

**Recording SC05**

**I: Okay, so the recorder is on now. So can you just start by telling us a little bit about your role?**

R: Okay, so my role is - the job description is a Community Care Officer. I work for [county] Adult Care Services, and I work as part of the integrated hospital discharge team. The direct team that I work for are the Out of County hospital team, so that means that I work with [county] residents who are in hospital outside of the [county] area, or hospital area.

**I: Oh, I see.**

R: So, primarily, we deal with the XXXX Hospital, so we have a lot of cases for people who are on the edges of the villages within [county], that move over to the hospital outside of our area. So I work a lot with XXXX Hospital, and I actually base myself one day a week at XXXX Hospital, where I work very closely with the integrated discharge teams from the hospital, and from actually the ward itself, if I'm dealing with people. I also work with XXXX hospitals, so we have a lot of people that go for specialist treatment into the XXXX hospitals. And those cases are primarily - even before Covid - dealt with by phone calls, interaction with the discharge teams, telephone calls to the patient, to the family, next of kin networks. So pre-Covid we had a very different process, so I don't want to sort of confuse you by talking about it, but if you want me to say pre- and post-Covid process, would probably help.

So prior to the Covid situation, most of my role, which is primarily to work with the patients in hospital who may or may not require care and support when they leave hospital, to return back to independent living. So, as I say, prior to Covid, I mainly worked on a face-to-face basis with people, within sort of travelling distance of [county]. So I would visit the ward, speak to the patient, speak to the medics, the therapists, get a background and base the assessment on a collection of information gathered from those parties. I would also, with the patient's permission, speak to their next of kin and find out what support networks they've got at home, what ongoing support they're going to have. And then from that, I can determine what we, as the [county] Council, would need to do to support that person to go back home and, let's say, remain living independently.

Sometimes people who suffer a stroke, for example, may have a very different baseline when they go home. And they may need to go into either rehab placements, or what we call a discharge to assess beds. And that is where the person will get ongoing therapy, ongoing support to determine what their new baseline is and, again, what they will need when they actually go back home. So that's fundamentally what I did and, as I say, primarily face-to-face. XXXX hospitals - different - if it was a complex case and I did need to be, do a face-to-face, then obviously that could be arranged. But a lot of the cases, the more straightforward cases were actually dealt with by telephone contact. With the new Covid process that was brought in very quickly and very efficiently, I feel, we work differently; so mostly, we don't visit the hospital wards. Again, we can do, and I have done, as long as we're wearing full PPE, and adhering to what the regulations on the ward at that time.

But the change to the way we work means that the referrals or the assessments, for want of a better description, that I used to do, is now done in the first instance by the therapy team in the hospital. So that will either be the Occupational Therapist or the Physiotherapist, or indeed a combination of those two inputs. And what they do then, is they send that referral to the Out of County hospital team that I work in, and then those get allocated to the workers, depending on our workload. So what's different, is that initial assessment provides a lot of the information that I would have gathered by going down to the ward, looking at the hospital notes and speaking to the therapist and physios. Is there still a need to speak to the physios and the occupational therapists, and a lot of times to clarify what they're requesting, and why they're requesting, and sometimes the jargon that they're using. So I don't always know exactly what the terminology might mean, so there is intervention with that.

So my role now is primarily looking at the social aspects of that person's life. So they will - the therapy will have identified what their mobility levels are, how they can move about within their home, what equipment they might need in their homes to support them going back to their home. And they will also look at basically what support they need in terms of washing, dressing, making meals or other, yeah, aspects of daily life, really. But they don't really delve into, well, what did that home life look like, and what support is at home and how could we build on the strengths that that person has at home, and get them back home as quick as possible? So I will speak sometimes to the patient, and sometimes the patients will have a mobile phone on them in the hospital. And if they're happy to speak to me and they're well enough to speak to me, and they have mental capacity to speak to me, then I will still endeavour to speak directly to the person that I'm actually providing that service for.

I liaise a lot with the discharge officers. So that's the discharge officers in the hospitals who, again, are working with the therapists and organising the discharge to get the person out of hospital as quick as possible. And, as you can imagine, in the current climate, there is a need to move swiftly with hospital discharges, whilst maintaining the same level of service and, indeed, ensuring that the health, the safety of that person is paramount before we make those discharges. So it really is very much now about liaising with integrated teams, in order to get the information that I need to support that individual.

**I: Okay. So, I mean, that's very thorough and helpful. Thank you. So in terms of video technology then, like Zoom, or do you use AttendAnywhere or WhatsApp, or anything for...?**

**R:** Well, internally, with internal partners, for want of a better description, very much Teams, that we're on today, is used. So you can liaise with more than one person to discuss a case. People can even look at the work that you've got, or if you say, oh, I need a bit of advice on this, and somebody else can zoom in and look at it with you. So, yeah, Teams is very much a key part of the way that we work now, and that has become the norm even for keeping in touch. And we're all working in our little isolated bubbles, and to be able to use Teams to keep that interaction is really, really significant. But in terms of liaison with the hospital, I actually work out of one of the hospitals, so I still have a very close working relationship with the discharge teams in those, in that hospital. But with the XXXX hospitals, I'm not using any

sort of video conferencing with gaining the information that I need to support that individual, at this time.

