Greater Nottingham Transformation Partnership

10 May 2018 public event table feedback

Table 1

Discussion topic 1: New models of cross organisational care

Stroke – husband, carers, lifeline, outreach physios

- put in place by hospital – ran smoothly
- equipment
- positive experience – smoothly done
- trying to take on board how many organisations involved – overwhelming
- All care plans for husband
- 2 hrs per week for herself, 2 weeks respite
- wrong information from social worker – should have been 6 weeks respite
- e.g. time for funeral – had to save time up – new experience
- Husband – care home 2 years ago
- Capacity of social workers

Deaf person @ City hospital

- Tube inserted and sent home – tube fell out phone number – couldn't ring – no way to contact
- Member of deaf society had to ring

- ❖ diversity/inclusion, different needs, ethnic minorities, English language challenge, barriers for deaf people
- ❖ Wellbeing meeting – all deaf in group
- ❖ Different barriers / issues
- ❖ NHS – lots of information difficult to share
- ❖ Deaf ISBL charter – meeting every three months
    - Talks, roleplay, videos
    - Different numbers difficult and needs classified
- ❖ Best practice in the system
- ❖ Deaf community – difficult process – challenge
- ❖ ISO different nationalities at university – tryoing to help – diffivult
- ❖ Complicated then becomes a challenmge
- ❖ We can get good care in pockets
- ❖ Complexity – patients with more than one illness

2007 – Husband brain tumour

- Behaviour changing, jotting down symptoms
- Tumour growing for 10 years
- NHS – cannot fault the process
- Dealt with very quickly
- Intermediate care / rehabilitation 2 weeks

- Didn’t happen – was told it was unavailable
- Felt let down by this 0 frightened
- Detrimental to health

2001 – Husband, bladder cancer. Family took on responsibility for coordination of care

Do we get patients out of hospital too quickly?

Hip replacement that got infected – had to go back in hospital.

Sometime it isn’t right for patient

Heart problems – cardiac arrest – friend in November, pacemaker fitted and was discharged from hospital then had a cardiac arrest, the care received was positive.

We join up psychical care focus – what about mental care?

- Difficult!
- Anxiety/depression is a concern, confidence affected

Key points

1. Patient and carer – support for carer
2. Information – deaf community, English as a second language
3. Stroke – multiple organisations coming together
4. Physical / mental health

Discussion topic 2: Standardised pathways

Journey = Patient – NHS – referral - completion

How we make the system clearer to patients and clinicians

- Sometimes choice is relevant – knee arthritis
- Initial treatment – community
- Imaging not a lot of choice
- Surgery – choice
- Right patient – right time
- Rehabilitation – how
- Design pathways with patients – clinicians need help too

Decision making

- Record of decision making – positive
- Questioned decisions – GP explains through
- Positive experience – comfort to challenge
- Confidence in GP’s – not scared to challenge
- Clarify decisions – website address to take home
- 15 years ago – Doctors were changing – consistency wasn’t there
- Harder to see the same doctor
- Evidence – same doctor – less likely to need to go to hospital

GPs under pressure – increase of GPs hours

- Saturday / Sunday
- GP hub from different practices
- Time pressure
- Triage system seems to work in her own practice
- Happy to challenge – with her husband
- Changes to behaviour
- GP's didn't listen – mental health team – she requested – GP questioned this.
- CT scan – brain tumour
- GP apologised

Time is really important!

Is the GP meant to know the whole process?

High volume areas – GP have a good idea of this process

High volume areas – GP have a good idea of the process rarer conditions – unclear

Pathways on a computer system – something for patients to see.

Can GP's see the best pathways?

F12 project – all local pathways – helpful – built locally changes can be done across practices

Key points

- Continuity if GP – create an environment comfortable to challenge
- Time and pressure – 10 minute appointments – challenge
- Clinicians access to pathways – much easier – easy for patients to see this too?

Table 2

Discussion topic 1: New models of cross organisational care

Making the care system more easy to navigate if you are not in the know and/or don't speak English

Advertising services in more widely frequented places e.g. hair-dressers not gp surgeries

Fitting organisations around people's lives rather than fitting lives around organisations

Keep the focus on patient needs, one size does not fit all

Physical accessibility through local services and good transportation links is as important as clinical accessibility

Table 3

Discussion topic 1: New models of cross organisational care

GP – change blood glucose metre strips used to measure sugar level. Type 1 – with no consultation. No one spoke to patient / under Dundie House care managing for patient.

After complaining and going between hospital and GP remain unchanged caused stress. Westdale Lane Surgery. Practice/cost/nurse

Frailty tool / test communication not shared with patients

Competition / services/costs example re referral forms from 44 to 1

Example of care home patients with complex needs expecting staff member to understand I know what pathways is for the patient.

