improving
health
together

NHS
South Tees
Clinical Commissioning Group

# IMProVE

## Vulnerable Groups Survey

December 2013

*In partnership with* Carers Together

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# Background

## The ImProve Project

NHS South Tees Clinical Commissioning Group (CCG) has started talking to the public about services for the vulnerable and elderly and those living with long-term health conditions such as diabetes, heart disease or chronic obstructive pulmonary disease (COPD).

Over the past year, we have been working with GPs, hospital doctors, managers and local authority partners to consider the challenges we face in meeting the needs of a growing population of older patients with long-term conditions and other health and social care requirements.   We now want to listen to the views of local people, stakeholders and professionals and encourage as many as possible to get involved and have their say about this important issue.

## About the survey – a joint project between the CCG and Carers Together

With the Improve project, NHS South Tees Clinical Commissioning Group is aiming to move the focus of the current model of care for particular groups of patients from a reactive model to one which is proactive and designed to prevent a deterioration into ill health and hospital admission. The CCG is very committed to involving local people in it's decision making.

Those patients that are elderly and vulnerable, who are often admitted to hospital, who are frail, elderly or live with long-term conditions, and who may also be in receipt of other community or home-based services are specific groups of patients identified in the project.  Best practice is that any strategy for engagement should include seeking the views from all those affected by any change in services, in order to meet the Duty to Involve placed on commissioners of health care services.

A targeted piece of work has been undertaken in partnership with Carers Togetehr, Redcar, to engage and obtain the views of those described in the Improve project briefing.

The aim was for 50-100 people aged 65 plus in Redcar, Eston, Brotton, Middlesbrough and Guisborough to complete questionnaires.   It was intended that these responses would be from the elderly and vulnerable people in those areas, that is those who are housebound, have limited mobility or living with significant long term conditions.  Carers Together from Redcar undertook to deliver the survey, working with their own volunteers, clients and local groups to get the numbers required.  The responses were then uploaded on line and a joint analysis of the findings was undertaken between Carers Together and the CCG, using Wordle, Survey Monkey and Excel software.

# About Carers Together

Carers Together Foundation is a registered charity and a limited company and was established by a group of carers in 2004, who had identified the need for a local carers' information and support service that could also ensure that carers were recognized, listened to and valued. Since then Carers Together has continued to be carer-led and has developed into an organization with a team of staff and volunteers, who provide a range of services and a voice for carers in Redcar and Cleveland. Over 4000 carers are registered with our services.

Our vision is ”A better future for carers” and we work to achieve this by informing, supporting and representing carers living in Redcar and Cleveland and the surrounding area.

Our aims are:

- To provide information and support to carers so that they are able to make informed choices about their lives
- To promote the health and wellbeing of carers
- To represent the views of carers and to positively influence policies and services, so that individuals and agencies understand, value and recognize carers and their caring roles.

## Acknowledgements

Carers Together and NHS South Tees Clinical Commissioning Group would like to thank the following organisations for their assistance with this project:

Royal Voluntary Service

The Older People’s Partnership for Redcar and Cleveland

Age UK Teesside

Redcar & Cleveland Visually Impaired group

# Findings

## What people said about help from local services

Question 4 - people were asked if they had received enough support from local services in the six months before completing the survey to help them manage their long term health condition(s).

**Overall**

Only 11 ( 3.4%) said they definitely had received enough support. The largest proportion of people said they had to some extent - 221 (69.1%). Forty three (13.4%) answered no to this question.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Yes, definitely | 3.4% | 11 |
| Yes, to some extent | 69.1% | 221 |
| No | 13.4% | 43 |
| I don't have a long term condition | 14.1% | 45 |
| Comments - what could be improved? | | 96 |
| Answered question | | 320 |
| Skipped question | | 28 |

There were many and varied comments about what could be improved:

A simple word analysis shows the most common words describing local services.

General themes are set out below.

**Appointments**

Generally people wanted to see more and better organisation of appointments and more information relating to appointments.

**Communications**

Comments about communications included improving communication between departments, liaison with carers, a more joined up approach, a holistic view of the family situation. '*The different departments do not interact with each other which confuses everyone. No one department seem to have the full, up-to-date information.'*

**Continence supplies**

'Incontinence pads that are fit for purpose and not to have standard, cheaply bought ones.'

**Costs**

There were a number of comments about the cost of services/ support, lack of information and difficulty obtaining information

**Duration and number of visits**

A number of comments made about the frequency and duration of paid carers visits. 'Carers visits could have been longer than 15/20 minutes and some more helpful rather than filling in forms.' 'Receiving bathing help twice a week and respite care and daycare three times a week part days. No other help given.'

Regular visits from nurse or doctor would be an advantage, currently they 'only attend when requested. 'Longer time spent with district/community nurses, more contact from GP', 'District nurse visits can be erratic.'

**Equipment**

'Speed at which equipment recommended is actually delivered'

**GP**

People would like an improved relationship, doctors who stay longer in the practice and understand their conditions, easier access to appointments. One comment was about worry about being able to explain problems over the phone which is why it would be '*better to see a doctor'. 'Easier access to GP as it costs me £7.00 to get there so I don't go as often as I should." GP should be more involved in monitoring situation'*

**Lack of information**

'We had carers for 6 weeks when changed over, no one would say what it was going to cost and how was going to pay for it, no good having a big bill, so the carers asked not to come.'

There were a number of comments made about lack of information, relating to help and support from different services – the council for mobility, more information because doctors not available, one comment about support from Parkinsons nurses, lack of support on discharge for a carer.

**Medicines**
Someone to identify medication and its specific use.

**More services**
This included osteopathy, chiropody and physiotherapy (more than one comment), also hydrotherapy. *'Make better use of the endoscopy unit and hydrotherapy pool at Redcar.'* There was a comment about how difficult it was to get a wheelchair and also a comment about support to clean the house. In relation to caring responsibilities '*More frequent calls from 'HomeCare' would benefit us'*

**Other comments**
There was a comment about the withdrawal of a blue badge.

**Satisfaction with services**
There were over twenty comments from people saying how much they appreciated/ are satisfied they are with their care from local services.

**Support and understanding**
More staff support for practical jobs such as shopping and housework and washing care. 'I was told that I needed help in bathroom. I was put on the list for a walk in shower along with my wife-she can't get into the bath due to her illness. I got a phone call yesterday saying we have to wait two years.'

More support was required for housebound people and there was a comment that the Young Onset Dementia Team should give more support.

There was one comment about 'Appropriate support for coping with continually deteriorating physical condition which impacts on my mental health problems. Six sessions with Talking Therapies is like treating a broken leg with a band aid.'

There were a couple of comments about understanding old age pensioners – 'tell people to be more patient and give me time to answer the door'.

**Trained staff**
There were comments about the need for more trained paid carers, social workers and occupational therapists and waiting times in relation to these.

**Transport**
Help with travel costs where patient transport cannot be arranged in time.

**Waiting times**
There was a comment about the time taken from assessment of and diagnosis of dementia and receiving care. There were a number of comments about waiting times being too long both for doctors' appointments (4-5 weeks 'not unusual', social services assessments,

specialist assessments from OT and for installation of equipment and three months for a cataract operation.

## Feedback on integration of services

Question 5 asked whether different people treating and caring for patients (such as doctors or nurses) work well together to give them the best possible care.

### Overall

Whilst people were very positive about the efforts people have made to work together, they made comments about a number of areas that could be improved.

A simple word analysis of the comments shows communication to be most frequently mentioned in the comments section of this question, followed by GP and doctors' appointments.

### Appointments

People commented that appointments need to be easier to make, the appointment system needs to improve and it needs to be easy and understandable to the elderly. It is also difficult for people to get there.

'You have to wait on the phone for ages'. 'Easier to get appointments.' 'Good support from GP but follow up hospital appointment took too long to wait for.'

Waiting times for appointments was also mentioned again by people.

### Communication/ liaison

This was a strong theme, with over 20 comments made about improving communication and liaison between professionals, hospitals and GPs, keeping each other informed of treatment and progress, patients knowing what is available.

'Doctor rarely visits even when requested, often prescribes over phone. 'Very little communication between doctor and nurses.'

‘Doctors don't always recognise when the slight but chronic cough I have is changing in character and indentifying the increased shortness of breath without activity is leading to Pneumonia. I have twice now reached the stage where sepsis is occurring when admitted to hospital. Sometimes the district nurses delay dressing my skin condition on my legs according to the hospital Dr's directions when it worsens and becomes very painful. I have recurring MRSA.’

‘The blind leading the blind. Information from doctors not relayed to family members.’

‘No link between departments. Different nurses for what used to be the same job. "District" nurse will not do simple task and quotes new rules as being the cause.’

‘Every unit works in a silo! There should be a one stop shop which coordinates and monitors progress’

**Costs**
One comment was about local GPs being reluctant to spend their budgets on drugs and services. *‘They act as managers rather than as doctors.’*

**Follow up**
There were comments about there being no follow up by the doctor , nurse and hospital staff, that it is easier to access your own doctor and this would be easier, although having the same GP is important *‘who knows about your condition and not doctors who hardly know you.’*

**Home Visit**
*‘Maybe a home visit from a nurse twice a year would be a great help.’*

**Impact of disabilities**
*‘Appreciation of all aspects regarding how any one of the disabilities effects the other i.e. fitting a hearing aid if one has a magnifying glass (10x) to see it and little, if any, sense of touch.’*

**Lack of information**
Comments about people knowing what services are available, when to contact them, how and what for.

*‘Access to relevant information when doctors and nurses have a collective review. Results of tests and treatments explained’*

**More physiotherapy**

**More staff**
*‘I had a visit from a district nurse approx every two months. This stopped around April.’*
*‘More staff, or any system will not work correctly.’*

## Knowing who to contact

Question 6 asked whether people knew who to contact if they were worried about their condition or any treatment they were receiving.

**Overall**

There was a range of comments (47) from people regarding improvements or their experience of services, although these were also balanced by positive comments about current services. Most people 288 (90%) said they did – either they did know who to contact, or ‘yes, for some things’.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Yes, I know who to contact | 67.5% | 216 |
| Yes, for some things | 22.5% | 72 |
| No, not really | 10.0% | 32 |
| Comments? | | 47 |
| Answered question | | 320 |
| Skipped question | | 28 |

A simple word analysis shows the most common words used in the comments:

The general themes arising in the comments are as follows.

**First port of call is GP**
Most people talked about the first port of call being their GP and how they rely on local doctors. They also commented on having a call button. *'I telephone my surgery with a problem and the doctor always rings back.'*

One person said they *'Can contact Stroke Association, GP Surgery and can ask to be re-referred to community matron service.'*

Some people said it was difficult to contact people as they didn't know who to contact.

There was a comment about not having a computer.

There were also a number of comments about support from family members to contact services when something is wrong.

*' I tell my daughter and she passes on information to the staff.'*

Two people talked about their homecall service.

**More written information**
*'A written list of contacts/conditions would be helpful'.*

*'Have written documentation which helps'. 'Totally confused and forgetful'. ' Update info re staff, constant changing of staff is most confusing.'*

**Passed between clinicians**
There were several comments about being passed between clinicians. *'No one seems to know who does what. You are passed from one organisation to another.'*

**Positive role of secretarial staff**
Secretaries *'sign post'. 'Reliable secretaries save time for all social workers - great at signposting'*

**Waiting times**
There were a few comments about waiting times.

## Is more information and/ or guidance needed?

Question 7 asked if people felt they needed more information or guidance to help them manage their condition or any treatment at home.

**Overall**
Just over half of the respondents – 158 (53%) – said they needed a little or a lot more information to help them manage their condition or any treatment at home. A further 47% said they didn't need any more information or guidance.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Yes, alot more | 17.4% | 52 |
| Yes, a little | 35.6% | 106 |
| No, I don't need any more information or guidance | 47.0% | 140 |
| Comments - is there a person or organisation you should receive more information from? | | 61 |
| Answered question | | 298 |
| Skipped question | | 50 |

A simple word analysis shows the following most frequently used words in the comments made.

However, unpicking these comments, people wanted to know more/ receive more services in the following areas:

**Arthritis / specialist associations**

**Better explained information**
*'Explanations are brief and covered in professional language.'*

**Carer support**
*'All the staff who have visited have been very thorough but I rely on my wife to understand what is said and if spoken to alone I can give wrong information.'*

When visited, assessed, asked for information.

