



CHANGING PLACES
CHANGING LIVES

Delivered by
Groundwork NE & Cumbria on behalf of
North East Commissioning Support (NECS)

Public engagement report to
inform the Better Health Programme:
Engagement with frail elderly people
living in care setting.

November 2016



Better Health Programme

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Executive Summary

This report outlines the main findings from the public engagement process carried out by Groundwork North East & Cumbria on behalf of **North of England Commissioning Support (NECS)** for the Better Health Programme. This engagement targeted elderly and frail people in care settings to gather experiences on the discharge process throughout five Clinical Commissioning Groups (CCG's) in the area. These CCG's were Darlington, Hartlepool and Stockton, South Tees, North Durham and Durham Dales Easington and Sedgefield.

In total, 85 conversations were carried out across the five CCG's. These conversations yielded mixed experiences from patients. 50% expressed positive experiences of the service, whilst the other half of participants (43 out of 85) expressed negative remarks about the service they had received when being discharged from hospital. In particular, 22% of participants (19 out of 85) made specific reference to the discharge process.

The main messages that can be taken away from this public engagement with older people in care settings about the discharge process are;

- I. Discharge is taking too long due to missing paperwork and medication (17%) – patient perceptions are that they are being left waiting for too long after they have been told they are ready to be discharged. Of those who did have perceptions of long waiting times the average was 4-5 hours, this figure is from across the service and not limited to one or two CCG's. Examples given include the discharge letter not being signed by the doctor on time or medication taking hours to be dispensed.
- II. Waiting for transportation - patient transport was noted as a one of the main cause of delays (5%). Two people that we spoke to suggested that patients are given a time window of 2-3 hours so they know roughly when they will be collected. Further to this, waiting time and pressure on the service could also be reduced if more patients were made aware that they can be collected by a family member and do not need to be taken by patient transport.
- III. Lack of communication between staff and patients/families (13%) - patients feel staff need to be communicating more, not only with the families, but also with the patient if they have the capacity to understand. Many told us they are left confused and frightened because they don't understand what is happening to them. They feel staff often leave them 'in the dark' even when it is their own care that is being discussed. Finally it was also expressed that medical staff should be more understanding and attentive of additional patient needs so they are treated appropriately; such as those with Alzheimer's or physical disabilities.
- IV. Lack of communication between hospitals, the primary care setting and other departments' e.g. social workers/other hospital departments (3.5%) - People expressed that the communication between the departments is too disjointed leading to miscommunications, delayed discharge and not all the necessary provisions being made for patients to ensure seamless care. Please see case study from an Anonymous Man in Darlington which demonstrates this point.
- V. There is a lack of support being offered to some patients (8% - Many expressed the view that if they were given further support after being discharged, such as referrals to other services like Occupational Therapy or Physiotherapy, it would have greatly improved their speed of recovery and quality of life. An example of this can be seen in a case study from an anonymous man from the North Durham CCG.

1. Introduction

1.1 North of England Commissioning Support (NECS)

NECS was established on the 1 April 2013. It is based in the North East of England and delivers high quality innovative commissioning support services to a range of clients who consist of 11 Clinical Commissioning Groups who between them serve the communities of County Durham and Darlington, North of Tyne, South of Tyne and Wear, Teesside and Cumbria. NECS also provide a healthcare procurement service for the NHS England North.

One of the service offerings that NECS deliver is healthcare procurement in order to improve the quality of people's lives and as a result drive up quality, value and service to stakeholders and customers through innovative practice.

NECS approached Groundwork North East and Cumbria to support with the public engagement around the Better Health programme.

1.2 Better Health Programme

Across County Durham and the Tees Valley, around 35,000 NHS staff serve a population of 1.2 million people in specialist and local hospitals, in GP practices and community settings, and at home.

Our care needs are changing. People are living longer and have different conditions and health needs: dementia, obesity and alcohol-related disease have become major challenges and more people have long-term health conditions and need support and management, often for many years.

Thanks to better care, we are surviving illnesses and living with conditions for much longer than we used to. This means that our health services need to change too. More services can be provided in community settings or GP practices, without the need for hospital visits, and the service can reduce the length of stay of any planned hospital admissions.

There is disparity between the quality of care across the area because of a lack of uniformity in provision or because services aren't available or have reduced staffing levels at different times of the day, or at weekends.

The Better Health programme aims to review the services that are provided across Durham and Tees Valley to make sure that these services are meeting the needs of our population, are of a consistently high standard across all our providers, and have the staffing and resources to be sustainable into the future.

