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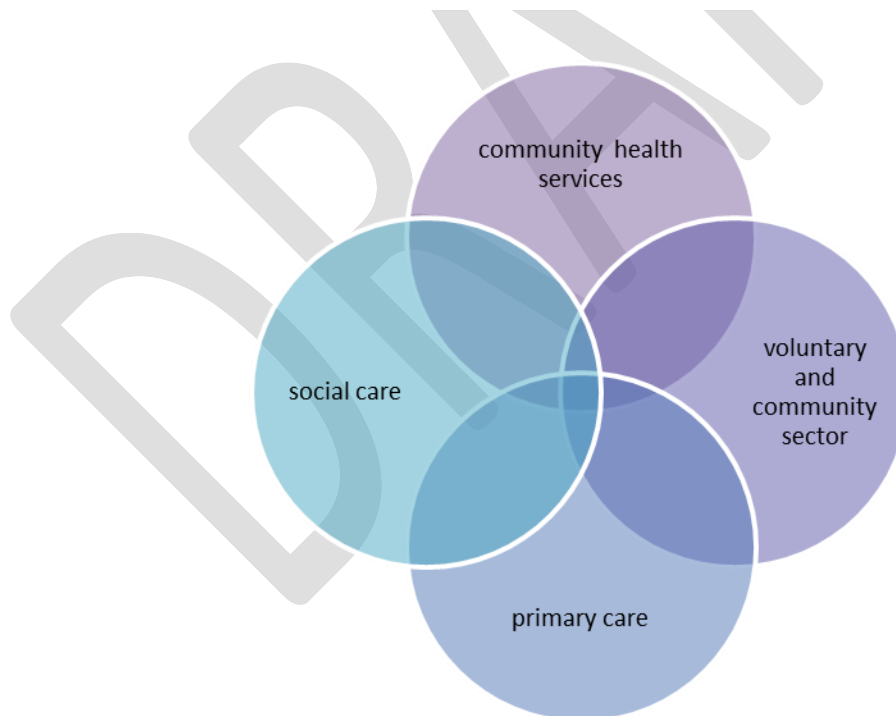
Northern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Integrated, personal and sustainable: Community services for the 21st Century

The Northern Locality of Northern, Eastern and Western Devon Clinical Commissioning Group

Involvement and Consultation Report



February 2015

Thankyou!

Our community health services in the NHS NEW Devon CCG area are under more strain with an increasingly elderly population and greater demands on the NHS. We know changes need to be made in order to provide the highest quality healthcare for local people within resources available.

We also know that people want to be at home and stay at home whenever they can. Clinical evidence tells us that many people recover much better and faster at home too. In order to do this we need to make sure we have the right community healthcare services in the community.

The CCG set out its proposals which are designed to meet the challenges ahead, in its document 'Integrated, personal and sustainable: Community services for the 21st Century.' This is sometimes described as the Transforming Community Services process (TCS) which is the name of the national policy direction. This was then followed up with the Northern Locality Commissioning Intentions which described how we thought the CCG wide strategy would be delivered in the Northern Locality. (Both of these documents are available on the CCG website)

This engagement report is a summary of the rich information that was shared with us by members of the public and groups in the Northern Locality during the last period of engagement which ran from 17 September to 12 December 2014.

Central to the development of community services, following the Health and Social Care Act 2012, is co-production. This means designing the future model of delivery jointly by engaging the public from an early stage and before plans are drawn up. This is helpful in ensuring the public get involved at an early stage, but at the same time can create frustration as we can't clearly describe the plans and people wanted to know for example exactly what was to happen to their own community hospital and we were unable to say at that point.

During this time we had fifteen public events which were attended people in their own communities. As well as the public meetings we had thirteen meetings with groups of interest, parish and town councils, practice managers, GP's providers of healthcare and voluntary and community sector groups. A list of all the meetings is on the website.

We have summarised the key themes in this report and also provided an indication as to how the issues raised are to be incorporated into our work for the future.