Carer could possibly be involved – *'informed of changes = medication and processes.'* And *'carers could be given more information about when a condition worsens.'*

**Carer (paid) training**

Carers employed to work with dementia patients should be given guidance on how to speak to and react with patients.

**Community matron**

*'I was well supported by a Community Matron but her services have now been withdrawn.'*

**Consistent information**

Constant information from all departments, i.e. one says eat plenty of one thing another says don't eat the sort of thing each time it is eat this don't eat this.

**Counselling**

*'Perhaps some counselling for depression resulting from caring for my wife.'*

**Dementia assessment**

*'An assessment in the house from someone who knows about dementia.'*

**Drop in service**

*'Information and support is hit and miss. Need a local drop in service.'*

**Follow-up**

*'Last year I missed my flu jab and ended up in hospital 26th December to January 6th. Could not get get to my doctors for it and was not phoned about it. Same up to now this year but at the moment I am in hospital with broken hip.'*

**Information on tests**

*'Patients to be told about results of x-rays and scans and not to be kept waiting for information'*

**Parkinsons' support**

*'Parkinsons' experts, we haven't seen or heard of one in 22 years.'*

**Physiotherapy / advice**

*'After going home physio ceased and I had no idea what I should attempt. I felt it was a case of once going home that was the end of it.'*

**Podiatry at home**

**Social Services / information**

This was a common theme. *'We see the GP regularly and know how to contact the OT but have had no contact or help with/from social services. Most of the things we have in place to help us remain living at home has been sourced and supplied by our family. We have even organised 'Home Call' ourselves.'*

**Waiting Times**

*‘There is often frustration about the time spent waiting. Screens in each waiting room would relieve the frustration.’*

## Organising care

Question 8 asked people how well they thought health and social care staff organise the care and services for local people.

**Overall**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Very well | 37.5% | 120 |
| Not very well | 5.6% | 18 |
| Fairly well | 38.1% | 122 |
| Not at all well | 5.3% | 17 |
| No opinion | 13.4% | 43 |
| What do you think could be improved? | | 82 |
| Answered question | | 320 |
| Skipped question | | 28 |

A simple word analysis shows the following:

## Where people think the majority of care for long term conditions should be given

Question 9 asked where people think people should receive the majority of their care if they have a long-term condition(s). They were given the examples of stroke, frail elderly people, people with dementia and people with chronic chest problems or heart disease.

Generally, people thought a mixture of places for care would apply, depending on their condition.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Mostly from their GP practice and community nursing staff? | 11.9% | 39 |
| In their own home? | 23.4% | 77 |
| Mostly from their local hospital? | 1.2% | 4 |
| A mixture of these? | 63.5% | 209 |
| Comments? | | 73 |
| Answered question | | 329 |
| Skipped question | | 19 |

A simple word analysis shows the most frequent words respondents used in their comments.

### About the mix of services

There was a range of comments about the mix of services which suggested that people thought it depends on what support is needed and what problems people have: *'A mixture depending on the condition'; 'as long as it's possible to reach out to these subjects above when needed I will be satisfied.' 'It is impossible to make very standard rules.'*

### Care at home

There were a number of comments which related to having an efficient and reliable network of care and feeling secure, with contact numbers and regular visits from named workers. There were also comments in relation to **transport** (public or otherwise) being available when people needed it. Home visits were relied on – taxi journeys were described as expensive although ' *sometimes going into hospital/surgery is important'.*

Transport, and mobility, was a factor in wanting more care in the home. *'My husband, who is 90 years old, is my main carer. Without my own transport access to services is difficult or nearly impossible.'*

There were comments that most people would prefer to be at home, provided there is support. There was also a comment about getting help from social services and having a handy man provided '*by the council if no relatives in the neighbourhood it's difficult to fix light bulbs, fasten curtains, etc.'*

Staff also need to know the people they were caring for at home, and support from their GP and practices nurses was considered important.

There was also a comment about the need for *'good'* care homes.

### Caring / dementia

There was a comment that more day care should be available.

*'Towards the end of life it's not always easy for the carer.'*

*'Those with dementia need special care from experience, the only alternative is nursing homes as family cannot cope eventually.'*

*'People with Dementia can and often do wander off outside and forget where they live and where they were going so should not be at home if they live alone.'*

### Communication

The idea of being at home was supported by comments about the importance of communication so that there is continuity of care which could be co-ordinated by community nursing staff, especially as everyone has different needs.

### Equipment

There was also a comment about more and better equipment would help.

A couple of people felt it would depend on the availability of family help.

**GP, practice nurse and community nursing support**

This and support from community and practice nurses for managing at home was considered important (there was also a comment that someone didn't think they currently got support from their practice for this). There was also another comment *'GP has a first class service. Nurses and community matron are superb and very helpful.'* More home visits wanted.

**Hospitals**

Where there were comments about hospitals, this should be local; there was a comment that the local hospital is not interested in caring for long term conditions because of cost to local doctors. There was also a comment about the bus being in the area of the patient for longer – *' hospital pick up bus could be given more time in our area'.*

**Vision**

*'The vision makes sense on paper but not in reality.'*

## Services that people thought could be improved for earlier discharge and independence

Question 10 asked people which services in the local community they thought could be improved to support people to leave hospital earlier and regain their independence. A simple word analysis shows the most frequently used words in the suggestions made.

**Care at home**

People generally wanted their care at home but feel they need more support including better provision of homecare services, 'more support for carers who work 24/7 to care for loved ones.' 'More time for (paid) carers to do their job.'

**Chiropody**

**Community and voluntary sector support**
Visiting charities, neighbourhood watch, police etc

**Day care centre**
Again, perhaps a day care centre, at the CO-OP building where health professionals could be on hand. As well as providing advice on care, it could also provide a bit of physio and social interaction. Ensure they are not left alone for long periods

**Discharge help**
Communication and contact with GP when discharged and support at home for as long as needed. One comment was '*No opinion, as I was sent home the day after my leg operation to a husband who I am his carer. No help offered.'*

**Discharge services**
Improvement needs to be in place prior to person leaving hospital, i.e. social GP, OT community care worker, so as not to cause upset or problems once home.

**Equipment and adaptations**

**GP practice and community staff / home visits**
Help in their own homes, a daily nurse visit. More health visitor services for people in their homes, GP home visits, 'doctors and community nurses based at Doctors'. 'District nurses should be on call as they used to be.' A call 'for the district nurse to be involved more'.

**Home help**
Home help and elderly watch needs improvement. '*Very poor when I left hospital.'* For shopping, lifts to appointments, hygiene, gardening. Positive comments about home care system were seen.

**Home visits from primary care and community staff**
More visits from GPs, nursing and community staff generally. '*Visits by the community nurse, preferably the same face can help who knows about your condition and circumstances. '*

**Local hospitals**

**Physiotherapy**
Shorter waiting times. '*Local physiotherapy services-too long a wait*.'

Joined up care Joined up working between doctors, nurses and social services.

**More staff**
Extra staff

**Occupational therapy services**
Occupational therapy including the local council with regards to adapting better access to housing, etc

**Physiotherapy**
*'More physios, nurses etc, to make home visits possible.' 'Post-hospital rehabilitation and physiotherapy-in home services …'instead of waiting in a hospital bed. 'Waiting times could also be improved. 'More physiotherapy input/falls clinics/training for the care staff in residential homes.' 'Physio at home instead of waiting in a hospital bed.' 'Physiotherapy definitely! '*

**Respite Care**
More local beds available for recuperation/respite care.

**Social services**
Assessments, visits, organised events, more joined up thinking. *'Social workers are not always the easiest people to contact and council telephone systems are a nightmare.' 'I think social services could visit them more and help them depending what's wrong with them and also tell them what special groups can help them. I go to take heart class twice a week and I think there must be other groups that do the same.'*

**Transport**
*'Council run help which I am sad to say had cut backs.' 'Dial a ride transport.'* Comments that transport needs to improve generally; also public transport.

## How important different aspects of health services are to people

Question 11 asked people to compare what different aspects of services are important to them.

| Answer Options | Not important | Important | Very important | Don’t know | Response Count |
|---|---|---|---|---|---|
| Services are easy to access | 3 | 76 | 228 | 7 | 314 |
| Services are available at weekends and in the evenings | 6 | 90 | 202 | 10 | 308 |
| There are good public transport links | 26 | 112 | 141 | 23 | 302 |
| Parking is easy | 13 | 99 | 173 | 14 | 299 |
| The service is close to where I live | 10 | 131 | 153 | 9 | 303 |
| The quality and safety of the service | 2 | 62 | 228 | 8 | 300 |
| Close to other health services eg GP surgery | 16 | 112 | 175 | 7 | 310 |
| Close to other amenities eg library, shops etc | 66 | 117 | 107 | 12 | 302 |
| Answered question | | | | | 328 |
| Skipped question | | | | | 20 |

Further analysis of the responses to the above, weighting* each number of responses against important at all, important or very important allows a more definitive ranking of importance for this group of older, less mobile, people:

1. Services are easy to access
2. The quality and safety of the service
3. Services are available at weekends and in the evenings
4. Close to other health services eg GP surgery
5. Parking is easy
6. The service is close to where I live
7. There are good public transport links
8. Close to other amenities eg library, shops etc

(*not at all important x 5, important x 10 and very important x 15)

Services/ suggestions for improvement were similar to question 10:

Care at Home
Care Homes
Communication
Community care
Day care support / activities
GP / community staff visits
Health visitors
Home visits
Joined up care
More staff
Paid carers
Physiotherapy
Rehabilitation
Respite Care
Shorter waiting times
Social services
Transport

There was also a comment that Redcar Primary Care hospital should have more varied clinics.

## What do this group of people think about not needing as many hospital beds in the area?

Question 12 asked what people thought if, by providing more care outside of hospital, not as many hospital beds across the South Tees area would be needed. A simple text analysis shows that 175 people responded to this – 50% of whom made comments about not enough hospital beds, which is a substantial proportion for this type of question.

## Other comments people made

Question 13 - those answering the survey were asked if they would like to make any other comments about the vision.

In contrast, there were 150 (43%) of people responding to the survey made positive comments about the vision outlined by the CCG, with the caveat that there should be good home care to support it.

## About the people who responded

In all, 348 people responded to the survey.

There were 122 (40.9%) of people had help to fill in the survey document. Note: some responses will total more than the total number of surveys returned and percentage of responses as people could tick more than one option for some questions.

**People living with a long term condition at the time of the survey**

Question 2 asked if the person had any long term conditions. 191 (61.2%) said that they had a long standing illness or condition which affects their day to day activities.

125 (40.1%) of people said they had a long-standing physical condition.

Only 27 (8.7%) said they did not have a long term condition, nor cared for someone with a long term condition.

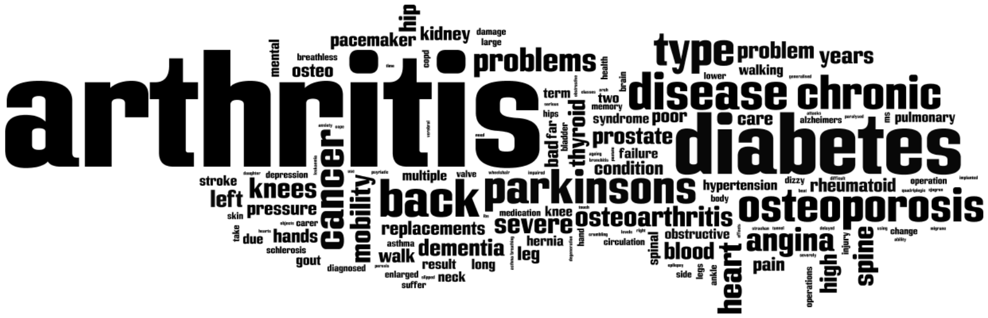
| Answer Options | Response Percent | Response Count |
|---|---|---|
| Deafness or severe hearing impairment | 26.3% | 82 |
| Blindness or partially sighted | 9.6% | 30 |
| A long-standing physical condition | 40.1% | 125 |
| A learning disability | 2.6% | 8 |
| A mental health condition | 14.1% | 44 |
| A long standing illness or condition which affects your day to day activities | 61.2% | 191 |
| No, but I care for someone with a long term condition | 25.0% | 78 |
| No I do not have a long term condition | 8.7% | 27 |
| Answered question | | 312 |
| Skipped question | | 36 |

105 (33.7%) of those who answered said they did not have a long term condition.

