healthwatch
Newcastle

Listening event 2016
Report

Contents

1. About Healthwatch Newcastle

Healthwatch Newcastle is one of 152 local Healthwatch organisations established throughout England on 1 April 2013 under the provisions of the Health and Social Care Act 2012. We have a dual role to champion the rights of users of publicly funded health and social care services for both adults and children, and to hold the system to account for how well it engages with the public.

We collect feedback on services from people of all ages and from all communities. We do this through our network of voluntary and community sector organisations (VCS), comments cards at events, regular drop-in sessions and listening events at a range of venues across the city, online through the feedback centre on our website, through social media and from callers to our 'Just ask' helpline. As part of the remit to gather views we also have the power to 'enter and view' services and conduct announced and unannounced visits.

2. Introduction

Building on the very positive feedback from our November 2015 listening event, we held a second listening event on 6 July 2016. The aim of this was to give people in Newcastle an opportunity to meet the providers and planners of social care and health services and exchange views between groups who rarely get the opportunity to meet.

3. Methodology

Listening events are one of a range of techniques that we use to engage with the public and gather their views about social care and health services. Attendees are able to raise issues directly with the people who plan and provide in a neutral and accessible environment.

The listening event was held at St James' Park in the heart of Newcastle. It was publicised extensively across the city as a free afternoon event, with parking and light refreshments. We offered help with reasonable transport and childcare costs where this was needed. People were asked to book a place in advance, but were also welcome to turn up on the day.

To encourage attendance from seldom-heard groups, we asked local VCS organisations to bring along their members and service users. A total of thirty-four people took part in the event.

4. Event format

People were asked in advance to sign up for two of eight tables, which were based around the following local service providers and planners:

1. Care Quality Commission, represented by Colin Potter, Suzanne McLeod and Linda Whittemore
2. Newcastle upon Tyne Hospitals NHS Foundation Trust, represented by Caroline McGarry, Margaret Gray and Julie Graham
3. Newcastle City Council, represented by Angela Jamson
4. NHS England, represented by Christine Keen
5. NHS Newcastle Gateshead Clinical Commissioning Group 'care homes vanguard', represented by Jane Mulholland and Marc Hopkinson
6. NHS Newcastle Gateshead Clinical Commissioning Group 'urgent care vanguard', represented by Lindsay Gibbins
7. North East Ambulance Service NHS Foundation Trust, represented by Mark Johns, Carl Bone and Adele Smyth
8. Northern Doctors Urgent Care (VOCARE), represented by Joanne Daglish and Lee Miller
9. Northumberland, Tyne and Wear NHS Foundation Trust, represented by Caroline Wild and Becci Campbell

The role of the organisational representatives was to respond to the points raised immediately or, where appropriate, to note the issue and ensure that the person concerned received a response at a later date. Each table also had a facilitator/note taker to note down key points in the conversations and encourage a broad and inclusive discussion. Discussions were held in two 45 minutes sessions.

5. Issues raised

Below is a summary of the discussions on each table, the points raised by members of the public and the responses provided by the organisations.

Care Quality Commission (CQC) table

1. **Question:** When inspecting services and domains, how do you take sensory loss into account?

   Response:
   - The CQC engages with organisations that work with people with sensory loss and holds public engagement events; information is sent out about inspections in advance so that these organisations have enough time to go to their clients to get their views about services
   - At inspections inspectors speak to a carer or relative of someone with sensory loss to get their views
   - Reports are provided in different formats
   - 'Experts by experience' with sensory impairment are used
   - Signers are arranged if needed although this can be hard when inspections are unannounced (social care inspections); during unannounced inspections in adult social care it is sometimes hard to speak to people with sensory loss due to the unannounced nature and timescales applied to the work, but CQC does try to make reasonable adjustments

- CQC is also doing work relating to the Equality Act and working with VONNE, which has been subcontracted to deliver the Regional Voices work, to look at protected characteristics
- Inspectors are happy to attend local groups if a request is made
- CQC also has an online community where people can give their views

2. **Question:** What work is the CQC doing on the NHS England Accessible Information Standard?