We would like to thank all of you who willingly gave generously of your time and views; we hope that you can see your comments are reflected in the themes we have highlighted.

Elaine Fitzsimmons and Kerry Burton
Northern Locality Commissioning Team

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1. About the Northern Locality of NEW Devon Clinical Commissioning Group (NEW Devon CCG)

The Northern Locality of NEW Devon CCG has a total population of 166,093 and this is expected to expected to rise by another 14.5 per cent by 2026 (190,176). 23% of our population are aged 65 years or over.

We have 22 GP practices all of whom are member practices of the NHS NEW Devon CCG for the Northern Locality. Our community services are mostly provided by the following organisations in partnership with primary care:

- North Devon Healthcare Trust – providing health and social care
- Virgin Healthcare for children's services
- Devon Doctors for out of hours medical services
- Marie Curie Nursing
- North Devon Hospice
- Devon Carers
- PLUSS equipment services
- Pharmacists, opticians and dentists,
- Domiciliary care providers and care homes.

There are five community hospitals in the Northern Locality all operated by Northern Devon Healthcare NHS Trust: Bideford, Holsworthy, Ilfracombe, South Molton and Torrington as well as our main acute hospital services run from Barnstaple.

2. Transforming Community Services (TCS)

Community services are those health services that take place in people's own homes or other local settings - for example community nursing or clinics and other services in community hospitals. They are extremely important in supporting people to maintain or improve their health and to care for them when they are ill. Valued by clinicians and patients alike, community services have a pivotal role in the future health and care system. When we talk about community health services in North Devon these are a combined service offering health and social care in one team.

The Transforming Community Services (TCS) programme is the programme of work to plan the future of those services that are based in the community and that support you to stay healthy, live independently and manage your own health effectively and safely. This programme produced the documents already mentioned, 'Integrated, personal and sustainable: Community services for the 21st Century.' and then the locality response – the commissioning strategy. In the North we had previously embarked on community redesign and this had been titled 'Care ***Closer to Home'*** the work, has now been subsumed into the TCS process.

We realise the sequence of events and processes can create confusion, but for the Northern Locality, Care Closer to Home and TCS are interchangeable terms.

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The overarching process has aimed to develop the strategy for community services in Northern, Eastern and Western Localities and develop arrangements and plans for future delivery of these important services.

We are reviewing these services for three reasons:

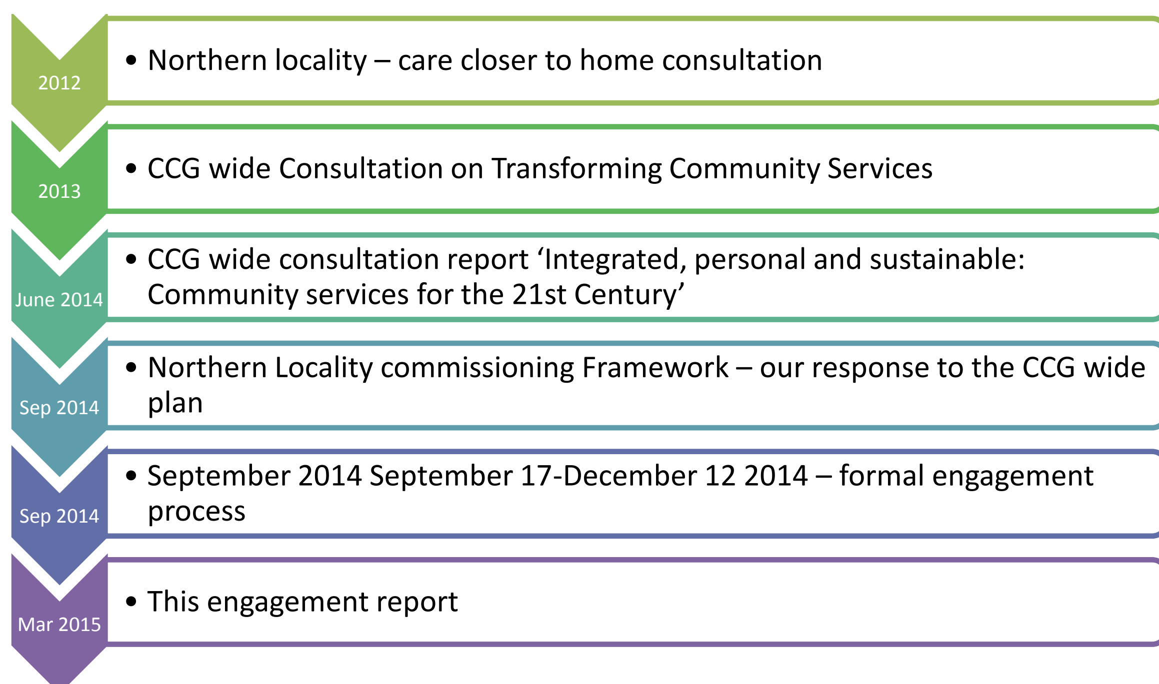
- The changing health needs of people living in the Northern Locality
- The evidence showing that community based services are both clinically effective and safe
- The need to ensure that services are sustainable in a challenging financial environment