People were asked, if they had a long term condition, what these were. They also had the opportunity to identify conditions other than those listed.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| I have had a stroke | 24.3% | 43 |
| I am generally frail (eg. I often fall ) | 29.4% | 52 |
| I live with dementia | 33.9% | 60 |
| I live with a chronic chest problem | 22.0% | 39 |
| I live with a chronic heart problem | 21.5% | 38 |
| Other - please say what | | 141 |
| Answered question | | 177 |
| Skipped question | | 171 |

The question also allowed people to say what other problems they suffered from – they mainly described conditions such as arthritis, Type 2 diabetes, Parkinson's disease, back, mobility and other heart problems. A simple word analysis shows arthritis (and other musculoskeletal problems) to be the most commonly described condition.



## Male/ Female split

| Answer Options | Response Percent | Response Count |
|---|---|---|
| Male | 43.1% | 141 |
| Female | 56.9% | 186 |
| Answered question | | 327 |
| Skipped question | | 21 |

## Age range

| Answer Options | Response Percent | Response Count |
|---|---|---|
| 66-70 years | 15.2% | 50 |
| 71-75 years | 23.7% | 78 |
| 76-80 years | 24.9% | 82 |
| Over 81 | 36.2% | 119 |
| Answered question | | 329 |
| Skipped question | | 19 |

## Ethnicity

317 (98.8%) people described themselves as white (one respondent did not wish to disclose their ethnicity and seven people skipped this question).

## Living at home

(263 (87.4%) of people responding lived at home at the time of the survey.  Ten (3.3%) lived in a relative's or friend's home, 14 (4.7%) in a nursing or residential home, and a further 14 (4.7%) in warden controlled (sheltered) accommodation.

Most people were living in their own home at the time of the survey, and were living in rented accommodation.

| Answer Options | Response Percent | Response Count |
|---|---|---|
| My own home | 87.8% | 280 |
| Relative or friend's home | 3.1% | 10 |
| Care home (residential / nursing) | 4.4% | 14 |
| Rehabilitation unit | 0.0% | 0 |
| Warden controlled accommodation (sheltered) | 4.7% | 15 |
| Other (please say where) | | 23 |
| Answered question | | 319 |
| Skipped question | | 29 |

## Older people caring

(Question 18)  Over half (198 - 56.8%) of those who answered the survey said they provided some form of care for someone.

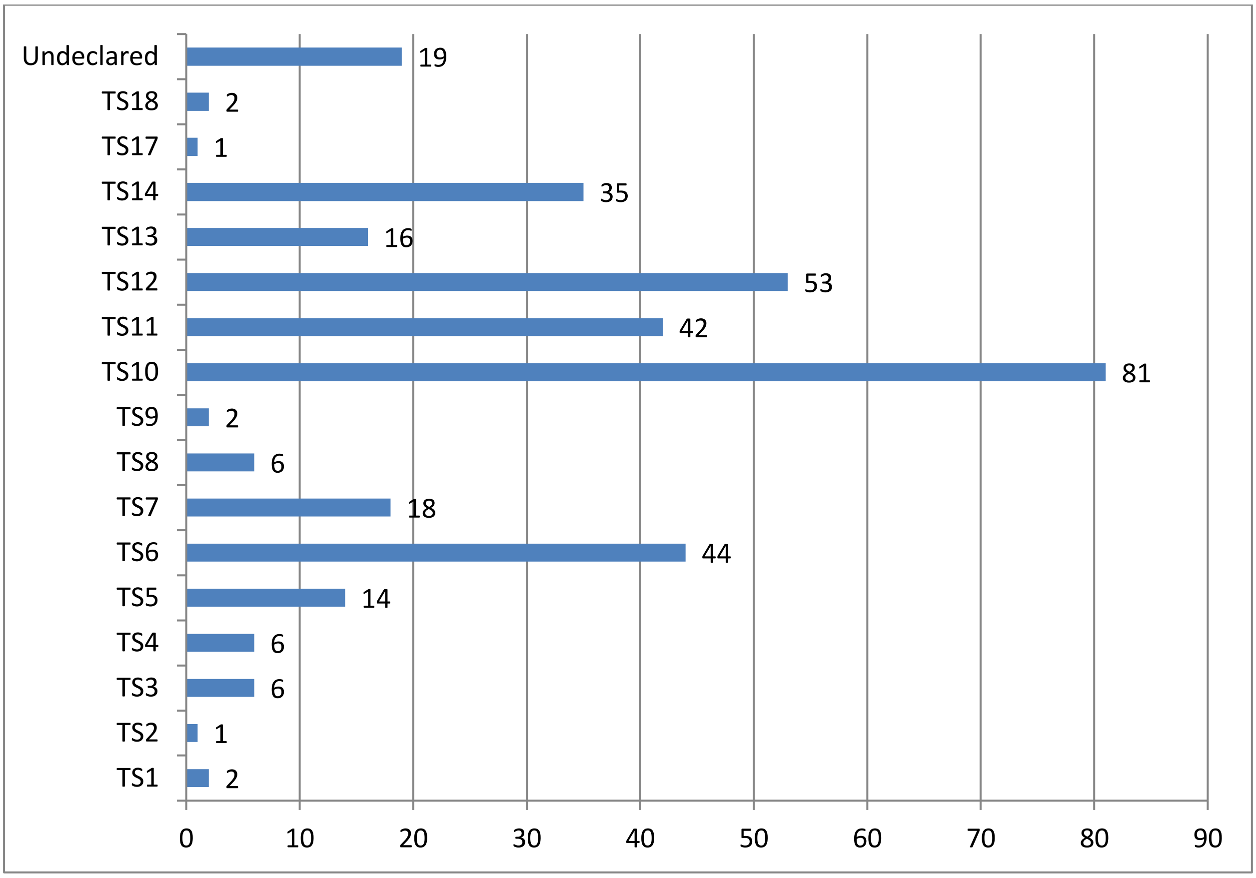
(Question 19) Many who answered the survey in their own right were living with someone who had a long term illness or condition  with 81 (23.3% of all respondents providing care for people with dementia.  (There were people who cared for others with multiple conditions for this question).

| Answer Options | Response Percent | Response Count |
|---|---|---|
| I care for someone who has had a stroke | 29.3% | 44 |
| I care for a frail elderly relative or friend | 24.0% | 36 |
| I care for someone with dementia | 54.0% | 81 |
| I care for someone with a chronic chest problem | 17.3% | 26 |
| I care for someone with a chronic heart problem | 20.0% | 30 |
| Other - please say what | | 108 |
| Answered question | | 150 |
| Skipped question | | 198 |

Other conditions mentioned included Parkinson’s disease and arthritis:

See appendix 2 for the full list.

# Where people lived



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# Conclusions

The aim of including at least 50 people in the target areas was achieved, with a range of different long term conditions, illnesses and other mobility problems being included.

All were also over 65, with as many as 36% over the age of 81.

There is a wealth of information and feedback about each service.

In most questions, there was a proportion of people answering the survey skipped that particular question. There is no evidence that this was not consistent and it is likely this is down to the length of the survey, people missing the odd question and people feeling there was some similarity between questions, and had already expressed their view.

## Conclusions - overall themes

There have been some strongly consistent themes:

‘Appointments’ is an area that people strongly thought could be improved, including access and 1. waiting times.

Many people had arthritis and mobility problems, find it difficult to either give or receive information and worry about whether it’s accurate, whether they are listened to. See appendix 2 for a list of other conditions people said affected their day to day life.

People want to see more information, they want more communication and integration between services and they want more visits and continuity from the people who come to their home, such as the GP and practice/ community staff. There were also comments about involving carers more. See appendix 3 for the many comments made in relation to each question.

There were a number of services suggested that people felt they either wanted more of, or wanted delivered in the home. Examples include physiotherapy, occupational therapy, day care, GP and practice/ community nursing home visits.

There is support for a mix of services venues and for more services in the home, but this requires more staff, networks and information to do this.

Transport was mentioned as an issue, and lack of public transport.

There are some very elderly carers who are getting a variable level of support from health and social services in the community. Some people advised they had no information, out of date information or didn’t know where to go, although the GP usually was a ‘first port of call’.

# Next Steps

The feedback from this survey will be used to help put together plans for the future shape of health services across South Tees, with the input of key partners and stakeholders, patients and the public. These options will be presented to the public as part of a formal consultation process during 2014.

# Appendix 1

## Survey questions and answer options

1. Are you completing this questionnaire on behalf of someone else? Yes / No

2. Do you have any of the following long term conditions? (please tick all that apply)

Deafness or severe hearing impairment
Blindness or partially sighted
A longstanding
physical condition
A learning disability
A mental health condition

A long standing illness or condition which
affects your day to
day activities
No, but I care for someone with a long term
condition
No I do not have a long term condition

2. If you have a long term illness or condition, please say which of the following apply

I have had a stroke
I am generally frail (eg. I often fall )
I live with dementia

I live with a chronic chest problem
I live with a chronic heart problem
Other please say what

4. In the last six months, have you had enough support from local services to help you manage your long term health condition(s)?

Yes, definitely, Yes, to some extent, No, I don't have a long term condition, Comments – what could be improved?

5. Do the different people treating and caring for you (such as doctors or nurses) workwell together to give you the best possible care?

Yes, always, Yes, sometimes, No, Comments - what could be improved?

6. Do you know who to contact if you are worried about your condition or any treatment you are receiving?

Yes, I know who to contact, Yes, for some things, No, Comments?

7. Do you feel you could be given more information or guidance to help you manage your condition or any treatment at home?

Yes, a lot more, Yes, a little, No, I don't need any more information or guidance, Comments – is there a person or organisation you should receive more information from?

8. How well do health and social care staff organise the care and services for local people?

Very well, Not very well, Fairly well, Not at all well, No opinion, What do you think could be improved?

9. Where do YOU think people should receive the majority of their care if they have a longterm condition(s)? For example, people who have had a stroke, frail elderly people, people with dementia and people with chronic chest problems or heart disease.

Mostly from their GP practice and community nursing staff? In their own home? Mostly from their local hospital? A mixture of these? Comments?

10. Which services in the local community could be improved to support people to leave hospital earlier and regain their independence?

11. In relation to health services, how important are the following?

(not important, important, very important, don't know)

Services are easy to access
Services are available at weekends and in the evenings
There are good public transport links
Parking is easy
The service is close to where I live
The quality and safety of the service
Close to other health services eg GP surgery
Close to other amenities eg library, shops etc

12. By providing more care outside of hospital, we may not need as many hospital beds across the South Tees area. Do you have any views about this?

Our vision for South Tees means that more people will be treated in the community and those who need a stay in hospital will be supported to return home earlier.