   Response:
   - Work is taking place despite the fact that it does not apply to the CQC; it is working on applying the information standard to its work and to its inspections
   - As part of CQC five-year strategy it is looking to produce summary reports that are written for the public audience

3. **Question:** Some groups aren't linked to organisations so do not have an obvious voice. Speech disability is a group often very isolated. How does the CQC deal with that?

   Response:
   - IPads are used to gather views of people with speech impairments; it also speaks to carers or relatives
   - For domiciliary care it is harder to talk to people due to the nature of the work because it is taking place in people's homes; CQC uses the support of the providers to engage with people in this case

4. **Issue:** The 'North East Care Alliance' used to run open meetings for providers which the CQC attended. It gave providers a chance to talk to the CQC but these meetings are soon to stop. Will the CQC continue them as they are valuable?

   Response: The CQC is happy to go to meetings like that and local groups of providers and CQC workers are often set up (CQC representative provided the questioner with a contact to take this forward with the CQC)

5. **Question:** How do I get the mark of outstanding with a CQC inspection?

   Response:
   - You need to provide examples/case studies/video clips of how you are providing outstanding care going above and beyond the call of duty
   - The CQC national panels really scrutinise reports that say a service is outstanding so examples need to be really good
   - Look at what other services are doing that win them their outstanding mark
   - Examples showing good multidisciplinary working is a good way to provide evidence of outstanding services

6. **Issue:** Some of my employees (social care provider) also work for other providers which is not a problem. However it would be really helpful if other providers were willing to share evidence that an employee has completed training to save resources by not duplicating training an employee has already completed with another provider; I share my training record but other providers do not.

Response: Having an open training record would be a good example to use to aim for outstanding; if it helps you get an outstanding mark, use this to encourage other providers to do the same.

7. **Views passed on about services**
   - Mental health trust — is really good. The professionals sit and listen to the patients.
   - Eye clinic — patient was discharged without telling patient. When patient found out was told that it was because appointments had been missed (but had missed only one appointment). The lack of communication was disappointing and it would have been good for the service to simply be more honest regarding the reason for discharge. When it came to it, there was nothing more that the service could do for the patient. Patient now just sees own optician on Grey Street — an excellent service.
   - Ambulance service — outstanding at engaging with people. Runs regular groups and engagement sessions and its equality and diversity function is outstanding.
   - District nurses and doctors that work with Lincoln Healthcare Ltd are outstanding, and Regent Medical Centre is phenomenal.

Newcastle upon Tyne Hospitals NHS Foundation Trust Hospital table

The following issues were raised:

1. **Pre admission** — patient felt that there was a failure to ask social circumstances questions before admission.

2. **Discharge** — discharge to social care was a problem for one attendee. From a Newcastle hospital to Northumberland was given as an example. There was confusion which resulted in a patient staying in hospital for an extra week until social care could be arranged for him to return home to Northumberland. In addition an assessment can't be done until the patient is ready for discharge. Discharge was on a Friday but Northumbria social care wasn't available until Monday — no weekend support. It was stated that there are examples like this with discharge in Newcastle too.

3. **Lack of coordination of long term care** — a request was made for more joined-up care packages. An example was given about the care costs causing concern to the patient who was not informed of the package costs and when this would begin and end.

4. **Liaison between services** — a request was made to improve the liaison between health and social care, especially on weekends.

5. **Accessible Information Standard** — an attendee said that any work being undertaken to achieve the Accessible information Standard needs to involve groups and patients. It is essential that the implications for patients and providers are well understood.

   Response: Many requirements will be in place but won't be fully compliant by the end of July due to the information technology requirements involved. The trust does have processes in place to record and meet the accessible information needs of patients.

