your care your way

Summary Report:
CCG Staff Away Day

Thursday 16th April | 9:30 am

Fry's Conference Centre, Somerdale Road, Keynsham, BS31 2AU

Meeting Summary

The CCG Staff Away Day brought together all employees of NHS BaNES Clinical Commissioning Group along with a number of professionals working in roles across the Council and the CCG.

Jane Shayler, Mike MacCallam and Sue Blackman gave a briefing to staff on the progress of the project and some of the early feedback provided so far. Staff were then asked to write down their feedback on paper "tops" or "pants" which were then hung out on a washing line for everyone to see.

Tops

- Integrating, albeit slowly, health & social care with primary care services
- Development of MDT meetings and care plans through community cluster model and community matrons
- Where services are properly integrated – we have many excellent local examples across a number of organisations
- Integration and opportunity to integrate further
- Quality and efficiency of some of our services
- Effective safeguarding services
- Caring staff, well intentioned and motivated
- Services that communicate with the patient e.g. phone them up to confirm appointments/follow them up well/feedback to the GP re outcomes

- Very good support from Dorothy House nurses/medics to general practice
- I see examples of true kindness from carers and district nurses who often go further than necessary to help “like a good family member”
- Integrated provider/ pooled budget/ one team – need to get MDTs really performing
- The frontline staff normally work beyond the required duties for the sake of the patient
- Integration to avoid a patient having to recount their problems/symptoms is a fantastic way forward. The care plan database is imperative
- The former expert patient programme has already looked at self-management. To use the DOH learning from this would be a positive for long term conditions
- The amount of support available in the community via Sure Start and children’s centres after the birth of my child – now families live far apart, support in the community can be verbal when you fall into a different phase of your life
- Staff, carers, professionals, people who manage to exercise patience, empathy and calm when dealing with frail, elderly and vulnerable people
- The district nurses seem key to everything. We need more and copy what they are doing
- Pharmacists are already working in GP practices helping join up medicines and also working in care homes – great!
- My mum received excellent rehabilitation support after having a stroke
- Good personal experience of referral from GP to Sirona for physiotherapy – fairly swift and efficient
- Support to elderly relative in their home, allowing happier and more independent lifestyle
- Introduction of PHBs enabling more individualised management of care and long term conditions
- Range of providers for diagnostic services – more choice, less waiting for patients
- There are some good services that I have personally used – excellent GP service
- Excellent school nurse service and health review
- Helped to identify visual impairment and support for my daughter

- GP surgeries offering more services which historically was undertaken by secondary care
- Ability to get x-rays in community setting as opposed to visiting “major” hospital
- GPs visiting elderly patients at home
- Some excellent specialist nursing resources which other areas don’t always have
- In reach into RUH for some community services is very positive and fosters better relationships and integration
- Commitments from many of the services to drive improvements
- The range of services available is vast and not the end though – more to do
- Fantastic MSK service – from GP to physio to OIS within 6 weeks – well done!
- Heart failure community nursing service in Bristol/South Glos – great support to my friend using tele health to promote self-care and providing easy to access phone support
- Good GP service
- Delegation of social care by the council to enable integration at a local event
- Level of support in the community for people who are vulnerable and at risk (adults and children)
- Development of cluster working
- Strong relationships across health and social care and co-location
- People providing care are great but need to be connected with each other better
- Everyone involved in someone’s care (including the patient) should all be working from one care plan
- Flexing of services to meet changing need SP4 & D24 development
- Befriending service – home visits for people housebound - my mum used the service and found it helpful for a chat
- Access to GP excellent – same day appointment system
- Some dom-care workers are kind, confident and reliable
- Current innovation e.g. community cluster teams
- A lot of very committed and experienced people working in community services

- We can use their knowledge to help to shape future services and work with others e.g. charities/carers
- Attitude and commitment of home care workers
- Skilled workforce
- Coaching and development; free support for carers and nurses
- Personalised plans per patient now coming into effect
- New funds and schemes focussing on improving service and experience (e.g. wellbeing college)
- Integration and relationships but how to take further and deliver wider “alignment” e.g. GPS to Community services to acute
- Integrated services with CCG & council (up to now) good use of third sector across children and young people
- Aspirational engaged young people who can help us!
- We have an existing provider who is willing to innovate and experiment with new models of delivery
- Using strengths based approaches eg abcd rather than just focusing on needs
- New audiology unit
- Once admitted to a ward recent experience has been attentiveness by staff
- There are so many services that people can receive at home
- We are lucky to have these services available in the first place
- Flow of people through the walk in centre (Withywood area)
- Integrated services crossing both health and social care
- Build on willingness of staff to always “go an extra step” for their patients
- Services supported by pooled budgets allowing the focus on person-centred needs being met
- Community physio – seamless service between RUH and Sirona physios when recovering from fracture
- 24/7 mental health support for CYP to avoid admissions to hospital
- Community diabetes services

