Rehabilitation and Discharge from Hospital

29th February 2012
Riverside Suite, Stadium of Light, Sunderland

Summary of round table discussions

TABLE 1

Theme 1 – **Reducing Hospital Admissions**

What could be improved?

- There is well documented evidence that people in the North East do not present early enough and wait until conditions become chronic before presenting to their GP, especially men. More education\information is required to encourage earlier contact with health services with better use/more awareness of screening services. This could help prevent admissions for chronic illness.
- Sometimes admissions to hospital including via A & E are not on clinical grounds – is this often because of a breakdown\gaps in the caring framework? - more support to cares/families could result in fewer admissions
- Lack of confidence in Community Support Services – need to raise awareness of what is available – would result in possible reduction in admissions i.e. Break culture of 'when in doubt go to hospital'
- Perception that Community Nurses are not able to back up urgent care cases
- Families of people who are dying tend to panic and ask for patient to be admitted to hospital even though there is no other medical treatment that would prevent their death. Often it would be better for the patient to die at home in their own surroundings and it's more often what the patient would want. More support to families/carers at home could prevent admission in these circumstances
- Discussion around Houghton Walk-In Centre and delays in this opening with all the services in place - Someone on the table mentioned that this centre will have 24 beds, original intention for cases of minor surgery. Beds will now be utilised for intermediate care between hospital and discharge home.

What would be your priorities?

- Improve health education – People being made more aware of how to manage their health in the long term

- Much better understanding of services available to keep people out of hospital – people have no idea of what services/support is out there – Huge lack of knowledge of availability of support services.

- When patients are taken into Accident and Emergency, if they have underlying health problems as well as the issue they are presenting with at that time , those underlying health problems should be taken into account when being assessed – when the patient is simply treated for the presenting problem they may be readmitted due to complications resulting from the underlying health issues because the right questions were not asked during the assessment at A&E (This was a key point agreed strongly around the table)

Theme 2 – **Time in Hospital**

<u>What could be improved?</u>

- Right care not being given if hospital staff do not get an understanding of all medical conditions the patient has. Patients feel that the doctors are not listening when they are trying to tell them about any underlying or existing health problems – Not enough joined up thinking between departments, doctors etc.

- Treat patients with dignity courtesy and respect. Listen more to carers and respect patient's wishes

- Put systems in place that give carers confidence in services

- Someone mentioned a 'Laminated Book / Binder that was at patient's bedside a sort of Patients Handbook giving information about the ward and the hospital (but not everyone was aware of this.) It was felt that this could be expanded to include details of nursing staff involved in patient care developed into a 'welcome pack' – also to make sure everyone is aware of this handbook. This book or similar should be made available for carers too. Also suggested that a comments book be left on the ward so that patients/carers could leave any messages, these could then be followed up or considered during patient consultation. .

- Patients with sensory impairments (and others) not being treated properly e.g people with sight problems still not being helped at mealtimes despite red tray systems being implemented– such systems must be applied rigidly or there is no point in having a system

- Named nurses taking more responsibility for their patients

<u>What would be your priorities?</u>

- Give nurses more time to do their job properly to allow them to treat patients with dignity, care and respect.

- Staff to take more notice of patients and carers comments whilst they are in hospital.

- To make patients feel safe and secure when they are in hospital – examples given of patients being approached by other patients in inappropriate ways – patients left to wander etc. – Families/carers need to have confidence that the patients are being looked after in a safe and secure environment.

Theme 3 – **Reducing Delays**

What could be improved

- Make sure that things are done correctly first time round i.e. at assessment stage taking into account all health problems not just what they are presenting with.
- Getting test results as this sometimes holds up discharge, also waiting for medication – if these processes were speeded up it could reduce delays in discharge.
- Better communication – amongst all agencies involved in patient care
- Good practice at Farmborough Court – It was hoped that similar services available at the Houghton Centre (when it is fully operational) would mirror this.
- Notice given when a patient is going to be discharged – sometimes not enough time is given so that families/carers can prepare for the patients discharge.
- More consultation with carers - group felt that there was not enough of this done by hospital staff, this should be taken into account within the Multidisciplinary Team
- A representative from the Carers Centre mentioned that they had been recently involved in Discharge Training delivered by the hospital and this had been well received – this was very encouraging that carers were being consulted – this could be built upon.