6. **Communication** — several examples were given about the consequences of incomplete, poor or insensitive communication:

   - A patient was upset because she overheard staff taking about her particular condition
   - A patient with a long term condition was informed that her time was up when receiving pain management counselling, which upset the patient
   - There was a request to improve links between GPs and the hospital so that information isn't missing between them
   - There was a request that consultants spend more time talking to patients as they felt rushed and this left questions in patients' minds
   - An attendee raised the broader issue where they felt that consultants do not look at the whole person, which affected their health and wellbeing
   - An example was also of insensitive communication with a patient which caused upset after being told by staff that there was "nothing more we can do"

7. **Nursing** — examples of poor nursing where shared by the group, including a patient's false teeth not being put in a hygienic container, and a more general comment that they had experiences of nurses not knowing patient needs and requirements, or keeping them informed at all times.

8. **Dignity** — some people needed help with feeding during their hospital stay. Sometimes the bedside emergency buzzer isn't accessible to patients. An attendee shared examples of where they had seen a patient's medication on the floor or table.

Main themes from the session

- General nursing care to always follow the 'six Cs' (care, compassion, competence, communication, courage and commitment)
- There should be better communication, especially between hospitals and GPs
- Improve processes between hospital discharge and social care in both Northumberland and Newcastle
- Inform patients at each stage of their long term care

Summary

- It was a positive session and everyone appreciated the opportunity to discuss issues together around the table
- Closer working with interpreters was proposed for patients whose first language is not English
- Admission information would be best shared with an interpreter to reassure patients that they can ask and complain without hindering their standard of care
- It was suggested that comment cards are promoted more with interpreters, to make sure more feedback is heard from those who use interpreters
- The representative from the trust positively took on board patients' views and experiences and provided information when asked, as well as taking notes of particular concerns which would be taken forward as appropriate within the trust

Newcastle City Council table

The following issues and questions about adult social care were raised:

1. **Issue:** A person is in receipt of home care said his regular carer is very good but the administration of the service is very poor

   Response: The current contract expires on 30 September. A new tender specification has been published which includes almost all of the recommendations from the Healthwatch Newcastle home care report. There is a lot of focus on back office procedures.

2. **Question:** Will providers have to comply with the new standards around accessible information?

   Response: Yes, this is included in the specification. The council will also be making providers aware of the new standard and will be monitoring compliance.

3. **Question:** Does Newcastle City Council provide 24-hour support workers to families at risk of having their children removed via care proceedings, as is the case in Northumberland?

   Response: 24-hour home support is very rare and is not currently available in Newcastle. However, things can change and the council is always open to looking at new ways of doing things. Happy to discuss further with colleagues and then to meet up as the long-term aim is always to keep families together.

4. **Issue:** A provider of home care services is finding it very difficult to recruit high quality carers. Caring is not seen as a viable career due to the lack of financial rewards and it is particularly difficult to recruit and retain young people. Many people also find the required training onerous.

Response: Skills for Care could support the development of more accessible training packages.

5. **Question:** How do providers respond to the problems of people who have sight loss plus other additional needs?

   Response:
   - Providers gave examples of specialist support, using tactile resources and communicating through different touches
   - For those with complex needs they always have at least two, and preferably three, staff members trained to support them and provide continuity, but also to cover for holidays and sickness from work

6. **Issue:** When someone was discharged from hospital there was no co-ordination between the hospital and social care. No care was in place and the person ended up on the floor unable to move.

   Response: The hospital social work team should have picked this up — Angela Jamson will raise it with their manager.

7. **Issue:** An attendee's elderly parent didn't receive a visit from the rehab team prior to discharge but the person in the neighbouring bed did. The person felt that ward staff were not always aware of the correct procedure.

   Response: Angela Jamson will ask the hospital Social Work Manager to raise this with Ward Managers.

8. **Issue:** The assessment for post discharge support is not consistent and younger people are often missed; procedures to assess for support needs should be universal.

   Response: Angela Jamson will raise this with the people concerned.

9. **Issue:** The re-enablement service is in chaos, with is no consistency in when they arrive, how long they will stay, what they can/will do and there is no information provided beforehand.

