide advice and signposting to the service user to enable them to access other agencies/support to meet their needs
- A central record of care is maintained as required by their agency.
- A copy of the current care plan is always offered to the service user
- The service user is offered copies of letters as outlined in NTW(O)22 Sharing letters with patients policy
- A copy of the current care plan is sent to the persons GP and any other significant care provider, including carers, if appropriate.
- Ensure that the care plan and risk assessment is subject to on-going review as required, involving the service user and any other significant care provider, including carers. This can be recorded using a clinical letter which meets the directorates' standards (appendix 4) or using the care co-ordination review document (Appendix 8) if this enables clarity for the service user.
- In partnership with the service user and any other significant care provider, including carers, consider at each review whether a service user's needs have changed, and if there is need for enhanced care co-ordination support.

9.2 The role of Lead professional can be undertaken by Medical staff and Qualified Nurses, Qualified Social Workers, and Qualified Allied Health professionals who are suitably experienced and skilled under appropriate supervision to be able to assess service users

10 CARE COORDINATOR ROLES AND RESPONSIBILITIES

10.1 The Care Co-ordinator may fulfil these responsibilities through effective, agreed and appropriate delegation to other members of the care team. Such delegation will be recorded in the clinical record or on the care plan or review documentation as appropriate to when delegation occurs.

10.2 Consent **must** always be sought from a professional prior to them being identified as a Care Co-ordinator. Under no circumstances must any professional be stated as Care Co-ordinator without negotiation and agreement.

10.3 The person who is best placed to oversee care management and resource allocation should usually take the role of the Care Co-ordinator.

10.4 The Care Co-ordinator will have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin.

10.5 However, it is not the intention that the care coordinator is necessarily the person that delivers the majority of care. There will be times when this is appropriate, but other times when the therapeutic input may be provided by a number of others, particularly where more specialist interventions are required.

10.6 For people who have had damaging experiences of sexual abuse or violence, choice of gender of the Care Co-ordinator may be a crucial factor in establishing trust and a therapeutic relationship.

10.7 **The Care Co-ordinator will:**

- Ensure the service user's involvement in the process of decision-making.
- Ensure where appropriate, any carer's involvement in the process of decision- making.
- Ensure that, where in place, an Independent Mental Capacity Advocate or an attorney through a Lasting Power of Attorney (LPA) or an Independent Mental Health Act advocate is fully involved in the process of decision making.
- Promote, build and maintain relationships with others involved in the service user's care.
- Act as the "acknowledged" name for contact by all agencies relevant to the service user's care.
- Ensure that a comprehensive, formal written care plan including risk and crisis plan care plan is negotiated and agreed and that responses to crisis situations during working hours and outside of working hours are included. The level of response should be appropriate to the degree of crisis.
- Ensure that the documented plan accurately reflects the agreements reached. This is indicated by the Care Co-ordinator signing the care plan.
- Ensure the service users and all members of the care team (including the GP) has a copy of the care plan
- Ensuring the care plan is recorded on the electronic care record as access to the electronic care record (RiO) is rolled out.

- Ensure that any advanced statements or advance decisions are considered and recorded as part of the Care planning process.
- Consult and seek appropriate advice if any aspect of the care plan proposes significant restrictions of liberty to ensure that such restrictions do not constitute "deprivation of liberty"
- Monitor the agreed care plan and record progress.
- Ensure appropriate review of the service user's care plan
- Provide support and care, taking positive action in the event of a service user disengaging from services in accordance with Trust procedures
- Work with in-patient services to ensure that prior to discharge a joint review takes place.
- Ensure the service user's GP and staff identified in the care plan are informed within one working day of the service user being admitted to hospital. Where appropriate it may be necessary to ensure that there is support for the service user to register with a GP
- Ensure the provision of follow-up and assertive outreach where this is available should the service user disengage from services.
- Ensure, whenever possible, any change of Care Co-ordinator should be agreed through the care co-ordination review process. This will ensure there is an effective hand-over of information to the new Care Coordinator.
- Where a service user plans to move area the Care Co-ordinator must liaise with the appropriate professionals in the receiving care team to ensure that the service user's care is transferred effectively.
- Ensure Carers are supported and offered an assessment of their needs

10.8 The role of Care Coordinator, depending on capability and capacity, can be undertaken by

- Medical staff (except Senior House Officers)
- Qualified Nurses,
- Qualified Social Workers,
- Qualified Allied Health professionals

Who are suitably experienced and skilled under appropriate supervision?

11 RESPONSIBILITIES OF MEMBERS OF THE CARE TEAM

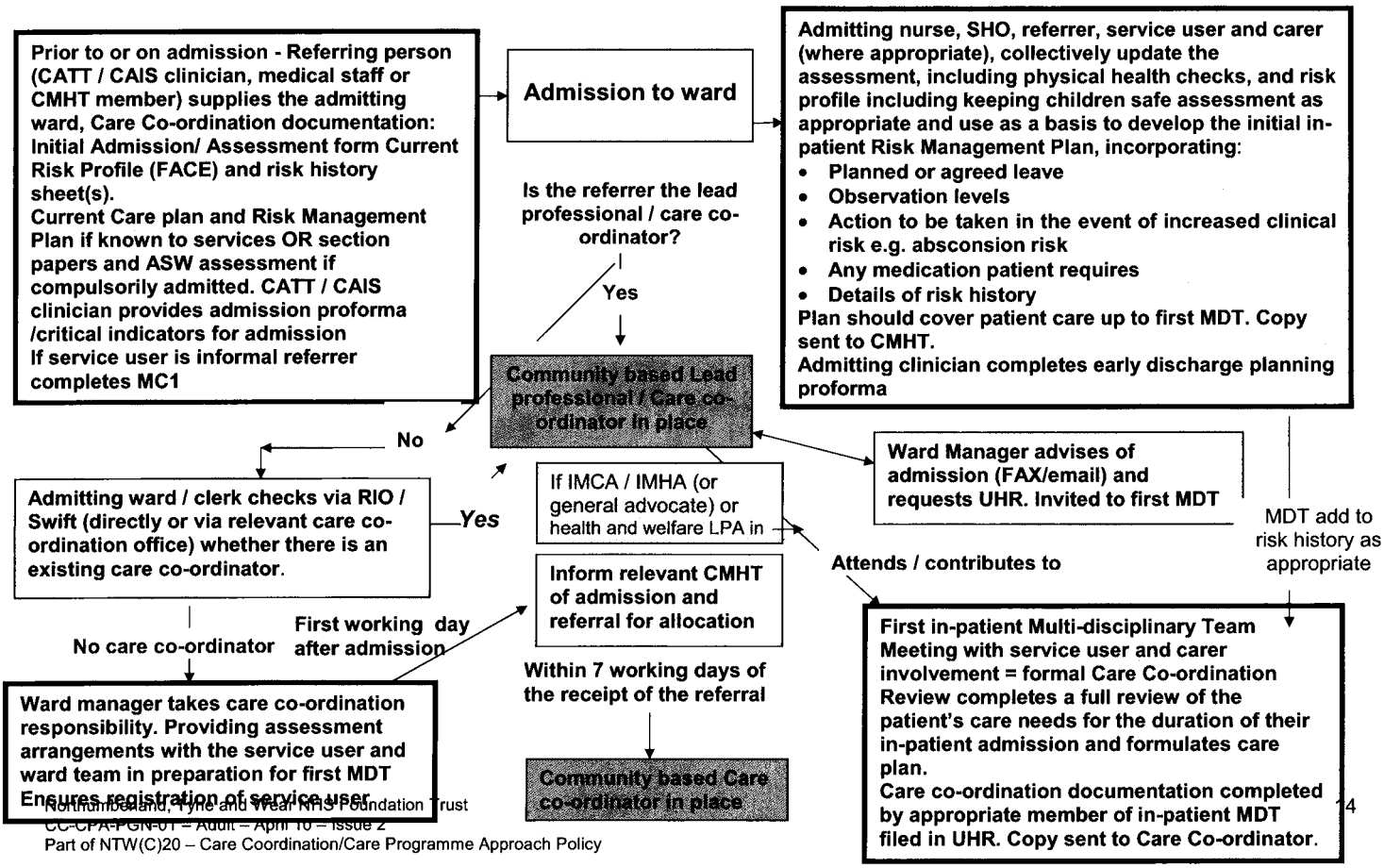
11.1 All professionals whether employed in the statutory or voluntary sector, and any carers, have a responsibility to:

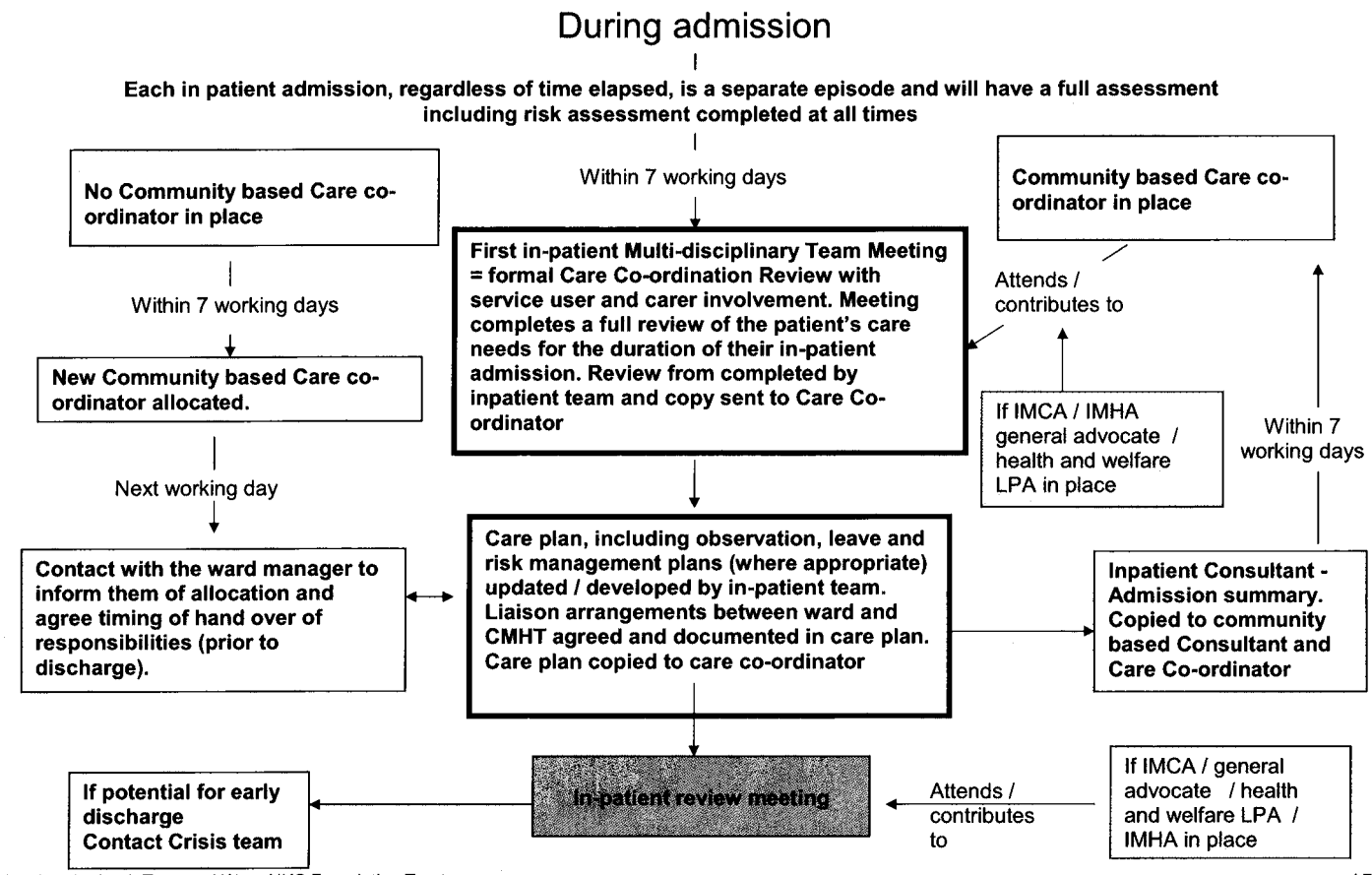
- deliver agreed interventions,
- undertake their own dynamic and ongoing risk assessment
- contribute to the overall assessment of risk through sharing of their professional assessment

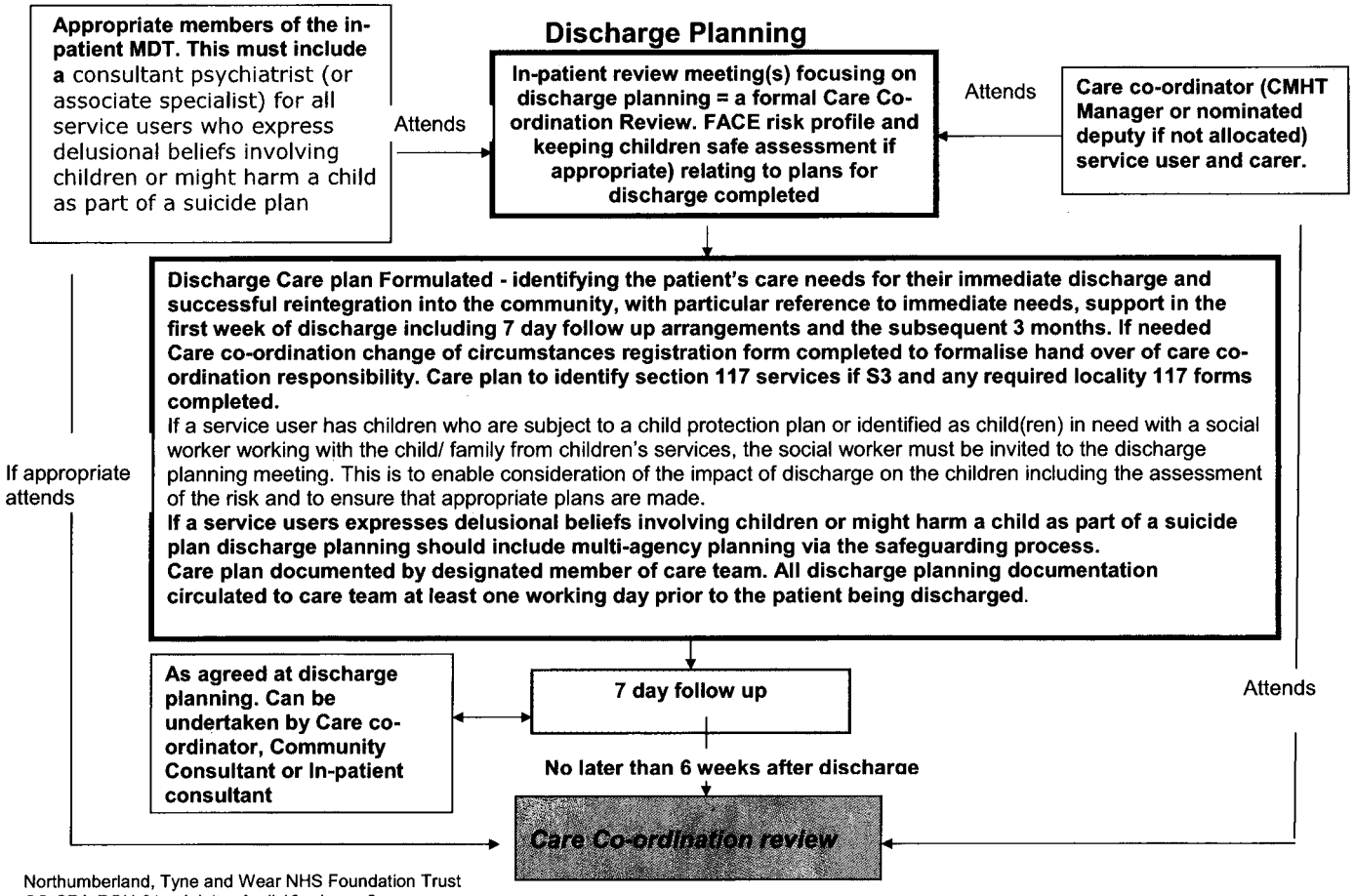
- communicate with the Care Co-ordinator regarding
- their assessment of risk ;
- their role in the care plan and progress of associated service delivery.

11.2 This is particularly important following any major change in the circumstances of the service user or should service delivery cease or no longer seems appropriate

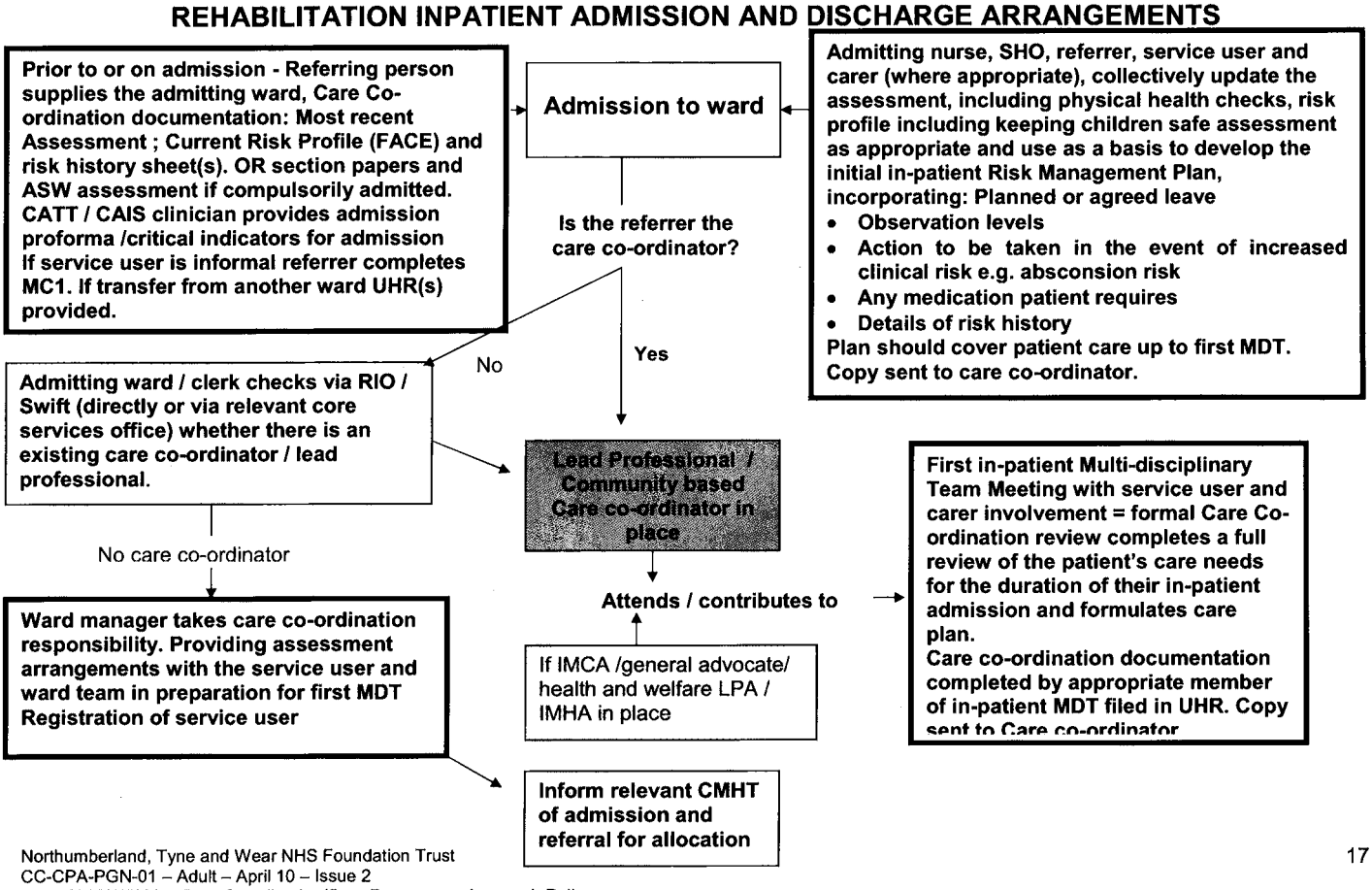
ACUTE INPATIENT ADMISSION AND DISCHARGE ARRANGEMENTS



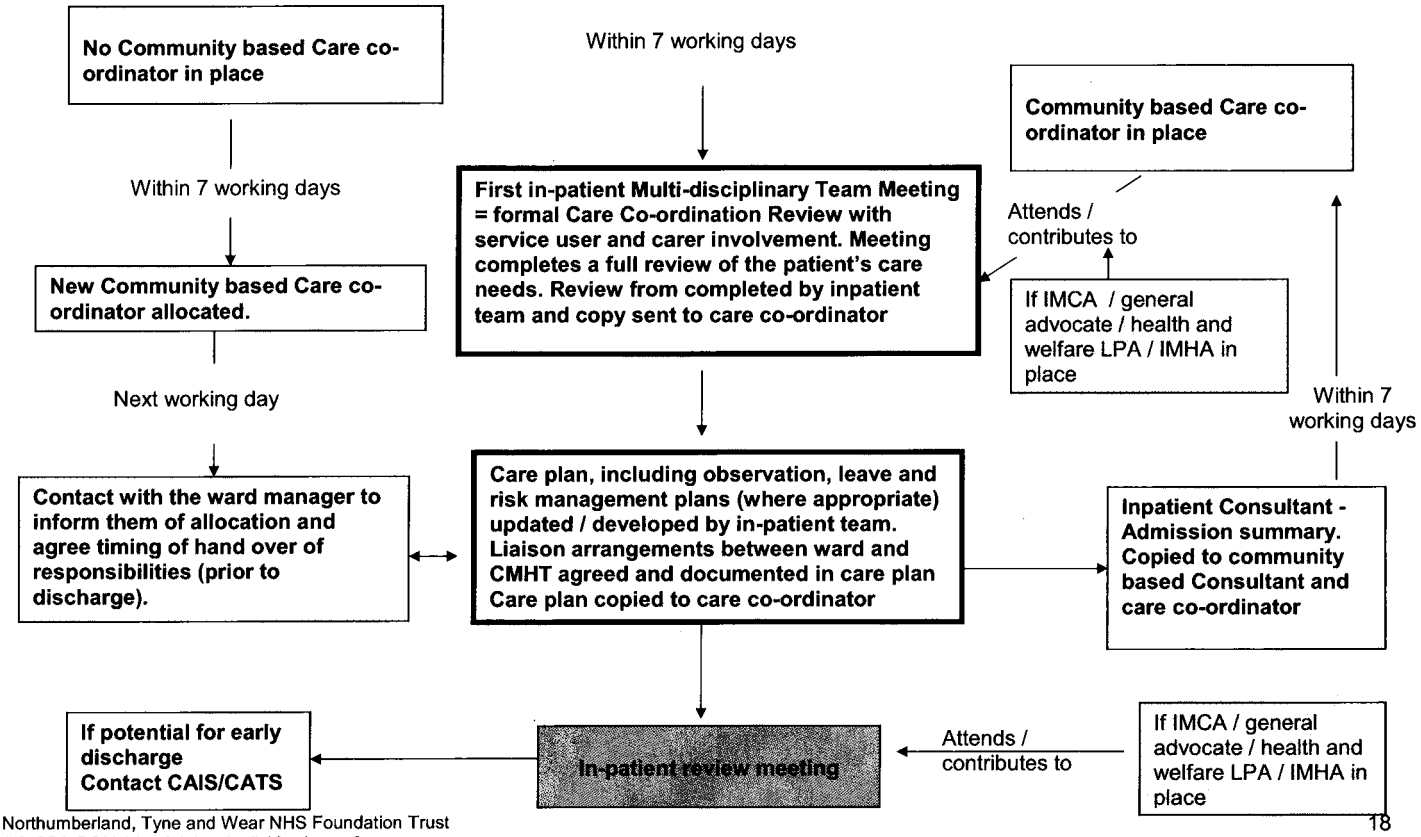

During admission
Each in patient admission, regardless of time elapsed, is a separate episode and will have a full assessment including risk assessment completed at all times
No Community based Care co-ordinator in place
Within 7 working days
New Community based Care co-ordinator allocated.
Next working day
Contact with the ward manager to inform them of allocation and agree timing of hand over of responsibilities (prior to discharge).
Within 7 working days
First in-patient Multi-disciplinary Team Meeting = formal Care Co-ordination Review with service user and carer involvement. Meeting completes a full review of the patient's care needs for the duration of their in-patient admission. Review from completed by inpatient team and copy sent to Care Co-ordinator
Community based Care co-ordinator in place
Attends / contributes to
If IMCA / IMHA general advocate / health and welfare LPA in place
Care plan, including observation, leave and risk management plans (where appropriate) updated / developed by in-patient team. Liaison arrangements between ward and CMHT agreed and documented in care plan. Care plan copied to care co-ordinator
Within 7 working days
Inpatient Consultant - Admission summary. Copied to community based Consultant and Care Co-ordinator
If potential for early discharge Contact Crisis team
In-patient review meeting
Attends / contributes to
If IMCA / general advocate / health and welfare LPA / IMHA in place

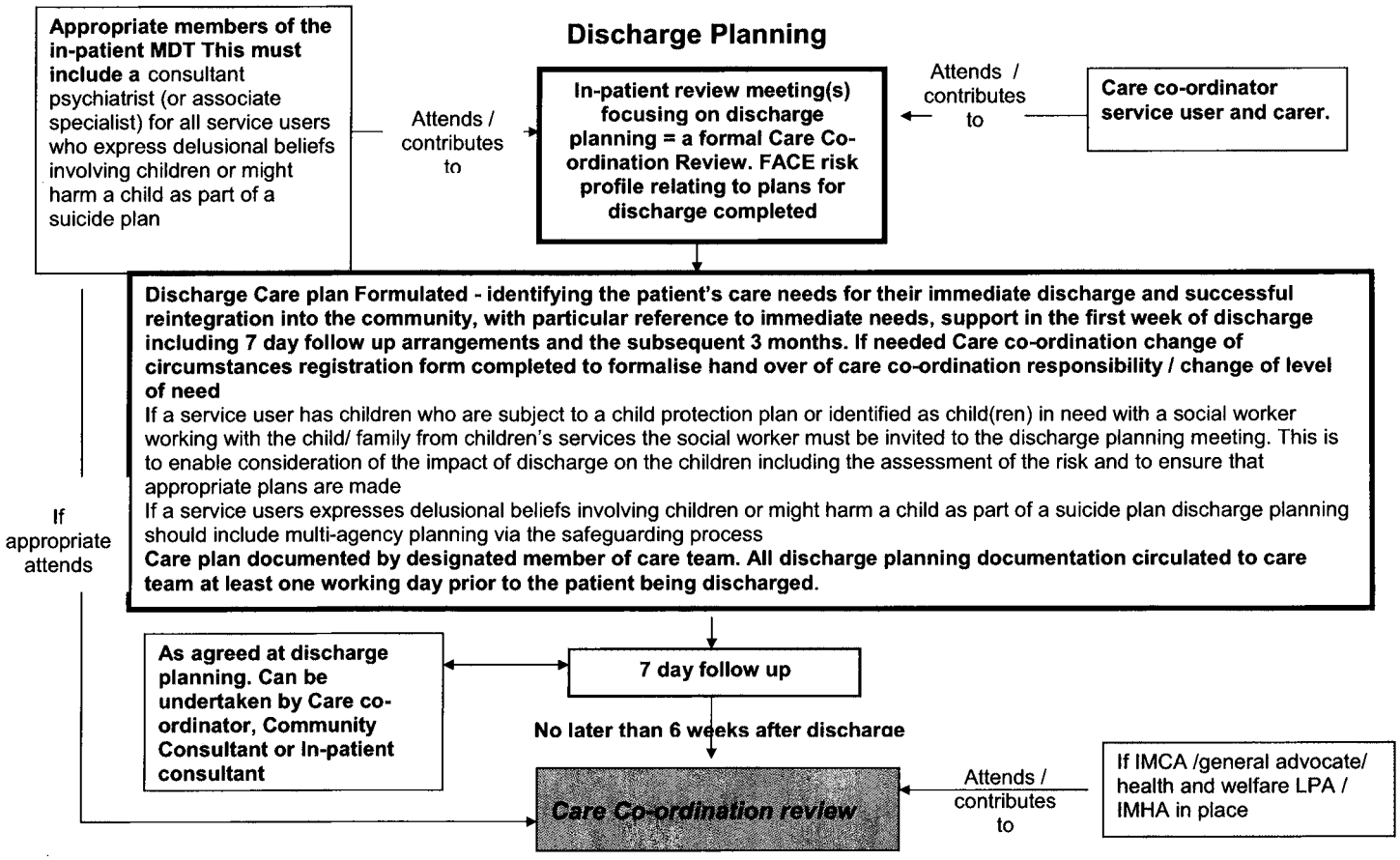

Discharge Planning
Appropriate members of the in-patient MDT. This must include a consultant psychiatrist (or associate specialist) for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan
Attends
In-patient review meeting(s) focusing on discharge planning = a formal Care Co-ordination Review. FACE risk profile and keeping children safe assessment if appropriate) relating to plans for discharge completed
Attends
Care co-ordinator (CMHT Manager or nominated deputy if not allocated) service user and carer.
Discharge Care plan Formulated - identifying the patient's care needs for their immediate discharge and successful reintegration into the community, with particular reference to immediate needs, support in the first week of discharge including 7 day follow up arrangements and the subsequent 3 months. If needed Care co-ordination change of circumstances registration form completed to formalise hand over of care co-ordination responsibility. Care plan to identify section 117 services if S3 and any required locality 117 forms completed.
If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services, the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made.
If a service users expresses delusional beliefs involving children or might harm a child as part of a suicide plan discharge planning should include multi-agency planning via the safeguarding process.
Care plan documented by designated member of care team. All discharge planning documentation circulated to care team at least one working day prior to the patient being discharged.
If appropriate attends
As agreed at discharge planning. Can be undertaken by Care co-ordinator, Community Consultant or In-patient consultant
7 day follow up
Attends
No later than 6 weeks after discharge
Care Co-ordination review

REHABILITATION INPATIENT ADMISSION AND DISCHARGE ARRANGEMENTS



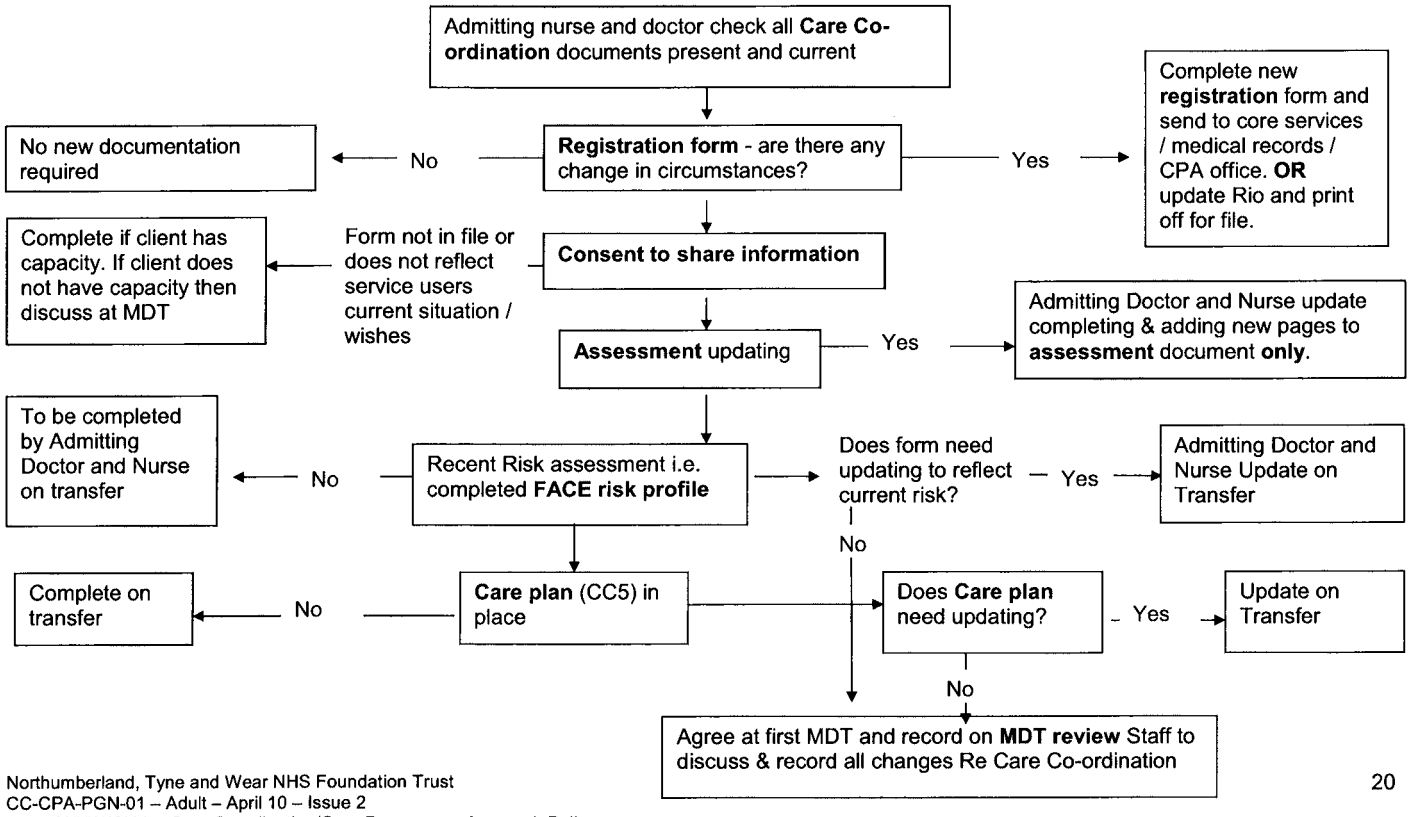
During admission




Discharge Planning
Appropriate members of the in-patient MDT This must include a consultant psychiatrist (or associate specialist) for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan
Attends / contributes to
In-patient review meeting(s) focusing on discharge planning = a formal Care Co-ordination Review. FACE risk profile relating to plans for discharge completed
Attends / contributes to
Care co-ordinator service user and carer.
Discharge Care plan Formulated - identifying the patient's care needs for their immediate discharge and successful reintegration into the community, with particular reference to immediate needs, support in the first week of discharge including 7 day follow up arrangements and the subsequent 3 months. If needed Care co-ordination change of circumstances registration form completed to formalise hand over of care co-ordination responsibility / change of level of need
If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made
If a service users expresses delusional beliefs involving children or might harm a child as part of a suicide plan discharge planning should include multi-agency planning via the safeguarding process
Care plan documented by designated member of care team. All discharge planning documentation circulated to care team at least one working day prior to the patient being discharged.
If appropriate attends
As agreed at discharge planning. Can be undertaken by Care co-ordinator, Community Consultant or In-patient consultant
7 day follow up
No later than 6 weeks after discharge
Care Co-ordination review
Attends / contributes to
If IMCA /general advocate/ health and welfare LPA / IMHA in place

