

Thanks -in many respects it looks good.

- Ambition correct
- Reasoning correct
- Comments re divisions/separation correct as far as they go. No mention of the Elephant in the Corner In hours v Out of hours
- How do patients escape? OOH; inadequate information; crisis but without appropriate anticipation ie predictable problem; inadequate info re services ;inadequate provision of services; inadequate practitioner knowledge of what is available; no incentive to follow these principles ie a community disposition as alternatives are easier to organise, and to justify, and quicker, require less input from the practitioner.
  - eg patient at home with diarrhoea, probably infective, otherwise well except she is 98 deaf++ and lives alone with local son to support her; 10pm at night What are the options? No rapid response No community nursing overnight community hospital? patient infective barriers to admission -no idea of bed state no time to admit; Acute admission ? easy to do mention dehydration and that gets round the infective problem or speculate re diverticulitis. No info re services in place no PMH. It seems logical that we should be able to maintain her at home but that is the most difficult option to implement;
  - Elderly lady wandering at 830pm looking for her dog /enlisting police Dog died 5 yrs ago Lives alone no local family. Dementia? probably But ?acute problem or just her usual - no info from patient; No medication in house except old nomad out of date ? hidden so patient cannot self medicate but not available to team either! No data from CPN MH database -too old - SWD system down; Homecare -no data available at this time of night; community alarm -should have one with door sensors to detect egress. Patient has disconnected same- last contact with community alarm 4 months ago-reconnect alarm and wing it! 11 phone calls and 2hrs required to complete this call. Easy option confused elderly lady probably toxic confusion requires 1x admit Acute overnight; Safe and short. Minimal effort required. but a poor outcome for her and the service.
- As long as Primary care is divided into various segments and there is no coterminosity or responsibility or information all the integration in the world will be of limited effect.
- Problems often occur soon after discharge with a recent admission and no data available from it
- Patients with Palliative care diagnoses often do not have appropriate advice re status; no medication in house to deal with crisis; no info on system to inform re status despite epcs being available; Team members cannot administer opiates despite the fact that we know that is what the patient needs but regulations/protocols do not permit it. GP needs to visit just to admin Morphine. or in another case Team not happy to visit because patient has DNR and probable MI so if not going to admit cannot admin morphine only when persuaded to visit discovered DNR not in place at all! so MI treated with morphine and admitted! Palliative care Patients transferred during the day from NW to GPCH -not seen by GP after transfer-no baseline-no strategy available- no symptomatic relief policy and no anticipatory care drugs to deal with the crisis at 3am 1st night. No DNR cert in place
- We need to be careful that outside the joint budget there may be ways of caring for the patient without using this budget which are perversely incentivised because they cost nothing! It needs to be a complete envelope otherwise it will not work.