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CAERPHILLY COUNTY BOROUGH COUNCIL
CYNGOR BWRDEISTREF SIROL CAERFFILI

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For all enquiries relating to this agenda please contact Amy Dredge
(Tel: 01443 863100 Email: dredga@caerphilly.gov.uk)

Date: 15th June 2016

Dear Sir/Madam,

A meeting of the **Health Social Care and Wellbeing Scrutiny Committee** will be held in the **Sirhowy Room, Penallta House, Tredomen, Ystrad Mynach** on **Tuesday, 21st June, 2016** at **5.30 pm** to consider the matters contained in the following agenda.

Yours faithfully,

Chris Burns

Chris Burns
INTERIM CHIEF EXECUTIVE

A G E N D A

Pages

1 To receive apologies for absence.

2 Declarations of Interest.
Councillors and Officers are reminded of their personal responsibility to declare any personal and/or prejudicial interest (s) in respect of any item of business on this agenda in accordance with the Local Government Act 2000, the Council's Constitution and the Code of Conduct for both Councillors and Officers.

To approve and sign the following minutes: -

3 Health, Social Care and Wellbeing Scrutiny Committee held on the 3rd May 2016 Min no's (1-8). 1 - 4

4 Consideration of any matter referred to this Committee in accordance with the call-in procedure.

5 To receive a verbal report from the Cabinet Member(s)

6 Health, Social Care and Wellbeing Scrutiny Committee Forward Work Programme.
5 - 20

7 Notice of Motion - Remedial action to improve air quality on Hafodyrynys Road.
21 - 26

8 To receive and consider the following Cabinet report*: -

Voluntary Sector Grants Capital Allocation 2016/17.

**If a Member of the Scrutiny Committee wishes for the above Cabinet report to be brought forward for discussion at the meeting please contact Amy Dredge, Committee Services Officer, Tel no. 01443 863100 by 10.00am on Monday, 20th June 2016.*

To receive and consider the following Scrutiny reports: -

9 Regulation and Inspection of Social Care (Wales) Act 2016 - Presentation.

10 Public Protection Enforcement, Underage Sales Activity and Consumer Advice - 2015/16.
27 - 40

11 Hospital Discharge Task and Finish Group.
41 - 164

12 The procurement and implementation of the Welsh Community Care Information System.
165 - 168

Circulation:
Councillors: L. Ackerman (Chair), Mrs E.M. Aldworth, A. Angel, Mrs A. Blackman, Mrs P. Cook (Vice Chair), M. Evans, Ms J. Gale, L. Gardiner, C.J. Gordon, D.C. Harse, G. J. Hughes, L. Jones, A. Lewis, J.A. Pritchard, A. Rees and S. Skivens

Users and Carers: Mr C. Luke, Mrs J. Morgan, Miss L. Price and Mrs M. Veater

Aneurin Bevan Health Board: S. Millar (ABUHB)

And Appropriate Officers

HEALTH, SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD AT PENALLTA HOUSE, TREDOMEN, YSTRAD MYNACH ON TUESDAY, 3RD MAY 2016 AT 5.30 P.M.

PRESENT:

Councillor Mrs P. Cook - Vice Chair (Presiding)

Councillors:

Mrs E.M. Aldworth, A.P. Angel, Mrs A. Blackman, Ms J. Gale, C.J. Gordon, G.J. Hughes, Miss L. Jones, A. Lewis, J.A. Pritchard, A. Rees.

Cabinet Member: Councillor R. Woodyatt.

Together with:

G. Jenkins (Assistant Director Children's Services), J. Williams (Assistant Director Adult Services), M. Jones (Interim Financial Services Manager), C. Forbes-Thompson (Interim Head of Democratic Services), M. Topping (Supporting People Manager), B. Manners (Solicitor), A. Dredge (Committee Services Officer).

Users and Carers – Mrs M. Veater.

1. APOLOGIES FOR ABSENCE

Apologies for absence had been received from Councillors L. Ackerman (Chair), J. Bevan, L. Gardiner, N. George (Cabinet Member for Community and Leisure Services), S. Skivens, D. Street (Corporate Director of Social Services), and Mrs J.M. Morgan (User and Carer).

2. DECLARATIONS OF INTEREST

There had been no declarations of interest made at the beginning or during the course of the meeting.

3. MINUTES – 22ND MARCH 2016

RESOLVED that the minutes of the meeting of the Health, Social Care and Wellbeing Scrutiny Committee held on 22nd March 2016 (minute nos. 1 - 11) be approved and signed as a correct record.

4. CONSIDERATION OF ANY MATTER REFERRED TO THE SCRUTINY COMMITTEE IN ACCORDANCE WITH THE CALL-IN PROCEDURE

There had been no matters referred to the Scrutiny Committee in accordance with the call-in procedure.

5. REPORT OF THE CABINET MEMBER

The Scrutiny Committee received a verbal report from Councillor R. Woodyatt (Cabinet Member for Social Services). He informed the committee that it has been business as usual for the Directorate since the implementation of the Social Services and Well Being Act (6th April). It was explained that the Information, Advice and Assistance Team has been involved in a training pilot focussed on engaging people in 'meaningful conversations' which is one of the core principles underpinning the Act and is aimed at helping people to help themselves. Credit was given to the Directorate as Caerphilly was invited to pilot this training which will now be rolled out across Wales.

Members were advised that the Development of an Intensive Therapeutic Fostering Service in Caerphilly Report presented at the last meeting was subsequently endorsed by Cabinet.

The Chair thanked Councillor Woodyatt for his report.

REPORTS OF OFFICERS

Consideration was given to the following reports.

6. HEALTH SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE FORWARD WORK PROGRAMME

Mrs Catherine Forbes-Thompson (Interim Head of Democratic Services) introduced the report that informed the Committee of its draft forward work programme including all reports that were identified at the work programme workshop on 22nd March 2016 planned for the period June 2016 to April 2017.

Members were asked to consider the work programme and to make any amendments or additional agenda items to be included for future meetings.

A Member requested an updated report on the progress made with the recently combined Information, Advice and Assistance Team. Due to the Social Services and Wellbeing Act that was implemented in April 2016 it was considered appropriate to allow an opportunity for the Act to 'bed in' prior to providing an update in terms of progress made.

Following consideration and discussion, it was moved and seconded that subject to the inclusion of an item in relation to the Information, Advice and Assistance Team being included on the work programme for the 25th October 2016 the recommendation in the report be approved. By a show of hands this was unanimously agreed.

RESOLVED that subject to the inclusion of an item in relation the Information, Advice and Assistance Team for the 25th October 2016, the work programme appended to the report be approved.

7. GWENT FRAILTY PROGRAMME - REVISED SECTION 33 AGREEMENT

Mr Mike Jones (Interim Financial Services Manager) presented the report that informed members of the revisions to the Section 33 (Health Act 1999) Partnership Agreement (appended to the report) between Aneurin Bevan University Health Board and the five local authorities of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen that was approved by Cabinet on the 30th March 2016.

It was explained that the Gwent Frailty Programme is a transformational programme and its aim is to provide services to frail people across the area in a way that is person centred and focused on the needs of individuals, rather than organisations. It is regarded by the Welsh Government (WG) as one of Wales' iconic projects, and has been backed by repayable 'Invest to Save' funding of £6.3 million from WG.

A Member queried the current terms and conditions of the contract and it was confirmed that the current agreement is open ended and will remain in force until three months written notice to withdraw is received from one of the partners.

Clarification was sought in relation to the introduction of the new Frailty Director and it was confirmed that the post is fixed term for 18 months and was established following a recommendation of the independent review undertaken in 2014 in respect of the Gwent Frailty Programme. The post is jointly funded by each of the partners.

Following consideration and discussion, it was moved and seconded that the recommendation in the report be approved. By a show of hands this was unanimously agreed.

RESOLVED that the revised Section 33 Agreement as appended to the report be noted.

8. THE PROVISION OF FLOATING SUPPORT TO BED AND BREAKFAST ESTABLISHMENTS

Mr Malcolm Topping (Supporting People Manager) introduced the report and informed Members that an earlier report in relation to bed and breakfast establishments had been presented to the Policy and Resources Scrutiny Committee on 22nd October 2015. At that meeting it was proposed that a further report regarding the support for homeless clients whilst in bed and breakfast accommodation be presented to the Health, Social Care and Wellbeing Scrutiny Committee for information.

Members were advised that the number of individuals currently being placed by the Local Authority in bed and breakfast placements has reduced significantly over the past six months, principally, due to the implementation of the Housing Act 2014.

An overview was provided in terms of the current accommodation and supported housing schemes available across the borough. Reference was made to the floating support service that the Local Authority has commissioned provided by the housing

support agency 'The Wallich'. The agency work closely with the Council's Emergency Housing Team, Housing Advice Centre, Probation and other support agencies and Landlords to ensure that risk is minimised and that a client's stay in a bed and breakfast is properly managed, so that they can successfully move into a more permanent tenancy when it becomes available.

Clarification was sought in relation to the planned accommodation in Rhymney and how this will be managed. It was confirmed that an open evening was held with local residents three months ago and assurances have been given that there will be two members of staff on duty 24 hours a day 7 days a week and that CCTV will be installed outside the main entrance.

It was explained that having been assessed the majority of people that come into refuge are entitled to claim Housing Benefits. Most individuals are required to contribute towards the service charge in particular, however, those who work could be liable to pay several hundreds of pounds per week for the accommodation provided.

The committee thanked Mr Topping for the informative report and for responding to questions raised.

Following consideration and discussion, it was moved and seconded that the recommendation in the report be approved. By a show of hands this was unanimously agreed.

RESOLVED that the contents of the report be noted.

The meeting closed at 6.25pm

Approved as a correct record, subject to any amendments agreed and recorded in the minutes of the meeting held on 21st June 2016.

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CHAIR

HEALTH SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE – 21ST JUNE 2016

SUBJECT: **HEALTH SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE FORWARD WORK PROGRAMME**

REPORT BY: **ACTING DIRECTOR OF CORPORATE SERVICES AND SECTION 151 OFFICER**

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1. PURPOSE OF REPORT

1.1 To report the Health Social Care & Wellbeing Scrutiny Committee Forward Work Programme.

2. SUMMARY

2.1 Forward Work Programmes are essential to ensure that Scrutiny Committee agendas reflect the strategic issues facing the Council and other priorities raised by Members, the public or stakeholders.

3. LINKS TO STRATEGY

3.1 The operation of scrutiny is required by the Local Government Act 2000 and subsequent Assembly legislation.

4. THE REPORT

4.1 The Health Social Care & Wellbeing Scrutiny Committee forward work programme includes all reports that were identified at the scrutiny committee work programme workshop on 22 March 2016. The draft work programme outlines the reports planned for the period June 2016 to April 2017.

4.2 The forward work programme is made up of reports identified by officers and members during the workshop and has been prioritised into three priority areas, priority 1, 2 or 3. Members are asked to consider the draft work programme alongside the cabinet work programme and suggest any changes before it is finalised and published on the council website. Scrutiny committee will review this work programme at every meeting going forward alongside any changes to the cabinet work programme or report requests.

4.3 The draft Health Social Care & Wellbeing Scrutiny Committee Forward Work Programme is attached at Appendix 1. The cabinet work programme is attached at Appendix 2.

5. EQUALITIES IMPLICATIONS

5.1 There are no specific equalities implications arising as a result of this report.

6. FINANCIAL IMPLICATIONS

6.1 There are no specific financial implications arising as a result of this report.

7. PERSONNEL IMPLICATIONS

7.1 There are no specific personnel implications arising as a result of this report.

8. CONSULTATIONS

8.1 There are no consultation responses that have not been included in this report.

9. RECOMMENDATIONS

9.1 That Members consider any changes and agree the final forward work programme prior to publication.

10. REASONS FOR THE RECOMMENDATIONS

10.1 To improve the operation of scrutiny.

11. STATUTORY POWER

11.1 The Local Government Act 2000.

Author: Catherine Forbes-Thompson Scrutiny Research Officer
Consultees: Gail Williams, Interim Head of Legal Services and Monitoring Officer

Appendices:
Appendix 1 Health Social Care & Wellbeing Scrutiny Committee Forward Work Programme
Appendix 2 Cabinet Work Programme

Appendix 1

Health Social Care & Wellbeing Scrutiny Committee Forward Work Programme May 2016 to April 2017			
Meeting Date: 21 June 2016			
Subject	**Purpose**	**Key Issues**	**Witnesses**
Wales Community Care Information System (P3)	To update Committee on the development of the joint Health and Social Care Information System across Wales and to present the findings from the pilot Local Authority.	The report will identify the benefits of developing a single IT system for Wales which will enable information sharing and the effective planning, co-ordination and delivery of services across organisations. The report will outline the key stages in the implementation of the system across Wales.	
Regulation & Inspection Act (P1)	To update Committee on the changes to Regulation and Inspection in Wales due to be implemented between 2017 and 2019.	The report will highlight: • The links to the Social Services and Well Being (Wales) Act • The rebranding of the Care Council to become Social Care Wales • The regulation regime for care and support services and • The inspection regime for Local Authority Social Services Departments	
Annual Report Public Protection Enforcement, Under Age Sales & Consumer advice (P2)	To provide information on Public Protection enforcement activities. To consider the Council's CCTV surveillance camera system to ensure that it remains necessary, proportionate and effective. To consider enforcement activity in respect of under age sales of tobacco and aerosol spray paints. To provide information on the nature of Consumer Advice complaints dealt with by the Trading Standards Service.	The report will provide an overview of formal enforcement activity undertaken by the Public Protection Division and includes some examples. In accordance with the Surveillance Camera Commissioner's Code of Practice, the report provides a review of the Council's Public Open Space CCTV system. The report will also detail activity concerning under-age sales of alcohol, tobacco and aerosol spray paints over the previous year. Information will also be provided on complaints dealt with by the Consumer Advice function of Trading Standards with examples of assistance given to Caerphilly residents.	Head of Public Protection

Appendix 1

Hospital Discharge Task and Finish Group (P2)	Report and Recommendations of Task and Finish group		

Health Social Care & Wellbeing Scrutiny Committee Forward Work Programme

Appendix 1

Meeting Date: 13 September 2016			
Subject	**Purpose**	**Key Issues**	**Witnesses**
Performance Management (P1)			

Appendix 1

Meeting Date: 25 October 2016			
Subject	**Purpose**	**Key Issues**	**Witnesses**
Annual Safeguarding Board Report – Childrens & Adults (P1)	To provide Committee with an overview of the work of the Gwent Wide Adult Safeguarding Board (GWASB) and the South East Wales Safeguarding Children Board (SEWSCB).	The report will describe the key functions of the regional Safeguarding Boards Business Unit hosted by Caerphilly. The report will identify the key achievements of both Boards and the challenges faced. It will also identify future priorities going forward	Mel Roach Business Unit Manager
Budget Monitoring Period 5 (P2)			
ABUHB 6 monthly visit (P2)			ABUHB
Information Advice and Assistance Service	Member request	The progress and impact since the creation of the merged service. To include successes, any issues encountered and how they were resolved. To include the performance of new team compared to previous teams.	

Appendix 1

Meeting Date: 6 December 2017			
Subject	**Purpose**	**Key Issues**	**Witnesses**
SSWB Act Update (P1)			

Appendix 1

Meeting Date: 7 February 2017			
Subject	**Purpose**	**Key Issues**	**Witnesses**
CSSIW Annual Performance Evaluation (P2)			
Budget Monitoring Period 9 (P2)			

Appendix 1

Meeting Date: 21 March 2017			
Subject	**Purpose**	**Key Issues**	**Witnesses**
Aneurin Bevan University Health Board (ABUHB) 6 monthly visit (P1)			ABUHB

(key: P1,2,3 – Priority 1,2 or 3)

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Cabinet Forward Programme

Appendix 2

29TH JUNE 2016	Key Issues	Service Area
Cabinet Forward Work Programme **Blaenraglen Waith y Cabinet**	To seek Cabinet endorsement of the Forward Work Programme for the period April 2016 to June 2016.	Legal and Democratic Services
Governance Arrangements – SEW Education Achievement Service **Trefniadau Llywodraethu Gwasanaeth cyflawni addysg de ddwyrain cymru**	Update to current governance arrangements to reflect the new National Model of Regional Working for Education Consortia.	EAS/ Education
Amendments to Authorisation of officers within the Public Protection Division **Diwygiadau i Awdurdodi swyddogion o fewn Is-adran Diogelu'r Cyhoedd**	To inform Cabinet of required changes to the legal powers for officers of the Public Protection Division and to seek approval for additional authorisation under a number of Acts of Parliament in order to enforce the legislation and carry out their duties.	Public Protection
Closure of the Key Stage 2 Specialist Resource Based for children with Hearing impairment at Hendre Junior School, and Redesignation of the Social Inclusion Class of Cefn Fforest Primary School: Outcome of the Formal Consultation Process. **Cau Canolfan Adnoddau Arbenigol Cyfnod Allweddol 2 Ar Gyfer Plant Sydd Â Nam Ar**	To update Cabinet on the formal consultation process and to seek a decision on the proposal to close the Specialist Resource Base at Hendre Junior School, and Re-designation of the Social Inclusion Class of Cefn Fforest Primary School	Additional Learning Needs, Education

Cabinet Forward Programme

Y Clwy Yn Ysgol Iau Hendre Ac Ail-Ddynodi Dosbarth Cynhwysiad Cymdeithasol Yn Ysgol Gynradd Cefn Fforest: Canlyniad Y Broses Ymgynghoriffurfiol.		
Welsh Language Standards Annual Report 2015-2016. **Adroddiad Blynyddol Y Safonau Iaith Gymraeg 2015-2016.**	The purpose of this report is to consider the Welsh Language Annual Report on Monitoring and Improvement. The Welsh Language report must be published before the end of June each year.	Public Protection
Notice of Motion - Remedial action to improve air quality on Hafodyrynys Road.	Notice of Motion	Public Protection

13TH JULY 2016	**Key Issues**	**Service Area**
Community and Leisure Services Division – Various Issues Relating to Fees for Specific Services	The report outlines a number of service areas where there are either new services to be offered that require fees to be set or where fee increases have not been implemented for a number of years such that the fee structure is no longer sustainable and/or is not recovering the full cost of the service. The report therefore seeks cabinet approval to introduce certain new fees and to increase or change the fee structure of others.	Community and Leisure Services
Winter Maintenance Plan	To seek endorsement of the council's annual approach to Winter Maintenance	Engineering Services
Federation of Schools **Ffederasiwn Ysgolion**	This report outlines proposal to agree to support, in principle, the federation of schools. The specific recommendation is to proceed with proposals in the autumn term to include Bedwas Junior/Rhydri Primary, Fleur-de-Lys Primary/Pengam	Education

Cabinet Forward Programme

	Primary and Cwmfelinfach Primary/Ynysddu Primary schools.	
Property Services - State of the Estate Report 31st March 2016. **Gwasanaethau Eiddo - Adroddiad Cyflwr yr Ystâd 31ain Mawrth 2016.**	For some time now the Welsh Government (WG) has produced an annual report on the "State of the Estate" relating to property in their ownership. The report is very useful and has been widely circulated by WG. The report has prompted Property Services to prepare a similar report for the council. The main driver for that being introduced now is to reflect on the significant changes that have been made to the council's property portfolio and the way that portfolio is now managed.	C. Jones
School Instrument of Government	TBC	K. Cole

27TH JULY 2016	**Key Issues**	**Service Area**
Provisional Outturn for 2015/16 **Alldro Dros Dr oar gyfer 2015/16**	This report will provide Cabinet with details of the provisional revenue budget outturn for the 2015/16 financial year prior to the annual audit by the Authority's External Auditors, Grant Thornton. The report will provide an overview of the Council's financial performance and will set out the reasons for any significant variations against budget.	Corporate Finance
Reserves Strategy **Strategaeth Cronfeydd wrth Gefn**	Following a review of the Reserves Protocol this report will seek Cabinet endorsement of a reserves strategy setting out details of the types of reserves held by the Authority, their purpose and the processes for authorising use of the reserves.	Corporate Finance
Financial Resilience Report **Adroddiad Gwydnwch Ariannol**	Narrative Required	Corporate Finance
WAO Leisure Report. **Adroddiad Hamdden Swyddfa Archwilio Cymru**.	Narrative required	Corporate Services

7TH SEPTEMBER 2016	**Key Issues**	**Service Area**

Cabinet Forward Programme

21ST SEPTEMBER 2016	Key Issues	Service Area

5TH OCTOBER 2016	Key Issues	Service Area
Highway Maintenance Plan	To seek endorsement of the Council's approach to maintaining its highway network	Engineering Services

19TH OCTOBER 2016	Key Issues	Service Area

2ND NOVEMBER 2016	Key Issues	Service Area

16TH NOVEMBER 2016	Key Issues	Service Area
Highway Asset Management Plan **Cynllun Cynnal a Chadw'r Priffyrdd.**	To update on the current All Wales approach to Asset Management and seek endorsement for CCBC's development of its Highways Asset Management Plan	Engineering Services

Cabinet Forward Programme

Treasury Management –Review of MRP Policy **Rheolaeth Y Trysorlys – Adolygiad o'r Polisi Isafswm y Ddarpariaeth Refeniw**	This report will set out options for revising the Minimum Revenue Provision (MRP) Policy to identify potential savings to support the Medium Term Financial Plan (MTFP).	Corporate Finance
Mid-Year Budget Monitoring (Whole Authority) **Monitro Cabol Blwyddyn Cyllideb 2015/16**	This report will provide details of projected whole-Authority revenue expenditure for 2016/17 along with details of any significant issues arising. The report will also update Cabinet on progress in delivering approved savings for the 2016/17 financial year.	Corporate Finance

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HEALTH SOCIAL CARE AND WELL BEING COMMITTEE – 21ST JUNE 2016

SUBJECT: **NOTICE OF MOTION - REMEDIAL ACTION TO IMPROVE AIR QUALITY ON HAFODYRYNYS ROAD**

REPORT BY: **CORPORATE DIRECTOR, SOCIAL SERVICES**

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1. PURPOSE OF REPORT

1.1 To respond to a Notice of Motion asking that CCBC take all remedial action, urgently to improve air quality on Hafodyrynys Road.

1.2 The report is seeking the views of members prior to its presentation to Cabinet.

2. SUMMARY

2.1 A Notice of Motion has been received from Councillor A. Lewis.

2.2 The Notice of Motion meets the criteria set out in the Council's Constitution and in accordance with the Council's Rules of Procedure is now referred for consideration.

3. LINKS TO STRATEGY

3.1 Local Air Quality Management is a statutory requirement. Addressing air quality contributes to the Healthier Caerphilly and Greener Caerphilly, priorities within the Caerphilly Local Service Board single integrated plan, Caerphilly Delivers.

3.2 Addressing air quality contributes to the following Well-being Goals within the Well-being of Future Generations Act (Wales) 2015:

- A resilient Wales
- A prosperous Wales
- A healthier Wales
- A more equal Wales
- A Wales of cohesive communities
- A globally responsible Wales

In terms of the five ways of working set out in the sustainable development principle, as defined in the Act. Local Air Quality Management is integrated in that it contributes to a number of the Well-being goals and supports the objectives of other stakeholders. There is also an emphasis on acting to prevent problems from getting worse and a necessity for collaboration across a number of services and agencies.

4. THE REPORT

4.1 Councillor A. Lewis requests in his Notice of Motion that:-

'I call on CCBC to take all remedial action, urgently to improve air quality on Hafodyrynys Road'.

Members will be aware of recent reports in the media regarding air quality at this location.

