FINAL RESPONSES

Healthwatch Leicestershire Quarterly Meeting with Chief Executive of University Hospitals of Leicester

23 September 2015

Questions from a Patient Perspective

Healthwatch have compiled the following questions informed through engagement events, the information & advice service including drop-in clinics and other sources; news, journals, reports.

The themes are grouped by 'Caring at its Best' standards, which outline the essentials of care for patients in UHL Hospitals the services that all patients should receive in every department/area from all members of staff working together.

For each question background information has been included to provide the patient experience or context to what is being asked. Links to websites and documents relevant to the questions are also provided where possible for your information.

The meeting was an opportunity for local people to receive answers directly from CEO John Adler on behalf of UHL about services provided at Leicester Hospitals.

Theme: Promoting Health

Question 1	**Voluntary Sector Support and Services** 1. Will the Chief Executive consider any financial support towards helping to sustain the health activities that promote improved quality of life for local people with long-term chronic arthritis?
Background	For 9 years, CLASH 2012, a user-led charity, has been providing health and well-being services including: hydrotherapy, yoga, free seated and general exercise classes, a welfare service, a Drop-in and Basic computer sessions for people in the city and county living with arthritis. The charity is now facing the possibility of closure in the coming 12 months. The number of rejections for funding applications is at an all time high. Closure will mean all our member services will finish and the work we do with Intern placements, as a De Montfort University Graduate Champions Host Organisation will cease.
Response	The Head of Fundraising at Leicester Hospitals Charity writes: Leicester Hospitals Charity funds support for patients whilst they stay with us in hospital. Funding activities outside UHL would be a departure, which would require the agreement of the Charitable Funds Committee. In terms of the charity referred to - CLASH 2012 - we would be happy to meet with them to discuss their predicament.

	They might also want to talk to the Development Office at De Montfort, and to the Leicester Leicestershire and Rutland Community Foundation, who might be able to signpost them to alternative sources of funding.

Theme: Documentation | Communication

Question 2	**Data Storage and Access** 1. What are the arrangements for keeping patient records in relation to MRI scans?
Background	A HWL member has asked why have her MRI notes been destroyed? We understand that the radiologist will send a report to the doctor who arranged the scan, who will discuss the results with the patient. Unless they are needed urgently, it usually takes a week or two for the results of an MRI scan to come through. Source NHS Choices
Response	' MRI scans and the consultant's report are stored on the Trust's Picture archiving system (PACS), all scans and reports performed in the Trust are archived and none have ever been deleted. A paper copy of the report may be destroyed as part of the medical records destruction policy, but this is not the primary record of the MRI or the report which are both held digitally. ' If the patient would like us to follow this up directly please would Healthwatch provide their details.

Theme: Privacy and Dignity | Caring for Patients' Emotional Well-being

Question 3	What is UHL doing to support survivors of Female Genital Mutilation (FGM) in the city and county? In particular: 1. What support services exist? 2. What are the referral pathways? 3. What training do staff have to deal with survivors? 4. How many girls and women have accessed services in the last year?
Background	A HWL member has this question. **Female genital mutilation (sometimes referred to as female**

	circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK. It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime. The girls may be taken to their countries of origin so that FGM can be carried out during the summer holidays, allowing them time to "heal" before they return to school. There are also worries that some girls may have FGM performed in the UK. In February 2014, the UK government announced plans to part-fund a new study into how many women and girls living in England and Wales are affected by FGM. This was part of a wider commitment to preventing FGM during the International Day of Zero Tolerance for Female Genital Mutilation. (**Source NHS Choices)** http://www.nhs.uk/Conditions/female-genital-mutilation/Documents/FGM_June_2015_v10.pdf https://www.gov.uk/government/publications/female-genital-mutilation-guidelines
Response	1. We provide a specialist clinic for women with FGM in Leicester i.e. the FGM clinic. 2. Currently the referral pathway to this clinic is a) via the community midwife if pregnant, b) by the GP if not pregnant c) rarely by another specialist service e.g. GU or paediatrics if not pregnant. I have been trying to get self referral to the clinic and have attached a business plan which was presented to the commissioners last year, but because of the lack of exact figures how many more women would attend the clinic it was not accepted, although there was an interest and I will pursue this. In the business plan it explains what is done in the clinic, so I won't get into any details here (the clinic complies to national standards set up by the RCOG, but in fact was set up before the guideline was developed). 3. Regarding training: Ann Buckley and I do a regular teaching session for junior doctors at the Friday afternoon regional teaching. The junior doctors are encouraged to attend the FGM clinic. The midwives receive teaching at their mandatory training day. Ann and I have