INPATIENT - TRANSFER BETWEEN WARDS

The service users unified health record should always transfer with the service user



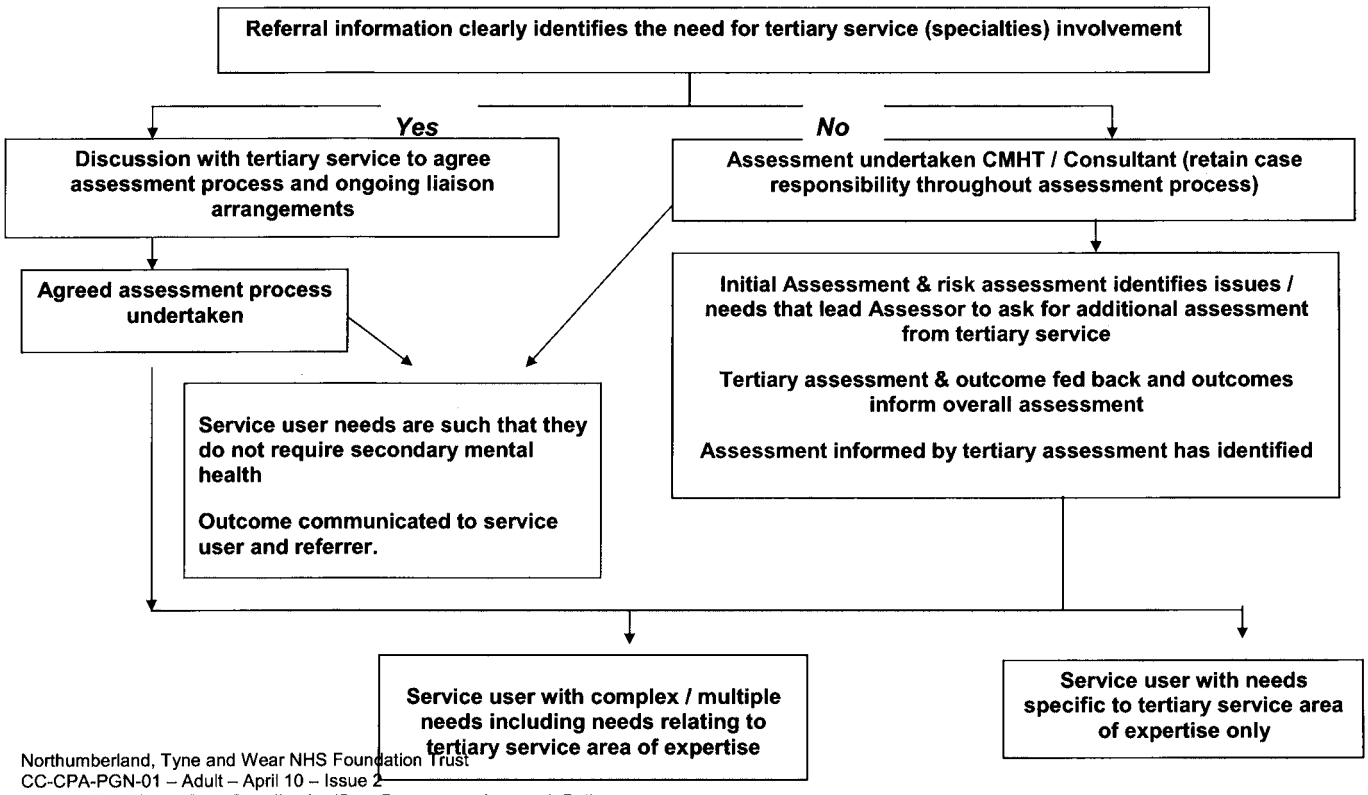
FORENSIC SERVICES ADMISSION AND DISCHARGE ARRANGEMENTS

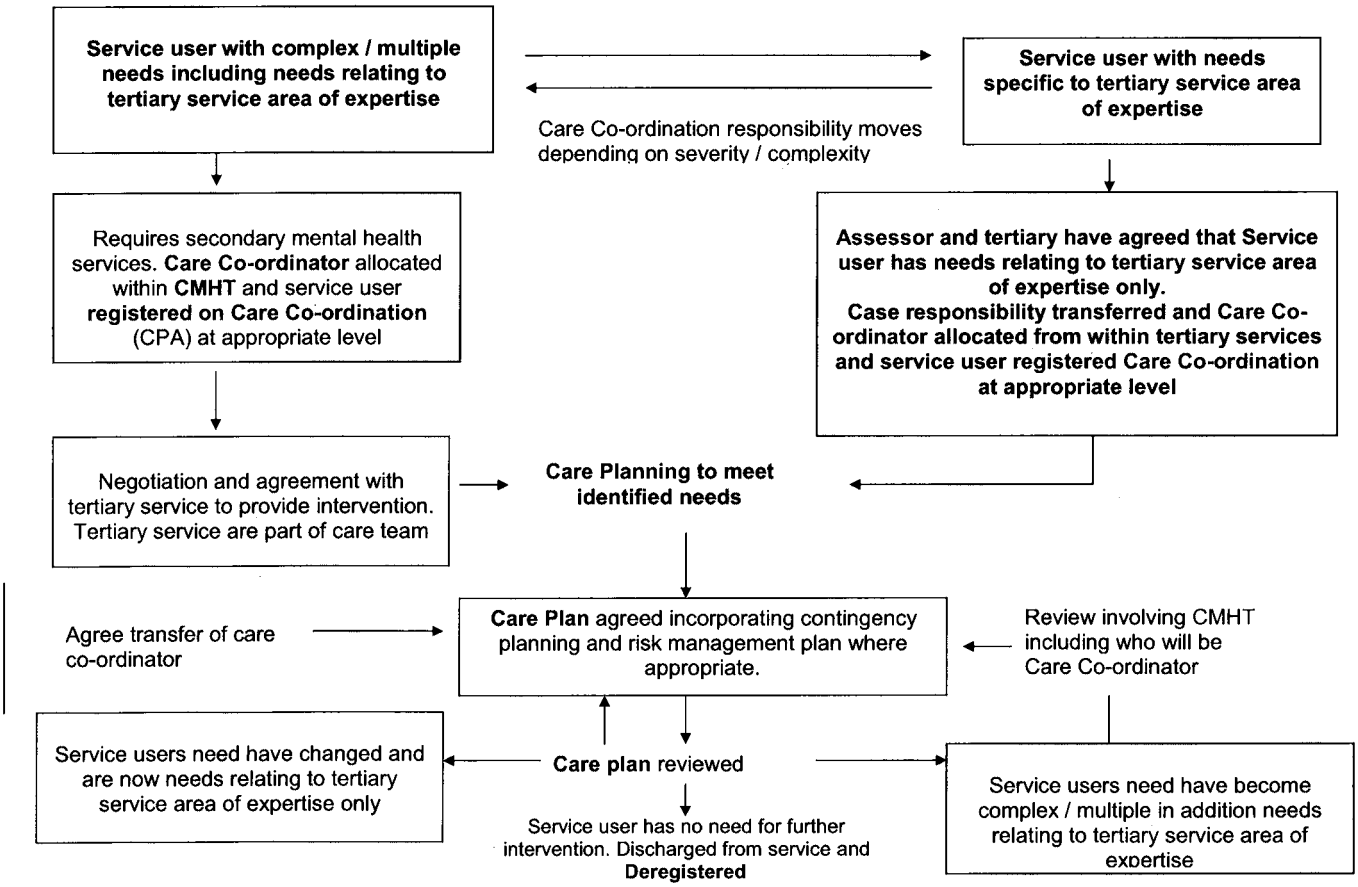
Document (or the equivalent section of the electronic care record) **Name**	**Timescale for completion**	**Who to complete**	**Review timescale**
Registration / front Sheet.	In 24 hours of admission	Admitting nurse and send COPY to Care co-ordination office SNH or ensure completion of the equivalent section of the electronic care record.	Only if Care co-ordinator changes or patient is admitted from out of NTW area
Assessment (This is also used as a pre-admission Assessment)	As part of admission process. (completed in 24 hours and typed within 5 days)	Should be jointly completed upon admission- Nurse and SHO. Can be cross referenced to any pre admission assessment.	A care plan review is a review of the original assessment, but if new information comes to light it can be added to. A new assessment would be completed if clinical need changes.
Consent To Share Information o Assessment o Care planning	As part of admission process As part of work with Service user leading up to care plan agreement	Admitting Nurse Care co-ordinator / lead nurse	Each Care co-ordination review meeting (Only do a new form if it has changed), but document review date. Review every 3 months.

Forensic FACE Risk Profile Document including **Risk history**, IR1s, Untoward incident forms, and MVA physical intervention forms.	In 24 hours of admission and used to develop the risk management plan.	Admitting Nurse to prepare and discuss with RMO as signature needed. A consultant psychiatrist (or associate specialist) should be directly involved in formulating **all** risk assessment(s) and management plan(s) for service users, who express delusional beliefs involving children or who might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).	Each Care co-ordination review document should be reviewed. (If clinical need changes risk assessment should be reviewed sooner). Additional risk tools can be used as clinically indicated.
Care Plan	At first care review (3 months)	Nurse within the MDT review/117 meeting	Review formally every 3 months (6 months in community) at Care co-ordination review and update. (If clinical need changes care plan should be reviewed sooner). Used as part of 117 process also.
Care Plan Review If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services, the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made	At each case review	Nurse in care review and send COPY to Care co-ordination office SNH	Within 24hours of case review. If the person is having a 117 and needs to be deregistered it should be prepared at this meeting, with relevant professionals present. Then completed on discharge date.
De-Registration process	When service	Nurse involved in discharge, should finish form	Within 24 hours of leaving

	users is discharged **from NTW services**	started at 117 Meeting.	services (not ward)

Patient Pathway and Care Co-ordination in Specialties
Referral for mental health assessment (e.g. by GP)




Service user with complex / multiple needs including needs relating to tertiary service area of expertise
Service user with needs specific to tertiary service area of expertise
Care Co-ordination responsibility moves depending on severity / complexity
Requires secondary mental health services. Care Co-ordinator allocated within CMHT and service user registered on Care Co-ordination (CPA) at appropriate level
Assessor and tertiary have agreed that Service user has needs relating to tertiary service area of expertise only.
Case responsibility transferred and Care Co-ordinator allocated from within tertiary services and service user registered Care Co-ordination at appropriate level
Negotiation and agreement with tertiary service to provide intervention. Tertiary service are part of care team
Care Planning to meet identified needs
Agree transfer of care co-ordinator
Care Plan agreed incorporating contingency planning and risk management plan where appropriate.
Review involving CMHT including who will be Care Co-ordinator
Service users need have changed and are now needs relating to tertiary service area of expertise only
Care plan reviewed
Service users need have become complex / multiple in addition needs relating to tertiary service area of expertise
Service user has no need for further intervention. Discharged from service and Deregistered

12 DE-REGISTRATION (Appendix 9)

12.1 De-registration occurs when the service user ceases **all** contact with secondary mental health services provided by this Trust and should be recorded using the appropriate section of the electronic record. Where a team does not have access to do this directly onto equivalent section of the electronic care record the Care co-ordination de registration document (Appendix 9) will be used and sent to the relevant core services office.

13 CARERS

13.1 Relatives and carers often know a great deal about the service user's life, interests and abilities as well as having personal experience of the service user's illness. Some family carers will have a significant responsibility to support, protect and keep in touch with someone who cannot manage alone because of their mental health and /or complex needs. It is important to include carers in the care planning and review process whenever possible.

13.2 Carers should also be fully involved in the planning of and delivery of care during and following a service user's inpatient admission, if they wish to be and so far as is practicable on an equal footing with professionals. Information shared by professionals must also be shared with the carer, subject to the service user's consent.

13.3 If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment, staff must ensure that this is clearly and sensitively communicated to the carer and recorded in the service user's notes.

13.4 In the absence of consent, there may be exceptional circumstances in which disclosure of information and contact with involved carers can be justified in the public interest, for example, if someone has a history of violence.

13.5 Disclosure of information/sharing of information with carers based on public interest may involve weighing that interest against the duty of care in the particular set of circumstances. The balance can be delicate and it may be necessary to take legal advice. If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment – staff must ensure that this is clearly communicated to the carers and relatives and recorded in the service user's notes. It is anticipated that such cases will be relatively few and the expectation is that the majority of carers will be involved.

14 YOUNG CARERS

14.1 Young carers are children and young people under the age of 18 whose lives are restricted by the need to take responsibility for the care of a person who is affected by mental ill health.

14.2 Where a young carer is involved in the care of an adult with mental health problems, the professionals involved have a responsibility to make an assessment of the family circumstances and the needs of the child/young person and, where appropriate, refer them to Social Services. Support services can be provided for young carers to enable them to maintain their usual activities outside of the caring role.

14.3 In addition, health professionals need to be aware of children's needs for access to a range of information, both regarding the nature of the mental health problem and/or learning disability and what services and support are available to them.

15 APPLICATION OF CARE CO- ORDINATION STANDARDS WITH LIAISON PSYCHIATRY SERVICES

15.1 This section of the practice guidance sets out the framework within which

- Newcastle Liaison Psychiatry Services (a specialist service that delivers psychiatry to and within a general hospital population)
- The Self Harm / A&E Mental Health Liaison Team (the team) based in Sunderland, (who provide a specialist service that undertakes assessment to individuals 16 years+ who presents within a general hospital population to Sunderland Royal Hospital with acute mental health issues/self harm or overdose 7 days per week. Young people **under** the age of 16 years are admitted to the Paediatric Ward and are assessed by a member of the Child and Family Psychiatric Service).

15.2 It identifies the required documentation that supports the collection, recording organisation and management of the key elements of the service user's pathway and meets Care Co-ordination standards.

15.2 Assessment

15.2.1 Service users who are referred to Newcastle liaison psychiatry for assessment are under the care of the medical team. Assessment will be recorded using the teams SH Doc 1 or non-SH Doc 2.

15.2.2 Service users who are referred to the Sunderland Self Harm / A&E MHLT for assessment will continue to be under the care of the referring Medical Team. Assessment will be recorded using the Sunderland MHL / SH Assessment Form 1 unless the individual has been previously assessed by the team when the assessment document 1A will be used to update the previous assessment

15.2.3 The teams' assessment framework and recording meets the standards required by Care Co-ordination including assessment of risk and encompasses the specialist nature of the services. The assessment includes the completion of recognised, validated scales in relation to suicidal intent, risk or repetition, depression, violence etc. and potential protective factors and incorporates a management plan for each contact.

15.2.4 All staff in the team are trained in relation to the specialist risk assessment as part of their induction and as part of the supervisory process until competence has been consistently demonstrated.

15.2.5 The Sunderland Self Harm / A&E MHL team assumes responsibility under the authority of Northumberland, Tyne & Wear NHS Trust for discharge decisions/arrangements with regards to mental health issues. The Responsible Medical Officer (RMO), City Hospitals, Sunderland retains responsibility for discharge decision/arrangements with regards to the individuals medical status.

15.3 Registration Care Planning and Review

15.3.1 Sunderland

- The Team currently provide an assessment service and therefore do not carry Care Coordinator responsibility however should the team provide interventive follow up in the future Care Coordination requirements will apply

- The timescales of contact with Professional(s) already involved, or those who may need to become involved, especially those in need of continuing mental health care, is stipulated in the Team Operational Policy and in accordance to level of risk identified i.e. immediate / actual and is communicated verbally and in writing

- Following assessment the Sunderland Team makes **direct** referrals to other Mental Health Services if mental health care is indicated after discussion and acceptance with the appropriate Team Coordinator

15.3.2 Newcastle

- If the involvement of liaison psychiatry does not continue after assessment then the service user remains under the care of the medical team and is not registered on Care Co-ordination.
- Those service users whose involvement with liaison psychiatry continues into an intervention phase i.e. through outpatient clinics will be registered on the Care Co-ordination by completion of the Care co-ordination registration form or the equivalent sections of the electronic record. All service users registered have a lead professional or care co-ordinator, who will be the mental health clinician with responsibility for the outpatient clinic,

- All service users registered on Care Co-ordination will have a care plan, which in the context of people attending out patient clinics as their only intervention' will be the letter generated following clinic attendance, using the standardised format (**Appendix 4)**.

- Risk management plans are an integral part of the Care Plan and will be developed when the level of risk is significant, serious or serious and imminent. A consultant psychiatrist (or associate specialist) should be directly involved in formulating <u>all</u> risk assessment(s) and management plan(s) for all service users, who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

- A Copy of the Care Plan, in which ever format is used, should go to the service user and any one else involved in their care (including the GP).

- The Care Plan must be reviewed regularly in line with any risk management plan, with planned review dates using the process set out on this practice guidance.

- De-registration occurs when the service user ceases **all** contact with secondary mental health services provided by this Trust and should be recorded using the appropriate section of the electronic record. Where a team does not have access to do this directly onto equivalent section of the electronic care record the Care co-ordination de registration document (Appendix 9) will be used and sent to the relevant core services office

APPENDIX 2c

Care Coordination /care Programme Approach Policy Learning Disability Directorate Practice Guidance Note – V02			
V02 issued: **Issue 1 – Apr 11**	**Planned review** **April 2014**	**Responsible officer** **Liz Bowman**	**CC-CPA-PGN-03** Part of NTW(C) 20 CC/CPA Policy

CONTENTS

Practice Guidance to be read in conjunction with NTW(C)20

1 Introduction

1.1 This practice guidance relates to adults with a primary diagnosis of a Learning Disability receiving services within the Learning Disability Directorate of Northumberland, Tyne and Wear NHS Foundation Trust (NTW/the Trust)

1.2 Care coordination provides and establishes clear standards for practice, including the recording and sharing of information.

1.3 The core electronic recording screens of the Directorate have been developed to incorporate the standards and requirements of person centred planning, health action planning and DOH Refocusing CPA (2008)

1.4 The Directorates' approach enables the application of all required standards to the assessment and care planning and associated recording for all service users regardless of diagnosis.

2 Assessment

2.1 All service users referred to learning disability services will have their demographic information recorded on the electronic care record RiO.

2.2 The information provided at referral may be insufficient to complete all demographic sections; consequently it is important that where a referral is appropriate the assessing clinician(s) update demographic during / following assessment. The collection of the service user's employment and accommodation information is mandatory.

2.3 All service users accepted to Community learning Disability Teams will have an initial assessment of their needs (regardless of the clinician allocated to) using the Care coordination assessment framework. As a minimum this will always include:

- Reason for referral
- Advocacy needs
- Service User's account of their current problems, needs and mental health issues
- Service User's expectations and wants from the service
- Mental state (at interview)
- Mental health history
- Cultural or faith needs
- Assessment of social circumstances including identification of Fair Access to Care Services eligibility criteria (including Direct Payments / Individualised budgets) and information gathering about children if in the family (see section 1.7 - 1 9)
- Intial Formulation and action plan
- Mental Capacity/ Best Interest determination in relation to proposed future action
- Risk assessment; the outcome being recorded as a minimum requirement using the appropriate FACE risk profile

2.4 A consultant psychiatrist (or associate specialist) must be directly involved in formulating risk assessment(s) and management plan(s) (including multi-agency planning via the safeguarding process where applicable) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan

2.5 In addition to the risk profile the assessment will be recorded using the Care coordination assessment section of the electronic care record. This provides the framework to support professional assessment practice and recording within the standards required by Care Programme Approach (CPA), the National Service Framework (NSF) and professional bodies.

2.6 The prompts within the assessment screens / forms included are designed to illustrate the issues that might be considered in each area of the assessment but are not intended to be used as a checklist or exclude additional assessment components or relevant information.

2.7 Whether other sections of the assessment framework will be used at initial assessment will be a clinical judgement informed by the referral information, the service user's needs and the assessment process.

2.8 When assessing and providing services to an adult, professionals must be alert to the needs of children for whom the adult has parental or caring responsibilities, or with whom the adult has substantial contact to ensure that the children have adequate support and protection. A child is defined as someone under 18.

2.9 All assessments must inquire about the children in the adult's family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact; even if there appears to be no immediate concern of significant harm. Health professionals must consider the needs of both the adult and the child, but the welfare of the child is always paramount.

2.10 Staff have a responsibility to contribute to the assessment of all children and families in need, not just those in need of protection and reference should **always** be made to Trust policy NTW(C)04 - Safeguarding Children and local safeguarding children procedures.

2.11 If the individual's assessed needs are to be met by Trust services an initial care plan should be agreed with the service user and recorded in the Plan of actions section of the assessment.

3 The Assessment Formulation (see Appendix 2) should drive the Care Planning process and as such should link directly into CPA process

3.1 The outcome of the initial assessment should be communicated promptly in writing to the individual (in a way they will understand), to the referrer and the individual's GP.

3.2 If the service user's needs are not to be met by Trust services and the individual is provided with appropriate advice and / or signposting this information / advice should be included in the assessment outcome letter.

3.3 If it is **clear** from the initial assessment that the service user has more straight forward needs and does not meet the criteria of enhanced needs (see section 4.3) a **lead professional** will be identified.

3.4 The **lead professional** will develop the initial care plan with the service user, and others as appropriate, to ensure there is a shared understanding of how care and treatment will be carried out, by whom and when.

3.5 The **lead professional care plan** should be recorded using the Lead professional Care plan / Review screen / the Nurse led clinic Care plan / Review screen (as appropriate) or using the directorates' care plan document if this enables clarity for the service user.

3.6 Whatever format is used the service user must **always** be offered a copy of this care plan unless doing so would constitute a significant risk to the service user or others and a copy sent to the General Practitioner (GP) and any others who are part of the care team and do not have access to RiO

3.7 The service user will be registered on the electronic care record using the CPA management screen as "not on CPA" with the lead professional registered as a Care Coordinator until the updating of the system enables this to change. This registration will **not** confer the responsibilities of a Care Coordinator onto the lead professional.

3.8 If there is any uncertainty about the complexity of needs then the assessor must undertake further assessment of health and social care needs using the Care Coordination assessment framework involving other professionals and any specialist assessments as required to enable a clear decision to be made

3.9 Where the initial assessment is indicative that the service user has enhanced needs (CPA) the assessor will ensure that the initial assessment is developed into a comprehensive assessment of health and social care needs completing the Care Coordination assessment equivalent sections of the electronic care record which meets the requirements of CPA. They will also update the initial risk assessment the outcome being recorded as a minimum using the appropriate FACE risk profile. The comprehensive assessment and risk assessment outcomes and formulation will be used to agree the appropriate professional to be the Care Coordinator

3.10 Other professional / specialist assessment / risk assessment tools will be used as appropriate to the service users needs.

3.11 Responsibility for decisions following assessment rest with the professional carrying out the assessment with support and advice from their supervisor if necessary. However team meetings are essential to good team practice in supporting colleagues and in guiding and informing practice. Team members have a responsibility to give sound advice, particularly where there are risk issues.

3.12 Once a service user has received an assessment, or part of the assessment process where two or more sessions are required, the service assumes some responsibility for that person. In practice, this means that the assessing clinician needs to put in place care arrangements that meet any urgent clinical needs.

This responsibility does not mean that the service user will necessarily be offered longer-term services by a team, but is designed to ensure that service users do not fall into gaps between services at transition points and is of particular importance when presenting risks are substantial or high.

4 Consent to Share Information

4.1 **Consent to seek and Share Information** should be discussed agreed with the individual as part of the initial assessment if they have capacity to give this consent. This will be recorded in the consent to share information section of the electronic care record.

4.2 If the service user does not have capacity to consent to the seeking and sharing of information this should be recorded on consent to share information section of the electronic care record. A best interest assessment will need to be undertaken (as per Trust policy NTW(C)34 – Mental Capacity Act) and can be recorded within progress notes if clearly identified as a best interest assessment.

4.3 Consent to share information should be revisited as part of the care planning process and documented in the relevant section of the consent to share information section of the electronic care record.

5 Care Coordination (CPA) Registration

5.1 For service users with enhanced needs the Care Coordinator will ensure that the service user is registered on the electronic care record using the CPA management screen as being on enhanced level care coordination. If the care coordinator is external to the Trust the named nurse / NTW staff involved will ensure registration is undertaken

5.2 For service users who do not have enhanced needs the lead professional will ensure that the service user is registered on the electronic care record with the lead professional registered as a Care Coordinator until the updating of the system enables this to change. If the Lead Professional is external to the Trust the named nurse / NTW staff involved will ensure registration is undertaken. This registration will not confer the responsibilities of a Care Coordinator on the lead professional.

5.3 **Enhanced Needs (CPA) applies to all service users with**

- Active, complex mental health problems
- Severe challenging behaviour,

And these complex needs require multiple professional involvement from the Trust

5.4 Risk Assessment and Management

5.4.1 Risk assessment is a dynamic and ongoing process in the provision of care and treatment to all service users. It is a multi disciplinary responsibility and the outcome of risk assessment should be formally documented using, as a minimum, FACE LD risk profile tool.

5.4.2 A consultant psychiatrist (or associate specialist) should be directly involved in formulating risk assessment(s) and management plan(s) for service users who

express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

5.4.3 This involvement should be whenever risk assessment is required and should be formally documented (as a minimum) on the FACE LD risk profile tool and through completion of the Keeping Children Safe Assessment.

5.4.4 Risk assessment is required:

- As part of initial assessment/ongoing assessment/reassessment
- When admitting and discharging from hospital
- As part of community or inpatient care coordination or Multi-Disciplinary Team (MDT) reviews
- When there are major changes to presentation/personal circumstances or following an incident
- When alerted by Carers
- When transferring to other teams/service providers
- When alerted by other members of the care team

5.4.5 If after reassessing risk there is no change to the risk indicators / level of risk recorded on the FACE LD risk profile then this profile remains current providing

- The date fields on RiO of all sections of the risk profile is completed with the date of the new assessment
- For service users who do not have enhanced need there is clear recording of no change. This should be via the Lead professional care plan / review record or within Nurse led clinic care plan / review (as appropriate).
- For service users with enhanced needs there is clear recording of no change via the care coordination review record within current assessment of risk and the new FACE risk profile radial button is set at No

5.4.6 Risk Assessments may be carried out in Partnership with other organisations, using Tools other than FACE (LD) Risk Profile. The scanned copy of the Partnership assessment should be stored under image type **LD Risk Assessment (External)** and a note should be made in the FACE Risk Profile summary in RiO and in Progress Notes that directs to the location of the scanned assessment."

6 Risk management

6.1 Risk management plans are an integral part Care Planning and will be developed when the level of risk is significant, serious, or serious and imminent {FACE risk profile ratings scale 2, 3, or 4}.

6.2 The risk management section of the FACE risk profile should be used to

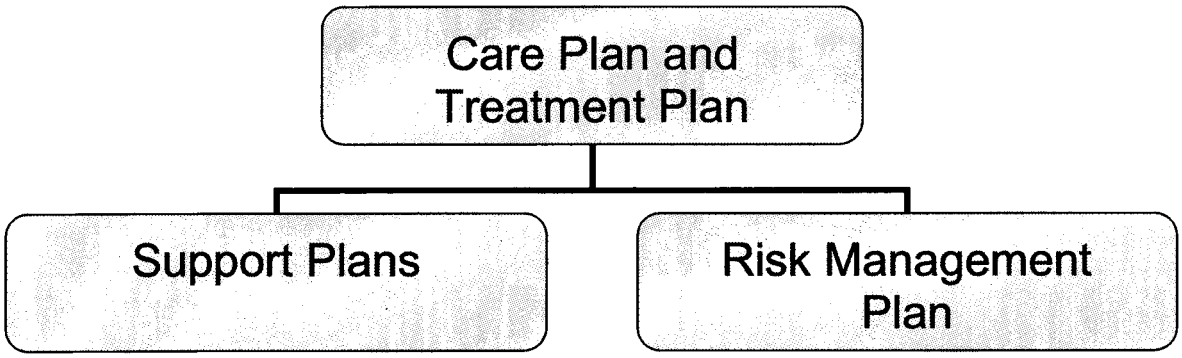
- Clearly identify the areas of risk that are to be covered by detailed risk management plan (risk rating of 2 or above) or that the care plan needs to address (risk rating of 1)
- To record any immediate actions needed to manage risk
- To identify, who will be document the risk management plan.

6.3 Where the risk profile rating is 2 or above, **and** the service user has enhanced needs, the risk management plan will be recorded by an agreed member of the care team on the risk management screens within the care plan folder on RiO

6.4 The management of risk issues for service user with enhanced needs that are rated 1 do not require a specific risk management plan and should be covered by the Care Plan specifying the problem type Arrangement to Manage Crisis and Risk

6.5 Service users who do not have enhanced needs should have any risk management plan recorded within the appropriate non enhanced care plan / review document

7 Care Planning, including Treatment, Support and Risk Management Plans



7.1 The "Care Plan" is the overall record of the service user's assessed needs, interventions to be carried out, outcome of interventions and evaluation of effectiveness.

7.2 The content of the Care and Treatment Plan is derived from needs identified in the Care Coordination Assessment and any Specialist Assessments which have been carried out.

7.3 Consent to share information should be revisited as part of the care planning process and documented on the electronic care record.

7.4 **For service user with enhanced needs** the "Care Plan" will consist of Care and Treatment Plan where the service user's assessed needs are identified and the support & risk management plans; developed from identified issues, outcomes from assessments & direct observation, as well as those that arise from; Formulation or MDT meetings that require monitoring, treatment, improvement, maintenance and safeguarding.

7.5 The plan will be concurrent with FACE Risk management profile, Mental Health Act Legislation/guidance, Health Action Plan (HAP), Formulation, communication

passport and their Person Centred Plan (PCP) or any other document developed specifically for an individual that encapsulates all needs, support and encompasses the roles of those who are involved in the care delivery process.

7.6 The "Care Plan" will be agreed by the Multi-Disciplinary Team in partnership with the service user, carer and any Attorney (Health and welfare LPA) and agreement made as to who will develop and undertake implementing the specific plans, these will be evaluated and reviewed at each Multi-Disciplinary Review.

7.7 All service users should have within their care plan a crisis plan identified by using the problem / need type **Arrangements to manage crisis and risk.**

7.8 For the duration of admission every patient will have an observation care plan developed as per Trust policy NTW(C)19 - Observation; this is essential and integral to the care/ treatment process. Observation care plans will be developed utilising the policy guidance and documents; the aim of the process is to foster therapeutic relationships between staff & patients, whilst maintaining safety and monitoring of health & well being.

7.9 Within Inpatient Services, on occasion, it maybe the sole responsibility of the Named Nurse/Care Coordinator to develop Nurse-led support Plans that reflect the patient's ongoing complex needs, these will be discussed at Multi-Disciplinary Reviews.

7.10 The Care Coordinator/Named Nurse is responsible for the overall coordination and monitoring of plans, evaluating & amending plans as required ensuring care delivered remains holistic and effective to meet the patient's needs.

7.11 Where a Health Care Professional is the sole NTW worker, they may complete the 'Lead Clinician' Care Plan/Review Form if this is more appropriate.

7.12 Nurse-Led Clinics will use the 'Nurse-Led Clinic' Care Plan/Review Form as a record of the service user's current wellbeing and need for further interventions.

7.13 All treatment, crisis support & risk management plans will be developed in partnership with the service user, carer and any Attorney (Health and welfare LPA) and the MDT, reflecting the persons needs, have an evidence base and utilise the principles of "SMARTER" (specific, measurable, achievable, realistic, timed, evaluated, reviewed).

7.14 Care planning may be carried out in Partnership with other organisations and an external Care Co- ordinator / Lead Professional and recorded that organisations documentation. The scanned copy of the Partnership Care plan should be stored under image type **LD Non NTW Care Planning Documentation** and a note should be made in the Care and Treatment plan on RiO and in Progress Notes that directs to the location of the scanned Care plan."

8 Behaviour Support Plans (appendix 3)

8.1 Some service users with challenging behaviour may need a behaviour support plan in addition to or as their crisis plan. If the crisis plan is the behaviour support plan then this should be cross referenced with in the care plan.

9 Review

9.1 For all service users their Care Plan must be subject to ongoing monitoring and review but should be reviewed formally in line with the risk management plan, and planned review dates.

9.2 The Care Coordination Review Document is to be completed at each Multi-Disciplinary Review. The type of review being carried out should be stated on the front sheet

9.3 Frequency of Reviews should be determined by the needs of the service users but should be **at least**

- Every 6 months for service user who have enhanced needs
- Once a year for service users registered not on CPA

9.4 A consultant psychiatrist (or associate specialist) must attend the review and be directly involved in formulating risk assessment(s) and management plan(s) (including multi-agency planning via the safeguarding process where applicable) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan.

9.5 The review should be arranged and managed to maximise service user and carers involvement. This may be through direct participation enabled though accessible information and appropriate support.

9.6 If the service user and/or carer do not wish to attend the review then a member of the care team must be identified to discuss the review with them, elicit their views prior to the meeting and represent those views at the meeting. Service users and carers can, if they wish, provide these views in writing to the review

9.7 The outcome of the review must also be shared with the service user though discussion in addition to being offered a copy of the review record

9.8 If a service user's care had been reviewed through Multi Agency Public Protection Arrangements (MAPPA) or Safeguarding Vulnerable adult's processes this can be logged via the CPA management screen. The care coordination review record on RiO should be dated and reference made to the meeting notes which should be scanned into the RiO record using the appropriate image type.

9.9 A separate care coordination review should only be held if there is a clear need or if requested by the service user or Carer.

9.10 The Care Coordinator or Named Nurse is responsible for ensuring the record of discussion, current assessment of risk and changes to Care Plan are completed at or shortly after the meeting (within one working day).

9.11 Where the meeting has been a Pre-Discharge Review, the Named Nurse will ensure the section 'Record of Pre-Discharge Review Meeting' is completed

instead of 'Record of Discussion'. The Named Nurse will make a note in the 'Record of Discussion' section to say this is the case.

9.12 The Named Nurse is responsible for the completion of the Discharge Plan. The Care Coordinator is responsible for recording outcomes of the 7 day discharge plan

9.13 **For service users who do not have enhanced Needs**

9.14 Each review will involve the service user, any identified carer and any professionals involved in an individual's treatment or care including any involved from a multi agency perspective e.g. due to a child protection plan being in place. As a minimum, this would be the social worker working with the child/ family from children's services.

9.15 **The review will**

- Review progress of Care Plan against the agreed outcomes
- Review current assessment of risk including where appropriate keeping children safe assessment
- Review any crisis and risk management plan
- Consider if any changes in the service user's presenting needs and/or risks are now of a level of complexity and characteristics, to require enhanced Care co-ordination to be the framework used to deliver a continuity of care
- Agree any changes to the care plan (if required)
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Consider the impact of care plan changes
  - On Carer / need for a carers assessment
  - Service users capacity to consent to the care plan

9.16 The review will be recorded either on the Lead Professional care Plan/ review screen of RiO in the form of a clinical letter which meet s directorate standards (Appendix 1).