The work presented in this report is the Northern Locality contribution to the co-production that is taking place across Devon. In the Northern Locality Locally we will continue to use the phrase ***Care Closer to Home*** as it connects the earlier work with the TCS process, although it has been commented upon by people that perhaps care in the home may have been a more accurate title.

We are really pleased that the ideas and principles in the early ***Care Closer to Home*** work are themes that have been shared in other parts of the county as well. This is helpful in having a joint approach to creating solutions where sensible and being able to share and learn from each other.

The co-production process has taken place in stages and in September 2014 we started a formal engagement process, taking our ideas and themes out to the public to check if we had interpreted the conversations correctly. This report focuses on what we were told about how you wanted us to commission community services.

Timeline



3. This report

This report sets out what you told us about how you felt about our proposal to commission to prevent ill health, promote well-being and help people with long-term conditions to live well and what you felt we needed to know about commissioning an effective, and sustainable service for the future. The final section sets out where the themes you suggested were important to you are included in our planning.

What you have told us will ultimately help us to form our action plan to deliver the changed models of services for the community in the locality. For ease this document details:

- The key themes which were shared with us, main concerns but also key positive support for the principles of what we were trying to set out.
- The key pieces of work we believe we need to undertake to provide confidence to the public that the plan can work.
- A review of the lessons learnt in undertaking engagement for the future.

This is a summary report but the more detailed summary of meetings content is available for people to read on our website.

It is useful to note that during the process there were other factors in play in the Locality:

- North Devon Healthcare Trust made a separate short term decision to close the inpatient beds in the Tyrell Hospital in Ilfracombe. This decision was taken because of increasing concerns about the clinical safety of the staff and patients in the unit. Registered staff members were working alone without support or opportunities for collaboration with others and NDHT had declared their desire to stop this practice and felt unable to wait until the consultation process was complete. This was unfortunate and created confusion. It is important to note that no decisions have been taken around bed numbers or locations and the short term closure is a separate issue from the TCS process.
- The permanent closure of the Torrington Community hospital beds, continued investment in the community services and the redesign of the community hospital to create a health and social care hub were agreed at the Northern Locality Board in November 2014. This had been subject to an earlier process which had been extended to enable sufficient engagement to take place. The evidence collated as part of the process has helped to inform our thinking about community services and has given us some localised evidence around the impact of redirecting funds into the community.
- At the same time as our work there were difficult conversations taking place in the county with regards to council funding for social care, transport and care home provision which created a realistic degree of caution about the impact on our plans but also placed our discussions in the context of a decreasing statutory role and concerns around the sustainability and reliability of other partners to support the NHS.

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3.1 What you told us…….