The programme aims to deliver:

- ✓ Improved results for patients
- ✓ Consistency of a high standard of care wherever, and whenever it is provided
- ✓ Sustainable services resourced for the next 10 -15 years
- ✓ Services provided 7 days a week where necessary
- ✓ Services that are easier for patients to understand and use
- ✓ Improved life expectancy and quality of life for everyone in Darlington, Durham and Tees Valley.

1.3 Groundwork North East & Cumbria

Groundwork NE & Cumbria were approached to undertake this work due to successfully managing community-led environmental projects for over 30 years in the North East. Groundwork NE & Cumbria is a region wide organisation committed to local delivery.

What stands us apart is our ability to be in touch with local communities across the whole region and we pride ourselves on delivering grass roots projects in partnership with others. We have an experienced team of dedicated staff and a proven track record in the delivery of high quality community-led programmes across the region.

Community engagement is an area in which we have vast experience, adapting the techniques used in each project to ensure the relevant stakeholders are involved and the correct information is gathered from the process. The aim is to ensure the communities' opinions are captured in order to provide information that can be used by the client. We find that a "bottom up", community driven approach results in more sustainable projects as they are truly supported by the community.

2. Approach to Community Engagement

NECS approached Groundwork to focus on engagement of the frail or elderly, predominantly living in care homes or sheltered accommodation. The brief was to capture patient experience of being discharged from hospital and capture individual accounts and opinions around the discharge process, quality and continuity of care upon discharge. This work will supplement the findings of the wider public engagement.

The proposal aimed to have conversations with 20 people in each CCG area (100 in total) predominantly living in a range of care settings across the area (a target of 25 care homes). Where appropriate Groundwork will provide, or signpost participants to, additional information about the Better Health programme (as provided by NECS).

Groundwork Land and Neighbourhoods teams, covering Durham, Darlington and the Tees Valley carried out a series of one to one conversations to collect a range of quantitative and qualitative data from people who had recent experience of the local care and discharge process.

A prompt sheet was created for interviewers, to ensure that key points were covered, however the conversations were conducted in an informal manner which allowed the patient to share their experiences and offer opinions on the current process and suggestions for improvement.

3. Methodology

To ensure the data could be easily collated and common themes could be gathered a standard format was agreed for gathering the information from the conversations.

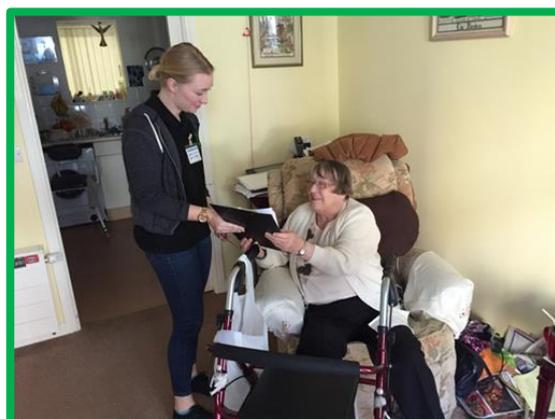
Desktop research allowed us to map the care homes and sheltered accommodation across the identified areas. Teams then approached the staff at the settings in the first instance to help identify participants. Participants were then asked whether they would be willing to take part in a conversation, and a meeting time was arranged. Staff members then carried out the conversations on a one to one basis in the home setting.

Groundwork produced a registration document to capture details of participants partaking in the conversations. This included demographic information and was completed at beginning of each conversation with interviewer supporting as necessary.

All conversations were captured with detailed notes taken to record people's views and opinions. Prompt questions were provided to help the interviewer gain useful information.

The participants were then engaged in discussions around their experience. Conversations were individual, but in general covered topics such as;

- ✓ Nature of admission
- ✓ Duration of admission
- ✓ Circumstances around discharge
- ✓ Communication
- ✓ Quality of Care
- ✓ Quality of experience
- ✓ Suggested improvements



Groundwork staff recorded the conversations on discussion sheets.

1. Engagement process

In total we approached, 176 settings across the area, as broken down in the table below.

Area	Number of settings approach	Number of settings who identified appropriate participants
North Durham	31	4
DDES	30	6
HaST	43	10
South Tees	41	13
Darlington	31	9

It was challenging to locate appropriate people in the identified demographic who had the capacity to speak to us about their experiences. Many settings reported not having people with capacity to partake in the conversations or not having people with the necessary experiences, with care home staff reporting not having a high volume of people who they care for after a hospital admission.