9.17 If recorded in the form of a clinical letter then Lead Professional care Plan/ review screen of RiO should be dated and reference made to the letter which should be scanned into the RiO record using the appropriate image type.

9.18 Whatever format is used:

- the service user must be offered a copy of the review record
- a copy sent to the GP and any others who are part of the care team
- the review must be logged on the CPA management screen

9.19 At each service user's care coordination review, where there is carer involvement:

- Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision.
- Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review.

9.20 **For Service Users with enhanced needs** the monitoring of a care plan must be regarded as an ongoing process.

9.21 Informal reviews will be undertaken at least 6 monthly and documented using the Care coordination review form by the Care Coordinator involving the service user, any identified carer and all those professionals involved in an individual's treatment or care. This would include any professionals involved from a multi agency perspective e.g. due to a child protection plan being in place as a minimum this would be the social worker working with the child/ family from children's services. The frequency of these reviews will be determined by the service users needs. Involvement in these review does not require attendance but may be achieved through the provision of written views; discussion prior to the review with the lead nurse / consultant

9.22 An Informal review could be undertaken for example through an extended outpatient appointment or a home visit

9.23 The minimum requirement is that a formal review will take place **at least** once a year

9.24 This formal review will usually involve a meeting of all concerned including those involved from a multi agency perspective e.g. due to a child protection plan, as a minimum this would be the social worker working with the child/ family from children's services.

9.25 The review should take place in a setting where the service user feels comfortable and will:

- Agree a chair (this will usually be the Care Coordinator)
- Agree a scribe to complete the review record on RiO The scribe will print and check completed form with the service user and Care Coordinator for accuracy and if agreed obtain the service user and Care Coordinator's signature
- Review progress of Care Plan against the agreed outcomes
- Review current assessment of risk including, where appropriate, keeping children safe assessment
- Review crisis and risk management plan

9.26 The 'Service User's Views' section of the form can either be completed at the meeting or before the meeting with support from the Care Coordinator/ named nurse if this is more appropriate.

9.27 The 'Family/Carers Views' section of the form can either be completed at the meeting or before the meeting with support from the Care Coordinator if this is more appropriate. Professional reports should whenever possible be entered before the meeting but can, if needed, be entered at the meeting

9.28 **The review will Consider if any changes in the service user's presenting needs and/or risks are now of a level of** complexity, to no longer require enhanced Care coordination to be the framework used to deliver a continuity of care.

- Agree any changes to the care plan (if required)
- Consider the impact of care plan changes
    - On Carer / need for a carers assessment
    - Service users capacity to consent to the care plan
    - On any potential deprivation of liberty
- Agree who will record the new care plan
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Agree who will undertake to recording of new risk assessment (if required)
- Agree who will undertake the record new crisis and risk management plan (if required)
- If the service user has an Advance Statement and / or advance decision

  Review if this still reflects their wishes / views.
- Agree action to be taken (if any)
- Date and Time of next meeting agreed and documented

9.29 If an NTW member of staff, the Care Coordinator will be responsible for ensuring that a record of the review is made.

9.30 If the service user is an inpatient this will be undertaken by the named nurse.

9.31 A copy of the review record will be distributed by the Care Coordinator / named nurse to the service user, GP and all those participating in the review process who do not have access to RiO

9.32 At each service user's care coordination review, where there is carer involvement:

- Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision
- Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review

9.33 If the service user care plan is to be revised, and incorporates services/interventions being implemented as a result of carer's needs identified at assessment, carers should have the opportunity to identify if the revised care plan still meets their assessed needs.

9.34 There may be circumstances where it is inappropriate to review carer's issues within the service user's review. In such circumstances within 2 weeks of the service user's review the carer(s) should have the opportunity to discuss the implications of the review on their role with the Care Coordinator. This should provide the opportunity for:

- Carers who have declined a carer's assessment to revisit that decision;
- Carers who have a separate care plan to identify whether they feel there is a need for a review
- Those carers whose support is incorporated in the service user's care plan to identify if the revised care plan still meets their assessed needs

10 Discharge Planning - Community

10.1 Where a review is considering discharge from a service an associated risk assessment must be completed and if required a new FACE risk profile completed. If the risk profile remains current then this should be recorded on Rio by Selecting Create New for a new FACE Risk Profile (all sections) entering the date and saving

10.2 If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services the social worker **must** be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made.

10.3 A consultant psychiatrist (or associate specialist) should be directly involved in formulating the discharge risk assessment and management plan for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable)

11 Risk History

11.1 If a service user has been in service previously and is re referred, the historical records must be accessed to determine if there are any risk events in the previous records to inform the initial assessment of risk.

11.2 The **Time line on RiO** is used to document significant events including those relating to risk throughout the service user's pathway of care.

11.3 It can be added to by any member of the care team through the use of the significant event and / or add to risk history check boxes in progress notes

12 Responsibilities of the Lead Professional

12.1 The lead professional will ensure that

- The service user's previous consent to seek and share information is discussed and updated as needed

- In partnership with the service user and any other significant care provider, including carers, develop a clear understanding of how care and treatment will be carried out, by whom, taking into consideration any existing Advance Statement or advance decision to refuse treatment

- The agreed care and treatment (care plan) is recorded using a clinical letter which meets the directorates' standards (Appendix 4) or using the Care coordination care plan document (Appendix 5) if this enables clarity for the service user
- Provide advice and signposting to the service user to enable them to access other agencies/support to meet their needs
- A central record of care is maintained as required by their agency
- A copy of the current care plan is always offered to the service user
- The service user is offered copies of letters as outlined in the Trust's policy, NTW(O)22 Sharing letters with service users
- A copy of the current care plan is sent to the persons GP and any other significant care provider, including carers, if appropriate
- Ensure that the care plan and risk assessment is subject to on-going review as required, involving the service user and any other significant care provider, including carers. This can be recorded using a clinical letter which meets the directorates' standards (appendix 4) or using the care coordination review document (Appendix 8) if this enables clarity for the service user
- In partnership with the service user and any other significant care provider, including carers, consider at each review whether a service user's needs have changed, and if there is need for enhanced care coordination support

12.2 The role of Lead professional can be undertaken by Medical staff and Qualified Nurses, Qualified Social Workers, and Qualified Allied Health professionals who are suitably experienced and skilled under appropriate supervision to be able to assess service users

12.3 The decision to transfer lead professional responsibility should take place within the care coordination review process involving the service user, unless exceptional circumstances prevent this

13 Care Coordinator Roles and Responsibilities

13.1 The Care Coordinator may fulfil these responsibilities through effective, agreed and appropriate delegation to other members of the care team. Such delegation will be recorded in the clinical record or on the care plan or review documentation as appropriate to when delegation occurs.

13.2 However during a period of Inpatient stay responsibility will automatically be delegated to the Inpatient team for

- Care planning
- Risk assessment
- Care plan review

13.3 Consent **must** always be sought from a professional prior to them being identified as a Care Coordinator. Under no circumstances must any professional be stated as Care Coordinator without negotiation and agreement. The decision to transfer Care Coordinator responsibility should take place within the care coordination review process involving the service user, unless exceptional circumstances prevent this.

13.4 The person who is best placed to oversee care management and resource allocation should usually take the role of the Care Coordinator.

13.5 The Care Coordinator will have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin.

13.6 However, it is not the intention that the Care Coordinator is necessarily the person that delivers the majority of care. There will be times when this is appropriate, but other times when the therapeutic input may be provided by a number of others, particularly where more specialist interventions are required.

13.7 For people who have had damaging experiences of sexual abuse or violence, choice of gender of the Care Coordinator may be a crucial factor in establishing trust and a therapeutic relationship.

13.8 **The Care Coordinator will:**

- Ensure the service user's involvement in the process of decision-making
- Ensure where appropriate, any carer's involvement in the process of decision-making
- Ensure that, where in place, an Independent Mental Capacity Advocate or an attorney through a Lasting Power of Attorney (LPA) or an Independent Mental Health Act advocate is fully involved in the process of decision making
- Promote, build and maintain relationships with others involved in the service user's care
- Act as the "acknowledged" name for contact by all agencies relevant to the service user's care
- Ensure that a comprehensive, formal written care plan including risk and crisis plan care plan is negotiated and agreed and that responses to crisis situations during working hours and outside of working hours are included. The level of response should be appropriate to the degree of crisis
- Ensure that the documented plan accurately reflects the agreements reached. This is indicated by the Care Coordinator signing the care plan
- Ensure the service users and all members of the care team (including the GP) has a copy of the care plan
- Ensuring the care plan is recorded on the electronic care record as access to the electronic care record (RiO) is rolled out
- Ensure that any Advance Statements or Advance Decisions are considered and recorded as part of the Care planning process
- Consult and seek appropriate advice if any aspect of the care plan proposes significant restrictions of liberty to ensure that such restrictions do not constitute "deprivation of liberty"
- Monitor the agreed care plan and record progress
- Ensure appropriate review of the service user's care plan
- Provide support and care, taking positive action in the event of a service user disengaging from services in accordance with the Trust's policy NTW(C)07 – Promoting Engagement with Service Users (Non-compliance with treatment /

Difficult to Engage service users

- Work with in-patient services to ensure that prior to discharge a joint review takes place.
- Ensure the service user's GP and staff identified in the care plan, are informed within one working day of the service user being admitted to hospital. Where appropriate it may be necessary to ensure that there is support for the service user to register with a GP
- Ensure the provision of follow-up and assertive outreach where this is available should the service user disengage from services
- Ensure, whenever possible, any change of Care Coordinator should be agreed through the care coordination review process. This will ensure there is an effective hand-over of information to the new Care Coordinator
- Where a service user plans to move area the Care Coordinator must liaise with the appropriate professionals in the receiving care team to ensure that the service user's care is transferred effectively.
- Ensure Carers are supported and offered an assessment of their needs

13.9 The role of Care Coordinator, depending on capability and capacity, can be undertaken by

- Medical staff (except Senior House Officers)
- Qualified Nurses
- Qualified Social Workers
- Qualified Allied Health professionals
    - Who are suitably experienced and skilled under appropriate supervision

14 Responsibilities of members of the Care Team

14.1 All professionals whether employed in the statutory or voluntary sector, and any carers, have a responsibility to:

- Deliver agreed interventions,
- Undertake their own dynamic and ongoing risk assessment
- Contribute to the overall assessment of risk through sharing of their professional assessment
- Communicate with the Care Coordinator regarding
- Their assessment of risk ;
- Their role in the care plan and progress of associated service delivery

14.2 This is particularly important following any major change in the circumstances of the service user or should service delivery cease or no longer seems appropriate.

15 Non NTW Care Coordinator

15.1 Community

15.1.1 Risk Assessments may be carried out in Partnership with other organisations, using Tools other than FACE (LD) Risk Profile. In these cases, NTW staff must refer to the location of a scanned copy of the Partnership assessment carried out for full

details of the assessment and a note made in the FACE risk profile summary that directs to the location of the assessment

15.1.2 If local authority documentation is used to record the pre admission assessment then the document should be scanned onto RiO and can be referenced in the assessment section of RiO and may be the complete record of assessment where there has been no change of circumstances.

15.1.3 If local authority documentation is used to record of the care plan then the document should be scanned onto RiO and referenced in the care plan section of RiO appropriate to the service user's level of need. The record on Rio should be completed by nursing staff if involved, or if there is no nursing involvement by an agreed member of NTW staff. If only one NTW clinician is involved it is their responsibility to ensure the RiO record is completed

15.1.4 If local authority documentation is used to record of the review then the document should be scanned onto RiO and referenced in the review section of appropriate to the service user's level of need and the date also recorded on the CPA management **record**. The record on Rio should be completed by the Nursing staff if involved or if there is no nursing involvement by an agreed member of NTW staff. If only one NTW clinician is involved it is their responsibility to ensure the RiO record is completed

16 Care management

16.1 Some service users may have complex social care and or physical health needs which are being addressed by the Local Authority care management process within which NTW provides a one off intervention within the package of care. These service users **would not** meet the requirements for enhanced need.

16.2 Assessment would only be required to enable appropriate intervention if there were gaps in the care management assessment / risk assessment. The LA documentation should be scanned onto RiO and cross referenced in the relevant section of RiO. The involved member of NTW staff who would be registered for this short period of intervention as Lead professional.

16.3 The service user would be deregistered once the intervention was completed.

17 Inpatient Services and admission (see appendix 4)

17.1 All service users admitted to an IP unit will be registered on enhanced care co-ordination on admission

17.1.1 During the service user's patient stay in hospital clinical recording will be via NTW documentation /and Rio. It will be the named nurse's responsibility to ensure that risk assessment, care plan behaviour support plan and review is recorded on Rio as required.

18 Servicer users admitted from out of NTW services

18.1 The majority of local community LD services are not managed by the Trust and as a result use a number of different Risk Assessment / Management tools. Therefore wherever possible and as good practice prior to or on admission the referrer should

- Provide information to enable the service user's demographic details and additional demographic and Care coordination registration to be completed on RiO at the point of admission.
- Provide the current assessment used by the patients care co-ordinator
- Provide the current Risk assessment used by the patients care co-ordinator
- Provide the current Care plan
- For service user who are not detained provide the record of the Capacity Assessment and if needed the record of the best interest decision re admission

19 Servicer users admitted currently in NTW services

19.1 Service users who are already in service within NTW LD Teams will already have recorded on RiO

- A current Care coordination Assessment and associated Risk Management / Crisis Contingency Plan.
- A current Risk Profile (FACE)

  And may also have dependant on their length of contact with Trust services
- A community based care plan
- Behaviour Support Plan or similar Relapse Plan (WRAP / NORAP).

20 Informal Admissions

20.1 For patients who are not detained and have a Care Co-Ordinator from NTW services the following documents must be completed (as well as those documents outlined in section **19**:

- the referrer must a provide on admission an completed MC1 form (as per Trust policy NTW(C)34 – Mental Capacity Act) to clearly document if the service user has capacity to agree to the admission and if not the best interest decision relating to admission

20.2 For patients who have been admitted but are not detained and receive care from a non NTW Care Coordinator the Care Coordinator should provide the completed record of capacity assessment and, if needed, the record of the best interest decision re: the admission.

21 Service users who are Compulsory admitted following a MHA assessment

21.1 The Section papers and AMP assessment are the most recent assessment and risk assessment

22 On Admission

22.1 The admitting nurse and doctor , in conjunction with the patient and carer (where appropriate), will collectively update / complete consent to share information, Care coordination assessment and FACE risk profile and record on RiO as appropriate and use this as a basis to develop the initial Care and Risk Management Plan, which will incorporate the following as a minimum:

- Planned or agreed leave
- Observation levels
- Action to be taken in the event of increased clinical risk e.g. absconsion risk
- Any medication patient requires

22.2 A consultant psychiatrist (or associate specialist) should be directly involved in formulating risk assessment(s) and management plan(s) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

22.3 This involvement should be whenever risk assessment is required and should be formally documented (as a minimum) on the FACE risk profile tool and through completion of the Keeping Children Safe Assessment.

22.4 On admission to an in-patient unit the service user will be allocated a named nurse who will, with the clinical team, co-ordinate the episode of care and facilitate the care coordination process.

22.5 The ward manager, or the person who they delegate to, will advise the community based Care Coordinator / lead professional / Care manager and any involved advocate (IMCA / IMHA / general advocate) of the admission and invite them to attend / contribute to the first MDT which will be a care coordination review.

22.6 If the service user does not have Community based Care Coordinator / lead professional / Care manager then a member of the ward nursing staff (usually the named nurse or ward manager) takes on this responsibility and makes a referral to the relevant community service / single point of access for allocation.

22.7 Within NTW the standard for allocation is for the appointment of a Care Coordinator within 7 days of referral.

22.8 On admission, or at least within 24 hours of admission, service users, having been offered a chaperon of the same gender, should have a physical examination as set out on the Trust's policy NTW(C)29, Trust standard for physical assessment and examination.

22.9 Where, after discussion with the service user, it is agreed to delay the examination or when the service user refuses the examination, the reasons for this will be recorded by the doctor and the decision will be reviewed regularly.

22.10 The physical examination findings will be clearly recorded on the care coordination assessment document and other local documentation as appropriate.

22.11 Any actions stemming from physical examinations such as further investigations or referrals to physical care specialists will be recorded. The examining Doctor will clearly state who is responsible for ensuring investigations are carried out and that the appropriate referrals are made.

22.12 Where a service user lacks capacity to consent to examination this will be recorded, as will the Doctors reasons for proceeding with, or not proceeding with, physical

examination.

22.13 Each in patient admission, regardless of time elapsed, is a separate episode

23 Within 7 working days of the admission

23.1 The first in-patient Multi-Disciplinary Team Meeting will hold a formal Care Co-ordination Review involving the service user, carer any advocate and the Care Coordinator

23.2 The named nurse or delegated person will contact everyone verbally to arrange the first care coordination review and if someone is not able to attend ascertain how they will input to the review e.g. written report, discussion with named nurse / consultant.

23.3 This first MDT meeting will:

- Identify the purpose of the admission and review risk assessment / risk management plans
- Complete a full review of the patient's needs for the duration of their in-patient admission including reviewing current planned or agreed leave, Observation levels and risk management
- Agree any specialist assessments required
- Agree the care and treatment plan and broad timescales for completion of that plan
- Agree behaviour support plan if needed
- Agree risk management plan if needed
- Agree who will record / update the relevant sections of RiO
- Agree the date for the next care coordination review. The frequency of reviews should be based on the service user's needs but will not exceed six months from the first care coordination review

23.4 A consultant psychiatrist (or associate specialist) must attend the review and be directly involved in formulating risk assessment(s) and management plan(s) for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable).

23.5 The service user should be offered a copy of their care and Treatment plan in a format appropriate to their needs. Whether the service users accepts or declines a copy of the care plan must be recorded on RiO in the care plan agreement screen.

24 Within 2 weeks of admission

24.1 A Full physical health review should be completed. This information should be documented and any action should be care planned, which may include, where appropriate, Health Action Plans, which have been agreed with the service user.

25 Reviews

25.1 Subsequent care coordination reviews should take place **as a minimum** every 6 months. There will be some areas in the trust that hold meetings more frequently e.g. every 8 to 12 weeks. These Multi Disciplinary Team reviews can meet the requirements of a care review and can be logged as such on RiO.

25.2 Routine clinical team meetings e.g. ward rounds are not care coordination reviews but can be used as a mechanism to convene a care coordination review. i.e. the MDT will identify the need for a care coordination review the due to, for example, if the MDT establishes that the current care plan is not meeting the service users needs; if the MDT establishes that the service user or their family are in disagreement with the care plan; there is the need to develop a more robust discharge plan etc.

25.3 All members of the multidisciplinary team, including the responsible clinician, ward manager/deputy, named nurse; Care Coordinator, service user, carer, advocate and all other professionals who are involved in the service user's assessment / treatment and care will be invited to attend or contribute to the care coordination review. If the Care Coordinator is unable to attend, then the meeting should still go ahead, the meeting should consider issues around the in-patient care of the service user.

26 Urgent Care coordination Review Meetings

26.1 Any member of the multidisciplinary team, service user, advocate or carer can ask for a care coordination meeting at any time.

26.2 The meeting will be organised by the named nurse in consultation with the Care Coordinator. It will be held within five working days of the request. The following people should be at that meeting:

- Responsible Clinician
- Ward manager or deputy named nurse
- Person requesting the meeting
- Service User (unless they decline to attend)
- A consultant psychiatrist for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan

27 Care coordination and Extended Leave

27.1 As part of a service user's discharge planning the multi-disciplinary team may decide to offer the service user extended leave. All decisions relating to leave must be informed by risk assessment and a consultant psychiatrist must be directly involved in decisions about leave for service users who express delusional beliefs involving children or might harm a child as part of a suicide plan.

27.2 There should be a care plan for the extended leave and a care coordination review at the end of the leave where decisions should be made on whether to further extend leave or fully discharge the service user. It should also agree on what future involvement is required from the inpatient clinical team. The meeting, at an agreed venue, should be recorded as per the care coordination policy.

27.3 Service users who are detained in hospital for treatment under section 3 of the MHA or are unrestricted Part 3 patients (Section 3, 37, 48 and 51), and are receiving, or are to receive, S17 leave for 7 consecutive days or more must be considered for Supervised Community Treatment (SCT).

28 Discharge

28.1 Planning for discharge should be part of every review and prior to discharge there should be a care coordination review where a Discharge Care plan is formulated.

28.2 The team must make a decision on whether the patient needs are such that they continue to have enhanced needs / CPA.

28.3 The discharge care plan will-identify the patient's care needs for their immediate discharge and successful reintegration into the community, with particular reference to immediate needs, support in the first week of discharge including 7 day follow up arrangements and the subsequent 3 months.

28.4 If the service user is remaining in NTW services post discharge and 7 day follow up is being undertaken by non NTW staff then the discharge care plan should detail the agreement as to how the other members of the community based care team will be informed of the outcome. The plan will identify an agreed member of NTW staff to appropriately record 7 day follow up on RiO.

28.5 Where discharge from the ward is also discharge from all NTW services then the responsibility for 7 day follow up is with the local community services where the service user will be residing and this should be detailed in the discharge care plan.

28.6 The care plan agreement section should identify any section 117 services and any required locality 117 forms will be completed.

28.7 If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services, the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made.

28.8 A consultant psychiatrist (or associate specialist) must attend the review and be directly involved in formulating risk assessment(s) and management plan(s) (including multi-agency planning via the safeguarding process where applicable) for service users who express delusional beliefs involving children or might harm a child as part of a suicide.

28.9 If needed the CPA management screen on RiO will be updated, including formalising hand over of care coordination/lead professional responsibility.

29 Care Coordination Information to be circulated to Non-NTW personnel from LD A&T Wards.

29.1 Whilst NTW personnel can access a patient's Care coordination documentation (and associated Risk Assessment / Risk Management plans) electronically via RiO, other stakeholders in the patient's care (e.g. Family / Paid Carer's / Advocates / Health and Social Care Professionals from other organisations) require access to such documents via paper copies.

29.2 At all Care Coordination meetings it will be confirmed with all Non – NTW personnel attendees if they require information which will be discussed at the CPA / Care coordination Meeting.

29.3 The patient's GP and Care Coordinator will always receive the below information. All such documents will be provided and posted by the Ward's respective dedicated Administration and Clerical Support.

29.4 First CPA / Care Coordination Meeting;

- Covering Letter detailing other documents attached and date and time of next meeting.
  1) Agreed FACE Risk Profile and Risk Management Tool (Printed from RiO)
  2) Minutes from Care coordination Review (Printed from RiO '**Care Co-ordination Review'** link within Care Plan Documentation Folder)
  3) Agreed Care Plan (Printed for RiO **'Plan of Actions to be taken from Assessment'** link within Care coordination Assessment Folder)

29.5 Regular CPA / Care Coordination Meeting:

- Covering Letter detailing other documents attached and date and time of next meeting
  1) Agreed FACE Risk Profile and Risk Management Tool (Printed from RiO)
  2) Minutes from Care Coordination Review (Printed from RiO **'Care Co-ordination Review'** link within Care Plan Documentation Folder)
  3) If Care Plan has changed; Agreed Care Plan (Printed for RiO **'Plan of Actions to be taken from Assessment'** link within Care coordination Assessment Folder)

29.6 Discharge from Hospital CPA / Care Coordination Meeting:

- Covering Letter detailing other documents that are attached and date and time of next Care coordination meeting which must be received within seven days of the patients discharge. These documents are:
  1) Agreed FACE Risk Profile and Risk Management Tool (Printed from RiO). This must also clear reference to a detailed 7 day follow up discharge plan
  2) Minutes from Care Coordination Review (Printed from RiO **'Care Co-ordination Review'** link within Care Plan Documentation Folder). This must have clear discharge summaries from all professionals involved in the patient's care whilst in hospital. This must also clear reference to a detailed 7 day follow up discharge plan
  3) If Care Plan has changed; Agreed Care Plan (Printed for RiO **'Plan of Actions to be taken from Assessment'** link within Care Coordination Assessment Folder)
  4) Copy of completed and reviewed Physical Health Screening tool to GP
  5) Dependant on the Patients individual circumstances Relevant Behaviour Support Plan, Relapse Plans, Risk Management Care Plans (Printed from RiO) developed during the patients stay at hospital

30 De-Registration

30.1 De-registration occurs when the service user ceases **all** contact with services provided by this Trust and should be recorded using the CPA management screen on RiO.

31 Carers

31.1 Relatives and carers often know a great deal about the service user's life, interests and abilities as well as having personal experience of the service user's illness. Some family carers will have a significant responsibility to support, protect and keep in touch with someone who cannot manage alone because of their mental health and /or complex needs. It is important to include carers in the care planning and review process whenever possible.

31.2 Carers should also be fully involved in the planning of and delivery of care during and following a service user's inpatient admission, if they wish to be and so far as is practicable on an equal footing with professionals. Information shared by professionals must also be shared with the carer, subject to the service user's consent.

31.3 If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment, staff must ensure that this is clearly and sensitively communicated to the carer and recorded in the service user's notes.

31.4 In the absence of consent, there may be exceptional circumstances in which disclosure of information and contact with involved carers can be justified in the public interest, for example, if someone has a history of violence.

31.5 Disclosure of information/sharing of information with carers based on public interest may involve weighing that interest against the duty of care in the particular set of circumstances. The balance can be delicate and it may be necessary to take legal advice. If a service user does not want their carer or relatives to receive information, or to be involved in their care and treatment – staff must ensure that this is clearly communicated to the carers and relatives and recorded in the service user's notes. It is anticipated that such cases will be relatively few and the expectation is that the majority of carers will be involved.

32 Young Carers

32.1 Young carers are children and young people under the age of 18 whose lives are restricted by the need to take responsibility for the care of a person who is affected by mental ill health and or a learning disability

32.2 Where a young carer is involved in the care of an adult with mental health problems and or learning disability, the professionals involved through the care coordination process have a responsibility to make an assessment of the family circumstances and the needs of the child/young person and, where appropriate, refer them to Social Services. Support services can be provided for young carers to enable them to maintain their usual activities outside of the caring role.

32.3 In addition, health professionals need to be aware of children's needs for access to a range of information, both regarding the nature of the mental health problem

and/or learning disability and what services and support are available to them.

APPENDIX 2d

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Care coordination Policy Older People's Directorate Practice Guidance Note			
Issue 1 – May 09 **Issue 2 – Oct 09** **Issue 3 – May 10** **Issue 4 – Sep 10** **Issue 4 – Nov 10**	**Planned review** **May 2010 – extended to November 13**	**Responsible officer** **Liz Bowman**	**CC-CPA-PGN-02** Part of NTW(C) 20 CC/CPA Policy

CONTENTS

Appendices – listed separately to practice guidance note	
1.	Initial Specialist Mental Health Assessment – reissued Oct 09
2.	Consent to share information
3.	Care co-ordination registration form
4.	Standards for clinical letters as care plan or review record
5.	Community Care plan document – reissued Oct 09
6.	FACE risk profile– reissued Oct 09
7.	Specialist mental Health Review document – reissued Oct 09
8.	In Patient flow chart
9.	Initial In Patient Assessment care and discharge plan
10.	Admission checklist
11.	In Patient specialist care plan – reissued Oct 09
12.	In Patient leave plan
13.	In Patient discharge care plan– reissued Oct 09
14.	In Patient Discharge Summary Standards
15.	Community Flowchart
16a 16b 16c	Within arms length observation care plan Within eyesight observation care plan Intermittent observation care plan observation care plan
17	Keeping Children Safe Assessment – Issued Oct 09
18	Proposed changes to RiO – issued Oct 09

Older People Directorate Practice Guidance to be read in conjunction with NTW (C)20 Care Coordination and Care Programme Approach Policy

1. Introduction

1.1 The recording documentation of the directorate has been developed to meet the standards and requirements of the specialist assessment component of the Single assessment process for Older people and the DOH Refocusing CPA (2008) and "Care Management for Older People with serious mental health problems" (Policy and guidance 25/07/2002

1.2 The Directorates' approach enables the application of all required standards to the assessment and care planning and associated recording for all service users regardless of diagnosis.

1.3 When a person's mental health and social care package is complex, predominantly mental health related and the characteristics in section 1 of this guidance are present, their care will normally require care co-ordination and a Mental Health Care Coordinator should be allocated. Care Co-ordination will provide the specialist assessment care planning, review framework for the health and social care provision that is required to meet this person's needs.

1.4 This practice guidance relates to Older People receiving mental health services within Northumberland, Tyne and Wear NHS Foundation Trust (the Trust). It applies to staff within the Older Peoples Directorate managed by the Trust.

2. Criteria for Enhanced need (CPA) in Older Peoples services.

- **Severe mental disorder** (including functional mental health needs) with high degree of **clinical complexity**
- **Significant risk to self or others / rapid onset of symptoms requires immediate assessment and treatment**
- **Needs require a period of inpatient care**
- **Mental Health needs are having significant impact on activities of daily living and requires prompt assessment and interagency treatment plan**
- Current or potential **risks** including suicide, self harm, harm to others, relapse history, self neglect, non-concordance, vulnerable adult, adult/child protection
- Current or significant history of **severe distress/instability or disengagement**
- Non-physical **co-morbidity** e.g. substance/alcohol misuse, learning disability
- **Multiple service provision** from different agencies
- Currently/recently **detained under MH Act, or referred to crisis/home treatment team**
- Significant **reliance on carer/s, or has own caring responsibilities**

- Disadvantage or difficulty as a result of:
    - **parenting** responsibilities;
    - **physical health** problems/disability;
    - **unsettled accommodation;**
    - **employment** issues;
    - significant **impairment of function** when mentally ill;
    - **ethnicity, sexuality or gender** issues

2.1 The list is not exhaustive and there is not a minimum or critical number of items on the list that should indicate the need for enhanced Care Co-ordination. Professional experience, training and judgement should be used in using this list to evaluate which service users will need this support.

2.2 All service users subject to Supervised Community Treatment (SCT), or subject to Guardianship under the (MH) Act (section 7) status should be supported by enhanced care co-ordination (CPA). A Care Coordinator will be identified; this may or may not be the responsible clinician.

2.3 Correspondence should always incorporate the service user's NHS number which is a unique identifier and documentation should also always use the service user's RiO number.

3. Assessment (Appendix 1)

3.1 All service users referred to secondary mental health services will have an initial assessment of their mental health needs. This assessment will use the Directorates' Initial Specialist Mental Health Assessment framework (ISMHA). The column headed considerations included in the assessment document contains suggestions designed to illustrate the issues that might be considered in each area of the assessment, but are not intended to be used as a required set of questions / checklist or exclude additional assessment components or relevant information.

3.2 As a minimum, an initial assessment will always include.

- Reason for referral including advocacy needs / capacity issues
- History / service users account of their current problems, needs, mental health issues, expectations of the service, hopes and aspirations
- History / carers account of current problems, needs mental health issues
- Current Medication and Adherence
- Physical Health history
- Taking care of yourself (ADL strengths and needs)
- Mental Health history
- Mental state (at interview)

- Risk assessment, the outcome being recorded, as a minimum requirement, using Older Peoples FACE risk profile (Appendix 6) and, where appropriate, keeping children safe assessment (Appendix 17)

3.3 The assessment will be recorded using the ISMHA document or the equivalent RiO screens. More than one professional, if appropriate, may complete the assessment. The documentation enables different contributions to be identified though appropriate signing

3.4 Whether other components of the assessment framework will be used at initial assessment will be a clinical judgement informed by the referral information, the service user's needs and the assessment process.

3.5 The outcome of the intial assessment should be communicated to the individual (in a way they will understand) and to the referrer promptly.

3.6 If the service user's needs are not to be met by secondary services and the individual is provided with appropriate advice and / or signposting this information / advice should be included in the assessment outcome letter.

3.7 Some older adults referred to specialist mental health services will already have been assessed and their care planned using SAP or through the local authority care management processes. In this instance the mental health services assessment will build on and gather only the additional information required to deliver and direct care without unnecessary duplication or repetition.

3.7 If the individual has assessed needs to be met by secondary mental health services an initial care plan should be agreed with the service user and recorded in the Initial Management Plan and Follow up Arrangements section of the ISMHA and should be included in the assessment outcome letter.

3.8 When an older person's needs are met and managed predominantly in primary **and** social care, and they have assessed mental health needs which are not complex, secondary mental health care will form part of the overall assessment and care plan and overall care management will be co-ordinated through existing Care Manager. A **lead professional** from mental health services will be identified.

3.9 Where the initial assessment is indicative that the service user has enhanced needs, (which meets the requirements of CPA) the service user will be allocated a Care Coordinator

3.10 The Care Coordinator will ensure that the initial plan is implemented whilst the assessment is developed into a comprehensive assessment of health and social care needs by updating the ISMHA (or the equivalent sections of the electronic care record) and using relevant additional specialist assessment tools. Other professionals will contribute to the assessment as appropriate to the service users needs.

3.11 The Care Coordinator will also ensure that the initial risk assessment is updated, the outcome being recorded as a minimum using FACE risk profile. Other professionals and any specialist assessment / risk assessment tools will be used as appropriate to the service users needs.

3.12 If there is any uncertainty about the complexity of needs then the assessor must undertake further assessment of health and social care needs, involving other professionals as required; to enable a clear decision to be made

4 Consent to share information (Appendix 2)

4.1 Consent to seek and share information should be discussed and agreed with the individual as part of the initial assessment. This will be recorded on page 1 of the consent to share information document (Appendix 2) or the equivalent RiO screens.

4.2 Consent to seek and share information should be revisited with the service user during care planning. This will be recorded on page 2 of the consent to share information document (Appendix 2) or the equivalent RiO screens.

4.3 Some service users may not have the capacity to consent, or be able to understand the implications of sharing information. If concerns about the service user's capacity to consent arise, a decision will be made by the "decision maker" following an assessment of capacity with clear reference to the Mental Capacity Act best interest checklist.

4.4 Assessment of capacity should involve discussion with relevant members of any multi disciplinary team, carers and/or advocates and will be clearly recorded in the service user's record.

4.5 There may be occasions when it is deemed necessary to share information with professionals against the service user's expressed wishes. In this instance the professional involved and the outcomes/reasons must be fully documented in the service user's care record.

5 Registration (Appendix 3a & 3b)

5.1 For service users with enhanced needs the care co-ordinator will ensure that the service user is registered on the electronic care record as being on enhanced level care co-ordination. Where a team does not have access to do this directly onto the electronic care record appropriate pages of the Care co-ordination registration document (Appendix 3a for community and 3b for in patient services, if not admission not entered directly on RiO, which incorporates the admission form) will be used. The forms is designed to be used as the UHR front sheet

5.2 For service users who do not have enhanced needs the lead professional will ensure that the service user is registered on the electronic care record with the lead professional registered as a care co-ordinator until the updating of the system enables this to change. This registration **will not** confer the responsibilities of a care co-ordinator on the lead professional.