Because we had already undertaken earlier work on our own community planning we were not starting with a blank sheet of paper, you had let us know what you felt, what you were keen to keep and where you felt changes could be made. You were really clear about elements of the services that worked well, but also very knowledgeable about elements of care which didn't work so well and gave us strong indications of where you needed greater reassurance that the services would be good enough to take forward plans.
This summary does not reflect any of the wider CCG feedback from other organisations unless staff or representatives were participating in the public sessions.

3.2 Overarching themes

This section just highlights some key overarching messages to us; the next sections then divide the feedback into the four key work streams of the TCS process for ease.

As an overall plan you said…..

- ✓ You understood the financial challenge we have in the county as it mirrors similar discussion with the council and other statutory organisations and the general financial climate of the country. Our financial position is complex and we were too reticent at times in being explicit about the size of the financial problem and the impact this has on our plans.
- ✓ The move to care for more people in their own homes was supported as the right model of care for the future but you were explicit about areas of concern around this.
- ✓ You understood the issues around lone working for people working in our community hospitals and the impact this had on the team and the patients.
- ✓ You could understand that hospital beds were often used for non NHS functions and this could not continue.
- ✓ You understood we would be reducing our bed stock in community hospitals and this would lead to a reduction in overall bed numbers and locations. We did not convince you we had not yet made the decision with regards to the location or the actual numbers. The models in our consultation paper could have been clearer and this would have helped to reassure people that decisions had not been made.
- ✓ You understood that we think that minor injury units have not met needs and that we need to consider other options to avoid people having to travel to North Devon District Hospital unless absolutely necessary. Minor injury units in their current format were not destined to continue but the future models were still unclear as we were waiting for more national guidance.
- ✓ You recognised there is inconsistency in the provision of some community services with a perception that the further away from Barnstaple the less responsive the offer especially for urgent care, out of hours and rapid response services. Whilst accepting rurality and sparse populations were an issue, you challenged us to be more consistent in our service commissioning so that people living and working across the community felt that services were provided fairly to those of greatest clinical need, not because of their location.
- ✓ You were keen on the ideas of bringing more services out into the community avoiding the need to disrupt lives to travel to the main hospital site at all times.

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- ✓ You liked the idea of connecting health and social care services with the community and voluntary sector.
- ✓ You felt that the various parts of the community services didn't always work as well as they could together and challenged us to integrate community services, social care, primary care and the community and voluntary sector with more success and with better outcomes for people.

This next section now details more of the feedback in the themes described in TCS

3.3 Preventive and personalised support

Community services designed to help people who are older, frail or otherwise have complex health needs to remain well, support them to recover and enable them to have choice and control of their own care through a new model and design of services.

We had many comments made about the desire for people to take charge of their own care as much as they were able. We also had a considerable amount of feedback about the voluntary sectors' ability to support the community. Key points were:

- The voluntary and community sector is a valuable support in the community, but on occasions they struggle to connect with those people that need their services. We should use our influence to support the connections between these services and the public.
- The impact of wider community issues on health and wellbeing were well made and acknowledged, there was realisation that sometimes this was outside the NHS control but a strong message that the NHS should place importance on working with partners to use our ability to influence in support of community development.
- Medication reviews were not universally or consistently offered but were felt would be a saving for the NHS.
- Long term condition case review for a person and their family was felt to be a good use of clinical time but ad hoc in some places and unhelpful in others. Where people could describe good review this was a positive and enabling experience.
- People wanted to have discussions around plans for the instances when their health may deteriorate or they experience a health crisis. There was a strong message of wanting to plan and be in control, rather than react.
- Health and social care services would be greatly enhanced if people were able to access voluntary and community sector support at the same time, for example the leg club was mentioned as being more helpful than the sum of the various parts, people also asked why we didn't add in local support into some long term condition clinics and services e.g. help with transport for mobility related services and education for diabetes etc.
- The three areas where there was a strong emphasis in improving community support were for the following:
    - Carers, enabling them to continue to care and have the right support to be able to do so
    - Activities which support the need to overcome loneliness and isolation for older people

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- Public transport was recognised as a challenge and we should us our influence to support community developments and challenge changes being proposed by the council.