13. Would you like to make any other comments about our vision?

14. Are you male or female?

15. Age – please tick the category which best describes you:

66 – 70 years, 71- 75 years, 76 – 80 years, Over 81

16. Ethnicity – please tick the category which best describes you:

White, Mixed, Asian/Asian British, Black/Black British, Chinese, Other ethnic group, I do not wish to declare my ethnicity

17. Where do you live? My own home, Relative or friend's home, Care home (residential / nursing), Rehabilitation unit , Warden controlled accommodation (sheltered), Other (please say where)

18. Carer – do you provide care for someone who is elderly or living with a long term condition?

19. If you live with or care for someone with a long term illness or condition, please say which of the following apply (please tick all that apply):

20. Please tell us the first four characters of your postcode: (eg TS1, TS10, TS17 etc)

# Appendix 2

## Other long term conditions and illnesses described by people answering the survey

- *10 years suffering with arthritis, now with rheumatoid arthritis.*
- *A long standing skin condition that cannot be healed because ulceration can occur and I have MRSA.*
- *Acute myeloid leukaemia (breathlessness)*
- *After breaking my ankle both sides and leg I have trouble with some of my house and garden jobs.*
- *After effects of badly fractured hip in 2010. Tumour of the spine diagnosed 5 years ago. I have one kidney.*
- *All boxes ticked apply about my wife. I am a full time carer for her.*
- *Alzheimer's disease*
- *Angina*
- *Angina which is under control, Arthritis in hands, Thyroid.*
- *Angina, high blood pressure, high cholesterol, underactive thyroid.*
- *Angina, Thyroid condition, Visual impaired.*
- *Angina. Gout*
- *Anxiety and migraine*
- *Arthritis*
- *Arthritis*
- *Arthritis*
- *Arthritis (Osteoarthritis)*
- *Arthritis in both legs from knees to ankles. High blood pressure. Take aspirin.*
- *Arthritis of spine and knees. Have had two operations on front and back neck. Now waiting to see Mr * again about lower back and legs.*
- *Arthritis of spine. Both hips need replacing and knees.*
- *Arthritis with poor mobility.*
- *Arthritis worse in hands*
- *Arthritis, back pain*
- *Arthritis, osteoporosis*
- *Arthritis, osteoporosis, Type 2 Diabetes*
- *Arthritis, poor mobility*
- *Arthritis, Sjogren's syndrome, hernia*
- *Arthritis.*
- *Asthma*
- *Asthma/breathing difficulties.*
- *Asthmatic*
- *Atrial Fibrillation - On Warfarin.*
- *Attends classes for very short term memory. Prostate removed, left with bladder trouble.*
- *Back problem*
- *Blindness. Mental disorder*
- *Bowel cancer*
- *Brain damage and lack of mobility*
- *Cancer of the rectum*
- *Car crash victim - impact damage, memory problems*
- *Cerebral palsy*
- *Chronic arthritis with high pain levels. Bad knees. Crumbling spine.*
- *Chronic bad back, walking problems*
- *Chronic Obstructive Pulmonary Disease*
- *Chronic Obstructive Pulmonary Disease, I have a colostomy bag fitted*
- *Chronic Obstructive Pulmonary Disease.*
- *Chronic osteoarthritis and ageism*
- *COPD, Lumbar left neck and right neck, poor blood circulation in feet, osteoarthritis, osteoporosis, vertebral fracture hip, wobble when walking.*
- *Crohn's disease*
- *Crohn's, thyroid, heart valve change twice, bronchitis, osteoporosis.*
- *Curvature of the spine*
- *Diabetes*
- *Diabetes type 2. High blood pressure*
- *Diabetes, hips, knee.*
- *Diabetes, prostate cancer.*
- *Diabetes, prostate condition, breathless and dizzy*
- *Dizziness, irregular heart beat*

- *Due to an accident, my daughter has difficulty walking.*
- *End stage kidney failure. Heart attack - stent implanted. Balance problems. Mental health issues (depression)*
- *Epilepsy since 2001*
- *Five back operations, two knee replacements, diabetes, thyroid, extreme arthritis, aneurism, cholesterol.*
- *Had a bleed within brain. Diagnosed as having vascular dementia.*
- *Heart condition, kidney problems, breathlessness, 2 knee replacements.*
- *Heart problems/breathing. Severe generalised arthritis in all of the body. Diagnosed in April with arthritis in my hand - still not completely moveable. Exceptionally large hernia as a result of delayed reversal after colon cancer 8 years ago. Bad circulation down left side result of melanoma operation in left leg - large graft taken 3 years ago.*
- *Hernia*
- *Husband has dementia.*
- *Hypertension.*
- *I also care for my wife following her strokes. She uses a wheelchair and crutches.*
- *I cannot get up and downstairs. This is slow work and walking getting down to cupboards and dropping things on the floor to pick them up.*
- *I care for my husband who has cancer*
- *I have a heart problem, but not chronic*
- *I have had a long term mental health problem. Also I have osteoarthritis, osteoporosis, and I suffer with parathyroidism.*
- *I have skin cancer and have just had a mastectomy for cancer. I am disabled, had hip and knee replacements, have arthritis in hands and arms and Osteoporosis in spine.*
- *I have spinal stenosis, severe arthritis of the shoulders, collapsed arch of foot, aerial fibrillation.*
- *I have type 2 diabetes.*
- *I have very bad Arthritis from my waist down.*
- *IBS and osteoarthritis.*
- *Incontinence.*
- *Intermittent claudication.*
- *Kidney failure. Stroke. Heart pacemaker.*
- *Kidney transplant. Permanent pacemaker. Type 2 diabetes. Asthma*
- *Leukaemia*
- *Lung cancer and bladder problems.*
- *Lung condition.*
- *Lymphedema*
- *M.S and a quadriplegic as a result.*
- *Macular degeneration. Carpel tunnel operation a failure losing sense of touch plus difficult in gripping objects*
- *Major back surgery has left me unable to walk, but able to cope.*
- *Major spine illness.*
- *Medication for raised blood pressure.*
- *Mobility affected-can only weight bear with use of tripod-left hand side of body paralysed.*
- *Motor neurone disease*
- *MS*
- *MS*
- *Multiple sclerosis*
- *Multiple sclerosis*
- *My husband is 86 and has hypertension which causes him to be dizzy and unsteady. His mobility and ability to take care of himself is severely affected and I am his carer.*
- *My wife had a stroke in 2009 but is 90% ok*
- *My wife has dementia (Alzheimer's)*
- *My wife has dementia and up until two months ago I cared for her.*
- *My wife suffers from COPD. I suffer from chronic back and leg pain.*
- *No but I care for someone who has had a stroke and is severely depressed.*

- *None of these. I have had both hip replacements and lower back pain.*
- *Osteoarthritis*
- *Osteoarthritis*
- *Osteoarthritis. Cardiovascular heart disease*
- *Osteoporosis*
- *Osteoporosis, Angina, Tremors in hands*
- *Osteoporosis, diabetes, arthritis, chronic obstructive airways disease*
- *Pacemaker*
- *Parkinson's disease, Lewy Body Dementia, Anxiety, Depression, Low Mood, Enlarged Prostate.*
- *Parkinson's disease. Paget's disease. Pacemaker*
- *Parkinson's*
- *Parkinson's*
- *Parkinson's*
- *Parkinson's*
- *Parkinson's*
- *Parkinson's disease. Arthritis*
- *Parkinson's, Dementia*
- *Parkinson's, Mind problem, Breathing, Diabetes*
- *Parkinson's. Type 2 diabetes. Serious prostate condition. Catheter*
- *Polymyalgia*
- *Polymyalgia Rheumatica and Gout. Enlarged Prostate.*
- *Poor mobility die to stroke/fall which broke hip.*
- *Psoriatic arthritis, enlarged heart (had 3 attacks), diabetes, pernicious anaemia, stomach cancer in 2011, amputated toe by pass veins in RT. leg 2013, some prostate problem, some (only little) confusion.*
- *Rheumatoid Arthritis*
- *Rheumatoid Arthritis.*
- *Rheumatoid factor RO4LA antibodies gout, type 2 Diabetes, hypertension, Sjogren's syndrome.*
- *Sciatica*
- *Severe active Rheumatoid Arthritis which does not respond to any of the modern "wonder" drugs. Long term depression. Fibromyalgia. Chronic Fatigue Syndrome.*
- *Severe Arthritis and multiple joint replacements.*
- *Severe Arthritis in both knees and I'm unable to walk far*
- *Severe back problems*
- *Spinal injury. Osteoarthritis. Scoliosis. Osteoporosis. Discitis (spinal infection)*
- *Thomsen's disease (linked with muscular dystrophy)*
- *Triple bypass and valve change.*
- *Type 2 diabetes*
- *Type 2 diabetes (medication and diet)*
- *Type 2 diabetes and angina*
- *Unable to walk far due to age related problems eg osteoporosis in knees, soon gets out of breath and also has type 2 diabetes.*
- *Unable to walk far, am using an electric scooter.*
- *Very very breathless*
- *Weak back due to slipped disc 20 years and also problems arising from an ankle injury.*

# Appendix 3 – individual comments

**Comments about what could be improved (support)**

*Excellent support from medical services, stroke association and GP surgery.*

*At the moment I don't need much help.*

*More frequent contact to keep an eye on me.*

*The organisation of appointments and information provided.*

*Local health and social care services seem short on trained carers, especially social workers/OTS. Timescale following assessments? Dementia care.*

*Understanding of OAP.*

*Communication between departments.*

*I am very pleased with the service I get from my doctor and nurse.*

*With previous council care I received, I felt that areas of help should have been more clearly identified, and that information was not forthcoming on what could be offered to assist my mobility, whether council provided or privately.*

*Help with shopping and housework.*

*Good support initially, then it disappears.*

*Waiting times too long*

*Relationship with GP*

*More frequent visits by wardens etc.*

*Had to pay for private care 6 hours a day after surgery left me unable to walk.*

*Only help from GP*

*Carers visits could have been longer than 15/20 minutes and some more helpful rather than filling in forms.*

*Just from the doctor.*

*More practical help in the home.*

*Need more knowledge on what is available to help. Everything to help seems to be a secret. Not even the doctors know what is available.*

*My care is excellent.*

*Social Non Caring Services visited some years ago-first and last question-"Do you have 23500 pounds including your house"-?? Answer:yes-"In that case cannot help you"*

*Liaison with carers is patchy.*

*Doctors who stay long enough at the practice to know and understand my condition and health problems. Our doctors keep changing. (Marske Medical Centre)*

*Haven't needed any.*

*Regular visits from nurse or doctor would be an advantage, only attend when requested.*

*Only get information from doctors.*

*Receiving bathing help twice a week and respite care and day care three times a week part days. No other help given.*

*All help good.*

*I was told that I needed help in bathroom. I was put on the list for a walk in shower along with my wife-she can't get into the bath due to her illness. I got a phone call yesterday saying we have to wait two years.*

*Please see Ralph Brown's Report.*

*The different departments do not interact with each other which confuses everyone. No one department seem to have the full, up-to-date information. Long waiting time between problems being raised and an appointment being made.*

*No complaints regarding doctors. Memory Clinic and GP have been good.*

*Difficult to see the Dr you want to see. A wait of 4-5 weeks is not unusual.*

*To see a doctor you have to ring the reception, then you have a phone call from the doctor but sometimes you cannot explain what is wrong with you yourself. It would be better to see the doctor.*

*The waiting time for an OT assessment was 18 weeks which is too long when the need for more care suddenly changes. By the time professional help came we had ourselves installed a stair lift, wet room etc. We were lucky that our family was able to help us.*

*At the moment everything is stable.*

*The local doctors have been very helpful.*

*Parkinson’s nurse is a good support in James Cook hospital.*

*Availability of osteopathic and chiropody treatment on the NHS.*

*Longer time spent with district/community nurses, more contact from GP, incontinence pads that are fit for purpose and not to have standard, cheaply bought ones.*

*My wife receives visits from COPD matron, at this moment this seems to be sufficient.*

*I have had no reason for their help.*

*After a decade of being accepted for disabled driving, I have now had my blue badge discontinued.*

*I am satisfied.*

*Frequency and duration of visits from Social Services and medical services.*

*More joined up approach. Take a holistic view of family situation.*

*Speed at which equipment recommended is actually delivered*

*Not much support from specialist nurses for Parkinson's*

*Better use of local hospitals ie. More physiotherapy staff. Make use of the endoscopy unit including the hydrotherapy pool at Redcar Hospital*

*Regular physiotherapy is missing*

*Clients not getting time which is paid for staff. Should have more time with clients.*

*Just finished a very good cognitive therapy group. Now looking for further group therapy*

*More frequent calls from 'Home Care' would benefit us*

*We are very happy with our doctor and the service he provides, he has telephoned us when needed and made sure we saw consultants quickly if needed.  It is difficult to get an immediate appointment but he's so popular.*

*I try not to complain; I have given in and have help to clean the house once a week.*

*Now deceased.*

*Problems left knee. Also right shoulder. Had some treatment for shoulder but not effective.*

*It was dependant on person's motivation.*

*My husband has treatment at James Cook.*

*Less red tape. People in authority listening to experience.*

*All satisfactory.*

*Something to tell people to be more patient and give me time to answer the door*

*GP should be more involved in monitoring situation. Young Onset Dementia Team should give more support*

*Doctor is concentrating on supportive measures and seeing me in 6 months*

*I have only needed blood tests.*

*Some assistance in understanding modern technology, reducing waiting times, eg. I have waited over three months to have cataracts removed.*