4.2 The Environment Act 1995 introduced a strategic policy framework for air quality management. The strategy established a set of standards for a number of pollutants having regard to scientific and medical evidence on the effects on health. Local authorities are required to carry out regular reviews of air quality within their area to determine whether they comply with these standards and, where they do not, to designate an Air Quality Management Area (AQMA) and incorporate controls to improve air quality bringing it within the accepted levels.

4.3 Air quality monitoring began at Hafodyrynys in 2009, at that time a single diffusion tube was deployed on Woodside Terrace to give an indication of levels of nitrogen dioxide within the area. Initial readings suggested that there was a need to extend the monitoring and undertake a more comprehensive assessment within the area. An additional 2 diffusion tubes were placed on Hafodyrynys Road and a continuous air quality monitor was installed in September 2011.

4.4 Air quality objectives for nitrogen dioxide are 40 µg/m3 (measured as an annual average) and 200 µg/m3 (measured as a 1 hour mean) not to be exceeded more than 18 times a year. The table below shows the continuous monitoring results dating back to 2012. Whilst the annual average has remained consistent since 2013, the amount of 1 hour mean exceedances have decreased over time. The rise in this figure in 2015 will be attributable to queueing traffic during the Crumlin Junction improvements that took place between January and October.

4.5 As the air quality monitoring station is located on the roadside it is a requirement when assessing measured data to consider what levels would be at the façade of residential properties some 2 metres away. The adjusted data is also presented in the table.

Table: Air Quality Monitoring Results 2012-2015

	2012	2013	2014	2015
Continuous Monitoring Results				
Annual Average (µg/m3) (Objective Level 40 µg/m3)	98	68	68	68
No. of 1 hour mean exceedances (per year) 18 allowed per year	137	85	75	108
Annual Average (µg/m3) adjusted for façade.	71	50	50	50
Diffusion Tube Monitoring Results (µg/m3)				
CCBC 48 (1 Woodside Terr)	45	48	46	42
CCBC 50 (Top Woodside Terr)	46	50	47	47
CCBC 60 (3 New Houses)	41	41	39	32

4.5 A Detailed Assessment of air quality was undertaken in 2013 based on monitoring data from 2012 and was submitted to Welsh Government. The Detailed Assessment confirmed that monitoring results were continuing to fail the air quality objectives for nitrogen dioxide and concluded there was a need to designate an Air Quality Management Area (AQMA). The area was designated as an AQMA at the same time that the Caerphilly Town Centre AQMA was extended in November 2013.

4.6 A Further Assessment report was undertaken and submitted to Welsh Government in April 2015. The Further Assessment report considered contributions from the different traffic types and modelled mitigation scenarios. The recent Crumlin Junction improvements were one of the modelled mitigation scenarios within the report. The air quality modelling study that was undertaken as part of the Crumlin Junction improvements concluded that there would be an improvement in the annual mean, a reduction of up to 23µg/m^3 and that the 1 hour mean exceedances would no longer fail the air quality objective.

4.7 The Crumlin Junction improvements were undertaken to address peak time congestion at this key junction of the A467/A472 strategic highway network for the County Borough, improve journey time reliability for public transport bus services, and provide capacity to accommodate future development identified under the Council's Local Development Plan. The works to date have totalled £1.3m.

4.8 The recently completed scheme has already resulted in efficiency benefits but post scheme monitoring is ongoing, including a review of junctions outside the scope of the actual works undertaken, to better understand the impact of the scheme and identify whether further minor amendments could improve the efficiency benefits further. At least a full year of air quality monitoring data is required for to fully

understand the impact/benefits of the Crumlin junction highway improvement.

4.9 Air quality action planning, as required by the Act, will concentrate primarily on reducing levels of nitrogen dioxide within the Air Quality Management Area, it is important to note that the pollutant of concern is traffic related. Traffic queuing and congestion is an issue along the junctions that feed the A472 not just within the confines of the Air Quality Management Area. When producing the Action Plan, it will be necessary to consider areas surrounding the junctions that feed the A472 and require an input from many services across the Local Authority as well as from external partners, local residents and businesses.

4.10 There is a requirement to consult members of the public during the production of the Action Plan and through an appropriate communication strategy it is intended to engage with residents, community groups and other key players and an Action Plan Steering Group meeting is proposed for September. All proposed actions will be assessed and those that are deliverable will go forward into the Hafodyrynys Air Quality Action Plan. It is envisaged that the draft Action Plan will go out to public consultation in early 2017.

4.11 Air quality from traffic is a national problem and is not something that can be addressed quickly; the solution often requires physical interventions as well as encouraging behavioural changes. Options in Hafodyrynys are likely to be quite limited due to the nature of the area. The topography is a large influencing factor as well as the fact that there are no alternative routes for traffic in the immediate vicinity without having to add substantial mileage to the journey.

4.12 In support of his Notice of Motion Cllr Lewis has also made reference to a planning application submitted to Torfaen Council. This application relates to reclamation of former opencast workings, recovery of secondary aggregates and construction of new access road affecting public rights of way. The application has not yet been determined by Torfaen Council, but the resolution of Planning Committee on 8 July 2015 was: that Torfaen County Borough Council be advised that Caerphilly County Borough Council Planning Committee raises objections to the application on the grounds of the detrimental impact on residential amenity, highway safety and air quality. A letter to that effect was sent to Torfaen Council.

5. EQUALITIES IMPLICATIONS

5.1 There are no equalities implications arising directly from this report as the assessment work is being undertaken by existing Council staff and by utilising existing revenue budgets.

6. FINANCIAL IMPLICATIONS

6.1 There are no financial implications arising directly from this report.

7. PERSONNEL IMPLICATIONS

7.1 There are no personnel implications associated with this report.

8. CONSULTATIONS

8.1 This report has been sent to the Consultees listed below and all comments received are reflected in this report.

9. RECOMMENDATIONS

9.1 The Notice of Motion be duly considered by the Scrutiny Committee and referred to Cabinet in accordance with the Council's Constitution.

10. REASONS FOR THE RECOMMENDATIONS

10.1 To be in accordance with the Council's Constitution.

11. STATUTORY POWER

11.1 Local Government Act 1972, Section 123 and Environment Act 1995

Author: Maria Godfrey, Senior Environmental Health Officer

Consultees: Cllr. Nigel George, Cabinet Member for Community and Leisure Services
Cllr Lyn Ackerman, (Chair) Health Social Care and Well Being Scrutiny Committee
Cllr P Cook, (Vice Chair) Health Social Care and Well Being Scrutiny Committee
Dave Street, Corporate Director, Social Services
Ceri Edwards, Environmental Health Manager
Jacqui Morgan, Trading Standards & Licensing Manager
Gail Williams, Interim Head of Legal Services and Monitoring Officer
Clive Campbell, Transportation Engineering Manager
Tim Stephens, Development Control Manager
David A. Thomas, Senior Policy Officer (Equalities and Welsh Language)
Mike Eedy, Finance Manager
Shaun Watkins, HR Manager

Background Papers: Air Quality Assessment Hafodyrynys 2013 & Air Quality Further Assessment Hafodyrynys 2015

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HEALTH SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE - 21ST JUNE 2016

SUBJECT: **PUBLIC PROTECTION ENFORCEMENT, UNDERAGE SALES ACTIVITY, AND CONSUMER ADVICE – 2015/16**

REPORT BY: **CORPORATE DIRECTOR, SOCIAL SERVICES**

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to:

- To provide information on formal enforcement activities within the Public Protection Division including outcomes of investigations undertaken under the auspices of the Regulation of Investigatory Powers Act.
- To consider, in accordance with the Surveillance Camera Commissioner's Code of Practice, the Council's CCTV surveillance camera system to ensure that it remains necessary, proportionate and effective.
- To consider the enforcement programme in respect of under age sales of tobacco and activity regarding the under-age sales of aerosol spray paints.
- To provide information to Members on the nature of Consumer Advice complaints dealt with by the Trading Standards Service.

2. SUMMARY

2.1 The Public Protection Division consists of a wide range of protective and regulatory functions, which seek to protect, promote and improve the health, safety and economic well being of our communities, as well as regulate trade, commerce and the environment. In compliance with the Public Protection Enforcement Policy the report provides an overview of the formal enforcement activity undertaken including outcomes of investigations undertaken under the auspices of the Regulation of Investigatory Powers Act.

2.2 The Surveillance Camera Commissioner's Code of Practice states that the local authority should consider, on an annual basis, its surveillance camera system to ensure that it remains necessary, proportionate and effective. This report considers the Public Open Space CCTV system.

2.3 The report details the nature and number of complaints received concerning under-age sales of alcohol, tobacco, e cigarettes, butane lighter refills and lottery tickets over the previous financial year. An overview of test purchasing activity is provided including the results of enforcement action and the penalties that may be applied. The Authority is required by law to annually review its approach to tackling under-age sales of tobacco and spray paints.

2.4 The report provides information to Members on the number and nature of complaints dealt with by the Consumer Advice function of Trading Standards in 2015/2016.

3. LINKS TO STRATEGY

3.1 Enforcing public protection legislation is a statutory duty and this activity, together with the assistance provided to Caerphilly residents with consumer problems, also contributes to the Healthier Caerphilly, Greener Caerphilly, Prosperous Caerphilly, and Safer Caerphilly priorities within the Caerphilly Local Service Board single integrated plan, Caerphilly Delivers, and Objective 1 of the Council's Strategic Equality Plan 2016-20.

3.2 Public Protection Enforcement activity also contributes to the following Well-being Goals within the Well-being of Future Generations Act (Wales) 2015:

- A resilient Wales
- A prosperous Wales
- A healthier Wales
- A more equal Wales
- A Wales of cohesive communities
- A Wales of vibrant culture and thriving Welsh language

4. THE REPORT

4.1 The Public Protection Division has a major role in protecting, promoting and improving the health, safety and economic well being of our communities. This role includes the enforcement of numerous statutes, many of which include criminal sanctions on those who infringe the law.

4.2 The Committee will also be aware that prosecution details are published on the Council website and in Newsline.

4.3 In order to ensure a fair and consistent approach to enforcement responsibilities the Public Protection Division has an Enforcement Policy, which was updated in April 2015 to reflect changes in legislation. The Policy requires an annual review of activity.

4.4 The information in Appendix 1 provides a broad picture of the range and number of formal enforcement actions initiated during 2015/16 (some prosecutions may still be awaiting hearing). In addition to the formal interventions detailed, hundreds of other informal warnings and cautions (both written and verbal) are issued every year. The table also includes activity of the CCTV Control unit for the last financial year.

4.5 The Public Open Space CCTV system comprises 152 cameras covering 28 town and village centres. Cameras in Blackwood, Caerphilly and Bargoed town centres are used to monitor the highest number of incidents followed by Rhymney, Risca and Ystrad Mynach cameras respectively. While cameras in villages tend to be used to monitor less incidents they are regarded as providing a deterrent effect and help in maintaining community reassurance. The location and number of permanently fixed cameras is considered as necessary, proportionate and effective.

4.6 The CCTV Control Room refers incidents and suspicious behaviour directly to the Police for their action. Descriptions provided by the Control Room can result in arrests being made at the time of the incident and in some cases Control Room Operators are able to guide Police Officers to offenders as a result of on-going monitoring after an incident. The Control Room will store the relevant footage for use by the Police as evidence in the course of their criminal investigations. This substantially reduces the amount of time Police Officers need to spend investigating offences, provides best evidence of a perpetrator committing offences, reduces the need for victims to give evidence in Court and assists the Courts to sentence appropriate to the gravity of the offence. The CCTV Control Room monitors other activity. During the year 165 warnings were given for out of hours access to Council depots, Amenity sites and schools, in some cases police response was required. 158 calls were received from the Storenet system to deal with suspected shoplifters. Police asked for assistance in monitoring 55 threats of suicide.

4.7 **Regulation of Investigatory Powers Act 2000 Authorisations**

4.7.1 The Regulation of Investigatory Powers Act 2000, places safeguards and controls over activities undertaken by Public Bodies, when they use legitimate tools to enforce breaches of the law, which interfere with the Article 8 Rights of individuals under the European Convention on Human Rights. Insofar as Trading Standards are concerned the permitted activities are:-

- Directed Surveillance (the covert surveillance of individuals)
- The use of Covert Human Intelligence Sources (either undercover officers or informants)
- Access to Communications Data (restricted access such as subscriber details and data traffic-not the content of any calls/texts etc, but merely the numbers sent to/received from)

4.7.2 The Act and subordinate legislation sets out strict criteria that must be met, before the activity can be authorised and undertaken. In all cases, the interference must be both proportionate and necessary, and full details of activities and the criminal investigation needs to be set out.

4.7.3 Within Caerphilly Council applications are reviewed by a Senior Manager and if all the criteria are met, the application will be authorised. In the case of Directed Surveillance and Covert Human Intelligence Sources (CHIS), the Authority's Monitoring Officer will also vet the applications, to ensure they are correctly authorised. The Monitoring Officer does not have this responsibility in relation to Communications Data. Communications Data is accessed using the National Anti Fraud Network (NAFN), who have their own internal safeguards.

4.7.4 Once applications are Authorised, Officers must then apply to the Magistrates Courts and obtain Judicial Approval to carry out the activity. During 2015/16, Trading Standards obtained RIPA Authorisations as below:-

Directed Surveillance -	6
Covert Human Intelligence Sources -	0
Communications Data -	1

4.7.5 In relation to the Directed Surveillance Authorisations, 5 related to under age test purchase operations for alcohol held throughout the year. 1 sale took place resulting in the issue of a Penalty Notices for Disorder to the seller. Additionally intelligence gained from one targeted premises, assisted the Police in organising and executing a major operation at a premises, where not only were under age persons being habitually sold alcohol, but also evidence was obtained of the use of controlled drugs. The outcome of this operation was that the premises were closed down. Also a number of offences were discovered under the Licensing Act 2003, resulting in 5 premises being cautioned. The sixth Authorisation related to a serious problem in the Bargoed area involving the use of unlicensed taxis. This operation again proved successful, and currently 8 individuals are under investigation.

4.7.6 With regard to the Communications Data request, this related to an investigation into the supply of food supplements, some of which contained banned and dangerous substances, resulting in a successful prosecution.

4.8 **<u>Underage Sales</u>**

Complaints about premises supplying age-restricted products are received from members of the public, local elected Members, Police Officers, Community Safety Wardens, and other businesses. Complaint data is used to target enforcement activities and also to support authorisations for directed surveillance using covert recording equipment, under the Regulation of Investigatory Powers Act 2000. During the financial year 2015/2016 the Trading Standards Service received:

- 6 complaints about tobacco sales
- 13 complaints about “on” licence alcohol sales
- 14 complaints about “off” licence alcohol sales
- 1 complaint about premises selling both tobacco and alcohol
- 1 complaint about E cigarettes (Nicotine Inhaling Devices, NIDs)
- 1 complaint about the supply of butane lighter refills
- 2 complaints about the supply of lottery tickets

4.8.1 In the previous financial year the service has carried out test purchases for alcohol, tobacco, butane lighter refills and for the first time Nicotine Inhaling Devices (NIDs), commonly known as e-cigarettes. These are prioritised as such products carry risks of anti-social behaviour and health concerns for young people. E-cigarettes were also targeted as a means of educating retailers. Test purchasing is achieved by using young volunteers selected in accordance with national guidelines. The volunteers, who often work in pairs, carry covert recording equipment, which captures sound and images. If a sale is made the recording is used to support enforcement action. Where volunteers are test purchasing in “on” licence premises support is provided by a witnessing team of officers, including officers from Gwent Police, in order to secure the health and safety of the young people in an adult environment. All activities are risk assessed and parental consent is required before a volunteer is allowed to work with the Trading Standards Service. When the law changes, or Trading Standards test for products not previously covered by the law, test purchase operations are used in conjunction with educational visits, and in these situations formal action is usually not taken, but follow up test purchases.

YEAR	**15/16**		**14/15**	**13/14**
Product	**Sales/ Attempts**	**% Sales**	**% Sales**	**% Sales**
Alcohol On	1/8	12.5%	37.5%	50%
Alcohol Off	5/40	12.5%	15%	4.4%
Tobacco	0/1	0%	10%	0%
Butane (lighter refills)	0/1	0%	N/A	N/A
E-Cigarettes (NIDs)	0/12	0%	N/A	N/A

4.8.2 In previous years Trading Standards have dealt with and assisted Gwent Police in tackling complaints about premises believed to be deliberately selling alcohol to local youths or who are not preventing local youths from obtaining alcohol via proxy sales. During 2015/16 the service received 4 complaints about the proxy purchasing of alcohol and associated anti-social behaviour. As this is a Police matter, it is necessary to work in partnership with Gwent Police utilising surveillance via CCTV or covert cameras, and officers with stop and search powers to seize alcohol from youths and establish the dispersal routes away from the premises. Such exercises are complex to set up and also costly in terms of police and local authority resources.

4.8.3 The Children and Families Act 2014 creates a new offence for the Proxy sale of tobacco products. From 1st October 2015. A person aged 18 or over who buys or attempts to buy tobacco or cigarette papers on behalf of an individual aged under 18 commits an offence. Trading Standards have not carried out any Tobacco Proxy sales enforcement activity due to the lack of any reports of such activity.

4.8.4 The Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015. These Regulations, made under Part 5 of the Children and Families Act 2014, contain provisions which make it an offence to sell certain nicotine inhaling products to persons aged under 18 and for an adult to purchase nicotine inhaling products on behalf of a person aged under 18 (proxy sales of e-cigs and e-liquids). There is an exemption for products that are licensed as either a medicinal product or a medical device and is sold by prescription.

4.9 **Legislation and Penalties**

4.9.1 The Children and Young Persons (Protection from Tobacco) Act 1991 requires the authority to consider its enforcement programme in respect of underage sales of tobacco on an annual basis. The Clean Neighbourhoods and Environment Act 2005 places a duty on the authority to consider activity regarding the under-age sales of aerosol spray paints.

4.9.2 Where alcohol is sold it is likely that the staff member will receive a £90 on the spot penalty notice issued by a Trading Standards Officer. The owner/seller of the alcohol will be investigated formally and unless the business has an adequate defence it is likely that they will be prosecuted in court. The maximum fine under the Licensing Act 2003 is £5000.

If it is deemed likely that the premises may not improve their systems the licence may be taken to review before the Licensing Committee. The Committee has a number of options open to it: -

- Impose additional conditions
- Remove the designated premises supervisor (responsible person named on the licence)
- Suspend the licence for up to three months.
- Revoke the licence

4.9.3 Where tobacco is sold both the staff member and the business owner may be liable to court action unless there is an adequate defence in place. There are further sanctions for premises found to be repeatedly selling tobacco to underage persons. If a person / business is convicted of selling tobacco to persons under the age of 18 and at least two other offences occurred in the preceding two years relating to the same premises, trading standards can make an application to a Magistrates' Court for a restricted premises order and/or a restricted sales order.

A restricted premises order prohibits the sale from the premises of any tobacco products to any person, by the business or any of its staff for a period of up to one year.
A restricted sales order prohibits a specified person who has been convicted of a tobacco offence from selling any tobacco products to any person and from having any management function related to the sale of tobacco products for a period of up to one year. The maximum fine is £2,500. In the case of Aerosol Spray Paints the maximum penalty is also £2,500 and six months imprisonment.

4.9.4 Results for the preceding 12 months (which may have included cases from the preceding financial year) are shown in the table below.

Type of Enforcement Activity	Alcohol	E Cigarettes	Tobacco	Butane Lighter Refills
Failed test purchases	6	0	0.	0
Prosecutions	0	Not applicable.	Not applicable.	Not applicable
£90 Fixed Penalty Notices for Disorder	2	Not applicable.	Not applicable.	
Reviews of Licence	0	Not applicable.	Not applicable	

4 of the 6 failed test purchases for alcohol were informal intelligence gathering exercises, each was followed up with a formal test purchasing exercise where there was no sale and appropriate advice and guidance was given.

4.10 **Consumer Advice**

Consumer complaints are categorised on the authority's database by trade sector and by product or service. Categorisation of complaints follows the current national scheme and allows the data gathered to be used in planning services and, in particular, intervention against particular problem trade sectors.

4.11 The table below gives the top 10 products/services and the monetary value involved that were complained about during 2015/2016:

	Product/Service	Number	% of Total	Value £000
1.	***Second-hand cars***	***213***	***12***	***619***
2.	***Home maintenance and Improvements***	***185***	***10***	***518***
3.	***Furniture***	***69***	***4***	***43***
4.	***Other Professional Services***	***62***	***3***	***34***
5.	***Telecommunications (including mobiles)***	***57***	***3***	***3***
6.	***Vehicle Repairs and Servicing***	***56***	***3***	***32***
7.	***Road, rail, air and sea travel***	***39***	***2***	***5***
8.	***Toiletries and Beauty articles***	***39***	***2***	***3***
9.	***Tobacco products***	***38***	***2***	***1***
10.	***Large White Goods***	***34***	***2***	***7***

The analysis is comparable with national data, with second-hand cars and home maintenance being the highest sources of complaints both nationally and locally. The variance in the number and value of the most complained about goods and services over the last four years is presented in Appendix 2.

4.12 Referrals to Caerphilly Trading Standards have decreased slightly, and the number of complaints to the National helpline from Caerphilly residents has similarly slightly decreased However, the numbers of complaints requiring intervention, which are of a more complex nature, have continued to increase. In the current economic climate complaint resolution is significantly harder to achieve with many businesses less willing to offer consumers redress where it is due to them. As such the complexity of cases and the time taken to bring them to resolution has increased significantly. Additionally the new Consumer Rights Act, although strengthening the rights of consumers, has not persuaded traders to comply with the law, whilst at the same time consumer expectation has risen.

4.13 The total value of all goods and services dealt with by the Council's advice service for the financial year was £2,095,892.15 and the total value of all goods and services where Caerphilly consumers sought advice either directly from the service or through CACS was £7,432,078.24. These figures exclude high value complaints regarding financial advice and prize draws.

4.14 A monthly quarterly satisfaction survey is sent to all users of the service. This year's results show that 90% of users were either very or fairly satisfied with the service provided. The service users who were not satisfied, described the root of their dissatisfaction as the failure of businesses to respond to intervention, as opposed to the quality of service provided. Response time indicators show that 98% of users had an initial response within one working day.

5. EQUALITIES IMPLICATIONS

5.1 There are no potential equalities implications of this report and its recommendations on groups or individuals who fall under the categories identified in Section 6 of the Council's Strategic Equality Plan.

5.2 Equalities Impact Assessments would be undertaken on specific action plans and projects related to Trading Standards work.

6. FINANCIAL IMPLICATIONS

6.1 Whenever prosecutions are taken in the Courts we do seek to recover the reasonable costs of investigation and prosecution.

6.2 The income that is generated by the imposition of fixed penalty notices or recovery of court costs is included in the revenue budget.

7. PERSONNEL IMPLICATIONS

7.1 There are no personnel issues with regard to this report

8. CONSULTATIONS

8.1 This report has been sent to the Consultees listed below and all comments received are reflected in this report.

9. RECOMMENDATIONS

9.1 Members are requested to consider the review of Public Protection enforcement activity and CCTV provision.

10. REASONS FOR THE RECOMMENDATIONS

10.1 To provide Members with an opportunity to note the annual review of enforcement activity in accordance with the Public Protection Enforcement Policy.

10.2 To apprise members of activities undertaken in this area aimed at preventing access to all age restricted products.

10.3 To ensure that the Authority complies with its legal obligation to annually review its approach in relation to tobacco and spray paints.

10.4 To keep members informed of the type and level of complaint activity within the county borough and the assistance provided by the Consumer Advice service.

10.5 To ensure the Public Open Space CCTV system remains necessary, proportionate and effective.

11. STATUTORY POWER

11.1 Officers within Public Protection enforce a large number of Acts of Parliament which are listed in part 3 of the constitution, Responsibility for Functions.