What would be your priorities?

- Give people a greater understanding of the difference between straightforward discharge and complex discharge
- Improvement on length of time/notice given around when a patient is going to be discharged
- Improvement on length of time between patient being told they were being discharged, and waiting to receive any letters/test results/medication that they need to take out with them.
- Carers consulted to make sure that an appropriate discharge plan is in place
- Improved availability of information regarding hospital stay, who to contact if any problems etc

Theme 4 – **Support after discharge**

What works well

- Support given by Age UK Discharge Team
- Farmborough Court
- Community Nurses

What could be improved?

- Appears to be a bit of a 'Postcode Lottery' in terms of some services in the community – some areas of Sunderland *appear* to have excellent services where others fall short. – Levels of Community Services should be the same across the city.
- Lots of strategies appear to be in place and are talked about but this is not mirrored in actual delivery of services
- KEY POINT **-** Evaluation after discharge - unclear who, if anyone, reviews the care plan after discharge – initially the patient may not need lots of support when discharged but circumstances could change re availability of carer/family member but this is not being taken into account but would be captured if regular reviews were undertaken.
- Initially communication between hospital staff and The Age UK Discharge Team was patchy because of shift / staff changes but this is now improving.
- Discharge Plans – The planning process should begin when the person is admitted (or pre admission if possible) as this would ensure that timely support was in place after discharge reducing hospital stays due to advanced preparation
- Service from Community Nursing Teams should be exactly the same (table discussed differing CNT service standards in some areas) – uniformity of care across the city essential.

What would be your priorities?

- That patients and carers receive the appropriate support for as long as is needed
- Someone at 'The Hub' – only need to contact one person / number to find out what support is available
- Identify family carers or ' good neighbours' and make sure they know where they can get support
- Make sure that Carers Assessments are given to all carers

Theme 5 – **Communicating with Patients / Families / Carers**

What could be improved?

- Patients given more dignity and respect
- Hard to get doctors to talk to Carer/Families and this makes them panic around discharge.
- Carers need to be consulted regularly and included in any discharge plans
- Give people as much time as they need to discuss their discharge requirements
- Involving all carers when discussing patients' needs e.g. medication etc as some hospital staff will only discuss things with patients next of kin. And patient may be returning to supported care not the family

What would be your priorities

- Making sure that patients/carers/families understand all terms used, checking regularly that they are comfortable with what is happening and fully understand
- The book given to patients when they are admitted should be enhanced – same given to carers/families (A Welcome Pack)
- Communication times to suit patients and carers – not just consultants.
- Communication pitched at levels that everyone understands especially around care / medication / treatment / future treatment.

TABLE 2

Theme 1. **Reducing hospital admissions**

What works well

- NHS Direct Service has good advisors. It is a good service with professional staff.
- The Urgent Care Team can be a good tool for keeping people out of hospital – excellent service (but low awareness of it).

What could be improved?

- Confusion over number of health and social care services available and remit – unsure whether some are available/still available/changing etc.
- Communication – people don't know what's best and when to go to hospital – what needs hospital attention straightaway or whether to wait. Confusion over walk-in centres and services. Make information simple.
- Need general advice – confusion over services and out of hours. Promote NHS Direct more. Are qualified nurses being removed from NHS Direct? – these are needed.
- Urgent Care Team – useful service but low awareness of public and GPs of this.
- Find out cause of why are there increased admissions in Sunderland – is it because of health inequalities? Who uses hospital more e.g. parents with babies/young children, is it due to alcohol etc or because of ease of use – can get seen quickly.
- Gentoo and other housing providers could do a lot more health-related preventative work – use the staff as a resource more. Concerns over removal of housing-related support – not sure Council is aware of how much this is needed, how much is currently done.