	given workshops and teaching sessions for a mixture of social workers, teachers and health care workers within Leicestershire in conjunction with SAFE. There is also a UHL maternity guideline for FGM. 4. 1st January 2014 - 31st December 2014: 34 women attended the clinic. 1st January 2015 - 31st August 2015: 40 women attended the clinic. I don't know how many women have not been referred to the clinic by the midwives (I suspect a small number) and how many have been seen by a different Gynaecologist (again I think the numbers are small as most of my colleagues seem to refer them to me if they slip through the clinic coordinator net). NB: answer supplied by Cornelia Wiesander, UHL Consultant.

Theme: Caring for Patients' Emotional Well-being | Nutrition

Question 4	Patients spend a short amount of time in hospital and their patient experience is important. 1. What is the audit regime for monitoring the Interserve contract for estates and facilities? 2. What sanctions are there for failing to meet the contract? 3. If, during an audit of services, a contract specification is missed, is the next audit date brought forward to check if improvements have been made?
Background	Interserve is the provider the NHS with estates and facilities services. http://www.leicestermercury.co.uk/Interserve-seeking-300-million-NHS-contract/story-26230964-detail/story.html http://www.leicestershospitals.nhs.uk/aboutus/our-news/press-release-centre/?entryid8=14493
Response	Interserve Facilities Management Limited (IFM) produces a monthly performance report, which includes their Key Performance Indicator results. The Estates & Facilities Management Collaborative (EFMC) audit the evidence provided by IFM to assure the organisation. The EFMC carry out routine joint and ad hoc audits covering specific areas including catering, cleaning, portering services, which are

	reported to the Contract Management Panel. EFMC undertake a follow up audits to ensure issues have been addressed. The contract includes a robust financial payment mechanism, which is invoked when standards are not met.

Theme: Personal and Oral Hygiene | Caring for Patients' Emotional Well-being | Communication | Pressure Area Care and Mobility | Privacy and Dignity

Question 5	**Special Needs and Disability** Members of Leicestershire Family Voice have worked with UHL in the past to improve their disability awareness but despite many promises being made by the Trust not much has changed. We would, therefore, like to ask the Chief Executive the following: 1. When are UHL going to fit Changing Places toilets in their three sites? Parents who are visiting LRI can use the disabled changing areas on Ward 14, but this is not ideal and, in any case, does not solve the problem of changing our children when we visit Leicester General or Glenfield. At this stage, provision of Changing Places toilets has not been included as part of the new EF floor. We will ensure it gets raised at the next Project board for consideration. In addition, as part of the reconfiguration of the acute sites, we will: 1. Ensure the project team leading the development of the treatment center include this function within the general circulation space next to the main outpatient facility 2. Ensure that the team developing the 2 acute sites model write the operational policies for wards to include the provision of a combined function to meet the needs of changing places and bariatric patients 2. Could we have confirmation of the agreement made that any parent/carer can stay the night on the adult ward with their 16+ Young Person? This has been agreed, but many staff don't seem aware of it. The UHL Carers Charter was launched in the Trust in May 2015. It promises carers support, recognition and involvement in the care planning and discharge planning of their cared for person during their stay in hospital. Part of this charter is that the carer is offered an involvement form to complete, this identifies the level of involvement that the carer would like while the person they care for is in hospital. As part of the

