

## Event Report Form

My care My Way – Home First Consultation Event #5	
<b>Organisations responsible for the event</b>	North Staffordshire and Stoke-on-Trent CCGs, Midlands and Lancashire CSU.
<b>Attendees from CCGs and CSU</b>	Marcus Warnes, , Becky Scullion, Dave Sanzeri, Linda Longshaw, Kay Hayward, Sarah Evans, Jane Barnes, Ann-Marie Dale, Filippa St Aubin-D'ancey
<b>Date of event</b>	23 November 2015
<b>Venue</b>	Bentilee Neighbourhood Centre
<b>Other groups who supported the event</b>	Healthwatch Stoke on Trent and Staffordshire, My Care My Way Forum Group, Patient Reference Groups, Revival, VAST,
<b>Attendees from those groups</b>	Wendy Sandbrook, Peter Bailey, Dave Rushton, Susan Turner, Lisa Bridgwood, Lorien Barber, Karen Warren, Robin Morrison (Chair), Peter Bailey
<b>Other attendees</b>	X 16
<b>Agenda</b>	
<b>Outcome and feedback</b>	See Attached Notes

# My Care My Way

## Patient and Public Engagement

Monday 23 November, Bentilee Neighbourhood Centre, Bentilee

Presentation – Marcus Warnes

### TABLE 1

#### Q&A from presentation:

- How can the CCG manage the performance at the Royal Stoke when they are not presently achieving current targets? (in relation to physio, x-ray and therapies)
- Is NSCHT signed up and actively involved in this process?
- Primary Care are key players in order to keep patients out of hospital. Will the clinical ownership of the patients rest with the GP particularly in view that there will be a higher acuity of patients within community services?
- Patients resident in private residential care homes do not currently have their medical needs managed by the home. What happens to this cohort of patients when they can't be returned to the residential home for ongoing treatment? Will they be transferred to nursing homes? Will the CCG strengthen contracts with residential home providers to allow nursing care to be provided by outside bodies?

#### Question 1: Is there anything further we should be considering with regards to My Care My Way model of care?

- How is the New Model being funded?
- Do we have enough staff in place i.e. occupational therapists?
- Are we sure what/where the barriers are?
- MH visibility needs to be higher- RAID service now up and running.
- Communications around MH services could be more robust.
- Need more MH preventative work.
- Need more robust pathways for housing - problems.
- Is housing ok to be discharged too?
- Dementia Primary Care Service is a new service that covers care homes.
- Shortage of Domiciliary care – How will it be managed?
- Current domiciliary care service is old fashioned and needs modernising- get rid of 15 min calls.

#### Supplementary Health Watch questions to question 1:

1. What are people's experiences of services at the moment-any concerns/issues?  
Pharmacy can delay discharge and needs to be reviewed.
2. What services need to be delivered to help people receive care in their own home?  
Preventative services within the third sector should be utilised more.
3. How do people want to be able to access community services?  
Single point of access to ensure simplicity and should be independent of the GP surgery. Patients would like it to be their GP but feel this would put undue pressure on practices.

4. How should patients/families and Carers be involved in decisions about their own care?  
Support for carers would reduce carer breakdown.

#### Top feedback

- Discharge process within the community.
- Communication between professionals.
- Management of medication support and discharge pharmacy.
- Funding for services.

#### **Question 2: Are there further actions we should put in place/consider in proposing this change?**

- Health service/ social care information is confusing.
- Once a plan is in place and reviewed in a timely manner.
- Co-ordinator of services to oversee care plan/appointments/advocacy.
- Perhaps need one compliment/complaint service to ensure independent reporting.
- Follow up of service satisfaction.
- Communication of the New Model to continue to embed with the public.

#### Top feedback:

- Communication of the “New Model” needs to have a wider audience.
- Sharing of information between professionals is paramount.
- Treat people as individuals and to not fit a Health pathway.
- Post code lottery within some services, why?

