Event Report Form

My care My Way – Home First Consultation Event #3 CoRE Longton	
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, Linda Longshaw, Kay Hayward, Ann-Marie Dale
Date of event	9 November 2015
Venue	CoRE, Longton
Other groups who supported the event	Healthwatch, My Care My Way Forum Group, Patient Reference Groups
Attendees from those groups	Lloyd Cooke, Jo Hall/Jeff Love Healthwatch, Dorothy Clohesy, Margy Woodhead
Other attendees	X13
Agenda	
Outcome and feedback	See Attached Notes

My Care My Way

Patient and Public Engagement
Monday 9th November, CoRE Longton

Presentation – Marcus Warnes

Question from presentation:

- Although CCG's have increased community provider staffing by 30%, is their assurance that there are enough staff within the community to support the new model of care?
- What services have been considered to support the model? e.g. GP's
- What are we going to do with community hospitals?
- Grave concerns over UHNM capacity to manage the step down pathway. How will they accommodate this major change?
- What plans are there to upgrade the IT systems?
- Given the recruitment issues for recruitment of Health professionals (including GP's) within Stoke on Trent. Do you think this will work?
- Which parts of the UK are using this model?
- How will Social Care and the third sector support the new model?
- Will the community provider cope with this change?
- OOH services, in the majority of cases, trigger admission to A&E as they don't work in tandem with the rest of services. Has consideration been given to 24 hour services?
- The New Model appears to support older people. What about younger with Long Term Conditions?
- Have you considered demographic modelling on a locality level?

TABLE 1 FEEDBACK

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

- Some discharges occur later in the day with no services to support discharges. These people end up back within A&E.
- Discharges from hospital are not supported by comprehensive information. No one explains
  - How long my stay will be?
  - What will happen when I get home?
  - Who will check what has happened?
  - Booklet would be useful.
- GP 24/48 hour contact- GP is key.
- Discharge professionals say they will come out but don't turn up.
- LTC support at home needed.
- GP appointments hard to get.
- Specialist nurse support needed- Principles already there but needs to be expanded.
- Consultants need overall say.
- EOL nurses organise/coordinate everything that is what should happen.
- Need to ensure patients take medication to prevent falls etc. Pharmacy support.

- Number of carers/ continuity of care is not good.
- 111 remit- Should they be asking the question "Have you recently come out of hospital?"
- Different people coming in for various tasks but do not communicate to patient or each other?
- Patients need to know that they can ask questions.

Supplementary Health Watch questions to question 1:

1. **What are people's experiences of services at the moment-any concerns/issues?**
   Patient admitted to the UHNM acute hospital in the early evening when requiring a bed at Harplands. Harplands would not accept until the following morning.

2. **What services need to be delivered to help people receive care in their own home?**
   Organisations like Age Concern work within the discharge pathway. We need more low level support provided e.g. bread, milk, tea basics provided to support low level discharge.

3. **How do people want to be able to access community services?**
   - Single point of access via their own GP.
   - Access to 24/7 responsive services including pharmacy.
   - Whatever the access is, their records should be accessible.

4. **How should patients/families and Carers be involved in decisions about their own care?**
   - Should use nominated representative that is not necessarily a family member.
   - Respect wishes if they do not want to receive services.

Top 3 Feedback

- 24 hour services that wrap around patients and support discharge.
- Communication between professionals.
- Management of medication support.

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

- General Health service information is confusing.
- Admission to hospital pack would be useful-Giving useful contact numbers and "What will happen when at home?" booklet with useful contact details.—Discharge pack
- Packs to be issued by ward staff – patients more accepting of information from ward staff.
- Organise discharge on admission.
- CCG's need to look at services from a patient point of view.
- Go to hospital ward and follow patients through the system.
- Discharge sometimes prevented by lack of services e.g. adaptations – need to look at services available for patients when they go home.
- How will CCG's monitor how the "New Model" works?
- CCG's require independent feedback.
- Lack of consistency with domiciliary care, health care support worker roles.

- Sensory disability patients need immediate access to interpreters- need to ensure that cultural sensitivities are considered e.g. younger members of the family asking elders/grandparents personal questions.
- Consideration given in how to support rough sleepers/homeless population – and they may not have a GP.
- Domestic violence support.
- Communication of the New Model should continue to embed with the public.

Top 3 Feedback:

- CCG needs to look from a patient perspective i.e. visit wards and chart a patients progress through the system.
- Communication between professionals – in the community and from the acute hospital to community / Information sharing between agencies and to family.
- Independent feedback on assessment of the "New Model".

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 FEEDBACK

Question1. Is there anything further we should be considering with regards to the My care My Way model of care?