1. What would be your priorities?

- Promoting services in an on-going and regular way – often there is initial promotion for a service but then it dies off. Would take the pressure off parts of the system if people aware of services and when to use
- Need to know who to go to for support – telephone number and access information
- Confusion over which services to use when
- Need a holistic approach for admissions (physical and mental)

Theme 2 – **Time in Hospital**

What works well

- Community Stroke Team works well – speeds up process in a good way – look at this as model of good practice
- Good links with Stroke Association and Stroke Team

What could be improved

- Nurses attitude re patient care sometimes poor
- Speed of discharge depends on condition – some are getting out too quick and then readmitted
- People are sometimes sent out without information
- Struggle to get timely assessments – for e.g. brain injuries sometimes patients are ready to be moved out but are waiting for assessments, social services. Delays are because of complexity in identifying resources for rehabilitation, adaptations etc
- Need to give people more information on their treatment and care and listen to families too
- Need points of support and contact (named)

What would be your priorities?

- "Pow wow" approach mentioned in presentation is important rather than sequential approach. Need multi-agency planning – look at follow up services.
- Care plans shared across agencies – for everyone – needs to include whole process from admission to discharge.
- Stronger links with housing providers – inform housing if people discharged so they can put in support if needed.

Theme 3 – **Reducing Delays**

What works well

- Farnborough Court works well for rehabilitation. People can be discharged from hospital when they need extra support before living independently.

What could be improved

- Delays for medication – can this be speeded up in hospital? Medication has to be signed by doctor – can be up to 5 hour delays.
- Home adaptation delays.
- Delays because no one at home to look after
- Needs coordination across the board – across agencies and services
- Do weekends/times make a difference to delays
- Sorting out funding for health and social care needs can lead to delays – e.g. for support at home or residential care

What would be your priorities?

- Discharge process should start from when admitted – planning etc – should know people's circumstances
- Social and health interface needs improved coordination.

Theme 4 – **Support after Discharge**

What works well

- Age UK home support services work very well
- Sheltered housing services in Sunderland
- Need to spread out their good practice

What could be improved

- Use of support plans – need filling in by housing providers as well as health & social care services
- Medication – if have lots of medication (e.g. if older and confused) – forget what has been taken. Support is limited. Managing medication is an issue – might it lead to hospital admission if over or under-dose. Home carers not often qualified re medicine management – going in twice a day not enough. Short term support service input would be useful alongside Telecare to help.
- Changes in social networks and families has effect on support
- Need more information on improvement work
- Better communication between hospital and GP
- More support for carers

What would be your priorities?

- Improve medicine management – who does this and who can help. Does it need a service in people's homes who may be on their own/vulnerable
- Support plans need multi-agency input
- Level of care and support is minimal – long periods of isolation for some elderly/vulnerable people – need to use volunteers (e.g. home visiting)
- Training and support for carers – information and education needed – information on what they need to do to support the patient (sometimes they have to find this out for themselves which can take time and be stressful instead of people giving them the information they need when they need it).
- Home carers (staff) need to be better paid and have higher status.

Theme 5 – **Communicating with Patients/ Families /Carers**

What works well

- NHS Direct
- Clinics without appointments (e.g. at Freeman) give back-up support for cancer patients – this could be model of good practice
- Knowing who to ring, having named people
- Stroke Association is pro-active re communication – contact patients after discharge to see how getting on (don't wait to be contacted)

What could be improved

- Train carers – give them information on patients' illness, treatment and care etc. Empower carers and help them and the patient make informed decisions etc
- Start as soon as possible with information and give frequently – repeat information so people can absorb
- Doctors need to be approachable
- Training needed for health staff in communicating to people with learning disabilities, autism etc
- Don't just communicate and give information without checking whether it is understood
- Signpost to sources of support – e.g. in community, third sector
- Not much communication post-hospital – more follow-up needed
- Patients to be involved in decisions affecting them
- Listen more to patients

What would be your priorities?

- Involvement of patients and carers in decision-making about their treatment and care
- Communication/information on support services – knowing who and where to ring
- Some people can't use 0845 numbers – give alternatives if don't have landlines. Not everyone can afford to ring premium lines.