Author: Rob Hartshorn, Head of Public Protection – Ext. 5316
Consultees: Cllr. Nigel George, Cabinet Member for Community and Leisure Services
Dave Street, Corporate Director, Social Services
Ceri Edwards, Environmental Health Manager
Jacqui Morgan, Trading Standards & Licensing Manager
Gail Williams, Interim Head of Legal Services and Monitoring Officer
David A. Thomas, Senior Policy Officer (Equalities and Welsh Language)
Mike Eedy, Finance Manager
Shaun Watkins, HR Manager

Appendices:
Appendix 1 – Public Protection Enforcement Activity 2015-16
Appendix 2 – Consumer Advice Service Requests 2012-2016

Appendix 1 – Public Protection Enforcement Activity 2015-16

Type of Enforcement Activity	13/14	14/15	15/16
Trading Standards and Licensing Legislation			
Significant breaches identified during inspection.	84 (95% rectified)	101 (99% rectified	203(63%)*
Simple Cautions	12	10	33
Prosecutions	32	27	23
Fixed Penalty Notices under Section 146 of the Licensing Act, i.e. underage sales of alcohol (in conjunction with Gwent Police)	8	5	1
Fixed Penalty Notices under Section 6 of the Health Act 2006	N/A	1	1
* Rectification rate reduced by low level of compliance with new Allergen legislation.			
Environmental Health Food Safety Legislation			
Written Warnings/Advice	776	980	1120
Improvement Notices	61	46	54
Remedial Action Notices	3	1	3
Prosecutions	1	1	0
Voluntary Closure	9	4	7
Emergency Prohibition	0	0	0
Simple Cautions	0	0	0
Food Hygiene Rating Scheme Fixed Penalty Notices	1	7	2
Environmental Health - Health and Safety Legislation			
Written Warnings/Advice	179	165	213
Improvement Notices	40	15	24
Prohibition Notices	4	0	0
Simple Cautions	0	1	0
Prosecutions	2	0	1

Type of Enforcement Activity	13/14	14/15	15/16
Environmental and Nuisance Legislation			
Warnings for dog fouling	1	9	7
Warnings for litter	33	129	88
Fixed Penalties for Dog Fouling	46	44	37
Fixed Penalties for Litter	239	268	178
Prosecutions for Littering	2	4	9
Prosecutions for Dog Fouling	5	6	6
Confiscation of noise making equipment	3	1 destruction order	2
Prosecutions for Statutory Nuisance (Noise)	1	3	3
Stray Dogs Impounded	307	318	269
Prosecutions for Fly tipping	4	10	8
Cautions for Fly Tipping	2	0	2
Community Safety Legislation			
Referrals by Community Safety Wardens into 4 Strike Anti-Social Behaviour process	25	14	43
Verbal Warnings (Name and address, date of birth taken)	159	89	123
Words of Advice given (acting contrary to acceptable standards of behaviour)	NA	824	1003
Items of Alcohol Confiscated	153	175 and 6 tobacco	156 and 1 tobacco

Total no. of incidents monitored/dealt with by CCBC CCTV service	4766	3829 including requests detailed below	4179 including requests detailed below
Evidence recorded and provided to Gwent Police	886	834 DVDs burnt for evidential purposes and 787 provided	957 DVDs burnt for evidential purposes & 890 provided.
Requests for monitoring from Gwent Police	1680	1358 requests from Gwent Police for CCTV assistance	1251 requests from Gwent Police for CCTV assistance.

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Product/Service	**12/13**	**13/14**	**14/15**	**15/16**
Second-hand cars				
Number / Value	***174 £594,331***	***157 £393,372***	***249 £644,575***	***213 £619,000***
Home Maintenance and Improvements				
Number / Value	***165 £300,395***	***221 £277,631***	***190 £436,716***	***185 £518,000***
Furniture				
Number/ Value	***69 £62,787***	***71 £48,897***	***47 £33,731***	***69 £43,000***
Other Professional Services				
Number/ Value	***52 £18,631***	***73 £32,449***	***54 £18,018***	***62 £34,000***
Telecomms (inc mobiles)				
Number/ Value	***60 £3,185***	***77 £5,831***	***91 £6,214***	***57 £3,000***
Vehicle Repairs and Servicing				
Number/ Value	***59 £40,810***	***50 £48,775***	***64 £73,127***	***56 £32,000***
Road, Rail, Air and Sea Travel				
Number/ Value	***N/A***	***N/A***	***N/A***	***39 £5,000***
Toiletries and Beauty articles				
Number/ Value	***N/A***	***43 £4,114***	***53 £7,440***	***39 £3,000***
Tobacco Products				
Number/ Value	***N/A***	***N/A***	***N/A***	***38 £1,000***
Large White, Goods				
Number/ Value	***N/A***	***N/A***	***N/A***	***34 £7,000***

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HEALTH SOCIAL CARE AND WELL-BEING SCRUTINY COMMITTEE – 21ST JUNE 2016

SUBJECT: **HOSPITAL DISCHARGE TASK AND FINISH GROUP**

REPORT BY: **ACTING DIRECTOR OF CORPORATE SERVICES & SECTION 151 OFFICER**

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1. PURPOSE OF REPORT

1.1 To inform and seek the endorsement of the Health Social Care & Wellbeing Scrutiny Committee of the final recommendations of the Hospital Discharge Task and Finish Group.

2. SUMMARY

2.1 The Health Social Care & Wellbeing Scrutiny Committee established a Task and Finish group to look Hospital Discharge for residents of the County Borough and make recommendations.

2.2 This report outlines the main findings of the review group and makes a number of recommendations for the future of this service.

3. LINKS TO STRATEGY

3.1 The operation of Scrutiny is a requirement of the Local Government Act 2000.

4. THE REPORT

4.1 The Hospital Discharge Task and Finish Group were set up to review hospital discharge within the county borough and held a workshop at its first meeting in order to determine the key areas to be reviewed. The areas identified were as follows:

- Communication.
- Discharge planning from admittance to hospital.
- Integrity – the need for a solid package of care to reduce readmission.
- Methodology – look at best practice examples to provide context.
- Single point of contact within hospital – information exchange within hospital.

Membership

4.2 The membership of the task and finish group were as follows:

Councillor L Ackerman (ex-officio)
Councillor P Cook
Councillor J Gale

Councillor L Gardiner
Councillor C Gordon (Chair)
Councillor J A Pritchard (Vice Chair)
Mrs M Veater Co-opted Member

FINDINGS

4.3 The review group held a series of five meetings between September 2015 and May 2016, with a suspension of meetings during the winter period to allow the outcome of the winter plan to be reported at the last meeting. The review group examined the following areas of practice:

- Discharge process including what contributes to a well-planned discharge.
- Performance measures - national indicators, inappropriate discharges, volume of work (in context of social services).
- Seasonal planning, to look at preparations for the winter period, across both organisations to prevent admission in the first instance, then reduce length of stay in hospital and number of people classified as a delayed transfer of care on census day.

Overview of hospital discharge practice

4.4 Initially work focused on discharge process and what was integral to achieving a positive experience for people and carers/families. Members were very clear in terms of identifying that good communication was essential at all stages in someone's journey to ensure everyone was informed and contributed to decision making.

4.5 Members were provided with documentation that should underpin discharge planning which should start at point of admission such as "Passing the Baton" (please refer to appendix 1). Particular issues were identified in respect of people moving to long term care from hospital. The review group were informed that the revision, launch and training on the Accommodation Choice Policy should have a positive impact on this, particularly the use of the third sector in terms of training CHAAT (Care Home Ask and Talk) volunteers to assist with the process of decision making and then following people up in their new homes.

Performance

4.6 Members received a presentation which covered background data to hospital discharge, inappropriate discharges and delayed transfer of care. Full details can be found in appendix 2.

4.7 To put the work in context members were advised that for a 6 month period 1st January 2015 to 30th June 2015 there were 6686 discharges involving Caerphilly residents from a variety of hospitals, this excludes day cases, of these 123 requests were for restart of existing care provision, 269 were referred to the joint hospital discharge team for an assessment.

4.8 Information was provided in terms of support people require to be discharged, this included details on vacancies available in long term care across the region. The current vacancies position illustrated capacity in the care sector to meet levels of demand which is essential for seasonal planning purposes.

Inappropriate Discharges

4.9 The review group considered inappropriate discharges in terms of reporting, investigation and the main reasons that a discharge was seen as poor or inappropriate. Members found that the reasons for this included:

- Medication management.
- Providers not informed.
- Person was medically unwell resulting in readmission.
- Paperwork not available in relation to Continuing Health Care.

4.10 Members were informed that the hospital discharge team had a reporting mechanism to record instances of inappropriate hospital discharges since January 2015. The review group found there had been 23 reports between January 2015 and October 2015, however it was suspected that there was significant under reporting. Members were reassured that efforts to encourage and raise awareness of the importance of reporting these cases had been undertaken.

4.11 The review group were informed that all cases are logged and will identify individual hospital wards. These cases are reported directly back to the Health Board who will investigate, with some cases highlighting a training need for ward staff.

Delayed Transfer of Care

4.12 Delayed transfer of Care is seen as the main reporting mechanism and is the judgement used by Welsh Government to determine how well a Health Board and Local Authority are performing. Members recognised that this is an arbitrary measure that counts people rather than percentage of the population for each local authority and noted that this issue has been raised with Welsh Government.

4.13 The review group were pleased to note that social care delays had improved dramatically from the previous year where Caerphilly County Borough Council were ranked at 22nd in the all Wales league tables, it was noted that CCBC is now ranked 13th which is below the target identified for delays for social care reasons.

4.14 The review group sought information on the impact of the Continuing Health Care assessment process upon DTOC and whether the approach adopted in England could be considered. Members were informed that the approach involves discharging to a care home whilst the CHC assessment is carried out, and would require the Health Boards to commission beds in the care sector. This has been tried in Cardiff area but subsequently ceased, there are concerns that vulnerable people could be moved more than once which can have a negative impact on their wellbeing. This is something that is being given further consideration in relation to the Intermediate Care Funding available to the region.

4.15 The review group asked if there have been improvements in the CHC process and were informed that new guidance received last year has improved the process but assessments can still take up to 2 months. The CHC team meet weekly to consider applications but there can be delays where the ABUHB funding panel seek clarification and evidence from ward staff to support the CHC application.

Communication

4.16 The review group sought information on the involvement of people and carers/advocates in the hospital discharge process. Members were informed that there is new documentation with clear pathways and plans, and people and carers are always involved and provided with feedback. The review group expressed concerns that it can be difficult for some people to fully understand and retain this kind of information and that it would be helpful if there were leaflets available with the generic details set out. The health Board are currently out to consultation on a range of leaflets designed to improvement communication, the consultation ends on the 11th June and LA will be sending a response. It was acknowledged that a key factor for an inappropriate hospital discharge was poor communication.

4.17 The review group discussed the use of key workers to ensure that people and carers have a named point of contact however a key worker cannot always be on duty. Members agreed that there needs to be a universal process for discharge and the Health Board needs ensure that a key worker is allocated with a backup or system to ensure continuity. The Health Board acknowledged this, and advised due to the current reliance on bank and agency staff this is difficult to implement.

4.18 The review group questioned why the NHS continued to use fax machines to send information to GP surgeries, and what plans are in place to improve efficiency. Members were informed

that there are plans to pilot a single information system that by Health Board and Social Services in Bridgend, which could make a difference.

Winter Plan

4.19 Integrated winter planning was a key strategic priority for Welsh Government and Aneurin Bevan University Health Board for the winter period. The review group received an overview of the plans submitted to the Minister for winter pressures on a Pan Gwent basis on behalf of the 5 local authorities, ABUHB and Welsh Ambulances Services Trust (WAST). The aim of the plan was to reduce both the amount of people classed as delayed transfer of care and the time they spend in hospital referred to as length of stay.

4.20 The key themes of the plan were as follows:

- Prepare the population
- Work in collaboration to provide quality services
- Plan services to optimise effective service user care and experience
- Make the best use of the resources we have to deliver safe and efficient health and social care

4.21 This included plans for the following areas:

- Public engagement
- Admission avoidance
- Operational readiness
- Patient flow and discharge
- Human resources
- Communication – interagency and staff
- Local Authority actions
- WAST actions

Public Engagement

4.22 The plan outlined a significant public campaign to help people “make the right choices” in terms of who to contact rather than go to Accident & Emergency (A & E), promote healthy life styles and increase up take of the flu vaccination.

Admission Avoidance

4.23 The plan outlined how admissions to hospital can be reduced or avoided by putting in place services and support in the community. Members commented on the plans to target people who attend A & E on a regular basis, with specialist nurses available to triage patients and direct them to more appropriate places. The review group felt that alternative provision would have to be available 24/7 and other agencies would have to reconsider their current practice, for example, GP’s and ambulance staff who will often advise hospital admission when called out.

Operational Readiness

4.24 The plan included modelling of likely demand during the winter period by partner organisations based on the previous year’s data. Members noted that Health considered the previous Christmas period as the most difficult in terms of pressure on services whereas social services found the biggest pressure during the May and August months. There is a need to have reliable data and explore and understand these differences.

Patient flow and discharge

4.25 Where people were admitted to hospital, daily meetings were established to track individuals throughout their stay. In order to ensure they were referred to social services at the right time

and appropriate actions were taken to either pull people out of hospital early or meet their estimated date of discharge.

Human resources

4.26 Plans were in place in terms of staffing for the health board who have recognised a problem with recruitment to certain professions. i.e. Nurses, hence arrangements have been reviewed for the increased use of bank staff, use of agencies and recruitment from overseas which has commenced as well as increased numbers of health and social care workers. The health board are also moving to electronic rostering for staff to improve efficiency.

4.27 Both agencies actively promoted the flu vaccination for front line staff, to reduce sickness absence and prevent the spread of infectious diseases. This year the local authority issued vouchers to enable staff to receive the flu vaccination at a local chemist. This proved popular in terms of increasing up take and is also more cost effective.

Communication

4.28 The review group were informed that there are multi-agency strategic and operational meetings to exchange information. In addition daily conference calls occur between Local Authorities, Ambulance Services and Health Board. There is open dialogue between agencies to try to resolve issues before they escalate

Local Authority actions

4.29 The Local Authority is working to promote wellbeing in the community and awaited guidance from Welsh Government on use of the remaining Intermediate Care Fund in respect of potential of commissioning beds in the private sector by Health to aid discharge. The review group were informed that many vacant beds are residential care beds, whereas the need is for EMI and /or nursing beds.

4.30 Members commented that there are too few EMI and nursing beds available. However the capacity of nursing and residential homes is an area that needs to be addressed nationally this is currently being looked at by the national commissioning group and the care homes steering group.

4.31 Local authorities agreed to standardise response time for commencing assessments to 48 hours and keeping packages of care packages open for up to 2 weeks to enable them to be restarted where an individual's needs remain the same. This is already the case with CCBC. There is also a role for the voluntary sector in supporting hospital discharge for those people primarily deemed as not eligible for social care intervention.

WAST actions

4.32 WAST put specific plans in place, to triage people who fall rather than take them straight to A & E and hoped this will have a positive effect on prevention of unnecessary admissions to acute hospitals. The service introduced a 5 step plan and was achieving better performance by managing its demand. There were also plans for specialist paramedic practitioners, a falls response team and consideration of an alcohol treatment centres.

Initial Conclusions

4.33 The task and finish group recognised that hospital discharge is complex, and contributory factors include the number of discharging hospitals and health boards that relate to Caerphilly residents. The impact of other policies and national drivers that specifically relate to the county borough such as the Health Repatriation Policy and reporting mechanism will put different tensions in the system.

4.34 There has been a national focus on delayed transfers of care and winter pressures by Welsh

Government. However there is a need to get things right for people and their carers/families, ensuring good communication to enable effective decision making. Partners need to work together across the statutory and third sector to ensure best use of scarce resources in a time of austerity. There is a need to inform and involve the public, manage expectations and plan for increasing demographic pressures to ensure the system is fit for purpose going forward, with the development of preventative services.

4.35 However before finalising its conclusions and recommendations the review group felt it was appropriate to allow the winter plan to be put into place and receive feedback on the success or otherwise of the plan.

Feedback on Winter Plan

4.36 The review group received a presentation on the outcome of the winter plan and were pleased to meet with representatives from Aneurin Bevan Health Board. The main feedback included the following points:

Integrated Working

- Weekly updates were provided to Welsh Government to give performance data (RAG).
- Seasonal pressures - Royal Gwent Hospital peaked at level 2 (compared to red/black).
- Joint Training on Accommodation Choice Policy was implemented and monitored.
- There is a clear commitment to work jointly.

Initiatives

- The vouchers for flu vaccines were introduced,
- WAST falls pilot was implemented with the aim to reduce hospital admissions.
- Weekly meetings to discuss complex cases along with an escalation process.
- A discharge procedure for Continuing Health Care assessment was implemented.
- A 24/7 nursing provision was introduced.

Welsh Government

- Additional funding for the Intermediate Care Fund was provided during the January to March period.
- Quarterly meetings were held with all partners to discuss hospital care
- DToC regional validation is carried out across Gwent to ensure consistency.
- There are plans to hold a workshop with Welsh government to discuss DToC codes.

Local Context

- Additional beds were opened at Royal Gwent Hospital (RGH).
- A media campaign aimed at both the public and staff using the 'choose well' was carried out.
- The anticipatory care planning pilot in Newport targeted people to prevent hospital admission by anticipating care needs.
- Staff recruitment in the NHS for Hospital Nurses recruited both locally and from Italy.
- More focus on length of stay for those in hospital as opposed to focussing on the number of people delayed in hospital.
- The closure of the Brin Darvan care home where 28 people had to be moved into new homes across Gwent, was carried out successfully.
- Assessment beds criteria was made consistent across the region

4.37 The review group were informed that the evaluation of the plan identified key learning points, detailed as follows:

- Importance of whole system partnership working.

- Recognition that there wasn't any significant winter weather and winter illness however the system still remained under significant pressure.
- Focus on length of stay was positive in terms of reduction of overall bed days lost.
- Regional validation of DToC ensured consistency.
- Greater focus on prevention of admission was needed.
- Use of vouchers for flu increased uptake.
- WAST pilot considered successful - 67% remained at home 33% previous year
- Additional capacity in respect of beds was identified and used 28 beds in RGH.
- Health Board recruitment was successful and assisted with capacity.

4.38 Members sought reassurance that people were not being left at home with injuries such as fractures, which are difficult to detect. The review group were informed that if WAST staff were in any doubt they would take the person to hospital. The Health Board also assured the review group that they had received additional funding which has enabled them to engage additional 15 FTE nursing staff who provide 24/7 cover to provide care for falls patients as part of their remit.

4.39 Members sought additional information on the recruitment of nurses from overseas. The Health Board informed the review group that overseas recruitment is part of the approach, alongside re-skilling existing workforce and encouraging young people to take up nursing.

4.40 Members asked ABUHB how they would measure improvements in hospital discharges, and were informed that monthly indicators show that concerns are decreasing, the average length of stay is reducing and readmissions are decreasing. Compliments are increasing and there are tangible examples of improvements.

Communication

4.41 The review group explored what improvements there had been with communication for both patients and carers during this period. The Hospital Discharge Team Manager stated that he felt that communication had improved, there is a collaborative and collective effort to improve in this area, although there can still be cases where communication can break down. Staff within the team report that things have improved and data around complaints and the number of inappropriate discharges appear to back up this perception.

4.42 Aneurin Bevan Health Board representatives outlined their actions during the previous 6 months. Patients being discharged were asked to complete a questionnaire, and communication was identified as a key issue. This had resulted in the development of new leaflets to be issued to patients and carers (appendix 3). In addition previous information had been re-issued, such as the 'who's who' which gives an explanation of hospital staff uniforms. Members commented that this was an improvement, particularly the leaflet on 'Choice of Accommodation' which better explains the choices available to those who need to consider the transition to a care home setting. Members were reassured that these leaflets serve as a back up to a conversation with the patient and carer and are not a replacement.

4.43 The Hospital Discharge Team Manager informed the review group that the Older Peoples Commissioner for Wales has also produced a useful booklet to help people choose a care home and his team will offer to assist relatives with the process. Members were also informed that CSSIW are piloting a rating system, although they have no plans to introduce this yet. In addition Health have set up a Good Care Guide on the same lines as Trip Advisor where residents and families can give reviews on the care homes. It was noted however that homes do not have to participate.

CONCLUSIONS

4.44 The review group recognised that plans had been put in place to cover the winter period alongside other pilot schemes to deal with communication issues within hospitals and with partner organisations, patients and carers.

4.45 Members welcomed the outcome and learning from the winter plan and also the production of the information leaflets which will be available to both patients and families.

4.46 The review group concluded that further examination of the differences between the pressures on Health during the Christmas period and social services where the pressure is during the May and August months. There is a need to have reliable data and explore and understand these differences.

5. EQUALITIES IMPLICATIONS

5.1 An EqIa screening has been completed in accordance with the Councils' Equalities Consultation and Monitoring Guidance and no potential for unlawful discrimination and/or low level or minor negative impact have been identified, therefore a full EqIa has not been carried out.

6. FINANCIAL IMPLICATIONS

6.1 There are no financial implications in this report.

7. PERSONNEL IMPLICATIONS

7.1 There are no personnel implications in this report.

8. CONSULTATIONS

8.1 There are no consultation responses that have not been contained in this report.

9. RECOMMENDATIONS

9.1 The review group recommend to Health Social Care & Wellbeing Scrutiny Committee the following:

9.2 That Aneurin Bevan University Health Board, Caerphilly County Borough Council and Wales Ambulance Services Trust recognise the fundamental importance of good communication between patients, relative's carers and staff.

9.3 That Scrutiny committee endorse the production of the information leaflets attached as appendix 3. These should be available in other formats.

9.4 That Health and Social Services continue to work together to improve joint planning arrangements in respect of hospital discharge.

9.5 That a follow up report is brought to Scrutiny committee within 6 months, this will include an update on the numbers of inappropriate discharges (as set out in 4.10 and 4.11).

10. REASONS FOR THE RECOMMENDATIONS

10.1 To ensure Health and Social Services continue to work together and provide the committee with information to scrutinise.