**I: Okay, so you're still just using the telephone for any interaction?**

R: Yes.

**I: So that's as normal?**

R: Face-to-face, if it is absolutely necessary.

**I: Right.**

R: But, yes, it's primarily using the telephone for contact with everybody, really, relating to that patient, including the patient themselves.

**I: Yeah, okay. So, in that case, I mean, do you think there would be any advantages to using any of the sort of video-conferencing type technology when you're...as part of your work? Is there any reason why you might decide you want to use it?**

R: Yeah, I personally think it would be really useful, because although it's not face-to-face in the way sitting next to somebody is, observational factors really do play a part. So if I'm speaking somebody, sometimes their body language will tell me something that they're not vocalising, or, equally, I can visualise seeing somebody. So, for example, I had a patient, or somebody who had gone home and I'm doing a post-hospital review and they say, oh yes, I'm walking beautifully now with my walking-frame. Well, you could say, well, if it's safe to do so, and you've assessed that they're safe to do so, well, can you show me how you're doing that? Show me how you're sitting down. Because particularly with the older generation, they really don't like to admit when they can't do things anymore, so they will tell you sometimes what you want to hear. And I think having that visual help with assessing people is really beneficial.

**I: So has it been suggested at all that that should be incorporated into the kind of work that you're doing?**

R: I have looked into it, in terms of I had a patient whose wife, I could see, would benefit from a carer's assessment. And I did explore it, and I was told that, at the moment, we're not doing that because [unclear 11:47] happy to set up a team. So it's not really - I don't think it's being discouraged, as such, I just think it hasn't been explored enough for people to say, yes, let's go and do that. So I personally feel that there's more of a caution with us using it for the people that we're working with, who are not the professionals in the system, for want of a better description.

**I: I see. And you said earlier that you haven't had as much to do with care homes recently, is that a change from normal?**

R: Yeah, well, in terms of my role, I don't have a huge, or I haven't had a huge interaction with care homes, because what would normally happen is if somebody goes into hospital and, as I say, and they have a dramatic change to how...what their baseline is, they will go to a care

home or a rehab centre for the initial post-hospital reviews. So that they can then determine whether this is a long-term need or a short-term need. However, I do have interventions with care homes where we have somebody who has come from a care home. So they were resident in a care home before they came into hospital, and then they go back to the care home. So, obviously, I'm then liaising with the care homes to say, okay, this person's now ready to come back home, are you happy to accept them? And then I will update them if there's been any changes to that person [unclear 13:37], or [unclear 13:41]. But [unclear 13:46] level of support anyway, so [unclear 14:01] to have the equipment they need for the person.

**I2:** *I think [Interviewer] might have just frozen.*

**I:** I'm here; I've just turned my camera off, because I suddenly got a bad network, and I'm sorry I didn't catch that, but I'm sure [I2] did, so that's okay. I'm just going to - sorry, I'm going to just keep my camera off for a moment so that we can, I can continue...

**R:** Yeah, that's fine.

**I:** ...to record. So your current use of technology is not really a part of the way that you've been encouraged to respond, since the Covid situation then.

**R:** Yeah, that's fair to say.

**I:** Okay, and could you - so, I mean, I think a lot of what we're going to go into probably isn't particularly relevant. But I just wondered if you'd seen scenarios within your wider team, of how that kind of technology has been used in communication with patients, or with care home residents; and if you've observed any particular benefits or challenges through that, would that be a fair question to ask you?

**R:** Yeah, I think that, more broadly, there has been, or there is interactions with people. So, for example, in the hospital environment, I understand that they have been using Zoom and iPads for people to speak to relatives within that situation. But I think for a lot of - a significant amount of the work that I do, or the people that I deal with are older and not as familiar with technology.

**I:** Yeah.

**R:** We - I deal with people who have cognitive impairment. So, for example, you'll have people who have dementia who would not... Well, I'm not saying they couldn't use it, but it might be more challenging for those people to use those systems. In terms of other teams, I really can't say what - to what level they are using technology. It's because I'm only seeing, from my own teams, but I know that the hospital team, the integrating hospital teams are definitely keen to explore more about how we use technology moving forward. And I know that there are people within [county] County Council who are very much looking at how we expand, how we communicate with people, moving forward.

**I:** And so - and you were saying that you're using Teams fairly regularly within your own team, and you found that a useful way to sort of communicate?

R: Yeah, really useful. Yeah, it's - I mean, it takes a bit of getting used to, because we were used to having our team meetings and meeting face-to-face. And you have more of a social side to explore when you're sitting with somebody, and having lunch with somebody.

I: **Sure.**

R: But I think as we - the more we use it, the more comfortable people are with it; and it does almost feel like you're all sat in a room now. So I do think that there is an acceptance that this is the norm; it's the new norm, and it feels like normal to speak to people. I mean, I will often ring my colleagues and my managers and talk to them, often just on the phone, but quite often on video as well.

I: **Yeah, okay.**

R: So, yeah, very much being used within the teams.

