Feedback from Health and Care Forum
12 June 2013

Care Closer to Home – What does success look like?

All parts of the pathway are in place, working, costed, including risk management for crises Better use of community assets to achieve this: • buildings, communities, people, transport • need to know that they are there • myth busting and support about carers being allowed to support their neighbours Lots of different types of services available Lots of different types of providers – possibly as community interest as "community shares". This needs to be developed Pump priming of expertise/relationships/skills is needed
Does not have to be sophisticated and clinical, just whatever is appropriate Patient expectations that they are going to be getting what is best for them
Ask patients if they will get level of care Use of 'phone might not get attention Balance Make sure get an expert when needed Could there be more multi-disciplinary services, i.e. district nurses taking samples/readings for a consultant? The GP needs to 'sell' services and encourage use When a patient is in the system/hospital they get lost to the GP
Particular issue for people with dementia being spread throughout the hospital Not NHS non-clinical funding to ensure care at home No-one in setting they don't need to be in (people afraid that hospitals will be closed and no alternative in the community) Single funding pot/single computer system that everyone can access NHS expertise and advice available to all – what's there and what to do, including self-funders Good easily available support for carers Clinicians will have support and training to individual needs of carers

Care Closer to Home – Delivery actions and prioritisation

GPs need to engage and 'sell' services more, i.e. Telehealth is an opportunity for it Could there be more integrated multi-disciplinary use of staff, i.e. district nurses taking readings for acute consultants When a patient is "in the system" (acute) they can get lost to the GP. How can this be prevented?
Give voluntary organisations opportunities to provide training/presentations to GPs Recognition of referrals for voluntary organisations Establishing pathfinders of good practice – celebrating and sharing the outcomes GPs to have access to a database of services/support Someone's job to disseminate information to GPs, available to different client groups Revisit 111 service and build public trust – make it a desirable/acceptable service Ensure they know about voluntary sector/social service options
With the closure of day services people are becoming more isolated and lonely. Work with voluntary sector to find these people and put appropriate services in place Appropriate transport, even on a local basis, to be able to access services, including voluntary Appropriate access to respite for carers to allow people and patients to stay at home People within intermediate care need to have access to appropriate services to stop them progressing to dire need Joint funding health and social care so people do not battle to get appropriate services
Cultural change in public organisations – boundaries and budgets Develop or enhance existing scheme. Review or audit what exists, e.g. troubled families, and develop best practice from the approach – holistic/individually centred. Build around team working/boundaries and communication

Services Designed Around Patients – What does success look like?

Empowered to make their own decisions Advocate to assist in making own decisions if desired Request help and at a time of own choosing, especially when concerned, not wait and see Information and encouragement to make most of choices and remain in control Pooled budgets/cultural shift Seek views of individual on how they would like services delivered – plan ahead – aspirations – e.g. advanced directives – personalisation, i.e. mental health Early interventions Preconceived ideas about what is needed if healthcare profession goes in the volunteers? Voluntary sector creativity – huge assets to tap into Expectations – high- should they be lowered? Can they work within the budget Communities can be creative Jonathan – partially sighted blind – people come through the door without a title – trust build up, not big brother Accreditation system for organisation – training/vetting – staff are responsible for happens Individual chooses Created environment where good neighbours are worried about helping – other callers – postman, milkman Circles of support – back to individual to take some control – holistic assessment of needs – risk averse re look—break down Common assessment framework – not ourselves - to support individual GPs – extension of role to volunteer support travel Success – cultural change within certain levels of the public sector (health and social care) qualification 'knows best' education process so that accredited and recognised voluntary organisations can be trusted and valued What is a community? Who is in your community? Care closer to me –'bringing my care closer to me' e.g. choose and book agenda – good agenda if options Informed choice – manage expectations – plan jointly Important that treatment/care quickly or location more important
Terminology changed – but nothing else Mental health – length of treatment – options other than CBT Listen to patients – prevent patients going into crisis NHS funding for treatment from voluntary sector organisations

Services Designed Around Patients – What does success look like?