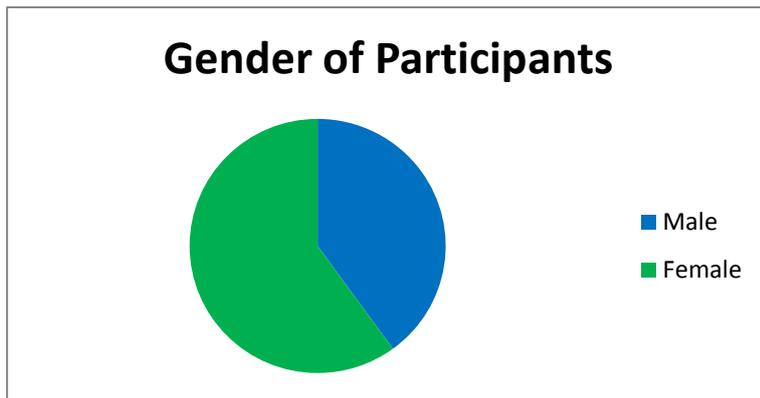
The following is a list of the settings who identified individuals and where conversations took place.

North Durham	DDES	HaST	South Tees	Darlington
Rosemount Residential Care Home	Defoe Court Care Home	Dinsdale Lodge Care Home	Prospect Place	Eden Cottage
Brockwell Court	Lothian House	Bramley Court	Clayton House	Eastbourne Care Home
St Andrews Nursing and Residential Home	Brancepeth Court	Park House Rest Home	Pembroke Residential Home	Elderwood Care Home
Westerleigh Care Home	Barrington Lodge	Ingleby Care Home	Belmont View	Oak Lodge
	Tenlands	Greenlodge Care Home	St Peter's Court	Riverside View Care Home
	Jack Dormand Care Home	Green Links Group	Primrose Court	Rosemary Court
		Kathleen McNamee	Yew Tree Care Home	Rockcliffe Hall Care Home
		Robert Dalton	Burlam Road Care Home	Greencroft Court
		Wynyard Woods	Cleveland View	Branksome Hall
		Hartfields Retirement Village	Parkville Care Home	
			Ascot Care Home	
			Bramble Lodge	
			The Gable Care Home	

In total we spoke to 85 participants across the area of interest. The table below sub divides the number of participants per CCG area.

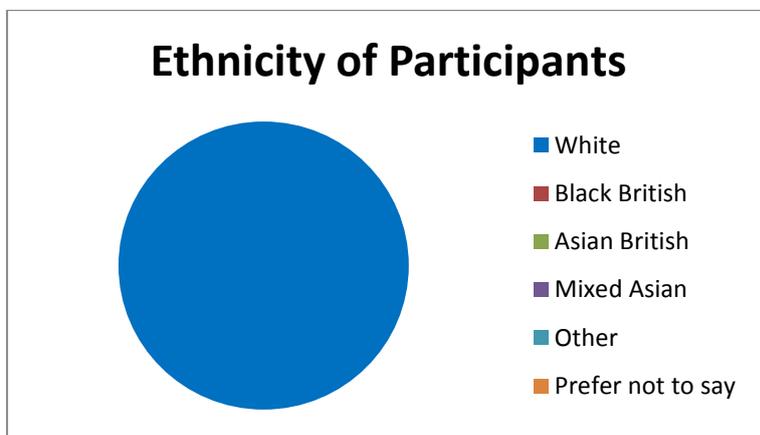
Area	Number of conversations
North Durham	10
DDES	16
HaST	20
South Tees	20
Darlington	19
Total	85

Gender



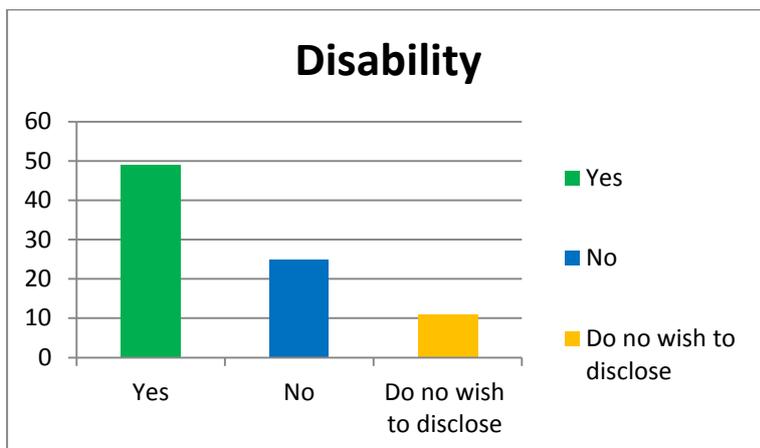
In total we spoke to 31 males and 54 females across the area of interest.