11. STATUTORY POWER

11.1 Section 21 of the Local Government Act 2000.

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Appendices:
Appendix 1 - Passing the Baton – Chapters 2, 3 & 4
Appendix 2 - Presentation hospital discharges, failed discharges & DTOC
Appendix 3 - ABUHB Leaflets

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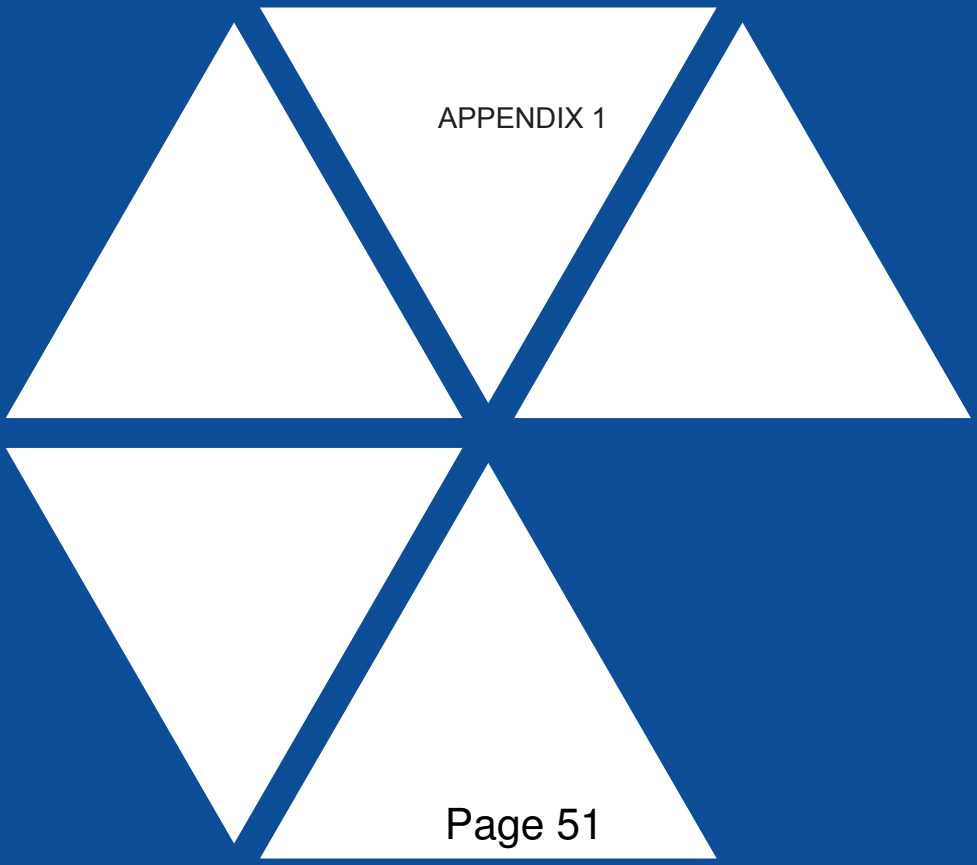
Chapter 2

Communicating with Patients and Families



Communicating with Patients and Families

Chapter Overview

The aim of this Chapter is to emphasise that communication is the most important tool in supporting the individual's experience. Not only can good communication help the individual and their carers at a particularly frightening and confusing time, but it can also ensure that the team who are caring for the person are doing just that – working as a team with all the information they need at their disposal.

This Chapter suggests considering communication from the perspective of the patient or service user. How would you like to be spoken to? What information do you think you need?

Practitioners work in a wide variety of settings and the demands made upon them can be immense.

"If we can build up a rapport with people by being able to empathise with their predicament, fears, and concerns and have an understanding about what is of value to them, then we will have a significant positive impact upon their experience of our care services."

Having an open and positive relationship with patients, their family and carers will make the discussions required to plan the discharge productive and smooth. Tools such as the Communication Audit can help Practitioners to think about the information that is needed especially when care is provided from different care settings and other supporting organisations.

The Most Important Skill

Although communication has a specific chapter, the theme of communicating effectively is uniquely sewn in and amongst everything within this Guide, underpinning all of the ideas and recommendations.

"Communication is the most important human skill... up to three quarters of our waking time involves reading, writing, talking and listening... 40% of that time is spent in listening yet we are never really taught how to listen."
S. Covey

Throughout this Guide there are a variety of ideas, techniques and examples of good communication practice in relation to discharge planning. There are also examples from organisations across Wales, on the accompanying CD, of good information, written for a huge variety of circumstances, in a wide range of formats, aimed to meet the needs of diverse groups of people.

The principles of this Chapter, and indeed the Guide as a whole, reflect on and comply with 'Fundamentals of Care: Guidance for Health and Social Care Staff' which you can access via:

http://www.wales.nhs.uk/documents/booklet-e.pdf

There may seem to be a distinct separation between communicating with a patient, their family and carers and communicating with colleagues and allied professions across the multidisciplinary team.

This Chapter is written in the context of communicating with a patient, their family and carers, however, the principles of being a good communicator are completely transferable. Chapter 1, Principle 1, describes this as creating effective dialogue.

It is this ability to adapt to meet communication needs that determines how effective we are. Although there are some examples of what information to communicate, the learning and practice is focussed on how and when to communicate:

- In a way that always considers the whole person and their past and present circumstances, as well as their need for information
- At a time that helps to reduce anxiety, maintain realistic expectations and promote and enable shared decision making

Planning & Communication

"Planning in its simplest terms is merely the formation of a collective view of the future."

It is a view because it is based on what has happened so far and it is collective, because forming the view and enacting the future will inevitably involve agreement with other people.

In terms of planning for discharge, this definition seems to relate directly to what is required of the multi disciplinary team. Gather information on what has happened to the patient so far; form an agreed view of when the patient could leave hospital and enact what needs to be achieved to reach a safe and timely discharge in the future.

Understanding Expectations

One of the biggest problems identified in managing discharge is dealing with surprises towards the end of the episode of care. Many surprises are not even clinical in nature and are simply where the patient, their family and carers did not expect things to happen in the way they do.

This mismatch of expectations is the result of inconsistent or poor communication earlier in the patient's experience.

"A normal busy day involves working within limited resources and following organisational policies and procedures, constrained by time. Subsequently our day to day systems and processes can lead us away from some of the essential components of practice that are less easy to define and measure."

The most common theme in formal complaints across the entire NHS is poor communication. It is therefore important that communication is seen as more than information giving. People can tell very quickly if you are distracted and not engaging with them in a meaningful way.

Aiming to understand and manage expectations is a useful objective in considering when and how to communicate. It is important to keep checking that the person has heard and understood what has been communicated.

Those aspects of a patient's experience that are considered most valuable, are grounded firmly in the compassion of frontline staff, are developed from a deep sense of respect for each other and are evident as a bond of trust when it matters most.

Obligations & Empathy

Practitioners are obliged to ensure that patients are fully aware of their circumstances and are able to give informed consent.

This means they must have enough information, and understand that information, to be able to make choices and arrive at a decision. If the patient may not have capacity then an assessment will need to be made to decide whether:

- More support is needed so that the patient can make decisions
- The patient does not have capacity and the rights and obligations under the Mental Capacity Act will be triggered (see Chapter 5)

This requirement is explicit in training and reinforced in practice. There are specific questions to ask and forms to sign and these are an important professional and legal requirement.

However, there is a side effect of this process driven interaction, especially when it is perceived by Practitioners as professionally right and therefore the right way to speak and engage with people.

It is normal on a busy day to deal with people quickly and even efficiently, but without really taking time to listen and understand their needs. With no intention to be offhand, Practitioners can easily slip into poor practice, jumping in, quickly predicting questions and almost using a set of scripted phrases or familiar responses.

"I know that lots of people come and go, but by the end of the week I could tell you what he was going to say next, no matter what the question."

In essence we have a professional obligation to ensure that we are properly understood. Yet the most effective communication methodologies suggest that to really engage with someone, you must first seek to understand the other person before trying to make yourself understood.

"Research has shown that the paperwork required to comply with these obligations is often used to script the conversation. The process becomes dominant and can actually result in distracting the Practitioner from properly engaging with the person in front of them."

Understanding the other person is not just listening to their words. To fully understand someone, you must put their point of view into context. Pay attention to their frame of mind, how they are feeling, who is involved and why they happen to find themselves talking with you. Quite often these feelings are expressed or accentuated through a person's body language.

This understanding of another person from their point of view is called empathy. Once you consciously have empathy with another person you are better able to adapt yourself to meet their needs and enable them to understand you.

The first product of communication is Empathy

There is a really simple technique for breaking your train of thought, reminding yourself not to script and reframing things in your mind to be more attentive and empathic:

STOP ↓	Say the word "stop" in your head; stand still, preferably put down anything you're carrying, remind yourself this is important and recognise your own frame of mind.
LOOK ↓	Say the word "look" in your head; be aware of your immediate surroundings, notice how the person may be feeling and move to respond to them; stand up or sit down, as they are.
LISTEN	Say the word "listen" in your head; don't think of answers while they are speaking, make a point of really trying to understand them by checking back with them, before answering.

If you practice this regularly, especially in busy moments, the three words will start to come naturally to you. It will take literally a few seconds to change your frame of mind, empathise with the person and be a better communicator.

Understanding Implications

The implications of good and bad communication are far reaching, like a pebble thrown into a pond the ripples can be seen long after the first splash has gone.

We know that the effects of poor communication on a person can be emotional, social and physical. In clinical governance terms ineffective communication can cause real harm in the form of events like medication error. These sorts of events have a consequence for the professionals involved as well as the organisation as a whole, giving them a high profile.

On the other hand, good communication practices have less of a profile, with most of the best outcomes going virtually unnoticed. This may sound discouraging at first, but actually helps to understand how good communication works in practice and there are no individual grand answers or universal techniques.

"Effective communication relies upon many simple things done consistently."

Public and patient involvement work across the NHS has provided an element of feedback that is consistent across many groups; that patients, their family and carers are confused by the system.

This results in a lack of understanding and a feeling of a loss of control. The system therefore, appears complicated and disempowering especially when language changes and processes don't appear joined up. In truth, this feedback is echoed by a large proportion of staff.

A Vicious Circle

When the care plan doesn't follow the expected route it is even more important to communicate relentlessly:

"My 84 year-old Grandmother who died recently in a nursing home would have been able to live independently in her own home for much longer had communication systems been more robust when she fell and broke her hip 3 years ago on Christmas Eve. Initially she recovered well from the operation and was walking again the next day but suffered 2 falls on the ward, contracted MRSA, malnutrition for not eating for 5 days un-noticed, and her mental health declined after 16 weeks of bed-blocking due to a catalogue of delays in scans and assessments, treatments and discharge arrangements. Hospital advocacy services would have improved her informed choice on accommodation and care on discharge. There are many competent and caring staff within the health service but time again it is the information systems that let patients down."

A Virtuous Circle

Recognising some of the simplest human needs with empathy and acting upon them in practical ways can improve the patient's experience and create trust:

"One out of 10 of the nurses showed common sense. She asked us what my mother's children's names were; she had 4, and wrote them on big piece paper and put them above the bed. She instructed all nurses to communicate using one or all names in conversation and then asked some simple questions how she liked her favourite cup of tea; her favourite food and the town she lived in. These were familiar things which enabled her to feel she was being cared for in between our visits."

Understanding Practicalities

"Information in any form is never an adequate replacement for effective dialogue."

Despite the limitations of information, considerate language, well written literature, clearly designed diagrams, simple signposting and accessible media in any format all help to complement and reinforce the dialogue.

The task of communicating effectively then becomes a process of considering how to engage with the person from a menu of tools and techniques. There are six practical steps to consider:

1. Be clear about who should be communicating what and with whom, to avoid duplication
2. Be able to relate yourself to the person and adapt your approach to suit their needs
3. Identify the best medium for supporting information using appropriate content and format. Be particularly aware of the need to adapt the type of communication method you use when dealing with people with sensory or cognitive impairment
4. Use standardised basic information but individualise it with further details specific to the person
5. Ask directly how the person would prefer to have information and identify special communication needs
6. Explain your responsibility to communicate effectively and always invite the person to ask anything, however simple

A key determinant of this effective dialogue is acknowledgement of the level of understanding of the people involved in the dialogue.

For example if you are talking to a person with a long term condition and several previous admissions to hospital, it is likely that they will have a good understanding of their circumstances and the journey ahead. The dialogue in this case could be more sophisticated than the dialogue with a person who has never been in hospital before.

Consequently over a period of time in hospital the patient, their family and carers will increase their understanding gradually and the dialogue with Practitioners should change to complement the increased understanding.

This flexibility in approach is discussed in "The Knowledge Barometer" section at the beginning of the Guide.

Setting Time Aside

Considering the potential consequence of good and bad communication on both the patient's experience and the organisation's credibility, communicating effectively is a core business and the responsibility of every member of staff.

If you have something important to communicate, reflect the importance of the dialogue by taking some time to plan what you're going to say. Agree with your colleagues to protect some time from interruption, and let the patient know that you've set aside some time to come and talk with them. Chapter 3 advocates this sort of dialogue as an everyday duty called a 'Daily RAP'.

"I saw my Dad in that chair and made it my mission to make sure he got home. It was all he really wanted and I made sure everyone knew it."

Continuous Improvement

"Communication issues are notoriously difficult to distil down to specific improvement work as the subject touches on such a broad range of areas across all of our work."

Monitoring the effectiveness of team communication is an essential and proven method of slowly and consistently improving the experience of the patient and developing better working relationships.

Action Not Just Words

The key to making small and continuous improvements in practice is having the courage and opportunity to question the way things are currently done.

"The real key to making significant improvements is not in an organisation's ability to solve its problems; it is the ability to see its problems."

Once issues are identified, people need to feel that it is safe to constructively criticise existing practice. This is hard to do as the common response is to defend what is done now.

So that issues do not become confrontational, the goal should not be to solve all the problems in one go. Try to find consensus on a particular issue that everyone agrees on and act on it. No matter how small, this will start to gain momentum and the trust of everyone concerned.

This is an important principle that can quickly become part of the culture of a team or department. In order to find consensus you must talk to people openly and honestly in a supporting way and regularly check back with them that you all agree on the same thing.

This process is equally relevant for the relationship with the patient, their family and carers. It is a method of engaging with people so that they can be involved and share decision making. It is based on a simple test; that what was intended to be communicated is the same as what was understood.

The last product of communication is Agreement

This does not mean that everyone has to agree intellectually with everything that has been communicated, but they do have to agree that what was said was understood.

Communication Audits

There are a number of communication audit tools available on the internet that can be found from a simple search. They are usually designed to meet a specific local need or subject of inquiry but are fairly straight forward to adapt.

The following audit tool was developed as an exercise for working teams to identify broad areas of weakness in local communication practice.

The statements are like goals that reflect good practice and, subject to a little consensus across the team, small scale improvement projects can be designed to help achieve the goal.

Communication Audit Tool

Aim to Reduce Anxiety:

☐	There is a consistent use of language and terminology across the whole clinical team and acronyms are avoided
☐	The patient experience leads the drive for improvement rather than other performance indicators
☐	Consideration is always given to how and when to communicate and then what information to give
☐	There is a clear process of escalation where needs and circumstances are becoming more complex

Recognise Cultural Differences:

☐	Ethnicity, gender, sexuality, geography, economics, social history and family structure are taken into consideration
☐	Literature is always designed to reduce the apparent complexity of health and social care system
☐	Non clinical information is communicated every time for every patient at formal handovers
☐	The patient's own language is used on reports and assessments to emphasise important issues

Overcome Operational Issues:

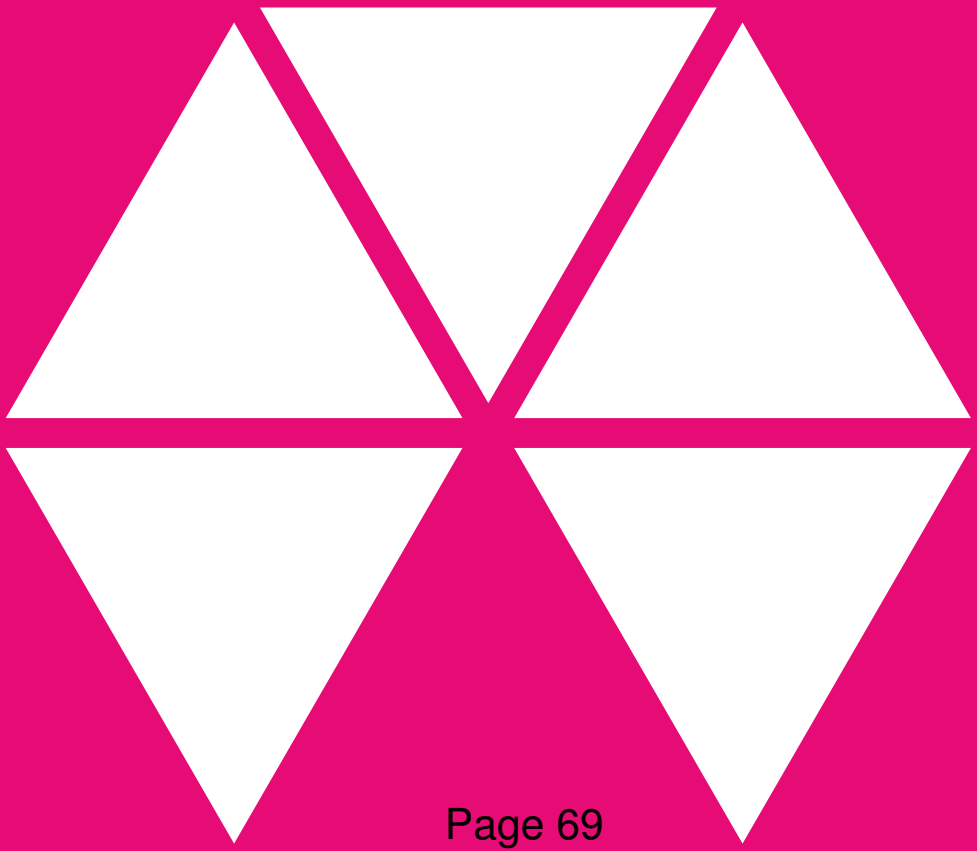
☐	Practitioners responsible for communicating are trained with the appropriate level of knowledge and skill
☐	Practical options are in place to provide information at all times of day throughout the episode of care
☐	Communication and supporting literature is designed to meet the needs of elective and emergency pathways
☐	Documentation is shared professionally at every opportunity and checked back with the patient

Take Personal Accountability:

☐	Communicating continuously without having to be asked is a core duty, so the patient plays an active role
☐	Staff take personal responsibility to act on information and the wishes of the patient as their advocate
☐	Standard literature and information is supplemented to meet the needs of each individual
☐	New technologies and methods are used to trigger active engagement and enable effective communication

Chapter 3

Assessing the Whole Person



Assessing the Whole Person

Chapter Overview

This Chapter will show the importance of assessing the person from a number of perspectives in order that their needs can be understood and planned for. To make discharge safe and effective for everyone will require a great deal of skill and expertise on behalf every Practitioner involved.

People who are admitted to hospital have such a broad range of needs. They could receive care for less than four hours in an A&E, or more than four months in a community hospital. In such diverse circumstances a person centred approach to assessment is required to ensure that individual needs are met. In truth, most Practitioners can assess most of the people who require our services.

The '4Ps' and the 'Daily RAP' are tools described in the Chapter that will help Practitioners to complete the assessment process and build confidence and expertise. If they are undertaken consistently, they will inform and enhance the care delivery process contributing ultimately to a smooth discharge. Over time, this will mean less reliance upon the Discharge Liaison Nurse and other specialist Practitioners. Assessments done well will help to plan for discharge, and where appropriate take remedial action to resolve issues and problems at an early stage.

Finally, discharge is a multidisciplinary process driven by team working, however rather than this being an opportunity to rely on others to facilitate the discharge, it emphasises personal accountability.

Working With Whole People

This Chapter re-visits many of the tried and tested assessment and discharge planning processes that are routinely used by Health and Social Care Practitioners. It suggests how to get the best out of these talents.

When a person is admitted to hospital, Practitioners must quite rightly focus on immediate clinical issues. However, prompt consideration of the individual as a 'whole person' is required to ensure that optimum recovery is possible and that the return home, or transfer to ongoing care, is safe.

"A patient is the most important person in our hospital. He is not an interruption to our work. He is the purpose of it. He is not an outsider in our hospital. He is a part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so."

Admission to hospital is an unpleasant disruption to people's normal lives. Professional priorities should focus on supporting timely return to the previous, or a new, equilibrium.

Assessment for Discharge, what is it?

Discharge planning has become a priority for the NHS and its partner organisations, with increasing requirements to demonstrate improvements in their assessment and planning processes.

The purpose of assessment is to evaluate the effect of an individual's presented need on their independence, daily functioning and quality of life, so that appropriate action can be planned.

National Assembly for Wales Circular 2005/17 states that:

> *"An assessment of the patient's needs by the care co-ordinator to determine actual or potential problems begins on admission or even pre-admission wherever possible. This enables continuity and co-ordination of health care on discharge."*

Assessment is a continuous process that commences in the community where early proactive intervention can avoid the need for an emergency admission, or aid prompt discharge following an elective procedure. It must include the individual, their family and carers and is a process made up of several key interlinked components:

- Person Centeredness
- Early Planning
- Communicating Effectively
- Continuity of Care
- Assessing & Managing Risk

"People may not say it out loud, but hospital is frightening. I'm a grown man and it made me feel like being a kid again; not quite sure where I am or what's going to happen next ... and when can I go home?"

Person Centred Approach

Health and Social Care Practitioners must recognise that the individual and their carers are the "experts" in how they feel. Furthermore, some individuals and carers also gain expertise in living with or caring for someone with a particular long term condition.

National Assembly for Wales WHC 2002/32 states that:

> *"The Practitioner needs to achieve a person centred approach to assessment where the patient is an active partner. The assessment should be proportionate to need with family and carers involved as appropriate."*

It is essential that any assessment and care planning process continually engages the individual and their carers and provides information in a way that helps them.

The benefits for the **Person** of effective assessment and discharge planning include:

- Understanding how the person's situation has arisen to identify and meet their needs
- Maximising independence by feeling part of the care process, to really understand and sign up to the ongoing care plan
- Experiencing care as a seamless journey not a series of unrelated activities
- Believing they have been supported and have made the right decisions about their future

The benefits for the **Carer** of effective assessment and discharge planning include:

- Feeling valued as partners in the process
- Having their contribution recognised and not taken for granted
- Being aware of their rights to have their needs identified and met

- Feeling confident about support in their continual role and getting support before it becomes a problem

More information and the rationale for Person Centred Care can be found in the National Service Framework for Older People in Wales (Welsh Assembly Government, 2006).

Estimated or Predicted Date of Discharge

Creating this joint working relationship will facilitate the setting of a predicted or estimated date of discharge (EDD).

Department of Health toolkit published in 2004 states that:

> "The Estimated Date of Discharge will be proactively managed against the treatment plan, usually by the ward staff on a daily basis and changes communicated to the patient. This is vital for the patient to understand how long they are likely to be in hospital to plan for their return home."

The 'Guide to Good Practice: Emergency Care' produced by Innovations in Care (IiC) Team in 2004 and available from NLIAH, describes the use of EDD also referred to as PDD in some areas, as follows:

> "EDD is based on the expected time required for tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be medically/clinically stable and fit for discharge. Decisions regarding discharge should involve patients and carers and be made following senior assessment on admission. The expected date of discharge should be documented in the patient notes/record and care plan.

Predicting Length of Stay or Planned Discharge Date:

The prediction of Length of Stay for patients enables an organisation to ensure that patients are progressing through their care pathway at a predetermined rate. This should be based upon best clinical practice and ensuring that patients progress in a structured manner through the value steps with the minimum of waits, mistakes and other wasteful inhibitors.

There are a number of ways in which predicting length of stay can be undertaken. It can be based on the actual current performance using:

- ICD 10 codes
- Health Resource Group (HRG)
- Sub specialty information systems

It can be based on benchmarked information:

- National Audit Office: Acute Hospital Portfolio www.audit-commission.gov.uk
- CHKS data subscribed bench mark information: CASPE Healthcare Knowledge Systems Limited

It is important that organisations understand the system, which will give them a predicted length of stay for each patient admitted to hospital, emergency cases as well as elective cases. The process for predicting this length of stay has to be both valid and sustainable."

Planning Assessment for Discharge

Using the person centred approach, the admitting nurse needs to identify whether the patient's discharge is likely to be simple or complex.

A method of making this decision is described within the 'The Knowledge Barometer' at the start of this Guide. In addition, if it is suspected that the patient lacks mental capacity, a further assessment is required as described in 'The Mental Capacity Act' section of Chapter 5.

The following definitions of simple and complex discharge are taken from the IiC 'Guide to Good Practice: Emergency Care':

"Simple discharge:
Patients with simple discharge needs make up about 80% of all discharges and are defined as patient who will usually be discharged to their own place of residence, or who have simple ongoing care needs not requiring complex care planning and delivery. The level of on going care required is the important factor in the relative complexity of the discharge process.