- Communication methods can be a barrier – e.g. support/communication through the internet is not always appropriate for older people and/or those without internet facilities and for those who need active help and support with understanding information
- Complex information needs help to understand – best provided face-to-face through active support.

Overall priorities from Table 2 discussion

1. **Communication – has to be appropriate**. People are confused over services – how, when, where to access and what is available. Needs more promotion and information on health and social care services available. Cost of some services such as NHS Direct (0845 number) is a barrier to accessing for some – need choices/range of methods of accessing services.

2. **Medication** - more support is needed in medicine management including quantity, when to take etc – especially for more vulnerable people. Investigate short-term support service for medication support if vulnerable people are living at home (relying on home carers is not enough).

3. **Care/support plans for everyone around hospital care & discharge**. These should cover pre- hospital stay right through to discharge and should be joined up and shared across agencies. Should be all about the person (individualised) and include all needs – i.e. aspects such as housing as well as medical needs (holistic). Include sources of support in community from all sectors (statutory and voluntary).

TABLE 3

Theme 1 - **Reducing hospital admissions**

- Assess benefits / use of Primary Care Centre
- Patient does not know what is going to happen – wants to go home at any cost.
- Inform patient what is going to happen – options.
- What action – Health Intervention – 999 – A & E – GP's have awareness of what is out there.
- Talk to patients - give all the options.
- Useful menu of services and options for people in hospital. Then once they are home to Mobile Support to help people who cannot manage. Making sure people are aware of what is out there – scared to be put in a home.
- More investment of families with Drs etc in discharge.
- Can't reduce all admissions some are right.
- What support provided between provider – lack of communication between Agencies.
- Sometimes have to rely on one motivated worker to deliver – policies not implemented.
- More Community Services – increasing population – if you haven't got enough services.
- Care providers – staff members don't get paid when care person is in Hospital – have to take other jobs / roles.
- Social Worker - should be involved on admission and not 7 days down the line.
- Communication in hospital – breakdown myths and whispers.
- Prevention – system not working yet.
- How many GP's health check - where are the figures?
- Ageing population in Sunderland also creates issues.
- Where are the 'hard to reach people'? areas in Sunderland – living on own – never see anyone – never access services.
- Pubs and Clubs – ready made access to some people – could do blood pressure etc or prevention agenda.

- New MH staff for 18 months – but nothing communicated.
- Also need to look at Health & Wellbeing of Nation.
- Where on the agenda is Public Health.
- Whole system prevention issues needed.

Theme 2 - **Time in Hospital**

- System really pressurised – beds vacant then full within 10 minutes.
- Never informed of the patients status.
- Values & principals – old fashioned values. Need to go back to this – keep people informed.
- Psychiatric Hospitals – reluctant to leave bed in case it is filled.
- Blocks in wider system – knowing what is available – in terms of service - formal and informal networks that are available.
- After 5pm can't get services therefore delays. More planning required.
- 7 day working – issues around funding.
- Don't want to discharge on Fridays if support is not set up.
- Social Care – different people coming into peoples homes.

Theme 3 - **Reducing Delays**

- Social Workers / other Specialists don't work 7 days week.
- Weekend discharges particularly an issue.
- Carers to telephone health or medical - help people be discharged quicker. Only the right type of people. Look at better use of technologies.
- Delays Mental Health – lack of appropriate accommodation - patients with complex needs
- Housing Options Team – Supported Accommodation excellent but limited.
- Psychology Services – waiting lists – Services developing rapidly.

Theme 4 - **Support after discharge**

- Time to think – beds – need further convalescence.
- Need access to residential beds – dementia beds – nursing needs – time to think (period of 6 weeks)
- Work with service providers / families / patients to get best results.
- All about reablement – make sure people are in best position to make right decision (maximum potential).
- Nurses need to have people moved on – bed management.
- Sometimes patients don't make the best choice.
- Also issues around self discharge.
- Acute mental health needs – how many self discharge – to have a Care coordinator – also use Mental Health Act on the wards.
- Management of medication – prompt needed – memory problems – really important point – non compliance with medication, biggest issue re-admittance.
- Part of Care Package – also people need advise how to take medication.
- How fast information to GP when discharged – how quickly turnaround – systems have improved.
- Older people don't use personal budget – people leaving hospital just want services.