Ethnicity of participants



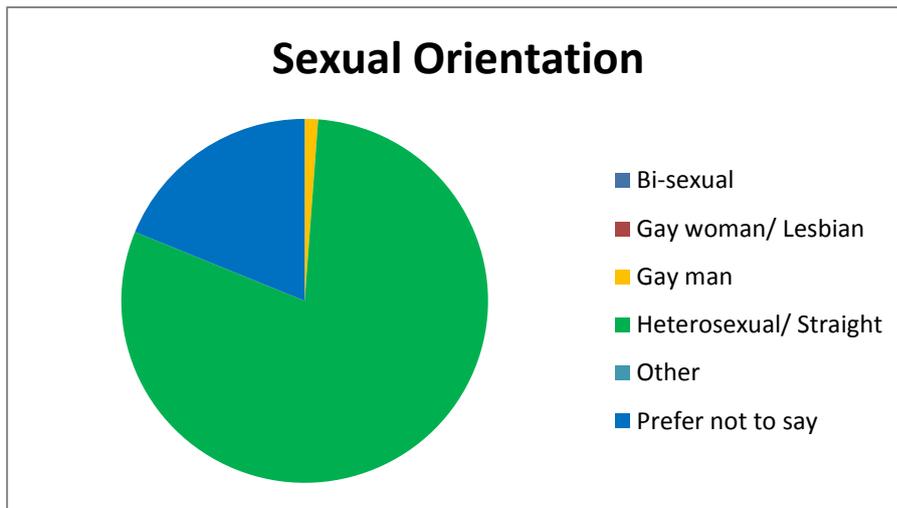
In total all 85 participants that we spoke to described themselves as white

Disability



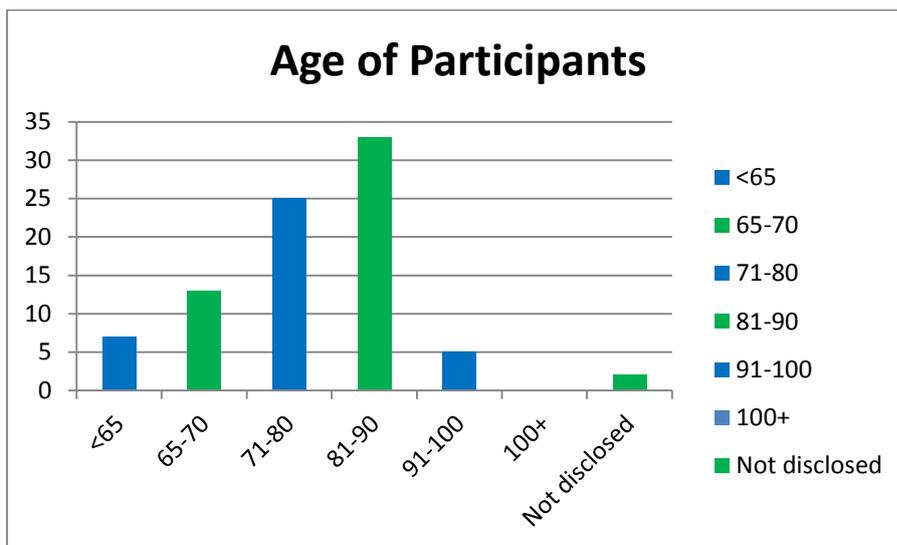
In total of the 85 people we spoke to, 45 people considered themselves to have a disability, whilst 25 people said they didn't and 11 did not want to disclose that information to us.

Sexual Orientation



Of the 85 people spoken to 68 people described themselves as heterosexual/straight, 1 person described themselves as gay and 16 people preferred not to say.

Age



As show in the above graph, in total we spoke to 7 people aged 65 and under, 13 people aged 65-70, 25 people aged 71-80, 33 people aged 81-90, 5 people aged 91-100, 0 people aged over 100 and 2 people who did not wish to give their age.