#### **Question 3: Are there any questions/issues that individuals would like to raise as part of this process?**

*No time for this question*

#### **TABLE 2**

#### **Q&A from presentation**

- How can CCGs manage and co-ordinate Royal Stoke i.e. waiting times for physio, pharmacy etc.
- Combined Health Care Trust need to be actively involved in real MDTs within the community and not fragmented.
- Mental Health is not evident within the presentation.
- There needs to be clinical ownership by GPs and they need to actively monitor patients.
- When care home patients are admitted to hospital, private homes will not take the resident back if they have care needs, will these residents be moved to nursing homes? Do the contracts need to be changed to ensure the care home has to accept the resident back?

#### **Question 1: Is there anything further we should be considering with regards to My Care My Way model of care?**

- Very confused, used to work for social services within a council funded home, where the staff were very well trained, people are now being passed from pillar to post, there is no consistency feel as though we are eroding what is already there. For example friend broke his hip, the hospital could

not get him home as there were no care staff available, also no re-ablement services available and he stayed in hospital for 19 weeks.

- Domiciliary care staff (Stoke LA) are still doing only 15 minute calls which is an appalling service, people are waiting up to 8 months for equipment.
- There is a massive waiting list for disability facility grants (up to £25000).
- Tightening of disability criteria is making things extremely difficult.
- Can't ignore self-funders.
- When performance managing providers, contract leavers are not working, need to look at other methods of performance managing to ensure patients receive good quality service.
- Need to ensure patients are not warehoused in their own homes.
- Social care is means tested.

**Question 2: Are there further actions we should put in place/consider in proposing this change?**

- Capacity of Mental Health providers, staff retention, work force planning.
- Independent providers have minimum staff training, standards and skill levels.
- CHC funding issues and LD is missing.
- Concerned regarding the psychiatric liaison services in acute services.
- Winter pressures - If escalation where do the beds come from should not have pre-empted by closing the 37 beds at Longton - Longton is poorly served.
- Rumours that Longton Hospital has opened a few beds and being used as an overspill.
- The need for a crisis team within dom care with key workers.
- Within the local health economy there is a shortage of therapy services.
- Transport issues for relatives and friends to access Cheadle, Leek and Bradwell.
- How will bed bound patients be looked after i.e. pressure sores?
- Loneliness.

**Question 3: Are there any questions/issues that individuals would like to raise as part of this process?**

*No time for this question*

**TABLE 3**

**Question 1: Is there anything further we should be considering with regards to My Care My Way model of care?**

- How are you going to support if Moorlands have problems recruiting and retaining DNs and Mental Health nurses?
- Discharge is un-coordinated, no consultations with their families.
- Problems waiting for patient transport.
- Discharge lounge not being utilised correctly.
- Pharmacy – people sitting waiting for their drugs.
- Should have a pharmacy for inpatients and one for discharge patients.
- There is a scheme in Manchester where pharmacists are working closely.

- Have an advocate to help people at discharge, especially if they don't have someone else/family with them at the time.
- Part of the discharge should include someone who knows who to contact and when. Family can collect elderly patients and don't always know when they are being discharged, could avoid patient transport intervention.
- Need to be smarter at using technology need to go paperless, need a robust system.
- Community nurses are fantastic, explained everything that was happening, who would phone GP etc.
- Need to look at all conditions not just what patients have been admitted for.

**Question 2: Are there further actions we should put in place/consider in proposing this change? /**

- Cheadle and Bradwell Hospitals - where do people of Longton go if they need step up? What if patients and family do not have transport, if family can't drive then patient will be isolated during their stay in hospital – access and facility issues remain
- Example – people living in Leek have to go to Cobridge and Meir for blood tests and warfarin
- Written care plan for patients/carers/family/advocates and all should have a copy, this can help patients and professionals
- Look at individuals not the system, you can have two appointments at either end of the day
- Once family have POA this should be on “the system” and shared across all departments rather than having to keep doing it for each department.
- How to reach out to communities and harder to reach groups – could use pharmacies, supermarkets etc

**Question 3: Are there any questions/issues that individuals would like to raise as part of this process?**

*No time for this question*

**TABLE 3**

**Questions raised on table:**

- How much did the leaflets cost to produce, concern that money is being used.
- Questionnaires don't have in depth questions.
- Need to have the opportunity to raise questions after.