   Response: A care plan should be in place prior to discharge and this usually happens for elective surgery. However, if treatment is non-elective (i.e. unplanned and often urgent), or the patients isn't expected to require support and then does, an assessment should still be carried out and a care plan drawn up and shared with the patient but this may be delayed. However, because the person raising the issue lives in Northumberland Angela Jamson could not say much more.

10. **Issue:** Charging for home care is a very opaque process, it should be common knowledge and it isn't. It is also very confusing as the care clan will only cover certain elements of care and not others. Providers then charge for additional care while social services charge (if applicable) for the other bits, leading to two bills.

    Response: Unfortunately this is what the legislation requires the council to do to do.

11. **Issue:** If a carer doesn't turn up once, the client needs to report this and the care worker can forget to do this (person who lives in Northumberland).

Response: This shouldn't happen in Newcastle, the client is encouraged to inform Newcastle City Council, but the onus to do this lies squarely with the provider.

12. **Issue:** Providers now keep contact with their carers via mobile but this means carers are often taking phone calls during their visit and while providing personal care (person who lives in Northumberland).

    Response: Again this shouldn't happen in Newcastle, clear guidelines about this are in place.

NHS England table

Introduction by NHS England

- It is a national organisation
- There are 440 GP contracts in the local area
- The organisation's role is to ensure GPs provide good quality services
- NHS England is also responsible for dentists, pharmacists, opticians (including diabetic prescriptions), public health services such as screening services, flu vaccinations, etc.
- NHS England works closely with CCGs and decisions are made in partnership between the two organisations

The following issues were raised:

1. **Optical services** — a representative from Deaflink raised concerns that BSL interpreters/signers are quite often not provided, especially for optical services. Information is often written in jargon and needs to be plain English. BSL translation needs to publicised and offered more effectively.

   Response: Christine Keen agreed to look into this. She added that by autumn this year there will be a national standard for information which will address the concerns raised.

2. **Support for deaf patients** — there was a proposal to recruit volunteers from the deaf community to support deaf patients. Interpretation services are very 'hit and miss'.

   Response: Interpreting services will be re-commissioned in the next 12-18 months.

3. **Unclear information** — there is overuse of acronyms in information.

   Response: It may be useful for information to be passed to Healthwatch Newcastle in the first instance before general public distribution in order to communicate better with those who use health services.

4. **Accessible information** — there was a discussion about accessible information for blind/visually-impaired people. A lot of information is distributed in large print but not Braille. There are wide discrepancies in services offered to blind people throughout Newcastle. Larger organisations such as Boots the Chemist offer information in Braille and large print but this may not be financially viable for some smaller independent organisations. Generally, the group agreed that isolation for many people is a big issue.

   Response: The New Care Act (Section 8) highlights issues around sight and isolation and how this reflects on services offered.

5. **Social media** — one attendee is a member of the Parkway Medical Group patient participation group. He commented that there is too much information displayed on social media, internet, smartphone apps, etc. Many people still prefer printed information via letters, posters, etc. Information also needs to be broader as many people would like to hear about general CCG decisions and proposals and not just updates on the surgery.

   Response: Practice Managers meet regularly and this is a time when funding is discussed. However, funding is often offered to NHS at short notice putting added pressure on partners/Practice Managers.

6. **GP Practice Manager meetings** — do Healthwatch Newcastle staff regularly attend Practice Manager meetings?

   Response: Not routinely but on occasion.

7. **Lack of choice** — some people commented on the lack of NHS dental practices.
   Response: There are quite a few dental practices but provision is patchy in some areas. Some NHS dental practices have long waiting times compared to private practices.

8. **Other discussions:**
   - One attendee noted that sign language has different local languages. Production of DVDs for some groups of people may be a good way to communicate. People commented there are very different levels of services offered for interpreting services.
   - There was a request that local people be appointed as interpreters. Sometimes people who require an interpreting service require it at short notice because they are acutely unwell and cannot access services in a planned way.
   - A representative from Newcastle United Foundation offers walking football and highlighted the social element of walking football. Although this is predominantly male-orientated, some women have joined in.

