Notes from HWP Development Board #2 meeting; 29.3.18 at Learning Links offices, Portsmouth

**Overall:**
The Healthwatch Portsmouth Board members attending the Development Board #2 meeting thought that if you looked at the overall picture of what the CCG is seeking local people's opinion the cost for the number of staff required to support a good delivery of these multi-site hubs or community services would be prohibitive, in consideration of what staffing levels are currently.

In relation to each scenario as described by Portsmouth CCG the Development Board meeting provided a critique, as follows:

Supporting Someone with Several Long Term Conditions:

The Board members wondered whether patient feedback so far gathered in the CCG's 'MCP Long Term Conditions Hub Project Working Group' (of which Ken Ebbens, HWP Board member was invited and attended in March) was being reflected in the scenario as set out? The section 'NHS in the future' sets out how teams working together would be able to give Jean the advice, support and treatment she needs in one place (for all the conditions she has); we understand that an organisation such as Diabetes UK which can provide patient insight on the planning of a multiple-long term condition service in Portsmouth has not been involved so far in the discussions of the LTC Hub Project Grp. Board members commented that the John Pounds Centre and Age UK have been offering a broad range of support for people in Portsmouth with a range of Long Term Conditions. Would the new one person/team co-ordinating the 'big picture' of Jean's health divert funds for existing community based voluntary sector provided services? In addition, Board members asked:

- Would every Long Term Condition be supported at the local facility? Any exclusions due to cost?

- While the one person/team had resonance with HWP Board members we wondered if it was likely to be a GP or practice nurse who would take on this role of care co-ordination? Since there aren't any 'community hospitals' in Portsmouth the only location for the one person/team could be a GP surgery. For a sufficient supply to meet patient demand and prevent long journeys for patients there would need to be many of these 'big picture services' across the city? Where would these staff be recruited from? It is difficult to find enough locums in Portsmouth to cover for staff AL.

- Are community nurses who visit patients (with multiple Long Term Conditions) in their homes included in this scenario? When providing support to the 'big picture service' will hospital staff receive training in how to communicate effectively in a community based setting, or when visiting a patient in their own home? What will be the management and support structure be for these health care professionals?

- Would service be 24/7 or 5 days/week? Any weekend cover? Any online support for patients? Would the IT systems in the GP surgery be compatible with IT used by the wide range of staff in hospitals, pharmacists, physios, doctors and nurses (and across providers) to provide the combined advice, support and treatment for Jean? In order to provide a triage service in the (GP surgery based?) local facility the patient's history of care would need to be visible to all staff needing to discuss and make a decision about care for Jean.

- What could be done to provide Jean with a preventative health care service rather than just 'keeping Jean feeling well' ? Advice provided on the 'wider determinants of health' (e.g. whether the patient had suitable housing to aid good health, whether there was good advice available on debt?) could form a very important part of Jean's preventative health strategy and avoid hospital appointments.

- In relation to the carer for Jean – the suggestion of working with the voluntary sector to provide non-medical support for the carer's needs - would the voluntary sector be expected to provide the services suggested (befriending, transport, respite breaks) for free? Would there be eligibility Qs?

- Patients will need to increase their trust of community based health services and not feel the need to go to hospital 'to see a specialist'. In the 'big picture service' patients may even end up not being seen by a doctor in the facility which will require a change in mind-set for the patient.

<u>Supporting someone who is extremely frail</u>

In general the Development Board felt that it was a good idea, referencing the 'care plan approach', but the practical implications required to deliver this new type of service could present problems:

- If a person is frail it is likely they will have multiple needs. HWP Board members said that feedback they have gathered over time was that GPs are interested in providing support for a range of needs for people who are frail but other front line staff in GP surgeries tend to be less interested in providing the holistic approach – so there could be a staff training need? Perhaps 'Make Every Contact Count' (MECC) local training could be provided for frontline staff?

- In this scenario if Maureen is falling over and her husband is quite frail, she is attending more GP appointments and needs more home visits, the idea for the NHS in the future to 'build stronger teams of staff working in the community' (with all the staff training implications) would require a consideration if home adaptations could provide more tangible preventative care? Perhaps the CCG should be considering increasing the use of a 'home adaptations/re-ablement' type grant, for frail elderly person(s) in their home to prevent hospital admissions?