	initiative the visiting element has also been changed to allow for carers who wish to remain during the day to do so. With regards to staying overnight it is agreed on an individual basis depending on the patient's needs. If the patient requires familial support /care overnight we would always try to accommodate this. We have recently purchased some Z beds that can be accessed by families if available. If families are not being allowed to stay overnight, could you contact The Learning Disability Acute Liaison Nurse Service for advice on what to do. Their contact number is 0116 258 4382. 3. Will the Hospital Trust continue to ensure that all Childrens' Out Patients (OP) Units have high tables so that our children who use wheelchairs are able to play? We will review the requirements to ensure that we have enough high tables so that children who use wheel chairs are able to play when visiting out patient department. We do try to provide facilities for play for all children that attend our out patient department. There is always a play specialist available to support children and families. Please ask for the play specialist if you feel that there is not the required high table available and they will be more than happy to help provide the correct equipment. 4. It was agreed over a year ago that there would always be a member of staff with an awareness of autism and learning disability on every shift at LRI A&E. This doesn't seem to have happened. Could the Chief Executive please confirm that it is being enacted? It would also be ideal to have a Youth Worker in all of the UHL hospitals, during working hours. Our Specialist Learning Disability nurses are always available for advice to support staff within working hours. In addition to this there are always staff in the children's emergency department who are familiar with Autism. It is acknowledged that this may not always be the same within the adult services. In order to resolve this, the Matron and specialist LD nurses have agreed to look to provide additional training regarding awareness. Hopefully this will be achieved by the end of the year. 5 We feel that it would be extremely useful for all UHL staff to have a CAMHS-LD emergency out-of-hours phone number available. Please could the Chief Executive arrange this? UHL staff is aware that CAMHS team can be contacted out of hours via the UHL Duty Management Team. This includes

	learning disability patients. The adult Learning Disability Outreach Team work until 9pm at nights to provide telephone support etc. for crisis. The Adult Mental Health Crisis Team provides an out of hours service for support as needed. We have ensured that our Emergency department and switchboard are fully aware of these so can be easily accessed by staff if needed. 6 It would be very helpful if there could be a ward specifically for 14 -25 year olds. This age-group are too old to be on a Childrens' Ward but also too young, really, to be on an Adult Ward - especially if they are learning disabled. They need their own Ward and, ideally, their own A&E service. This was discussed and agreed in principle some time ago, but nothing has yet happened. It would also be helpful to have a 'teen' section in all Out Patient clinics so that our Young People don't have to sit with small children. Children's Services provide care up to a patient's 16th birthday with some exceptions based on individual clinical needs. The Children's Hospital is including in their plans for the new Children's Hospital facilities to meet the needs of the different age groups up to 16. This is being considered in the context of meeting the child's specialist health needs. The Trust is also considering how best to meet the needs of the 16 to 25 year old; again in the context of both the physical environment and the specialist health needs. A Trust group to look at the transitional care arrangements from children's to adult services will help guide future planning. 7. Could the Chief Executive confirm that there will be more disabled parking? At the moment, it is very difficult and somewhat dangerous for parents to have to manoeuvre their disabled child out of a Wheelchair Accessible Vehicle in the LRI car park. A new multi-story car park is currently under construction at the Leicester Royal Infirmary creating more disabled parking which is due for completion this winter. The ground floor will be exclusively for disabled parking providing an additional 21 bays. There will also be an additional 417 standard parking bays. 8 Could there be an agreement with all OP staff, at the various OP Clinics, that they Fast Track patients with autism? For these patients, the hospital situation already leads to considerable anxiety; long waits just make this worse. When we are aware that a patient requires to be seen at a particular time or needs specific support when attending

	hospital we would always endeavor to do this. It works well when the Acute Liaison Nurse is contacted in advance of the patient attendance so that appropriate arrangements can be put into place to minimize anxiety and stress.
Background	Questions from Leicestershire Family Voice, the Parent Carer Forum for Leicestershire, which represents the parents of children with Special Needs and Disabilities.

Theme: Communication | Promoting Health

Question 6	**Falls Prevention Programme** 1. Can UHL provide information on a programme to help people avoid having falls?
Background	http://www.leicestershospitals.nhs.uk/aboutus/departments-services/physiotherapy/physiotherapy-services/medicine-and-ae/ Specialist Falls Service - clinics, individual treatment and falls prevention programme.
Response	UHL runs a Specialist Multi-disciplinary Falls Service/Clinic at LGH for City patients. GPs have full knowledge of this and regularly refer patients to the service. Referred patients are seen by a Consultant or Registrar and then discussed with therapists with onward reviews by therapists, investigations as deemed necessary. This includes advice on falls prevention and, potentially, enrolment on UHL's Falls Prevention Programme. Comparable services run in the County at Loughborough, Melton, Market Harborough, Oakham & Hinckley. The Consultant input for these is provided by UHL but the Falls Prevention work & therapy input is provided by the locality and is variable. Thus information about this can be obtained from these localities. There is a piece of work underway at present, with Dr Lakhani's involvement, to try and 'revamp' these services across Leicestershire to improve the services provided for the population of LLR.