Complex discharges:
Occur where the length of stay is difficult to predict, where patients are likely to have complex on going health and social care needs requiring detailed assessment, planning and delivery by multi-professionals and multi-agency teams.

The timely assessment process commenced on admission will identify those patients who will potentially have complex discharge needs and facilitate further comprehensive assessment and planning."

Staff such as Discharge Liaison Nurses or Care Coordinator will be able to provide you with specialist advice and support with complex cases.

The function of assessment Heartfield [1996] and Allen [1998] can be summarised as follows:

- To ascertain patient, family and friends potential needs
- To provide information on which to plan interventions and thus to achieve appropriate outcome
- To document and record the relevant areas assessed, to act as a baseline for reassessment and evaluation of care given
- To act as an instrument for safety, continuity and quality of patient care
- To facilitate the structuring of knowledge for nursing practice
- To fulfil legal and professional obligations

"It is vital that Practitioners do not prejudge the eventual outcomes for the patient prior to completing the whole person assessment."

The patient has the right to be given every opportunity to meet their optimum potential, for example through rehabilitation and to have full access to the range of services for which they are eligible.

Communicating during assessment

At the heart of coordinating and planning discharge is:

- the ability to communicate accurate information from the patients and carers perspective and to ensure that their views are conveyed and understood
- the ability to share the relevant assessment information between the professionals involved in the patient's episode of care
- the ability to provide feedback to the patient, their family and carers in a way that they can understand

In order to ensure the patient receives appropriate care at home or in their new care environment further coordination with the following agencies may be required:

- GP/Practice Nurse
- District Nurse Service
- Specialist Chronic Conditions Management Teams
- Community Mental Health Teams
- Social Services
- Local Authority or Voluntary Sector Housing
- Intermediate Care Services
- Voluntary Agencies providing 'low intensity support' eg Hospital Discharge or Good Neighbour Schemes
- Care homes and independent domiciliary care providers

"Careful talk saves lives"

Coordinated, safe and timely discharge planning is based on professionals working together with the individual to develop shared outcomes and an agreed plan of care. A lack of communication and compatibility of assessments can result in a domino effect for people with complex needs:

- undergoing multiple assessments
- uncoordinated and premature discharge
- result in the patient being poorly prepared
- discharge with needs unidentified and unmet
- increased risk of readmission

The following is an example of what can go wrong if we don't all work together. It is taken from 'You can take him home now; carers' experiences of hospital discharge' (2001):

"Admitted by ambulance to A&E, 21 February. A few tests. Go home, take antibiotics. Next day, GP visited, called 999, readmitted. Discharged 3 March contrary to my wishes. Ambulance again to go to A&E. Longer stay and recuperation at local cottage hospital. Home 25 March. 21 May during routine check up at surgery, ambulance called to go to A&E. Discharged too soon, on 4 June. On 7 June called 999 again, back on oxygen on the way to hospital. This went on until I learned about the hospital discharge drill at my carers' forum. I refused to take her home. After the right discharge procedure, help was arranged at home, the patient improved much more quickly and a better recovery than ever before."

Managing Medication

This is a common area where miscommunication can directly lead to an adverse effect on the patient's condition.

A typical scenario is where the patient is admitted with one set of prescribed medication, which is changed during their hospital stay.

It is vital that these changes are properly communicated to the patient, their family and carers and that the new routine is fully understood. There are a number of high profile cases where failure to do so has led to catastrophic results.

A relevant case study has been included later in this chapter.

Continuity of assessment

In undertaking individualised assessment it is recommended that professionals consider the '4Ps' principle:

1 Previous	The patient's general circumstances, lifestyle and events leading up to the admission
2 Present	The patient's current condition and how they are dealing with the changes
3 Predict	The factors likely to impact on completing a successful discharge for this patient
4 Prevent	The actions required to overcome problems and prepare the patient for discharge

Creating an individualised assessment is the best way to fully understand the patient. It is more than answering a set of predetermined questions and is therefore, difficult to complete in one go.

Whereas a great deal of information can be gathered at the first assessment, building a picture of the whole person will require an ongoing approach. Over time, the picture will gain additional detail and should reflect changes in the patient's circumstances or condition.

Using the analogy of passing a baton, imagine the day of discharge is like the Olympic Final of a Relay Race. To successfully carry the baton across the finish line in a good time, each team of athletes must work as a single seamless system. In athletics, a good performance on the day is achieved through relentless preparation and developing the necessary skills and tactics.

Using the '4Ps' is like developing the race tactics. It requires an in-depth understanding of physical and emotional strengths and weaknesses, deciding in advance how to run the race on the day and taking responsibility to maximise the chances of success by putting the plan into practice. Think of it as all the things you need to know, to produce your best performance.

The table below contains a sample of simple questions under the '4Ps' that should form part of an individualised assessment. The things you need to know! The lists are not exhaustive and in practice the questions must be relevant to the individual.

The table has been formatted with extra space so that Practitioners' can add in any additional questions that are particularly relevant to their own area of practice.

Principle	Example questions
PREVIOUS What were the circumstances prior to admission?	Do they live alone? What was their mobility status? Do they sleep upstairs? Are there stair rails in the home? Is there a toilet downstairs? Are there carers at home or close by? Are they a carer? Do they have any pets? Do they self medicate? Can they cook for themselves? What was the contact with health and social care prior to admission? Were they deemed to have capacity to make choices and decisions? Is their ability and safety awareness consistent? How do they feel they are coping in their usual situation? Is their admission for a new condition or was it an exacerbation of an existing problem?

Principle	Example questions
PRESENT What has happened now to cause admission?	What is mobility status? Do they need help with washing and dressing? What is wound status? Can they still self medicate? Have they fallen and if so why? Has there been any change in mental capacity? Has nutritional risk been formally assessed? If the patient has a long term condition that has been jointly managed with secondary care – is that consultant aware that the patient has been admitted?

Principle	Example questions
PREDICT Identify risk factors that impact on discharge	How will they manage stairs? How will they manage shopping? How will they prepare meals? Will they need assistance with food preparation/eating? Are there environmental factors to cause falls? Will they be able to self medicate? What is the expected level of recovery compared to before? Is any support required likely to be for the short or long term? Is any deterioration in mental capacity likely to be short-term (e.g. resulting from infection) or longer-term (e.g. diagnosis of dementia)?

Principle	Example questions
PREVENTION Act to minimise risk on discharge	Have appropriate referrals been made? Has assistive technology been considered? Adaptations or equipment arranged? Have nutritional needs been met? Carer assessment completed? Care plan agreed & communicated? Has the multidisciplinary team fulfilled its obligations under the Mental Capacity Act?

'4Ps' in Practice

"Mr Thomas is an 82 year old widowed gentleman, admitted following a fall. He sustained a fractured neck of femur and has undergone surgery."

Previous

What were his circumstances before admission?

Mr Thomas normally lives alone in a three-bedroom terraced house, that was home to his family and which he does not want to leave. He has a son who lives away and a daughter who lives locally and provides informal support whilst balancing a full-time job and family of her own. Until now, Mr Thomas has been fiercely independent, and has continued to sleep and use the bathroom upstairs, even though he has experienced increasing difficulty managing the stairs. He exercises regularly with his small terrier dog and normally does his own shopping. His only previous contact with health and social care services has been with his GP surgery. He is on medication for his arthritis and carries a GTN spray for occasional angina. There is no indication that Mr Thomas lacks the mental capacity to make his own choices.

Present

What has happened to cause hospital admission?

Mr Thomas slipped on an icy path whilst walking his dog. His wound is healing well following surgery on his fractured femur and his pain is well-controlled, but he is frustrated by being in hospital. He is able to wash with a bowl at his bedside, but his mobility is severely limited and he needs assistance to shower and go to the toilet. He has become quiet and withdrawn and has

confided to his nurse that he is worried about his ability to keep his beloved dog and about being a burden to his family. He has become increasingly withdrawn and is not eating well.

Predict

Identify risk factors impacting on discharge:

Physically, Mr Thomas was in reasonable good health prior to his fall and was able to cope in his own environment. His ability to cope on discharge will depend on his level of recovery and his motivation. It is evident that the incident has been a great shock to him and he is anxious about his future. In order to achieve the best possible outcome for Mr Thomas, health and social care staff will need to work together in a timely fashion to restore his confidence, to promote his independence and to prevent a downward spiral of depression and increasing physical vulnerability.

The exact risk on discharge is therefore difficult to predict prior to rehabilitation. However, the early assessment information will have alerted Practitioners to the fact that this could be a complex discharge and that the following areas will need discussion and planning:

- The bedroom and toilet are upstairs and even if a reasonably full recovery is achieved, managing the stairs will continue to be problematic. To prevent further risk of falls Mr Thomas, his family and the MDT could consider fitting a stair lift or stair rails or moving sleeping and bathroom arrangements downstairs. Although this must be balanced with the need to maintain activity and increase strength
- Mr Thomas is likely to require support, in the short term at least, with shopping, meal preparation, fetching prescriptions etc
- His dog is an important part of his life and consideration will need to be given as how he can continue to manage to exercise or care for him

Prevent

Minimise risks on discharge:

In order to maximise Mr Thomas's potential for recovery and continued independence, it will be essential to commence rehabilitation as soon as he is medically fit to do so. Timely referral to the MDT will help to address his anxieties regarding resumption of his life at home.

Possible care options to minimise risk on discharge, whilst abiding by Mr Thomas's choices and desire for independence include:

- Adaptations either to enable him to continue to use his upstairs rooms or to bring the facilities onto the ground floor
- Comprehensive assessment of home environment for falls risks
- Support from the intermediate care Reablement Team to restore confidence and continue rehabilitation post discharge
- Assistive technology, including personal alarm and falls detection
- Social care package if required for ongoing assistance with personal care
- Informal support from daughter with shopping etc subject to carers assessment if desired
- Voluntary agency support eg to exercise dog
- Day hospital follow up

Impact of '4Ps'

'4Ps' is an aide memoir that enables you to gradually build a holistic picture of the individual's unique circumstances.

This information will directly inform the discharge planning process ensuring that issues are identified and acted upon in a timely way.

"All clinical areas have some form of admission documentation does yours comply with the 4P's Principle?"

Early identification of a potentially complex discharge can trigger the Unified Assessment and Care Management Process.

'4Ps' will help to manage this process and ensure that the subsequent assessments are carried out at the appropriate stage of treatment and recovery, when the patient's needs, can be accurately assessed.

If transferred either to another ward or hospital, for example for rehabilitation, the same information collated to produce the assessment must be shared with the receiving area or professional to avoid duplication.

Some organisations have developed Integrated Care Pathways that include a framework for discharge planning to assist in ensuring the appropriate steps are taken in a timely fashion.

Assessment information might also indicate the need to commence other pathways which should be actioned by the MDT and linked into care planning and the discharge process.

Assessment & Management of Risk

Identification and management of risk is central to any decision making that surrounds care planning and future care options.

When managing risk in relation to hospital discharge consideration should be given to four factors:

Health & Safety

- Risk to the person's health and safety – consider risk of falls, self harm, ability to manage medication
- Risk to the safety of others – consider safety awareness and behaviour, consider manual handling, behaviour, home environment
- Clinical risks; communication to ensure clarity and accuracy of take home medication & prescription, robust communication of treatment plans to primary or intermediate care services and follow up appointments

Ability to Carry out Daily Routine:

- Physical mobility
- Ability to carry out daily living tasks safely for self and for others
- Requirement for supporting equipment

Capacity for Involvement:

- Strength of social network
- Relationships with family friends
- Work related issues

Autonomy:

- Does the individual have the capacity to make choices and decisions?
- Can they make their wishes and views known, make choices, or do they need help to do so? Does the person have the skills and equipment to be as independent as possible?
- What is their level of self-motivation and initiation?

Risk Record

Relevant evidence needs to be gathered and documented to identify risks in order to reduce or alleviate them and therefore further consideration should be given to:

- Timescale
- Likelihood and Consequence
- Severity and Impact
- Intensity and Complexity

The assessment of the presenting needs and circumstances of people in hospital must involve patients in a meaningful way. Where patients cannot represent themselves, the next of kin, carers, relatives or an advocate must be involved.

Independent advocates may enable views different from the carers to be heard. They can help the patient understand the process, explain the choices and act as intermediaries when conflicts of opinion arise.

Whilst the value of independent advocacy is recognised within the National Service Framework for Older People, such services are not universally provided. Further information can be obtained from www.accymru.org.uk.

"As professionals we are bound to act in the patient's best interests. In your experience have patients been persuaded to enter long-term care as a result of clinical 'risk-aversion'? Is this acting in their best interests?"

The construction and negotiation of risk management requires multidisciplinary team involvement in order to ensure that all the different perspectives are considered and that a way forward is agreed between all those concerned.

The effective management of risk is an obligation throughout all aspects of health and social care work. Specific areas of risk encountered when planning for discharge include:

Medicines Management

A significant risk associated with medicines is mainly due to the potential for error in the information transfer process between the hospital and the new care setting or home.

Risk can be exacerbated by:

- Omissions and errors on the discharge summaries from the hospital
- Delays in the hospital sending the discharge summary to the GP practice
- Delays in acting on discharge information at a practice
- Patients being unclear or ill-informed about their new medicine regimen once they're discharged for example, patients using previous medications as well as new medicines to take away

Failure to manage these risks can result in patient harm and readmission, as highlighted in the following case study:

"District Nurse received a referral to visit and assess a patient who had been discharged from the local hospital. On arrival the family expressed concern that the patient was very drowsy and was difficult to manage. Further questioning resulted in the family producing a large bag of medication which had been prescribed on discharge. As well as the "usual tablets" being offered for examination! It soon became apparent that the patient was taking Nitrazepam and Mogadon and Diazepam and Valium as well as a cocktail of other drugs. The patient and family had understood when and how to take the tablets prescribed by the consultant and were concordant. However, unfortunately they also did not want to offend their long standing GP and were also continuing to take the tablets he had been prescribing for sometime. Diplomacy and communication skills were required to unravel the situation, ensure patient safety and maintain trust and clinical relationships."

Equipment provision

Identified equipment needs to be in place in time for discharge and in full working order. This may involve checking that previously provided equipment remains appropriate and safe to use. Users, including the patient, their informal carers and professionals from health and social care, need to be trained in the use of any new equipment, prior to discharge.

Assistive technology products such as community alarms, falls detectors, pressure pads, gas alerts, can also form a vital part of a care package aimed at maintaining independence in a person's own home. They are provided subject to professional assessment,

installation and maintenance and may involve some cost to the individual – so you will need to factor in time for planning prior to discharge.

Accommodation Issues

Ensure there is safe access to the property with consideration to environmental factors such as outside steps and obstructions.

Ensure ability to manage stairs if required, access to toilet and bedroom, ability to use the phone, location of property and ability to access facilities such as transport.

Also check that home security is attended to and access is properly organised for example, that they have keys to get in to the house.

Discharge of Homeless People

Guidance is currently under development which will assist agencies when a homeless person, or person from a specific vulnerable group at risk of moving frequently, is discharged from a hospital setting. The guidance will aim to provide a joined up approach from health and housing to ensure that a patient is not discharged to an unsafe environment, insecure housing or homelessness.

From this guidance, a working example of a protocol will be developed which might then be tailored for local use. It is expected that the protocol will be piloted in different areas in Wales and re-drafted as necessary. There will be the usual external consultation on the guidance.

Key issues to consider in preventing inappropriate discharge are:

- Working in partnership with the person so that they are empowered through joint decision making; are less likely to self-discharge and are not unduly anxious about losing their accommodation while in hospital
- Identifying a patient at risk of insecure housing or homelessness on admission to hospital
- Planning for discharge from the time of admission, not at the time of discharge
- Training on homelessness issues for health staff
- Identifying a link nurse in Emergency Care Units to promote liaison between health and other agencies
- Robust links in place between health services and housing or homelessness services for ease of joint planning and service provision
- Liaison with key health professionals previously involved with a patient's care before discharge so that follow-up is seamless. This is particularly important if the person is discharged to a hostel setting or other temporary accommodation, so that they are not lost to follow up
- Having a directory of services available to support a person leaving hospital, for example access to drug and alcohol services

It is not acceptable to simply discharge a homeless person with instructions to attend their local housing office. Adequate provision must be in place for someone recovering from a hospital admission. If the measures detailed above are implemented, it will help prevent the following type of scenarios.

"A young homeless man, living on the streets, was admitted to hospital following a knife assault. His abdominal wounds were stitched up and when he was ready for discharge he gave a friend's address where he was to stay. After a few days the sofa-surfing arrangement with his friend broke down and he was back living rough. Although the wound needed checking, follow up was difficult as he had no GP and no secure address."

"A young homeless man, previously detained under the Mental Health Act (1983) was due to be discharged in the near future. He took his own discharge before there was time to arrange any community follow up. This resulted in him having no accommodation to go to, no prescription for his medicines and no plan to manage his on-going mental health needs in place. He was planning to rough sleep but was found by a homelessness worker in a confused state that evening."

Care & Support

Ensure that the person has the appropriate level and type of support to maintain their safety on discharge. This will require timely referrals being made to community services taking account of service response times and availability, for example, district nurses, community psychiatric nurses, social services, information to GP.

In order for the discharge to be safe contingencies must be in place where services are unable to respond at the appropriate time – it should not be assumed that families and friends can and will fill any gaps.

Needs of the Carer

Where informal carers are being asked, or offering, to provide support ensure that they fully understand what this will entail and are willing and able to provide the support.

It should never be assumed that the carer is able or willing to continue or assume the role. As part of the assessment process it is essential to consider:

- What was the previous situation regarding the provision of informal care (who, how, when)?
- Was it working well for both parties?
- Has anything changed eg has the patient's condition deteriorated or have the physical, emotional or social circumstances of the carer changed?
- Does the carer clearly understand the responsibilities they are taking on?

Carers should be offered an assessment by a social worker in order to identify their needs as a carer and to see what support they can be offered to fulfil this role.

Further information for carers, including the document "Looking after someone: a guide to carers' rights & benefits 2007/2008" can be accessed from Carers UK at www.carersuk.org or telephone 0808 8087777.

There may also be a local carers group and Discharge Liaison Nurses or Social Work Teams that will be able to provide contact details. The following are examples of bad and good carer experiences, taken from the Carers Association document "You can take him home now" (2001):

A poor experience; "My father-in-law is aged and lives alone. He was discharged from hospital despite being in pain and still bleeding. I am his sole carer but I also care for my own mother. I was told that even if I refused to look after him he would still be discharged because a) they wanted the bed, b) they felt there was nothing more they could do, c) of course you must realise how short of money we are."

A good experience; "The experience was brilliant. I attended a meeting of nurses, OTs and social services at the hospital where a care plan for my wife's return was agreed, plus home visits. She was not discharged until the complete plan was in place."

Social Network

To avoid the risk of isolation, ensure that the patient is enabled to continue links with their social network: family, friends, regular visitors and neighbours etc.

Nutritional needs

Adequate nutrition is an essential part of recovery. If the patient can prepare food themselves, ensure that they can, for example, access the kitchen, reach into the fridge, open jars or tins and use a kettle. Are they able to go shopping or get help provided by family, friends or carers?

For those people who have been assessed as not being able to reliably prepare their own meals, appropriate support services such as Meals on Wheels must be provided.

Given that food supplements can be prescribed in the same way as medication, instructions may be included on the discharge summary for the GP to action. This must be managed appropriately on discharge to ensure continuity. Whilst as an inpatient, food supplements may be appropriate, every effort should be made to return to a normal diet.

Care Coordination

The role of the Care Coordinator is pivotal to ensuring continuity and consistency in the assessment and care planning process.

The Care Coordinator during a hospital admission will often be a named or lead nurse, but this does not have to be the case. The role can be undertaken by the professional with the largest contribution to the discharge process. This could also therefore be a Discharge Liaison Nurse, Social Worker, Physiotherapist, Occupational Therapist or other allied health professional.

The person acting as Care Coordinator can change as the patient progresses through the journey of care.

Some patients will already have a community-based Care Coordinator, such as a social worker or specialist Chronic Condition Nurse, who should be involved in providing information and support to the patient and hospital team throughout the individual's care pathway.

In some cases it may be appropriate that they continue to be the Care Coordinator during an inpatient episode of care, particularly for short or planned admissions. It is important on admission and discharge that the role of Care Coordinator is clarified and passed on where necessary.

The Care Coordinator should act as the patient's guide, ensuring timely referrals and completing the detailed arrangements for transfer or discharge.

Even though all members of the MDT do not work over seven days, effective communication and continuity is essential to ensure that progress is maintained.

"Effective shift handover procedures must be implemented so that the Practitioner can safely pass the baton for continued discharge planning."

The challenge for the ward staff is to ensure that discharge planning is a coordinated and proactive seven day a week process in which, the ward team understand how to involve the patient and their carer in care decisions.

The Department of Health Toolkit published in 2004 states:

> *"Patients need to sense they are moving forward and feel involved in all decisions about their clinical, rehabilitative and social care needs and carers feel valued, supported and part of the process."*

Regular multidisciplinary or multi agency team meetings should:

- Monitor the patient's plan of care and achievement of desired outcomes
- Identify any problems impacting on the expected date of discharge
- Ensure that actions are identified and attributed to members of the team

Multidisciplinary Team Meetings

The usefulness of multidisciplinary meetings, or case conferences, often depends on how effectively they are chaired. Some organisations have already developed local guidance and supporting documentation to manage these meetings. The following handy hints will help Practitioners build their experience and confidence to chair meetings.

Case conferences in particular, can be emotive or even stressful events and care needs to be taken to ensure that issues can be properly resolved. This includes using simple techniques such as comfort breaks and using colleagues to de-escalate any tension.

Responsibilities of the Chair:

Any member of the MDT can chair the meeting, although it does require someone with sufficient knowledge and experience of the care process. Less experienced Practitioners seeking to develop their skill can chair the meetings with support from a more experienced participant.

Duties:

- Ensure sufficient time has been allocated to deal with the issues and keep the meeting focussed
- Ensure that the patient and carer's viewpoints are voiced and listened to. If they are unable, or do not wish to attend and give consent, arrange for an advocate to be present. If the Mental Capacity Act applies, make sure you comply with those requirements (see Chapter 5)
- Ensure each professional viewpoint is considered
- Ensure that the meeting follows a structured format
- Ensure that at the end of each patient discussion, a clear plan of action is evident
- Ensure each action is allocated to a specific individual

- Ensure a consensus decision is reached regarding patient treatment plans and future care arrangements
- Ensure that the MDT has considered eligibility for Continuing NHS Healthcare funding and NHS funded nursing care. Clearly document the rationale for decisions made in accordance with Welsh Health Circulars WHC (2004)54 & WHC (2004)024

Responsibilities of the Note-taker:

It is difficult to both participate and take notes during a meeting. The accurate recording and documentation of the discussion and the decisions reached is important for the communication and continuity of patient care and to support safe and timely discharge.

The notes are a formal document to demonstrate that the team has appropriately discharged its legal and professional obligations. The records should reflect the contribution of each professional and the agreed action that is determined following the multidisciplinary discussion.

Duties:

- Accurately record the contributions of each team member and the agreed actions
- Summarise the agreed actions
- Ensure that the documentation can be easily understood by individuals who were not present at the case conference
- Distribute the final document to all represented parties, including the patient, carer and advocate

Responsibilities of Professionals

A successful meeting can only be achieved if every participant is properly prepared and willing to contribute in a constructive and mutually respectful way, putting the patient's best interests first.