Reduction on reliance on benefits

Individual involvement – wider involvement/influence from what's the matter with you to that matters to you

Being able to see same (named) clinician

Personalised budgets – with support on how to use

Individual feeling they are the most important person

Dementia for life – continuity important; sustainable services – joint consultations with the carer. Specialist dementia lead in each GP practice

Up to date training for dementia specialists

Good discharge arrangements and communication – homeless- elderly – mental health – young people

Information about who to refer to including voluntary organisations in GP surgeries, built into structure of GP practices

Patients able to participate across the process – design – co-production – delivery

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Seamless care, joined up models

Timely and planned – advance care plans

Key workers for people – coordination

Take some stresses off family/carers

Better coordination and partnerships around all services

Appropriate patient representation at all levels

Do not take information away and present final picture

Make sure that all services are linked together and those services see the patient as a whole

Understand the language as a whole, that the patient is using

Get rid of jargon

Communication is key to all groups, including children – teams should be working closely together e.g. discharge team

No closing cases when patient is moved on to the next stage

People know who to contact

Work as seamless whole

Clear pathways that everyone knows and follows for patients

'Neuro passport' – all information in one place

What is the norm and what is a crisis?

Plan for prevention

Services Designed Around Patients – What does success look like?

Make more of an effort to engage Go out to people Cast the net wider Patients listened to and expectations managed

Services Designed Around Patients – Delivery actions and prioritisation

Timely patient questionnaires/feedback to be able to improve services Patient education on appropriate services Feel primary care not open enough Recognise appropriate funding required to allow voluntary sectors to fulfil their role Awareness of contract opportunities Give people enough time to feed back appropriately from events such as this Scorie – re-publicise this, promote this within both GP practices Might be a bit clunky – update Put effort into making key local people linked into this Flexibility in contracts – adequate contracts to suit this and consultation When patient leaves, contact should not come to an abrupt stop Improved IT to be able to access the history/journey so far Ensure that all IT systems talk to each other Depending on clinical case, voluntary sector could support patients on leaving hospital Follow up on patients post hospital –staff training
Make sure we cast the net for engagement as wide as possible Where possible go out to people not always hold events in the same locations Make sure we listen and taken on board what people say and manage expectations
Discharge - needs to be something in place for when people are discharged. Quick follow up in the community. Release pressure on hospital beds. 48 hour communication window prior to discharge CPA – properly implemented for all client groups with a designated care coordinator recognising all the differences

Sustainable Health Care Services – What does success look like?

Relates to community assets
Voluntary sector can be dynamic and creative Make sure NHS engages and explains

Sustainable Health Care Services – Delivery actions and prioritisation

The voluntary sector can be dynamic and creative The NHS needs to engage more to tap into that creativity as they need to be nimble to be sustainable

Preventing Ill Health and Reducing Health Inequalities – What does success look like?

Starting early – at school. First aid taught in schools would be good. PHSE is a lost opportunity – local voluntary sector could assist Changing expectations so that people do not go to the GP when they are a bit unwell: • look after yourself at home more • people should be able to manage their conditions themselves Reviewed with the education department, the PHSE agenda and delivery at schools Ambassador mentoring by people with experience with the condition Engage with local leaders e.g. football coaches, to deliver/support health messages – community development workers Explore different ways to support, e.g. IT platforms such as Facebook Health will be more aware of /talk to the community infrastructure Health has got to get more relaxed about non health outcomes e.g. rehousing, whole person measures
Closing hospitals and creating sustainable systems Data to show the changes Change in mind set Change in emphasis as will have more preventative Patients to know where to access support Voluntary services would be a key/integrated part of the service Evidence based Working together to understand inequalities, voluntary sector have the local focus
Homeless/drug addicts: getting clinics to visit shelters and hostels to identify issues earlier. Making sure services visit hostels. Any work with charities

Preventing Ill Health and Reducing Health Inequalities – What does success look like?

Post code lottery – patches of work dotted around the county Use Partnership Boards Drugs and alcohol difficult to get blood tests – need nurses to

Preventing Ill Health and Reducing Health Inequalities – Delivery actions and prioritisation

Supporting pilots to be able to justify longer term spending to be able to gather the evidence base Taking a leap of faith Work on locality basis to look at inequalities, look at what these are, why and then ground up commissioning to sort out how to change this Use voluntary sector to establish what these areas are and work through this process, e.g. DATT, homeless, specific areas of attitudes
Where homeless shelters and hostels operate make sure existing services such as mobile dentist got to them Join up with the resources such as Partnership Boards to gather information