3.4 Pathways for people with complex health needs

Range of community hospital and community services to support people with complex health needs such as multiple long term conditions, frailty or disability with a new co-ordinated pathway design from pro-active care through crisis responses and to ongoing care.

This section had the most responses and was subject to the greatest areas of concern for the public. The model of reducing the reliance on expensive hospital beds and having more community care available was understood and supported although the level of support for the changes reflected the opinions of local people and their use, knowledge and relationship with their community hospital.

Community hospitals are much loved institutions and are a visible sign of the NHS. Community services are often invisible and there is little knowledge shared about the number of people on a daily basis receiving health and social care in their own home.

There were also strong advocates of community based care, especially in enabling people to recover after illness in their own home with the right support and terminal and palliative care. Older people were also very keen to receive care in their own home when ill providing all the conditions were right to allow this to happen safely.

The concepts of using hospital space to bring together more services so that the local community can receive, health, social care and link with voluntary and community sector in one place was a well-received approach,. We were able to describe examples of the type of care that is already available which prevented people travelling to the main hospital sites for care which could be received locally. We described these as **health and social care hubs**.

People likes these concept as they were offered for the whole population, not just older people so younger people and children could benefit as well as people of working age who would benefit from not taking so much time off work.

The decision about the numbers of beds and the location has not been made by the CCG but there was scepticism about this. People were very clear with us when we asked what criteria we should use to make the decision about locations and these will be factored into the planning. The message the CCG gave was that at this time and in the foreseeable future there is a need for some community hospital beds for healthcare needs but we would prefer to use the funds available to us to provide more community based care for more people than the current model.

- People understand the proposal to reduce hospital community beds as they are an expensive way of providing care and the NHS pound can treat more people in their own home. People who live in communities without beds are more ambivalent about their retention. The strength of feeling and assumptions about hospital use in communities with beds was the bulk of our feedback.
- People were not aware of the cost of hospital beds and the higher costs associated with smaller units. The discussion about the safety of small units and lone working

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were broadly understood and people supported the need to consider this, although were concerned about what they saw as an inevitable closure of some units by default.

- People gave a number of reasons for keeping beds for uses which were not core business for the NHS as a way of keeping them, there were discussions about using them instead of care homes, more avoidance of hospital admissions, terminal care, and respite care and when social care was lacking. There was a need to be very clear about what the NHS should and could afford to pay for bed based care.
- The concept of care in people's own home was positively received but the CCG was challenged around a number of issues. Home care relies heavily on people for delivery, there are known problems in the northern locality generally and in some specific areas where capacity for domiciliary care in people's own homes is poor. This knowledge was also supported by stories about gaps in provision, unreliability, lack of continuity of care, poorly delivered care with untrained staff, a lack of compassion, poor equipment, poorly paid staff, lack of travel time and poor retention. We were challenged around our ability to improve this as a bed rock requirement for more care closer to home.
- Likewise the information people had received about gaps in clinical staff, especially nursing and doctors meant they were confused as to how we would contemplate a model of care which looked more labour intensive. We had to discuss the overall recruitment issues which are a national and local problem, but also describe the roles people played in community teams versus community hospital management and the greater job satisfaction, community nursing provided.
- We had suggested that we could use care home beds in some locations to offer local care for some people who did not need an acute hospital bed, nor could be cared for at home. Similar to the domiciliary care debate we were asked about quality and capability of care homes and their staff and how we would work towards being reassured of this before using the beds on a regular basis.
- You felt that community services should integrate better with primary care services so that all aspects of healthcare and social care with voluntary care are part of the same team.
- There was nervousness that a community service would be provided to allow closure of beds but would then reduce over time and the community would be left with very little.

3.5 Urgent care in the community

Urgent minor injury and illness services to a new design that will achieve consistent, quality, resilient and networked urgent care in line with the requirements of the recent Keogh report. This new system design aims to listen to, see or treat people in the right setting.