*We had carers for 6 weeks when changed over, no one would say what it was going to cost and how was going to pay for it, no good having a big bill, so the carers asked not to come.*

*I could not cope if my wife was not with me but I have had a lot of equipment and some monitor jobs to the home and my wife gets 2hrs a week respite. I do feel as well supported as is possible for the moment. Thank you.*

*Local health service, particularly Teesside Hospice have provided excellent support.*

*Satisfactory.*

*More support needed for house bound people, say friends.*

*Appropriate support for coping with continually deteriorating physical condition which impacts on my mental health problems. Six sessions with Talking Therapies is like treating a broken leg with a band aid.*

*Doctors have been very good*

*Still awaiting physiotherapy. Family had to hire a wheelchair. Staff seem to waste hours and hours form filling.*

*Recent client of Carers - exploring flexibility - one size does not fit all!*

*District nurse visits can be erratic. If they could be better coordinated this would help.*

*Local GPs seem reluctant to refer patients to Outpatients for treatment*

*Could and should have had it earlier*

*At the moment quite good health*

*Easier access to GP as it costs me £7.00 to get there so I don't go as often as I should*

*Appointments*

*I manage to help myself*

*I have been in hospital for about 2 weeks but have been discharged. Took about 7 weeks to recoup and had carers in to see my wife. Now I am well enough to look after her and I have to do everything for her.*

*Don't know, have had the problem for approx. 10 years*

*More staff*

*Nothing at the moment but could change soon*

*Quicker visits by Social Services. Assessments could be better managed*

*Reviews of care*

*Stephen Parry (Mental Health Nurse, Guisborough) is our life line. Invaluable help and kindness every time he visits.*

*Homecare assistants should have longer times in the home even if it's just to talk to the person living on their own*

*More doctors' appointments available. A person to identify medication and its specific use. Help with travel costs where patient transport cannot be arranged in time.*

*Nothing can be improved for us. We know that more help would be available if needed*

*Good question but no idea of the answer*

*Very helpful at the time of hand problem, but need the RIGHT people or services for my problems*

*Have had nothing at all. As they was nothing that could be done for me.*

**Comments about what could be improved (people working together)**

*Community matrons and GP Practice worked excellently together. CAN NOT fault GP Surgery, they have been wonderful.*

*Local GP Dr Scott is excellent, but feel we need a bit more from specialists.*

*How can I tell?*

*Getting an appointment with your doctor.*

*If all carers were aware of ALL conditions in the people they are dealing with, sharing information about different evaluation dealt with by various groups.*

*When I call doctor for a visit they don't come out. I get a phone call from practice nurse.*

*They don't see or contact me often enough to really know me.*

*Poor liaison between GP and hospital consultant at times.*

*Waiting to see staff. On occasions it is a straightforward experience but other times it is very frustrating.*

*Link up following assessment to communicate together in a care package and treatment review.*

*Communication.*

*I had a visit from a district nurse approx. every two months. This stopped around April.*

*More staff or any system will not work correctly.*

*Easier to get appointments.*

*Good support from GP but follow up hospital appointment took too long to wait for.*

*More communication needed*

*Communication between professionals*

*More communication between hospital and GP*

*Better communication between hospitals and GP.*

*More communication between each so that they are kept informed of treatment and progress.*

*Life could be made easier if everyone knew what is available, I could have been helped years ago before I became so ill.*

*Again, I receive excellent care-encouragement to do my best and with good communication between all medical staff and receptionists.*

*Ease of seeing above.*

*Again, carers do not always know about contact from Health Services.*

*N/A*

*Doctor rarely visits even when requested, often prescribes over phone. Very little communication between doctor and nurses.*

*Can't always get an appointment when you want it or get through on the phone for ages.*

*Excellent doctors.*

*Waiting time.*

*No link between departments. Different nurses for what used to be the same job. "District" nurse will not do simple task and quotes new rules as being the cause.*

*No follow up by Doctor, nurse and hospital staff.*

*It would be better if all departments communicated more.*

*Very difficult to get appointments with GP. Have to attend another surgery 3 miles away because I can't see doctor.*

*Easier to get appointment with doctors.*

*Improve communication between hospital and surgery regarding changes in medication.*

*Waiting time for appointments.*

*I don't go to the doctors regularly. My husband regularly goes and does get looked after when there.*

*Better appointment service.*

*Nothing. They are very helpful.*

*Left hand frequently does not know what right hand is doing.*

*Better communication.*

*I am very satisfied with the help I have received*

*More interaction*

*Very good service*

*Better communication between departments*

*Maybe a home visit from a nurse twice a year would be a great help*

*I look after someone with long term illness.*

*My wife looks after me.*

*Nurse comes every other day to dress my husband's legs. At present he is in James Cook. I hope he will come back to Brotton hospital.*

*Appointments system made easy to make and understandable to the elderly.*

*Yes, recently decided to monitor diabetes 3 monthly. Everything else is done by nurses.*

*District nurses only contact through GP surgery. Not available.*

*Passing on of information*

*Every unit works in a silo! There should be a one stop shop which coordinates and monitors progress*

*Doctor’s telephone system is always satisfactory*

*Not enough communication between GPs and other staff.*

*More information about one lot of carers, changing over to other carers, more assistance wanted*

*A greater sharing of information between staff.*

*Answer not known but it is important*

*Doctors don't always recognise when the slight but chronic cough I have is changing in character and identifying the increased shortness of breath without activity is leading to Pneumonia. I have twice now reached the stage where sepsis is occurring when admitted to hospital. Sometimes the district nurses delay dressing my skin condition on my legs according to the hospital Dr's directions when it worsens and becomes very painful. I have recurring MRSA.*

*The blind leading the blind. Information from doctors not relayed to family members.*

*Timely communication needed between departments. Notes to be read thoroughly before procedures*

*McMillan nurse is very helpful*

*Local GPs are reluctant to spend their budgets on drugs and services. They act as managers rather than as doctors*

*Also help from Sanctuary Support Group and Woodside very helpful*

*Physio - My wife does not get any*

*More communication between the different people regarding the best possible care*

*Surgeries open longer*

*Communication with each other*

*Sometimes there is a lack of communication between care staff in homes and GPs - and also not enough feedback to family members*

*Could do with always having the same carers. Sometimes people turn up who have no idea of the person's condition. Information has not been passed on e.g. where tablets are kept*

*Access to relevant information when doctors and nurses have a collective review. Results of tests and treatments explained*

*Doctors to be informed sooner with regards to x-rays and scans*

*Appreciation of all aspects regarding how any one of the disabilities effects the other i.e. fitting a hearing aid if one a magnifying glass (10x) to see it and little, if any, sense of touch.*

*Easier access to own doctor*

*As our doctors are always changing I look after my own condition.*

*Having the same GP who knows about your condition and not Doctors who hardly know you.*

**Comments about who people contact**

*Can contact Stroke Association, GP Surgery and can ask to be re-referred to community matron service.*

*Again, local GP surgery very good.*

*Yes, but that doesn't relieve the frustration of waiting so long.*

*Family help by putting together a list of contacts I may need, remind me when appointments are due - talk with family who talk with GP.*

*We should be given appointments in less time than 2-3 weeks at doctors.*

*I have 4 chronic illnesses and my doctor make sure I know who to contact.*

*My wife sees to this.*

*I telephone my surgery with a problem and the doctor always rings back.*

*Don't have computer so don't know how to find out.*

*Consultants told me to go back through GP rather than contact them again.*

*Have written documentation which helps*

*My father cares for my mother who suffers from dementia. She relies on 24 hour supervision. This has been completed by their daughter.*

*Our GP practice is very helpful and vital.*

*No one seems to know who does what. You are passed from one organisation to another.*

*Person form is being completed for no longer has capacity to access any medical services independently-needs me the carer to do this. I am aware of who to contact.*

*My first call is to the GP practice where I am treated with respect and help always available.*

*I would contact my GP.*

*We contact via nurses who put us in touch with the correct people.*

*Probably GP*

*Cardiac Department. Thanks for their guidance.*

*I need to see someone about carpal tunnel. I was told over telephone I needed to make my own appointments.*

*Department rules change with no advice note being sent out to inform patients.*

*Have to go through doctors to get specialist.*

*There needs to be a better, integrated service.*

*Home call service*

*Our doctor will phone us if necessary to reassure us and now a consultant we saw contacted carers together they have been most helpful and the facilities offered to my husband, cookery is great.*

*See Dr Moira Royal, Manor House Surgery who is really helpful. I couldn't ask for more from her.*

*My husband and I have a button, or we would contact the doctor.*

*If I needed a Dr wait anywhere from 2-4 weeks. (Age being a barrier).*

*System complicated. Too much health and safety - Gone mad.*

*Unable to contact myself.*

*Daughter does know contacts etc.*

*Passing on of information*

*Rely on local doctors*

*All depends on what it is. One gets the impression that each individual is only interested in their patch!*

*Doctors are very helpful*

*More help wanted, more assisted wanted*

*Once you have been diagnosed with a chronic condition which affects your energy levels and general wellbeing, everything is put down to that. It took years before anyone considered treating my hay fever even though every spring I turned up at my GP saying I was feeling worse than ever.*

*I cannot recognise anyone be they staff or residents to always tell them is something is bothering me. I tell my daughter and she passes on information to the staff.*

*Constant changing of staff is most confusing.*

*Reliable secretaries save time for all social workers - great at signposting*

*I need help to do these things*

*I do not know the name of my social worker if I have one. It used to be Georgina Willoughby*

*G.P> and staff, district nurses.*

*A written list of contacts/conditions would be helpful*

*Totally confused and forgetful*

*It can prove difficult to access the person you need to talk to*

**Comments about information and guidance that could help people manage their long term condition**

*Mental illness is a subject most people shy away from. There should be more information broadcast about this illness.*

*Note in container on unit in my lounge.*

*Yes, but I don't which person or organisation. That is the problem.*

*There is often frustration about the time spent waiting. Screens in each waiting room would relieve the frustration.*

*A people run information/guidance coffee morning sessions on specific medical conditions, especially dementia.*

*Who?*

*After going home physio ceased and I had no idea what I should attempt. I felt it was a case of once going home that was the end of it.*

*Carers could be given more information about when a condition worsens.*

*Not enough detail given to my problems, and no follow up from appointments.*

*Waiting to see the paint management specialist at James Cook.*

*Information and support is hit and miss. Need a local drop in service.*

*Dad might benefit from someone giving him more information as to the outlook of Mums dementia and what to expect.*

*I was well supported by a Community Matron but her services have now been withdrawn.*

*I would like to know more information on my Husbands condition, dementia.*

*It could be nice if regular "get togethers" for cup of tea and chat with people who have diabetes. Could pass on helpful ideas and encourage those newly diagnosed, who are frightened as I was.*

*Manage OK with help from wife and family.*

*Last year I missed my flu jab and ended up in hospital 26th December to January 6th. Could not get to my doctors for it and was not phoned about it. Same up to now this year but at the moment I am in hospital with broken hip.*

*HELP is needed-not more information.*

*From GP and community nurses.*

*My haematologist doesn't know what causes my conditions but is working well with me to help work this out.*

*We see the GP regularly and know how to contact the OT but have had no contact or help with/from social services. Most of the things we have in place to help us remain living at home has been sourced and supplied by our family. We have even organised 'Home Call' ourselves.*

*How do you know that? If you knew about them you would be in touch with them. Provision of information and advice is very poor.*

*Not for me.*

*I have had to use the DDD service for my wife as her condition can deteriorate suddenly. My greatest concern is that I will leave it too late. I need help to assess her condition before I require emergency services.*

*At this time I am managing with the help of GP and family.*

*Explanations are brief and covered in professional language.*

*NHS*

*The help offered after brain damage until in hospital approximately 10 months later*

*Parkinson's Society*

*Perhaps some counselling for depression resulting from caring for my wife.*

*Most are too busy with more needy cases.*

*Constant information from all departments, i.e. one says eat plenty of one thing another says don't eat the sort of thing each time it is eat this don't eat this.*

*District nurses. Care homes. Nursing homes.*

*Passing on of information*

*Not that I am aware*

*An assessment in the house from someone who knows about dementia*

*Had a couple of falls at home and the Falls Team have been very helpful and supportive with their visits and exercise routines*