Newcastle and Gateshead CCG table

The following issues were raised:

1. **Mental stimulation in care homes**
   - Mental stimulation can be lacking
   - An example was given of two similarly well-kept care homes, however, one always has activities going on but the other is very quiet
   - An attendee said that there are so many different providers and care home managers, with their own programme with different activities; it is up to individual providers and care home managers to develop activities based on residents' needs
   - An example was given of a resident who wanted to play dominoes but other residents didn't have the mental capacity to play with her
   - The care home research currently being carried out by Healthwatch Newcastle was explained; this will focus on how much residents are involved in shaping the care they receive

2. **Safeguarding in care homes**
   - Staff need to understand their policies; it wasn't seen as good enough to have policies written up and on display if staff members don't know about them
   - A safeguarding example was given, where a care home failed to act. It was escalated to the council, which failed to take action as it wanted the name of the resident (which wasn't known). The safeguarding concern had to go to the CQC to be investigated. It was commented upon that not many people would go this far, and shouldn't have to in order to raise a concern.

3. **Staff in care homes**
   - An attendee's experience of home care staff was that they were very defensive when given negative feedback
   - The importance of continuity of staff was raised
   - There is a need for better staff retention and improved training opportunities and other non-financial incentives (including work conditions and career progression) to encourage people to remain in the same employment
   - It was felt that many care home staff don't feel empowered to do certain tasks, but could if they had more training
   - There was a proposal to share best practice between care homes, which the council is best placed to do
   - There is the need to make some care homes more attractive and 'homely' places to move into

4. **Perception of care homes**
   - Some people fear that social services may force them to move to a care home which they don't want do, so are reluctant to ask for any help
   - It would be useful for care homes to have open days to help improve people's negative perception of care homes

5. **Individualism at care homes**
   - It is important to match individual peoples need to what is provided, for example, an elderly person without dementia being in a care home with residents who have dementia is not appropriate. Residents need stimulation/conversation.

- There was a proposal to match people where possible with similar abilities and what they want to do, although it was acknowledged that not all activities will not be suitable for everyone
- Care homes are needed for specific communities/cultures, for example, Jewish or transgender, that will provide for their specific needs; it was noted that it is common that for people in the Asian community to remain at home and be looked after by their families
- It was proposed that for time efficiency that care homes standardise their procedures
- It would be helpful to support care home residents to runs activities themselves, for example, bingo or baking

6. **Young people with learning difficulties**
   - Support for younger people with serious and profound learning disabilities is severely lacking; help is available only when it gets to crisis point
   - What would happen if carers (parents) of younger person with special needs had to have operation or something else that meant they can't look after him or her — would social services would step in?
   - There is not much support for carers of young people with special needs — some when at school age, but nothing later
   - When a carer visits a GP you are asked how are you but it feels like a tick box exercise and nothing comes of it
   - Carers need to fight all the way — even need to bluff to get action/results.

7. **GP appointments**
   - A point was made that 'one size does not fit all'
   - It was becoming more difficult to get appointment with the same GP, which attendee thought was partly due to having many part-time GPs
   - GP practices need to explain problems/issues better
   - An attendee spoke about a GP practice that decided to stop the appointment system; now people need to queue because people say they prefer a walk-in clinic, but there are complaints about the new system
   - There are different expectations for access to health providers —different countries have different and often private healthcare systems

8. **Education**
   - A point was made that you can educate people about where to go for what service but then people will do what they want
   - A lot of literature is produced about services but do people read it — can they understand?