6 Care planning (Appendix 4)

6.1 If it is **clear** from the initial assessment that the service user has more straight forward needs and does not meet the criteria of enhanced needs a **lead professional** from within Older people's services will be identified. The **lead professional** will further develop the initial care plan with the service user, and others as appropriate, to ensure there is a shared understanding of how care and treatment will be carried out, by whom and when.

6.2 This care plan can be recorded in the form of a clinical letter which meets the directorate's standards or using the Directorates' care plan document (if this enables clarity for the service user).

6.3 Whatever format is used the service user must **always** be offered a copy of this care plan, unless doing so would constitute a significant risk to the service users or others and a copy sent to the GP and any others who are part of the care team

6.4 Consent to share information should be revisited as part of the care planning process and documented on page 2 of the consent form (Appendix 2) or the relevant section of the electronic care record

7 Care planning for service users with enhanced needs (Appendix 5)

7.1 The care co-ordinator, through discussion and negotiation with the service user and others, will ensure that a comprehensive, formal written care plan is developed and agreed and recorded using the Directorates' care plan document (Appendix 5)

7.2 Consent to share information should be revisited as part of the care planning process and documented on page 2 of the consent form (Appendix 2) or the relevant section of the electronic care record.

7.3 The care plan will identify the service user's needs, the resources, and actions by individual members of the care team, including the service user and carer and any LPA attorney (as appropriate) to meet those needs.

7.4 The care plan will have a socially inclusive and outcome focus, these outcomes being identified by the service user and the team. The care plan will also include a crisis plan. Responses to crisis situations during working hours and outside of working hours must be included.

7.5 The crisis plan should incorporate trigger factors/relapse indicators specific to the service users and record the agreed the respective responsibilities of all members of the care team. This should include the service user e.g. increase their use of established coping skills), the family, the community e.g. support lines.

7.6 The service user must **always** be offered a copy of this care plan unless doing so would constitute a significant risk to the service users or others and a copy will be sent to the GP and any others who are part of the care team.

7.7 Service user led documents such as an Advance Decision and / or Advance Statement; can inform or even be used to fully formulate the crisis plan. Crisis responses from statutory services should be increase in a graded sense in relation to the risk.

8 Risk assessment and management (Appendix 6 & 17)

8.1 Risk assessment is a dynamic and ongoing process in the provision of care and treatment to all service users. It is a multi disciplinary responsibility and the outcome of risk assessment should be formally documented using the Older People's FACE risk profile tool.

8.2 A consultant psychiatrist (or associate specialist) should be directly involved in formulating risk assessment(s) and risk management plan(s) for all service users who express delusional beliefs involving children or who might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable). This involvement should be whenever risk assessment is required and should be formally documented (as a minimum) on the FACE risk profile tool and through completion of the Keeping Children Safe Assessment (appendix 17)

8.3 Risk assessment is required

- As part of initial assessment (documented as a minimum on Older People's FACE risk profile) / ongoing assessment / reassessment.
- When admitting and discharging from hospital (documented as a minimum on a FACE risk profile risk) and as part of planning and agreeing leave.
- As part of review considerations
- When there are major changes to presentation / personal circumstances or following an incident
- When alerted by Carers
- When transferring service users to other teams/service providers
- When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

8.4 Risk management plans are an integral part of the Care Plan and will be developed when the level of risk is significant, serious, or serious and imminent {FACE risk profile ratings scale 2, 3, or 4}

8.5 The management of risk issues that are rated 1 do not require a specific risk management plan and should be covered by the Care Plan and appropriate crisis plan.

9 Review (Appendix 7)

9.1 For all service users their Care Plan must be subject to ongoing monitoring and review but should be reviewed formally in line with the risk management plan, and planned review dates.

9.2 If a service user's care has been reviewed through MAPPA or Safeguarding Vulnerable Adults process then a separate care co-ordination review should only be held if there is a clear need or if requested by the service user or Carer

9.3 Frequency of Reviews should be determined by the needs of the service users but should be **at least** once a year.

9.4 Reviews for **service users who do not have Enhanced Needs** will:

- Review progress of Care Plan against the agreed outcomes
- Review current assessment of risk including where appropriate keeping children safe assessment
- Review any crisis and risk management plan
- Agree any changes to the care plan (if required)
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Consider the impact of care plan changes:
    - On Carer / need for a carers assessment
    - Service users capacity to consent to the care plan

9.5 The review can be recorded in the form of a clinical letter which meets the directorate's standards (Appendix 4) which will also constitute the new care plan. The Older Peoples Multi disciplinary review document (Appendix 7) can be used if this enables clarity for the service user.

9.6 Whatever format is used the service user must be offered a copy of the review record and a copy sent to the GP and any others who are part of the care team

9.7 At each service user's care co-ordination review, where there is carer involvement:

9.8 Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision.

9.9 Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review.

10 **Reviews for Service Users with Enhanced Needs** the monitoring of a care plan must be regarded as an ongoing process. Informal reviews will be undertaken and documented using the Older Peoples Multi disciplinary review document by the Care Co-ordinator involving the service user, any identified carer and all those professionals involved in an individual's treatment or care.

10.1 The frequency of these reviews will be determined by the service users needs.

10.2 As a minimum a formal review will take place **at least** once a year. This formal review will usually involve a meeting of all concerned in a setting where the service user feels comfortable and will:

- Agree a chair (this will usually be the care co-ordinator)
- Agree a scribe to complete the documentation (Older Peoples Multi disciplinary review document (Appendix 7). The scribe will check completed form with the service user and care co-ordinator for accuracy and if agreed obtain the service user's and care co-ordinator's signatures
- Review progress of Care Plan against the agreed outcomes
- Review current assessment of risk including where appropriate keeping children safe assessment
- Review crisis and risk management plan
- Agree any changes to the care plan (if required)
- Consider the impact of care plan changes
- On Carer / need for a carers assessment
- Service users capacity to consent to the care plan
- On any potential deprivation of liberty
- Agree who will record the new care plan
- Agree any changes to risk assessment
- Agree any changes to crisis and risk management plan (if required)
- Agree who will undertake the recording of new risk assessment (if required)
- Agree who will undertake the record new crisis and risk management plan (if required)
- If the service user has an advance statement and / or Advance Decision Review if this still reflects their wishes / views
- Agree action to be taken (if any)
- **Date and Time of next meeting** agreed and documented

10.3 At each service user's care co-ordination review, where there is carer involvement:

- Carers who have declined a carer's assessment should be provided with an opportunity to revisit that decision.
- Carers who have a separate care plan should have the opportunity to identify whether they feel there is the need for a review.

10.4 If the service user care plan is to be revised, and incorporates services / interventions being implemented as a result of carers needs identified at assessment, carers should have the opportunity to identify if the revised care plan still meets their assessed needs.

10.5 There may be circumstances where it is inappropriate to review carer's issues within the service user's review. In such circumstances within 2 weeks of the service users review the carer(s) should have the opportunity to discuss the implications of the review on their role with the Care co-ordinator. This should provide the opportunity for

- Carers who have declined a carer's assessment to revisit that decision;
- Carers who have a separate care plan to identify whether they feel there is a need for a review
- Those carers whose support is incorporated in the service user's care plan to identify if the revised care plan still meets there assessed needs.

11 Inpatient Admission and Discharge Arrangements (including Section 117). See Flow Chart Appendix 8

11.1 All service users admitted to an in-patient facility will usually be registered on enhanced Care Co-ordination.

11.2 Where there has been previous involvement from Trust services the service user's unified health record should move with them to the in-patient setting. If there are practicable reasons why this is not possible then the clinician arranging admission / Care Co-ordinator / lead professional will supply the admitting professional with the following completed documentation

- Most recent ISMH Assessment;
- Most recent Risk Assessment (Older peoples FACE Risk Profile and where appropriate keeping children safe assessment as a minimum)
- Most recent Care plan
- Most recent 'consent to share information' form

11.3 Where the referring person is external to Trust services they will be expected to supply the admitting professional with the following documentation:

- Most recent Assessment; e.g. AMHP assessment
- Most recent risk assessment / information on risk

11.4 On admission, or at least within 24 hours of admission service users should have a basic physical examination and their physical condition and needs assessed as outlined in the Trust's policy, NTW(C)29 – Confidentiality.

11.5 Each in-patient admission, regardless of time elapsed, is a separate episode and will require assessment including a risk assessment being completed at all times.

11.6 On admission the Admitting nurse **with service user and carer / family:**

- completes **Initial Assessment Care and discharge plan (Appendix 9)** and first **observation** care plan **(Appendix 10)** if appropriate
- updates / completes **page 1 Consent to share information**
- Begin completing **Admission Checklist (Appendix 11)**
- **With Medical Colleagues** begin completing / updating **Initial Specialist Mental Health Assessment (ISMHA)**
- Ensure RiO / **registration** is updated if needed to enhanced level

11.7 In the 72 hours following admission and facilitated through the daily handover meetings the inpatient team will **with involvement of service user and carer / family**

- complete **ISMHA** and begin any additional specialist assessment tools as clinically indicated
- complete **Risk Profile and if appropriate keeping children safe assessment**
- begin to formulate the **Specialist Mental Health Care Plan**

11.8 **First in-patient full Multi-disciplinary Team Meeting**

11.8.1 Informed by the assessment and risk assessment and initial care planning at the first in-patient full Multi-disciplinary Team Meeting the team **with service user and carer / family and involving community staff** will

- Agree **Specialist Mental Health In Patient Care Plan (Appendix 11)** including as appropriate **observation plan (appendices 16a, 16b or 16c), leave care plan (Appendix 12) taking into account any keeping children safe assessment (Appendix 17) and planning for discharge care plan (Appendix 13)**
- Consider changes to risk including if new **risk profile and / or keeping children safe assessment** is needed
- Update / complete page 2 of **consent to share information**
- If required, agree who will undertake the role of care co-ordinator
- Agree timescales for completion of any additional specialist assessment tools as clinically indicated

- Ensure that a copy of care plan is offered to service user and to their carer / family (if appropriate)

11.8.2 Members of the MDT are responsible for completing their section of the **Specialist Mental Health Review** document **(Appendix 7)** including signing and dating. Professionals attending the meeting should complete their section of the MDT review form prior to the meeting if possible or during the meeting if that is not practicable.

11.8.3 If an individual professional is not able to attend the MDT their section of the **Specialist Mental Health Review** document should be completed prior to the meeting.

11.8.4 An Identified member of the multi disciplinary team will be responsible for supporting the service user to contribute their views to the review meeting. The service user, with appropriate support can complete their section of the form prior to the meeting or if they prefer their verbal contribution can be recorded during the meeting. If the record is made by a professional wherever possible this should be checked with the service user to ensure accuracy.

11.8.5 An Identified member of the multi disciplinary team will be responsible for supporting carers / family members to contribute their views to the review meeting either by, with appropriate support completing their section of the form prior to the meeting or if they prefer their verbal contribution can be recorded during the meeting. If the record is made by a professional this should be checked with the carer/ family to ensure accuracy.

11.9 **Subsequent full MDTs will with service user and carer / family involvement will:-**

- Monitor and record progress of care plan
- Consider changes to risk
- Agree any changes needed to any part of **Specialist Mental Health Care Plan, risk profile** and / or **risk management plan**

11.9.1 The recording requirements outlined in 14.3 to 14.5 will also apply

11.10 **Care Co-ordination Reviews**

- The frequency of a formal care co-ordination review will depend on the needs of the service user and the length of their inpatient stay.

- This formal review will be undertaken as outlined in 12.2

11.11 **At the pre-discharge meeting or final In-patient Care Co-ordination Review**

- Prior to the patient's actual discharge, the team would hold a formal Care Co-ordination Review. With the involvement relevant community staff a discharge Care Plan, identifying the patient's care needs for their immediate discharge and successful reintegration into the community will be completed and

recorded, with particular reference to immediate needs, support in the first week of discharge and the subsequent 3 months including:

- Medication changes, monitoring, follow-up etc;
- Out-patient appointments;
- Social requirements;
- A Risk Management Plan (if applicable);
- Crisis plan;
- Whether the service users needs remain at enhanced level at discharge

- Agree will undertake the role of care co-ordinator or lead professional as appropriate, at discharge.
- Agreement for any Section 117 services if applicable
- Agree who will be responsible for ensuring copies of the discharge care plan are sent to all relevant parties.

- A consultant psychiatrist (or associate specialist) should be directly involved in formulating the discharge risk assessment and management plan for all service users who express delusional beliefs involving children or who might harm a child as part of a suicide plan (including multi-agency planning via the safeguarding process where applicable)

- For service users whose needs continue to be at Enhanced level the Discharge Care plan will be recorded using the **Specialist Mental Health Care Plan** document. This should be complemented by a Discharge from in-patient treatment summary letter which is also sent to the GP. **(Appendix 14)**

- Service users who do not have enhanced needs will have their Discharge Care plan recorded using Discharge from in-patient treatment summary letter that meets directorate standards (Appendix 14)

12 Responsibilities of the Lead Professional

12.1 The lead professional will ensure that:

- The service user's previous consent to seek and share information is discussed and updated as needed.
- In partnership with the service user and any other significant care provider, including carers, develop a clear understanding of how care and treatment will be carried out, by whom, taking into consideration any existing advanced statement or Advance Decision to refuse treatment.
- The agreed care and treatment (care plan) is recorded using a clinical letter, which meets the Directorates' standards (Appendix 4) or using the Directorates' care plan document if this enables clarity for the service user.
- Provide advice and signposting to the service user to enable them to access other agencies/support to meet their needs
- A central record of care is maintained as required by their agency.

- A copy of the current care plan is always offered to the service user
- The service user is offered copies of letters as outlined in NTW(O)22 Sharing letters with patients policy
- A copy of the current care plan is sent to the service users GP and any other significant care provider, including carers, if appropriate.
- Ensure that the care plan and risk assessment is subject to on-going review as required, involving the service user and any other significant care provider, including carers. This can be recorded using a clinical letter which meets the Directorates' standards (Appendix 3) or using the Directorates' review document if this enables clarity for the service user.
- In partnership with the service user and any other significant care provider, including carers, consider at each review whether a service user's needs have changed, and if there is need for enhanced care co-ordination support.

12.2 The role of Lead professional can be undertaken by Medical staff and Qualified Nurses, Qualified Social Workers, and Qualified Allied Health professionals who are suitably experienced and skilled under appropriate supervision to be able to assess service users

13 Care Coordinator Roles and Responsibilities

The Care Co-ordinator may fulfil these responsibilities through effective, agreed and appropriate delegation to other members of the care team. Such delegation will be recorded in the clinical record or on the care plan or review documentation as appropriate to when delegation occurs.

13.1 Consent **must** always be sought from a professional prior to them being identified as a Care Co-ordinator. Under no circumstances must any professional be stated as Care Co-ordinator without negotiation and agreement.

13.2 The person who is best placed to oversee care management and resource allocation should usually take the role of the Care Co-ordinator.

13.3 The Care Co-ordinator will have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin.

13.4 However, it is not the intention that the Care Coordinator is necessarily the person that delivers the majority of care. There will be times when this is appropriate, but other times when the therapeutic input may be provided by a number of others, particularly where more specialist interventions are required.

13.5 For people who have had damaging experiences of sexual abuse or violence, choice of gender of the Care Co-ordinator may be a crucial factor in establishing trust and a therapeutic relationship.

13.6 The Care Co-ordinator will:

- Ensure the service user's involvement in the process of decision-making.
- Ensure where appropriate, any carer's involvement in the process of decision- making.
- Ensure that, where in place, an Independent Mental Capacity Advocate or an attorney through a Lasting Power of Attorney (LPA) is fully involved in the process of decision making
- Promote, build and maintain relationships with others involved in the service user's care.
- Act as the "acknowledged" name for contact by all agencies relevant to the service user's care.
- Ensure that a comprehensive, formal written care plan including risk and crisis plan care plan is negotiated and agreed and that responses to crisis situations during working hours and outside of working hours are included. The level of response should be appropriate to the degree of crisis.
- Ensure that the documented plan accurately reflects the agreements reached. This is indicated by the Care Co-ordinator signing the care plan.
- Ensure the service user and all members of the care team (including the GP) has a copy of the care plan
- Ensuring the care plan is recorded on the electronic care record
- Ensure that any advanced statements or Advance Decisions are considered and recorded as part of the Care planning process
- Consult and seek appropriate advice if any aspect of the care plan proposes significant restrictions of liberty to ensure that such restrictions do not constitute "deprivation of liberty"
- Monitor the agreed care plan and record progress.
- Ensure appropriate review of the service user's care plan
- Provide support and care, taking positive action in the event of a service user disengaging from services in accordance with Trust's policy NTW(C)07 – Promoting Engagement (including 'Difficult to Engage').
- Work with in-patient services to ensure that prior to discharge a joint review takes place.
- Ensure the service user's GP and staff identified in the care plan are informed within one working day of the service user being admitted to hospital. Where appropriate it may be necessary to ensure that there is support for the service user to register with a GP
- Ensure the provision of follow-up and assertive outreach where this is available should the service user disengage from services.
- Ensure Carers are supported and offered an assessment of their needs

13.7 Whenever possible, any change of Care Co-ordinator should be agreed

through the care co-ordination review process. This will ensure there is an effective hand-over of information to the new Care Co-ordinator.

13.8 Where a service user plans to move area the Care Co-ordinator must liaise with the appropriate professionals in the receiving care team to ensure that the service user's care is transferred effectively.

13.9 The role of Care Coordinator, depending on capability and capacity, can be undertaken by

- Medical staff (except Senior House Officers)
- Qualified Nurses,
- Qualified Social Workers,
- Qualified Allied Health professionals

  Who are suitably experienced and skilled under appropriate supervision.

14 Responsibilities of Members of the Care Team

14.1 All professionals whether employed in the statutory or voluntary sector, and any carers, have a responsibility to:

- Deliver agreed interventions,
- Undertake their own dynamic and ongoing risk assessment
- Contribute to the overall assessment of risk through sharing their professional assessment
- Communicate with the Care Co-ordinator regarding
- Their assessment of risk
- Their role in the care plan and progress of associated service delivery.
- This is particularly important following any major change in the circumstances of the service user or should service delivery cease or no longer seems appropriate

15 De-Registration

15.1 De-registration occurs when the service user ceases **all** contact with secondary mental health services provided by this Trust and should be recorded using the appropriate section of the electronic record (CPA management screen as a minimum).

APPENDIX 2e

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Care Coordination, Care Programme Approach Practice Guidance Note Discharge against Medical/Clinical Advice – V01			
Date issued **Issue 1 - May 11**	**Planned review** **May 12**	**Responsible officer** Veronica Holland Rachel Weddle Liz Bowman	**CC-CPA-PGN-08** Part of NTW(C)20 - CC/CPA Policy

Contents

1 Introduction

1.1 Many patients who are admitted to Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) in-patient (IP) units do so with their agreement and consent on an Informal / voluntary basis, usually following the advice of mental health professionals. Of these patients, the majority will follow the treatment plan that is drawn up for them, which will include specific interventions and a discharge plan.

1.2 However, a minority of patients who are admitted informally / voluntarily choose not to complete and/or follow their treatment plan and opt to take their own discharge against the advice of the clinical staff involved in their care. Because of their decision to do this, a discharge care plan may not have been formulated and the necessary community care package may not have been set up.

1.3 There are 2 terms associated with self discharge:

- **Discharge against medical advice (DAMA)** is where the patient takes their own discharge having been seen by a medical professional and chooses to ignore the advice given

- **Discharge against clinical advice (DACA)** is where the patient takes their own discharge not having been seen by a medical professional and chooses to ignore the advice given by nursing staff.

1.4 These patients may currently or have previously been, identified as presenting a risk to themselves, risk to others or risk of self neglect, and in need of follow up care, even though they have taken their own discharge and do not reach the criteria for the application of holding powers under Section 5 of the Mental Health Act (MHA) 1983 at the time.

1.5 It is therefore considered imperative that they do not lose contact with mental health / learning disability services and professionals and it is also important that all staff and carers who are involved in the patient's care be informed of their self-discharge from hospital.

1.6 Staff must carry out an assessment of the risk to the patient and/or others using the recognized tool for their service area if they were to leave the ward. When an informal/voluntary patient wants to leave the ward and staff feel there is a significant risk, different authority exists which can be used to prevent them from doing so. Which authority is used will depend upon the individual circumstances at the time. Generally speaking there are four different categories:

- **Use of holding powers – Section 5(2) and Section 5(4)** where the patient meets the qualifying criteria (See Trust policy NTW(C)55 – Mental Health PGN, MHA-PGN-02 – Holding Powers)
- **Mental Capacity Act 2005** – where the patient does not have the capacity to consent to their care and treatment and this is in their best interests – (See Trust policy NTW(C)34 – Mental Capacity Act.)
- **Supervised Community Treatment Recall** – where a supervised community treatment patient has been admitted voluntarily to hospital. (See Trust policy NTW(C)47 – Supervised Community Treatment)
- **Common Law** – Common law has established that sufficient authority exists for a mental health professional to act swiftly to prevent a mentally disordered person from causing harm to him/her, another person or to property. Any force used must be no more than is necessary and be proportionate to the harm threatened. It must be emphasised that these powers only allow for an informal patient to be detained for a limited period and will fall away when the crisis has subsided. Common Law should not be used or relied upon as an alternative to using the Mental Health Act 1983 or the Mental Capacity Act 2005

1.7 If a patient is making attempts to leave but it is assessed that they have no capacity in relation to this decision then staff must consider whether their actions are resulting in a deprivation of the patient's liberty. If staff should feel that action will be required that might deprive an incapacitated informal patient of their liberty they should seek advice from the Mental Health Act office. Out of hours advice should be sought from the relevant on call manager / medical staff. This may prompt a Deprivation of Liberty request for authorisation or a Mental Health Act Assessment. See Trust policy, NTW(C)26 - Deprivation of Liberty Policy for more detailed guidance on this point.

2 Process to be followed : Duties

2.1 In Patient care team

2.1.1 If there is a history of the patient taking unplanned leave or a strong suspicion that they may wish to discharge themselves at short notice then the clinical team, liaising with appropriate community staff, should discuss this within the Multi-Disciplinary Team (MDT) meeting / care coordination review and document strategies for that eventuality within the IP crisis / risk management plan.

2.2 Ward / Unit Nursing Staff

2.2.1 When a patient wants to self-discharge nursing staff should ascertain why he/she wishes to leave and the reasons given should be noted in progress notes on RiO. Wherever possible, and if felt appropriate the patient should be encouraged to stay.

2.2.2 The on call Doctor and/or the patients' Consultant Psychiatrist should be called to see him/her prior to their leaving the ward / unit.

2.2.3 Nurses should exercise their professional judgment as to the action they should take if there is a delay in the on call Doctor or the patients Psychiatrist arriving to see the patient.

2.2.4 In some circumstances there may be a section in the patients' care plan by the Consultant Psychiatrist recommending what action to take if the patient wishes to self-discharge. This may state the patient be allowed to discharge themselves. This can be considered guidance and the decision must be based on professional assessment at the time discharge is requested. If the care plan contains this section it is important that it is discussed at every MDT and kept up to date in light of the patient's current clinical presentation and behaviour.

2.2.5 In line with the Mental Capacity Act Policy NTW(C)34 an assessment of the patient's capacity to consent to care and treatment and admission should also be made and recorded within progress notes clearly identified as Assessment of Capacity and updated as any changes occur. Where capacity may be an issue this should also be referred to in care plans.

2.2.6 If the patient is unwilling to remain on the ward until the arrival of the 'On-call' or ward doctor, then the nurse in charge of the ward is required to assess him/her and make a decision about management. If the patient is not detainable then they are to be asked to sign the 'Discharge against medical/clinical advice form1. **Appendix 1;** The patient may then leave the hospital.

2.2.7 Prior to the patient's discharge, they should be encouraged to sign the 'Discharge against medical advice/clinical advice form', **Appendix 1.** This should be **scanned on to RIO** with an appropriate entry made in progress notes. If the patient refuses, this should be written on the form by a member of nursing staff. Where appropriate to the patient, the accessible 'easy to read' version of the form may be used **Appendix 2.**

2.2.8 Ward staff should re assess risk and update the FACE Risk profile if required. If the Face Risk profile remains current this should be recorded by re-dating **every** section of the FACE Risk profile on RiO. If indicated by the risk assessment, ward staff should notify the relevant crisis team of the patients' discharge.

2.2.9 If it is known the patient is to resume contact with children, this should trigger an assessment with medical staff as to whether there are actual or potential risks including delusional beliefs involving children or risks that a child may be harmed as part of a suicide plan. The assessment should draw on as many sources of information as possible, including concordance with treatment. If the on call or ward Doctor is a junior member of staff, they must get advice from a Consultant.

2.2.10 If potential or actual risks are identified staff should follow guidelines on how to refer to local authority children's services including accessing the pathway out of hours.

2.2.11 Staff should also have an awareness of the role of the designated lead for child protection and the process of appropriate information sharing

2.2.12 The requirement for 7 day follow up applies to patients who take their own discharge

2.2.13 Ward staff should offer telephone follow up within 24 hours of the discharge and offer the patient a copy of crisis / risk management plan that

- Details telephone follow up within 24 hours of the discharge
- The arrangements for the patient to return to the ward to collect medication or if the advice to contact their GP
- Local contact numbers and information necessary to access the service if problems occur.
- The arrangements for 7 day face to face follow-up

2.2.14 If the patient refuses a copy this should be recorded on the crisis / risk management plan and in progress notes

2.2.15 Ward staff must complete an IR1 form / and make an entry in the patient record, which should include on it information as to who has been informed, patient's destination (if known) and any risks he/she may present.

2.2.16 The Ward Manager/or on call equivalent should be informed at the earliest opportunity.

2.2.17 Ward staff must inform the locality Community Mental Health Team (CMHT)/ learning disability team, the client's IP Consultant Psychiatrist, the client's GP and any other professionals involved.

2.2.18 Ward staff will also inform relatives / carers with the consent of the patient. However if consent is not given and disclosure is felt to be justified in the public

interest e.g. to protect the patient or someone else from harm then in these circumstances the information shared will always be kept to the minimum necessary.

2.3 Duty Psychiatric Senior House Officer (SHO) / Consultant Psychiatrists

2.3.1 The on call Doctor **and/or** Consultant Psychiatrist should see the patient and ascertain the reasons why they wish to self-discharge and note these reasons in the RiO progress notes.

2.3.2 If the patient declines to stay, the on call doctor **and/or** the patients' Consultant Psychiatrist / Approved Clinician have the discretion to prevent the patient leaving by implementing the Mental Health Act 1983, Mental Capacity Act or Common law as described in section 1.6 above.

2.3.3 If it is known the patient is to resume contact with children, this should trigger an assessment with ward staff as to whether there are actual or potential risks including delusional beliefs involving children or risks a child may be harmed as part of a suicide plan and draw on as many sources of information as possible, including concordance with treatment.

2.3.4 If the on call or ward Doctor is a junior member of staff they must get advice from a Consultant

2.3.5 If potential or actual risks are identified staff should follow guidelines on how to refer to local authority children's services including accessing the pathway out of hours.

2.3.6 Staff should also have an awareness of the role of the designated lead for child protection and the process of appropriate information sharing

2.3.7 An interim discharge summary should be faxed to the GP and should include

- The information surrounding the DAMA / DACA:
- Patients name and date of birth
- Destination (if known)
- Name of the hospital
- Date of admission and date of DAMA / DACA
- Current prescription and medication provided on discharge
- Any relevant risk information and concerns.

2.4 Ward Managers/Unit Managers

2.4.1 Upon receipt of the completed incident form, inform their line manager.

2.4.2 Clarify and seek out any information not stated on the incident form.

2.4.3 Monitor compliance with this procedure.

2.5 Care Coordinator / Lead Professional

2.5.1 The ward staff will notify the patients Care Coordinator / lead professional or the CMHT/ community learning disability team manager of the patients self discharge, the current assessment of risk and with the community member of staff agree the initial care plan to be implemented including 7 day follow up.

2.5.2 The urgency of follow up should be informed by the current risk assessment and must be planned to be Face to Face.

2.5.3 The care coordinator / lead professional will ensure that the initial plan is recorded on RiO. If the care coordinator / lead professional does not have access to Rio they will delegate this to an appropriate member of NTW staff

2.5.4 If no care coordinator / lead professional are in place the CMHT/ learning disability team manager will allocate as a matter of priority.

2.5.5 The Care Coordinator / lead professional must assertively attempt to make contact with the patient to ensure that the necessary community care is identified and/or implemented

2.5.6 The Care Coordinator must formulate / review the patients' Risk Management plan (this may necessitate further contact with staff working on the inpatient ward).

2.5.7 If the patient has left without having had a care coordination meeting / review (if applicable), arrangements must be made by the Care Coordinator to arrange such a meeting.

2.6 Ward Administration / Ward Clerks

2.6.1 The ward administrator / ward clerk will fax through the patients most recent Risk Assessment / Management Plans to Care Coordinators (if not a RiO user), GPs and other agencies and/or persons as specified and requested by ward staff.

3 Service users who leave NTW area on discharge

3.1 If the patient has gone to an address outside the area covered by NTW on a temporary basis then telephone contact can be used for 7 day follow up. However, if indicated by risk assessment, then contact with the appropriate services local to where the patient is residing should be initiated to try and further assess current clinical presentation.

3.1 If the patient has gone to an address outside the area covered by NTW on a permanent basis then telephone contact can be used for 7 day follow up. Contact with the appropriate services local to where the patient is now residing should be initiated to arrange transfer of care.

4 Monitoring

4.1 Ward Managers/Unit Managers to monitor ward nursing compliance with Practice Guidance Note (PGN).

4.2 A random audit to be undertaken of patients discharged against medical advice (DAMA) or discharged against clinical advice (DACA) to ascertain compliance with PGN.

APPENDIX 3

In partnership with

SMSR House 51-52 Market Place Hull HU1 1RQ Tel: 01482 211 200
Fax: 01482 211 201 info@smsr.co.uk www.smsr.co.uk

Formative evaluation of the reablement and winter pressure schemes for NHS South of Tyne and Wear
Evaluation of Sunderland schemes
May 2011

Table of Contents

1 Executive Summary

1.1 Introduction

Douglas Management Consultancy (DMC) and Social and Market Strategic Research (SMSR) Ltd have been commissioned on behalf of NHS South of Tyne and Wear (SoTW) to undertake a formative evaluation of the impact of reablement and winter pressures schemes. Investment was provided in December/January 2011 to existing schemes and new initiatives, funding was provided to NHS provider services and also to local authorities.

1.2 Aim

To provide an independent evaluation of progress to date of three schemes across Sunderland, including an assessment of the evidence presented, detailing key findings of the evaluations. The evaluators were also asked to consider and make recommendations including future investment for these schemes and how delivery of services in relation to these schemes can be enhanced.

1.3 Background

Funding for the schemes is from allocations to PCTs of the additional £70 million available during 2010/11 from the Department of Health for post-discharge support. In addition non-recurring winter pressures monies were made available from South Tyneside PCT and Sunderland Teaching PCT.

The reablement schemes implemented across SoTW focus on increasing and enhancing established services, for example additional reablement services focused on hospital discharge and therapists working alongside reablement staff, as well as piloting new services, such as ambulatory care pathways within Accident and Emergency.

The evaluators have reached their conclusions following an assessment of available higher level system data, interviewing a range of service provider staff and also a sample of service user and carer's feedback to assess the system impacts.

The key findings and recommendations of this report were presented to the Long Term Conditions/Urgent Care Commissioning group on Monday 9 May; the group has endorsed the main recommendations as contained in this report.

1.4 Methodology

There were three main elements of the methodology that underpinned the evaluation of each of the reablement schemes; these were:

- Staff interviews

- Service user involvement
- Data analysis including a self assessment undertaken by each scheme and a high level review of key metrics

A detailed description of the methodology to undertake this evaluation is detailed in Appendix 1.

1.5 Investment

Total investment to date for staffing across the Sunderland region is £228,623.

Planned and actual recruitment is as follows:

Proposal Requirement	Additional Comments
5.74 WTE Occupational therapists	The majority of posts have been filled using agency or seconded staff. Where staff have been seconded, their role has often been filled using agency staff adding at least 20% to employment costs. Not all posts have been filled and or have been in post for a limited period only.
4.74 WTE Physiotherapists	
3.74 WTE Rehabilitation Assistants	
1.87 WTE Discharge Nurse	
1.00 wte Nursing assistant	
Reablement at Home Team (numbers of staff not identified)	
Community Equipment Out of Hours (member of staff on-call)	

The evaluation team also assessed the following scheme:

Proposal Requirement
Overnight Service Telecare: additional van (£25,000)

1.6 Output and Activity

For those schemes that commenced operations in January/February 2011 activity has grown during the audited period. For many of the schemes, training and education has played a major role in developing the services and promoting effective practice, be that identifying appropriate referrals to empowering and educating patients and staff in reablement and treatment delivery.

For all schemes assessed patient and staff feedback has been very positive and timeliness and quality of services has been enhanced with this investment.

Not all schemes are operating at full capacity, but already there are impressive claims of reduced admissions and facilitated discharges with associated patient and financial benefits (see individual schemes for detailed output and activity data). Despite this, the impact on reablement high level metrics for the region is unclear

and for some schemes, questions exist as to whether the investment has been directed as efficiently as possible.

1.6.1 Reablement High Level Metrics

High level metrics relating to reablement have been collated by NHS SoTW Business Information department around a number of areas including (see Appendix 2):

- Emergency admissions
- Length of stay (LoS)
- Excess bed days

Data has been provided for the six month period commencing October 2010 and equivalent data for the years 2009 and 2008 for comparison.

Emergency Admissions: When comparing the 2010/11 emergency data for City Hospitals Sunderland NHS Foundation Trust with that of 2008/09 and 2009/10, there is an average decrease over the six month period of 0.48% (comparing the six months for 2010/11 to 2008/09) and 3.37% (2010/11 to 2009/10). Month on month both increases and decreases can be seen and it is too early to say what impact the investment in these services may or may not have had on emergency activity. In addition, this investment is just part of a much wider area of work relating to emergency care and any reduction could equally be attributable to other initiatives, in part or whole.

Number of emergency Admissions: 0 to 1 day's length of stay: For the six month period investigated, City Hospitals Sunderland NHS Foundation Trust recorded an increase of 7.02% (when comparing the six months for 2010/11 to 2008/09) and also an increase of 5.95%, (2010/11 to 2009/10). In the three months prior to Jan 2011 i.e. before investment in the reviewed schemes was implemented, two out of three months saw decreases in lengths of stay. This would indicate that the schemes assessed have failed to have any significant impact on reducing lengths of stay of less than one day, however, it is likely that this when assessed most of the schemes were at a an early stage of implementation and require more time to begin to make an impact.