*Our Doctor is very good but I feel I could receive more information about my dealing with my wife's problems. I feel that caring is affecting my health.*

*More information from care supporters what it's going to cost, who will pay for it.*

*All the staff who have visited have been very thorough but I rely on my wife to understand what is said and if spoken to alone I can give wrong information.*

*Carer could possibly involved - informed of changes = medication and processes.*

*Social services*

*No*

*I rely completely for my care on the staff at the retirement home.*

*Sometimes I don't understand medical terms and would like it explained in plain English*

*I would not understand. Too much dogma. The mind BOGGLES*

*Difficult to coordinate when there are several complex issues*

*Parkinson's experts, we haven't seen or heard of one in 22 years*

*Arthritis associations*

*Access to podiatry at home*

*No*

*Doctors and nurses*

*MND Clinic*

*Social Services*

*Would like more info re Alzheimer's following diagnosis*

*Social services*

*Carers employed to work with dementia patients should be given guidance on how to speak to and react with patients*

*Totally confused and forgetful*

*We are just being given this information now.*

*Patients to be told about results of x-rays and scans and not to be kept waiting for information*

*Close watch kept on short memory loss by a specialist*

**Comments about what could be improved in the organisation of health and social care services**

*We live in Loftus. Accessing social care is difficult. There are facilities in the CO-OP building and a community bus for transport. A day centre would be marvellous here.*

*My impression is that the care arrangements are pretty good, but I don't I am really in a position to judge.*

*More staff to cope with people's needs.*

*Fewer variety of people.*

*The availability of personal information about where and how to access care.*

*Dementia awareness training - more social workers.*

*Maybe a rare house call from doctor or nurse.*

*At the moment don't know enough about this to comment.*

*There must be more well trained staff to allow people to do their jobs correctly and treat patients in less stressful atmosphere.*

*Longer times for home visits are required.*

*Social workers could be more helpful. They need more time.*

*I felt like a nuisance because I had to chase them up to find out things. The impression is that a lack of funds means they do as little as possible.*

*Patients stigmatised.*

*No help offered for some things.*

*Better understanding of the needs of the old required.*

*Coordination*

*Remittance of payment for care. Organisation won't take payments from VISA Debit card, Cheques not convenient.*

*Services are disjointed. They do not communicate effectively. GPs are not consistent and vary between different practices.*

*GP Surgeries need to see people when patients need to be seen, not told you have to wait 2 weeks for an appointment.*

*More information for looking after someone with dementia.*

*More staff.*

*They need more staff and resources to enable them to give a better service.*

*The care is so poor, I sometimes feel isolated and don't know who to contact.*

*I have no knowledge of health and social care organisation. From my experience of care at my GP practice I would assume it is excellent.*

*Availability and speed.*

*Sorry not impressed at all. Can they even spell EMPATHY.*

*Difficult to comment. Our experience has generally been a positive one but we get the impression that access to services/support is often dependent on the degree of proactivity.*

*Not enough flexibility to deal with individual needs.*

*Not given any information except from doctor.*

*They do a very good job.*

*Have part-time social worker-unable to contact when needed.*

*Social Services more visits twice in one year. My eldest son at times struggles with his special need boy.*

*Social care staff extremely helpful.*

*Given a local visit. Both my wife and I are pensioners.*

*See Ralph Brown's comments.*

*Interaction between departments. Long delays between appointments due to shortage of staff and department restructuring.*

*Time scale, things take so long to sort out.*

*Just a number when dealing with social services, especially the finance department. R&C are a joke.*

*We do not get any social care.*

*Better communication between staff about what is being done and what needs to be done.*

*I really think we need more staff.*

*Nobody tells us what is available so I do not know.*

*Communication between services.*

*We stopped carers' attendance because the office administrators bungled the attendance times.*

*My husband and I care for my 3 batchelor brothers who all have long term health conditions and disability. All 5 of us are over 70 years old. I receive a one hour direct payment for help in the home, it is not enough.*

*More integration of services.*

*Have had no experience.*

*More communication*

*Communications information for people who are not knowledgeable about what is on offer*

*Services are often away from where people live*

*Staff should have more time to do their work properly by spending more time than 2 or 3 minutes with each client, some of whom are spending their whole life savings on services which are not being met.*

*I feel strongly people are better cared for in their own home than going into hospital as many become disoriented when out of their own surroundings as long as carers are given time to do the job when calling on patients living alone.*

*Due to being short staffed, too eager to refuse care at home.*

*Not closing the files on people with a social worker so early, if reopened you have to deal with someone new.*

*Some reject outside help. Some remain ignorant of services available.*

*GPs need to be more involved or Social Workers IF they have the right skills*

*District nurses and doctors are excellent but I don't have any contact with Social Care staff*

*Not enough time given to carers to carry out jobs needed.*

*Have never had social care people.*

*Access to day centres with health care access*

*We have had a lot of consideration. The main problem is the new appointment system for the GP.*

*In our case social care services have not been involved.*

*Over the past 30 years since my wife contracted this disease we have had the occasional help but have managed to cope pretty well between the two of us.*

*More money spent wisely. Short term economies frequently take a toll on extended families. In worst cases the carer dies before the family member they were caring for. More research is needed into the long term implications of caring for a relative.*

*More advice from social workers about the viability of individuals remaining in their own homes regarding finance, adaptations and care options.*

*Many health professionals don't have time for you. Doctors have been good but I would have benefitted from more physio, occupational therapy, community nursing support*

*Staffing levels, information from homes, etc. Care Plans - compulsory family input*

*New to social services - difficult to find out what is available and no continuity*

*A better bus service from our area as it costs £7.00 for every visit*

*Quickness of physio appointments*

*More support for elderly at home*

*Social care services have been good*

*Maybe visit more often*

*At 90 I should get routine contact from doctors and nurses*

*Carers Together have been very helpful and put us in touch social care/telecare.*

*Communication between patients and professionals*

*Unfortunately, because of where we live - Easington near Staithes - we do get the best care possible.*

*Not enough recognition of needs of residents in care homes. Perhaps more unannounced inspections would help.*

*Communication between various organisations*

*We are just being given this information now.*

*In the past well, but they are so busy and have such a tight schedule that visits are VERY limited and ongoing problems keep ongoing*

*More nursing staff required at hospitals.*

**Comments about where people feel patients with long term conditions should receive the majority of their care**

We have had care in our own home from GP practice and community matrons. The team at Skelton have been wonderful and have explained aspects of care and have put us in contact with other health care professionals.

Most people feel safe in their home.

You would recover better in your own home

Need support from all the above so that each one aware of their problems.

Various people can give access to various help or care. It would be good if there could be an average way of accessing all kinds of help.

Colin's GP, and mine, are very good at co-ordinating our care. Colin's GP has spoken to other agencies and nurses about his care.

I think it is difficult to decide where the majority of their care should be. Conditions such as dementia can be very complex.

I have had a fall in August. I have not had any one come from my surgery. I have been 3 times in a taxi which is very expensive.

Help from GP hospital so they can manage at home.

Everyone has different needs. The main thing should be continuity of care with someone that can be contacted when a problem arise whether in hospital or at home.

People would always prefer own home if care was good.

As long as there is efficient and reliable network of care most people would like to be at home. But there must be a feeling of security for the individual with contact numbers and regular visits from named workers.

I struggle to visit GP or hospital due to age and bad public transport.

Depends on family.

Obtaining GP appointment difficult. Waiting times very long.

Vital to help independence.

Hospitals need to be as close as possible to home.

My wife has had a stroke and is now in a care home.

I don't think we get the support from GP practice.

People get better quicker if they are in familiar surroundings and family and friends can visit easier.

Most people would prefer care in their homes.

Preferable people are able to live at home with help available from as many sources as needed and available.

Each person needs different care so it’s impossible to make very standard rules.

We have had to rely mainly on the social workers.

At home if possible.

At home if possible.

It's good when GPs can visit us/me at home but sometimes going into hospital/surgery is important.

It depends on how bad they are but I think most people prefer to stay in their own home providing there is ample support for them.

People must be supported to remain in their own homes. On the whole that would be most people's wishes.

I find my GP and community nurse work very well.

In the home if possible with the community support if possible and the understanding that staff have the knowledge of the patients they are taking care of.

My wife had a major stroke six years ago and I have looked after her ever since.

Primarily in their own home with support from GP practice and community nurses.

As long as it's possible to reach out to these subjects above when needed I will be satisfied.

Home care not sufficiently appropriate or frequent. Family often at a loss to know best treatment.

Too many examples to give a good answer. The individual case needs discussing and a program arranged - not always done at the moment.

I wish to say in my own bungalow if possible for the remainder of my life

More day care should be available

GP has a first class service. Nurses and community matron are superb and very helpful

Initially no help offered from either GP or Social Services although for some time prepared to carry on independently

I am told people receiving care in their home is not a practical proposition though

People with Dementia can and often do wander off outside and forget where they live and where they were going so should not be at home if they live alone.

Keep people in their own homes as long as possible providing they get help from social services and handy man provided by the council if no relatives in the neighbourhood it's difficult to fix light bulbs, fasten curtains, etc...

Those with dementia need special care from experience, the only alternative is nursing homes as family cannot cope eventually.

If GP carried out more patients care i.e. seeing more patients instead of making phone consultations. Then this would mean fewer people going to AE within minor complaints.

Local hospital not interested in caring for long term Diabetes, Lymphedema, Heart, Due to costs to patient’s doctors!

Hospital in emergencies.

GOOD care homes are a must.

In a nursing home for my condition.

Facing the outside is difficult.

Dependent on the availability of their own family to help

Most should be in care homes when they are incapable

Depends on the condition of the person. Towards the end of life it's not always easy for the carer

Getting hold of anybody at the weekend is the most difficult time, the doctors could be on duty at weekend

Better in home if partner can help them.

In my case as a day patient at Teesside hospice medical staff there are main decision makers.

The vision makes sense on paper but not in reality.

There is no simple solution as everyone is different. More and better equipment would help.

In own home if possible - otherwise a mixture is needed

Depends on the illness

More regular visits at home on a regular basis from GP for nursing staff who can spot changes when they happen

My husband, who is 90 years old, is my main carer. Without own transport access to services is difficult or nearly impossible.

If they have to go to hospital it should always be the local hospital

Depends what happens. I will get in touch with Dr and hospitals when transport required

Coordinated by community nursing staff

May be a need to attend clinics sometimes

At home if possible with sufficient caring support and time donated to them

Hospital pick up bus could be given more time in our area

At home for as long as it is safe for the individual.

As long as there is communication between them

Unless going into hospital is for the best

A mixture depending on the condition

A mixture depending on the condition

**Comments about which services in the local community could be improved to support people to leave hospital earlier and regain their independence**
Again, perhaps a day care centre at the CO-OP building where health professionals could be on hand. As well as providing advice on care, it could also provide a bit of physio and social interaction.

Physiotherapy definitely! More support for carers who work 24/7 to care for loved ones.

Care at home to get pulled back to do your own things.

Making their home to fit their needs.

Don't know.

More support in their homes so they can live in familiar environment.

If there could be a group of people who could point people in the right direction to get help on leaving hospital.

GP Services.

Welfare associations.

Day centres.

Social support and organised events with other elderly people.

Social services can do more joined up thinking in organising care at home.

Improvement needs to be in place prior to person leaving hospital, i.e. social GP, OT community care worker, so as not to cause upset or problems once home.

? Tell me.

Help in their own home.

Council run help which I am sad to say had cut backs. Dial a ride transport.

All services.

Extra staff

Visits by the community nurse, preferably the same face can help who knows about your condition and circumstances.

Help in their own homes.

A daily nurse visit

Local nursing staff and doctors

Home care system.

Home helps - for shopping, lifts to appointments, hygiene, gardening.

Public transport.

Doctors and community nurses based at Doctors.

Home help and elderly watch needs improvement. Very poor when I left hospital.

Visiting charities, neighbourhood watch, police etc.

Care at home services. Communication and contact with GP when discharged and support at home for as long as needed.

GPs and Community Nurses

Nursing/daily help care

Help when they get home.

All

Home care.

Sorry I cannot comment, I hope to keep my independence.

More health visitor services for people in their homes, GP home visits?