9. **Technology**
   - Telecare, for example Skype, has been tried in care homes in the south; can be used for care home staff to seek advice rather than have a consultation between doctor and patient, leading to reduced number of GP visits to care homes
   - Smart toilets — analyses waste before flushed away.
   - Some people's expectations are high due to on-demand services and online shopping, so why is it so hard to see a GP?
   - The value of having 111 as a video call was raised
   - The technology exists for several specialist doctors or a GP with a specialist that could discuss a patient by conference call

North East Ambulance Service NHS Foundation Trust table

The following issues were raised:

1. **Question:** Would an ambulance come from Keswick to Newcastle?

   Response
   - If the ambulance was near the border and no other ambulances were nearby, the control centre could ask for an ambulance to come over the border in exceptional circumstances
   - There is a mutual agreement between ambulance divisions to come across the border if unable to meet area demands; the three services are working together for service development and improvement

2. **Question:** Are people who drive the ambulance trained paramedics?

   Response
   - There can be a paramedic crew of two who take turns driving
   - The paramedic driving is clinically trained but is not the clinical lead
   - There is not just an ambulance driver role, all are clinically trained
   - All staff members in frontline A&E take a four week high speed driving course

3. **Question:** What are paramedics allowed to do to defend against attack?

   Response
   - Restraint techniques used by the police are going to be taught in September
   - From a Healthwatch Newcastle perspective, the public should be educated about the need to learn restraint techniques

4. **Question:** What is the difference between urgent and emergency calls?

   Response
   - There is a tiered system used for call priority depending on situations.
   - Red 1 is life threating i.e. heart stopped, not breathing etc.
   - Red 2 is chest pains/strokes which has a response time of 8 minutes from answering the phone.
   - Green calls are less urgent
   - Emergency response calls are always before urgent calls

5. **Question:** What is the ambulance service doing to make its services accessible to deaf people? What about deaf awareness training, use of interpreters and how a deaf person would book non-emergency patient transport?

   Response
   - All ambulance stations have posters in key sites with basic sign language
   - British Sign Language (BSL) has never been integrated into training but, on the suggestion of an attendee the service will look to see if a basic sign language session can be included in the statuary and mandatory training each year
   - It was suggested that each division across the North East have BSL champions and, if possible, they could help during calls where a deaf person is involved

- The current pilot of the interpreting visual relay service at the Royal Victoria Infirmary emergency department was discussed; it was felt that there could be signal and connectivity issues that could affect the ambulance service's use of this when working in rural areas
- The ambulance service now offers a 999 by text service (can be accessed by texting 'register' to 999) but it was felt that there was a need to raise awareness of this: the member of the public reported that they'd heard the service works well and was very useful — more information at www.emergencysms.org.uk
- When patients want to book non-emergency patient transport they are given a letter asking them to call to arrange an interpreter; arranging a method of booking using text or email would be better
- The ambulance service agreed to report back on the work it is doing to achieve the Accessibility and Information Standards and who it is working with to meet these

6. **Discussion about emergency ambulances**
   - People aren't using ambulances appropriately and this is wasting ambulance service time
   - There has been an increased demand for service since licence laws changed; there used to be one call an hour after 2am, now calls are frequent and usually involve fights, drug misuse and are alcohol related
   - Members of the public felt there should be advertising campaigns about when it's right to call an ambulance

7. **Discussion about 111 service**
   - Call handlers are not clinicians but are trained for 6 weeks
   - When experiencing ongoing medical conditions it is best to use GP
   - If an ambulance is called it can just go to GP and not hospital

8. **Issue:** Urgent ambulances seem to take a long time to arrive. A member of the public described a time when they had to wait a very long time for urgent transport to hospital. GPs have reported booking more urgent ambulance responses because they know that the patient will have to wait.