Theme: Communication | Documentation | Caring for Patients' Emotional Well-being

Question 7	**Cancer referral times** 1. Why is UHL breaching the two-week wait for cancer referrals?

Background	The Chair of the PRG at Latham House, Melton Mowbray has asked the question as they experiencing this problem repeatedly. Achievement of the national cancer waiting times (CWT) standards is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organizations deliver. Delivering timely cancer pathways is crucial for the following reasons: Despite improving survival rates, cancer is the Fourth leading cause of death in the UK; Patients continue to present late to their GP with their symptoms, resulting in delayed referral; There is variation in2 week wait(2WW)referrals across the country suggesting that GPs are not always identifying suspicious symptoms; Once a patient has been referred, they want to be told "It's not cancer" as soon as possible or have their treatment planned in a timely manner; Where the diagnosis is cancer, a speedy diagnostic pathway is critical for 62-day compliance. Despite consistent achievement of the cancer standards at a national level, it is recognized that many organizations either struggle to maintain compliant performance on a consistent basis or achieve below standard performance. Source: http://www.england.nhs.uk/wp-content/uploads/2015/03/delivering-cancer-wait-times.pdf http://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Response	As the table below indicates, UHL is comfortably achieving the 2WW standard in all tumour sites with the exception of Gynaecology, Lower GI and Upper GI, with Lower and Upper GI significantly underperforming. The reasons for underperformance in Lower and Upper GI can be attributed to the current performance issues being experienced in Endoscopy. For these tumour sites, the first appointment following an urgent Cancer referral is usually a scope and access to this service is currently significantly hampered. The issues currently faced include in adequate capacity to meet the demand and admin processes that require significant strengthening. Actions that we are taking in order to reverse this trend and improve performance in Lower and Upper GI

cancer pathways more generally are detailed in a robust action plan for Endoscopy, which is being monitored by the Director of Performance and Information. This action plan tackles administrative processes and includes the introduction of an electronic scheduler, nursing shortages and revising the Standard Operating Procedure (SOP) to ensure that Cancer patients are appropriately prioritised. The service manager for Endoscopy has been given the authority to unbook scope appointments for non-Cancer referrals in order to prioritise 2WW referrals. Additionally, as a short term fix, the Endoscopy department is putting on extra capacity to help reduce the backlog at weekends and in evenings.

Gynaecology also has breached the 2WW standard for 2015-16 YTD. While coming a lot closer than Lower and Upper GI, the reason for failure is patient choice, as there are rarely capacity problems within the service. As many patients coming through the Gynae 2WW pathway are young women, they are often unable to make the appointments offered within the two-week window. This points to the importance of on-going work with commissioners and the GP community around preparing patients fully for urgent Cancer pathways upon original referral.

As a Trust we are confident that achievement of the 2WW standard in Lower and Upper GI is in our gift, as improving Endoscopy is a key priority for the organisation. Ultimately, improvements in Lower and Upper GI will mean that the 2WW standard will be achieved at Trust level. Collaborative working with commissioners and GPs to improve patient preparations for urgent pathways will continue to encourage Gynae patients to attend appointments sooner.

Tumour site	**YTD performance 2015-16 (target = 93%)**
Breast	96.3%
Children's	97.7%
Gynaecological	91.3%
Haematological	95.7%
Head and Neck	93.5%
Lower GI	64.9%
Lung	94.7%
Sarcoma	98.6%
Skin	95.9%
Testicular	97.1%
Upper GI	78.1%
Urological	95.5%