Visiting nurses or doctors.

Community Nursing.

Home nursing to provide longer visits to patients.  Also, help with practical needs in the home, especially if the patient lives alone.

More Physios, nurses etc. to make home visits possible.

I cannot comment.  I've had most support from Carers Together (Redcar)

From Community Nursing Staff.

More Physiotherapy Units.

Community nursing.

Local physiotherapy services-too long a wait.

Joined up working between doctors, nurses and social services.

Physio.

Social Service.  I have good services from people when my wife was ill.  Thank You.

Satisfied with our experience.

Post-hospital rehabilitation and physiotherapy-in home services.

Care homes to discharge patients into.

Never ask for people to come, I have managed on my own, I am 82 years, I don't know.

Carers.  More community nurses.

In all areas.

Social workers are not always the easiest people to contact and council telephone systems are a nightmare.

I think social services could visit them more and help them depending what's wrong with them and also tell them what special groups can help them. I go to take heart class twice a week and I think there must be other groups that do the same.

Back up generally.

Care visitors.

Plenty of care when leaving hospital.

Specialist nurses to visit on a regular basis.

Have only been resident in this community for the last 5 months so cannot comment adequately on all services.

I find that care workers in the community have not had the training to take care of patients in the home with Dementia and stroke and heart problems.

Not enough information available to make a judgement.

As question 8 - Don't know what is available so cannot comment.

A free to use service for some support without recourse to means tested benefits.

Weekend visiting at GP, Saturday morning if needed.

Chiropody

More time for carers to do their job.

Home physios.

Depending on the individual requirements.

More local beds available for recuperation/respite care.

Visits from Social Services and community nurses. Hospitals decide on home care inappropriately to clear bed space (3 times in this case).

More respite care for people living alone with no carers.

Carers Together - More funding. Dedicated support workers/nurses.

Social services

Community nurses

Local district nurse

Social Services. Occupational Health. District nurses

Transport links to service express service

Occupational therapy services including the Local Council with regards to adapting better access to housing, etc.

More nursing care under the service of our GP

More time for home care staff and maybe voluntary people to help people who live alone.

More information about who to contact

Social Services.

GP Practice

Social Services After care.

Social Service carers should have more time for each elderly or disabled person paid by N.H.S. Then they could be cared for from home with extra help and care free of charge.

Nursing and social services.

Social care services.

More people to help to motivate and encourage.

Home help. Carers - Caring is based on the paid carers and what they are NOT able to do, not the person being cared for.

Social Services.

For the district nurse to be involved more.

District nurses should be on call as they used to be.

Dependent on the availability of their own family to help

Ensure they are not left alone for long periods

Short term care homes

Not enough time given to home care service.

The nursing staff could be improved.

More district nurses easily accessible to link with patients and surgery.

I don't know as I have 24 hours care from my wife so could return home promptly.

Social Services

No turfing people out of the hospital in the middle of the night. Especially if they rely on an ambulance.

Home visits of a more regular nature.

Social services

Local hospitals.

More physiotherapy input/falls clinics/training for the care staff in residential homes.

Physio at home instead of waiting in a hospital bed

More staff in all cases. 70-80 year old people are being exploited.

Short term respite with physio services to enable early return home

Didn't receive adequate care when discharged to a small community hospital

Home Care. It is an excellent service

Social visits to patients and carers

Nursing

Just as long as the carers keep coming I am satisfied with this

Easier access by written information to caring services.

None available

Social Care Service

Community nursing staff numbers

Home carers

Respite care

More help from District Nurses. Better information about help that's available

It would depend individual's needs

Social Services. Health Authorities

Difficult to say for where we live. Carers Together do a good job but Redcar is a 45 minute drive from us.

Help for care at home

The Redcar Primary Care Hospital should have more varied clinics

Better provision of homecare services

More doctors and nurses

Total care

No opinion, as I was sent home the day after my leg operation to a husband who I am his carer. No help offered.

**Comments about not needing as many hospital beds**

An excellent idea to keep people in their own homes, but carers do need advice and help. As I am housebound looking after my husband, it is often difficult to travel to access all the help out there.

I agree, but we certainly need more help to keep these people at home.

I think reducing the number of beds would be a big mistake. What happens if there is, for instance, a flu epidemic or a spate of falls in icy weather?

Don't know.

More staff could change this.

No

Still need beds in hospital but could cope probably with less.

Do not know how it could be improved.

As long as it's not at the cost of trained staff offering the services.

You will always need as many beds as possible in hospitals as a lot of people would be sent elsewhere because of this.

Yes. The concerns are that beds are not ready available. The worry is that some people are definitely better looked after in hospital. But people with good support at home do better.

Many cuts have had a negative impact on care in the community, especially learning disabilities care and support. Dementia care homes inadequate! (Staff trained)?

There should be enough beds still available for anyone who needs hospital care at all times.

Yes it's a good idea, providing that we can get proper care in our homes.

Indeed. Going by treatment in the last 12 months WE DON'T HAVE CARE.

Feel the number of beds should not be depleted too drastically.

As long as this does not mean people are sent home from hospital just to free up a bed.

We do need care outside of hospital - Independence make elderly happier.

The main point is to get services improved and enlarged and running more smoothly before this could happen.

Hospital beds are very important

I find it hard to accept if more home staff isn't provided.

Good

Good. Takes the strain off the hospital services.

Always prefer to stay in their home with familiar settings

Beds will still be needed for emergencies.

Number of beds should not be reduced. They will still be needed.

Would not be enough beds. People sent home too soon.

You don’t need more hospital beds, you need more convalescent beds. Once medical treatment has ceased people should have time to mentally recover and adapt. This is *not* a hospital responsibility.

You are still going to need the beds available.

Minor care units might help GPs and hospitals but they would need to have independent staff

I fully agree that care in the home is more important.

Can’t see this happening due to cuts.

Not enough beds at moment, so more available is most desirable.

Hospital beds are very important.

I agree.

Care outside of hospital is ideal for some, but growing elderly population means beds will still be needed.

We need more hospital beds not less.

Due to aging population, this is unlikely to happen

Don't agree. Never enough beds anyway.

All beds are needed due to long waiting lists at James Cook.

We should try to maintain the beds and improve the service.

More beds in South Tees area

Yes more beds are needed.

KEEP THE HOSPITAL BEDS.

Good idea providing there is DEFINITELY care in the community.

More care outside hospital, do not like hospitals.

By providing more care outside of hospital, waiting lists may be reduced and those who need to be in hospital can be there.

Community care would need vastly improving to take the place of care within hospital environment.

I think there should be as many hospital beds as possible. Is a tendency to discharge patients too soon at present. If day care surgery is possible that is the best. But more serious surgery patients knowing help is at the bedside in hospital can help recovery. It is frightening if alone at home not knowing what to do.

Agree fully but where is the EXTRA care to come from and the money to pay for the extra care and services.

No. I think as many beds as possible is priority.

May be true, but should not be used as a reason for reducing hospital beds till seen in practice.

People are better in their own homes as long as possible.

It is often difficult to get a bed at James Cook so if the number is cut, this will get worse.

Hospital beds must not be closed.

If care could be organised more quickly, this would free up hospital beds.

It is good to know hospital beds are available in an emergency but family and home is very important.

Care in the community is NOT WORKING-majority of care is left to wife/carer.

Do we have faith in nursing home after the recent publicity.

Use small local hospitals (ie-Brotton/Guisborough) for local/easy access treatment rather than James Cook.

We agree that there should be fewer inpatient beds at James Cook-but NOT at local community hospitals which provide absolutely CRUCIAL 'step down' care for elderly people prior to returning home-if you dispense with these, you are likely to end up with MORE pressure on James Cook-which is difficult to access for elderly and frail people.

Makes sense.

Depends on the care given-some areas will be better than others.

I think all the beds are needed in the South Tees area.

More care outside of hospital.

More care outside of hospital.

The number of available hospital beds should be proportionate to local population numbers. Increasing more care outside of hospitals should not affect bed numbers.

This argument has to relate to current conditions, but these are themselves variable e.g. is the present need for beds covered by the number available? If not, is there sufficient care outside available to repair the deficiency? Are there enough external resources-such as qualified staff, funding etc.

I think you do need more hospital beds. We have had to wait two and a half hours once for my wife to have a bed.

If doctor and hospital staff gave you more information.

If you have people in their own homes you could monitor them but I don't think you would need less hospital beds as you would have to provide more nurses to attend people at home.

I have received good care from hospital and community staff.

We need the hospitals we have. There is always a need for more beds than there is now.

The number of beds must not be reduced until the community resources are enough to provide safe and proper care.

We will always need more hospital beds.

Less time spent in hospital the better.

Local hospitals should be used more than they are now.

Beds should be there if needed.

Most patients consider recovering from illness at home is most beneficial. There are too many readmissions to hospital with people in too big a hurry. Take the best advice of the experts and do your best to comply with what they think best for you. Post hospital care is so valuable where necessary.

1. The number of hospital beds should not be reduced until the problem of beta-blocking is COMPLETELY eradicated. 2. More GP led local hospital places needed.

These need to be managed to fit with the demands winter brings but generally that is an excellent idea.

The need for beds in hospital are needed when patients are at their worst of an illness but I feel they are sent home without full support when needed.

This is an unknown quantity, any disaster calls for immediate hospital beds, therefore there should be beds in reservation.

More beds are definitely needed.

There are already shortages so why close more? Putting cost over care will let people down.

More care outside of hospital.

Need more beds and nurses.

Using home visits will ensure that as always useless bureaucrats will slash hospital beds too much causing delays, and inevitably deaths.

I have not had access to a hospital bed since the millennium.

Asking for care at home for long term health conditions does not absolve the NHS of the responsibility to provide beds for cases that require specialist emergency care.

No idea, as it depends on circumstances in each case I would think.

This may help bed shortages.

I would not like to lose our local hospital.

I agree if care could be given outside of hospital, it would ease pressure for hospital beds and visiting journeys.

Home care inefficient - used to clear bed space when patient not fully fit to leave hospital.

Probably OK, as long as the money remains in the NHS.

There are not enough hospital beds available at the moment so there should be no reduction

I agree

If we had more care in the community not as many beds would be needed

Experience shows that sometimes patients are bed-blocking when kept hospitalised; but receiving minimal medical treatment and rehabilitation efforts stopped if difficult under the ridiculous health and safety attitudes

There are not enough beds now

It makes sense for some but not for the very vulnerable

There is no reason that services more close to the people

There is still a need for beds in case of major accidents or an outbreak of flu

I understand that there is already a shortage of beds so why reduce further?

I don't think people who work as carers spend enough time at the cared for person's house. My parents pay for 4 x 15 minutes of care time but only receive 1 x 15 minutes and 3 x 2 minutes to dress, wash, toilet, etc. We're fobbed off with excuses.

You still need plenty of hospital beds

It would save money for the health service and make life pleasant for the elderly to be in their own homes just as it is sure the standard of care they receive at home is done with consideration and keeping the dignity of the patient.

I think more hospital beds are important.

It is important to have a number of beds for elderly who cannot be looked after at home.

Too many is better than too few.

There are too many beds, especially in A&E that are taken up with self-inflicted injuries and conditions such as drug addicts and drunks.

If at all possible, it is beneficial for the ill person to be looked after at home.

There should always be more beds to cater for emergencies.

More hospital beds are needed.

We need more hospital not less. At times patients really need hospital treatment.

Hospital beds should always be available for people  who need them at all times.

Doesn't seem right as hospital is for sick people. They are needed.

Wrong, beds are vital and a lot are waiting for beds outside care helps for better treatment to emergency patients.

I do agree they should have care outside hospital.

Ensure you always have enough beds in case of an emergency.

Would need more varied help not the usual - we are not able to lift, can't put our foot on the walker etc.

Don't know.

In an ideal world it would be better to receive 24hr care at home where necessary even in the short term, but I doubt if this is financially viable even when patients pay for their own care.

No one could know as illness come quickly and beds would be needed.

Patients cared for at home will assist the NHS with bed shortages etc.

Home care must be reliable and easily accessible

Is this an excuse to save costs?

Only if there are social care homes

It sounds right from an accountancy point of view, but it's vital that support is first class - currently it's third class

Being at home is very important but hospital beds should be available when necessary

Beds should still be available, to cut waiting times for operations etc.