Key issues

- need to make people aware of the Personal Budget's.
- how to communicate this – and how realistic is this.
- need based assessment – in relation to PB.
- communication on PB's need to be improved.
- where do you draw the line with PB – longer term complications – sustainability.

Theme 5 - **Communicating**

- no single patient file – big gap – number of systems which hold valuable information – but don't talk to each other – big barrier.
- Need menu of services - packs to provide information about discharge.
- Patient questionnaire – do they give a true impact.
- Need advocacy services.

TABLE 4

Theme 1 – **Reducing Hospital Admissions**

What works well

- Telecare scheme (button around neck). prevention falls. Telecare. Facilities, equipment, services available.

Improved

- Statistics are they accurate?
- Prevention of falls, pavement; dropped kerbs; human side of this; how patients are treated; support levels etc. provision of support – disabilities..
- Detecting dementia earlier, Alzheimer's etc.
- No joined up approach.
- Support for carers needs to be improved.
- Don't like terminology 'Care Package'.
- Feel this is pushed rather than down to the individual requirements.
- Need to tailor individual requirements – person-centred
- Domiciliary care – weakness. Quality of carers providing services – pay issues with carers, issues with agency staff.

Priorities

- Communications within different agencies.
- Time delays – travelling time – carers.
- Procurement of services
- Quality checks.
- GP referrals.
- Prevention measures
- Earlier intervention

Theme 2 - **Time in Hospital**

What works well

- Identifying early discharge immediately.
- Details of after care given.

Improvements

- Processes – concerns over self discharge . Does aftercare vary per department.
- Need awareness of patients histories.
- Don't want to be pushed out of hospital just to meet targets. Look at physiological impact – no continuity. Need to be passed to area specific professional i.e. dementia ward.

Priorities

- Standard health check on patient.
- Admission procedures – fast tracked to specialist wards
- Need to reduce repeate patients

Theme 3 - **Reducing delays**

- Passed to specific areas Alzheimer's etc.
- Joined up agency work. Process of discharge too complicated.
- Rushed discharge.
- Signage, organisation.
- Lists of medication.

Priorities
- Lack of communication
- Joined up working from agencies
- Communication and prioritisation

Theme 4 - **Support after discharge**
- Support for carers as well as patients.
- Would like useful contact sheet / support for recovery sheet and for carers also.
- Assessment needs to be done early.
- Need more coordination of services. Someone direct who you could speak to.
- Named GP, someone who recognises patient. Time for GP's appointment too rushed. Funding issues.
- Carers card? Have not received this.
- Sunderland Royal Cancer Unit have been fantastic. Support very good.

Priorities
- Contact of who will be support person.
- Personalised / tailored care package

Theme 5 - **Communication**
- Patient / family / agency interaction.
- Allocated support for carers.

Priorities
- Standard invitation for Health checks for people as this is only offered if you attend the surgery.
- Central point for information / database
- Single point of contact – helpdesk
- Awareness of conditions, specialist care needed i.e. Parkinson's
- Access to Specialists

Overall Priorities Table 4

Theme 1 – Reducing Hospital admissions
Prevention measures
Earlier intervention

Theme 2 – Time in hospital
Admission procedures – fast tracked to specialist wards
Non repeated patients (re-admissions)

Theme 3- Reducing Delays
Lack of communication
Joined up working from agencies
Communication and prioritisation

Theme 4 – Support after discharge
Personalised / tailored care package
Prejudice self discharge

Theme 5 – Communicating with Patients / Families / Carers

Would like to see a central point for information / database, single point of contact, helpdesk
Awareness of pre existing conditions, specialist care needed i.e. Parkinson's
Improved access to specialists