	Total	90.1%

Theme: Communication | Documentation | Caring for Patients' Emotional Well-being

Question 8	**Process for referral** 1. How does the process work for shared care agreements and what are the timescales?
Background	A new HWL member from our Community Conversations at the Loughborough Mela 16 August is very concerned that she does not have her medication and has been waiting for 2 months because of a delay. Her GP won't prescribe the medication her consultant recommends because the consultant needs to send the shared care agreement. This has not happened.
Response	Shared care is the mechanism of sharing patient care between primary and secondary care providers. A shared care agreement outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber. The shared care process in Leicesteshire is co-ordinated by the Leicestershire Medicines Strategy Group (LMSG) working on behalf of the three local Clinical Commissioning Groups (CCGs) and the two NHS Trusts (UHL and LPT). Leicestershire Health Community operates a Traffic Light system as a way of classifying appropriateness of prescribing of drugs across the community. Red: Drugs that should be prescribed only by secondary care clinicians. Amber: Drugs that would initially be prescribed by a secondary care clinician and then by a GP. Green: Drugs for which GPs would normally take full responsibility for prescribing and monitoring. Black: Drugs not recommended for use in the Leicestershire Health Community Shared care involves the prescribing of Amber drugs. If specific on-going patient monitoring or intervention is required a full shared care agreement will be produced, if general patient monitoring only required drugs will be classed as simple amber.

	For full amber drugs the specialist initiates treatment and, if it progresses without concern, once a stable dose is reached a request is made to the GP to prescribe treatment. This is done by fax using the Shared Care Agreement Form (for transfer of care to GP). GPs should respond within 10 working days and the initiating specialist must secure GP agreement, prior to transferring shared care and informing the patient. The intention to share care is usually explained to the patient by the prescriber initiating treatment. For simple amber drugs, treatment is initiated and if it progresses without concern the specialist notifies the GP of Simple Shared Care using the SCA GP note. The onus is on the GP to inform the specialist if they feel unable to take on the prescribing. GPs are expected to undertake shared care for LMSG-approved AMBER drugs subject to specialist compliance with shared care processes and SCA, and GP clinical confidence to do so. However, primary care prescribers are advised not to take on prescribing of these medicines unless they have been adequately informed by letter of their responsibilities and are happy to take on the prescribing responsibility. Prescribing responsibility remains with secondary care until shared care has been agreed. There are a small number of instances where the agreed process fails. This can be due to failure to send a shared care request to the GP, incomplete requests being sent or requests to share care where the drug is not amber. In addition, the GP may not be prepared to accept prescribing responsibility. If these issues arise they are usually highlighted to the Interface Pharmacist (based in UHL) by the GP directly or through the CCG. The Interface Pharmacist will investigate and take action to resolve the issue to ensure on-going drug supply either through the GP or from secondary care. All such incidents are logged and reported quarterly within the trust and to commissioners. These reports include actions taken to avoid recurrence. Trends are monitored, and where there are a number of incidents relating to a single prescriber or service these are addressed e.g. by ensuring the agreed process is fully understood by all prescribers within the service. In the last 3-4 months several GP practices have raised concerns about the shared care process, including about the number of occasions where shared care requests have not been received or are incomplete, or where the process has not been fully followed. There is also a desire from both primary and secondary care clinicians to simplify the process and maximise the use of IT to reduce workload pressures. To address these concerns LMSG convened a joint meeting between GPs and secondary care clinicians in July to agree actions to

	improve the current position and a further meeting has been scheduled for October. A key aim of this work is to ensure transfer to shared care is seamless for our patients and does not leave patients in a position where they are not able to access drugs. If the patient would like us to follow their case up, please supply us with details.

Theme: Communication | Privacy and Dignity | Caring for patients' Emotional Well-being

Question 9	**Equality and Diversity** 1. How do you ensure that staff does not fall into the '*Enlightened Denial'* trap when dealing with diverse communities. We do provide all our staff with equality training and whilst this doesn't make them 'expert' I hope it provides them with sufficient skill to be able to deal with all of our patients, irrespective of background with dignity and compassion. We also have the Equality Team who can provide additional expertise when required. We would see Enlightened Denial as a term describing an organisation's recognition that it must do more to support equality and improve representation of under represented groups. However, it does so without addressing the barriers that may exist which have contributed to under representation and inequality. For example, an organisation may work hard to recruit more women in to senior positions but still fail to acknowledge or address barriers that have prevented women from succeeding in the first place. In short, the organisation thinks it "gets it" but doesn't. We regularly seek guidance and feedback from the community we serve with the aim of understanding how different communities are experiencing our services. This helps to develop our knowledge at a department level to continue to improve patient care. We have also started to analyse our patient feedback by some of the protected groups to ensure that patient satisfaction levels are equitable across all patient