- Child protection teams doing excellent work across the patch
- Support for carers
- Growing trend towards social prescribing
- Focussed weekend working plans
- Skilled workforce
- Excellent facilities
- Caring staff and dedicated staff
- Excellent hospices in the Bristol area
- Need more community centres and meetings
- Website forms
- Voluntary sector – willingness and enthusiasm to help people to manage their conditions
- Clinicians and practitioners work towards common goals
- Identify the people that are likely to need more care or joined up services soon (be proactive)
- Involve families
- Use technology to give patient info to urgent care/first response teams at first contact
- Take a video of the patient telling their story
- Pushing at an open door
- National direction for integration
- Willingness of providers to think differently
- Recognised ambition of programme overall
- Public appetite for improvement

- RUH recruitment – headed by Mel Ross
    - Because many providers are struggling to recruit and retain!
    - Using NHS Jobs and developing new processes to streamline recruitment checks = getting staff in places within KPIs
    - Joined up approach with Occ Health and L&D to ensure all new staff are healthy, safe to work and given essential training asap
    - Dedicated team to support ward managers through the recruitment process who also handle candidates = joined up service
    - Close links with RUH HR to understand organisation needs and goals

Pants

- My grandmother had care provided at home, but it was very uncoordinated. DNs, social workers, meals on wheels etc. turned up at all times of the day and she didn't know who to expect and when. No one person was responsible for her overall care. If there was a problem, we didn't know who to contact.
- Health services linking with social needs of individuals
- Insufficient time given by professionals/carers when visiting individuals in their homes
- IT systems that don't join up to form 1 plan for a person and "concerns" re data protection that stop this from changing
- Integration – looking at the patient as a whole – having to report info to different health care professionals
- Interoperability
- Communication between all providers
- Lack of communication between primary and secondary care
- Care management/coordination for patients with complex problems
- Multiplicity of services and professionals confusing – service users not sure how to access or navigate the system
- Additional pressures on Sirona with new S Glos contracts
- Information links between services

- No knowledge/foresight of patients that will be coming into the radar – reactive
- No clear pathways for patients
- Waiting times in A&E
- Care coordination and overview of services available and pathway integration
- Could there become a reliance on the carer? What happens with continuity if the carer is off or leaves? Back to square one – no individual carer is the same with both soft and hard skills
- Where will the funds for running in this way come from? There is already a deficit
- When using health visitor services after childbirth, there was a lack of coordination with GP, also the person kept changing and they were not well informed on current issues – left us with little faith in their ability
- Coordination and communication across all organisations/services about and with individuals with health and care needs
- Waiting times from GP referral to appointments for x-ray/scan
- Opening hours of services – needs 8-8 Monday – Saturday
- People don't always know what's on offer or where to go for services
- Carers can't give medication (from care agencies) DNs then have to do it – we need to invest and value our carers (skills, pay, support etc.)
- Lack of personal relationship between GP & many community teams esp. DN
- Patients often tell me that they aren't up until very late (eg lunchtime)
- As carer, can't get there until late am
- Community services for adults with LD
- Not same opportunity for socialising as previous model
- Post code lottery
- Waiting times
- Information from professionals not consistent – sometimes not correct
- Provider not fully accountable for agreed delivery eg CHC services leading to resources not being best used – arrangements too complex with too many parties all leaving responsibility for someone else

- Communication between services can be appalling i.e. GP telling hospital they do not have patient contact details when they do
- Duplication of actions – meetings seem to be suggesting these ideas as in they are new
- This project is so obvious – why is it not in place already
- Fobbing off by GPs
- Lack of health visitor support
- Not maximising benefit of community pharmacy anywhere
- Lack of support for medication review on discharge from hospital
- Lack of communication between different services – wastes time and effort and money
- Frustration as a carer around having to be proactive and chase up support or press for appointments instead of h/professionals taking responsibility for this
- Communication – don't fully understand what is out there for community services outside of the larger providers
- POA nursing service at my local GP practice – hence varied provision of care
- The ability for professionals to share information about the individual
- Loss of services within community hospitals due to funding
- No follow up after major illness once recovered from illness i.e. no support for possible onset of depression
- Follow up/self-care resources for people with LTC once discharged form community services
- Care is not necessarily joined up for people with multiple co-morbidities
- Weekend/out of hours cover is limited (and even where it is in place, do patients and other HCPs know about it?)
- Lack of follow up advice/care following admission to hospital. GP unaware of aftercare arrangements also, so no care coordinator

