

## **MORNING WORKSHOPS**

### **Workshop A**

#### **Performance Management**

- Proper structure to weekly meetings
- Improve information systems
- Joint funding
- Empowered to make decisions
- Real time information
- Ownership – can be down to senior management style, different levels should all be committed or difficult to sustain
- Consistent leadership
- Accountability - NHS and local authority

### **Workshop B**

#### **Adults with Incapacity**

- Multi-disciplinary training for delayed discharge teams and care managers on AWI
- Multi-disciplinary training on assessing capacity for staff involved in the assessment process
- More MHOs in certain areas - plus more training on AWI for MHOs
- Care management - tool like Tayside (I agreed to get permission to have this circulated and to suggest that it goes on an appropriate website - I think it may be subject to evaluation and will find out)
- Information - local solicitors need better information about AWI and about the circular - families need to be informed that guardianship may not be necessary (some authorities have written to all local solicitors to inform them about developments).
- Professional health and social workers need to have better information about provisions of the act to advise people also where to signpost people for further information and advice - publications available etc.
- Strategy by local authorities to respond where families delay and guardianship is needed. Edinburgh, for example, avoids this completely by telling families that they (the authority) will make the application - this takes away the guilt some families might feel about putting an objecting relative in a home - sometimes nominating a family member as guardian.

## **Workshop C**

### **Complex Case Planning**

- General acknowledgement of difficulty in managing younger adult population, brain injury, behavioural difficulties, Korsakov and substance misuse, complex physical and health care needs.
- Issues in relation to some national services, regarding transfer/placement to local community, especially where services are generally poorly developed, and where care package costs high (e.g. brain injury services).
- Joint Funding arrangements, protocols and systems for resolution of financial issues are generally poor.
- Labelling and stereotyping can hinder provision of appropriate services, and locating appropriate service response can be problematic (e.g. patient labelled as brain injured but requires response from learning disability service).
- Availability of appropriate specialist input to assessment and care planning.
- Need to revisit Continuing Care Guidance, to locate in joint multi-agency decision making, not just clinical decision, and to specify responsibility for tasks in relation to health needs.
- Need for clarity on who has responsibility for a range of 'health' tasks when moving to community and social care settings, especially in relation to nursing tasks.
- Better attention to behavioural management, and the complexity it brings to planning process.
- Impact of charging systems, and complexity of funding sources.
- Choice directive still problematic in some areas, requiring 'political', managerial, and clinical ownership in escalation strategy.
- Lack of effective IT systems which talk to each other.
- Six week target for some groups is unhelpful, especially where rehabilitation will deliver better outcomes.
- Work with Consultants, GP's required to reinforce their role in partnership and multi agency/disciplinary practice.
- Still issues of interpretation of guidance.

## **Workshop D**

### **Intermediate Care**

- Intermediate care should not mask the delayed discharge issue, cannot just be a shift to another form of institutional care. Criteria has to be right to avoid this.
- Learn from other countries – Australia.
- Need local area co-ordination.
- Sheltered housing as step up/down facilities.
- Care management and use of single shared assessment is essential.
- Lack of shared IT system prevents best use of assessment knowledge being shared.
- Discharge planning from before admission and improve communication within hospital between health and social care.
- In-reach service approach.
- Need better support after interventions i.e. after 6-8 week intensive support.
- Lessons to be learned from the breach analysis in A&E.

## **Workshop E**

### **Telecare**

- Use of telecare equipment should be included (or mainstreamed) as part of arrangements for assessment – and should be a fundamental part of any review of services.
- It is important to sell the package (whether Telecare or Telehealth/ Telemedicine) to those who are benefiting from it – patients/users/carers – so they are fully aware of what is on offer and how it will contribute to their quality of life.
- Developing Telecare at local level should concentrate in building up service specifications in a whole systems way – engaging not only stakeholders and response services but other players at a local level. This needs to reflect the national approach to 'whole systems' in a consistent way.
- Information requirements on how successful Telecare is will need to take account of readmissions as well as more immediately available data. Otherwise they will not adequately highlight how well Telecare is helping to address delayed discharge and other system blockages in a comprehensive way.