GP (18 months ago) podiatry (recommend self-care) Went back one year later for advice service gone, mother lost leg years ago. Nurse/GP saw husband re bad finger, suggested antibiotics then next visit suggested x ray. Long term may cause more problems needed for prevention – need to get basics right first.

Main point – lack of communication between organisations.

Dementia 92 years fractured hip / 10 days on ward, two discharged to sheltered accommodation / no assessment on dementia. Went back onto active ward for 10 days until realised self-funded. Was not fit to be discharges and return home.

Need to be looked at holistically not by condition

Communication between hospital and GP

Update on what's happening so regular visits to manage if required.

Statement 'Discharge back home' (if they come from their home) In terms of elderly patients, seems wrong/cruel.

Lack of mental health resources and services in Nottingham – time from admission to referral

Table 4

Discussion topic 1: New models of cross organisational care

- Depressed with services
- Outstanded by the ability of staff
- Are we reinventing the wheel – new terminology – doing same thing. Adequate time to change?
- If we don't change inequalities in people they will have bad health
- Use service users rather than bureaucratic management!
- There is an enormous gap, too much time wasted, vast gulf, loads of meetings just to free up one bed!
- Unless funding is joined up it will not work

- People are medically fit but due to a shortage of carers end up back in hospital – the bills for hospital care should go to social care.

Experience: Husband diagnosed with dementia very little help or support given – had to find out everything myself although daughter head a head fracture and the service was exemplary. Variation of care between specialities, long term health conditions services is very poor compared to emergency care.

Discharge process would be much easier iof the care was joined up and processes are improved. Carers in 70's looking after parents in their 90's - needs to be more support

Discussion topic 2: Standardised pathways

Experience:

Information needs to be more readily available and simplified for patients, daughter had an accident needed 50k worth of titanium in her back, information was given but even though we are both graduates we only just understood what the professionals explained. It would be nice to understand the process of where decisions have to go about surgery i.e. to the different panels of healthcare professionals

Multiple conditions – extremely difficult when providers don't share information – not fitting on a standard pathway.

Table 5

Discussion topic 1: New models of cross organisational care

Difficulty of lack of integration of MH care across City and county boundary depending on where you live i.e. City or County

It works in south of Rushcliffe – as they use Leicester!

Boundaries changed for open door so people who used to use it before still do – new people can't.

Main focus on centralisation means pensions have to travel further for treatment.

Took 18 months to work out that he couldn't get care for Dad who was County and he was city. Budget is the only consideration – get to fight for every penny.

Where are integrated care plans/budgets. People can't budget for themselves – they can't manage. You need to understand the population and their ability to make health decisions and budgeting decisions.

Personal budgets – I know how they work. Letter from NUH – 16 x he used the word cognitive. Substantial amount of people don't understand the language or the money. Be very careful.

Falls and breakages in the elderly – A&E triage – older people ward then it all goes downhill. Not very nice environment at all. Person needs treatment but what was the cause of the problem – broken slabs in the street.

Falling over is mainly in the home. There is a focus on housing and health. Loneliness is a bigger problem though. IT has resolved the care of the elderly but the houses that do that are not suitable for families.

My father fell down the stairs – found by carer – rang 111 – try to move him but father screamed and we got ambulance. 6 – 8 weeks wanted a bed bar – 6 weeks wait was too long. Reality is not the lovely patient flow that you describe – it's much more complicated.

I spent 6 weeks in hospital last March – after a fall and it was all sorted – equipment and support in the community for 6 weeks. Marvellous. I had a similar experience – very good.

There are a few good examples but for most it is a chasm that they can't get out of.

Ring Co helpline – you're not available to get and support/help. Depends on who answers the phone.

How much money is spent om training staff in the NHS? Occ therapy are very good and they try to help. Financial assessment no longer done by Co Co – outsourced.

Are CCGs capping money? CQC should be involved – what is going on – to ensure services are being provided.

Red Cross and medical equipment is very efficient and collecting it too.

End of life care is contracted out for assessment . My father was assessed for that care – I got two letters 2 days after he died. Money in the drawer all along. Good staff exploit the groups – once it becomes this slick then it will get worse.

44-1 forum is to be commended.

Hip replacement – whole team was there and it was clear what you could expect – excellent.

Care workers – pirate CO's – work unpaid or for travelling. That needs to be improved to make a difference and keep people out of hospital.

Discussion topic 2: Standardised pathways

Referral from GP for podiatry – so we thought sorted – 6 weeks later meeting been rejected. Podiatrist doesn't deal with chilblains – was a split nail! Physician turns up – not told she couldn't be seen so another wasted visit.