I: **And are you finding that you're able to make decisions over video calls, that you feel that your... That you have enough information to make to decisions through that medium?**

R: Yes. Yes, I do. I'm just trying to think of examples where I wouldn't have them. I suppose, as an example, if I have a situation with a case that I'm working on, and I speak to my managers about it, I can have confidence through that discussion on the outcome of it. I think that it's - it feels secure, it feels safe and it feels like I have the opportunity to fully explain what I need, or what I'm doing. And, as I say, being able to show the actual work as well. So, for example, I've got this assessment and I don't need to move... How to move that on to the next stage, and I can actually get one of my more experienced colleagues to come on and say, right, I'm looking at it now, this is what you have to do, this is where you have to go. And we can share the task, which almost is what you would do if you were sitting in the same office with somebody. So, yeah, I think it's - it works.

I: **And so do you have any concerns about the potential to expand the use of this kind of platform to your face-to-face... In lieu of face-to-face conversations with patients?**

R: I think the only - the concern that I would have is around data protection, and making sure that, for example, I'm not seeing documents or videoing, or having things online that I shouldn't have. So I think, for me, it's more about - it's there's no concerns whatsoever about talking to somebody on a video Zoom, and interacting with them. And, to me, I think in a lot of ways, it would actually be beneficial because, as I say, your body language really helps with engaging with somebody, so I think that would be really useful. I think, from a health and safety point of view, I'd want to know what would I do if I witnessed something that happens?

I: **Yes.**

R: How quickly could I resolve a situation that I might be seeing, as part of a video conferencing? So it's things like that that I would want to explore, and nothing to do with the actual face-to-face with somebody, it's just the security aspects of it. And the - as I say, the health and safety around what I'm seeing.

**I: Yeah, that makes sense. Can I just go back to what you were explaining earlier about your - how the job has changed, or how the work routine has changed? Not so much with the XXXX hospitals, but you were saying that the local practice has changed, that you, that the initial assessment would be done by other professionals within the wards now?**

R: Yes.

**I: How has that impacted on your ability to make decisions? Has it changed anything? Is there anything that you feel you're missing from that change in routine?**

R: I think, in the main, the new process is actually more efficient, because I think I explained before, what I... Pre-Covid, I would go on the board, I would find the patients notes, and I would spend time pulling together the information from therapy reports, and sometimes speak to the therapist. Well, with this process, what you actually have is the therapists have done that groundwork for you, so when the referral actually comes through to me, I've already got a lot of that information that I need to start working on, to - for want of a better description - have a picture or form a picture of the person that I'm actually assessing. The thing that I personally miss most is that face-to-face with that person in the hospital, and being able to talk directly to them. Because I feel that sometimes I don't always get the information from that individual, that I probably would have been able to tease out of them if I'm sitting next to them.

**I: Yeah.**

R: And gaining their trust, because they don't know me. And I think when you go and introduce yourself, and meet somebody, they form, you form some sort of relationship with that person. And I think that's easier to do when you're next to somebody, or on something like Teams. If that was something that the hospitals had in place, and they could take the Zoom or Teams to the person in the hospital bed, if they weren't well enough to do that, obviously, or ready to do that, and accepted to do that, that would be a beneficial way to move forward. But I think there's lots of obstacles in the way of that for the patients and the hospitals, especially at the moment.

**I: Do you mean in terms of the support they might need to be able to use that?**

R: Yeah, absolutely. Absolutely, yeah, because at the moment, I think it would be down to the nursing staff and they find it difficult sometimes to even get a phone to somebody to speak to a relative, because... And, obviously, there's no relatives visiting at the moment in hospitals.

**I: No.**

R: So that social welfare point of view, wellbeing, is really, really difficult for the patients.

**I: Yes. Yeah, absolutely. Yeah, no wonder if there is something about the visual aspect, which would make it easier. So having somebody on-screen and seeing the face of somebody often makes a difference, doesn't it?**

- R: I absolutely think so, and I don't have any doubts at all that... And in the hospitals, the people who do have the technology do FaceTime, and do speak to relatives and keep in touch with them. But I think it is - I don't want to come across as ageist, but it is a generational thing, and my experience, both with my own family and with people that I'm assessing and support, the older generation are not as au fait with using this technology.
- I: **Okay, that's helpful. Thank you. I think we've got everything that we need. What do you think, [I2], is there anything that I've missed?**
- R: I'm just having a look at the questions, but I think - I do think you've got everything.
- I: **Yeah, just... Sorry that I've gone off-screen, it's - of course it...**
- R: That's okay.
- I: **...would be today that my internet goes a bit sort of shaky. So, okay, I'm going to stop the recorder anyway now, unless there's anything that you feel that we... That you would want us to know about, based on the sort of questions that we've asked, if there's anything you think we might have missed?**
- R: No, I don't think so. I just hope that I've come across as basically promoting the fact that within the service that I work in, that there is a desire to move forward with more technology and using those services. And although I'm not seeing immediately what's happening around, how we move forward with that? I am very aware that it's something that we do want to promote.
- I: **No, that's - thanks for summarising that, that's clear. Okay, I'm going to stop the recording.**

**End of Transcription**