5. Key themes from the conversations

5.1 North Durham

Patients in this CCG area reported receiving treatment from a number of hospitals including Darlington, Freeman's Hospital and Durham and the majority of the 10 people spoken to reported positive experiences. The majority of participants reported having positive experiences and being satisfied with the service they have received.

"I feel the care has been brilliant, joined up and seamless"

"I feel that the services and care I've had in both hospitals [Durham and Stanhope Cottage] was very good, in particular Stanhope was excellent."

However, 2 participants did tell us about their negative experiences of the discharge process. One participant reported being transferred to different hospitals multiple times, explaining that he was unsatisfied with the level of service as he felt excluded from the decision making process.

"I wasn't told why I had to be transferred to different hospitals and found the staff often spoke about me rather than to me. I was moved from place to place without being told why."

Another respondent reported missing personal items and a lack of paperwork on discharge, which made it difficult for care home staff to accommodate her needs.

5.2 DDES

Again, the people we spoke to had had mixed experiences of their time in primary care settings and the discharge process, with over half of the 16 people engaged sharing with us negative comments about their experience .

One person reported feeling that staff shortages resulted in poor quality care whilst in hospital. In particular one participant reported feeling that the staff on the wards lack of understanding about additional needs of patients with dementia.

Two participants in this area shared experiences of extended stays in hospital (primary care setting) due to lack of arranged care provision. They felt the stay was due to the need for appropriate accommodation and not for any extended requirement for medical treatment, and therefore questioned if this was the best use of the resources.

One participant spoken to in this area felt that there was very little support for families when caring for a patient immediately after discharge. When a family member released home with different care requirements, very little information or support was provided and it was left to families to sort care in the

short term resulting in the family feel quite alone in dealing with the patient's needs. They felt the process was less than seamless and were very clear that care should not end when the person leaves hospital.

Throughout the conversations multiple participants highlighted the need for better communication. 25% felt that direct communication with the patient was lacking, despite the patient still having adequate capacity to understand and make decisions for themselves. Examples include a lack of communication around the cause of illness and course of treatment, reasons and requirements for transferring to alternative settings and a lack of information regarding support services, leaving people feeling 'out of the loop' when it came to their own care.

Others reported that better communication could have made their experience better, for example one patient reported having a planned admission arranged for the early morning, but upon arrival having no beds available resulting in an extended wait time for treatment, which they felt could have been avoided and the treatment could have been rescheduled.

Others stressed the need for family members to be more informed. Again this materialised in a number of examples through the conversations, including families not being informed regarding transfer and discharge arrangements and not being given enough information on discharge to support the care of the patient.

Some people did report receiving follow up care and support; however one participant reported delays in getting the follow up referrals recommended upon discharge. Of the 16 spoken to, 4 explained that if more support had been offered it would have aided their recovery.

Another participant felt that the service was not individual enough. They reported receiving OT support on discharge, but only for a set period, which is not long enough in some cases. The duration of the support provided should be based on the individual need and not predetermined.

Another participant felt there was a lack of communication between the care home setting and the OT. In their case a brace and support was issued, however the care home staff were unsure how to fit them properly as there had not been any handover or explanation from the OT.

In this area there were fewer issues regarding the discharge transportation system, with some participants specifically commenting positively on the system. However one participant experienced a delay in discharge due to vehicles not being able to accommodate their wheelchair and felt better communication, so that everyone knew what had to be accommodated, could have prevented this. Poor communication whilst in hospital regarding cause of illness and what course of treatment will occur were the main themes in this area.

5.3 HAST

People engaged in this area reported mixed opinions when it came to their 'in hospital' experiences, with 2 main hospitals being mentioned in the conversations (North Tees and James Cook). A couple of examples were given of planned admissions which were reported on positively, and the process was portrayed as well managed and seamless.

“I’ve had some great hospital experiences and some very good nurses – I am very lucky”

“I don’t know what I would have done without them – the nurses during my stay in hospital”.

However, of the 20 people engaged in this area, on three occasions attitudes and behaviours of ward staff have left respondents feeling unsatisfied and anxious about future experiences. In addition two people mentioned feeling 'loneliness and isolation' during their stay.

People commented on several occasions regarding a lack of information at points throughout their hospital /discharge period. 3 reported feeling there was a lack of information provided regarding the causes of the illness and two people reported being discharged without finding out the reason, which in turn has resulted in negative feelings.

Some respondents felt there was a lack of information and support upon discharge, with a sense that information was only provided 'if you knew the right questions to ask', whilst another reported feeling like they weren't being listened too. Patients also highlighted the need for better communication between the hospitals and the care homes.