TABLE 5

Theme 1 - **Reducing Hospital Admissions**

What works well

- Older people are generally well served (not so much for young people)

What could be improved

- More joint funding / pooled budgets to expand services
- Need long term approach and truly shared work. Integrating all services that are available
- Need long-term approach
- Over-servicing in some areas. De-commissioning where things are demonstrated not to be working. We have a lot of provision, it's just not used effectively. There is a lot of duplication and a lot of waste. Some services are underused and others are not achieving any outcomes.
- Everyone needs to be self-critical – costs nothing to evaluate and improve
- Service users don't know what's out there to be able to use services e.g. people don't know they can self-refer to physiotherapy services.
- Also, GPs don't know what services are out there and they quite often don't have the relevant information (It is also very difficult to get timely information from GPs)
- A shared directory is needed. Tried a few times and never gets off the ground because of maintenance / upkeep.
- No consultation on major service re-designs with those who actually deliver the services on the ground – decision makes not talking to the experts e.g. Houghton PCC has rehab bedrooms but no treatment rooms. There has been poor communication about what the facility is for. Seems to just be low level. Cherry Tree Gardens also has no treatment rooms and the furniture is not suitable for people with any mobility problems (it wasn't chosen from a point of view of how do people get in and out of the chair) again, experts (professional delivering treatment / services) not consulted about H'ton PCC facilities. Criteria for use exclude younger people.
- Grindon Mews reablement suite not being used for intermediate care. Thousands of pounds of equipment e.g hoists etc. and now used for LD and absorbed into day care. Was designed for 24/7 usage.
- Mental health nurses should be in A&E. A MH nurse in A&E could avoid admissions. Patients with complex MH needs can be in hospital for many weeks once admitted because of complex problems and they don't need to be in hospital at all if they could be referred from A&E appropriately.
- Referrals are made under pressure – just moving the patient on to the next person without proper consideration.

What would be your priorities

- Properly integrated shared working including shared budgets
- Need to be better at using the services that are there and making appropriate referrals.
- Shared information directory
- Consult more with the experts on the gound

Theme 2 - **Time in Hospital**

What could be improved

- Patient may not be involved or even told what treatment they are going for.
- Communication can be poor, between professionals and with the patient
- Even in planned admission not always good communication e.g. PD patient not told how to take meds.
- Care pathway for planned admission not always happening. Doctors have ultimate decision regardless of anything else.
- There is no where for MH patients to be discharged to.
- 'Time to Think' beds staff not clear about the criteria for referral.
- Staff will refer to all services to move a patient on. Patients sometimes arrive with no information. This is because staff operating under pressure just need to move on the problem to anywhere and manage the flow of patients through the beds. They can refer to Farmborough Court and the 'pressures off' but everyone has to take responsibility
- Can wait a long time for social work assessments
- Nursing unit at Farmborough Court is not ideal. Being used as a waiting room. Again, professionals weren't consulted. Should have been rehab beds instead.
- Little emphasis at Farmborough Court on prevention – seems to all be about early discharge.
- Some discharges are too soon. Assessments in intermediate care centres are not always helpful – kitchens are unfamiliar to patients, not their own.
- Hospital needs to make appropriate referrals e.g. referrals to OT as a matter of course, not personalized to the patient.
- High volume of patients – referrals will be made under pressure.

What would be your priorities

Theme 3 - **Reducing Delays**

What could be improved

- Social work assessments cause delays and deciding where a patient gets referred to. Assessing risk is an issue.
- Families and carers don't always understand what they are taking on
- 'Advanced' Care Planning would allow patients to be involved in planning their own future.
- Whole system not moving forward together, at the same pace
- Too much wasted time and duplication – need to work better together. One team will assume next team will deal with a problem and patients having to deal with too many different staff. Often have to rely on one good individual in a team to get anything moving. Teams work with each other but not necessarily with other teams.
- Difficult to access information about the patient – each organization won't share information e.g. don't even have access to Joint Manual Handling Planning.
- MH delayed discharge figures not required by DH so this group of patients are not measured

What would be your priorities

- Information / communication. Sharing information with each other and having access to information needed to do the job

Theme 4 - **Support after discharge**

What works well

- Outreach service at Hawthorn been running for 8 years. Successful at preventing re-admission. Works by one person following the patient. Includes early prevention. Approach which proves case for supported discharge.