**Question 1 – Is there anything further we should be considering with regards to the My Care My Way model of care?**

- Increased level of patients going into residential care as housing becomes unsuitable as become more disabled. Need links with housing associations to improve housing stock.
- GP Access an issue, model is advocating that GPs are the centre of care access; need to have a more robust approach.
- Difficulties with accessing updates on progress from carers for patients cared for at home (when in hospital can obtain regular updates); more likely to defer to A&E/GPs to gain level of assurance required. Model could cause conversely increase the number of A&E attendances.
- Out of hour care; what is the process?
- Concern that carers and family members are getting older, how is this being supported?

- Who will co-ordinate the model of care?
- Positive that number of community services are increasing; will GPs have direct access to these services (in particular SALT, dietetic and other therapies).
- Social care workers are not able to administer medications, unable to help situation if regular medication required.
- Need to look at the criteria for admission, low needs if help was available which would lead to reduced admissions.
- Extra care staff, which staff and how much addition resource is required? Is there backup available to cover sickness. What %age of back up are care workers? Are these from private companies or in house (rate of pay differences between the two)?
- What is going to happen if there are significant amounts of demand unable to cover?
- Who is monitoring the care, how often will this be monitored?

**Question 2 – are there further actions we should put in place/consider in proposing this change? /**

**Question 3 – are there any questions/ issues that individuals would like to raise as part of this process?**

- My care, my way – choose to have a community hospital setting, will this be agreed to?
- Concern that the consultation is inadequate due to the number of people who have attended events.
- Individuals should have a single number, manned 24/7, who will take ownership of the issue, provide re-assurance and timeframes to resolve / action.
- Have we considered learning difficulties and how the changes to care environments can affect wellbeing? Ensure staff in community hospitals are able to communicate. Ensure high level of knowledge and additional time to provide equity in care (same for dementia).
- No 1:1 support available within hospital wards to assist at meal times, reliance on family and carers.
- Increased staff training for patients with complex needs. Important for hospital stays and community.
- In community there is a requirement for another source of information to provide / cover a level of need/support. This affects care providers, 111 and ambulance services.
- Frustrations that there is nothing to prevent escalation in a crisis.
- Care workers need to have a fairer pay deal and be trained.
- Requirement for a consistent service.
- Care workers are providing care to too many people impacting on quality. Need to have guidelines / law to ensure there is a consistent approach to number of staff per patient, this also applies within care homes.
- Issues expressed with discharges, service not providing quality support at present. Concern expressed that we are stepping into the unknown.
- GP's are expected to have medical oversight however there is not enough of them.

## TABLE 4

### **Question 1 – Is there anything further we should be considering with regards to the My Care My Way model of care?**

- How will the CCG manage and improve hospital care for dementia patients? There are issues with communication with this cohort who are reliant on a carer / advocate. They tend to have a longer length of stay once admitted to hospital as needs are not understood.
- Consider implementation of 'This is me' leaflet / document. This can be taken to hospital with them and used within nursing and residential homes.
- Concern raised over the diagnosis rate of dementia. Large proportions go undiagnosed.
- Increase staff training in relation to geriatric care.
- More community services available over the weekends.
- Introduction of follow up system, this is to ensure that patients fully understand the advice given and the importance of following the medical advice given. This in turn should reduce the number of DNA's.
- Issues with communication across all services including language barriers.
- Support for carers required outside of normal hours, this currently seems to stop at 5pm on a Friday.
- Emphasis on patient self-awareness – spotting the signs and having a basic understanding of their condition.
- Requirement for additional District Nursing support.

### **Question 2 – are there further actions we should put in place/consider in proposing this change?**

- Dementia awareness / dementia friend training for all staff. Dementia nurses talking to staff within nursing and residential homes.
- System does not appear to be joined up, not clear who is responsible for care.
- Increased meaningful education at all levels including patients and carers.
- Increased pharmacy involvement, patients are not aware how qualified pharmacists are.
- Increasing the level of input hospital staff have with nursing and residential homes.
- Increased / better access to GPs and District Nursing services.
- Compilation of a directory of services – in order that you know who to contact.
- Development of toolkit and sharing of best practice.
- Shared information across all services.

### **Question 3 – are there any questions/ issues that individuals would like to raise as part of this process?**

*No further comments*