Again, some patients reported being transferred to another care setting prior to returning to their usual residency. People we spoke seemed to appreciate this 'stepping stone' to allow them to fully recover and had a positive experience of this.

5.4 South Tees

In general the majority of people spoken to in the South Tees area reported positive experiences of their time in James Cook with 50% of people reporting that they were satisfied with their length of stay and felt they were discharged at the right time. One individual reported feeling that it was a ***“seamless service with a range of support”***. Another patient reported she was ***“delighted with the treatment [at James Cook], the staff were all friendly” and I have no complaints at all”***. Only one individual reported feeling like they were 'being pushed home' without the right support.

Some of the participants had experience of being transferred to alternative Primary Care settings after their initial admission, for support with extended care, rehabilitation or in their opinion 'bed shortages'. Whilst some people reported this as a positive step in their journey (i.e. getting support to arrange care home accommodation for release) others found the transfer process 'unsettling' and 'upsetting' with individuals reporting that they felt there should be more choice in the discharge process and others.

Again participants reported mixed reviews on the on-going support and care they received upon discharge. Some participants reported being discharged with support from Occupational Therapists and Physiotherapists which helped them to be more independent.

One participant felt the he had been let down by the after care, with discussions with OT's not being followed up on resulting in the individual not being able to return home and having to find supported accommodation.

¼ of the 20 people spoken to in this area reported were around the lack of discharge notes and / or medication upon release, which in some cases delayed the discharge process and in other cases resulted in confusion and upset upon arrival at care setting.

5.5 Darlington

Through these conversations we received some good reviews regarding the care and satisfaction with the service at Darlington Memorial and Bishop Auckland hospital.

“The hospital was marvellous and that I received a great service. I would also give the discharge process a 9/10 and felt that no improvements need to be made.”

We also received some negative patient feedback on their in hospital experience with one person reporting ***“laid waiting the corridor for a bed to be free”*** for a long time and another reporting poor quality care having been *‘left unwashed for days’* and felt that better communication between staff in the hospital was required as things were being missed.

Some of the people we spoke to had experience of receiving specialist treatment in other hospitals elsewhere in the North East (Durham and James Cook). On both of these occasions the patients commented that they felt the distance from their home and the hospital was too far and that they found this unsettling, especially when staying in for a longer period of time, as the distance can be a barrier to visitors.

“I did not like being so far away from family. I felt isolated as everyone else was getting visitors and I wasn't.”

6 people complained about the delays in the discharge process, and the long time spent waiting for transportation. One person reported not being discharged until 9.30pm, which they felt was too late to be going home (to a care home) and felt they had been left waiting too long for the transport. The nurses allowed him to stay in his own bed until this happened. However, it wasn't until 9.30pm that night that he was actually discharged and taken back to the care home where carers were waiting for him. The man explained he felt that 9.30pm is too late to be going home and he had been left waiting too long for the ambulance.

The delay in discharge also affected people who were being discharged home to family.

“It took 4 to 5 hours to be discharged as they had to get my medication sorted and wait for discharge letter. It was annoying to have to wait so long because my wife was waiting for me, so it was frustrating to both of us”

Again 5 people experienced what they felt was poor communication with the patients whilst in hospital and after being discharged. One patient reported being admitted for what she thought was a straight forward planned surgery and was told she would only be in hospital for a couple of days, but ended up staying in for three weeks without an explanation to why this was the case. She feels that something went wrong in the surgery that was not explained to her. Another patient reported;

“I felt that the staff there did not communicate with me enough and I had many questions that went unanswered.”

Others felt that better communication was needed between in hospital departments and out of hospital support to prevent delays in on-going treatment after discharge. There were also reports of services which were recommended on discharge having long waiting lists to access.

Some people reported feeling that the problems identified were the result of overworked and overburdened front line staff. They felt there need to be less administrators and more money spent on nurses so that everything takes less time and no one is left waiting.

However some people did report the system working, and when it did patients reported being very satisfied with the services they received.

“I felt better at home [in a care home] and was able to get better quickly. I was given a lot of support after both by the hospital and the care home; I felt that I could talk to the nurses at the Breast Clinic at any time and this helped me to recover well.”

“On discharge I was taken home to my husband. The district nurses came out to make sure everything was alright and before I came home they check the house to see if I could manage. The aids I needed were brought within the hour.”

5.6 Additional conversation with staff

In addition to the conversations we had with individuals, some staff in the care settings wanted to share their opinions. We recorded conversations with 7 staff members at various settings across the area.