- My father-in-law has been sectioned and detained under the mental health act at an out of area location. This has left my mother-in-law alone at home with no offer of support from anyone other than family. She is depressed and has become socially withdrawn and is likely to deteriorate to a point when she will also need full time care. This could be avoided, but the people left behind get left behind
- Warfarin in the community run by the rules not the patient's needs because the practice nurse/GP have no expertise - include phone access to specialist
- No mental health support for individuals unless in a crisis or labelled
- Community physiotherapy – it takes too long to get an appointment; you need physio quickly, not 3 months later after the injury
- Coordination of care – skilled workforce in right place
- Lack of information about the services available – need to spend more on marketing/comms
- Carers/volunteers need more
    - Recognition
    - Reward
    - Training
    - Support in their own health
- Assuming we know what people want, based on limited engagement
- Patients only really want three things
    - An appropriate assessment
    - An appropriate HIGH QUALITY pathway to treat and manage their need
    - And a consistent offer, not postcode but universal services
    - The lack of meeting these is pants!
- Access to services – where and how to find out information
- Service users have no idea what is out there to help them – what they are entitled to and where to get help
- People expected to attend multiple appointments for diagnostic tests especially difficult for elderly or working people
- Why can't more diagnostics be carried out locally? Results by phone

- There's not one number to ring about community services eg (not in BANES) had a lot of ringing around – audiology, equipment, mental health. Make a difficult situation of dealing with one elderly relative very frustrating
- Conditions and pressures of work for home care workers
- Waiting times in hospital
- Liaising between third party suppliers and CCG/BANES leading to miscommunication
- Communication across agencies/professionals at critical points and linking to carers/family so that interventions/support are timely and right
- Lack of joined up care services; who is leading on care at home?

  DNs? Sirona? Agencies? Dorothy House?

  Difficult to know who's who, all written in separate notes
- No communication between each other suing the Dr as the point of information
- Communication problems between paediatric, outpatient, GPs and patients regarding prescription
- Too easy to obtain antibiotics for children by shopping around for a soft-touch GP
- AF management too focussed on hospital support
- Lack of capacity in social care eg care packages
- Waiting times/targets do not align across health and social care
- Inflexible financial arrangements to truly deliver integrated care
- Ability to share information across agencies so that people don't have to keep repeating their story/history
- Maternity services – not being left for long periods of time and no one helping you
- GP receptionist more friendly and understanding your needs. Asking the right questions
- Mental health or community services helping family stay together through children suffering MH problems
- Awareness of services in the community
- Lack of share information between clinicians – retelling story, latest developments etc.

- Insisting an outpatient appointment when telephone consultation would do
- Our poor understanding of what we currently get for our £40m
- Disjointed services – “out of hours” issues
- Consultants having 3 patients in at once and not op’ing to 7 hours later
- Coordination and planning of services
- Assessing patients twice
- New equipment needed
- Lack of parking at new hospitals
- Fragmented services
- Communication between professionals poor – often redo assessments just done by another professional – no professional trust
- “passing over” of a patient rather than carry the service through (eg instructing family to call in to sort out a problem that could be sorted)
- Back door of hospital and discharge mechanism too slow, not coordinated
- Lack of alternatives to admission
- Too fragmented – no one seems to be in charge/take responsibility
- Navigation through system
- People don’t know what they don’t know
- Gatekeepers too busy
- Professionals too – don’t understand how to navigate
- Not having the same midwife during pregnancy/labour – it would have been much more helpful to have seen one person
- Prime point of contact for public – personal example…
- I have cantankerous ex mother-in-law who is paying for 100% live-in as she is isolated and unsteady…money will run out soon. What is next step? DN twice per week – who do I contact that I can coordinate across providers? Need financial contact
- From experience of my close friend – LGBT/gender services ☹

- Long wait for referral (14 months)
- Few opportunities for care (1 clinic option)
- GPs unfamiliar with GPs and barriers to support (i.e. mental health)
- Clerical error in referral = dropping off the waiting list (after 14 months!)