

Event Report Form

My care My Way – Home First Consultation Event #6	
Organisations responsible for the event	North Staffordshire and Stoke-on-Trent CCGs, Midlands and Lancashire CSU.
Attendees from CCGs and CSU	Marcus Warnes, , Becky Scullion, Dave Sanzeri, Linda Longshaw, Kay Hayward, Sarah Evans, Ann-Marie Dale, Maria Anderson
Date of event	27 November 2015
Venue	The Guild Hall, Tape Street, Cheadle
Other groups who supported the event	Healthwatch Stoke on Trent and Staffordshire, My Care My Way Forum Group, Patient Reference Groups, Stoke on Trent City Council, North Staffordshire Combined Healthcare, Staffordshire and Stoke on Trent Partnership Group.
Attendees from those groups	Peter Bailey, Dr James Shipman, Daryl Gwinnet, Stephanie Zahorodnyj, Ian Wright, Malcolm Barber.
Other attendees	X 13
Agenda	
Outcome and feedback	See Attached Notes

My Care My Way

Patient and Public Consultation

Friday 27 November,

Presentation – Marcus Warnes

TABLE 1

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

- What help can be provided for people at home particularly for those living alone?
- Information for patients on discharge should be comprehensive both pre and post discharge.
- Aids and adaptations within the community could be improved. What is being done about it?
- Assessment letters to GP's should be sent in a timely manner.
- If the Royal Stoke uses the private sector to provide acute services is the discharge procedure the same?
- Is Secondary Care training sufficient to support the community element of the model?
- Services need to be integrated i.e. Better Care Fund should be used as intended and not in silo.
- Social Care vital to get people home.

Supplementary Health Watch questions to question 1:

1. What are people's experiences of services at the moment-any concerns/issues?
 - Inconsistent advice on discharge.
 - Discharge planning is inconsistent.
 - Discharge of mother was very challenging for patient and family with the ward insistent on rehabilitation status to be higher than before admission to hospital.
2. What services need to be delivered to help people receive care in their own home?
Responsive aids and adaptation services that currently has a long waiting list.
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.
4. How should patients/families and Carers be involved in decisions about their own care?
Appropriate advocacy and timely assessment, to involve patients in decision making process.

Top feedback

- Dom Care/ NHS carer continuity.
- Communication between professionals.
- Comprehensive assessment – Robust assessment whilst maintaining dignity and choice.
- Workforce development.

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

- NHS and Social Care delivery point/charges different. Can/should these be aligned for patient continuity?
- Vital that professionals going out into people's homes communicate to older people appropriately.
- Communication across professionals needed.
- Single co-ordinated care plan needed.
- Concept of age now different but agencies not keeping up.
- Educating people in own Healthcare.
- Continuity of care - @point of care.

Top feedback:

- Waiting in hospital for test results – can that be done at home
- Voluntary sector involvement
- Educating people in own healthcare.

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

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

- What help will be provided when people go home from hospital if they are single?
- Communication issues between organisations.
- Social worker financial assessments are taking too long - also peoples' perception of how much hourly care costs are not realistic (they think too expensive).

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

- Concerns around low capacity in domiciliary care.
- LIS service is excellent but when finished patients receive very poor quality of care from the private sector/agencies and then proceed to cancel their care package so left with nothing and vulnerable.
- Social workers are not interested in assessing low level needs.
- Communication between agencies.
- Quality of assessment is poor.

TABLE 3

Presentation Q&A

- GPs are very busy it is difficult to get appointments.
- Will GPs sign up to this?
- Will they go out to visit?
- Is IT linked and able to share information?
- Additional concerns regarding GPs retiring leading to problems in availability.
- IT – lots of different systems even across GPs.
- Where will you get the people from to do community domiciliary care?
- Mental health beds when people are sectioned are too far away from home and family.
- Is the care received at Nuffield the same level as the trust?
- First assessments used to be conducted with a social worker, nurse from the hospital and physiotherapist.
- What education will you put in place for people working in GP practices?
- Example – son very ill and needed a district nurse on a Sunday, there was no way of contacting one to find out if they were attending that day had to dial 999 and an ambulance attended, just as the district nurse turned up (Dr J Shipman spoke with this member of the public after the session).
- Do you have a system re issues around workload and if the district nurse called to say could not meet their case load would this go against them?