The main concern was around the lack of direct contact the homes have with the hospital. Often staff lack clear information regarding changes to medication and they felt the current system of recording a patient's medication made it difficult to identify changes required after discharge. Improved, or more direct, conversations between the hospital staff and care home staff would save a lot of time and reduce the chances of incorrect medication being given.

Staff reported medication being wasted. They said the medication the patients are discharged with is packaged in a form that the care homes are not allowed to administer under their regulations. This often results in the medication which has been sent to the care home with the patient from hospital being wasted as it cannot be administered, neither can it be returned to be re-used.

There were several reported cases of missing discharge paperwork, medication or mobility aids and personal items (i.e. dentures or glasses) on the person's arrival at, or return to, the home. Some staff reported that discharge notes sometime directed staff to contact GP in order to find out about the medication instead of providing the information directly to them. This resulted in the staff members lacking clarity around the care required, and patients lacking the prescribed aids for living outside of a primary care setting. Staff also felt it made their roles more difficult and onerous, with time wasted chasing up missing items.

Staff felt patients were often left too long in the discharge room waiting for transportation, which can result in safeguarding issues and inadequate care. They reported instances where patients had arrived at the home in the evening, despite clear rules around cut off periods for admissions, leaving the staff unable to plan and arrange the necessary care on arrival, again potentially resulting in inconsistency of care. In other instances patients from the same hospital due for discharge have arrived at different times in different vehicles.

Staff also reported feeling that patients are released too early due to bed shortages. They reported instances when patients still required medical care, but were discharged to a care homes, which in their opinions increased the pressure on them beyond the remit of their role or expertise. Other staff felt that there is a delay in admitting patients (either due to delays in admission transportation or due to doctors dismissing reported changes in symptoms), putting more responsibility on the care home to manage the medical needs of their residents. There seems to be a lack of understanding by hospital staff around the level of care and support available in different types of settings.

6. Summary

Throughout the process we were able to capture the views, opinions and experiences of 85 older people. People often provided information about their in hospital experiences, alongside discussing the discharge process and satisfaction of services and this information collected has been presented in the report. This has been supplemented by information provided from care home staff at 7 settings.

It was challenging to identify suitable participants in a care setting, as in multiple instances homes reported having no residents with in-hospital/discharge experiences, whilst others reporting that residents had advanced stages of dementia resulting in them having a lack of capacity to be able to consent or cooperate. Even when we were able to identify people, we experienced barriers to being able to collect a full, accurate account of their experience including:

- ✔ Limited information as family members or care home staff are now taking responsibility for their health care and have received information on their behalf.
- ✔ Memory issues, preventing some people from being able to present a complete account.

Despite this, we were able to engage with a range of people across a large geographic area to provide insight into how older people feel, what is important to them and improvements they believe are needed in the services discussed.

As expected, the information we collected was very individual and no two experiences being the same. Satisfaction levels of the care and services received also varied due to the personal experiences. The most common concerns were;

Discharge Process

- ✔ The discharge process from wards is often subject to delays due to waiting for medication and notes.
- ✔ Linked to this, people then experience delays in being provided with discharge transportation, in multiple instances, resulting in older people waiting for long periods in a discharge lounge and potentially not receiving the appropriate care during this period.
- ✔ Late discharges resulting in the care home not having time to make the appropriate arrangements for the patient on arrival. In addition, there have been multiple reports of patients arriving without essential medications, paperwork and personal items.
- ✔ There are reports from staff that medicines are wasted due to patients being discharged with medication in a form that the homes are not authorised to administer.

Communication

- ✔ Communication with elderly people whilst in hospital could be improved, especially around transferring of patients and discharge options.
- ✔ Support offered upon discharge is inconsistent, with some people feeling like they lacked appropriate information and on-going care.
- ✔ Communication between primary care setting and care homes could be improved to provide a more seamless experience.

In summary, during this engagement process a total of 85 people were consulted and their experiences recorded. Of the 85 people engaged, 50% had positive experiences and were happy with the service they had received. .

However, 22% of participants (19 out of 85) shared their negative experiences of the discharge process. Overall, 50% of participants (43 out of 85) expressed negative remarks about the service they had received on being discharged from hospital. This figure brings into account not only the data collected regarding the discharge process itself, but also the communication aspect; this was identified as a major theme throughout the area and has therefore been taken into account.

