Bath and North East Somerset Health and Wellbeing Network

your care your way

Wednesday 15 April 2.00pm – 3.30pm

The Folly Farm Centre, Stowey, Pensford

Introduction – Mike MacCallum (click here to view the slides)

your care your way is a two year project to review, design and deliver integrated community services locally. It is being done jointly by Bath and North East Somerset Council and NHS BaNES Clinical Commissioning Group (CCG).

Community services need to be reviewed for a number of reasons. There is a need to ensure community services are in line with local and national policy including the NHS Five Year Forward View, the Care Act and the Better Care Fund. These all have the common themes of more integrated health and care services, and more choice and control.

Locally, there are many examples already of very good community services. However there are factors that are driving a need to review services include:

Population – including growing numbers of older people and local housing development.

Financial – the review does **not** have a savings target attached to it but there is a need to make sure that services are as efficient and effective as they can be.

Urgent care – experiences over the last winter help show the need to be sure that services are in place to ensure people are able to move through the system.

Technology – needs to be harnessed fully to improve and enhance systems including information sharing and support to people using services.

Community services are health and care services that are delivered at a person's home or in nearby local care settings. ***Your care, your way*** divides these services into nine broad functions ranging from prevention and self-care to complex care management and end of life care. They are 'cradle to grave' services and almost everyone will come into contact with them at some point, although some people may access the services for a short period, some may use them on a daily basis all their lives. All of the services aim to provide support for people to independently manage their own health, lives and conditions. Primary care, residential care homes and inpatient hospital care is outside the scope of the review.

The engagement so far has heard some very consistent messages about the local vision for community services and the scope of the review with interesting ideas already emerging including the idea of local navigators who can help people in finding their way around the health and care system. The meeting today provided the opportunity to discuss some of these emerging ideas in more detail and particularly to look at how more seamless care might be better provided.

Workshop feedback

Group 1

What is seamless care?

- Being able to get through the system without having to retell your story.
- Everyone has a helper to guide them through the process.
- Everyone's mental health conditions are unique to them.

What are the barriers?

- People don't know where to go. They visit GPs but they don't know everything. Patients won't know about services if their GP doesn't tell them.
- Curo no longer take under 50s for Independent Living Service.
- If you don't fit into specific categories you fall between the gaps.
- Older people might be wary of technology. There is no standard tech for everyone – it needs to be personalised.
- We all know about recycling information – why don't we have the same publicity for health services?
- Marketing needs to be fully resourced. Shift funds to finance it properly.
- Separate health and care budgets make it very confusing.
- Have a dynamic review not a 'big bang'. Evolve over time but get going now – we have heard all these words before – now action is needed.
- Integrate with mental health- there is a delay in how mental health conditions are dealt with.
- How does NHS 111 fit in? Lacks local, personal touch.

What are the solutions and local opportunities?

- Need an advocate to help you through the assessment process
- Knowledge is key – need info about services that are available
- Navigators do not have to be a clinician or specialist (or people will fall through gaps). They should be generalists as long as they have access to the right information.
- If you have a condition you need to be the expert. GP is a generalist.
- Navigators would be good value for money.
- Based around GP clusters – need practices to work together.
- Base them in GP practices – easier to refer vulnerable patients.
- Navigators need to provide an outreach service as well. Use technology: phone, email, skype.
- Those identified as most at risk could be referred to navigator e.g. BEMS+ weekend service very good – but who do they refer on to after the GP has left?
- Telecare – feedback data about condition to GP surgery.
- Need access points throughout the system for information.
- Review process so everyone can feed back about service performance.
- 'Feedback' not 'complaints'. Need to encourage as much as possible.
- Emergency mental health doesn't feel like emergency service.
- Need an effective out of hours service offering services 24/7. On-call/out of hours community services?
- Could there be a local navigator phone number, 24/7? (Would it be abused? Maybe it's just the out of hours, NHS 111 service who would refer to it?)
- Look at B&NES Doctors Urgent Care help line – how well does that work? Need to set expectations for response time.
- Family Information Services Helpline is a great system combining helpline and database.
- Database easy to update and filter – needs to be easy for operator to use. Make it public.
- Local knowledge is key. Link with Town Council websites – trusted by older people.
- People want to find out how they can find local people to help them out.