Duties:

- Have up to date information for all your caseload and those of your colleagues, if appropriate
- Ensure actions agreed previously have been followed through
- Ensure you have spoken with patients and their carer's and that their views are supported or represented at the case conference
- Be clear on your own actions for each patient and ensure follow through
- Ensure adequate support for colleagues new to the case conference process

A Daily RAP

If the '4Ps' can be thought of as developing the race tactics, then the 'Daily RAP' represents the day to day preparation of training for the race. Similarly the 'Daily RAP' is a physical activity that includes checking that the goals are achievable and the tactics include everything you need to know.

The 'Daily RAP' is a simple and specific face to face interaction with the patient for a few minutes everyday. It will ensure that the individualised assessment is up to date; new information can be added; and an opportunity to check that the discharge process is progressing as planned.

It requires basic observational clinical skills, an effective dialogue with the patient and carer and a personal drive to achieve the best experience for your patient.

A Daily RAP

REVIEW

- Ask the patient, "how do they feel?"
- Is the patient responding to treatment?
- How is the patient's general condition?
- Has there been any change in mental capacity?
- Is patient meeting their outcomes and goals?
- Is the expected date of discharge accurate?

ACTION

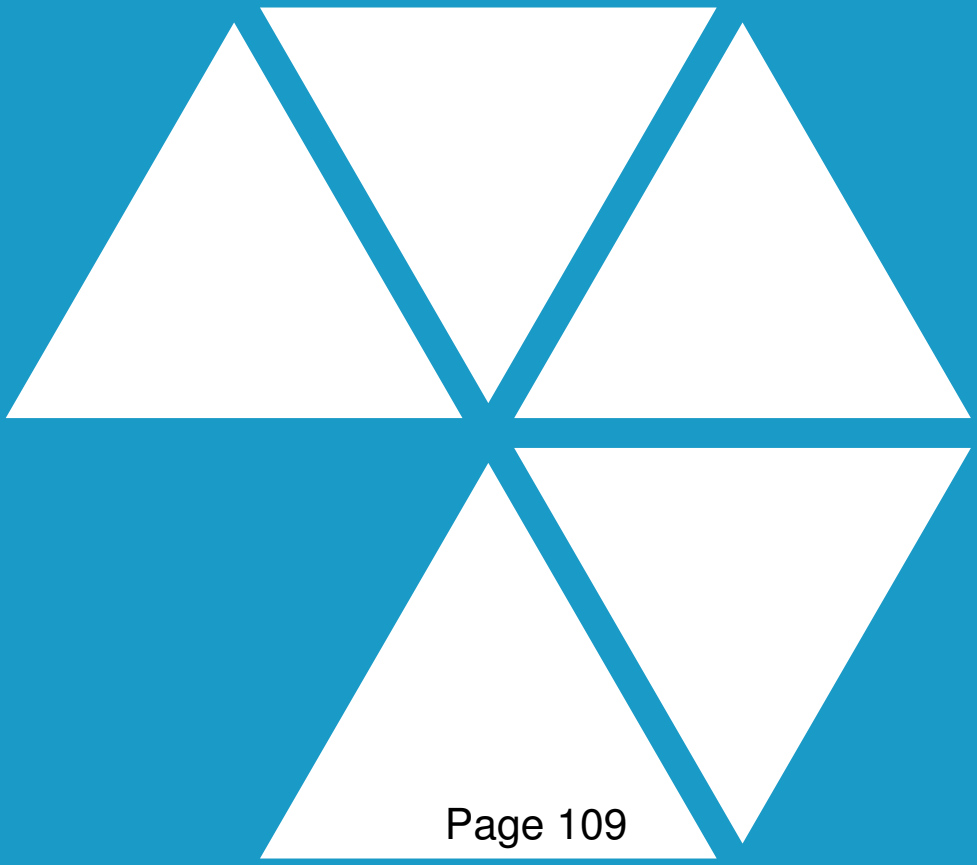
- Talk to patient and carer about progress
- Monitor and evaluate care plan
- Identify actions required to make progress
- Assessment of mental capacity if required
- Liaise with multidisciplinary team
- Review expected discharge date

PROGRESS

- Advocate on behalf of patient and carer
- Check pathway milestones are being achieved
- Chase up outstanding actions
- Check obligations under Mental Capacity Act
- Escalate problems and expedite solutions
- Update discharge checklist

Chapter 4

Individualised Care Options



Individualised Care Options

» Chapter Overview

» Creating Individual Solutions

» Managing Expectations

» A Full Range of Choices

» Access to Care Options

» Clinical Follow Up

Chapter Overview

For a person with complex needs an individualised care package can only be designed following a thorough and timely assessment of the whole person which must involve their family and carers.

Appropriate choices can only be made when there is effective dialogue and empathy with the person. Even with excellent communication skills, choices will depend upon having sufficient knowledge of the variety of local services available.

The list of locally available options must contain a description of the services, together with the eligibility criteria and potential costs, for which the person may be liable. Although discharge planning is a process, it needs to be individualised to support people to make informed choices:

- Individuals, families and carers need to understand how and when discharge arrangements are going to take place so that they can be involved in planning
- Staff need to involve other professionals across the MDT so that they have sufficient time to assess the patient and make appropriate arrangements
- Information about creative care options needs to be comprehensive, accessible and up to date. This is easier to achieve if it is centrally coordinated
- Staff and patients need to have information about eligibility criteria, referral protocols and capacity in order to be able to access alternative care options

Creating Individual Solutions

The social model of health encourages people to take accountability for their own wellbeing. However to achieve this, individuals need good information about the choices that are available to them and support from professionals on how to access them.

"Not everyone wants to go out to Bingo, day-care, luncheon clubs or special interest groups."

This Chapter explores the need for discharge assessment and planning to take a much more creative approach to the development of care packages. The purpose is to tailor responses to individual needs in such a way that they are empowered to maintain their health and well-being for the longer term. This involves:

- Managing expectations
- A full range of choices
- Accessing care options
- Identifying other enablers

Care options can only be determined following a thorough assessment of need. It is important that specific care options are not discussed or considered too early in the process and that any discussions do not pre-judge the assessment process.

Managing Expectations

It is important to manage the expectations of all parties with regard to:

- The practical discharge process
- The outcomes that can be planned for
- The service options that may be available
- How and when information will be communicated
- Voicing concerns

The expectations need to be understood from the following three perspectives.

1. Individuals

Individuals must feel fully included in the discharge planning process, and to know that their pathway is planned around their specific needs.

The care plan should be shared with them and they should be encouraged to ask questions, especially if the expected care or timescales vary from the plan.

It is essential that health and social care Practitioners use the assessment process to help individuals to:

- Identify any personal risks to their health and well being
- Jointly formulate plans that minimise and manage those risks
- Have mutually transparent discussions about the realistic care options available

"Not having time is not an excuse. Five minutes spent asking the right questions now can save weeks of delay and distress for everyone."

Research has shown health and social care services can sometimes decrease independence both on admission to hospital and when providing community care. Increased dependency will have a negative impact on the individual's physical and emotional well-being.

It must be clearly communicated at an early stage that the aim of the care provided is to restore the individual to their maximum potential. This will help to manage expectations and is particularly important when the care plan includes transfer to a rehabilitation facility or intensive Reablement at home.

2. Family and Carers

As described in Chapter 3, it is essential that family members and carers are consulted with on admission and at the beginning of the assessment process. If the patient does not have mental capacity, then any further consultation will need to comply with the Mental Capacity Act, as described in Chapter 5.

Carers Groups often report that they feel frustrated that they are not listened to and that essential information such as medication administration is lost. This carries obvious risks both from a patient safety perspective and with regard to effective discharge planning.

The use of EDD as described earlier, also allows families and carers to plan ahead and be able to support the individual when they come home from hospital.

Practical examples include:

- Booking time off work to take their relative home in the morning, rather than relying on ambulance or voluntary transport later in the day
- Getting shopping in
- Making sure the home is warm

It is important not to make assumptions regarding what care and support will be provided by family members or neighbours.

"Simple checks can save distress and prevent possible readmission later."

It may be the case that a crisis in informal social support has led to the hospital admission. In which case, early identification of these issues will assist in managing the expectations of all those involved and facilitate timely discharge.

Practitioners need to explain that the service provided will be dependent on:

- Full assessment of need undertaken at an appropriate time in the individual's journey, for example following a period of rehabilitation
- Meeting appropriate eligibility criteria for service provision

"Don't forget that funding for social care is provided subject to eligibility criteria being met and is means-tested; individuals should be forewarned that this is the case."

This can be a stressful time for patients and carers that are unfamiliar with the care system:

"You may have to repeat information and check understanding.Written information sheets are helpful to supplement verbal dialogue but should not replace it."

3. Practitioners

It is important that appropriate members of the MDT are involved in discharge planning as early as possible.

Some patient needs will be predictable, while others will be dependent on the impact of treatment and the recovery that takes place during the hospitals stay. Practitioners should recognise these possible changes and avoid discussing specific services options in detail, too far in advance

Patients and carers are often provided with different answers to their queries depending on which professional they speak to. This in turn leads to confusion, anxiety and loss of confidence in the health and social care system, which is a significant contributory factor of delayed transfers of care.

As increasing numbers of individuals are admitted with existing community-based support for their long term conditions, it is vital that prompt and effective communication is established in accordance with local information sharing protocols.

Professionals who may already be involved in delivering care could include:

- GP
- Practice Nurse
- District Nurse
- Specialist Nurse eg for Chronic Conditions
- Social worker
- Community-based Therapist
- Domiciliary Care Agency
- Voluntary agencies
- Consultant

If the individual has an existing Care Coordinator, they may continue to manage liaison between the other agencies involved.

If the individual has been admitted from a care home, the Registered Manager will be a key link in the assessment and care planning process. Early liaison will also help identify any issues that may impact on discharge from hospital, for example:

- Increased frailty requiring assessment for NHS-funded nursing care
- NHS Continuing Health Care funding
- Transfer to a different category of care home

"As a professional working in hospital, your ultimate aim is to get your patients well and back to their optimum level of health and independence as quickly as possible."

A Full Range of Choices

To promote independence and support individuals at home in their community, NHS Trusts, Local Authorities and Local Health Boards have developed a range of intermediate and long-term care solutions.

The table below provides some examples of the types of services that may be available in your area to support individuals to minimise and manage risks to their health and social well-being.

"It's better to ask advice about these sorts of services than miss an opportunity. Speak to your local teams."

This is not an exhaustive compendium and each locality will have a unique range of choices, some of which may be subject to means testing.

Examples of Care Options

Need	Providers	Type of support offered
Benefits and allowances	Social services, voluntary sector e.g. Citizen's Advice or Age Concern	Advice on eligibility and how to apply. Support with form filling
Direct payments	Local authorities	Receipt of direct payment of funds so that the individual can employ there own carers/create their own care package
Housing issues	Local authorities Housing associations	Advice and support on dealing with accommodation issues, including housing benefit and larger adaptations
Extra care housing schemes	Local authorities Housing associations Private sector	Provision of supported living accommodation/ sheltered housing, that can be an alternative to care home placement with a comprehensive care package
Small household repairs/ adaptations	Voluntary sector and local authorities	'Care and Repair'-type services. 'Man in a Van' to fit equipment essential for discharge e.g. handrails

Need	Providers	Type of support offered
Remote support at home using telecare	Social services Private sector	'Assistive technology' e.g. personal alarm systems, fall detection, dementia care packages
Homelessness	As above plus voluntary sector and LHBs Trusts	Advice and support on specific issues facing those who are homeless or at risk of becoming so Counselling, practical help. Outreach clinics/direct support
Short-term low level support checking service on discharge	Voluntary Sector	Hospital Discharge Schemes. Usually maximum of 5 days e.g. checking house is warm, shopping, organising prescriptions, help with meal preparation or light personal care
Supported Recovery and Reablement	Social Services LHBs	Intensive time-limited support (usually 6 weeks) from multi-disciplinary team

Need	Providers	Type of support offered
Intensive clinical intervention	NHS Trusts/LHBs	Rapid Response Teams to access rapid diagnostics and/or to provide specific clinical intervention e.g. IV antibiotic administration, DVT treatment Community mental health/crisis intervention teams
Clinical monitoring	NHS Trusts LHBs GPs	Telemedicine: remote supervision of vital signs etc District nurse or specialist nurse visits/ community mental health teams GP/practice nurse clinics
Practical social & emotional support for living with a chronic condition	Voluntary agencies LHBs GPs	Support groups, practical advice, and internet Expert Patient programmes Specialist nurse input Counselling
Coping with bereavement	Voluntary sector	Practical advice and emotional support

Need	Providers	Type of support offered
Nutrition and Diet	Social services Voluntary sector Domiciliary care agencies	'Meals on Wheels', Frozen meals delivery, luncheon clubs, day centres Support with shopping/ food preparation
Medication compliance	Community pharmacies Social services Domiciliary care providers	Collection/ordering and delivery of repeat prescriptions Medication reviews Advice on administration, including use of Dosette boxes etc Supervision of medication compliance as part of a care package
Help with domestic chores low level social support	Voluntary and private sector	Cleaning, "washing the nets", ironing, shopping, and gardening
Care of pets	Voluntary and private sector	Pet-sitting or fostering, dog walking etc

Access to Care Options

Across Wales, it is evident that different types of services are provided in different localities. This can cause difficulties for staff working in hospitals that receive patients from many different areas, if information about these services is not easy to access or constantly kept up to date.

Details of intermediate care services are published on most Local Health Board websites and in local directories of services. In some areas, details are also available on NHS Direct and work is in progress to create a single national database.

In the meantime, it is recommended therefore that the most useful local information is collated centrally, perhaps by the Discharge Liaison Nurses or Hospital Social Work Team. These groups of staff usually act as the key point of contact for up to date local information, including details of eligibility criteria and contact points.

Clinical Follow Up

If the patient requires ongoing clinical review following discharge from hospital, clear information must be given verbally and in writing to confirm the arrangements for this.

Clinical reviews can be undertaken in a variety of settings including:

- Outpatient clinics
- GP clinics
- Day hospitals

Information on discharge will need to include:

- Date, time and location of appointment
- Reason for appointment
- What the patient needs to bring with them for example letters, specimens, medication
- Specific instructions for any investigations
- Transport arrangements if required

The patient may need to modify their normal routine or behaviours following their stay in hospital for example:

- New diet or nutritional supplements
- Restrictions on alcohol intake
- Giving up smoking
- Undertaking an exercise plan
- Change to medication and possible effects

Furthermore, some follow up services will be arranged on discharge to be provided at the person's place of residence, such as district nursing.

Patients, their family and carers must be provided with clear, easy to read information to take home with them, plus contact details of support services, in case of further query.

Hospital Discharge Task and Finish Group

Appendix 2

BACKGROUND DATA TO HOSPITAL DISCHARGES

PART 2 –
FAILED DISCHARGES

PART 3 –
DELAYED TRANSFER OF CARE

Hospital Discharge Task and Finish Group
PART 1

Background Data

The Caerphilly picture for hospital discharges:

- Which NHS hospitals do Caerphilly residents get discharged from?
- How many people are discharged from ABUHB hospitals?
- What responses do hospital discharge requests require?
- What support did people need on discharge?

Time frame and sources of data

Times frame:
6 month period – 1st January 2015 – 30th June 2015

Sources:
Aneurin Bevan University Health Board
CCBC Social Services
Frailty portal

Patient type:
18+ resident of Caerphilly
physical health admission reason not mental health

Hospital Discharge Task and Finish Group

Which NHS hospitals do Caerphilly residents get discharged from?

- Royal Gwent Hospital
- YYF
- St Wooles
- Neville Hall Hospital
- Prince Charles Hospital
- Royal Glamorgan Hospital
- Llandough
- Rookwood
- Velindra
- UHW
- Princess of Wales
- Morriston

Hospital Discharge Task and Finish Group

How many people are discharged from ABUHB hospitals?

- Elective 1214
- Emergency 4400
- Obstetrics 1027
- Transferred to hospitals outside Gwent 245

Total – 6886*

*Please note that this does not include day cases, patients assessed out from assessment units or patients discharged from mental health units

Hospital Discharge Task and Finish Group

What responses do hospital discharge requests require?

- Request for restart of same care provision:
    - 104 requests for 81 people
    - 19 people had care restarted 2 or more times.

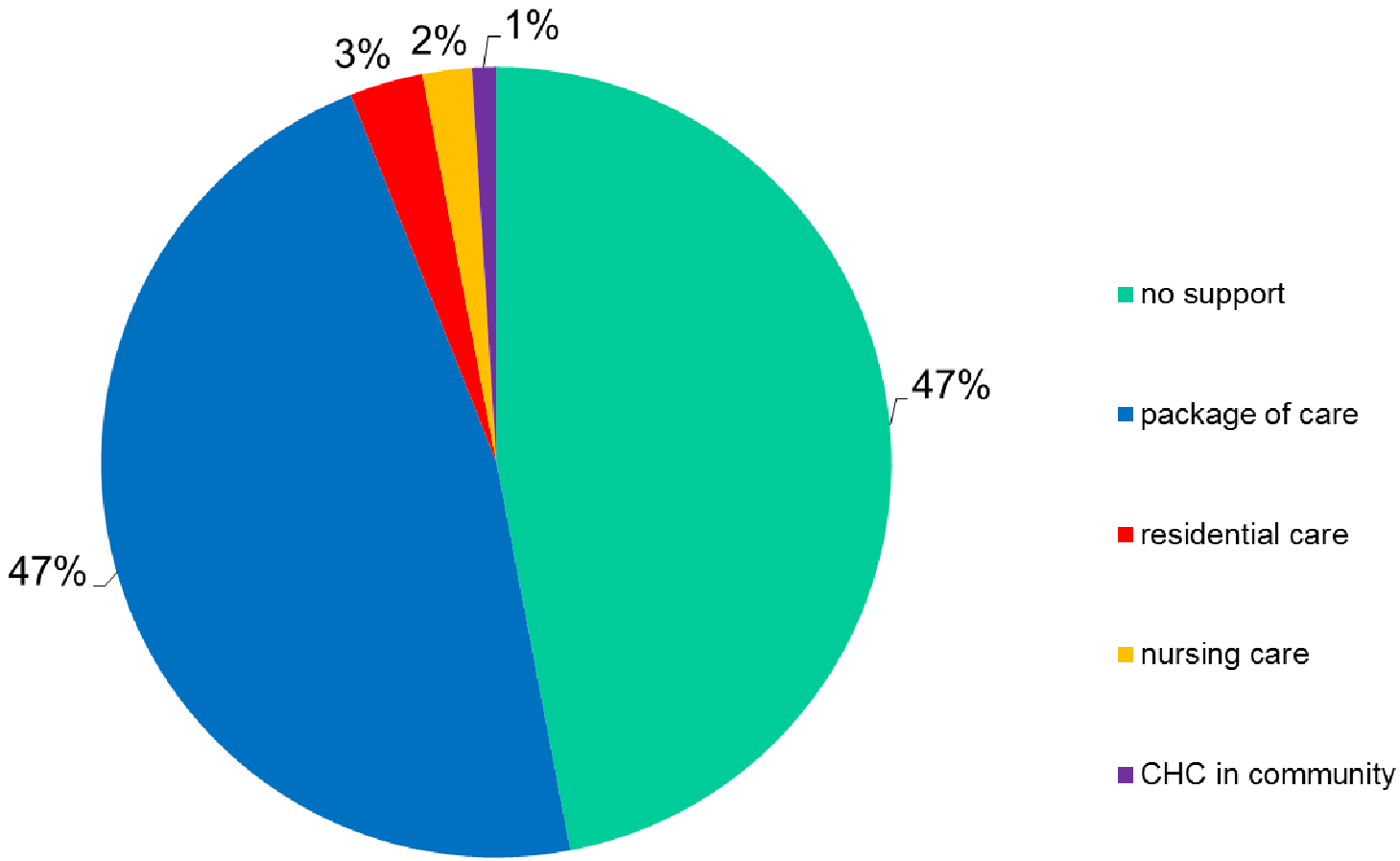
- Hospital discharge where circumstances meant assessment required to support discharge:
    - 269 assessments

That means out of a potential 5614 discharges, only 373 were referred to social services for support with discharge from hospital.

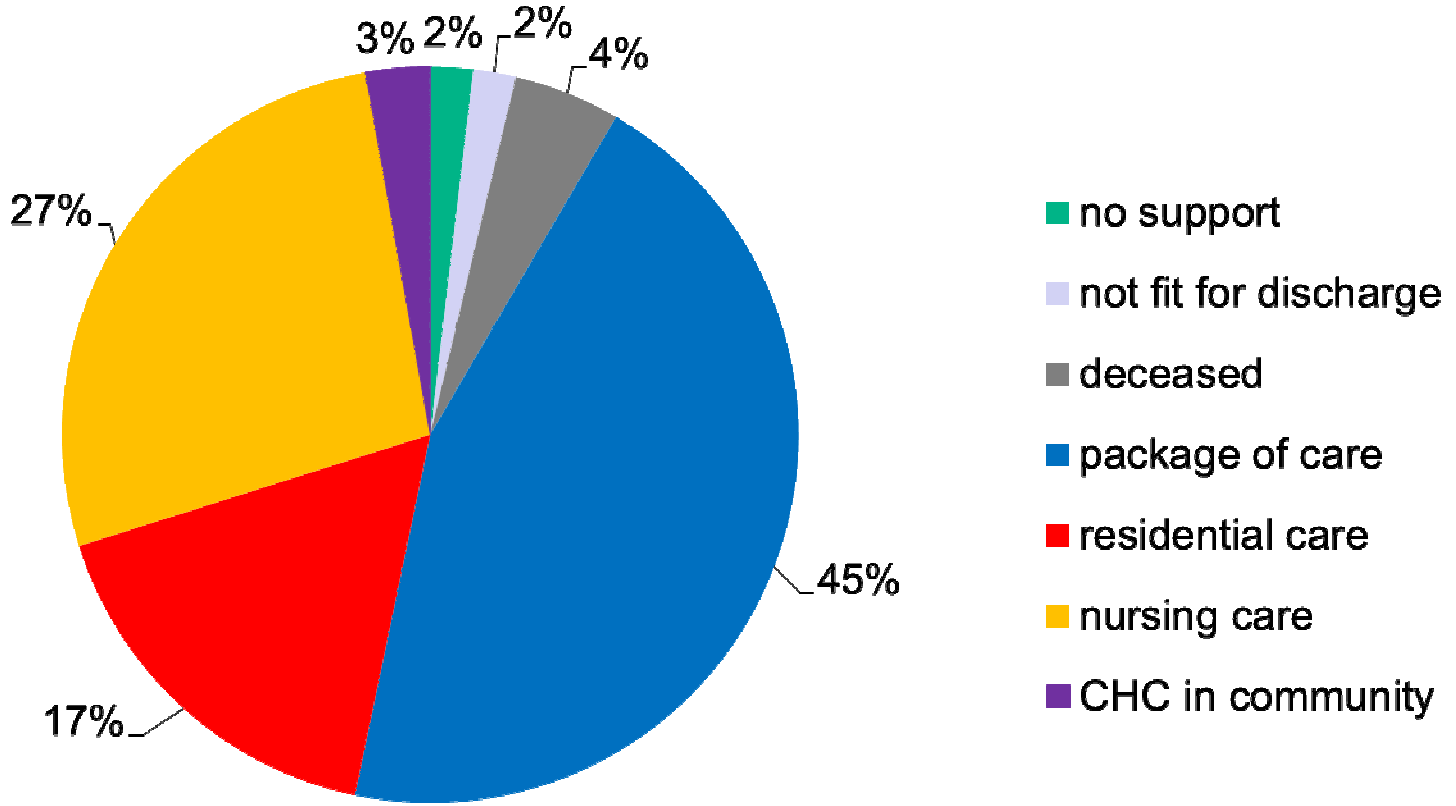
Assessments Completed in the period 01/01/2015 to 30/06/2015

Assessment Type	Count of Assessments
AS - OT Contact / Overview	556
AS- Specialist OT	491
AS- Specialist Reablement Assessment	287
AS-Hospital Discharge Assessment	269
UAP Assessment	347
AS Specialist SW Continuing Care Assessment	144
AS- Specialist Moving & Handling Assessment	82
UAP Contact Assessment	64
AS - Specialist Visual Impairment Assessment	38
Total Number Of Assessments	2278

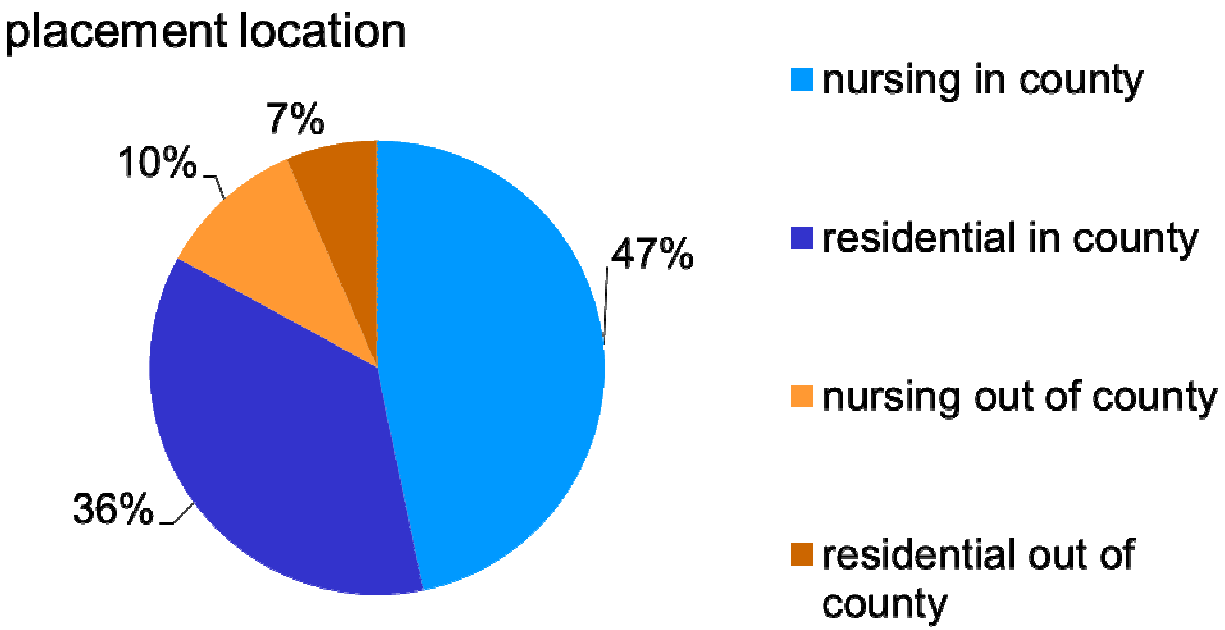
- What support did people need prior to admission?