- WMAS conveyancing is higher than other parts of the Country – how do we get their buy in?
- Are GP services on board and how will they cope with the follow up of patients when discharged home?
- Preventative care is limited not evident at GP level.
- District/Community nursing teams, do they have time?
- Supported housing and supported people schemes can be a model of care to prevent admission but there has been funding cuts to this project.
- Facility for assessment/re-assessment in own homes to prevent need for admission when in crisis.
- Untrained nurses/healthcare received limited training, is there scope, funding for additional upskilling i.e. HCAs to be able to dispense from blister packs, clean and operate nebulisers?
- The use of social media to help with loneliness and keep in touch.
- Are we being adequately consulted and involved in decisions?
- Informal carers, this will have huge implications – need employers to support flexible working if patient has come home.

Top three feedback

- Ambulance Service – call out responses, the need for WMAS to buy in and educate responders.
- Informal carers need support.
- Coordination and use of voluntary sector.

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

- Self - help/prevention/health workshops – patients to be more informed and take more responsibility. Affected by area, circumstances, depravation, poverty, low self - esteem and self – worth, employment and housing.
- Communication, breaking the cycle.
- Mental Health, where is it in this pathway, need a more holistic approach.
- More walk in centres and more services accessible within them i.e. appointments.
- Difficult for some who are struggling as to admit they are ill/Dementia e.g. elderly couple – can mask illness of each other.
- Sharing information effectively and universal service involvement e.g. fire service, more community involvement.
- Knowledge of local services in each locality that could play a role.
- Early intervention and prevention.
- Look at people as a whole; assess social circumstances, issues, problems, family structure.
- Local media to play a bigger role in informing people.
- True walk in centres 24/7 especially in Newcastle.
- Stop demonising elderly as a problem in the media (social justice).

Top three feedback

- Building stronger and resilient communities, promoting cooperative working, involvement of community services and resources, involvement of local community members
- Communication of the new model, all services involved and knowledgeable, better advice about self-help and self-care, social care
- Information sharing between agencies, can be a barrier to identifying need early, model needs not to be reliant on healthcare professionals, fire service, faith groups

Question 3. From a critical success perspective, what is most important – resource and cash or patient experience?

No time for question 3

TABLE 3 FEEDBACK

Questions following initial presentation:

- A lot of programmes need to be in place before this can go ahead,
    - GP retention, recruitment.
- There are problems with Walk in Centre facilities.
- Biggest issue is acute care to community care, can they accommodate the transfer?
- IT Systems are not in place, is this going to be fixed before commencement?
- Which parts of the country are successful at this model?
- Concerns around community care and social care (more so social care).
- Voluntary sector could do more but we're not joined up or managed well enough.
- Step up is not worked out as well as step down.

- You need to consider peoples environment – housing factors, facilities and people who don't have the right facilities.
- Are people aware of where they can get help, people of Stoke-on-Trent have a low level of Health Literacy and need information that is suitable for them to understand.
- What about younger people, they might not have a family around them who can support them when they are discharged from hospital?
- Have you thought of ageing people in Newcastle Borough itself?

Question 1 – Further considerations

- Concerned about inadequate resources, more people needing adaptations and there is already a 14 month waiting list for assessment for adaptations – this links to keeping people out of hospital.
- Warwick and Leicester are not good examples of a good model.
- Although I agree in principle there are major concerns around capacity.
- Medically fit doesn't mean you're fit to go home.
- Peoples mental state doesn't always mean people WANT to go home.
- Need to look at wider symptoms not just what patient has been admitted with for instance they may have depression.
- Worry about the pace that this programme is being implemented at, it's too fast/quick.
- Bradwell and Cheadle are not easy to get to for people from Stoke-on-Trent.
- What beds are in Stoke-on-Trent?
- Has public transport been considered?
- So many parts that need to be factored in doesn't give us confidence, remember Fit for the Future – this is almost the same.

Question 2 – Are there further actions we should consider?

- Buses – Transport, peoples working patterns, availability of taxis.
- There is confusion around the whole health service eg WIC's that aren't Walk in, services provide at the them aren't consistent, people don't know where to go for what service.
- You need to educate people around what A&E is for, people still go to A&E even though they can get a GP appointment.
- Some voluntary organisations getting contracts that aren't necessarily within their specialist area, seems as if contracts are being awarded to the cheapest tender.
- There is a directory of services available but GPs don't necessarily use them.
- Should be someone in each GP practice that gives advice on the social side of this ie how to get a new boiler and act as a signposter.
- City as a whole is not good at sharing information.
- There is no consistency around services in the city - services are fragmented. You can't go to one place for treatment for all of your conditions.
- A preventative process is being missed.
- Information packs should be available for each condition telling people where to go, what to do, who to call etc…
- Not enough generalists, we go to a specialist in X or a specialist in Y, were as a generalist will see you as a whole and recognise all conditions.

- Support groups are valuable, Primary Care Centres could host them and a specialist nurse could manage them.