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

- Patients who are discharged, what happens about their ongoing care? GP gets information but what about the patient getting the information? e.g. if the patient is discharged with medication? Example – lady collecting mother in law and told that she was ready to go, however the lady did not know results of bloods or what had happened.
- Issue with discharge e.g. if from acute trust the priority is to get patient home (what is their agenda).
- Communication on discharge is an issue , between hospital and GP, it is reliant on a letter going with patients.
- Concern regarding level of information on discharge and communications of this between different services and with patients.
- People waiting for tests in hospital when they could have gone home and had a test in the community.
- Example: ladies father could not go to a community hospital therefore no tube was fitted but they were expecting her to take him home where they would not have the appropriate equipment to deal with him. They turned up and he had all bags packed ready to move into a palliative care bed with no communication with family around that decision.
- Carer came within one hour of being home but then didn't come again for 36 hours.
- Decision makers moving patients into A & E so that decisions can be made there e.g. ECIST – suggested having consultants in A & E to avoid people having to be admitted to hospital to have decision made.

- Need to have sufficient staff including doctors, nurses and carers, there is a particular issue regarding cover in holiday time and especially Sundays/ weekends.
- Should not be too reliant on family members to do caring. They do not have time or equipment to deal with suitably. For some families problematic – especially if they do not live locally.
- Need reassurance that enough support to have patient at home. Is it ok to have 4 visits over 24 hours? Often the last visit can be at 8 pm but then nothing until 10 am. The patient may not have been moved at all during that time overnight.
- Additional concerns if a person falls and you may not be able to pick them back up.
- Issue – quality between LIS that is put in place (intermediary care service) and the long term maintenance package - LIS is by far superior.

Questions / comments raised by the public

- Agreement to statements made within the presentation however, how will we convince the GPs to sign up to the additional work? It is difficult to get GP to do a home visit at present. Will IT systems be joined up?
- Concern with GP availability, how will GP services be supported?
- Investment in general practice is required.
- Need everyone on board to put this model into practice.
- How will sufficient bodies be obtained for domiciliary care provision, these are traditionally low paid workers that are difficult to retain.
- Concern raised for mental health patients, the lack of beds in a crisis situation and the distance these patients are placed away from home and family members.
- Home assessments, social care previously completed one assessment. Have we moved away from this, will it re-commence?
- Agree that improvements in community services are required. What education will be put in place? Highlighted an issue within general practice, staff members are not able to attend education sessions due to pressures and staff shortages.
- Concern raised regarding District Nursing in relation to contacting / communicating with them to verify attendance. Questioned whether arrangements are in place to call on additional DN's if workload is too large during the day, would this go against the staff member?

Group Session Comments

- Discharges where ongoing care is required – how is the information transferred across as the information provided to the patient is not always sufficient. This can cause delays with medication. Improved communication is required.
- Challenges with patient discharge and the lack of detail provided; there is no level of conformity.
- Communications from the hospital to GPs is not particularly good, reliant upon a letter from the hospital as systems do not talk to one another.
- Quite often you are waiting for test results whilst in hospital, could these be done at home?
- Level of disparity in safety between the hospital and home environment; transfers need to be discussed with family members to ensure adequate support is available. Additional resources are required to provide care at home; overreliance on family members to provide care required.
- Consultant decisions are required within A&E environment to prevent unnecessary admissions
- Need to move to equitable services 7 days per week with access outside normal working hours and at weekends.
- Adequate staffing required; particularly DN's to cover holidays and periods of sickness.

- Reliance on family members undertaking a carer role. Large amount of pressure is placed on families to provide the care required to manage a patient at home. Impact of moving patients home and the impact this will have on family members needs to be considered and sufficient support put in place. Overnight support was raised as a significant area of concern with some families experiencing 12/14hrs between call visits.

Other areas of consideration

- Communication not quick enough between services / providers.
- No consistency in carers resulting in lack of trust.
- Continuity of care; same domiciliary care worker for patients (not a different one at each visit).
- A correct assessment of capabilities need to be undertaken; dementia patients may present well at assessment but require additional support (i.e. changing clothes).
- Greater integration between health and social care.
- Mobilisation of voluntary sector to support people.
- Encourage apprenticeships to 'grow our own'.