- What support did people need on discharge?



Placements


placement location
7%
10%
47%
36%
nursing in county
residential in county
nursing out of county
residential out of county

BOROUGH	VACANCIES AS OF 18TH SEPTEMBER 2015				
	RESIDENTIAL	NURSING	EMI RES	EMI NURSING	TOTAL PER BOROUGH
CAERPHILLY	33	19	22	7	81
TORFAEN	39	7	12	6	64
NEWPORT	29	19	1	0	49
BLAENAU GWENT	9	20	4	9	42
MONMOUTHSHIRE	10	13	6	13	42
TOTALS BY TYPE OF PLACEMENT	120	78	46	7	

Hospital Discharge Task and Finish Group
PART 2

Failed discharge notifications

There are 23 failed discharges to date this year. Approx. 50% are related to discharge without adequate care support.

RGH		PCH		NHH		UHW		YYF	
A & E	2	Ward 12	2	3/3	1	A1	1	MAU	3
C6E	1	Ward 11	2					OAKDALE	2
B6	1	Ward 9	1					UNK	1
Eyes	1	CDU	1						
D3E	1	MAU	1						

Other reasons for failed discharge notifications

- Dignity
- Discharge instructions omitted
- Medically unwell
- Equipment missing
- CHC paperwork not available
- Palliative care support not in place
- Reablement team not informed

Under reporting of issues linked to discharge

It is recognised that there is under reporting on issues.

What are we doing?

Hospital Discharge Task and Finish Group
PART 3

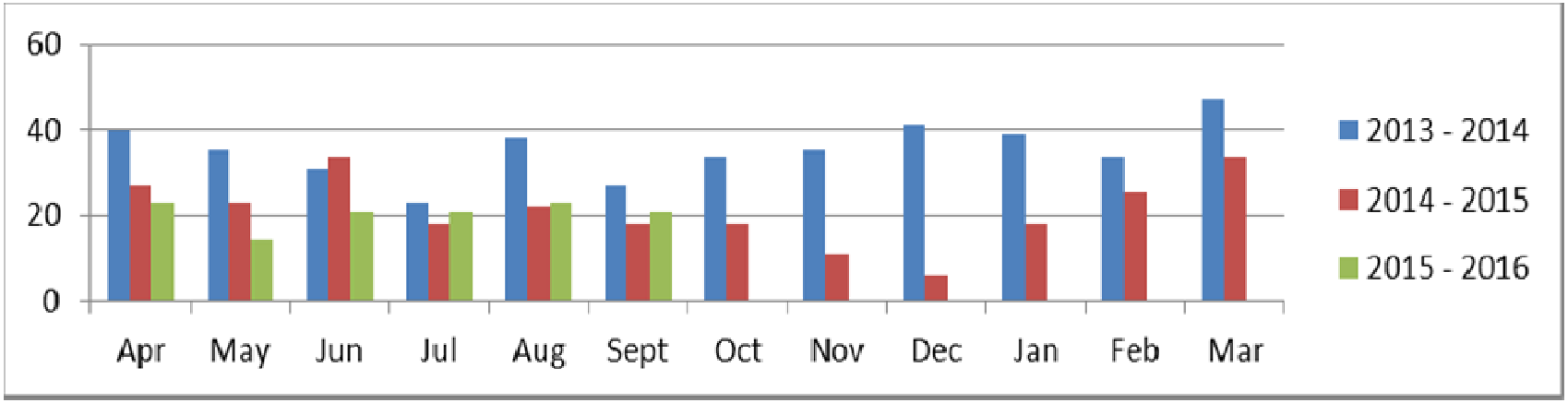
Delayed Transfer of Care (DToC)

What is delayed transfer of care and how is it measured?

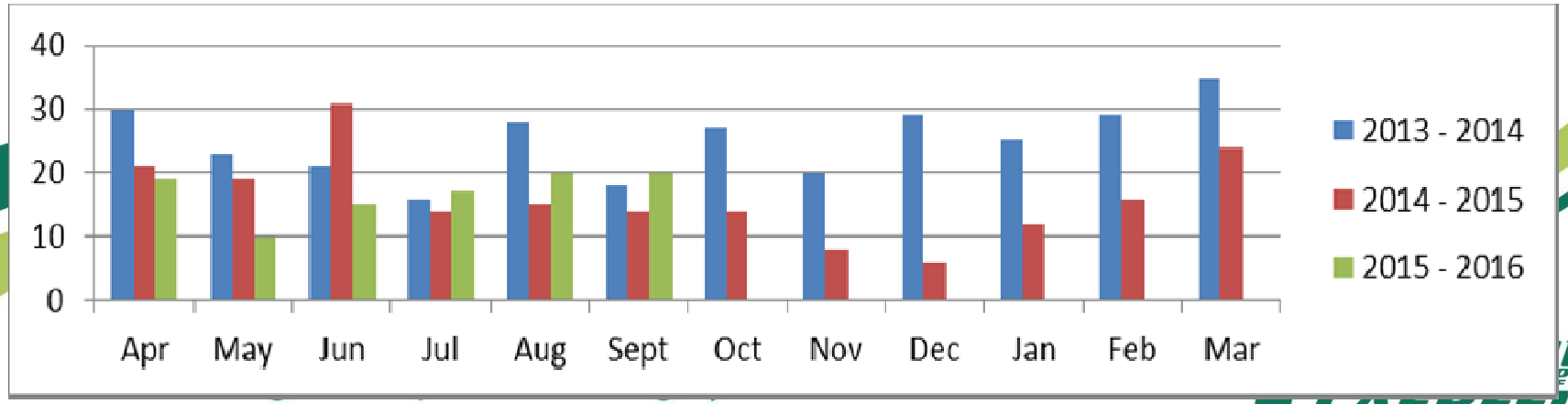
How are Caerphilly doing with DToC?

Contrast table for the past 3 years

Improvement and maintenance of lower DToC for the LA



ABuHB shows improvement, however sustainability of reduction year on year is not evident



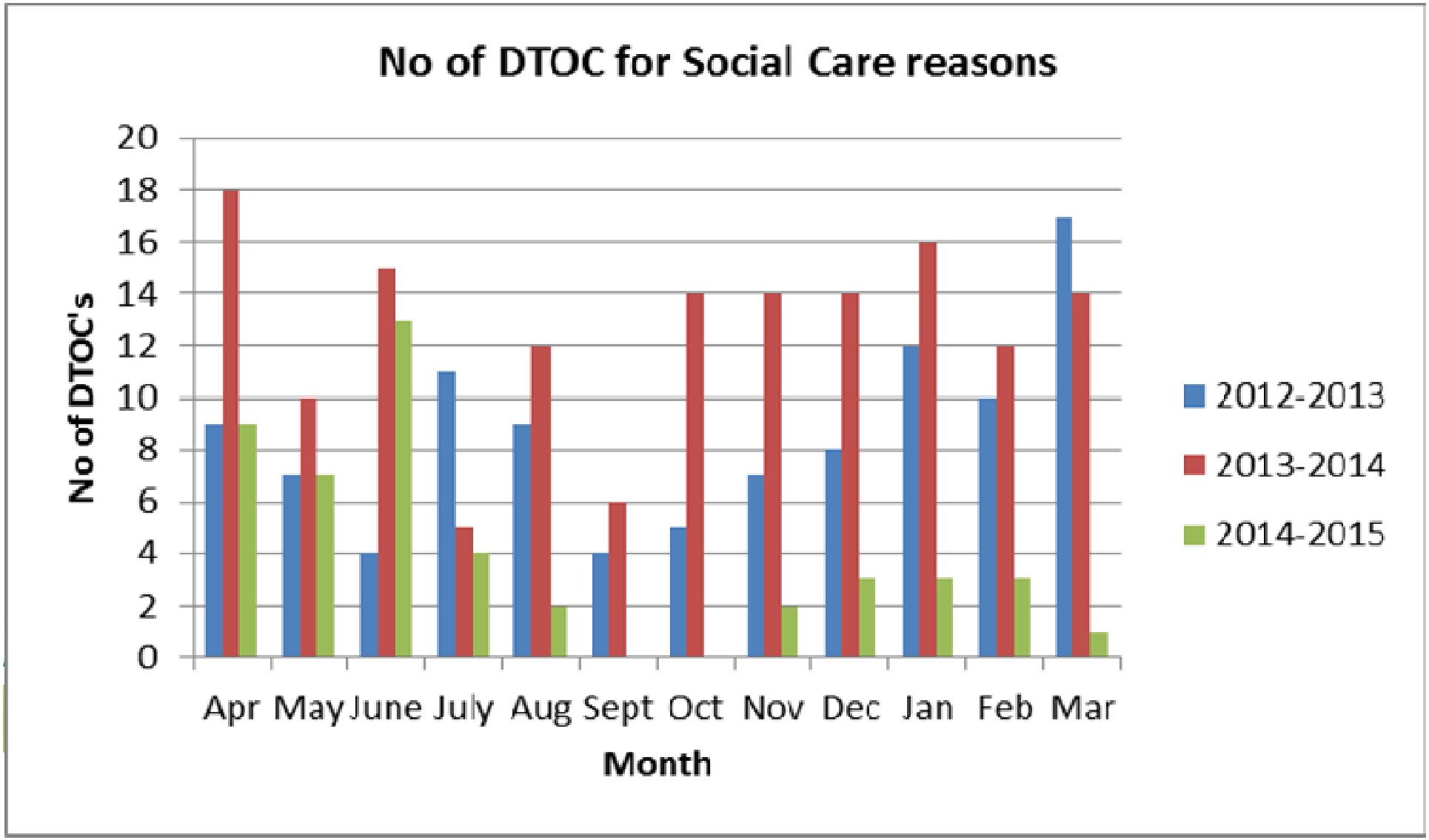
Current health position

- Most recent data suggests that ABuHB are reporting DToC figures under the national Welsh LHB average.
- The joint validation process is currently undergoing redesign to improve engagement.
- Senior health managers are currently being tasked with improving internal monitoring and reporting systems for ABuHB hospitals
- Health Senior managers are challenging the agreed national coding system.

National picture

- Between 450 -500 DToCs per month (Approx. 1% of available beds nationally).
- Close scrutiny by health minister and deputy health minister on a monthly basis.
- Commissioned all Wales piece of work to identify DToC monitoring systems “fitness of purpose”
- Collective perception that transparency of monitoring is not uniform across LHBs/Las
- Are we measuring the right things and is there a better way to achieve appropriate LOS in hospitals
- Accommodation choice policy doesn’t consider delays attributable to care home top up fees.

Caerphilly DToC social service reasons



Key themes for Caerphilly DToC

- CHC process delays
- Homes of choice
- Care package availability

Questions?

A greener place Man gwyrddach

CAERPHILLY COUNTY BOROUGH COUNCIL
CYNGOR BWRDEISTREF SIROL CAERFFILI

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Appendix 3

Choice of Accommodation

Your discharge from hospital care

Information for you, your family and carers, about choosing your future place of care in a residential or nursing home setting.

Aneurin Bevan Health Board

abhb.enquiries@wales.nhs.uk

Phone: ******

Fax: ********

The Health Board will make every effort to help you leave hospital as soon as you are able to be discharged. We need to only use hospital beds for those patients who need specific hospital services due to their physical or mental illness.
We cannot do this if beds are occupied by people waiting a long time for arrangements to be made for their accommodation when they are discharged.

If you cannot return to your home...

The Health Board together with Local Authorities, will support personal choice when people need to be placed in care homes based on the Welsh Assembly Government's 1993 updated guidance.

When a multi-disciplinary assessment meeting (MDT) has agreed that care in a nursing or residential home is the most appropriate place to meet all your care needs, staff in our Community Hospitals fully understand how difficult this decision may be for you the patient, your family or carers. We will make every effort to discuss this important decision with you explaining the choices available. This may be about the type of residential or nursing accommodation that is best for you, and what is available locally.

We will encourage you to identify **at least three care homes that are suitable for your future accommodation**. The care homes you choose can be ranked in your order of preference but you should look at all your choices simultaneously. Some areas have more numbers of care homes than others, and it may be helpful for you to consider options a little farther away if this is possible for you and your family or carers.
We understand that you may have a particular choice about where you wish to go, and that there may be a waiting list for your chosen home. However it is not appropriate nor in your interest to remain in a hospital bed until a place in a particular home becomes available, and temporary arrangements may need to be agreed and arranged to meet your needs.

Our Community Hospital staff and all the professionals involved in your care will help you to your chosen residential care or nursing home. We appreciate that for you as well as your family and carers this is a life-changing decision, extending far beyond the obvious practicalities. We will consider your best interests in all decision-making.

Preferred Accommodation

You are able to exercise **reasonable choice** about the residential, nursing or care home. If you will need care by a registered nurse, the health assessment of the Health Board and the MDT will decide how well that nursing or care home can meet your assessed nursing care needs. The Health Board and the relevant Local Authority will need to agree on your placement into the care home, and funding for that placement, before you can be discharged there.

The Health Board and the Local Authority will arrange for your care in your preferred accommodation subject to the following considerations:

1. **Interim Placements**

If it is not possible for you to move to your preferred choice of accommodation the Local Authority may identify another appropriate **interim** (temporary) care home.

In this case, we will meet with you or your nominated person to discuss your rights, as well as the risks of remaining in hospital and the acknowledged benefits to you for resettling into your new home as soon as possible.

We will then help you to move into this **interim choice** care home until a place in one of your chosen care homes becomes available. The local authority will ensure that you are placed on the waiting list of your preferred accommodation and will aim to move you into that accommodation as soon as a place becomes available. We will keep you informed of progress.

2. **Will I have to pay for my care?**

If assessment—(16)(17) in accordance with the **National Assistance (Assessment of Resources) Regulations to contribute towards his or her care costs 1992**— has shown that you will have to contribute towards your care, you will not be asked to pay more than your assessed financial contribution while waiting in a interim/temporary care home.

You and your family and carers will be given access to the best advice and information to help you make informed decisions about your care.

"Think About Me": Good Care Guide is a local web based feedback system where residents and relatives can rate care homes and provides a wealth of information for those choosing their new nursing or residential care home of choice **www.goodcareguide.co.uk/thinkaboutme**

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

3. **"Topping Up" to More Expensive Accommodation**

In certain circumstances, Local Authorities can arrange placements in more expensive accommodation, provided that you or someone else (for example a relative, a friend, or any other source) is able and willing to make up the difference (to **'top up'**).

Local Authorities would not pay more than their usual local fee if an alternative appropriate bed is available with reasonable access for your family carers or friends.

A Local Authority should not seek 'top-up' contributions in cases where there is no alternative with reasonable access. Where there are no placements at the authority's usual rate, the authority should not leave individuals to make their own arrangements having determined that they need to enter a care home and do not have care and attention otherwise available to them. In these instances, authorities should make suitable alternative arrangements and seek no contribution from the individual other than their contribution as assessed under the National Assistance (Assessment of Resources) Regulations 1992. Authorities must never encourage or otherwise imply that care home providers can or should seek further contributions from individuals in order to meet assessed needs. -

(*Need to make this more easy-read)

Welsh Government / NHS Guidance and the Law

The Health Board is under no direct obligation to provide the accommodation of your choice when you are discharged. There are no statutory principles (unlike for example, principles that apply to Local Authorities) that impose an express duty upon a Health Board to offer choice to a patient.

However the Health Board will take into account your wishes when planning appropriate accommodation for you. Your discharge will depend upon a number of different factors, including your wishes (and those of your relatives, carers or advocate), the location of family and friends, the cost of any accommodation, and the availability of a placement. The Health Board also has a duty to manage its resources and ensure that the needs of other patients are met as well.

Welsh Government Guidance to Welsh Health Services (12) makes clear that the process of moving a patient from hospital to a care home must be completed within three weeks of the date the person is assessed as being ready for discharge. We hope that this process will be completed within three weeks.

The Minister for Health and Social Services has emphasised that whilst patients do have a right to choice of care setting that must not be allowed to override the rights of other people who are waiting for a hospital bed to receive treatment (13).

Could we provide links to this guidance?

The Health Board has a responsibility to plan and provide a safe and appropriate discharge for you. If you do not make a choice about your accommodation, we will still have to carry on with planning your discharge. This means that the Health Board and the Local Authority may discharge you to alternative accommodation with a safe and appropriate package of health and social care.

Where the Health Board has arranged a Continuing Healthcare placement, affordability and sustainability of the placement will be considered when making the decision following the guidance **'Sustainable Care Planning in Continuing NHS Healthcare' 2011.**

List of Nursing and Care Homes
On the following pages you will find a list of nursing and care homes in the Gwent area.

Spaces in the accommodation and nursing provision varies from week to week.
Nursing staff will discuss current availability with you.

Please ask a member of staff if you require more information about your care or anything in this leaflet.

We hope you find this booklet reassuring and that it helps to make your experience a positive one where you have more choice and control.

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MONMOUTHSHIRE		
Name of Establishment	**Telephone Number**	**Category of Care**
Bethany (*Chepstow*)	01291 621425	30 Residential 6 EMI Residential
Castle Court (*Chepstow*)	01291 625597	25 Residential
Castleford House (OOC) (*Chepstow*)	01291 629929	20 General Nursing 20 Mild to moderate EMI Nursing
Cherry Tree (*Caldicot)*	01291 421940	36 Nursing 5 Residential
Crick House (*Caldicot*)	01291 430909	29 Nursing 6 Residential
Severn View (*Chepstow)*	01291 638921	16 EMI Residential 2 EMI Res Respite 11 Residential 3 Residential Respite
St. Anne's (*Chepstow*)	01291 622050	25 EMI Nursing
Sedbury Park (OOC) (Chepstow)	01291 627127	19 Nursing 12 Residential 49 EMI Residential
The Priory (*Llandogo*)	01594 530581	56 beds either Nursing or Residential
Avenue Road (Abergavenny)	01873 857607	28 Nursing 3 Residential
Belmont House *(Abergavenny)*	01873 850276	14 Residential 12 EMI Residential
Cantref (*Abergavenny*)	01873 852451	22 Residential
Gibraltar House (Monmouth) **Initial Administration charge of £49.95**	01600 775880	67 EMI Nursing 3 EMI Residential 21 Nursing 4 Residential
Glaslyn Court (*Abergavenny*)	01873 830218	22 Nursing 3 Residential 21 EMI Nursing 8 EMI Residential 20 under 65 MH
Mardy Park *(Abergavenny)*	01873 853706	4 Residential 7 Res Respite 8 Phys Rehab includes 3 under 65
Parade House (*Monmouth*)	01600 712821	18 Residential
Penpergwm (*Abergavenny*)	01873 840267	30 Residential
Rozelle (*Abergavenny*)	01873 854047	24 EMI Nursing

NEWPORT		
Name of Establishment	**Telephone Number**	**Category of Care**
Ashton Park—Central	01633 262723	18 Residential
Blaen-y-Pant (LA) - Malpas	01633 855548	23 Residential 12 EMI Residential
Caerleon House—Caerleon	01633 423535	52 Nursing 2 Palliative Care
Capel Grange—Central	01633 258902 258918 258909	44 Nursing EMI Unit 28
Danygraig Nursing Home	01633 282316	49 Nursing
Eleanor Hodson House—Caerleon	01633 430994 ext 0	7 Residential 25 Nursing
Emmaus—Central	01633 251845	16 Residential
Florence Justice—Central	01633 221800	27 Residential
Glenmore—Central	01633 258601	22 Residential Including up to 4 EMI
Hillside (LA) - Gaer	01633 246994	14 Residential 10 EMI Residential
Mayfield—Central	01633 215050	21 Residential
Millheath Nursing Home—Bettws	08714 232601	27 Nursing 11 EMI Residential
Parklands (inc 3 respite) (LA) - Malpas	01633 821249	32 Residential
Pentwyn Nursing Home—Marshlands	01633 680217 Ext 1	1 Residential 38 Nursing 2 Palliative Care
St. Catherine's—Central	08714 232603	30 Nursing
Spring Gardens inc 4 respite (LA) - Central	01633 222768	30 EMI Residential 4 Residential respite
Stow Park—Central	01633 212262	31 EMI Nursing
Summerhill Nursing Home—Central	08714 232602	27 Nursing
The Fields—Central	01633 265523	34 Nursing
The Oaks—Rogerstone	01633 893665 or 891278	30 Residential
Tregwilym Lodge—Rogerstone	01633 896100 Ext 4	31 EMI Residential 38 EMI Nursing
Willow House - Central	08714 232607	13 Residential 7 EMI Residential