Number of emergency Admissions: greater than 1 day's length of stay: For the six month period investigated City Hospitals Sunderland NHS Foundation Trust recorded an increase in emergency admissions of 0 plus 1 days' length of stay. When comparing the 2010/11 emergency data with that of 2008/09 and 2009/10, there is an average increase over the six month period of 7.55% and 9.64% respectively. It is difficult to assess why these numbers have increased and will require further investigation.

Excess Bed Days: For the six month period investigated, City Hospitals Sunderland NHS Foundation Trust recorded significant decreases in excess bed days compared to the same period in 2009/10 and 2008/09. There is an average reduction over the six month period of 36.94% (comparing the six months for 2010/11 to 2008/09) and 16.84% (2010/11 to 2009/10). Whilst the collated data demonstrated reductions in excess bed day, this has not been proven to have resulted from these investments.

Overall, few conclusions can be drawn from the high level metrics regarding the specific impact the investments in these schemes have had to date. In some cases the high level data is potentially contradicting what is being reported from individual scheme impact. A more informed picture is likely to be drawn given a further three to six months operation of these schemes, but to clearly ascertain the impact of these individual or specific services will require more detailed assessment.

1.7 Findings

Overall patient and service user satisfaction with the services provided is high. In addition, the evaluators have been particularly impressed by the enthusiasm of all the staff who were interviewed regarding the benefits that investments have brought in enhancing and improving these services. Of the services evaluated each and every service manager feels that there is a need for these services to continue.

The investment in each of the evaluated services has resulted in substantial numbers of patients being managed and remaining at home or in intermediate care beds.

From the data presented (in the service self-evaluation reports and feedback undertaken by managers) it has been difficult to assess how many patients would have required admission to hospital or resulted in speedier discharge if these services had not been provided with further investment. However, although difficult to quantify, expansion of schemes appears to have made an impact. For example, the Rapid Response and Early Supported Discharge scheme (KF4) has made a difference in providing the support to avoid admissions to hospital and discharge patients more quickly; the Reablement at Home scheme (KL1) appears to have accepted low numbers of referrals, however, therapy staff have spent a significant amount of time and effort in training reablement staff to understand more about reablement and rehabilitation which has led to service users being more independent

The impact, and therefore benefit of some individual schemes and roles is questioned. For example:

- **Out of Hours Access to Community Equipment (KL5):** It is claimed that activity during out of hours has increased, however, there is no indication that the numbers of larger pieces of equipment (the investment was intended to have two staff on duty out of hours to manage heavy pieces of equipment) needing to be transported to service users homes has increased.

- **Overnight homecare support for A&E** (KL9): From the information provided regarding the investment into van transport and with only one additional nightly visit per week during the audited period, the very limited increase in demand does not justify the continued support of the service.

- **Nursing Assistant support to Farmborough Court (KL10):** It is questioned if this post has delivered any significant impact in improving patient's nutritional state, preventing falls or avoided admissions to hospital.

Some services have not been fully implemented (staff are still being recruited). For those that have recruited, many have been appointed through agencies; this is understandable as service managers moved quickly to appoint staff and implement services, however, this has led to increased staffing costs for staff introduced into these services by at least 20%.

There is a wide range of services, several of which overlap and offer similar support and functions, which can be confusing for service users and staff. The evaluators certainly struggled to understand how services link together and there is a lack of coordination in referral pathways. Of those interviewed, some staff commented that communication, whilst in most cases is good, could still be further enhanced between some services, especially health care providers and local authorities.

During the pilot period, many services have not accepted direct GP or patient referrals, but plan to roll this out in the future. As a result, the disparate nature of service provision will potentially make efficient patient pathway navigation for GPs, health professionals and patients more difficult and inefficient.

1.8 Conclusion

For all schemes reviewed patient and staff satisfaction has been extremely positive.

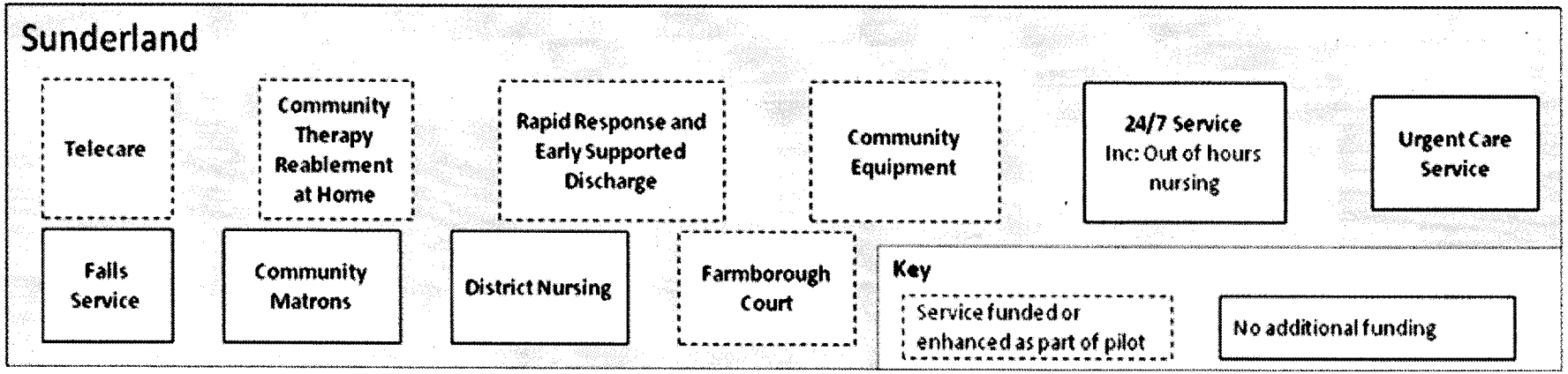
Staff reported being excited to have been involved with service development of this kind and spoke of the benefits the extra investment has brought for patients and also improvements to staff moral and working conditions, for example reduced overtime. A number of agency employed staff were enthusiastic regarding the prospect of substantive positions becoming available. The speed in which these schemes were developed understandably resulted in agency staff being recruited and secondments being utilised. Despite the increased employment costs this resulted in the rapid development of services.

When viewed in isolation each scheme is viewed as having a positive impact for patients. In expanding or establishing new services many of the schemes accepted referrals from a limited number of sources, as part of the planned development and roll out managers now plan to open up other referral routes in particular from GPs. This is a logical step and progression, but when viewed as part of the wider

intermediate and reablement services this is likely to create confusion. To provide an indication of how complex service provision currently is, figure 1 demonstrates the number of different teams and services available in Sunderland that the evaluation team were made aware of. Unless clear referral pathways are developed confusion, duplication of work and inefficiency is likely.

It is understandable in the timeframe why schemes were invested in as they were, but there is now opportunity to review and revise the overall structure of intermediate and reablement care across Sunderland, merging services and resources as appropriate.

Figure 1: Teams and Services



1.9 Recommendations[1]

- Assess the feasibility of a single point of access/referral for services in Sunderland TPCT.
- Undertake the process mapping of services and consider if the number of teams can be integrated and the overall number reduced.
- Consider links between services, especially social workers working with hospital teams.
- There is the need for most of the schemes that were evaluated to improve patient pathways and fully integrate teams, leading to more effective delivery of services and achieving economies of scale.
- Develop and implement referral protocols if they do not exist.
- Provide better information for GPs, secondary care providers and patients/service users by developing a service directory
- Reduce the number of locums/agency staff.
- Develop a specific intermediate care and rehabilitation/reablement strategy.
- Consider a communications strategy to raise awareness of services, especially for GPs.

[1] **Note**: findings and recommendations specific to the schemes being evaluated are contained in the individual reports. Appendices contain copies of data and documents including service self- evaluation reports and service users' feedback. A more detailed evaluation of service user feedback will be provided.

2 KL1: Reablement at home team

2.1 Project Aim

The aim of the scheme is to prevent hospital admissions by improving facilitation of hospital discharges.

2.2 Scheme Overview

This is an existing local authority service with additional capacity provided, which has allowed direct referrals from the Rapid Response (Interface Team) since 2011. The team also accepts referrals from the community, hospital social work team and Farmborough Court.

The therapy staff appointed to the posts have been working with reablement co-coordinators in Sunderland to assess and screen reablement referrals. Therapists see 90% of referrals other than service users with palliative care needs who are seen by other teams, for example the community team. Therapists also coordinate visits to service users with reablement staff.

Therapy staff have met with home care reablement staff to review service users goals, identifying people that need reablement and also clarifying differences between reablement and rehabilitation.

The majority of service users referred and seen have been discharged home from hospital where their needs were not been identified and have only become apparent when at home. It was reported that when in hospital ward staff can refer to both teams, the hospital social work team and the reablement team and often refer do so, and the quickest responder accepts the patient. Reablement staff now identify service users to the therapists.

This scheme has helped in encouraging service users to be more independent-majority of people want their independence back.

Part of the investment has been utilised to devolve training packages to all reablement staff including home and community based staff; this has focused on reablement and how it works.

The majority of people seen who have been discharged home from hospital where their needs have not been identified, which have only become apparent when home.

The local authority Intermediate Care service operates in parallel to the reablement team. The local authority has reorganised the management structure so reablement and intermediate care is now under one management structure and reablement and intermediate care is delivered as a 'joined up' service.

2.3 Investment

Total investment to date is £149,000

Planned and actual recruitment is as follows:

Proposal Requirement	Posts Recruited to and Additional Comments
2.00 wte occupational therapists	Full time locums recruited through agency
1.00 physiotherapist	Full time locum recruited through agency
Reablement team	Numbers recruited not identified

2.4 Output and Activity

In the period January to March there were:

- 60 occupational therapy assessments
- 27 Disabled Facilities grants awarded.
- 40 referrals to the team
- Referrals were from the Community, Hospital Social Work Team, Rapid Response (Interface Team) and Farmborough Court
- Lengths of intervention: from a minimum of three days to a maximum of six weeks
- Of the 40 referrals, the number of patients still at home: 34 with six onward referrals to Independent Sector

2.5 Findings

2.5.1 Key benefits delivered by the additional resource

- The team is seen as community resource for reablement services.
- The introduction of therapists in working with and providing support, education and advice to reablement staff has reduced the need and reliance on equipment for service users.
- A reduction in the need and reliance on reablement staff (i.e. more independent service users) for service users through the education and empowerment of reablement staff members.

2.5.2 Key outcomes of the enhanced service

- Of the 40 patients referred to the service, 34 (85%) were able to remain at home.

- Training (numbers not identified) delivered by therapy staff has enabled reablement staff to understand and clarify the differences between reablement and rehabilitation and how this affects care of service users.

2.5.3 Links to other services

- Referrals are received form from Community, City Hospitals Sunderland social work team, the Interface team and Farmborough Court.

- The team also has links into and works with the Community Equipment team, Community Stroke team, Care managers, social workers, district nurses and community matrons.

2.5.4 Observations

- The training of reablement staff has greatly increased the knowledge and awareness of reablement staff.

- An element of the investment has been used to devolve training packages to all reablement staff, to home and community based staff.

- This scheme has helped to encourage service users to be more independent.

- Training has been delivered to reablement staff by therapists, empowering staff to manage care plans and have greater input into patients care plan.

- It is claimed that this service prevents admissions and readmissions to hospital, reduces lengths of stay and delays and the needs for long term care including residential care. No data was presented to confirm these outcomes.

- There are increased and improved integrated working arrangements; the reablement and the local authority intermediate care service are now under one management structure.

- Links with other services are generally good and well established, however, the link with City Hospitals Sunderland's Interface team are unclear.

- For the investment provided, the number of referrals to the team appears to be low. However, it also appears that a significant amount of time and effort

has been invested in training reablement staff to understand more about reablement and rehabilitation. Benefits of the training have been difficult to quantify.

- This scheme has helped in encouraging service users to be more independent: staff have spoken about supporting people to become independent instead of the emphasis on dependence.

2.6 Conclusion

Therapy support is enhancing the quality of the service to patients; one of the key benefits has been the focus on patients becoming more independent rather than dependent on services.

The total number of referrals to this service to date (over three months) seems low (40), however, this does not account for the time that therapy staff have invested in the general training and education of reablement staff in assessing and meeting service users needs, for example developing more robust care plans.

The focus appears to be on staff working to encourage service users' independence rather than dependence on others and services.

2.7 Recommendations

- That investment continues until 31 March 2012 with ongoing evaluation and review in another six months.

- Explore how services can work more effectively together including further integration of the Interface, Intermediate care and reablement teams.

3 KL4: Rapid Response and Early Supported discharge

3.1 Project Aim

To prevent hospital admissions by improving facilitation of hospital discharges

3.2 Scheme Overview

This is referred to as the Interface team. It provides rapid assessment and intervention for patients attending A&E, AMU, the Walk in Centre and ward C36 at City Hospitals Sunderland, who are deemed medically fit and not requiring admission.

It provides assessment and intervention to support discharge within City Hospitals Sunderland to patients who do not require acute medical care but may have short term care or therapy needs to enable them to return home.

Original hours of operation were from 1000 to 2200 hours, seven days a week, the hours of working have been extended from 0800 to 2000 hours to meet service demands.

The Interface team accepts referrals directly from staff and also the hospital's Discharge Liaison team. There is direct access from the Interface team into the Sunderland Reablement services team.

The team has also introduced a range of systems, processes and assessment tools including a communications and handover policy, a screening tool to avoid inappropriate referrals, a falls screening tool and also an on site equipment store.

3.3 Investment

Total investment to date is £72,000

Planned and actual recruitment is as follows:

Proposal Requirement	Posts Recruited to and Additional Comments
3.74 WTE Band 6 Occupational therapist	Recruited to including locums
3.74 WTE x Band 6 Physiotherapist	Recruited to including locums
3.74 WTE x Band 4 Rehab Assistants	Recruited to including locums and seconded staff.
1.87 WTE Band 7 Discharge Nurse	Recruited.

3.4 Output and Activity

In the period January to May (13 weeks) there were:

- Total number of referrals: 727
- The average weekly number of referrals :56
- A&E referrals to the team:82
- AMU referrals: 216
- 24/7 referrals:9
- Walk in Centre: 114
- Ward C36: 97

3.5 Findings

3.5.1 Key benefits delivered by the additional resource

- Timely assessment and intervention to support discharge within City Hospitals Sunderland to patients who do not require acute medical care but may have short term care or therapy needs to enable them to return home.
- Rapid assessment and intervention for patients referred to the Interface team aimed at preventing admission and supporting discharge.
- Facilitate discharge and prevent unnecessary admission to secondary care.
- Minimise likelihood of re-attendance at A&E and facilitate continued maintenance in the community.
- Rapid access to Reablement at Home Services.

3.5.2 Key outcomes of the enhanced service

- Of the 727 referrals 278 (38%) patients were seen and discharged from the Interface Team within one day.
- Of the 727 referrals 278 (41%) patients were discharged home.
- Of the 216 referrals from AMU 62 (28%) were discharged home.
- Of the 82 referrals from A&E 51 (62%) were discharged home.

- Of the 114 referrals from the Walk in Centre 67 (58%) were discharged home.
- Upon discharge reablement was used 35 times.
- It was reported that over 50% patients are seen within two hours of referral.

3.5.3 Links to other services

- Key links are to Sunderland Local Authority, the Community Equipment Store, the Reablement and Intermediate Care teams.

3.5.4 Observations

- This service appears to have made an impact in the numbers of patients it has been able to manage and discharge home.
- Staff feedback on the impact of the investment including ease of referral and facilitation of discharge arrangements has been very positive.
- There is no social worker linked to the Interface team and it not clear how the Interface team and social work staff liaise or work together.
- The pathway needs to be clarified, it was reported that it can be confusing for ward staff.
- The access to services to discharge patients home or into the community at the earliest opportunity has improved; however there is a the need to look at how GPs use the services and not admit patients and that services still need to be more 'joined up'.
- The evaluators note that the hospital has its' own discharge liaison team from which the Interface team accepts referrals; it is not clear what the differences in roles are between the two teams; there may well be a replication of interventions being undertaken by the teams.
- There appears to be problems referring patients out of area where reablement services are less developed, for example patients from the Durham area.

3.6 Conclusion

This initial evaluation indicates that the introduction of extra staff appears to have made an impact in providing the support to avoid admissions to hospital and discharge patients more quickly.

3.7 Recommendations

- That investment continues until 31 March 2012.
- The pathway needs to be clarified; apparently it is confusing for some staff.
- Explore how the Discharge Liaison and Interface teams can work more closely together including integrating the two teams.
- There is a need for multi agency clarity, collaboration and unity in developing a whole system approach in avoiding unplanned unnecessary hospital admissions and maximising opportunities for timely transfer and discharge.
- The links with hospital based social services staff needs to be clarified.
- Explore how 'out of area' services can be accesses more easily, for example Durham Reablement Services.

4 KL5 Out of Hours Access to Community Equipment

4.1 Project Aim

Provide funding for two members of staff to move large items of equipment out of hours.

4.2 Scheme Overview

The current out of hour's service currently has one member of staff on call to deliver equipment. However, large pieces of equipment require two members of staff for delivery.

The investment is to ensure a second member of staff is on call if large equipment needs are identified and need to be transported.

4.3 Investment

Total investment to date is: £5,000

Proposal Requirement	Posts Recruited to and Additional Comments
1.00 member of staff (on call)	

4.4 Output and Activity

The service (Jan – April 2011):

- Received 31 prescriptions from the Interface Team for equipment
- 13 prescriptions from the Minor Injuries Unit
- 165 prescriptions from district nurses:
- Resulting in the delivery of 234 pieces of equipment out of hours

4.5 Findings

4.5.1 Key benefits delivered by the additional resource

- Out of hours, equipment is able to be delivered more quickly to a service user
- Improve and maintain the health and safety of staff.

4.5.2 Key outcomes of the enhanced service

- The outputs (4.4.) suggest that these were the total numbers of equipment delivered out of hours; there is no indication of how many large pieces of equipment required two members of staff to transport them.

- It is claimed that activity during out of hours has increased, however there is no indication that the numbers of larger pieces of equipment needing to be transported to service users' homes has increased.

4.5.3 Observations

- During the review process, no one was available from the local authority to be interviewed. As a result the data provided has not been verified as to whether this includes additional activity or the total out of hour's activity.

4.6 Conclusion

It is unclear what benefits have been provided by this investment. The self assessment undertaken by local authority staff has recommended that funding to support this enhanced out of hours support be absorbed into mainstream funding.

4.7 Recommendations

- Funding for this extra overnight support is discontinued, but the service still continue, absorbed into main stream funding, as recommended by the self assessment.

- If demand for the overall service continues to increase, to consider if additional funding needs to be made available in the future.

5 KL9 Overnight homecare support for A&E

5.1 Project Aim

Sunderland City Council Overnight Telecare Service: to provide additional staff to deliver overnight homecare for patients being discharged from Accident and Emergency (A&E).

5.2 Scheme Overview

This is part of the wider Sunderland City Council Overnight Telecare Service which delivers a range of services including:

- Emergency call buttons/alert service
- Sensors for movement, falls, lights, front/back door, incontinence etc for dementia, incontinence and pts at high risk of falls
- Telehealth: monitors patients with long term conditions and; alerts community matrons and other services as required
- Collects equipment for storage and decontamination

The investment has been used to provide out of hours transport for patients from A&E to their homes.

5.3 Investment

Total investment to date is £25,000

Proposal Requirement
Overnight Service Telecare: additional van

5.4 Output and Activity

During the three month audited period commencing January 2011 seven referrals were received, of which, five were accepted. These referrals created an additional 17 nightly visits.

5.5 Findings

5.5.1 Key benefits delivered by the additional resource

- It was suggested that this investment has provided additional capacity for the existing service

5.5.2 Key outcomes of the enhanced service

- Over the 12 week period, the use of the extra service appears to be very limited (five patients).

5.5.3 Links to other services

- Not indicated.

5.5.4 Observations

- It is reported anecdotally that the demand for the wider Telecare service in Sunderland has been steadily increasing over the past number of years, with a particularly steep increase seen in the last six weeks. The increase in the last six weeks may be coincidental but positively correlates with the wider investment in reablement services.

- The self assessment undertaken by local authority staff has recommended that funding to support this enhanced out of hours support be absorbed into mainstream funding.

5.6 Conclusion

From the information provided regarding the investment in transport, the increase in demand does not appear to have resulted in sufficient activity to justify the continued support of the service with only one additional nightly visit per week during the audited period.

With investment in wider reablement services and the potential correlation between this and increased demand for core Telehealth services, additional funding for Telehealth may be justified, if not for this particular scheme.

5.7 Recommendations

- Funding for this pilot is discontinued but the service still continue, absorbed into main stream funding, as recommended by the self assessment.

- If demand for the overall service continues to increase, to consider if additional funding needs to be made available in the future.

6 KL10: Nursing Assistant support to Farmborough Court

6.1 Project Aim

To enhance the nurse support in post at Farmborough Court to evaluate and enhance patient care

6.2 Scheme Overview

Farmborough Court is an Intermediate Care residential home. A nursing assistant (via an agency) has been appointed (1 March 2011) to support clinical observations and undertakes basic nursing tasks that reablement staff are unable to perform. The nursing assistant also provides falls prevention and nutrition support.

There is a nurse specialist who visits Farmborough Court and a band 6 nurse practitioner who is based at Farmborough Court and supervises the nursing assistant.

6.3 Investment

Total investment to date is £2,623

Planned and actual recruitment is as follows:

Proposal Requirement	Posts Recruited to and Additional Comments
1.00 wte Band 3 Nursing assistant	Full time locum recruited through agency

6.4 Output and Activity

The nursing assistant undertakes a range of nursing duties (trained and supervised by the nurse practitioner). These include the following observations and assessments: TPR, oxygen sats, height and weight recording, falls and nutritional risk assessments and also pressure ulcer risk assessments.

Data provided was is enclosed (Appendix 6, attachment 1, page 3)

6.5 Findings

6.5.1 Key benefits delivered by the additional resource

- It is claimed that the key benefit of this post is an improvement in the delivery of nursing care.

6.5.2 Key outcomes of the enhanced service

- It is suggested that this post will in the future help to reduce the number of hospital admissions from Farmborough Court; there is no evidence to indicate this to date.

- The data (Appendix 6, attachment 1, page 3) demonstrates is that the number of tasks including base line observations and risk assessments have increased, however, these do not indicate an improvement in the quality of care, nor are they indicators of improved outcomes.

6.5.3 Links to other services

- The key links is with the Reablement and Intermediate care teams.

6.5.4 Observations

- There are good links with other services including Reablement.

- It is claimed that the introduction of this post has improved the health and wellbeing of patients through changing the model of care; however, there is no evidence to date to support this.

- It is to be questioned if this post has delivered any significant impact in improving patient's nutritional state, preventing falls or avoided admissions to hospital.

6.6 Conclusion

Anecdotally it is claimed that this post has led to an improvement in the quality of nursing care delivered. However, one interviewee questioned if this post has delivered any significant impact in improving patient's nutritional state, preventing falls or avoided admissions to hospital; the evaluation team concurs and cannot see that there has been any significant impact resulting from this additional support. This post does not appear to offer value for money.

6.7 Recommendations

It is recommended that this scheme is further evaluated by the end of August and a decision made by the end of September whether to continue; outcomes of the inputs need to be the focus of the evaluation.

7 Appendices

7.1 Appendix 1: Methodology

NHS SoTW
Reablement Evaluatic

7.2 Appendix 2: Reablement High Level Metrics

AN_High_Level_Rea
blement_Metrics_xlsx

8 Appendix 3: KL1: Reablement at home team

KL1 Reablement at
Home Sunderlalnd.do

9 Appendix 4: KL4: Rapid response and Early Supported Discharge

KL4 Interface Team
Evaluation Sunderlan

KL4 Interface
Sunderland Outputs.(

KL4 Interface
Sunderland questionr

KL4 Sunderland
Interface comms.doc

10 Appendix 5: KL5 Access to Community Equipment

KL5 Sunderland
Equipment.doc

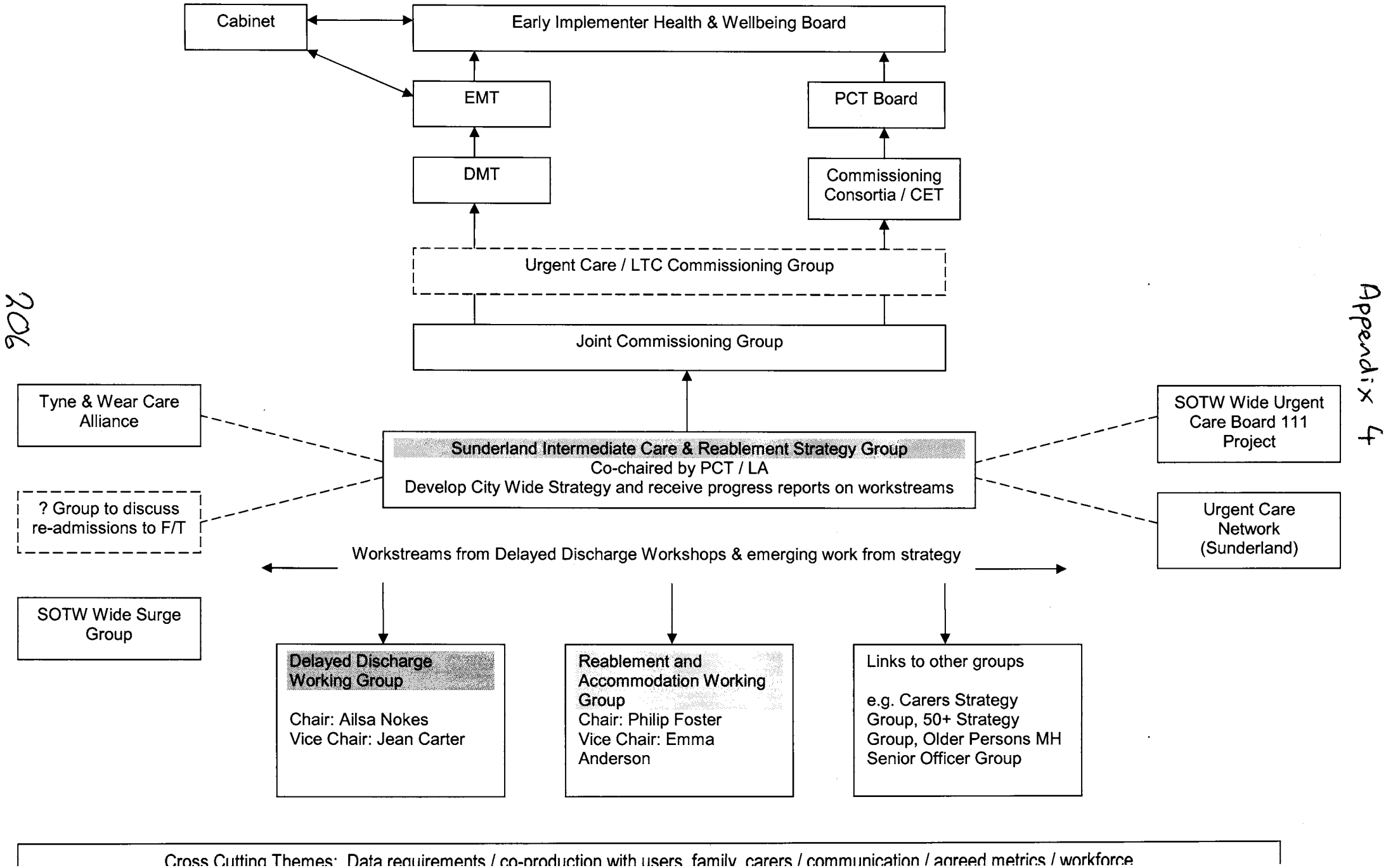
11 Appendix 6: KL9 Overnight homecare support for A&E

KL9 Overnight homecare support St

12 Appendix 7: KL10: Nursing Assistant support to Farmborough Court

KL10 Farnborough Court.doc

KL10 Farnborough Court Action plan.doc



206

Appendix 4

APPENDIX 5

Agenda Item 2

Working Group	**Sunderland Intermediate Care and Reablement Strategy Group (SIC&RSG)**
Working Group Number	1.1
Working Group Chair Co-Chair	Jean Carter (LA) Deputy Chief Executive Director HHAS Ailsa Nokes (PCT) Commissioning Lead LTCs
Reports to:	PCT / LA Joint Commissioning Group
Phase	1
Date	05 August 2011
Version	4
Working Group Members	Membership: Graham King - Head of Strategic Commissioning (LA) *Rotating membership from following LA Heads of Service:* Philip Foster - Head of Care & Support Pippa Corner - Head of Personalisation Alan Caddick - Head of Strategic Housing Wendy Kaiser – Commissioning Lead Mental Health (NHS SOTW) Ian Paterson (tbc) – Chair (CCG) Mark Smith (tbc) – Chief Operating Officer (CHS) Brent Kilmurray (tbc) – Commercial Director (SOTW CHS) Tim Docking – Director (NTW) Patient/User representative – TBC Third Sector/Community Organisations Rep - TBC

Terms of Reference / Aims of the group

Aims :

The Sunderland Intermediate Care & Reablement Strategy Group has been set up to provide senior leadership and strategic overview for the development and implementation of a Joint Intermediate Care and Reablement Strategy between the PCT / CCG and LA.

The group will also ensure organisational engagement and support for the recently announced Sunderland Overview and Scrutiny Committee (OSC) review '*to establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings*'.

The Strategy Group will also undertake and oversee actions required and identified by the Delayed Discharge Project undertaken from February to June 2011, as implementation of these actions will contribute to the successful implementation of the Sunderland Intermediate Care and Reablement Strategy. The Delayed Discharge Project actions have been delegated to the following new Working Groups:

1.2 Delayed Discharge Working Group

1.3 Reablement & Accommodation Working Group

Key Tasks include:

- Develop vision and strategy for Intermediate Care and Reablement in Sunderland
- Agree a future service model which facilitates joint working and integration where this will provide enhanced outcomes for individuals and their carers
- Develop an outcomes framework and performance metrics for evaluating the effectiveness and impact of current and future service delivery on the 'whole system' across health and social care
- Agree objectives and set deliverables for sub-groups in line with strategy and future service model, and monitor progress of sub-groups towards these
- Make recommendations to NHS and LA Commissioners regarding future redesign, investment or disinvestment in services as appropriate
- Ensure that any developments in Intermediate Care and Reablement are based on best practice and the opportunities for shared learning across the regional and nationally are maximised

Scope

The intention is to develop a draft strategy by the end of October 2011, which will then be available for wider consultation and engagement with all stakeholders.

The following actions arose from the Delayed Discharge Project and have been allocated to the Strategy Group as they are felt to be essential to development and implementation of the Strategy and require senior management leadership.

Number 2
Problem - No clear strategy and model for reablement.
Action
2.1 Develop strategy document and vision for intermediate care and reablement
2.2 Review impact of current reablement schemes/pilots. Consider impact on delayed discharges.
2.3 Outline preferred model for intermediate care and reablement.

Number 5
Problem – Lack of joint working leading to fragmentation of service delivery and confusion for professionals, individuals and carers
Action
5.1 Develop compact for working collaboratively to facilitate patient pathways across statutory and non-statutory sectors

Number 6
Problem – No common set of outcome metrics for whole system
Action

6.1 Agree standard set of performance and outcome metrics for all providers of 'intermediate care and reablement'

Number 11
Problem - 'Time to think', concept and model not clarified
Action
11.1 Clarify what we mean by 'time to think' beds ? Consider opportunity to support individuals to be discharged for 'Time to Think' at home rather then bed based solution

Number 14
Problem – Under use of beds at Farmbrough Court
Actions
14.1 Review need for intermediate care beds (both residential and nursing).
14.2 Compare to models elsewhere.
14.3 Develop model for Sunderland and consider opportunity for use of vacant beds at Farmbrough Court

Number 15
Problem – Need for increased access to psycho geriatrician and RMN input at City Hospitals.
Action
15.1 Enhance Mental Health Liaison service

Number 22
Problem - Care navigator/advocate required to support individuals with complex needs through their journey, especially on admission to hospital.
Action
22. 1 Explore role of dementia advisor (non professional) to undertake this role (consider needs of other client groups, could this be generic, could current services be re-designed to provide this role)

Number 23
Problem – lack of awareness and understanding amongst public re dementia
Action
23.1 Increase public awareness including early identification to signpost to Memory Protection Service or GP

Number 24
Problem – Lack of awareness and understanding amongst professionals re dementia.
Actions
24.1 Increase professional awareness, including identification to signpost to Memory Protection Service, not just health and social care but wider services eg fire brigade.
24.2 Education of care home staff re dementia and general wellness and wellbeing.

Number 25
Problem – Need to increase uptake of support for carers of people with dementia to prevent crisis.
Action
25.1 Extend the development of emergency carers plans.

Resources and outline estimates of time for Actions

The responsibility for the Sunderland Intermediate Care and Reablement Strategy Project Work will be divided between NHS SOTW and Sunderland LA.

The people involved in collating information, validating information, reviewing the information or providing the information are the Sunderland Intermediate Care and Reablement Strategy Group, and are identified and listed above.

The deadline for completion of the Draft Sunderland Intermediate Care and Reablement Strategy is October 2011.

ICT

Consideration needs to be given to

- Data Requirements of the group
- Current ICT provision and whether updated hardware/software requirements may be necessary when implementing required actions

Stakeholder and Partner Involvement

The following partners will be involved at every stage, through involvement within Working Groups, and also through their membership on the overarching Sunderland Intermediate Care and Reablement Strategy Group.

- NHS South of Tyne and Wear / Sunderland Clinical Commissioning Group
- Sunderland Health Housing and Adult Services
- South of Tyne and Wear Community Health Services
- Northumberland, Tyne and Wear Mental Health Trust
- City Hospitals Sunderland

Mechanisms will be established to involve and engage with the Third Sector and service users and carers in this work.

Each Working Group to identify any stakeholders that need to be aware of the work of the Group, and confirm lines of communication.

Links to other working groups and interdependencies

The Intermediate Care and Reablement Strategy Group has a direct reporting relationship to the PCT / LA Joint Commissioning Group. It received monthly reports from the following:

- Reablement & Accommodation Working Group
- Delayed Discharge Working Group

It is also interdependent with the following groups:

- South of Tyne and Wear Surge Group
- Sunderland Urgent Care Network

- Sunderland Older Peoples Mental Health Senior Officer Group
- Sunderland Carers Partnership
- Sunderland 50+ Strategy Group

Proposed Meeting Dates

The Intermediate Care and Reablement Strategy Group will meet monthly starting :

- 1st September
- Future dates (TBC)

APPENDIX 6

Attachment 3

directors of adass
adult social services north east

Briefing

To: North East ADASS

Date: 21st July 2011

Title of Briefing: Regional Priorities for the development of reablement services

Issue

1. Development of North East regional priorities and a programme of work for reablement services.

Background

2. The concept of reablement was established at the end of the 1990's and between 2005 and 2010 there was significant growth in the number of reablement services available in the UK.