7. Messages for the Better Health Programme

In summary, the 5 key messages that can be taken from this engagement with older people in a care setting about the discharge process are;

- I. Discharge is taking too long due to missing paperwork and medication (17%) – patient perceptions are that they are being left waiting for too long after they have been told they are ready to be discharged. Of those who did have perceptions of long waiting times the average was 4-5 hours, this figure is from across the service and not limited to one or two CCG's. Examples given include the discharge letter not being signed by the doctor on time or medication taking hours to be dispensed.
- II. Waiting for transportation - patient transport was noted as a one of the main cause of delays (5%). Two people that we spoke to suggested that patients are given a time window of 2-3 hours so they know roughly when they will be collected. Further to this, waiting time and pressure on the service could also be reduced if more patients were made aware that they can be collected by a family member and do not need to be taken by patient transport.

- III. Lack of communication between staff and patients/families (13%) - patients feel staff need to be communicating more, not only with the families, but also with the patient if they have the capacity to understand. Many told us they are left confused and frightened because they don't understand what is happening to them. They feel staff often leave them 'in the dark' even when it is their own care that is being discussed. Finally it was also expressed that medical staff should be more understanding and attentive of additional patient needs so they are treated appropriately; such as those with Alzheimer's or physical disabilities.
- IV. Lack of communication between hospitals, the primary care setting and other departments' e.g. social workers/other hospital departments (3.5%) - People expressed that the communication between the departments is too disjointed leading to miscommunications, delayed discharge and not all the necessary provisions being made for patients to ensure seamless care. Please see case study from an Anonymous Man in Darlington which demonstrates this point.
- V. There is a lack of support being offered to some patients (8% - Many expressed the view that if they were given further support after being discharged, such as referrals to other services like Occupational Therapy or Physiotherapy, it would have greatly improved their speed of recovery and quality of life. An example of this can be seen in a case study from an anonymous man from the North Durham CCG.

8. Contact Details

If you would like any more information on this project / report please contact:

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Please note; the points documented are the opinions of, and information given by, the participants of the engagement exercise and do not reflect the opinions of Groundwork North East & Cumbria. Some information provided by the participants may also not be factually accurate, but it reflects their understanding and experiences of the services received.

9. Appendix

9.1. Participant Registration Form

Better Health Programme – Pre engagement Aug- Oct 16

1. Name

2. Age

Under 65 <input type="radio"/>	81-90 <input type="radio"/>
65-70 <input type="radio"/>	91-100 <input type="radio"/>
71-80 <input type="radio"/>	100+ <input type="radio"/>

3. Gender

Male Female Prefer not to say Other (please specify)

.....

4. Do you consider yourself to have a disability?

Yes No I do not wish to disclose

5. Ethnicity. (Please mark one category which best describes you).

White <input type="radio"/>	Mixed Asian <input type="radio"/>
Black British <input type="radio"/>	Other <input type="radio"/>
Asian British <input type="radio"/>	Prefer not to say <input type="radio"/>

6. Marital Status

Single <input type="radio"/>	Civil Partnership <input type="radio"/>
Married <input type="radio"/>	Other <input type="radio"/>
Widowed <input type="radio"/>	Prefer not to say <input type="radio"/>
Divorced / Separated <input type="radio"/>	

7. Sexual Orientation

Bi-Sexual <input type="radio"/>	Heterosexual/straight <input type="radio"/>
Gay woman/lesbian <input type="radio"/>	Other <input type="radio"/>
Gay man <input type="radio"/>	Prefer not to say <input type="radio"/>

8. Religion or belief

- Muslim
- Christian
- Hindu
- Jewish

- Buddhist
- Sikh
- No religion or belief
- Other religion or belief
- Prefer not to say

9.2. Prompt Questions for Interviewer

Prompt questions

- When was the event?
- Was the admission a planned or unplanned admission?
- Which hospital where they initially treated in?
- How long was the participant in hospital for? And do they think this was the right length of stay for them?
- Were they transferred to another hospital / service prior to discharge?
- Where were they discharged to? (i.e. home / care home)
- Who was their main carer upon discharge?
- Did they feel they had any unmet needs at this point?
- Where there any incidents of readmission for same or connected problem after discharge?
- What support / services where they provided with upon discharge?
- Was communication/ information given to participant and or carer adequate?
- How did they feel about the experience? How would they rate the quality of the discharge process / out of hospital care they received?
- Do they feel they received seamless care (joined up between hospital and discharge services)?
- How could the process / experience have been improved?