Group 2

What are the barriers?

- Lack of communication between different professionals.
- Lack of understanding about different people's roles
- To-ing and fro-ing between different people who don't see things as their responsibility – grey areas.
- Overcoming blocks on the system – no-one taking responsibility or an overview.
- Transport is a key issue.
- Local authority and health service boundaries – complication. People 'out of area' do access services in B&NES e.g. those in North Somerset.
- Access to care services and travel times – care agencies in Chew Valley in particular hard to access or locate – this is leading to bed blocking.
- Confidentiality – what information can and can't be shared.
- Different generations access services in different ways: not a 'one-size-fits-all'.
- Different expectations of different generations.
- Raising awareness difficult – not all agencies have the same amount of resources to raise awareness of the service they provide: how can we raise the profile of all that's available?
- Separate websites for different agencies can make it hard to know where to go for information.
- There is a lot of information available! Hard to find things sometimes.
- Lack of understanding about people with complex or different needs/dual diagnosis. (If people don't fit neatly into a category they can fall between the gaps).
- There is a lack of emotional support services.

What are the solutions and local opportunities?

- Confidentiality – DoH principle that sharing information can be as important as withholding it – have protocols for sharing information and consents clearly set out. This is an issue for patients, clients and carers.
- Recognise that many people are already helping people navigate the system to some extent.
- RUH homeless project meeting with different teams to explain role.
- Village Agents performing a navigator style role.
- Well Aware information database
- Key agencies signposting to other sources of support.
- Sirona multi-disciplinary teams in surgeries could be broadened to other community services.
- To address competition and independence – navigators need to be independent. Not signposting to own agency.
- Current IT systems in place for sharing information about vulnerable patients.
- Technology such as health apps useful.
- GP surgeries hold the key for signposting people.
- Mobile libraries are a model that could be built on – idea of mobile services.
- Wellbeing college model could be extended.
- Making Every Contact Count event was useful – this idea could be built on.
- Health and Wellbeing Networks and Health and Wellbeing Board webcast very useful.
- Home from hospital model of liaison eg with housing options.
- Rethink Floating Support should be short term but in some instances providing more emotional support.

Group 3

What is seamless care?

- Governance, trust and communications between partners needed to make the service seamless
- Information sharing between agencies to prevent someone having to repeat their story
- Joined up systems to prevent client having to drive the system themselves.
- Safeguarding and trust are key to seamless services.

What are the barriers?

- Supported discharge form hospital seems to be working but what happens after can be difficult.
- Over 80s in particular can be very independent and not wanting to ask for help or admit they might need it.
- Equal and fair access difficult between health and social care as one system free at the point of access and the other isn't. Budgets are separate.
- Assessment process – disclosure of personal information in order to obtain funding can be a barrier and paperwork complex.
- Joining up of voluntary and community sector services – competition for contracts and funding can reduce or prevent joined up working.
- Reliance on contracts and funding to sustain organisations can result in organisations taking on areas of work that they may not be experts in.
- Social care assessments are still a hold-up in moving people through the system.
- People waiting until 'crisis point' to access services means they require more intensive support.
- The volume of schemes/initiatives taking place makes it almost impossible to know all that is happening. GPs can't do this.
- Navigators – concern that this is seen as an unpaid, voluntary role. Should it be paid? Community capacity an issue.
- Children and young people services provide excellent complex needs support but once the child transitions to adult services the level of support changes dramatically. Can be difficult for parents to adjust.
- Recruitment of health and social care professionals difficult due to negative publicity in the media. Undervalued and unrecognised.
- Domiciliary care contracts and coverage of area not including sufficient travel time.

What are the solutions and local opportunities?