TORFAEN		
Name of Establishment	**Telephone Number**	**Category of Care**
Leadon Court Care Centre, Cwmbran	0871 4232606	22 Nursing 11 EMI Residential
New Inn Nursing Home, Pontypool	0871 4232605	23 Nursing
Panteg Nursing Home, Pontypool	0871 4232604	38 Nursing
Thomas Gabrielle Nursing Home, Cwmbran	01633 868241	40 Nursing 3 Residential
Thomas Gabriel EMI Residential Home, Cwmbran	01633 869738	26 EMI Residential
Thistle Court Nursing Home, Cwmbran	01633 877845	34 EMI Nursing 2 EMI Residential
Ty Ceirios Nursing Home, Pontypool	01495 752358	20 EMI Nursing 17 Nursing 2 Palliative Care (Nursing) (65+)
Hollylodge, Cwmbran	01633 866326	27 EMI Residential 2 Residential
Llanyravon Court, Cwmbran	01633 876112	45 Nursing/ Residential 1 MH Residential 3 Palliative Care (Nursing) (65+) 1 Palliative Care (Nursing) (-65)
Sunnybank Nursing Home, Pontypool	01495 763473	24 LD Nursing (65+) 8 LD Nursing (-65)
Mayflower Residential, Cwmbran	01633 483537	23 Residential 1 EMI Residential
Regency House, Pontypool	01495 763597	53 EMI Residential
Ty Bryn, Pontypool	01495 772761	2 Residential (60+) 20 EMI Residential (60+)
Hafod Residential Homes		
Arthur Jenkins, Blaenavon	01495 790319	28 Residential
Cwmbran House, Cwmbran	01633 838806	56 Residential 19 EMI Residential 1 YMI Residential
Plas-y-Garn, Pontypool	01495 757708	24 EMI Residential 10 Residential
Ty Gwyn, Cwmbran	01633 838697	18 Residential 16 EMI Residential 2 MH Residential (-65)

BLAENAU GWENT		
Name of Establishment	**Telephone Number**	**Category of Care**
Bank House Ebbw Vale	304325	3 Res. 24 Nurs 29 Nurs EMI
Beacon Lodge Brynmawr	313463	6 Res. (Younger Adults)
Bedwellty Park Tredegar # (if requested)	711788	14 Res.
Bridge House Ebbw Vale	306837	28 Res. 12 EMI
Brynwood Brynmawr	314907	32 Nurs
Cwmseren Care Home Tredegar	717466	19 Nurs 10 Res
Cwmcelyn Blaina	290550	24 Nurs (Younger Adults 18-65)
Cwrt Mytton (LA) Abertillery	217736	13 Res. 22 EMI (Incl 2 Respite)
Glanbury Brynmawr	314909	35 Nurs EMI. 2 Younger Mental Health 3 EMI Res
Grosvenor Abertillery	320444	30 Nurs 12 Res.
Maes-y-Dderwen Tredegar	717181	24 Nurs (Younger Mental Health)
Plasgeller Brynmawr	314912	37 EMI Nurs 3 EMI Res
Red Rose Ebbw Vale.	352559	25 OP Nurs 3 OP Res 8 Younger Adults Physical Dis
The Rookery Ebbw Vale	302221	24 Res. 17 Res EMI
Woffington House Tredegar	717071 717667	34 EMI Res

CAERPHILLY		
Name of Establishment	**Telephone Number**	**Category of Care**
Ashville Residential Home Brithir	01443842842	35 Dem Res
Bargoed Care Home (Four Seasons Healthcare) Bargoed	01443 879005	10 OP /31 OP Nurs.
Beatrice Webb **(LA)** Blackwood	01495 225773	28 OP.
Brindavan Care Home Aberbargoed	01443 873205	32 Dem Nurs.
Gilwern House Residential Home Pontllanfraith	01495 226515	13 OP.
Glan yr Afon Nursing Home Fleur-de-Lys	01443 835196	19 OP./20 Nurs.
Highfields Nursing Home Blackwood	01495 225221	10 OP./26 Nurs.
Millbrook Residential Home, Pontllanfraith	01495 225861	28 OP.
Millview Lodge (HC-One) Newbridge	01495 249193	20 Dem Nurs.
Millview House (HC-One) Newbridge	01495 249193	35 Dem Nurs.
Min y Mynydd **(LA)** Rhymney	01685 840595	25 Dem Res.
Oakdale Manor Residential Home Oakdale	01495 230900	30 Dem Res.
Ty Clyd **(LA)** Bargoed	01443 875553	22 Res.
Ty Derwen Residential Home, Crumlin	01495 243028	32 OP
Ty Iscoed **(LA)** Newbridge	01495 243189	20 OP/10 Dem Res.
Valley Manor (Puretruce) Rhymney	01685 844127	28 OP Nurs.
White Rose Home New Tredegar	01443 837183	16 OP./16 Dem Res.

CAERPHILLY Cont		
Name of Establishment	**Telephone Number**	**Category of Care**
Abermill Care Home (HC-One) Abertridwr	02920 831622	9 OP./29 Dem Res.
Brodawel **(LA)** Caerphilly	02920 852552	22 Dem Res
Castle View **(LA)** Caerphilly	02920 852554	17 OP/11 Dem Res.
Church View (HC-One) Caerphilly	02920 852951	35 OP./10 Dem Res
Craig y Trwyn Nursing Home (Craegmoor Healthcare) Wattsville	01495 270475	4 OP/34 Nurs.
Medhurst Residential Care Home Crosskeys	01495 270385	22 OP/6 Dem Res
Parklands (HC-One) Bedwas	02920 880525	9 OP./35 OP Nurs.
Parkside Maesycwmmer	01443 816577	19 Dem Res.
Trafalgar Park (HC-One) Nelson	01443 450423	22 OP / 30 OP Nurs. / 24 Dem
Ty Penrhos (Hafod Care) 2 Beddau Way, Caerphilly	02920 854340	40 Dem OP / 20 Dem Nursing
Valley View Care Home (Four Seasons Healthcare) Hengoed	01443 862212	12 OP. /23 Dem Res / 30 OP Nurs.
Ynysddu Nursing Home Ynysddu	01495 200061	3 OP./28 OP Nurs.

We hope you find this booklet reassuring and that it helps to make your experience a positive one where you have more choice and control.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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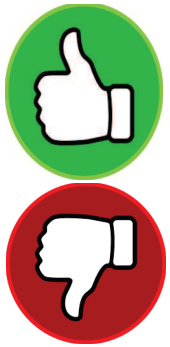
Before you leave – we would like to know what you think about your stay, as we are always trying to improve care for patients. Please complete our **Feedback questionnaire.**
Or Hootvox



Contact Numbers for
********** Ward –
01443 802285
01443 802302

********* Social Services Department

We hope you find this booklet reassuring and that it helps to make your experience a positive one where you have more choice and control.

Space for specific ward information not covered

Other useful contacts -

Age Cymru
0800 022 3444
www.agecymru.org.uk
Alzheimer's Society
0300 222 1122
www.Alzheimers.org.uk
Carers Wales
029 2081 1370
www.carersuk.org/wales
Macmillan Cancer Support
0808 808 0000
www.macmillan.org.uk

Please ask a member of staff if you require more information about your care or anything in this leaflet.

This information is available in Welsh or any other language on request, also in other formats.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

(Hospital)
Welcome to ***** Ward

All you need to know about your stay in the Community Ward from admission to discharge.

You have been transferred to (Hospital) because you no longer need care in an acute hospital setting (like the Royal Gwent for example) but you do need some more Community Hospital care.
(Hospital) is a Community Hospital.

We want to make your hospital stay a positive experience where you, your family and carers have more choice and control.
(Hospital) staff will support you to stay independent and be able to make your own choices. We will work with you to identify what matters to you, and help you to choose from the range of options that are available. Our aim is to support you to maintain a good quality of life.

About the ward -

(Hospital information) has three Community wards, all with single en-suite rooms for patients.

****** **Ward** is mainly for *****(e.g.Stroke/ Rehab) patients.

The Hospital also offers:-

- 24-hour nurse-led Minor Injuries Unit
- Out-patients Department, including Children's' Outpatients
- Physiotherapy and Occupational Therapy
- Dietetics
- Speech and Language Therapy
- Mental Health In-patients
- X-ray Department with CT and MRI scanner
- Day Surgery

The ***Café/restaurant is on Floor 1 and is open from * to * daily

The ****Hoffi Coffi Coffee shop is on the ground floor near Reception and is open from 9-6.

You are welcome to visit patients at any time from **11:00am until 8:00pm**, except for patient meal times between 12:30pm -1:30pm, and 5:30pm - 6:30pm. These are protected mealtimes, but ward staff will welcome support from carers or relatives if this will help patients with their diet.

- **Bring or tell us about any tablets , any medication (including patches, creams etc.) you have been taking**
- **Bring suitable clothes, including well-fitting slippers or shoes**
- **Bring contact numbers of close relatives**
- **Please don't bring valuables with you to hospital, and remember that any property or belongings are your own responsibility.**

Your ward has single en-suite rooms for all patients, to provide dignity, privacy and better infection control. Sunflower volunteers may visit to chat , read with you or help you with hairdressing or crafts. ***TVs are provided in all rooms, with individual remotes which won't work elsewhere, so please check you don't accidentally take these when you leave!

How may I feel?

You may feel nervous about leaving the safety, security and company of the ward. You may be thinking about the coming weeks and months and be concerned about managing alone, putting strain on your family, or using equipment and adaptations to your home. You may be worried about how your care will be funded.

The **MDT meeting** is the best time to discuss these concerns, but speak to staff if you are worried.

On the other hand, you may be eager to leave hospital. But it is important to be realistic about your abilities. If you overestimate what you can do, you might not get help that will be useful to you.

Leaving hospital –

- Make sure you have your
- medicines and know how to take them.
- Check whether you need a follow up appointment, more tests or a GP appointment.
- Ask for your valuables back if we have stored them.

What about Transport?

On the day that you leave us, we ask that you or your family/carers arrange for your own transport if possible . However we will arrange ambulance transport if you need it. Please ask a member of staff if you need help with this.

Returning to your home

If you are well enough and choose to do so, the Team will do all that they can to arrange a safe return to your home. This may be with support from family or carers, or with a **Care Package** tailored to your needs giving you support in your own home. Staff will discuss this process with you. If you need some on-going help when you leave hospital, there may be a team of Occupational Therapists, Enablement Workers, Social Workers or Physiotherapists who can help you. This is known as e.g. the Reablement/Integrated Services Team***.
If needed, the team will help you with any support you need when preparing to leave hospital and when you are home.

What if you cannot return to your home?

The staff in ******** Community Hospital fully understand how difficult this decision will be for you the patient, your family and carers. We will make every effort to discuss this important decision with you, explaining the choices available. This may be about the type of residential or nursing accommodation which is best for you, and what is available locally.

The Health Board has a **Choice of Accommodation Policy** to address the needs of patients whose future place of care from hospital may be in a residential or nursing home. A copy of this policy can be given to you or your family/carer.

About your treatment

A Team of people may come to see you –

Doctor (Medical Staff) - A doctor diagnoses you and discusses the best course of treatment for you.

Advanced Nurse Practitioner - A nurse who has received specialist training.

Nursing staff - Sister and Deputy Sister, with a team of Registered Nurses, Healthcare Support workers and domestic staff. These are trained to provide health care to patients. They will assess your condition, look after you and provide advice.

Occupational therapist - helps you to keep or regain your independence to carry out everyday activities, by teaching skills and/or providing equipment.

Social worker - will support you with needs such as housing, and work with you to find the best arrangements for you when you are discharged.

Physiotherapy – You may be referred to physiotherapy when you are admitted. The physiotherapist will look at your strength, balance, stamina and mobility.

All the wards are managed by medical staff, who are part of the Care of the Elderly Directorate. There are medical staff based on site Monday to Friday 9am – 5pm, with an on-call service operating outside these hours. (Different for Redwood)

You may need some Rehabilitation –

to help you recover and regain your independence.
It involves you the patient, your family, friends and carers-

- Working hard together
- Being active within your surroundings
- Re-learning skills you had before
- Learning new ways to do activities

The Team looking after you will explain what is needed.

What happens next?

During the first week that you are in ******** Ward, we aim to complete all of our initial assessments, and will speak with you and your family or carers.
A meeting will then be held with all the people who are responsible for your care.

This is called a **Multi Disciplinary Team (MDT)** meeting. Depending on your medical condition, this could take place within your first few days on the ward or may take a little longer.

Together with you and your family or carers the MDT meeting will:

- Listen to what is important to you
- Discuss your care plan and goals
- Discuss and agree a possible date of discharge
- Talk with you about options for the best place for you to live when you are discharged
- Talk about your rehabilitation progress
- Improve your knowledge and confidence in looking after yourself ready for your discharge

The MDT Team may include:-
You and your representatives, Doctors, Nurses, Physiotherapists, Occupational therapists, Mental Health team, Reablement Team, District Nurses, Social workers.

It is an opportunity for you and your family/carers to discuss anything that may make your discharge difficult, or to tell us about any issues that are relevant. We will encourage you and your relatives and carers to join in the discussions. We can then talk about the support you might need before you leave hospital.

A safe and timely discharge – Your choices as you leave hospital

We believe that the support you have when you are preparing to leave hospital is just as important as the support and medical treatment you receive when you are in hospital. We want to prevent you having a lengthy and unnecessary hospital stay.

As it is not possible or appropriate for you to remain in the Community ward for longer than necessary, it is important for you and your family/carers to speak to us about what you would like to happen when you are discharged. The MDT meeting is a good opportunity to do this.

We aim to:

- Communicate clearly with you
- Work with you and bring together only those people who can help you to live your own life
- Work with you to find solutions to any difficulties you might be experiencing
- Use our resources as creatively and flexibly as possible.
- Uphold your right to be fully involved in decisions about your care

Welcome to Rowan Ward
County Hospital

Ward Routines

'Welcome to Your Ward' Leaflet
If you have not received this please ask a member of staff.

Ward Rounds
You will be visited by the Doctor daily. An appointment can be made for you and/or your family to speak with your Doctor, please ask your named nurse for details.

Nurse Rounds
Your nurse will check every 1-2 hours that you are comfortable and have everything you need.

Visitors:
Visiting times – (except for Protected Mealtimes)
Mon—Fri 18:30—20:00
Sat & Sun 14:00—16:00 & 18:30-20:00

Nurse Shifts
Day: 7:30am—8pm
Night: 7:30pm—8am

Food and Mealtimes
The Nurse in Charge will give you a menu to help you choose your meals, however sometimes your diet will be restricted due to medical reasons. If you need gluten free, low potassium, pureed, cultural or vegan meals please ask your ward hostess or nurse.

Further information on food allergens is available on request.

Breakfast

8am

Lunch

12 midday

Supper

6pm

Refreshments and snacks are available all day

About Your Care

During your stay we would like you to be fully involved with doctors, nurses and other staff in decisions about your care. Please ask if you don't understand any plans or decisions.

The Named Nurse is the allocated nurse responsible for your care during their shift. They will be the person who you or your relative can ask for immediate information and they will know about your circumstances and care.

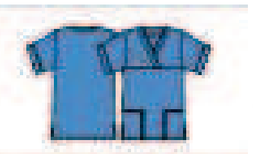
You will also have a Responsible Consultant/Clinician who will look after you throughout your stay.

Infection Prevention

Please wash your hands. You and your visitors can help us by always washing your hands with soap and water after using the toilet.
Before you enter or leave a ward, please wash your hands and/or apply alcohol hand gel from a dispenser. Simply rub the gel onto dry hands and let it evaporate. Please feel free to ask your nurse or doctor if they have washed their hands.

Who's Who Uniforms

Sister/Ward Manager (Navy blue)

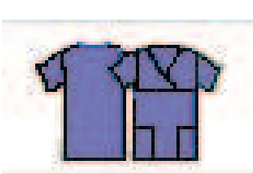


Registered Nurse (Hospital blue)

Clinical Nurse Specialist (Royal blue)

Domestic staff (Dark red)

Health care support staff (Dark green)



Student (Lilac)

Information on Patient services -

Pastoral/spiritual care
Sunflower volunteers
TV, phone and internet
Interpreters
Trolley service

Please tell us about your stay to help us improve our services and care. You will be asked to complete a Patient Feedback Survey at the end of your stay, you can also give feedback on our webpage at: www.....

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HEALTH SOCIAL CARE AND WELLBEING – 21ST JUNE 2016

SUBJECT: **THE PROCUREMENT AND IMPLEMENTATION OF THE WELSH COMMUNITY CARE INFORMATION SYSTEM**

REPORT BY: **CORPORATE DIRECTOR SOCIAL SERVICES**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide Scrutiny Committee with an understanding of the all Wales Community Care Information System (WCCIS) supplied by CareWorks Ltd. that has been procured by Bridgend County Borough Council under a Master Services Agreement (MSA) on behalf of all Welsh Local Authorities and NHS Organisations.

1.2 The replacement of the Social Care system is a key priority for Social Services in its ability to work in a more integrated way with NHS Wales to improve the delivery of integrated care which is one of the key aims of the Social Services & Wellbeing (Wales) Act 2014.

2. BACKGROUND

2.1 The Council's has used SWIFT as its social care information system since 2001. This system has been developed extensively over time to ensure that it can deliver the changeable national assessment frameworks and performance reporting requirements and is critical to the delivery of the Council's social services.

2.2 In its use of SWIFT the Council has worked collaboratively with other local authorities in developing the use of the system and in negotiating additional requirements with the supplier. Caerphilly CBC has also hosted the regional consortium for the implementation and development of SWIFT. The existing supplier contract for SWIFT is due for review in October 2017.

2.3 Since 2013, local authorities across Wales and NHS Wales have being working collaboratively to procure a Welsh Community Care Information System (WCCIS) that has been designed to meet the requirement of both social care and community health services. Whilst integrated services have been developed across Wales, information sharing between services has been a long standing problem that has often hindered health and social care services working closely. WCCIS is widely regarded as being the solution that would best enable information to be shared effectively between local authorities and health services.

2.4 The Local Authority contribution to the procurement process was initiated to the eight Wales System Consortium (WSC) Local Authorities which include Bridgend, Blaenau Gwent, Ceredigion, Gwynedd, Powys, Torfaen, Wrexham and Ynys Mon. The WSC was formed as a recognised social care system Consortium to work in partnership with the supplier to develop the DRAIG system, and due to the end of contract life, had begun to plan the procurement of a replacement for the DRAIG system in 2011.

2.5 It was timely that NHS Wales were also looking to procure a national system to support Community Health services. In recognising the opportunity to procure a system that supported both Social Care and Community Health services, WSC and NHS Wales agreed to commence the joint procurement of WCCIS.

2.6 The WCCIS procurement process ended in 2015 and all twenty two local authorities and health boards are able to procure WCCIS, as a replacement for their existing information system.

2.7 WCCIS has been endorsed by the Minister for Health and Social Care and Welsh Government have contributed an amount of £6.7 Million to fund the set up costs of WCCIS for the whole of Wales. This will cover central hardware costs and the provision of user licences. This contribution will reduce the costs for all participating local authorities.

3. THE REPORT

3.1 Welsh Government policies and strategies have consistently reflected the importance of citizens being appropriately cared for in their homes and in community settings. Consequently there has been increasing efforts by health boards and local authorities within Wales to deliver more integrated services to ensure services and support for individuals, their families and communities are effectively planned, co-ordinated and delivered. However, one of the common and key impediments to integrated working between health and social care services has been the inability of services to share information effectively and the WCCIS has been specified to ensure that its functionality overcomes such long standing issues.

3.2 Bridgend County Borough Council as lead authority has entered into a national deployment order on behalf of all Wales. This deployment order will deliver hardware, specially written software and an all Wales licence for WCCIS Microsoft Dynamics CRM. The WCCIS system will be hosted by NHS Wales Informatics Service (NWIS) in two data centres located in Blaenavon and Newport, to provide resilience. The support infrastructure costs are scalable and covered in each Authority Party's deployment order.

3.3 The local Deployment Order will set out local technical requirements and needs in terms of data migration, implementation, training, testing, local project governance, service charges and Caerphilly County Borough Council responsibilities. The local Deployment Order is the vehicle for all payments incurred by the authority.

4. PROJECT IMPLEMENTATION

4.1 The Association of Directors Of Social Services Cymru (ADSSC) has a clear role in helping to provide national leadership for the WCCIS project on behalf of local government. Governance for WCCIS will be at a national level and will be jointly led by the Director of Social Services for Caerphilly County Borough Council for ADSSC and the Chief Executive of the Powys Health Board on behalf of health boards.

4.2 Progress with regard to the project is overseen by an Implementation Board consisting of staff from local authorities, health boards, NWIS and Welsh Government. The Board is supported by a number of sub groups covering issues such as technical assurance, information governance and community information.

4.3 The Caerphilly CBC project implementation plan will be produced in conjunction with CareWorks during the completion of the Caerphilly CBC local Deployment Order.

4.4 The exact order of WCCIS implementation for all authority parties is yet to be confirmed. However, Bridgend CBC is now live with Ceredigion CBC the next to follow before Powys County Council and Health Board and become the first truly integrated implementation of the project. At present it is envisaged the Gwent authorities will implement in 2017/18 but preparatory work is already commencing.

4.5 The WSC has produced a working document "Assessment in Readiness" for each Authority to complete once they have signed the Deployment Order. This outlines the indicative tasks and expectations that an authority will need to go live with CCIS.

4.6 The Readiness Assessment framework consists of three broad areas of readiness that are necessary for technology adoption, each of which contains a number of components. These areas will help identify the overall readiness for implementing CCIS, and it can bring to light specific issues that need to be addressed in preparing for implementation.

The self-assessment is organised into three areas of readiness:

a. organisational readiness;
b. project readiness;
c. technological readiness.

This self-assessment is designed to identify additional steps we may need to take before beginning a technology-related reform. This tool does not provide a definitive assessment of readiness; rather, it presents a set of research based indicators that are related to the likelihood of WCCIS enabling successful transformation to integrated Social Care and Health working arrangements.

5. EQUALITIES IMPLICATIONS

5.1 The introduction of WCCIS will ensure appropriate information sharing between health and social care staff that will enhance the services received by children and adults. There are no equality consequences of this proposal.

6. FINANCIAL IMPLICATIONS

6.1 The costs of adopting WCCIS have been calculated on an authority by authority basis. The costs for this Council to purchase WCCIS have been calculated to be £93,176K per annum for the length of the contract. This compares to current costs for SWIFT of £84,000 per year. The additional monies will be found from the Social Services revenue budget.

6.2 These costs have been supplemented by the £6.7 Million Welsh Government funding contribution which has effectively subsidised the All Wales License and National hosting costs arrangements.

6.3 These costs are considered to be comprehensive and include:

- annual Support and Maintenance (including 24/ 7 support);
- supplier implementations costs that include migration of data and training days;
- integration interfaces that enables WCCIS to be connected with other systems as required.

7. PERSONNEL IMPLICATIONS

7.1 The implementation of WCCIS would require a considerable investment of existing staff time to ensure that the system is successfully adopted. There will no personnel implications beyond this.

8. CONSULTATIONS

8.1 All comments from consultations are reflected in the content of this report.

9. RECOMMENDATIONS

9.1 That Members note the Council's intention to move to the WCCIS as a suitable replacement for the authority's existing Social Care IT system and as a key driver to integration of health and social care information.

10. REASONS FOR THE RECOMMENDATIONS

10.1 The Social Services & Wellbeing (Wales) act 2014 has integrated services between health and social care at its core. The effective sharing of information is a fundamental foundation of integrated working and needs to be applied on a "once for Wales" basis. The initial core funding from Welsh Government has significantly reduced potential costs in this area.

11. STATUTORY POWER

11.1 Social Services & Wellbeing (Wales) Act 2014.

Author: Dave Street, Corporate Director Social Services
Consultees: Councillor Robin Woodyatt, Cabinet Member
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Paul Lewis, Acting Head of IT
Trevor Banks, Team Manager, South East Wales Consortium
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