3. Announcements of new policy direction and the new funding arrangements, made at the end of 2010 and the start of 2011, mean that most reablement service development is now in the context of a jointly planned and funded local reablement service that joins together 'homecare' reablement, therapy, community equipment and telecare and firmly positions reablement as an option within the intermediate care pathway [1]

4. Additional funding is going to the NHS between 2010/11 and 2012/13 for re-ablement and post-discharge support.

5. Marion Usher (SHA) presented a report to NE ADASS on 12 May 2011, summarising the key points of the North East CSED Reablement report and identified 3 key priorities for each local authority and their partners to consider in the development of reablement services.

   - Has the authority got a clear vision for and definition of reablement, jointly agreed with partners?
   - Is there a clear business case, based on accurate performance data?
   - How and where are GP commissioners involved in these discussions?

[1] North West Joint Improvement Programme – History of Reablement referenced

6. The purpose of this report is to develop each of these priorities and a subsequent programme of work for reablement services in the North East.

Priority 1- Definition of Homecare Reablement and link with intermediate care and rehabilitation.

7. There are many definitions of reablement, details of which can be found on the CSED website. In the North East, the Regional Excellence in Reablement Project[2] described the Kings Fund definition as 'A process of aiming to restore personal autonomy in those aspects of daily living considered most relevant by patients or service users and their family carers.

8. Until the revision of the Annual Operating Plan in 2010, the DH described reablement in general as, time limited home care services provided by the local authority. However, the AOP and subsequent guidance on the use of the funds allocated to the NHS have tended to use a wider definition of reablement, which has caused some confusion about that service, intermediate care and rehabilitation.

9. Payment by results guidance[3] defines these separate elements as

   - **Homecare re-ablement** – primarily social care services to help people with poor physical or mental health accommodate their illness by learning or re-learning the skills necessary for daily living and regaining or maintaining their independence.
   - **Intermediate care** - time-limited, residential or community based services, in community hospitals or other settings, designed to help people make a faster and more complete recovery from illness.
   - **Rehabilitation** - medical treatment to help restore physical functioning following a hospital admission or procedure. Examples may include physiotherapy following orthopaedic surgery or speech and language therapy following a stroke.

10. Unsurprisingly there is still scope for confusion and duplication within these parameters, which would be eliminated should a common language on reablement be agreed. However, it is considered by the regional reablment group that gaining regional agreement of a definition will prove difficult and unnecessary due to the complexities of individual LA approaches to reablement provision.

11. Most LAs are already working towards an agreed definition with their partners but currently there is little indication of when this will be achieved across the region. Some LAs have taken additional steps to achieve this. For example, in SOTW the LAs are working with the PCT to develop their reablement strategies or to focus upon specific reablement tasks through the employment of project managers.

12. As part of this work a draft definition of reablement has been agreed in Sunderland and South Tyneside and the same is planned with Gateshead in the

[2] North East Improvement and Efficiency Partnership. Reablement For All Final Report http://www.northeastiep.gov.uk/North%20East%20Councils/Reablement%20For%20All%20Final%20Report.pdf
[3] DH Payments by results guidance 2011-12. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126157.pdf

near future. LAs, the PCT and a Foundation Trust have all contributed to specific reablement posts (or part posts) to take work forward in that region.

- In Sunderland a Project Manager has been recruited through the SWITCH team (LA funded) to develop a reablement strategy

- South Tyneside have appointed a Project Manager post and Project Support post, to develop the reablement strategy part time and the dementia strategy part time. This post is funded by the PCT but not through reablement funding

- In Gateshead the Foundation Trust have appointed a post to work on reducing readmissions and the PCT and LA are hoping to use some of this postholder`s time for reablement , as the issues are linked. If so, reablement monies will be used to fund half the post.

- Hartlepool and Stockton are also considering a similar approach of funding specific project workers through reablement funding.

13. Based upon the apparent complexities the NE reablement group recommend that each authority, with their partners, review and amend their definitions in the light of their own service provision and the definitions previously referred to.

14. A decision is needed from DASS as to whether they feel this approach sufficiently meets their needs.

Priority 2 – a clear Business Case, based on accurate performance data.

Strategic Outcomes

15. A clear Business case cannot be produced until accurate performance data are agreed. This is a complex process, particularly since measures now need to go across health and social care- all PCTs are now engaged in this work, as they require performance monitoring for the local reablement plans.

16. The regional reablement group has examined the NHS, social care and public health strategic outcomes and have recommended the following are included as strategic outcomes for reablement. (Note that although the outcomes are similar, the wording for the NHS and social care is slightly different, so both are included):

    - Helping people recover from episodes of ill health and following injury (NHS framework)
    - Ensuring people have a positive experience of care (NHS)
    - Preventing deterioration, delay, dependency and supporting recovery(social care framework)
    - Ensuring a positive experience of care and support (social care framework)

17. Each authority may wish to add to these outcomes, but the group`s intention is to limit the volume of outcomes and metrics which are agreed across the NE.

Measures / Targets

18. In its published toolkit[4], CSED identifies a series of suggested performance measures, which it describes as the method of identifying how well a homecare reablement service is doing, by applying tangible targets by which its performance can be measured

19. The performance measures should clearly meet the requirements of the business case for reablement, and should include a baseline of the following measures:

- Service Outcomes
- Intake Volumes
- Average Weeks Duration
- Staff Contact Hours
- Source of Intake
- Staff Measures
- Cost
- Service User Feedback

20. The Social Care Policy Unit study and CSED found that home care reablement is cost effective in relation to health related quality of life outcomes and may also be cost effective in relation to social care outcomes.

21. The studies found that there was a reduction in the overall need for services and the ongoing need for services.

22. Performance measures therefore need to reflect unit costs, costs of intervention and the impact on other health and social care interventions, and a comparative example outside of reablement services, and should therefore be included in the performance management framework.

Performance/data set

23. In November 2010 the zero based review was launched which was a joint programme of work between the DH, NHS Information Centre, ADASS, LGG and CQC. This single data set will include all data which would be required at a national level and nothing would be requested outside of the data set although local authorities are able to collect their own data should they want to. The single data set will be based in the ASC Outcomes Framework.

24. In April 2011 a draft version of the zero based review was shared with the national ADASS Standards and Performance Network, which had a list of 95 data collections included in it. This has now been reduced to approximately 56 although this is not a final list. 7 of the original 95 data collections referred to reablement but only 2 remain in the current list of 56.

25. A gap analysis was completed of the draft data set and this showed that further work needed to be completed in the following policy areas:

- Reablement

[4]Establishing an effective performance management system to track and measure the service http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/PM/

- Personalisation
- Prevention
- Safeguarding

26. Workstreams are being set up to look at each of these policy areas in terms of what is already collected by local authorities and what new data would need to be collected in the future, which should then be included in the single data set. However, if a new data collection is required LAs are given an 18 month notice period which they are informed of in September. This partly explains the 3 year period for completion of the zero based review.

27. This leaves us in a position that we know there will be national data collection around reablement in the future but this may not be until 2014 /15. In the meantime, PCTS and local authorities need to agree joint indicators to monitor their reablement plans. North of Tyne (including the PCT) have taken the first steps in doing this by developing a number of indicators which they shared with the Reablement group.

28. The regional Reablement group recommends the initial adoption of five of these performance measures (using NoT descriptions) that combine the agreed North of Tyne indicators and the two measures reablement measures currently included in the zero based review. Individual authorities may want to include additional performance measures, but these measures would be used as a minimum.

Measure	North of Tyne	Zero based Review (not confirmed)
1	Number of people provided with a reablement package (increasing trajectory)	
2	Percentage of reablement goals (user/patient perspective) being met by the end of a reablement episode/package	
3	Number of people who received an intermediate care or reablement package on discharge from hospital who remain at home 91 days post discharge (NI125)	Three month follow up of reablement clients - Percentage still at home (versus died, in hospital, residential, other)
4	Percentage of people who have no ongoing long term care needs following provision of a reablement package	Percentage of reablement clients who required no ongoing support
5	Percentage of people whose need for home care intervention has reduced through provision of a reablement package	

29. The regional Reablement Board also suggest that if these measures are to be agreed then further work would need to be completed to develop and apply a

common methodology for each performance measure to ensure consistency in approach. If this is not done then any results will be limited in value due to the possible variance in data collection.

30. The NoT cluster is currently working on developing the metrics and denominators to measure the outcomes in the table above. Once agreed they will be shared with the reablement group to ensure that consistency in data collection is achieved.

Financial performance measures

31. At the ADASS branch meeting in May it was considered that a financial cost for reablement and how this linked to achieving cash efficiencies was an important measure to be collected. However, the reablement board believes that collecting this data on a regional scale will produce inaccurate comparisons and benchmarking (locally and nationally) due to the differences in provision (this links back to having a definition for reablement). On this basis they believe that a data collection of this kind would not bring any value.

32. In 2009 /10 the RIEP 'Reablement for All' project identified a national average cost for reablement (six weeks) of £1,963 and a regional breakeven cost of £2,500. The report also showed that if each episode of reablement could be achieved for between £1050 – £1200 (per person) then this translated into significant predicted savings for North East LAs. Should ADASS want a financial outcome to be included in the regional reablment measures they will need to decide what form this will take.

33. In relation to the outcomes of reablement services on other services provided by the local authority, and the issue of an aging population, the group recommends that reference is made to this in the Joint Strategic Needs Assessments, and the possible impacts on the prevention agenda and how reablement services will impact upon level of demand for residential care placements.

34. The Reablement Group also recommends that any NE resource also analyses performance outcomes and impacts on other services. This could include analysis of data from POPPI which could be used to build a picture of future demand for residential care so the impact of reablement could be measured against this in the future, taking into account the impact other service provision also makes. They concluded that the analysis would need to be done locally, but that a format could possibly be developed across the NE initially.

Evaluation of current reablement services

35. SOTW have also taken the approach of using reablement monies to independently evaluate their reablement and winter pressure schemes. A presentation was given to the reablement board at the July meeting which was well received although there was a feeling that the evaluation had given to much emphasis to health rather than social care. There was also an acknowledgement that the evaluation was performed at the early stages of implementation of schemes which had yet to bed in or produce significant results.

36. Despite these restrictions it was felt that the evaluations had delivered insight into areas of strength and opportunities for further development. They had also

set parameters for planning of reablement services in the next two years with future funding.

37. On this basis it was considered that an evaluation of this kind would be essential for all areas to complete. This could contain an element of regional evaluation (based upon agreed outcome measures) and local detail broken down into cluster areas. This evaluation would need to have a social care emphasis and include the potential impact of reablement on the demographic challenges of the future.

Priority 3- involving Clinical Commissioning Consortia and Partners

38. Each local authority and PCT need to consider and agree how best to include Clinical Commissioning Consortia and Partners in discussions about reablement. Progress is at very different stages across the region in terms of involving CCC. Those LAs who have signed off their plans for this years reablement money, or are close to doing so, have involved or will involve Consortia. However, this is not the case across the region with limited progress is some areas.

39. Reablement involves many other Partners other than CCC and the reablement group believe that it would be a valuable exercise to hold workshops in PCT cluster areas to promote and raise awareness of reablement services and wider issues of independent living.

40. The reablement group therefore recommends use of NE ADASS funding to hold workshops in PCT cluster areas to promote and raise the awareness of reablement services and wider issues of independent living. These should look to invite CCC as well as other Partners to be identified locally.

Recommendations:

41. The reablement board have proposed several options for a future regional work programme. NE ADASS are asked to consider each of the following recommendations:

- Each Local Authority, with their partners, to review and amend their definitions of reablement in light of their local strategies. *Are DASS happy with this approach?*

- DASS to agree the minimum of 5 regional performance measures for assessing reablement service outcomes

- DASS to decide if additional indicators are to be included to link to cash efficiencies and what indicators these should be.

- To independently evaluate reablement services across the region and each LA via reablement or ADASS funding. To include element of measurement or reablement success against demographic pressure. *DASS to decide if evaluation is needed and where it should be funded from?*

- To use ADASS funding to hold workshops in PCT cluster areas to promote and raise the awareness of reablement services and wider issues of independent living.

HEALTH HOUSING AND ADULT SERVICES

Completed by
NAME:Janette Oliver
TITLE:Intermediate Care & Reablement Co-ordinator

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by City Hospital Sunderland and/or LA Health Housing and Adult Services and / or NTW
Social Work Teams	Initial Advice & Assessment Teams/Complex Teams The IAAT consist of five geographically operational teams of Social Work and Care Managers who provide assessment functionality for customers within the community and who are in hospital and residential based services. Complex services; include specialist teams of Social Work and Care Managers whose customers present with a Learning Disability, Mental Health, Drug & Alcohol or Physical Disability and who require complex care planning. The hospital Social Work Team consists of Social Workers and Care Managers who are sited on CHS site and whose primary function is to support hospital discharge both from within CHS and out of City Hospitals.	Initial Advice and Complex Social Work Teams These teams are both geographically and strategically placed within the community to support customers in their own homes; they also have a pivotal role in supporting patients who are in hospital who are already known to them on admission or who are referred due to their complex presentation. For example; if a customer is admitted to hospital and has current active Social Work or Care Management involvement in their care; which requires a co-ordinated approach to their assessment due inherent physical or mental health complexities. Social Workers and Care managers will retain involvement and recommend provision of services to promote a safe discharge. They will formulate plans (as per Hospital Social Work Team remit) in conjunction with CHS professionals; patient and carer. Where the Hospital Social Work Team has identified complex needs; referrals will be sent out to the community teams for example; this could include assessment for those patients who require high levels of enduring care provision who may require complex care planning; re-housing i.e. to extra care, or have residential and nursing care requirements.
Reablement Services	**Reablement Services** The Reablement at Home Service provides vulnerable older people & their carers with high quality personal care, assistance, rehabilitation and basic health support; following an assessment of need by Care Managers; helping them to live as independently as possible at home through: o Supporting people who are discharged home from hospital o Supporting people at home to prevent unnecessary admissions into hospital or long-term care o A period of assessment of people's needs	There are currently 15 geographically based teams within the community who operate a reablement at home service. Staff have been trained to promote independence and wellbeing. Referrals are predominately from CHS and received from the Hospital Social Work Team, Therapies Interface Team and Care of the Elderly Occupational Therapists. Community Based Social Work and Therapies also refer into the scheme. include all new customers has been introduced as part of the preventative agenda. Whilst the remit of the teams is to promote customer centered goals and encourage independent activity; the service also ensures that a timely discharge from CHS remains a primary focus and facilitates a transitional period whilst customers are pass-ported onto care packages for those who present with enduring care needs. Reablement services can also operate alongside existing care providers (both formal and informal) both to support the cared for and carer(s). The customer's care requirements are co-ordinated by Social Work and Care Managers and are supported by community based therapies.

216

APPENDIX 7

South of Tyne and Wear Community Health Services

Completed by
NAME: Lesley Bainbridge
TITLE: Senior Nurse Business Manager – Intermediate Care

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by City Hospital Sunderland and/or LA Health Housing and Adult Services
Intermediate Care Team	A 24/7 365 team working across the whole of Sunderland offering an open access referral system meaning that patients and their families can refer directly along with all staff in other health and social care providers as well as those in private and voluntary agencies. Initially a nursing team over the past 18 months we have, through modernisation and service improvements changed our team structure to incorporate physiotherapy staff also and this has been positively evaluated through clinical audit and patient experience reports/stories. We embrace the clinical evidence and the direction of the NHS Institute for Innovation and Improvement [2006] confirming that intermediate care can be successful providing it is built upon a comprehensive assessment and individual care planning. Thus, we have embedded into our team a comprehensive assessment tool based on the daily living activities of our patient's and any family carers. Our clinical audit evaluation informs us that this tool prompts us to successfully identify and manage underlying health problems as well as seek the involvement of others such as therapy staff. Our philosophy therefore is to maximise independence through improving health and wellbeing.	We interface with City Hospitals Sunderland in the following ways: • Accepting patients for IV antibiotic administration from A&E predominantly but also some wards. Originally for cellulitis this is now for other conditions not really part of the service specification • Support with personal care during periods of post discharge recovery [small numbers as small amount of capacity] • Physiotherapists interface with other therapists sharing knowledge and skills We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Have a dedicated social worker in our team who is employed by them • Referring our patients for their services especially OT which is a gap in our team • Interfacing in forums such as the Urgent Care Network and others
Galleries Day Unit	A 5 day service providing group and one to one rehabilitation sessions as well as nursing services such as ambulatory BP clinics. Again, an open access referral but the majority is from GPs and community teams. We use the same comprehensive assessment document as our team above and have the same philosophy therefore of maximising independence through the promotion of health and wellbeing.	We interface with City Hospitals Sunderland in the following ways: • Accepting referrals for ongoing rehabilitiaon needs particularly from ENT for patients who need vestibular rehabilitation which is a service we're just developing on the back of our falls work • Physiotherapists interface with other therapists sharing knowledge and skills We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Refer for their services especially OT which is a gap in our team
HELP Team [Healthy Exercise & Lifestyle Programme]	The aim of the HELP Team is to address inequalities in health care, disease management and treatment, enhancing quality of life. The Sunderland Exercise on Referral scheme offers patients the opportunity to participate in activity programme giving them the support they need to make long term lifestyle changes which improve their health. They provide a range of rehabilitation and exercise programmes including those linked to the obesity, CHD and cardiopulmonary care pathways.	We interface with City Hospitals Sunderland and with LA Health, Housing and Adult Services in Sunderland given the obesity pathway includes e.g. dieticians from secondary care and exercise practitioners from the Wellness staff of the LA. The LA manage all referrals into the service and provide the service to patients with low and moderate risk while HELP provide the service to those with the highest risks.
Nurse Specialist Older People	There has been nursing input into Farmborough Court	We interface with City Hospitals Sunderland and with LA Health, Housing and Adult Services in Sunderland given the centre is LA led and they

and Nurse Practitioner Farmborough Court	for a number of years and with the growing needs of patients it has been necessary to develop this service further to provide more proactive care hence we now have a nurse specialist for older people and through the reablement money are piloting a nursing assistant post.	pay for one of the nursing posts and in terms of secondary care the nurses liaise with hospital staff particularly the geriatricians for medical advice and sometimes rapid access clinic appointments. Two years ago we led in the pilot of geriatrician ward rounds which was very successful in moving from a reactive to a proactive model of care. It is a gap that this isn't a substantive part of the Farmborough Court service.
Falls Nurse Specialist / Coordinator	Coordinates the falls pathway across Sunderland, works to reduce the risk of falls to prevent the number of people falling and to reduce the number of serious injuries sustained by those who have fallen. Runs nurse led clinics, provides education for a range of health and social care staff focusing particularly on care homes for 2011/12.	We interface with City Hospitals Sunderland in the following ways: • Vice chair of the Sunderland Falls Strategy Group the chair being Dr Andy Davies • Accept referrals into our falls services at Galleries Day Unit • Have previously supported the development of their falls e-learning training package We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Refer for their services especially OT which is a gap in our team • Accept referrals from any of their staff • Provide education and training to care homes
Community Matrons	Provide care to patients with very complex needs who are high intensity users of a range of services. Due to the nature of their individual conditions several consultants/teams/services can be involved in the patient's care and the CM acts as the key worker to ensure care plans are active and realistic changing as the chronic disease progresses and needs alter. T	We interface with City Hospitals Sunderland in the following ways: • Seeking to work collaboratively with hospital staff especially the discharge team to ensure that patients are only admitted if necessary and have the shortest length of stay possible t • Support nurse education by sharing knowledge and skills e.g. at discharge nurse training events • Visiting their patients when in hospital to share understanding of individual's home situation and optimum level of wellbeing We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Referring our patients for Telehealth and Telecare • Refer for their services especially OT which is a gap in our team • Accept referrals from any of their staff
Urgent Care Team	Provides care to patients with acute illness, injury or exacerbation of a long term condition and delivers initial assessment, diagnosis and patient management making a differential diagnosis. The team cares for all patients throughout Sunderland including those who live in care homes as well as their own homes. This team works more to prevent admissions than facilitate discharges.	We interface with City Hospitals Sunderland in the following ways: • Using diagnostic services • Liaison when unavoidably admitting patients • Accepting NEAS diverted referrals We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Providing care in care homes and Farmborough Court • Accept referrals from any of their staff
District Nursing Services	Provides care to housebound patents. Patients can be housebound due to a short term illness/episode or can be housebound due to a complex illness or disease.	We interface with City Hospitals Sunderland in the following ways: • Working collaboratively with ward staff to support discharge planning especially coordination linked to timeliest discharges including attendance at MDT meetings We interface with LA Health, Housing and Adult Services in Sunderland in the following ways: • Referring our patients for Telehealth and Telecare • Accept referrals from any of their staff
Funded Care Team	NHS (National Health Service) Continuing Healthcare relates to the health needs of an individual set against strict Department of Health (DH) Eligibility Criteria to access health funding for care. The Funded Care Team is made up of experienced registered nurses who co-ordinate multi-disciplinary assessments to determine the health needs of an individual and apply the eligibility criteria for "NHS	Hospitals - all departments/wards who can refer regarding Fast Track referrals for End of Life care Discharge Nurses All LA HH&AS (Care Managers refer and attend multi disciplinary Team Meetings) Learning Disability Integrated Team Broadway House (LA and NTW) Safeguarding Adults Team (LA) Palliative Care St Benedict's (multi disciplinary)

	Continuing Healthcare" The focus is on information retrieval from health records such as GP records, hospital reports, district nurses and social work assessments. The information is then discussed with invited multi-disciplinary team (MDT) members and the patient and/or a representative. The health needs are agreed and the MDT applies the eligibility criteria. The outcome is then recorded on a 40 page DH document known as "The Decision Support Tool" which is a DH summary document the funding decision is then communicated to the patient or their representative. Each patient is reviewed at 12 weeks and annually thereafter"	

Reablement – Occupational Therapy, Independent Living Team; Wheelchair services, Sensory Services and Rehabilitation Therapies	Professional teams of Social Work, Occupational Therapists, Physiotherapists and Assistants; facilitate therapeutic interventions to support customers who have a functional difficulty due to long term conditions and or recent injury and trauma. Provision includes, therapeutic intervention; advice and practical assistance via equipment and or alterations	4.1 There are currently 3 geographically operational teams of Community Occupational Therapy Services; and one Indpendent Living Team. These teams operate primarily to support customers to live within their own home environments; providing advice, assistance and practical solutions to identified needs; for example the provision of equipment and alterations. However; Occupational Therapists have distinct role in liaising directly with therapy colleagues within CHS and out of city hospitals; to promote a safe discharge home for those customers who have a complex presentation and who require the provision of practical solutions in order that they can be discharged home. 4.2 Wheelchair Services therapists are funded directly by health and operate routinely within a customers own home to ensure; those with complex mobility requirements are provided with a wheelchair to enhance independence or provide carers with a means of transporting the cared for. The team also links directly to CHS and out of city hospitals for those customers who require a wheelchair solution to facilitate a hospital discharge. 4.3 Sensory Social Work team operate a functionality similar to social work colleagues in Initial Advice and Assessment/Complex team. However they specialize in support services for those customers who present with a sensory impairment. Services include a rehabilitative element of intervention which can be implemented within a home environment or can support someone on discharge from CHS. 4.4 The Rehabilitation Therapies Team is currently based with Farmborough Court Intermediate Care Centre but operates on a city wide basis to facilitate a service both for those customers who require support on discharge from CHS or out of city hospitals and or in a preventative home based service. The team interacts closely with CHS to ensure a smooth transition on discharge both to the Intermediate Care Centre and directly home. The team supports customers who are admitted to the Centre by implementing rehabilitation interventions and transferring these interventions to the customers own home. They will also ensure all equipment and alterations required are implement to support a full recovery. The Team is also currently supporting referrals from the Interface Team based at CHS to the reablement at home teams; both in terms of staff training and education but also directly working with customers who are home based and receiving reablement at home services.
Sunderland Telecare	Sunderland Telecare provides over 22,000 vulnerable people and their carers across Sunderland with 'touch of a button access' to year round, 24/7, care and support services within their own homes. The service also offers a overnight planned home care service.	
Community & Equipment Services	**Community and Equipment Services** The Community and Equipment Service is a jointly funded partnership between Sunderland City Council and the South of Tyne and Wear Primary Care Trust. It supplies and fits equipment and minor adaptations to enable children and adults with disabilities to live at home. The equipment loaned is designed to promote personal independence, safety and mobility and is also supplied to the health and social care practitioners to	CES operates a supply and fitting service for equipment. The equipment provided is for both short and long term loan and is currently accessed by 'prescribers' who have the competence to assess and prescribe equipment to meet the need of the customer. Primarily customers are based within their own homes or are in a bed based service with the aim of returning to their own home in the community. CES provides a large amount of equipment required to support hospital discharge and also provides equipment necessary to promote patient recovery whilst an inpatient at CHS and Intermediate Care bed based services. Prescribers consist of professionals from a wide health and social care base and includes staff from the teams above as well as health colleagues based both in CHS, Primary Care and out of city hospitals.

	help in the course of their work in the community.	
Community Opportunities Resource Agency (CORA)	CORA arranges packages of social care with providers following an assessment of an individual's needs, on behalf of Service Users and their Care Managers. The **Community Opportunities Resource Agency**: • Provides people with a tailored social care package • Arranges care packages based on accurate up to date knowledge and provide a fast response for service users • Aids the commissioning of social care provision from the independent sector • Minimises the time spent by care managers in looking for packages of care and making best use of care management resources following an assessment • Signposts people to appropriate non-commissioned social care providers • Provides up to date intelligence on the availability of services • Researches available resources across Sunderland to extend choice for people • Informs the procurement of services to better respond to need in Sunderland • Helps with the monitoring of services to ensure quality for individuals •	
Home Improvement Agency (Including handyperson services)	**Home Improvement Agency (Including handyperson services)** The Home Improvement Agency aims to enable those in need of support to maintain their independence in their chosen home for the foreseeable future. This will be achieved by supporting people throughout the repair, adaptation or improvement process, so that individuals are able to remain in their own home, in a warm safe and secure environment. The service provides:- • Disabled Facilities Grants (DFG's) and adaptations • Housing Assistance (practical and financial advice)	

	• Handypersons and Minor Alterations Service • Energy Efficiency Advice and Signposting General Advice and Signposting in relation to practical tasks that support people to live independently.	
Extra Care	**Extra Care Schemes** Extra care enables people to live in their own homes independently with access to tailored care and support to meet the needs of the individual, and gives access to other social health and well being opportunities. It gives older people their own self contained home, with legal rights to occupy. Most schemes offer a choice of tenure which provides housing solutions for people with different kinds of incomes. The schemes developed in Sunderland offer rented; part rent and part buy or outright sale options. The ability to have care available over a 24 hour period, based upon assessed individual need promotes independent living. Care and Support supports older people living in the following Extra Care Schemes:- o Beckwith Mews, Silksworth o Woodridge Gardens, Washington o Bramble Hollow, Hetton	
Farmbrough Intermediate Care Centre	**Farmborough Intermediate Care Centre** Farmborough Intermediate Care Centre puts older people (65 years and over) and their carers at the heart of the heart of the rehabilitation process, which maximises their independence and quality of life. Intermediate Care is the term used to describe a range of services provided in the community to help older people to: • Recover from illness and trauma • Have a timely hospital discharge • Remain independent and living at home wherever possible	The Intermediate Care Centre is a partnership service which has 52 beds and is funded via a pooled health and social care budget. The centre primarily receives referrals from CHS in order to support timely hospital discharge. The centre works closely with the Discharge Nursing Team who prioritise referrals for admission to the centre. The service criteria; includes adults over the age of 65 who are medically stable but require further recovery time and or time for further assessment of need. The Centre operates two elements of care; reablement and rehabilitation and has a specialist unit for those presenting with dementia type illness. Placements operate between 2-6 weeks dependent upon need. The Centre is supported by a GP, Nurse Practitioner; Registered Mental Health Nurse and Therapies Team. Whilst referrals are primarily from CHS to promote discharge; in order to operate a prevention to hospital strategy; referrals are also received from primary care and social work teams. Social Work and Care Managers co-ordinate a supported discharge home, where therapies are involved there is also a transitional rehabilitation programme back into the community.
Palliative Care Team	To provide a specialist social work service to patients diagnosed with a terminal illness and work with our health colleagues to provide an integrated and responsive service at a extremely sensitive time.	
Community Mental Health Team	To provide social work input into an integrated team with Health partners that specialises in working with people with severe dementia in order to keep them living in the community as long as possible.	
Day Services	In Sunderland there are a range of facilities offering day opportunities and day care for people over the age of	

	65. Some of these facilities are provided by local organisations charitable and voluntary agencies or community groups. Some are provided in partnership with Sunderland City Council. People have different levels of need and similarly these services cater for differing levels of need. Some day opportunities can be accessed directly within the community or by contacting agencies such as Age Concern. Sunderland City Council helps to locate day opportunities through signposting. Day Services fall into three broad categories:- • Day Opportunities • Day Care • Luncheon Clubs	
Independent Sector	**Home Care** is part of a range of services which may be provided following an assessment of need under the 'Fair Access To Care Criteria'. The assessment would determine the person's level of need (eligible need) and the service required to meet the need. A Home Care package may be provided to meet a persons 'eligible needs'. This could include help within a persons own home with personal care, including bathing, toileting, dressing and general help with personal hygiene. It may also be to assist with getting up in a morning and going to bed in the evening. The care package would be arranged by the council and provided by one of the Independent Care Agencies with whom Sunderland City Council contract. The care package would be monitored by the Care Manager and reviewed when it is put in place, then either annually or every six months. Health, Housing and Adult Services can also help in 'signposting' someone to arrange services themselves if they do not qualify for services under the 'Fair access to Care Criteria'	
	Care Homes/Residential Care Care Homes (residential or nursing care) provide 24 hour support and accommodation for older people who following their assessment of need under the 'Fair Access to Care Criteria' need support to manage the risks associated with their eligible needs. There are 56 Care Homes across the city and the Council has contractual arrangements in place with	
	Direct Payments Direct payments are made by councils to people receiving social care services, instead of the council	

225

	providing the service directly. The council provides a direct payment to the individual's bank account. Sunderland City Council provides direct payments to people who are assessed as needing help from social services and who would like to pay for their own care. A person must be able to give their consent to receiving direct payments and be able to mange them even if they need help to do this on a day-to-day basis. The council is required to offer the direct payments to individuals based on their personal circumstances and the amount provided is based on the outcome from their assessment. Individuals can apply for Direct Payments through their social worker. Applications are assessed and managed through the Self Directed Support Team.	

You may also wish to identify any gaps in service below

City Hospitals Sunderland

Completed by
NAME: Ailsa Nokes
TITLE: QIPP Reform Lead

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by SOTW Community Health Services and/or LA Health Housing and Adult Services and / or NTW
Rapid Response and Early Supported Discharge	This is referred to as the Interface team. It provides rapid assessment and intervention for patients attending A&E, AMU, the Walk in Centre and ward C36 at City Hospitals Sunderland, who are deemed medically fit and not requiring admission. It provides assessment and intervention to support discharge within City Hospitals Sunderland to patients who do not require acute medical care but may have short term care or therapy needs to enable them to return home. Original hours of operation were from 1000 to 2200 hours, 7 days a week, the hours of working have been extended from 0800 to 2000 hours to meet service demands. The team has also introduced a range of systems, processes and assessment tools including a communications and handover policy, a screening tool to avoid inappropriate referrals, a falls screening tool and also an on site equipment store.	The team works closely with the Hospital Discharge Team, Reablement Team and 24/7 Team, and has plans to include a case manager and community nurse as part of the team in 11/12.
Community Stroke Team	The aim of this service is to deliver high quality, therapy led, community based specialist rehabilitation for newly diagnosed stroke survivors, facilitating ESD, reflecting evidence based outcomes, and maximising opportunities for care at home. The team provide multi-disciplinary coordinated specialist stroke rehabilitation, advice, social and emotional support to people who have experienced a stroke and their carers, offering support during the transition from hospital to home and beyond. The service operates 7 days a week.	The team is interdependent with inpatient services and an integral part of the stroke rehabilitation pathway. The team is expected to facilitate a seamless transition between hospital and the community by developing strong links with inpatient stroke services. In addition, the team is interdependent with longer term reablement and support services for stroke survivors both within the local authority and third sector. It is expected that there is regular communication with these services and that clear pathways are established.
Hospital Discharge Liason Team	This team is based at City Hospitals Sunderland. The main aim of the team is ensure that hospital staff, carers and relatives are supported in planning the discharge of patients with complex health and/or social needs whilst ensuring that those patients with simple needs are discharged in a timely way to facilitate patient flow. The team members attend a variety of multi-disciplinary	The team work closely with a range of hospital and community based health and social care professionals to ensure that patients are discharged safely and that the risk of readmission is minimized and that the move from hospital to community is as seamless as the patients condition allows.

	meetings and assist in identifying the safest and most streamlined hospital exit route for the patient. They link in with fellow health and social care teams to discuss issues and identify solutions to facilitate discharge from the acute hospital setting. They team liase with intermediate care colleagues to ensure that existing services are appropriately utilized. They also work with colleagues across the health and social spectrum to develop future services to meet the needs of the population. The team identify potential delayed discharges on a daily basis and liaise with the link social worker to move plans forward. They collect reportable Sitrep data on a weekly basis to measure performance standards. The team provides on the job education and reinforces local and national polices in relation to discharge. There is an allocated discharge sister for each specialty The service operates 5 days a week form 08.30 until 1700.	

228

You may also wish to identify any gaps in service below

Mental health/ substance abuse prevention of admission and facilitated early discharge

Northumberland, Tyne and Wear NHS Foundation Trust

Completed by
NAME: Russell Patton
TITLE: Group Director Urgent Care

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by City Hospital Sunderland and/or LA Health Housing and Adult Services
Sunderland Self Harm /A&E Liaison Service	To provide specialist mental health input into acute settings to enable the development of appropriate care plans and treatment plans that will support holistic interventions NTW has recently obtained additional funding that will result in the expansion of the liaison service to incorporate t he needs of other client groups i.e. Old Age Psychiatry. This service model is currently being developed	This service is based within City Hospitals Sunderland. The merits of this service are that specific mental health presentations can be addressed and therefore contribute towards the treatment and discharge process. The liaison Service is due for expansion to incorporate a broader client group (older people)
Farmborough Court	Farmborough Court is a large modern, 2-storey purpose built care home, which provides a base for a range of intermediate care services for older people who need convalescence or a rehabilitative stay. There are 4 distinct units within the building that provide up to 54 places for older people, some of whom may also have mental health and physical needs. Access to dementia care element of the service is via referral from all Health and Social Care Professionals. This element of the service is aimed at those older people who have features of dementia, who require support with mental well being and/ or practical support to enable them to live within the community as independently as possible. NTW provide 2 Band 6 RMN - The aim of this service is to enable older people with dementia to continue to live at home as independently as possible. The focus will be rehabilitation, recovery, supporting well-being and identifying care needs.	The intermediate service is provided in partnership with Sunderland Teaching Primary Care Trust, Northumberland, Tyne and Wear NHS Foundation Trust and Sunderland City Hospitals NHS Foundation Trust. The service has strong links with City Hospitals Sunderland with a focus upon • Recover from illness and trauma • Avoid unnecessary admissions to hospital • Avoid a timely hospital discharge • Remain independent and living at home wherever possible

229

Age UK Sunderland- Hospital Discharge Service

Completed by
NAME: Karen Copeland
TITLE: Independent Living Manager

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by City Hospital Sunderland and/or LA Health Housing and Adult Services and / or NTW
Hospital Discharge Scheme	Some years ago we identified that most older people discharged from hospital did not have a care plan in place and went home without any support and often to a home with no one else in it and were often quickly re-admitted to Hospital. We now provide a free service for people over 60, who are being discharged from hospital living in the Sunderland area who do not have a formal care package to support their arrival home and start the reablement process. Through the service we are quickly able to assess if further interventions are needed and make a referral to prevent unnecessary re-admissions to Hospital	We receive referrals from the city hospital wards, hospital social work team, interface team, day care units and adult's services – reablement team. We work alongside the City Hospitals discharge team in the Discharge Lounge.