Numbers should not be reduced too much, ie beds should always be available.

Sounds correct

It’s alright coming out of hospitals if you have more support at home.

Accidents can happen anytime or place. Would be better if you could know there would be always be an ambulance on call

Beds always seem in short supply as it is. More community help would be needed for people to manage their own homes more.

There is still a shortage of space on certain wards and moving patients is disruptive.

Fully agree with this policy

No

Provided help in available, home is best.

With an aging popular in an area of such high deprivation I consider we will need both the beds in James Cook together with all the beds in the local hospitals. Due to pressure on beds too many grail elderly people go in and out of hospitals repeatedly never staying long enough to get the treatment needed.

Patients with illnesses that have become critical and need oxygen or to be put on a drip to be treated quickly with antibiotics, need hospital care. Retirement homes are not equipped to provide this care, neither are the staff trained to use this kind of equipment. There are not enough care staff employed to monitor critically ill residents.

How would this be funded? Council care homes have all been sold off by our 'Tory Masters'. It's all about money, NOT CARE. How do you link care with profit?

Through assessment seems to be lacking. And there are never enough beds

This is risky so needs to be done properly."Chucking" people out of hospital to create empty beds overloads carers who have other responsibilities and may not be given the right support & information to care properly

This is a good idea in most cases

Great idea

I think we would still need many hospital beds

It costs a lot more money to keep a patient in a hospital bed when you could be at home with support

There isn't enough hospital beds available as it stands without reducing them even further

I agree in general, but I firmly believe that good hospitals provide specialised treatment and/or services, not available in the community (eg GP practice)

Always think beds should be available

Better to be treated at home if possible

Availability of beds is very important. The number of beds should NOT be reduced for any reason.

Excellent. Good for patients and saving NHS money. Staff need to be well trained though.

This would help as there is always a shortage of hospital beds

There will always be a big need for hospital beds. Different factors need to be considered for elderly patients and those with special needs

I think this survey may be trying to close hospitals which would be a very bad thing. We don't have enough hospitals or staff as it is. Always trying to save money by putting more responsibility on families.

Will this affect waiting lists?

Rubbish! There will always be a need for more beds in hospitals; there are more people to cater for and more ailments to deal with.

Staff available to ensure patients’ needs met and people aren't neglected

I know my husband is MUCH better at HOME. More visiting time for nurse *** would be really good.

I don't believe there are sufficient hospital beds available.

As long as the needs of the patients are put first and not performance targets.

There are not enough hospital beds now so by providing more care outside should reduce the number required to a more acceptable level.

We need all the hospitals constantly offering services. We need a transplant unit on Teesside as a matter of urgency

It depends how serious the case is, but really I don't think there should ever be a shortage of hospital beds. However, if a person is well enough to be treated at home and they want to be at home that's fair enough

The main reason for non admission is lack of beds and staff to attend to the patient. Small hospitals/clinics within easy reach would be more helpful

I still think they need as many beds as possible

Beds are in short supply at present and many people are being treated at home now.

More care provided outside the hospital once discharged

In my case I have paid for most of my appliances including a stairlift which was serviced by Social Services but now I have to pay for the servicing. I had to wait so long for a chair and now I've had to buy that.

We need more beds across south tees badly

It is much better to treat people in their own home rather than at hospital.

**Comments about the vision**
Yes, treatment in the community is an excellent vision, but perhaps the community matron service could be extended for those with permanent, life restricting conditions.

I think this is alright, so long as people are not discharged from hospital too early and then need to return.

Don't know.

The health of the people is all about money and targets rather than people's health.

No

Makes sense to get people back to familiar environment.

This is the ideal solution but there needs to be a lot more help available after discharge from hospital.

It is a good vision, but I am concerned as to how we get to that position. As a carer I can see many problems in accessing relevant services. Some people with dementia must be in very vulnerable positions.

I feel people, once diagnosed with dementia or visual impairment, could also play a part and any physical/other problems are not monitored.

Your vision? Is NIL. Come out into the real world.

Feel this would be acceptable to most people.

I agree, help to be independent.

Good idea but do you have the staff??

Good idea but more staff are required.

Excellent

I agree with what you are trying to do.

Whole heartedly agree with vision.

Sounds OK if it works.

I agree.

I fully agree.

I agree.

Jane Booth has been very helpful to us coping.

Depends on the quality of the support.

Whenever I needed help it was given quickly.

Its good idea providing other services such as transport and home care are in place and there is no extra pressure on carers.

A vision is no good without the services in the community. How are you going to provide services with all the cuts that the government are making.

Would be beneficial if support given.

More help needed in the community.

Good vision for the area

Agree

Hope your vision comes true.

A sensible and important concept.

With all the cut backs, due to lack of funds, it is impossible.

None.  Seems good to me.

Good vision!  When is it going to begin?  How about help for the carers.  They are elderly themselves but do the best they can, making themselves ill.

You have put exactly what I tried and failed to put into number 12.

Would say most people want to be at home but want to be confident they will get the help and care.

I agree with your vision.

Would support this view but as in 12, transition should be gradual...don't close wards/beds before need is clear.

Care in the home is far better than in hospital for us as we have been treated badly in hospital.

Vision is good-the practicality of it is harder.  Hospital social workers (although busy) are really good, maybe let down by local authority, social services and private care providers.

The support should be at home and if possible by two people are qualified and one in training.

Returning home early would cause problems for wife/carer-not enough support supplied.

Must have!  A backup of service.

Vision excellent-but do not close small local hospitals.

Fewer stays in James Cook for elderly people-but NOT at the expense of community hospitals-these provide a much better option for most frail/elderly people-specialist elderly services should be run from them, rather than concentrated in James Cook.

Fine if it works-you hear so many stories about how long people have to wait for treatment and also how many are discharged without proper treatment.  A lot more community staff would be needed for this to happen effectively.

I would like this to happen.  People going home from hospital need lots of support.

Question about carers: Would we be allowed someone to help cleaning etc.  (We are receiving pension credits.)

See Ralph Brown's comments.  Thank You.

A better social services department is needed to ensure ALL required services are fully in place before any patient is discharged from hospital.  Social services leave a lot of tasks to the patients' next of kin.

Your vision for the future appears worthy of every support towards achieving a successful conclusion. But see my comment in item 12 above! "Aim for the sky and you may hit the rooftops." Good luck in your effort! I wish you well.

I think some people are sent home far too quickly.

As I said if you have the money and the staff it might work but that depends on the care each individual will get.

It depends how often carers attend and for how long.

A good idea if the resources are sufficient.

I came home from having a hip replacement on 15/10/13. To date had my clips out at hospital seen nobody since.

Good vision.

Nothing wrong with your vision as long as there are the staff to maintain it.

Need more experienced people who really care about the illness and nursing the patient.

A THOROUGH home care assessment MUST be made before hospital discharge.

That must be a priority, with the proper resources this will be achievable and money will be saved in the long run.

It is nice to be treated at home with the support that is needed as long as the services are there when needed and know how to be contacted.

I think people prefer treatment at home but realise this is not always possible.

A good idea, but not optimistic that sufficient resources will be in place or available.

Treatment in the community is better.

More nurses.

Unless it can be guaranteed that home treatment will be of high quality, I fear that the service will be 2nd class with astronomical salaries for executives charged with carrying out this service.

Come off it! You are cutting back to save money.

Depends on the level of support for home recovery and whether family support is available as back up.

No, only try to help where and when.

I agree with your vision and hope it comes true.

I think your vision is right, the elderly like the comfort of home and not having lengthy stays in hospital.

Totally inappropriate. Home care used as an excuse to clear hospital beds!!!

A very commendable vision but a hard task to deliver.

We need a 24/7 NHS. Too many services finish lunchtime on Fridays.

I agree

In an ideal world this would be applicable but this is not an ideal world. Follow up appointments after discharge are continually cancelled

Make sure support is there ASAP

Sounds ok to me

I agree

Vision is admirable. Hospitalisation for other than acute conditions causes distress, patients wish to go home ASAP

Good in principal

Vision is good if the care factors are in place

The centralisation of services increases the time and effort

All departments throughout the NHS should talk to each other (communicate) to create better services for every patient

It is an admissible idea if the support will be forthcoming

The support and help must be carried out not just written down on a care plan and then not carried out properly

Need more support /advice for people who are self-funding, eg access to social workers.

When people go back home they should be very well supported and shouldn't be sent home too soon

I think it is a wonderful vision and workable as long as staff are well trained and selected in the first place for a caring nature.

We agree

Good vision.

I agree that after care from hospital is priority.

Not at the risk of relapse or infections occurring.

If GP surgeries made it easier to book appointments with the doctor this would relieve some of the stress taken up by people attending A&E for minor ailments that doctors are not seeing to.

I support the views expressed above.

You could try removing computer from nursing staff as they have little or no time to attend patients.

More care people need to be employed with adequate time to carry out all duties when visiting people in their own home.

A lot of support in the home will be required and not just dropped off.

GP's should be more accessible to people, instead of telephone consultation.

New hospital at Redcar is totally useless. All they can do is put a plaster on and send you to James Cook hospital BUT TO FIND YOUR OWN WAY THERE.

Please make sure that once the patient is home, he gets sufficient care and attention, especially if he lives alone.

Would have to be very reliable and have to deal with all the problems i.e. lifting etc.

Good.

I believe this is the right option.

There should be more day care centres for wheelchair disabled so that they may meet friends and give their carers a chance to recharge batteries.

There should be more day care centres for physically disabled people to be able to integrate and have a social life away from their carers.

An ideal vision to work towards. I personally received adequate support after a lengthy stay in: teaching me to shower independently, information from the hospital and delivery of frozen meals

Be aware that each patient has different needs

Seems reasonable

It's a good idea but requires more reliable staff which entails a lot more money invested in such a programme

Sadly domestic care in the home is not very good yet this is an important link

It's a good idea

I think it is a good vision as long as enough staff are available to give their time and care in the community.

I agree with your vision but staff levels should be adequate and qualified. Home asssistants should be well trained and have sufficient time with patients.

I agree

Longer nursing hours at home.

Frequent cuts in public services make it unlikely to work.

We do everything for the man concerned. I don’t think he would have it any other way

*Local* recuperation hospitals make life so much easier for visitors and carers where elderly persons have friends of similar age and unable to drive. Travel and parking at James Cook is time consuming and expensive. It is too far from East Cleveland to return home between visiting hours and costs extra because of the long stay parking plus travel costs. Ambulance services are over stretched in East Cleveland.

Would be very good but health and welfare of the patient must come first.

Good "support" is vital.

Provided this is not just another political dream and that help in the home WILL be provided.

I agree.

My mother had a slight stroke resulting in 8 weeks in the hospital even though within 24hrs of admission all the effects of the stroke had disappeared. She is now in residential care for her debenture. It is now almost a year since she had her stroke. For the 2 years prior to that I had fought the health and social care system to get my Mother the care she needed. Immediately Nice authorised medication for middle stage dementia I tried to access this medication for my mother. I spent 2011 and 2012 plugging the gaps in the system caused by financial issues. This has had a massive negative ongoing effect on my health.

Some people need to be in hospital longer so as long as they get support it is ok

I could not cope on my own. Changes in format and new rules abound for what reason? NO ONE knows - management?

Return home is too quick for some patients which puts even more pressure on the carer

There's never any proper communication. We always have to ask all the questions.

As long as patient is looked after with same care at home as in hospital

Depends on individual needs and family or friend support

As long as the after care is good and not left just to the carer

No, I agree with treatment in the community and people staying at home

The vision sounds fine, but unless the envisaged outside support is actually in place, some departures from hospital may be premature.

I think your comments about this good and very important

It depends how bad the situation is

I hope this happens soon!

Support it - but depends on better facilities/manning in the community

Depends on what condition an individual has and how quickly they were recovering. Not everyone is the same

I agree

We are very fortunate we have each other and good family. Others are not so fortunate.

A very good idea to help people - it must succeed

We agree entirely

Not to be sent home until adequate care is put in place.

Timescales need to be improved e.g. 15 minutes is not acceptable

This would seem to be a way of saving money.

More care provided outside the hospital once discharged

As above. Care needed once out of hospital

Good if they do get support.