Response
- Ambulances are requested for a one-, two- or four-hour response time dependent on the illness of the patient; unfortunately, the ambulances that usually transport urgent cases are also the emergency ambulances and the priority will always be for emergencies
- If the service can't meet the time frame given, hourly calls are made to see the patient can continue to wait or if another assessment is needed
- The ambulance service now has intermediate tier, urgent, ambulances which are focussed on urgent transport to try to reduce this problem
- When ambulances are booked for shorter response times than they actually need, this just makes the situation worse

Emergency and urgent care table

The following issues were raised:

1. **Issue:** Attendee said he has had to use the 111 service a number of times, but they ask him too many questions each time. He suffers from violent headaches, can't talk or move and his whole body shuts down — why can't they bring up his records? Gets passed to different people

who ask the same questions. Was asked to go to the RVI where he was asked all the questions again. He was asked also for a water sample which 111 did not tell him to take so that caused delays. Why don't the people who ask the questions communicate to each other? Difficult when ill to answer the questions.

Response
- Service will only have a record if it has been used previously; can't access your records because of confidentiality issues and data protection but work is being done on this
- 75% of calls are handled by the call provider but if the call is passed on, each clinician will want to ask questions and won't rely on answers already given
- 111 services use NHS pathways and does not pass information on to hospital, only the GP
- It is a busy service, with around 800 calls on a Saturday
- Proposed to questioner that it would be helpful to wear an alert bracelet if he has allergies
- Attendees were told that 999 is for emergency and 111 for anything else as long as not emergency; best to ring 111 before going to A&E

Mental health table

Issues were raised in relation to the following services:

1. **Community mental health team and supported housing**
   A representative from Mental Health Matters raised a concern about judgments and risks of taking people with mental health problems into supported housing. When they decide to take on a client for supported housing they assume there will be continued support from the

community mental health team. However, Mental Health Matters has instances where as soon as the person is in supported accommodation the community mental health support withdraw services, which changes the level of risk for both the individual and the supported accommodation. Example was given where a person could not be accepted as the organisation was told that once the person was in supported accommodation they will be discharged from mental health services.

Response

There should be a plan defined before discharge to match limited resource to real needs. Proposed that there should be a conversation between provider and managers of support homes to review this risk issue so the benefit of clients and supported accommodation providers.

2. **Deciding together**

Now that a decision has been made, what about next steps and urgent mental health support?

Response

Impatient services' changes will take 'a couple of years' due to building work and funding issues. However, for urgent mental health support, due to the CCG vanguard the community mental health aspect, including urgent mental health support, could be 'relatively soon'. The concern raised will be passed on to Alison or Gail and link Mental Health Matters with them (details exchanged).

3. **Lack of access to mental health services for those with drug and alcohol**

Representative of Creative Support, which provides social care services for people with learning disabilities, mental health and other needs, said that when support for mental health services in Gateshead is requested they are being denied because they have drug or alcohol psychosis and receiving support from their drug and alcohol team. It is felt there is a lack of integration of services or flexibility of these multiple needs. Label of 'drugs and alcohol psychosis' preventing accessed to mental health services. Clients don't go to A&E as they think they will be kept in which don't want. A lack of post-impatient support when leaving mental health hospital care was also highlighted, which heightens the risk of relapses and homelessness.

Response

- **T**he services are integrated with links to drugs/alcohol and mental health services and it is not the policy to reject clients; Gateshead is under strain but it's easy that some juniors can misinterpret the guidance (but this isn't an excuse for bad practice)
- It was suggested to get a second opinion and make a complaint as this is a process which goes to the Chief Executive and can bring changes
- Janet Thompson in Gateshead will be 'horrified' to hear about lack of access to services; it was proposed to link Creative Solutions to Janet Thompson to hear about this important issue

4. **Service users don't use the Crisis Team**

The client base of Creative Solutions in Gateshead **doesn't** use the Crisis Team, as there is a perception that the service doesn't want to help. If clients are on drugs or alcohol the team doesn't come out. In the daytime people are expected to call a GP, and at night-time the Crisis Team can't come out. Another attendee gave an example of a successful intervention of the Crisis Team.

Response

The Crisis Team can't come out at night, as it isn't an emergency service so people need to call an emergency service. It seems there is a misunderstanding between what Creative Solutions and what the Crisis Team service manager do, and a meeting was proposed between them to work better together. The Samaritans service is there to listen 24-7 but the Crisis Team's aim is to prevent people from being admitted (even though the name suggests otherwise and maybe should be named differently).