	groups. 2. What action plans can you put in place to ensure this does not have a detrimental impact on diverse communities? The Patient Inclusion, Patient Experience, Equality Assurance Committee (PIPEEAC) has been key in raising the profile of diversity at a patient level. I have spoken to our equality lead who feels that it has been a welcome addition that a member of our Equality Advisory Group sits on PIPPEAC. In addition we actively seek out local communities that we may not always hear from. The Equality Team in partnership with other health organisations have conducted a series of engagement events and if / where issues are highlighted these will be incorporated into next years equality action plan.
Background	The questions are from the CEO of Leicester Lesbian Gay Bisexual and Transgender Centre. Denial is when you are clueless but you are aware of the fact, " Enlightened Denial" is when you have a limited amount of knowledge and you suddenly become the expert. This is clearly evident when dealing with the LGB and T communities.

Theme: Privacy and Dignity | Documentation | Communication

Question 10	**Equality and Diversity** 1. How are UHL going to make sure the accessible information standards are going to work for people with a Learning Disability? Several members of staff within our Equality team are trained to in creating easy read information. As part of a CQUIN this year we are building a library of easy information starting with the most common 10 ten procedures which will be available on the UHL website by the end of this fiscal year. In addition to this: • Individually tailored easy read information will continue to be available where required as has been undertaken in the past few years. • The good communication standards from LPT are now starting to be shared as part of staff training sessions. • We now have a link Occupational Therapist for the therapies teams at Leicester Royal Infirmary for

	learning disabilities. We have met with them and any new publications around learning disabilities we share with them and they will share with the other therapists and upload to their shared drive so always available as required. • It is envisioned that the introduction of electronic patient records will also improve the flagging system highlighting an individual communication needs. 2. In regards to long waiting times at A&E for appointments and beds and long waiting times for transport. Patients are being left without being told what is happening or when they will be seen. What are you doing about this? Delays due to ambulance transfers are now addressed through increased utilization of alternative crews funded and provided by UHL. The coordination is through the Duty Management team and ED transfers are prioritized. If patients are waiting the EDU is utilized to ensure the patient is comfortable. The plans for the new department include visible screens keeping patients informed of waiting times to be seen. In the interim period the department is currently holding hourly catch up meetings to ensure staff can be moved to manage demand. This also ensures escalation internally and externally to the site management team. The Gold Command meetings also ensure escalation throughout the organization. The nurse coordinator in each area holds the responsibility of ensuring patients are kept informed of the situation and this is again a key part of Gold Command. 3. What support can people get if they are discharged and live on their own? We are working with partners across LLR to ensure people have appropriate support at home. We hold a daily conference call in which all partners from social services are present and discharge discussed on an individual patient level. We also have a discharge response team funded by UHL who can offer support at home and bridge care packages. The intensive community support service provides an intensive rehabilitation service to promote independence and recovery for people in the environment that they are most familiar with (i.e. their own home). The multidisciplinary service is advance nurse practitioner led, with medical input from the patient's GP as required. The service aims to prevent or reduce the need for permanent or long-term care packages,

	by promoting, supporting and encouraging self-management. The service is available to all suitable patients registered with a Leicester, Leicestershire or Rutland GP. It operates from 8.00am to 10.00pm every day of the year and patients receive up to four visits a day from the multi-disciplinary team of nurses, therapists and health care assistants who work closely with social care colleagues to ensure people receive coordinated and joined up care. 4. People are being discharged too early and then having to go back into hospital – Is this because there are not enough beds available? We are certainly focusing on discharge as soon as the patient is medically fit. The evidence shows clearly the frail, elderly patients decompensate whilst in hospital and we are therefore concentrating on ensuring patients are discharged in a timely manner with appropriate support. Readmissions are monitored on a regular basis to ensure that risk is monitored and appropriate actions taken. Attached is a paper detailing our current readmission rates. 5. There seems to be a lot of change at the minute, why is this? Richard Mitchell advises that this is due to our current site reconfiguration.
Background	Questions from the 'We Think'. Mencap run an Advocacy Group for people with Learning Disabilities every Monday 10am - 12pm called We Think. Members of group asked these questions - collated by the Services Co-ordinator One of the comments from members within the group. "People are being discharged too early and then having to go back into hospital."