The community in Northern Devon has access to three minor injury services and one emergency department, as well as a number of GP practices which provide minor injury services during practice opening times. The community also has access to the Devon Doctors out of hour's services. The conversations about urgent care were mixed, there was a sense of personal and community resilience with many comments made about people managing and making decisions themselves based on their interpretation of the urgency and the distance and timing of the incidents.

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During the consultation the future models of proposed urgent care were shared and the challenges this meant the community would have to face. The message was a clear one that current minor injury units do not fulfil the needs of people as anticipated and do not reduce the level of use of emergency department for these communities who have one. The urgent care centres were unlikely to be viable from a clinical or financial modelling and there is a need to work to redesign services for the local community as well as the increased number so holiday makers at key times of the year.

- People had a mixed view of the use of out of hour's services, there was a sense in some communities that the service did not understand the distance people had to travel and the service was reluctant to visit. There was a strong sense that people who lived furthest away from Barnstaple were the most poorly served by the out of hour's service.
- The availability of Stratton as an alternative was mentioned for the west of the patch and suggestions of working with this service as well to offer more urgent care services.
- People recognised that the out of hours services used GP's who were local to the community which was helpful.
- There were mixed views about the usefulness of pharmacy services in supporting urgent care needs and may be an untapped resource.
- There were lots of comments about the lack consistency of offer of the minor injury services in Ilfracombe and Bideford in terms of opening times and treatment availability. People recognised that without a consistent offer they would bypass these and go to ED.
- The Lynton minor injury services was identified as a model worthy of further exploration, where there were dual roles for nursing teams (minor injury, practice nursing and district nursing) working alongside primary care. This seemed to work very well, provide job satisfaction and the ability to retain skills for the clinical tem and meet the need.
- People commented that GP's and ambulance crews also appear to bypass the minor injury units.
- People were surprised that they had been in existence now for about ten years at least as there were comments about better advertising & reminding.
- People who used the services, where it met their needs were very complimentary.
- Good feedback about ambulance services and crews.
- Many people did not realise that many practices provided minor injury services and felt they were not advertised well enough.

3.6 Community specialty services

A range of specialist community services that support people who may be vulnerable and whose conditions or needs require more specialist input from professional in podiatry, bladder and bowel care, specialist nursing and others.

During this process less attention was paid to the speciality services component. There were few people who had experience of the services and it was recognised that in having any

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meaningful engagement we needed to do more work to share the issues and challenges and why these were included in the TCS process.

The types of services were shared with the public and comments on their role and possible outcomes were described but it was difficult for people to make comment on services which were generally not well understood.

It is recommended that in taking forward any changes to these services that engagement would need to be repeated with real examples and greater clarity of the issues

The CCG has undertaken a stock take of a range of services and the outcome of this and the way forward was unclear. In term of the potential impact on the northern locality.

4. What next?

This document summarises the key themes and further detail is provided on the CCG website.

Each of the identified themes has been explored as we needed to understand if there was work in progress to resolve some of the concerns and rose, or if new pieces of work needed to be commenced. We have identified the immediate priorities for us as a team:

Preventive and personalised support

- carers support
- using our influence to improve awareness of community sector services
- working with communities to support health and wellbeing
- baseline assessment of activity in our communities
- developing health and social care hubs
- Consider how we increase the numbers of crisis care plans for people and self-help for those with long term conditions.

Pathways for people with complex health needs

- bed modelling and decisions on numbers of beds and locations
- Supporting DCC by joint commissioning an increase in domiciliary care capacity and capability.
- care homes support programs
- reviewing end of life care
- understand the plans to improve the recruitment and retention of clinical staff
- Integrating community teams (a combined approach to social care, health care, primary care and voluntary and community sector).
- Developing an approach to agreeing how we move towards a new model of care and create confidence in the plans

Urgent care

- out of hours services procurement
- review of the new specification for urgent care centres
- use of ambulance crews and services to pilot mobile services

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- Exploring the role of pharmacy to offer urgent care.
- Reviewing the Lynton model more fully and understanding why it is successful and if it can be replicated

Community specialty services

- work with CCG team to understand findings of review
- confirm the speciality services which need to be reviewed or redesigned as a priority
- Confirm a further engagement process in relation to priorities.