- Future proofing requires a very different way of thinking about how we work and processes e.g. using smart technology, hand-held devices etc.
- Swallow provides services that their members say they want – it is member-led. Trustee board and management committee made up of members. Each year they hold an evaluation day where members say what they want.
- Curo has a similar approach – a SHOP group which brings together service users and members on a 6-weekly basis. Focus group where CURO asks for information on certain topics and gives service users the chance to have their say. Bi-annual election for reps.
- Sirona has the same.
- GP frequent attenders – how can social prescribing / navigators support and address this redirecting people to alternative support or other options?
- Transition – Swallow runs a weekly service at Fosseway School to try to prepare families and children with SEND for the future. Also peer support for young people approaching transition.
- Transition – Sirona's 'life time' service for children with life-limiting illness is now seeing an increase in the time that children and young people are living with conditions and the level of support they require. Although they are over 18 they continue to receive services.
- People at Fosseway in 6th Form can come to Swallow to learn life skills in order to increase their ability to live independently.
- Need to make caring professions more attractive and appealing as a career. New Skills for Care qualification is positive to motivate and recognise the role care staff play.
- Need a clearer career path within social care and the caring professions.

Group 4

What is seamless care?

- Co-ordinated with a named responsible person to manage the process and handover.
- Sharing of information between organisations.
- Effective partnership working.
- All working in one direction during the journey.
- Care plan where people have complex needs.
- Know background and stop repetition.
- Easy to use
- Handover at each stage
- Consistent information
- No gaps or duplication
- Keep people informed about changes and progress and planning takes place in a safe and timely way.

What are the barriers?

- Who coordinates – GP? Advocate? Patient?
- Communication – how to be clear about the stage in process – email? letter?
- Knowing what happens next – Professionals may know but patients do not.
- IT capability and how to apply it.
- Non-communication
- Lack of knowledge
- Fear of overload or taking on more
- Flexibility of part-time working
- Organisation and discipline limits
- Lack of flexibility to meet together
- People with high function autism with specific needs still being excluded from health services e.g. epilepsy. Occupational therapy with reluctance as not a learning difficulty.
- Mental health services inadequate and difficult to access or work alongside. Referral criteria too high or inadequate funding?

What are the solutions and local opportunities?

- Southmead Hospital patient view.
- Investment into role of smaller providers to assist with IT and making an input to a system.

Next Steps

There will be a series of ***your care, your way*** workshops focusing on the nine functions of community services in May and more information about these will be provided in due course.

Further information about the review can be found at www.yourcareyourway.org

Attendees

Emma Bagley	Bath and North East Somerset Council
Adam Bladwell	British Red Cross
Margaret Crossley	NAS
Kate Davenport	Chew Medical Practice
Corinne Edwards	Sirona Care and Health
Alex Francis	The Care Forum
David Ford	CURO
Barry Grimes	Bath and North East Somerset Clinical Commissioning Group
Mary Hall	Bath and North East Somerset Carers Centre
Claire Hicks	Rethink
Damaris Howard	Freeways Trust
Sarah Kay-Hawker	Home Group
Claire Lawrence	Julian House
Wendy Lovell	Somerset Care and Repair
Mike McCallum	Bath and North East Somerset Clinical Commissioning Group
Brigid Musselwhite	Research Instituted for the Care of the Elderly
Matt Owen	Bath MIND
Debbie Pepler	Bath and North East Somerset Carers Centre
Katie Pink	Bath and North East Somerset Council
Carolyn Portch	Care UK
Matt Rogers	WE Care and Repair
Claire Ruiz	B&NES Doctors Urgent Care
Denise Stainer	Healthwatch Bathnes
Nicky Tew	Swallow
Steve West	Julian House Homeless Hospital Discharge Team
Sarah Williams	SWAN Advice Network
Tracey Wilmot	Support Empower Advocate Promote
Pat Wilson	Alzheimers Society
Ronnie Wright	The Care Forum

Apologies

Katy Berwick	Alzheimers Society
Sue Breakah	St Johns Hospital
Tom Fox-Proverbs	Bath and North East Somerset Carers Centre
Philippa Forsey	Creativity Works
Jan Grenfell	M and J Care Homes
Jeff Griffin	Alliance Living
Caroline Latham	Sirona Care and Health
Adrian Marchment	Priory Group
Louisa Massey	Merlin Housing
Mandy Miles	Sirona Care and Health
Karen Reid	Care South
Kay Rose	Merlin Housing
Wendy Sharman	Bath and North East Somerset Council
Bernard Wildsmith	Aquila Partnership