What could be improved

- Rash promises made in hospital about what support will be available and no mention of delays because staff under pressure. Encourages early discharge but support may not be available in a timely way – creates unrealistic expectations. Must be honest and open with patient.
- Things usually go wrong at 5 pm when patient realises nothing is in place.
- Need shared record keeping.
- Admittance to residential care too high. Need therapeutic risk taking and information about services that are out there. Anyone can stay at home if they have good quality 24/7 care. Need to commission right services in the community.
- Simple things like 'medication prompts' can work, or incontinence help plus anxiety management – counselling. VCS could expand. Helps to avoid isolation at home.
- Direct Payments - patients can be waiting weeks for money with nothing in place.
- Personalisation has to be part of the option.
- Those who shout loudest get most help

Overall priorities from Table 5 discussion

- Information / communication, between professional and with patients / families
- Consult the people working 'on the ground' when make major service re-designs
- Better use of services already in existence (and de-commissioning services that are no longer effective)
- Referrals can be based on bed management and maintaining a flow of patients rather than what's best for the patient – not person-centred.

TABLE 6

Theme 1 - **Reducing Hospital Admissions**

- The main views on the table were that patients were not aware of all the other support that they could have in the community.
- Patients/carers should be advised to access the Community Teams before admission.
- The knowledge of Urgent Care Teams is poor.
- How do people find out about the care facilities to reduce the admission to hospital?
- The view was that the Walk in centres had reduced admissions as they had seen over 80,000 patients
- Joining up agencies - not working well enough if earlier interaction happened and agencies communicated then some patients would not end up in hospital
- Views were that there was a difference between Policies & Practice.
- Independent living is quite successful.
- Single point of entry – advertising in GP surgeries for other methods of care and support
- Knowledge of the Services need to be advertised includes coming to see groups.
- Carers Association – giving out information and making sure all agencies talk. Merging of data on patients would be a great advantage.

Theme 2 - **Time in Hospital**

- Not an overall standard in hospital.
- General feeling is people are moved from ward to ward and moved out too quickly.

- What works well? Staff are willing and discuss improvements and ways to communicate better
- Care in hospital – patients are not being bed managed – not being moved around – care is deteriorating.
- All agencies should be involved in all aspects – patients not being supported for feeding etc.
- Communication between Care in the Community and Hospital Staff.

Theme 3 - **Reducing delays**

- When the decision is made why delay the medication?
- A care coordinator for each patient.
- Multi-disciplinary team – for instance an OT– if they are aware of the patient going into hospital they can plan.
- The meeting of OT and staff at hospital – joining up works.
- On the whole the District Nurse Team are informed on a timely basis.
- The District Nurse Team do meet to involve other agencies.
- When back in community (own home) district nurses ask who is involved in their care – works well

Theme 4 - **Support after discharge**

- The District Nurses are working with other agencies.
- Do we have enough staff – capacity and demand – if discharge is going to be early – Nurses need the money to follow the patient.

Theme 5 - **Communications**

Clinical records

- Use a message book – sometimes the cases are not completed correctly – all points tend to be tasks and very rarely the emotional state of the patients which could work better.
- More detail could be provided by carer including details on the emotional state of patient.
- The Clinical records – trying to engage with Occupational Therapists and getting others to complete their parts.
- Patients should only have one contact number for them to ring.
- All professionals look for other symptoms / underlying health problems.
- Some instances – Care after is good / others not so good.
- If patients had a Case Worker this would work well for the patient to ensure that the patients had their right level of care.
- District Nurses do ask patients for feedback.
- Not every patient uses District Nurses but do use other services.
- The timing of care in the home – for instance putting patient to bed too early.