5. **Visually impairment and mental health:** a representative from Henshaws stressed the link of mental health with visual impairment, especially for those who lose sight either in older age or through an accident.

   Response: It was stated that there are some good booklets made by Northumberland, Tyne and Wear Trust on various topics including depression, anxiety, sleeping problems, etc. which are free and also available in other formats of audio book or BSL videos.

6. **Recovery College:** There was a discussion about the need and value of skills training for people with mental health issues. The Recovery College in Newcastle is a great idea and there's hope a site in Northumberland can be found for another.

   Response
   - Very pleased with the Newcastle Recovery College, which is open to anyone and provides skills training for those who have mental health issues
   - It is presently jointly funded by Northumberland Tyne and Wear Trust and the Newcastle and Gateshead Clinical Commissioning Group
   - People who run the college recognise that it's frustrating there isn't oneset-up in Northumberland yet; there was a discussion about the access challenges in Northumberland

7. **Other discussions:**

   It was agreed that loneliness and depression in older people is more common than is probably known but often people don't want to admit it and seek help.

   A request was made for a carer and mental health support for a child and person was advised to discuss mental health referral with GP; Newcastle Carers Centre in Byker Shields Road can help support mother/carer

6. Common themes

There were many diverse and rich discussions on various themes including:

- Home care services
- Ways to access urgent and emergency care
- Access to community mental health and crisis teams
- Care homes
- Access to GPs
- Training for people with mental health issues (Recovery College)

However, there were some themes which were raised on more than one table, relating to hospital discharge, BSL interpretation, communication and the Accessible Information Standard:

Hospital discharge
- The need to improve the coordination between hospitals and social services for hospital discharge to avoid delays and ensure the quality of follow-up care
- The need for improvements with the re-enablement team once someone has returned home from hospital, as often the team are delayed arriving at patients' houses and are not staying for the full allocated time
- Inconsistent support after discharge has been reported, with instances where the young are not receiving appropriate post-discharge support

BSL interpretation
- The quality of interpreters varies
- Interpreters/signers are not provided for the deaf when using optical services
- Interpreters should be informed about promoting the use of comments cards for service users in hospitals, to ensure that their feedback is received
- That it is difficult to get interpreters at short notice, as not all medical appointments are planned, so suggestion that fellow members of the deaf community could support
- The service will be recommissioned in the next 12-18 months

Communication
- The communication between hospitals and GPs is sometimes not joined up
- Hospital consultants sometimes don't give enough time to patients to ask questions and understand their condition better
- Sometimes too many acronyms are included in written documents
- Although use of electronic communication is valuable, many people still prefer letters and written communication

Accessible Information Standard
- The Accessible Information Standard is important for people who cannot read a standard letter format
- Newcastle City Council are preparing for the standard, as well as ensuring its providers are too
- CQC is preparing for the standard, even though formally it is not required to
- More provision of accessible information from the ambulance service for deaf people is requested
- Some providers will only be partly compliant from July when it is formally introduced
- Braille isn't universally available from providers or pharmacies

7. Next steps

The exchange of views between the public and planners and providers is valuable and this listening event is just one opportunity for this to happen. We expect that those who plan, pay for and provide health and care services to use the feedback gathered at our event, and contained within this report, to inform and improve the planning and delivery of services.

The information will also help to further inform our understanding of the social care and health needs of the citizens of Newcastle. We will use it, along with other feedback we receive, to help set our priorities for next year and inform our decision-making about which areas where action needs to be taken.

We wish to thank the service planners and providers who were open to listening and gave up their time to attend the event. We also wish to thank our Healthwatch Champions who worked so hard alongside Healthwatch staff to help make the event a success.

Finally we would like to thank all the members of the public and voluntary and community groups who attended the event for sharing their experiences and concerns so fully and candidly. Some of those who attended shared very powerful or difficult experiences and we thank them for the openness.

8. Contact details

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