GP – you need an investigation and needs to go to CCG for a decision, If GP says you need it you should get it.

New system is going to be cost based – standard quota of money available for social care and health. That's what is being forced on Nottinghamshire.

I trust my GPs – they're under huge pressure. Forced to be accountants – new breed of GPs – less medically competent more financially savvy. As system gets more integrated it gets more difficult to be a GP and be a human too.

Standardised pathways as a good idea but we need to look at outcomes. Who works will and makes a difference.

Is evidence – nobody listens. Needs to be reformatted for a new financial base. Will be an efficiency measure. In USA you can game the system and make it work for you. (medic)

I expect my GP to know what they're doing – if that is eroded then I man in trouble. I had dizziness – he gave me all the tests – vertigo + be careful. No medication - I am the GP you need to trust me, If not trust then – litigation and that will win all of us.

Money – all down t cost – Centene will act as a Health Experian – you will be referred if you can pay.

If younger people are being trained properly UK trained DRs – Australia. Can't get an apt. when you need one – overseas DRs not being allowed it.

You're not involved in decision making after you leave your GP. Nothing you say matters.

The system is in crisis – how do you think they can cope? Fatigue – people break too and then catastrophic failure we are pushing the system, and out to complete forms will not solve this problem. Standardised pathways won't deal with the discrepancies of age of living well. Stats are a minefield.

My experience is fine my GP (County)who can't prescribe things in the City.

We're not all robots – we are humans. Do you smoke? First question! My Dad died at 87 – smoked every day from the age of 10. One pathway doesn't meet everyone's needs.

Improvement that we have a named GP. See the same person each twice.

Message and posters need to be where people are – not GP surgeries. Go Dr – you get a direct service – that you paid for – taking money away from NHS.

Beeston Health centre has listened and they now answer the phones.

Nottingham West 90% budget goes to 10% of pts.

Difficulty of people with mental health accessing on GP – either not able to or some suggestions don't welcome them.

Table 6

Discussion topic 1: New models of cross organisational care

Stroke A&E – stroke unit integrated approach

Home quickly support from OT, Voluntary sector support

Broken leg issue – bungalow so easy access no stairs

Broken arm /epilepsy/Parkinson – 8 weeks in hospital due to multiple conditions and broken arm – no integrated acre system – arm in pot – reason unable to go home. 25 minutes away from home – isolated from friends – vast cost.

Issue is timeliness of discharge – right service, right time. Encourage to keep mobile/independent level of carers – training

Not enough value on people delivering care. Holland model – good buurzoog? Home care model trained nurses involved delivering care knowledge / skills. Increased level of acre, skills and finance.

Patient expectation needs to be involved early on 0 as a child and through like.

NHS to deliver healthcare and make decisions early on – health lifestyles, educate early on.

Public health – messages city diverse population

People in 50's are that group as they may become frail elderly of future – messages needed.

Home care – delivered differently. People want to stay at home – not enough community based services to enable to stay at home. Better in community to support stay at home and reduce hospital. Always admitted father in hospital care facilities disintegrated and then unable the discharge home. Home – ambulance hospital bed – discharged without telling family – wife didn't know who he was – dementia – hospital.

Friend losing sight no care package. In place to enable he's to go home, City hospital lost discharge papers. Hip replacement still not good. Morphine in hospital then paracetamol on discharge. Taken to care home – no bed – Gedling – Acorn (dumped) not welcomed 2 x DT remove catheter not had. Lack of continuity – Ombudsman case, breakdown in communication!

III NHS in East Mid's couldn't advise across areas – wanted advice for father in Manchester and who call in area.

Recognising and stories of agencies working together; Improvements can be made to service offer – improvements to be made; Communication; Homecare – expertise; Expectation setting; Documentation – what has been done; Ownership of our own health as part of NHS – information on healthy eating; START agenda

Key messages

- Homecare – disconnect
- Communications – documentation availability

Discussion topic 2: Standardised pathways

- Confusing, make it simple – no choice, not involved – responding to policy and changes
- Fragmented
- Not good use of buildings empty – Stapleford
- Complex – in NHS complacent (Staff) – very confusing to public
- Patients can be very passive and don't question.

Patient map/flow chart e.g. map in ED; Reliable point of contact whilst in pathway

Good info about services; Community nurses involves in multi-disciplinary – resources

Pocket midwife appointment – huge success

Care coordinates for patients were excellent but no one knew about them GP's etc

Self-referral needed for certain things – empower patients this takes await triage and could create lots of demand / activity

Pharmacy is promoted re self-care / referral but not widely used/promoted.

Derbyshire runs a time bank service where people can help others stopping support more access to own health information

Key messages

- Understanding where to go with what
- Simplicity / signposting
- More use of technology
- Care coordinators