Choices / personalisation

- If this is to work then the timing of care in the home needs to be improved.
- The providers have high demand for peak times to get up and put to bed.
- There is good work going on in the Community
- Case Study - to prevent an admission –OT phoned Carer and all the Services came together in one day including - bedding; Nurses and Social Worker.

<u>Priorities</u>

<u>Reducing Hospital admissions</u>
Knowledge of how to access all services.

<u>Time in Hospital</u>

Different standards are an issue from ward to ward.
Staff training

Reducing delay in discharge
Plan sooner and identify a key person and involve the community facilities.

Support after discharge
Multi-agencies working together and knowledge of who is involved.

Communication
Use a computer system which is joined up.

TABLE 7

Theme 1 - Reducing hospital admissions
- Better access and information to be given to 'falls groups'.
- Some people in unsuitable housing – causes falls.
- Nowhere to go for advice.
- Do GP's know all the info / services available.
- Referrals are patchy from GP's – do they know all of the preventative measures in place.
- More 24hr support needed.
- Need one point of access who can help with everything and solve issues in one go.
- Better support for carers needed.
- Carer's assessments – what happens after these are done?
- Housing issues – people need better access to homes catering for disabled people.

Theme 2 - Time in Hospital
- Informing people of what happens when being admitted to Hospital – leaflets on wards don't include any information on discharging.
- How is Carers Service highlighted through Discharge Team? To help people being discharged. Interface Team – explanation diagram needed on ward.
- Ward Managers need to take responsibility for wards and knowledge of patients / relatives / general situation.
- Some wards have times of Sisters / Ward Managers availability to speak to.
- Need to get to know the patients / relatives – better communication.
- Need nominated person to take responsibility for patient's welfare / aftercare – possibly Care Coordinator role.

Theme 3 - Reducing Delays
- Coordinator - someone who knows the person / patient.
- 'time to think beds' / 'step down' a very good move – will make a big improvement.
- Getting people to be independent puts pressure onto carers – need time to see if they can cope.
- Doing survey on 'Discharge Lounge' feedback on delays in transport i.e. 6hrs for an ambulance.
- Transport – a big issue.
- Discussions need to be held by staff with patients re not getting ambulance home / possible own transport.
- Patients in Discharge Lounge need support especially with mental problems – dementia – possibly keep on wards.
- Memory cafés work well
- Network links needed from GP's / family / hospital need to work together to provide a better service.
- Community Nurses – could be used to refer patient to GP etc.
- Staff attitudes – do they know how to deal with particular patients i.e. dementia etc.

- Hospital Carers Group – information not disseminated to the public at hospital – need better communication – lack of awareness from hospital.
- Liaison Officer in hospital now – but not very visual.
- Too fragmented – need to bring everything together under one umbrella – one telephone number / one centre etc staff knowledge needs to be increased.
- Priority is communication – if put in place would work very well – lack of it – need one place holding info for everything under one umbrella.
- How do you access the Interface Team – no name / number given - need info for patients.

Theme 4 - Support after discharge

What works well

- When proper discharge happens things do work but how often does this happen – need to ensure this happens all of the time.
- Carers providers in the Community work well but need more flexibility etc time going into homes and paying for service.
- Age UK – ongoing support needed for them. Contact support – contact with patients in side wards.
- No eye kept on people. Model piloting a Nurse on phone 24/7 to support discharge – need further information – check location
- Health / Social care wont take on support for what District Nurses used to do i.e. distributing medication, potential for people with dementia to go without medication – so who does this – need support to help with this – help carers / families out.
- Virtual Ward – North Tyneside – Ward Manager has responsibility of 20 patients in own homes, helps out - keeps them in their homes.

Theme 5 - Communicating

- Single point of contact – under one umbrella.
- Good professionals should be able to help patients and their families.
- Two way communication.
- Hospitals scary places – very daunting on families if lots of Drs / professional etc.

Main 4 points

1. one point of access – a single portal for information and action
2. discharge navigator – communicator / coordinator – acts as a Lead / Mentor through the whole process.
3. simple systems that everyone understands. – seamless role of care
4. embedded in a matrix of good communication