You may also wish to identify any gaps in service below

Although we are well established and have been working effectively for some years we are just starting to work with the new reablement team gaining referrals to support their work.

About one year ago we met with the business manager and matron, completed a presentation to staff at the Sunderland Eye Infirmary and set up a confidential NHS system to receive referrals. Sadly, we have had no referrals but we intend to address the situation again with the Eye Infirmary as patients are missing out on the support we offer.

We are aware that we handle few referrals from the Q.E. Hospital, Gateshead of patients who live in Washington and this is a gap that needs to be filled.

However, we are getting an increasing number of referrals on a daily basis and visiting more clients than we have previously. We have built up very positive relationships with hospital wards and different departments within the city hospital. Co-ordinators and support staff are extremely busy and are at full capacity on most days. We can easily expand the service but to do so we would require more staff hours to meet the extra demand.

Stroke Service – Sunderland Family Care Support Service
Completed by
NAME: Brenda Walker
TITLE: Information, Advice and Support Co-ordinator

Service name	Brief overview of service	Brief overview of how this service interlinks with services currently provided by City Hospital Sunderland and/or LA Health Housing and Adult Services and / or NTW
Sunderland Information, Advice and Support Service.	The Family Care support Service is a Home visiting service that gives practical information and emotional support to people who have had strokes, their families and carers. The Co-ordinator visit the Stroke Unit twice a week to introduce the service to clients and their families and also give information packs. Referrals also collected from the unit and Community Stroke Team. The Family and Carer Support Service is designed to provide information, emotional support and practical advice to people affected by stroke, their families and carers. Our staff work alongside a multidisciplinary team of professionals across health and social care to provide information and advocacy support for stroke survivors and their families as they work towards regaining independence. The service delivers: • Timely and appropriate information and advice relating to stroke • Support with discharge planning and/or transfer of care • Practical and emotional support for stroke survivors • Access to well-established carer support groups • Liaison and joint working with other key agencies to meet family needs • Stroke prevention advice aimed at encouraging lifestyle changes • Access to The Stroke Association's welfare grants • Access to other Stroke Association rehabilitation and support services • Signposting to ongoing support from relevant providers of care During hospital stay stroke survivors have access to on-call help and care, however after discharge they have to adjust suddenly to the impact of stroke and changes to their life at home. They require community-based rehabilitation support to ease their move from hospital back into the community. Early access to rehabilitation	**Good working relationship with both the Ward Staff and Community Stroke Team based at Sunderland Royal Hospital.** **Liaise with the clients GPs.** **Referrals are made to and from the Community Stroke Team.** **Referrals made to Adult Social Services for various assessments.** **Local Housing Department contacted on behalf of clients to support re-housing applications.** **Clients signposted on to all of the above if necessary.** **The Family Care Support Service also works alongside Other Stroke Association Services including Community Integration, and Communication Support services. The tree service area working together support stroke patients from Discharge into long term life after stroke support, these services are support and funded by the SOTW PCT, apart from the Community Integration which is supported by the PCT but joint funded by the NECVN and Sunderland Council**

231

	can restore movement, improve recovery and reduce delayed discharges. The Family Care Support service has been funded this year by both the PCT, and the LA through thier Grant Scheme	

You may also wish to identify any gaps in service below

Availability to access the computerized system to be able to obtain client information without involving ward staff. It would be very beneficial if Co-ordinators could have clearance from the Trust.

232

APPENDIX 8

NHS

NHS South of Tyne and Wear

serving Gateshead Primary Care Trust, South Tyneside Primary Care Trust and Sunderland Teaching Primary Care Trust

Sunderland Multi Agency Hospital Discharge Process Rapid Process Improvement Workshop

Workshop Delegate Feedback Pack

15th - 18th March 2010

Working together to make South of Tyne and Wear healthy for you

Contents

Thank You!

The thoughts, ideas and actions of the RPIW group are enclosed within this feedback document. The Commissioning and Reform Service Improvement Team would like to take this opportunity to thank everyone for their contribution, enthusiasm and innovation.

Contacts

If you have any queries or information relating to this document please contact:

Ailsa Nokes
Head of Service Improvement & Reform
Ailsa.nokes@sotw.nhs.uk
0191 529 7035

Helen Turnbull
Pathway Development Manager
helen.turnbull@sotw.nhs.uk
0191 529 7321

Introduction

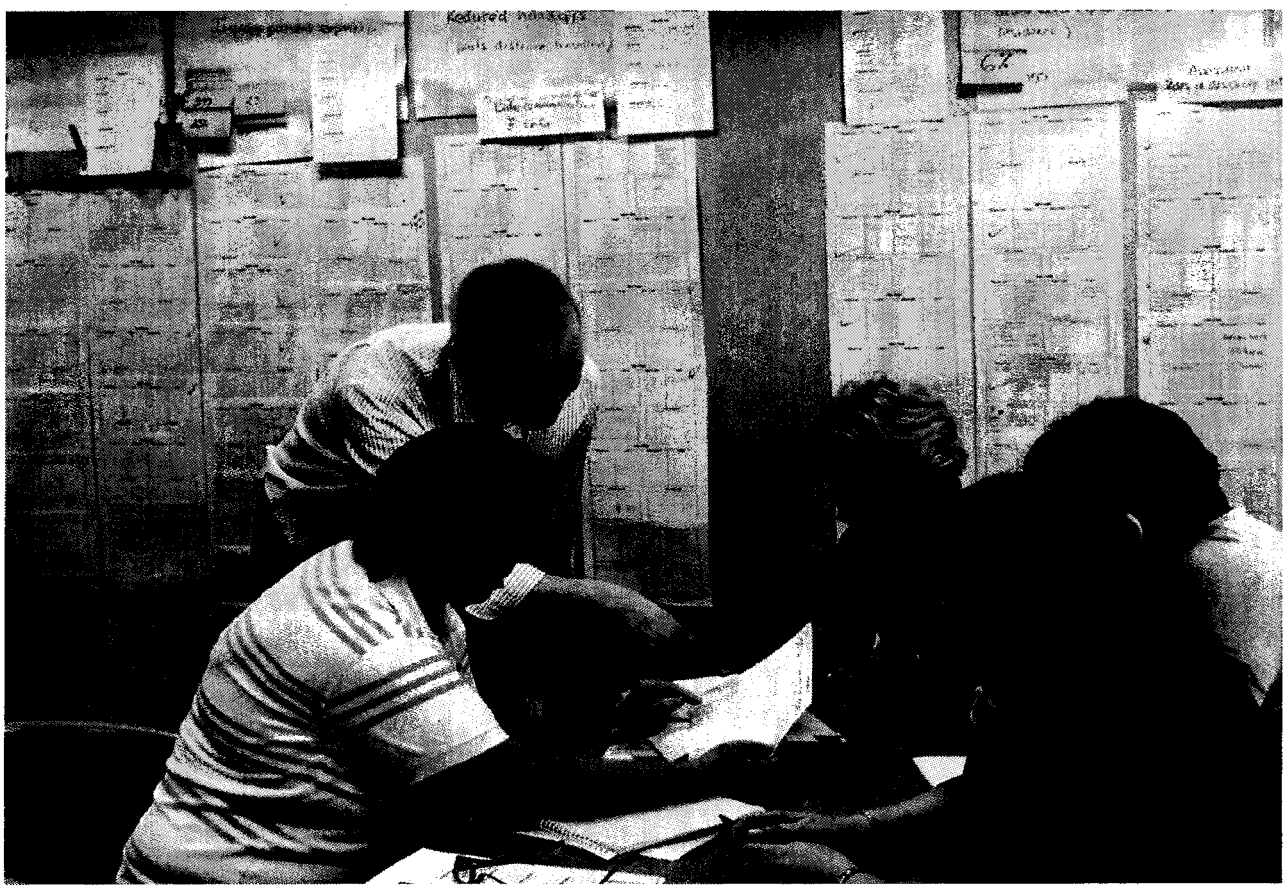
The Service Improvement and Reform Team of NHS South of Tyne and Wear (NHS SOTW) facilitated a Rapid Process Improvement Workshop (RPIW) across Sunderland, during the week of 15th March 2010, regarding the hospital discharge process for patients being discharged from wards M1, E51 & F61 at the Sunderland City Hospitals, with social care needs.

The stakeholders involved in the RPIW were:

- Sunderland City Hospitals NHS Foundation Trust
- Sunderland PCT/NHS South of Tyne and Wear
- Sunderland City Council

A full list of delegates can be found in Appendix I and many of the Team Members are in the following photograph:

Pow Wow Team Members



Background

Background to PCT Service Improvement Methodology

NHS South of Tyne and Wear is one of 6 organisations in the Strategic Health Authority (SHA) area that are adopting Toyota Production System (TPS) as a reform methodology for the organisation. The underpinning principles of TPS can be divided into 4 categories:

1. Philosophy - Long-term thinking
2. Process - Eliminating waste
3. People and Partners - Respect, challenge and grow leaders
4. Problem Solving - Continuous improvement and learning

One of the tools introduced through TPS is an RPIW. A RPIW is a four or five day intensive workshop where the people who do the work everyday are empowered to eliminate waste, reduce the burden of work and make improvements for the patients we serve.

RPIW Topic Background

Hospital discharge is a complex and often contentious issue. National guidance has tried to support this process, and a number of groups within Sunderland have tried to tackle the issues and processes involved over recent years.

Whilst there have been some areas of success and excellent examples of sound multidisciplinary working across a range of stakeholders, a number of issues have been more challenging. A huge issue has often been the complexity of processes which span a number of organisations.

The Hospital Discharge Policy, (City Hospitals Sunderland, NHS Foundation Trust, September 2008) states that patients will be discharged with an agreed discharge plan that takes into consideration any assessed continuing health care; this is supported by the following principles:

- The discharge process should be coordinated with multi agencies that have had involvement with the patient
- The discharge plan will take into full account the views of the patient and where appropriate those of the carer
- Discharge planning should commence before admission at pre admission clinics where possible and for those patients who have a planned admission

- All agencies who will participate in the care of the patient after discharge will come to an agreement with regard to the discharge plan

- Every patient will receive a planned coordinated discharge taking into consideration any health and social needs they may need ensuring this will be shared with the patient, their family and any carers this will allow a streamlined pathway and eliminate delays

- Taking into account the Patients' beliefs, religion and wishes

- Any referrals are made to the relevant multi – disciplinary team members are made in a timely fashion and with good quality information

It was agreed with the RPIW sponsors that this RPIW would address specific areas of the hospital discharge process, including some of the above issues, which involved representation from several organisations. The scope of the RPIW was identified as the reduction of overall lead time for the hospital discharge process for patients with social care needs on Wards E51, F61 and M1 at Sunderland City Hospitals.

Further details regarding the targets/boundaries, scope and outcomes of the RPIW are also included in this feedback pack.

RPIW Name: Sunderland Multi-Agency Discharge RPIW – SRH Wards F61, M1 and E51

Date: 15 March 2010

Sponsor:	Peter Sutton, Neil Revely, David Hambleton
Workshop Leader:	Ailsa Nokes
Team Leader:	Louise Burn
Process Owner:	Anna Hargrave, Norman Taylor
KPO Specialist:	Carrol Martin
RPIW Type:	**Multi-Agency**

Team Members	Department
Sue Martin	Divisional Discharge Coordinator, CHS
Lesley Dobson	Matron, CHS
Carol Luke	Ward Manager M1
Dorothy Greenwell	Ward Manager F61
Denise Bradford	Ward Manager E51
Jill Graham	Clinical Director for Therapies, CHS
Norman Wilson	Senior Team Manager Hospital SW Team
Pat Harris	Social Worker, Hospital SW Team
Stephanie Downey	Senior Team Manager, Area Team
Janet McCahill	Senior Care Manager, Area Team
Margaret Trethowan	Social Worker, CMHTOP
Gill Lawson	Home Improvement Agency Manager
Peter J Smith	Housing Options Team Manager
Ann Dingwall	Assistant Strategic Commissioning Manager
Anne De-Cruz	Registered Manager Farmborough Court
Emma Anderson	Disability Services
Graeme Miller	Service Improvement Facilitator, CHS
Lynn McKale	Modern Matron, Intermediate Care, PCT PS
Judith Anderson	Nurse Assessor, STPCT
Helen Turnbull	Pathway Development Manager, NHS SOTW
Gillian De'Ath	Strategic Development Manager, NHS SOTW
Denise Fascia	Service Improvement Officer, NHS SOTW
Julie Connaughton	Public Involvement Officer, NHS SOTW

Production Requirements/Takt Time Calculation

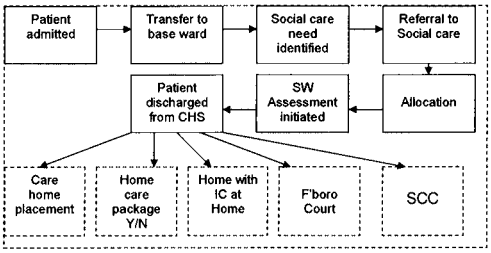
Time available / demand

= total hours available to d/c a patient (SW hours) / total number of patients d/c per week = 3hours 50mins

Current Situation:

- Delayed discharges are problematic especially regarding wait for care package/panel or placement for care home
- Lack of timely multi disciplinary team assessment
- Patient transferred to Sycamore Care Centre prior to completion of assessment (e.g. SW, OT and Physio)
- Estimated date of Discharge – process for agreeing this?
- The definition of 'medically fit for discharge' can cause problems in relation to the assessment process
- Lack of clarity – when to refer to Social Services?
- Quality of referrals to Social Services?
- Difficulty with communication especially in trying to contact the Community SW Teams
- Unclear multi agency pathways for patient transfer (e.g. Sycamore Care Centre v Farmborough Court; pathway for community rehabilitation if required?)
- Is there standard work/agreement on response time regarding acknowledgment of referral/initial assessment when referrals are made e.g. to SW, Farmborough Court, AHPs?
- Local Authority is currently poorly performing regarding direct transfers from acute hospital to 24 hour care
- Cultural issues around care homes as expected destination
- Hospital readmission rates perceived to be higher than average for older people (need to confirm with data)

Process Flow:



RPIW Theme/Overview

Improving the hospital discharge process for patients with social care needs on WardsF61, M1 and E51.

(Start: patient admitted to base ward and end: patient discharged from CHS)

RPIW Targets/Boundaries

Lead time
- Reduce lead time

Quality Defects
- Reduce inappropriate referrals to SS from identified wards
- Reduce incomplete referrals to Social Services from identified wards
- Reduce handoffs (Parts Travelled Distance)
- Reduce 'delayed discharges'
- Reduce transfers to long term residential/nursing care directly from an acute ward(if not usual place of residence)
- Reduce readmissions within 28 days of hospital discharge for ALL patients discharged from identified wards
- Increase number of patients receiving information regarding discharge

Boundaries
- Safeguarding of Adults
- 'Safe discharges'
- Cost
- Exclude processes prior to admission to identified wards
- Exclude processes post transfer from identified wards (include boarders but exclude transfers made for valid clinical reason e.g. transfer to surgery)

Targets

Baseline

The following targets were agreed with the RPIW Sponsors and can be viewed in more detail on the following page:

A 50% reduction in our baseline calculation of inventory (excess bed day costs), handoffs and Lead time

A 100% reduction in the following:

- Inappropriate referrals to Social Work – currently at 25%
- Incomplete referrals to Social Work – currently at 52%
- Formally reported delayed discharges
- Transfers to long- term residential/nursing care directly from an acute ward (if not UPR)
- Readmissions within 28days of hospital discharge for all patients

100% of patients will receive information about and contribute to plans for discharge form hospital.

Improving 5s from level 1 to level 4

Final

By the end of the week, the above targets had not only been achieved, but exceeded. The target sheet overleaf outlines the achievements at the end of the RPIW week. Looking to the future:

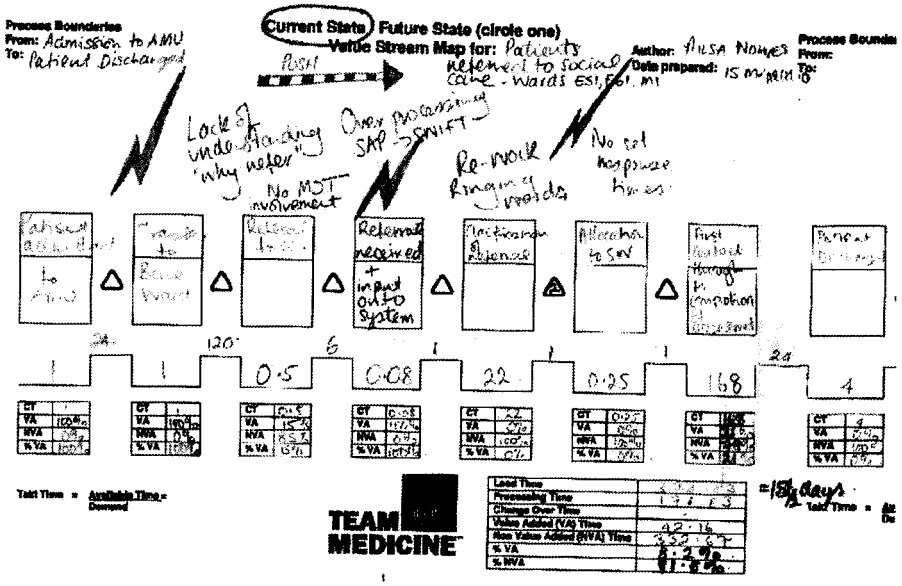
- We expect excess bed day costs to reduce due to reduction in lead time and inappropriate and incomplete referrals and this will be re-measured
- Handoffs in terms of clarification, telephone calls should reduce form 2 per patient to zero (some patients in the current state required as many as 10)
- Quality defects will be reduced by our ideas for improvement and these will be closely monitored as we carry the weeks work forward.

Team Name: Sunderland Multi-agency Discharge process		**Date**: 15th March 2010								
Department: Wards M1 , F61and E51, CHS		**TAKT Time**: (include calculation) 3 hours and 50 minutes based on 9 to 5 Mon to Fri with at demand of 2.1 patients per day								
Product/Process Summary: From admission on to F61, M1 or E51 to point of discharge from CHS (consider SCC) for patients requiring social care referral		**Workshop Leader**: Ailsa Nokes **Team Leader**: Louise Burn **Process Owner**: Anna Hargrave, Norman Taylor **KPO Coach** Carrol Martin								
Metric (units of measurement)	Baseline	Target	Day 2	Day 3	Day 4	Final	30 days mm/dd/yy	60 days mm/dd/yy	90 days mm/dd/yy	% Change
Inventory *(dollars)*	£11 045	Reduce by 50%				TBC				
Parts Travel Distance *(handoffs)*	2					0				
Lead Time *(minutes)*	374.83 (15.5 days)	Reduce by 50%				9.5				
Work in Process (WIP) (units observed in the process)	2.1					0				
Standard Work In Process (SWIP) (lead time/takt time); target SWIP should be target lead time/takt time	98.6					60				
Quality (defects)(%) • Reduce % inappropriate referrals to SS from identified wards • Reduce incomplete referrals to SS from identified wards 100% • Reduced 'delayed discharges' • Reduces transfers to long term residential/ nursing care directly form an acute ward (if not usual place of residence) • Have you been given any information about your discharge home? CHS Patient Experience Survey • • Reduce admissions within 28days of hospital discharge for ALL patients discharged from identified wards by 50%	25% 52% 19% 6% F61 25% E51 25% M1 37% 16.72%	REDUCE ALL 100%				0% 0% TBC 0% 100% 0%				
Environmental, Health & Safety (5S) (levels 1 thru 5) – specify for physical space or virtual space MDT Patient Transfer information	Level 1	Level 4				Level 2				
Set-up Reduction *(minutes)*										
Remarks: introduce standard work throughout the hospital discharge process for patients requiring a social care referral. Intellectual setup has been achieved with all teams through the "Pow Wow"										

Value Stream Maps

The Current State Value Stream Map is illustrated in Figure 2, below.

Figure 2



Kaizen Opportunities

The following potential kaizen ('improvement') opportunities were identified by the Team Leaders during the initial data gathering phase:

- Lack of understanding "why refer" leading to inappropriate referrals
- No social work in MDT
- Over processing SAP ⟶ SWIFT
- Re work ringing wards due to inappropriate and incomplete referrals
- No set response times for Social Work allocation
- Fragmented discharge pathways
- Significant hospital re-admission

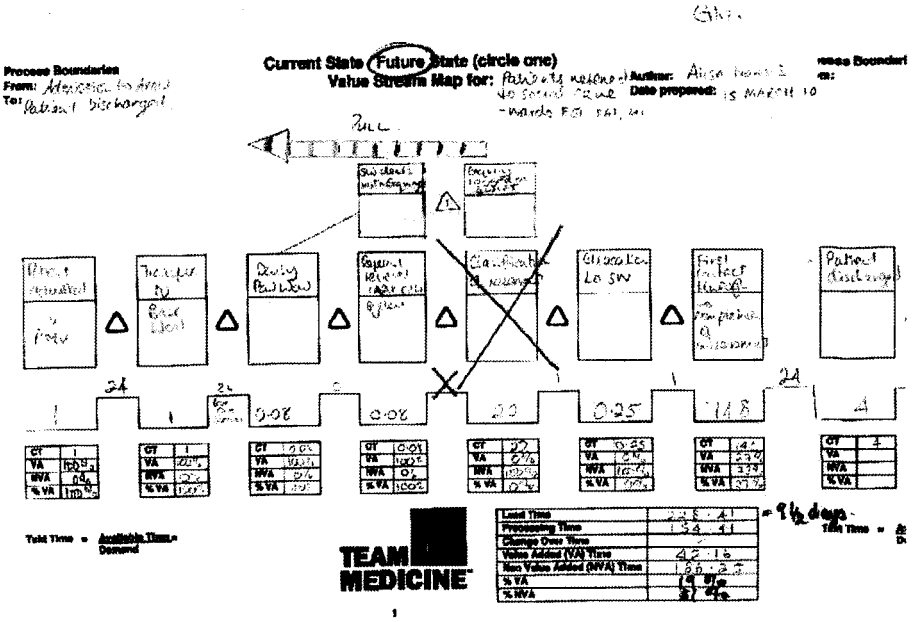
241

The Future State Value Stream Map is illustrated in Figure 3, below.

Our future state value stream map demonstrates that we have reduced the lead time by removing a cycle from the process. This has moved to a 'pull' system for social care referrals. The 'Pow Wow' has enabled us to determine inappropriate referrals by providing a forum for screening.

Clarification of referrals via telephone call will be reduced from 2 per patient to zero which were non-valued added for patients.

Figure 3



242

Day 1 - Expectations

- Smoother passage for people leaving hospital
- Clear plan to move forward
- Sharing Good and Bad
- Fantastic Ideas
- Improve discharge process
- Understand whole process
- More person centred discharge
- Straight forward simple discharge
- Clarity around process and roles
- Better information on sharing
- Limit number of pathway
- Excited! Pleased to be involved
- Learn more
- Identifying barriers
- Improve the way people work together and understand each others role
- Come across difficult/emotive issues
- Identify issues/solve all problems
- Understanding of process and how to contribute
- Concentrate on patient and service user
- Work hard together - appreciate and understand
- Accepted process as way forward
- Improve quality of discharge
- Everyone joins in
- More joined up approach to discharge
- Keeping people staff

Day 1 – Fears

- Will not happen
- We do a lot of work and things don't happen
- There maybe blockages that we can't get over and things cannot happen
- Things will not happen
- Complex process – are we going to be able to streamline process
- That we end up causing more confusion and confusing pathways
- What is happening whilst I am here (back at the ranch)
- Lots of people; will we struggle to get all points across report out Video a No!
- People may not fully input - may have their own fear of contributing to week
- Feel – probably a little out of Depth
- Not being able to 'unblock' difficult blockages
- We don't solve issues
- As my role only involves a little of what we are here for concerned I may not be able to contribute
- This is just a small part of the pathway (re-admission)
- That we can't deliver at end of day – quick process could patient be at risk
- As Process owner will need to lead on what team has come up with during week and implement
- How will ideas translate into all taking ownership and taking ideas forward and putting into practice
- The full week

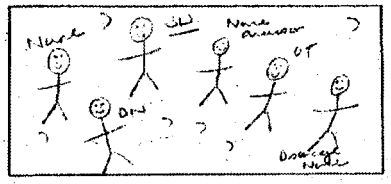
Ideas Generated

A sample some of the ideas generated during the RPIW are included in the following pages:

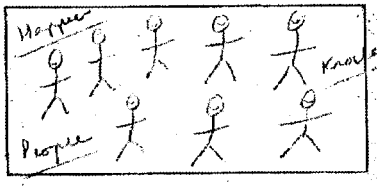
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
ALL Areas	lack of understanding of cost effective / demands	Possibly Strategies cost effective	Gain knowledge of effective - demands Appreciate how other professionals

Before Improvement



After Improvement



Remarks:

Name:

IDEA FORM LYNN

Employee / Area	Problems	Measures Taken	Results
CHS	Exit route		

Before Improvement

FC SCC 24/7
Rapid response
Intermediate care
Winter pressure team
Home
Rosters
Nursing Home

After Improvement

Clear pathway

Remarks:

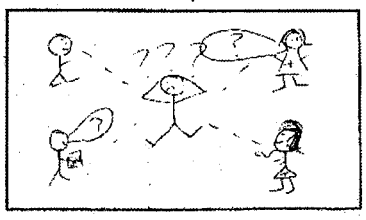
Name:

244

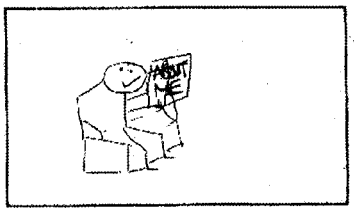
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
ALL	POOR COMMUNICATION BETWEEN ALL HEALTHCARE ALLIED PATIENT/ CARERS.		

Before Improvement



After Improvement



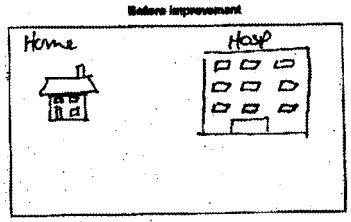
Remarks:

Name:

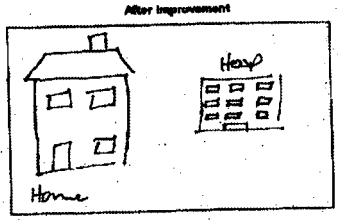
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
All	frequent readmissions to SRH	Protocol + pathway to be developed	Reduced readmissions to hospital

Before Improvement



After Improvement



Remarks:

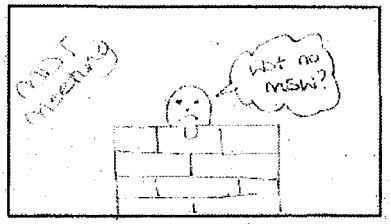
Name:

245

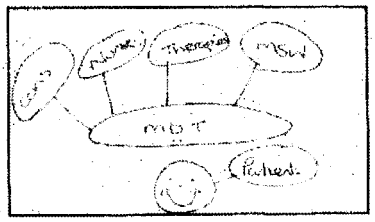
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
Head MDT meeting	No MSW present	Head based MSW who attends MDT Buddy system for hol/sick cover	True MDT working thru shared discussion + agreement Streamlined + co-ordinated discharge

Before Improvement



After Improvement



Remarks:

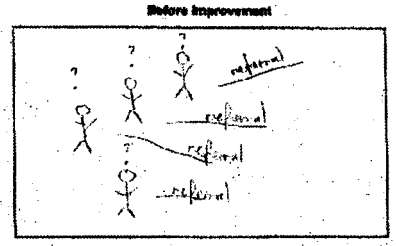
Name:

Reduce + improve quality of handoffs

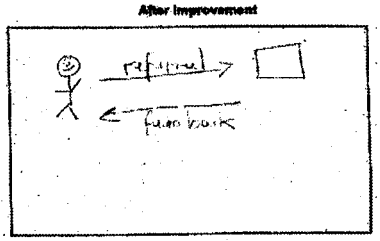
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
City Hospital	Communication between referral agencies & front line nurses + ward staff (inc social)	Agree system of communication	Saves - Time - Motion - unnecessary processes - over production

Before Improvement



After Improvement



Remarks:

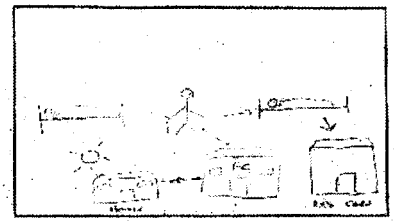
Name:

246

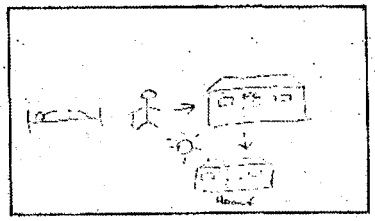
IDEA FORM

Employee / Area	Problems	Measures Taken	Results
Older Persons hospital ward	Patients who are medically fit at the ward round then become poorly following referral	Nurses to pull back referrals as soon as this happens and not wait for agency referred to to find out when all is in place	Decrease unnecessary overproduction

Before Improvement



After Improvement



Remarks:

Name:

247

RPIW Working Groups and Team Members

Workshop Leader: Ailsa Nokes
Team Leader: Louise Burn
Team Support: Helen Turnbull
Coach: Carrol Martin

Process Owners: **Anna Hargrave**
Norman Taylor

Group 1	Members
Pow Wow - referrals	Pat Harris Judith Anderson Anne De Cruz Sue Martin Dorothy Greenwell

Group 2	Members
Multi Disciplinary	Jill Graham Norman Wilson Stephanie Downey. Carole Luke Denise Bradford

Group 3	Members
Patient Experience	Lesley Dobson Margaret Trethowan. Julie Connaughton Peter J Smith Anne Dingwall

Group 4	Members
Assessment and Discharge	Emma Anderson Lynn McKale Janet McCahill Gill Lawson

Group Feedback

Throughout the week, each group worked collaboratively in addressing their area for improvement. The groups were asked to provide feedback in the following format:

- **The problem was.....**
- **Key defects in the current state were.....**
- **Our solution was.....**
- **Which has resulted in .....**

248

Group 1 Feedback
Referrals

The problem was.....

There was a scatter gun approach to referrals in relation to patient discharge. Leading to unnecessary time spent gathering, clarifying, processing information and awaiting responses. This also caused delays, risks and poor discharge experience for the patients.

Key defects in the current state were.....

The key defects in the current state were; referrals are made to inappropriate teams. Discharge planning was driven by bed pressures rather than patient focus.

Communication between professionals was unreliable and response times to referrals variable and often prolonged

Our solution was.....

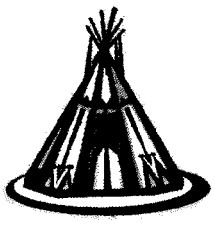
Our solution was to develop a pull system by creating a forum to eliminate waste such as Time, Over processing, Overproduction, Motion and Opportunity for defects. The Forum will bring together multi- professionals to make timely decisions about referrals required to enable a safe and appropriate discharge after consideration of all the exit routes.

Which has resulted in .....

This has resulted in a standard work process; in the form of a referral engine to be known as a 'Pow Wow'. This will mistake proof the referral process.

To clarify our aim is 'to ensure that the patient is at the centre of a streamlined, proactive approach to discharge planning by ensuring that professionals are involved only as appropriate at the relevant time'

Pow-Wow in progress.



Do not disturb

249

Group 2 – Feedback
MDT

The problem was.....

The problem identified was a lack of Hospital Social Work input into routine MDT meetings which created communication difficulties and delays in the patient pathway, also frequent readmissions to hospital for certain patients (Frequent Flyers)

Key defects in the current state were.....

Key defects in the current state were:

- The missing Link – the Social Worker
- Lack of clarity re the role of the MDT
- Lack of evidence to prove it worked; its historical rather than evidence based
- Its timing – is once a week in an acute hospital enough?
- No strategy has been agreed to prevent this for Frequent Flyers

Our solution was.....

Our solution was to consider alternative methods of achieving positive communication and improving Multi-Disciplinary working. Developing a protocol pathway to pull relevant people through the system.

Which has resulted in .....

This resulted in:

- A proposal to integrate the role of the MDT into the daily 'Pow Wow', subject to consultation agreement with medical staff
- Improving communication by Ward Sister agreeing to lead on awareness raising sessions with Local Authority services for older people
- Agreement to develop a buddy system or contingency system for part-time social workers.
- A high -level outline of a multi-agency, integrated care pathway and support plan.
- A co-ordinated approach should reduce mistakes.
- Looking at re-admission trends, preventing unnecessary admissions by mistake proofing and hence reducing length of stay.
- Suggesting the introduction of a 'visual control' to identify people at risk of frequent readmission

Group 3 – Feedback
Patient Experience

The problem was.....

The problem was patients, families and carers felt that there was poor communication between themselves and professionals leading to confusion on discharge.

Key defects in the current state were.....

Key defects were inconsistencies in information available in each area and how and where the information was located and recorded

There were no standard practices for how information, providing a single patient file was being communicated from the professionals involved in the patient's care. This was evidenced during discussions with patients, family and carers and ward staff including SALT.

Our solution was.....

Our solution was to simplify and standardise the information currently available, producing a single patient file and create a visual control with built in mistake proofing. This will be used by patients, carers, relatives and professionals. It will ensure that relevant information is conveyed in a timely and understandable manner to all involved in the patients' pathway.

Which has resulted in .....

This has resulted in; taking an existing Tool and improving the quality of information available and therefore keep the patients, families and carers fully informed and up to date prior to their discharge home

Group 4 – Feedback
Assessment and Discharge

The problem was.....