Finally….

We will keep returning to the findings of the engagement to check the messages and make sure we are 'on track'.

We will ask our public and patient participation group to work with us to agree the best process to keep people informed of our progress.

We know that we will have to undertake further engagement especially when we get to a final decision about the location of beds and also when we know more about community services. Engagement will be much more focused and meaningful for the public in terms of very specific proposals.

We would just like to end by thanking once again everyone who has helped us with these priorities. If anyone would like to add further comment this can be done by contacting the Northern Locality offices

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These are the practical lessons we learnt as part of the process which we would consider when next undertaking engagement and consultation.

- ✓ The use of short presentations and round table discussions were liked by people and gave more people the chance to have their views heard.
- ✓ People were put off in instances where people with political or lobbying groups made statements from the floor.
- ✓ The publicity should have been more carefully controlled in terms of being able to confirm where and when it had gone – especially posters about the open meetings.
- ✓ Where a response was not received back from a town or parish council an active approach should have bene used to ensure they had declined an offer, not missed it.
- ✓ The leaflet in the paper with dates was helpful and seen by quite a few people.
- ✓ Residents of Braunton were unhappy that a meeting had not been planned, but when booked at a later date two people came.
- ✓ Ilfracombe meeting should have been closer to the town centre.
- ✓ Mixed responses re afternoon and evening meetings – times need to vary to suit as many as possible.
- ✓ The process of scene setting, local discussions then feedback seemed to work well.
- ✓ Whilst people were keen to have answers the CCG was mindful that they needed to be engaging with people before decisions were being made and this created a conflict which needs to be considered in future.
- ✓ The use of nuggets of information on board was helpful in generating discussions.
- ✓ Having clinicians & managers in the discussions was appreciated.
- ✓ Honesty was appreciated even in difficult debates
- ✓ We should have had more information about the money!
- ✓ A greater range of GP colleagues would have been helpful to share the burden and create some variety.
- ✓ Three hour sessions were too long.

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Glossary of key words and phrases

CCG Clinical Commissioning Group - This is the statutory organisation that is responsible for commissioning health care services for a particular population. CCGs are made up of all the GP practices in an area and are run by GPs elected by those members. Elected GPs are supported by a staff with experience of commissioning.

Clinical The word is defined as describing anything relating to a clinic or the direct observation of a patient to make a diagnosis or to treat. Here it is used to describe things that relate to either of those or have a bearing on them.

Commissioning This describes a range of activities that are carried out to ensure that you have the right care for you when you are ill. Commissioners identify gaps or development needs in the health care services you use, decide on priorities, design or redesign services as required, write service specifications, identify providers and monitor and evaluate services against the specification.

Commissioner A commissioner is a professional (often but not necessarily) someone with a clinical background who is responsible for commissioning services.

Co-production Working together to design services

NEW Devon Northern, Eastern and Western Devon – this is the name given to the CCG that commissions services for most of Devon County. A separate smaller CCG (South Devon and Torbay) is responsible for commissioning services in that area.

TCS Transforming Community Services is a programme of work that examines people's healthcare needs, their views and opinions about healthcare and uses these to set the direction and plans for future community based care.

Patient Participation Groups
The National Association for Patient Participation promotes and supports patient participation in primary care. Groups are an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. PPGs are making a real difference across the UK.

Northern Locality The Northern Locality is part of NEW Devon CCG and covers the area in the north of the county from the borders of Cornwall to the borders of Somerset. We include the key market towns of Barnstaple, Ilfracombe, Bideford, South Molton, Torrington and Holsworthy.

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