The Problem was the current Discharge policy doesn't appear to inform current practice and is not used in a standard way.

Key defects in the current state were.....

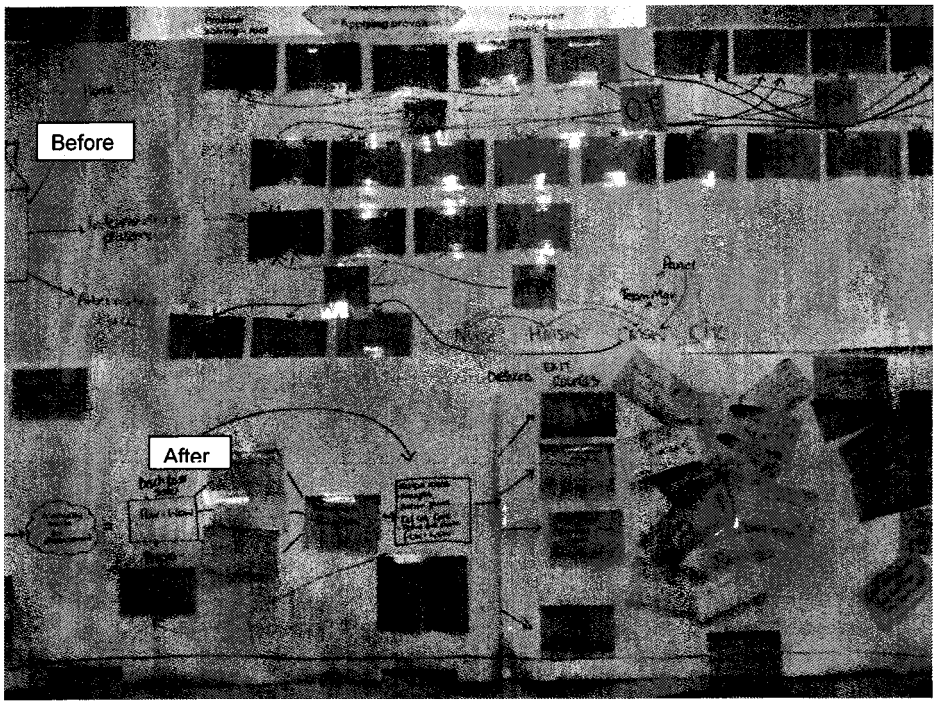
Key defects in the current state were; the document was in a format which practitioners do not appear to find helpful and quickly went out of date roles and responsibilities felt confused.

Our solution was.....

Our solution was to develop a visual control for the existing process as we understand it linked with the other groups to process and support standard work.

Which has resulted in .....

This has resulted in the production of a second visual control which depicts the pathway, including roles and responsibilities to create a more efficient and effective process and a plan around how to make this happen.

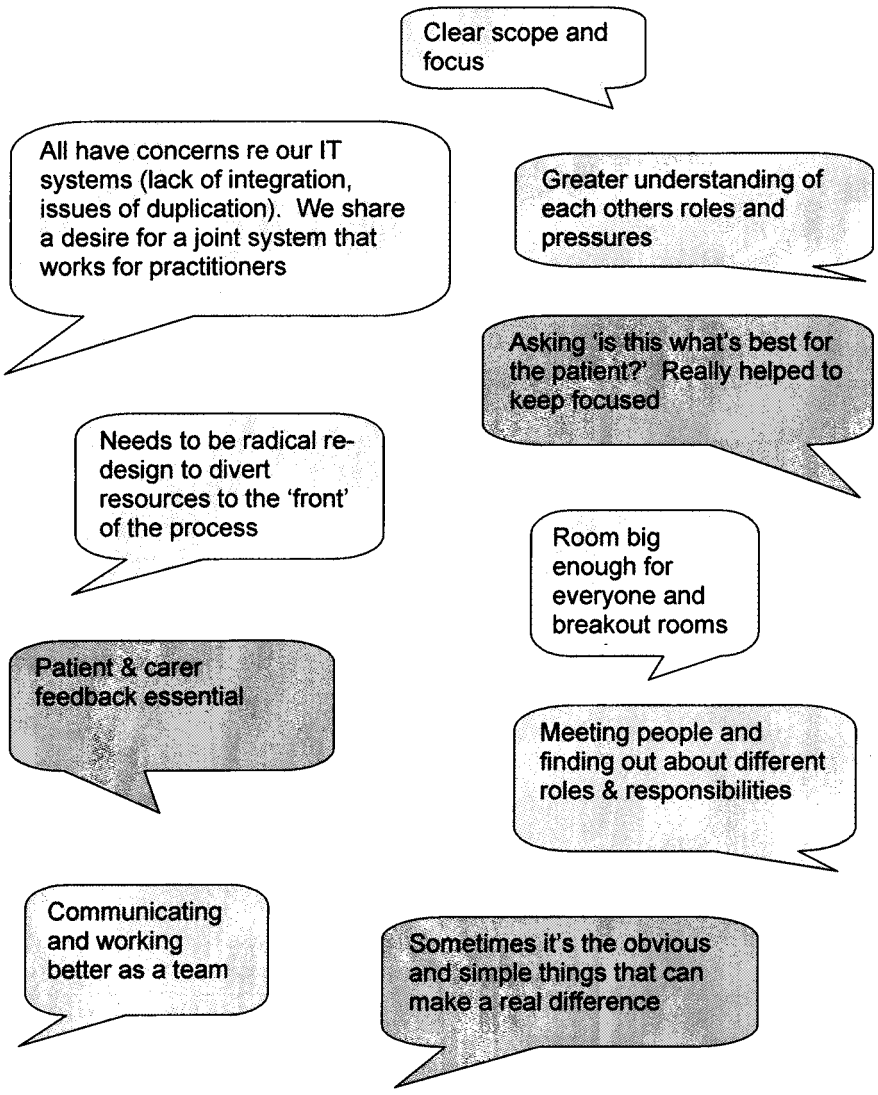


RPIW
Car – Park

The following ideas for improvements were generated as part of the RPIW process; however, it was felt to be outside the scope for the week. These will be discussed by the sponsors as part of the follow up meetings and consideration given as to how they can be addressed.

- CHC Nursing Assessment required prior to discharge
  - More trained assessors
- Medication issues
  - Patients who cannot administer own medication
  - NOMAD system – who should receive this, access issues
- Post-discharge issue's log linked to hospital Discharge group
  - Central point for learning
- Targeted approach for frequent flyers – complex discharge care plan
- Review of AMU patients re: therapy input - requirement for staffing
- Continuity of nursing care plans when moving from hospital to community

Key Learning



In Summary

(and in the words of our Process Owners)

Members of the group have worked hard and there have been some excellent examples of team work.

In most respects it's a job well done, however whilst undoubtedly our proposals will improve communication smooth out the processes and enhance the Patient Experience, it's only part of the journey and we must take positive steps to provide more alternatives to hospitalisation and more and varied Health and Social after care services to speed up discharges and reduce the need for re-admission.

Education is an important element in our understanding of how all of our professional teams' work and through better communication we can support and improve the service for patients but also for ourselves. Educating all our staff around the discharge process and communication are really important and we aim to implement this over the following 12 months.

Working closely with each other we can measure between the 3 organisations a detailed picture of the patient pathway and implement any improvements that are needed.

There are several areas that we couldn't cover in the RPIW which were put into the 'car-park' but we will set time aside with the appropriate professionals to work on these very important issues.

Thank You

We would like to offer our sincere thanks to:

Our sponsors: Neil Revely
Peter Sutton
David Hambleton

- Carrol Martin, our Coach
- John Robson for his support in recoding the RPIW Report Out
- George Hall for sharing his experiences as a patient and carer and ideas for improvement
- Kathryn Walvin and Chris Bartlett for their support with IT solutions
- Marie Walls – CHS performance Data
- Home Teams
    - Wards, M1, E56, F61
    - Patients, Carers and Relatives
    - Therapies
    - Continuing Health Care
    - Farmbrough Court
    - Hospital Social Work
    - Community Social Work
- Ward Managers + Staff Nurses E56
- Everyone who has lived and breathed the RPIW during the course of the week for their hard work and enthusiasm.

Appendix I

Contact List

NAME	JOB TITLE	E-MAIL ADDRESS	ORGANISATION
David Hambleton	Director of Commissioning and Reform	David.hambleton@sotw.nhs.uk	NHS SOTW
Neil Revely			Sunderland City Council
Peter Sutton	Divisional Director	Peter.sutton@chs.northy.nhs.uk	City Hospitals Sunderland
Ailsa Nokes	Head of Service Improvement and Reform	Ailsa.nokes@sotw.nhs.uk	NHS SOTW
Louise Burn	Head of Service Improvement and Reform	Louise.burn@sotw.nhs.uk	NHS SOTW
Helen Turnbull	Pathway Development Manager	Helen.turnbull@sotw.nhs.uk	NHS SOTW
Carrol Martin	Kaizen Promotion Office Manager	Carrol.martin@sotw.nhs.uk	NHS SOTW
Gillian De'Ath	Strategic Development Manager	Gillian.de'Ath@sotw.nhs.uk	NHS SOTW
Anna Hargrave	Divisional General Manager	Anna.hargrave@chs.northy.nhs.uk	Hospitals Sunderland
Norman Taylor	Deputy Head of Adult Services	Norman.taylor@sunderland.gov.uk	Sunderland City Council
Sue Maritn	Divisional Discharge Coordinator, CHS	Sue.martin@chs.northy.nhs.uk	City Hospitals Sunderland
Lesley Dobson	Matron	Lesley.dobson@chs.northy.nhs.uk	City Hospitals Sunderland
Carole Luke	Ward Manager (M1)	Carole.luke@chs.northy.nhs.uk	City Hospitals Sunderland
Dorothy Greenwell	Ward Manager (F61)	Dorothy.greenwell@chs.northy.nhs.uk	City Hospitals Sunderland
Denise Bradford	Ward Manager (E51)	Denise.bradford@chs.northy.nhs.uk	City Hospitals Sunderland
Jill Graham	Clinical Director for Therapies	Jill.graham@chs.northy.nhs.uk	City Hospitals Sunderland
Norman Wilson	Senior Team Management Hospital SW Team	Norman.wilson@sunderland.gov.uk	Sunderland City Council
Pat Harris	Social Worker, Hospital SW Team	Pat.harris@sunderland.gov.uk	Sunderland City Council
Stephanie Downey	Senior Team Manager, Area Team	Stephanie.downey@sunderland.gov.uk	Sunderland City Council
Janet McCahill	Senior Care Manager, Area Team	Janet.mccahill@sunderland.gov.uk	Sunderland City Council
Margaret Trethowan	Social Worker, CMHTOP	Margaret.trethowan@sunderland.gov.uk	Sunderland City Council
Gill Lawson	Home Improvement Agency Manager	Gill.lawson@sunderland.gov.uk	Sunderland City Council
Peter J Smith	Housing Options Team Manager	Peter.smith@sunderland.gov.uk	Sunderland City Council
Ann Dingwall	Assistant Strategic Commissioning Manager,	Ann.dingwall@sunderland.gov.uk	Sunderland City Council
Judith Anderson	Nurse Assessor CHC Team	judith.anderson@sotw.nhs.uk	NHS SOTW
Lynn McKale	Modern Matron, Intermediate Care, PCT PS	lynne.mckale@sotw.nhs.iuk	NHS SOTW
Anne De-Cruz	Registered Manager	Anne.decruz@sunderland .gov.uk	Sunderland City Council
Emma Anderson	Disability Services	Emma.anderson@chs.northy.nhs.uk	City Hospitals Sunderland
Graeme Miller	Service Improvement Facilitator	Graeme.miller@chs.northy.nhs.uk	City Hospitals Sunderland
Denise Fascia	Service Improvement Officer, NHS SOTW	denise.fascia@sotw.nhs.uk	NHS SOTW
Julie Connaughton	Public Involvement officer, Sunderland	julie.connaughton@sotw.nhs.uk	NHS SOTW

257

Appendix II

TEAM: Sunderland Multi Agency Hospital Discharge Process – Group 1 - Pow Wow **RPIW Newspaper** **DATE: 18th March 2010**

Process Owner: Anne Hargrave / Norman Taylor

Item #	Problem	Action Needed To Complete	Responsibility	By When	Status % Completed
1	Confirm dates and times for Go-Live on each ward	M1, E51, F61 speak to ward managers	Pat Harris	24/03/10	
2	Staff Education/awareness of Pow Wow Ward Staff/OT/Physio	M1, E51, F61 – Briefing Session with ward staff and AHPS	Carol Luke Denise Bradford Dorothy Greenwell Sue Martin	26/03/10 03/04/10 09/03/10 09/03/10	
3	Staff Education awareness of Pow Wow Farnborough Court/ CHC team	Farnborough Court – Briefing Session CHC team – Briefing Session	Anne De Cruz Judith Anderson	26/03/10	
4	Staff Education awareness of Pow Wow Discharge/Bed management/Matrons	Briefing Session	Sue Martin Pat Harris	24/03/10	
5	Ward Clerk Role	Review and Administration for Pow Wow			
6	Medical Staff awareness on pilot wards and beyond	Awareness: M1 E51 F61 All consultants	Denise Bradford Dorothy Greenwell Anna Hargrave	03/04/10 09/04/10	
7	Community Teams: Nurses/Matrons	Awareness briefing	Sue Martin		
8	Staff Education, awareness re: Pow Wow Social Worker	Briefing Session	Pat Harris		

TEAM: Sunderland Multi Agency Hospital Discharge Process – Group 2 **MDT** **RPIW Newspaper** **DATE: 18th March 2010**

Process Owner: Anne Hargrave / Norman Taylor

Item #	Problem	Action Needed To Complete	Responsibility	By When	Status % Completed
1	Query re ongoing need for MDT (in light of new daily meetings)	Dr Majmudar to confirm role of MDT in SPR training and discuss with medical colleagues	Dr Majmudar	26/03/10	
2	Community Nursing not reporting concerns to ward staff in a timely fashion	Lynne McKale to follow up re: 'transfer of care form' can this be re-introduced?	Jane Middleton Sue Martin Via Discharge Group		
3	Wards not aware of new contact process for District nurses	Lynn McKale to provide updated information to Anna Hargrave for dissemination	Lynne McKale Anne Hargrave	26/03/10	
4	Concerns re lack of information allowed to be recorded on 'ward board'	Anna Hargrave and Graeme Miller to re visit this issue and feedback, (may be an issue re standardisation of symbols)		09/04/10	
5	Continuity and availability of Social Workers (particularly P/T)	Stephanie Downey to meet with Social Workers and managers to establish protocol	Stephanie Downey	29/03/10	
6	Ward sisters to visit community S/W team to share info re project (and generally)	Arrange date for Carole and Denise to visit D Street to meet with social work teams	Carole Luke Denise Bradford Stephanie Downey	End of April	
7	Access to HISS for Hospital based S/W	To raise issues via RPIW with IT reps	All	End of RPIW rev 30 days	
8	Readmission rates to City Hospitals for 'frequent flyers'	Identify patients Develop group to analyse data and identify pathway and protocol	Norman Wilson and Ward Sister	Review at 30 Days	

TEAM Sunderland Multi-agency Hospital Discharge Process – Group 3 Patient Experience **RPIW Newspaper** **DATE: 18th March 2010**

Process Owner: Anne Hargrave / Norman Taylor

Item #	Problem	Action Needed To Complete	Responsibility	By When	Status % Completed
1	Checklists Lengthy, incomplete poor compliance. Not fit for purpose	Review required Kaizen event	TBC		
2	Format of care tool	Group to meet to finalise trial with staff and relatives	Discussion group	30 days	
3	Compliance	Training Staff Awareness Audit	Lesley Dobson	30 days	
4	Cost Implications	Involvement with Anna Hargrave Discuss procurement	Lesley Dobson	30 days	
5					
6					
7					
8					

TEAM: Sunderland Multi Agency Hospital Discharge Process – Group 4 Patient Pathway RPIW Newspaper
DATE: 17th March 2010

Process Owner: Anne Hargrave / Norman Taylor

Item #	Problem	Action Needed To Complete	Responsibility	By When	Status % Completed
1	Paper referral forms Can these be electronic?	Discuss with IT ref security issues and Information Governance issues	Anne Hargrave	05/04/10	
2	Referrals to Community Matron team?	Identify referral route and Process	Lynne McKale	26/03/10	
3	Insufficient MSW resource to see pathway through to discharge	Review staffing levels Review skill mix	Norman Taylor	30/04/10	
4	Insufficient HMSW to be ward based with buddy system	look at redistribution of workload hospital and community	Norman Taylor	30/04/10	
5	Decision making process for res/nursing home care inefficient	H.H.A.S to review this process to reduce process Lead time and waste	Norman Taylor		
6	Discharge policy out of date and wrong format	Update/review policy. Split into policy and practical documents Distribute to providers to review	Anne Hargrave		
7	Update nursing assessment to include new data	• Is the patient known to community nursing services • Named family contact to liaise with	Anne Hargrave		
8	Re-map process and include response time-scales	Lack of timescales agreed for actions	Anne Hargrave		
9	No joined up metrics for measuring process	3 organisations to agree metrics to measure whole pathway	Anne Hargrave/ Norman Taylor		

10	Definition of medically stable for assessment	• Communication across CHS/Social Worker teams • Reinforce co-coordinator roles and responsibilities	Anne Hargrave/ Norman Taylor/Lynne McKale		[redacted]
11	Re-launch of Discharge policy	• Across health and social care • Take to hospital discharge working group	Anne Hargrave/ Norman Taylor		[redacted]
12	Culture change re place on discharge	• Patient information booklet • Via discharge training – open up to community nursing team	Lesley Dobson /Sue Martin		[redacted]
13	Discharge training	• Develop e-learning package	Anne Hargrave		[redacted]
14	Removing defects from pathway	• Shared e-mail address • Form to complete • Review by H&S Governance Group • Distribution of changes to practice via HDWG	Anne Hargrave/ Norman Taylor		[redacted]
15	Monitoring progress of pathways	Follow patient through retrospectively to audit process			[redacted]
16	Non standard information on referral forms	Standardise initial information and demographics			[redacted]
17	Non use of traffic light system by discharge nurses	Re-launch traffic light system and add to front of discharge file	Lesley Dobson		[redacted]

Sunderland Delayed Discharge Workshops – Newspaper

Item	Problem	Action	Responsibility	Deadline	Status % Completed at 1 month and Update	Status % Completed at 3 months and Update	Status % Completed at 6 months and Update
1	No clear definition of 'reablement'	Review proposed definition(s) from workshop and principles.	Revised Reablement Operational Group		☐ ☐ ☐ ☐ **1 month review notes** **3 month action notes**	☐ ☐ ☐ ☐ **3 month review notes** **6 month action notes**	☐ ☐ ☐ ☐ **6 month review notes** **Any further action required**
2	No clear strategy and model for reablement	Develop strategy document and vision for reablement to including intermediate care Review impact of current reablement schemes / pilots Consider impact on delayed discharges Outline preferred model for reablement	Sunderland Intermediate Care & Reablement Strategy Group		☐ ☐ ☐ ☐ **1 month review notes** **3 month action notes**	☐ ☐ ☐ ☐ **3 month review notes** **6 month action notes**	☐ ☐ ☐ ☐ **6 month review notes** **Any further action required**
3	Mapping of services that do / could / should encompass 'reablement' is incomplete	Finalise mapping work Include third sector and non-commissioned services as appropriate Include review of all current contracts / service specs to ascertain if 'reablement' is encompassed and service capacity Be clear about inclusion of cognitive impairment Over lay onto to reablement model	Revised Reablement Operational Group (Capacity & Demand modeling)		☐ ☐ ☐ ☐ **1 month review notes** **3 month action notes**	☐ ☐ ☐ ☐ **3 month review notes** **6 month action notes**	☐ ☐ ☐ ☐ **6 month review notes** **Any further action required**
4		Develop shared gateway into reablement and intermediate care with common ownership / standard criteria for referral and assessment protocol Consider development of interface team for this role	Sunderland Intermediate Care & Reablement Strategy Group		☐ ☐ ☐ ☐ **1 month review notes** **3 month action notes**	☐ ☐ ☐ ☐ **3 month review notes** **6 month action notes**	☐ ☐ ☐ ☐ **6 month review notes** **Any further action required**

263

APPENDIX 9

Sunderland Delayed Discharge Workshops – Newspaper

5		Develop compact for working collaboratively to facilitate patient pathways across statutory and non stat sectors	Sunderland Intermediate Care & Reablement Strategy Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
6		Agree standard set of performance and outcome metrics for all providers of 'reablement' (use REIP data set, think about outcomes star)	Sunderland Intermediate Care & Reablement Strategy Group & Revised Reablement Operational Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
7	Lack of awareness of changes to the system amongst professionals and the public and lack of knowledge regarding alternatives to 24 hours care. Care home culture.	Publicise new arrangements (eg Reablement at Home now 18+) and promote what is available as a 'whole system' response. Promote 'Home?' as trigger question on admission	New Delayed Discharge Group (Home on admission question) Revised reablement Op Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
8	Need stronger approach to prevention in the community	Follow up on learning from Unique Care pilot. Link to work re Combined Predictive Model.	PCT / GPCC / LA		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
9	Lack of access to community discharge services 7 days	Ensure interface team going forward includes greater focus on hospital discharge, preventing readmission and navigating people into pathways. Map existing 7 day working and explore assumptions regarding access to services outside of core hours (Mon to	PCT (Ailsa Nokes) LA (Phillipa Corner)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required

Sunderland Delayed Discharge Workshops – Newspaper

		Fri)					
10	New resources for discharge and prevention of admission have greater focus on physical health and lack of capacity and skills to support people with mental health problems	Enhance role of interface team to support individuals with mental health as well as physical needs to prevent admission, and also pick up from MH liaison MDT to facilitate discharge. Ensure use if appropriate screening tools (link to Lesley Young work). Also consider enhancement of reablement service to work intensively with individuals	PCT (Ailsa Nokes) Include in Strategy Group discussions Revised Reablement Operational Group		**1 month review notes** **3 month action notes**	**3 month review notes** **6 month action notes**	**6 month review notes** **Any further action required**
11	'Time to Think' concept and model not clarified	Consider opportunity to support individuals to be discharged for 'Time to Think' being 'in your own bed'. What community resources would be required to enable this to happen? Learn from other conditions (eg stroke) and consider associated risks and management. Ensure inclusion of people with dementia within model.	Include in Strategy Group discussions ? Develop F/Court Operational Group into an accommodation group with wider remit		**1 month review notes** **3 month action notes**	**3 month review notes** **6 month action notes**	**6 month review notes** **Any further action required**

265

Sunderland Delayed Discharge Workshops – Newspaper

12	Gap in step up / down support for individuals with challenging behaviour (mental health, drug and alcohol)	Need to define which patients we are thinking about in this group / what are their needs? Consider what is stopping us looking after these patients at home. Consider Challenging Behaviour Team at home. Consider whether Houghton Extra Care would be an option ? What resources would be required to support such a placement?	Revised Delayed Discharge Group – in close liaison with ? Revised Accommodation Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
13	Lack of clarity regarding access to housing options for patients ready for discharge with housing needs	Develop protocol for housing needs – when to involve, what information is required	LA (Claire Foster) CHS (Sue Martin)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
14	Under use of beds available at Farmbrough Court	Review need for intermediate care beds (both residential and nursing). Compare to models elsewhere. Develop model for Sunderland and consider opportunity to pilot step up beds at FC	PCT (Ailsa Nokes) LA (Jean Carte & Philip Foster) ? To become part of the F/Court revised Accommodation Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
15	Need for increased access to psycho geriatrician and RMN input at City Hospitals	Enhance Mental Health Liaison service	PCT (Wendy Kaiser)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required

Sunderland Delayed Discharge Workshops – Newspaper

16	Limited therapy input into Sycamore Care Centre and lack of specialist nursing skills	Explore opportunities to enhance therapy input linked to reablement at home, and also consider additional support that may be available from community nursing services.	PCT (Ailsa Nokes)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
17	No Community Geriatrician	Explore Community Geriatrician role	PCT (Ailsa Nokes) CHS (Anna Hargrave)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
18	Currently do not provide reablement for carers	Explore carers needs and opportunities for 'reabling' carers	Carers Strategy Group PCT (Penny Davison) LA (Sharon Lowes and Pippa Corner)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
19	Lack of capacity and skills in the community re nutrition and hydration to prevent complications / and deterioration of general health post discharge.	Learn lessons from HCA pilot at Farmbrough Court. Consider increasing skills and knowledge within reablement at home service	PCT CHS (Lesley Bainbridge) LA (Phillip Foster)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required

Sunderland Delayed Discharge Workshops – Newspaper

20	Anxiety regarding continence management is an issue	Consider what training and support is required amongst professionals and carers / patients re continence	PCT CHS) LA (Phillip Foster)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
21	Lack of medication support in the community	Explore opportunities for discharging patients with appropriate medication and education and support systems to encourage and maintain uptake	Initially pick up in Delayed Dischage Group. Ailsa Nokes to discuss with Jeanette Stephenson (PCT Medicines Mgt)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
22	Care navigator / advocate required to support individuals with complex needs through their journey, especially on admission to hospital	Explore role of dementia advisor (non professional) to undertake this role. Consider needs of other client groups, could this be generic. Could current services be re-designed to provide this role?	Sunderland Intermediate Care & Reablement Strategy Group		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required
23	Lack of awareness and understanding amongst public re dementia	Increase public awareness, including early identification to signpost to Memory Protection Service or GP	Older Persons MH Senior Officer Group (Wendy Kaiser & Pauline Foster)		1 month review notes 3 month action notes	3 month review notes 6 month action notes	6 month review notes Any further action required

897

Sunderland Delayed Discharge Workshops – Newspaper

24	Lack of awareness and understanding amongst professionals re dementia	Increase professional awareness, including identification to signpost to Memory Protection Service Not just health and social care but wider services, eg fire brigade Education of care home staff re dementia and general wellness and wellbeing	Older Persons MH Senior Officer Group (Wendy Kaiser & Pauline Foster		**1 month review notes** 3 month action notes	**3 month review notes** 6 month action notes	**6 month review notes** Any further action required
25	Need to increase uptake of support for carers of people with dementia to prevent crisis	Extend the development of emergency carers plans	Carers Strategy Group PCT (Penny Davison) LA (Sharon Lowes & Pippa Corner)		**1 month review notes** 3 month action notes	**3 month review notes** 6 month action notes	**6 month review notes** Any further action required
26	Number of steps in current delayed discharge process causing frustration for staff	Value stream mapping exercise to be undertaken across CHS/SOTW Community Health Services & Sunderland City Council	Delayed Discharge Group Anna Hargrave & Jean Carter to escalate	ASAP	**1 month review notes** 3 month action notes	**1 month review notes** 3 month action notes	**1 month review notes** 3 month action notes
27	Gaps and overlap in groups meeting to discuss intermediate care and reablement	Circulate suggested group structure to deliver the wider actions . Chairs of current groups to propose to group members changes to accommodate this work. To complete a TOR/Accountability & revised membership template Matrix to demonstrate cross membership to avoid duplication	Jean Carter Chairs as identified on draft structure circulated as above Janette Oliver	ASAP Back to Janette Oliver by End of June Early July	**1 month review notes** 3 month action notes	**1 month review notes** 3 month action notes	**1 month review notes** 3 month action notes

Sunderland Intermediate Care & Reablement Strategy Group

Sunderland/PCT

RRI Project Ref	Projects	Latest Key Areas of Progress *Including reasons if a milestones has slipped*	Key milestones 2011/12					Risks to projects 2011/12				
			Key milestones *(Identify top 4 milestones for each project)*	Target date	Milestones progress to date	Revised target date	Progress against revised target date	Risks to projects	Impact	Likelihood	Risk rating	Mitigating actions if red, ambor or a milestone has slipped
	Overall Programme											
1	Sunderland Intermediate Care & Reablement Strategy Group		1 Define Terms of Reference/Membership/Governance									
			2 Write Strategy out for consultation October 11									
			3 13 Actions from Delayed Discharge Workshops Newspaper									
			4									
1.1	Delayed Discharge Working Group		1 Define Terms of Reference and Membership									
			2 5 Actions from Delayed Discharge Workshops Newspaper									
			3									
			4									
1.2	Reablement & Accommodation Working Group		1 Define Terms of Reference and Membership									
			2 12 Actions from Delayed Discharge Workshops Newspaper									
			3									
			4									
	Links to Other Groups		1									
			2									
			3									
			4									
			1									
			2									
			3									
			4									
			1									
			2									
			3									
			4									

Act Ref	Problem	Act sub ref.	Action Required	Task owner	Agreed Completion Date	Actual Completion Date	Notes and Comments
2	**No Clear Strategy and Model for Reablement**	2.1	Develop strategy document and vision for reablement including intermediate care	SIC&RSG			
		2.2	Review impact of current reablement schemes/pilots. Consider impact on delayed discharges.	SIC&RSG			
		2.3	Outline preferred model for reablement	SIC&RSG			
6		6	Agree Standard set of performance and outcome metrics for all providers of 'reablement' (use REIP data set, think about outcomes star)	SIC&RSG/Andrew Baker/Paul Allen			
7	**Lack of awareness of changes to the system amongst professionals and the public and lack of knowledge regarding alternatives to 24 hours care. Care home culture.**	7.1	Publicise new arrangements (eg Reablement at Home now 18+)	R&AWG			Check with Emma if Complete
		7.2	Promote what is available as a 'whole system' response.	All Groups to contribute	Mar-12		
		7.3	Promote 'Home'? As trigger question on admission.	City Hospitals to agree 'Home' on questionnaire	Nov-11		
18	**Currently do not provide reablement for carers**		Explore carers needs and opportunities for 'reabling carers'.	SIC&RSG(Lead Pippa Corner)			
			Feedback from pilot	R&AWG	Mar-12		
11	**Time to Think' concept and model not clarified**		Consider opportunity to support individuals to be discharged for 'Time to Think' being 'in your	SIC&RSG	Oct-11		
			What community resources would be required to enable this to happen?	SIC&RSG	Oct-11		
			Learn from other conditions (eg stroke) and consider associated risks and management.	SIC&RSG	Oct-11		
15	**Need for increased access to psycho geriatrician and RMN input at City Hospitals**		Enhance Mental Health Liaison service	SIC&RSG (Lead Wendy Kaiser PCT)	Oct-11		
14	**Under use of beds available at Farmbrough Court**		Review need for intermediate care beds(both residential and nursing). Compare to models	SIC&RSG (Lead Phillip Foster)	Dec-11		
5		5	Develop compact for working collaboratively to facilitate patient pathways across statutory and non statutory sectors	SIC&RSG	Mar-12		
22	**Care navigator/advocate required to support individuals with complex needs through their journey, especially on admission to hospital.**		Explore role of dementia advisor (non professional) to undertake this role. Consider eeds of other client groups, could this be generic. Could current services be redesiged to provide this role?	SIC&RSG(Lead Wendy Kaiser - start with dementia)	Mar-12		
			Feasibility Study		Mar-12		
23	**Lack of awareness and understanding amongst public re dementia.**		Increase public awareness, including early identification to signpost to Memory Protection Service of GP	SIC&RSG (Lead Wendy Kaiser)	Mar-12		
24	**Lack of awareness and understanding amongst professionals re dementia.**		Increase professional awareness, including identification to signpost to Memory Protection Service. Not just health and social care but wider services, eg fire brigade. Education of care home staff re dementia and general wellness and wellbeing.	SIC&RSG (Lead Wendy Kaiser)	Mar-12		
25	**Need to increase uptake of support for carers of people with dementia to prevent crisis.**		Extend the development of emergency carers plans	SIC&RSG (Lead Pippa Corner/Penny Davison PCT)	Mar-12		
	SINGLE POINT OF ACCESS		R&AWG to Lead on this and inform other Groups		?		

Sunderland Intermediate Care & Reablement Strategy Group

Sunderland/PCT

RRI Project Ref	Projects	Latest Key Areas of Progress *Including reasons if a milestones has slipped*	Key milestones 2011/12					Risks to projects 2011/12				
			Key milestones *(Identify top 4 milestones for each project)*	Target date	Milestones progress to date	Revised target date	Progress against revised target date	Risks to projects	Impact	Likelihood	Risk rating	Mitigating actions if red, amber or a milestone has slipped
	Overall Programme											
1	Sunderland Intermediate Care & Reablement Strategy Group		1 Define Terms of Reference/Membership/Governance									
			2 Write Strategy out for consultation October 11									
			3 13 Actions from Delayed Discharge Workshops Newspaper									
			4									
1.2	Delayed Discharge Working Group		1 Define Terms of Reference and Membership									
			2 5 Actions from Delayed Discharge Workshops Newspaper									
			3									
			4									
1.3	Reablement & Accommodation Working Group		1 Define Terms of Reference and Membership									
			2 12 Actions from Delayed Discharge Workshops Newspaper									
			3									
			4									
	Links to Other Groups		1									
			2									
			3									
			4									
			1									
			2									
			3									
			4									
			1									
			2									
			3									
			4									

SUNDERLAND INTERMEDIATE CARE AND REABLEMENT STRATEGY

SUNDERLAND/PCT

Project Ref	Project Name	Act Ref	Problem	Act sub ref.	Action Required	Task owner	Agreed Completion Date	Actual Completion Date	Notes and Comments
1	DELAYED DISCHARGE WORKING GROUP	7	**Lack of awareness of changes to the system amongst professionals and the public and lack of knowledge regarding alternatives to 24 hour care. Care home culture.**	7.1	Publicise new arrangements (eg Reablement at Home now 18+)	R&AWG	Sep-11		CHECK WITH EMMA ANDERSON IF COMPLETE
				7.2	Promote what is available as a 'whole system' response.	All Groups to contribute	Mar-12		
				7.3	Promote 'Home?' as trigger question on admission.	City Hospitals S/Land	Nov-11		City Hospitals Sunderland to agree 'Home' on questionnaire.
		13	**Lack of clarity regarding access to housing options for patients ready for discharge with housing needs.**	13.1	Develop protocol for housing needs.	DDWG	Oct-11		
				13.2	When to involve	DDWG	Oct-11		
				13.3	What information is required?	DDWG	Oct-11		
		21	**Lack of medication support in the community**	21.1	Explore opportunities for discharging patients with appropriate medication	DDWG	Mar-12		
				21.2	Investigate education and support systems to encourage and maintain uptake Project Plan	DDWG	Mar-12		
		26	**Number of steps in current delayed discharge process causing frustration for staff**		Value stream mapping exercise to be undertaken across CHS/SOTW Community Health Services and Sunderland City Council	DDWG (Leads Anna Hargrave & Norman Wilson)	End Sep-11		
			SINGLE POINT OF ACCESS			R &AWG leading on SPA, to be discussed at all Groups and reported back to SIC&RSG	?		