- What if technology was installed in people's homes to support GP surgeries to monitor the ongoing health of people who are frail to remain in their homes rather than attend appointments?

- The 'stronger team' to include GPs as well as hospital, ambulance and social care staff is not likely to have the same availability, specifically with hospital based staff's shift patterns. It's a large team 'to all know about Maureen's needs' rather than just a few staff in her local GP surgery. So which would be the *lead team* – GP or Hospital developing Maureen's care plan? How would patient data transfer seamlessly between primary and secondary care?

- The 'frailty team' in hospitals tend to already help divert need away from hospital? If Portsmouth CCG manages to reduce demand in QA with this initiative it would need to be dovetailed with whatever is being planned at Hants CCG otherwise any gain in demand management could be lost?

- Regarding hospital staff knowing Maureen's full story in order to help her smooth return home after an in-patient stay and staying in touch with other professionals : what about mentioning the social workers and voluntary sector in this part of the scenario? The Care UK Café (? at St Mary's)

could offer a range of services to patients, soon to be discharged, such as signposting to other support services in the local area that they can access.

Supporting someone who needs occasional same day care

In general the Development Board felt that access to patient records, knowledge of the patient's history and the ability of the GP surgery to provide a 'same day service' within say 30 minutes of arrival would be crucial to prevent Lisa reverting to use A&E services to access the care she needs.

- Southsea is poorly served for GP surgeries so the provision of triaged rapid access services (with signposting to other immediate support?) in that area of Portsmouth could be difficult.

- Would Lisa be satisfied that it may not necessarily be a GP that she/ her young family member sees? If the triaging service at her surgery or another local GP surgery identifies that a physio/pharmacist or a new 'physician associate' (for example) is more appropriate they would need to build greater trust in the public that the standard of healthcare they would receive from other health professional is equivalent to the 'GP standard' that Lisa/ her family member would receive?

- On the idea of Lisa perhaps needing to be asked to travel further to access an appointment that day: – who would be making that decision? Unless additional healthcare staff are recruited there will the same, if not more patients (if being encouraged away from A&E) trying to access the same number of available 'same day appointments' across the city? There is generally a shortage of GP appointments across the city.

- Is the premise of the patient travelling further afield to access 'same day GP surgery level of service' to be marketed as 'you know you want a GP standard service locally but you don't mind if another equally good health professional could give you the level and type of care or advice you are looking for' ? There needs to be an implied 'GP standard-as-good-as-alternative healthcare professional service' offer made.

- The Development Board thought that in the future, providing same day access via a face to face assessment in these 'same day service GP surgeries' rather than restricting rapid access to care just via the 111 service would be a good thing. But would there necessarily be a ***broader range*** of healthcare skills/personnel available to Lisa as a consequence of a group of local GP practices coming together in order to cover a larger constituency with 'pooled staffing, buildings and skills'? It is also important that signposting/information about local teams providing support on the wider determinants of health, such as housing, debt advice and legal advice is made available at the time. Reminders that Lisa and her family might be able to access support from her local network of friends and neighbours should feature during the initial assessment of Lisa/her family member?

- In reference to the 'new technology' idea that more people would be able to contact NHS staff from their home, does the CCG simply mean patients being able to text GP surgeries or request online consultations? How much clearer would the information be received by the patient about their condition/query compared to the current 111 service that people use? More healthcare staff would be needed to field and provide advice on the calls/texts?

Supporting someone with several mental health problems

While the Development Board produced in January a critique of the mental health scenario version as issued by the CCG at the end of December (version 2) we felt that this version (version 3, produced further to our feedback on v2) should still receive some consideration, so the critique below is on version 3 of the mental health scenario:

In general the idea of offering a 'care plan approach' to supporting people with several mental health problems was praised but Board members observed it hasn't worked well so far in practice.

- Building stronger teams in the community (even offering 3 – 5 teams would be aspirational) would not actually provide services 'close to people's homes' across the city.

- Ref 'mental health staff working together with GPs, nurses, pharmacists, physios' which hospital staff would be identified to work with the community based teams? Would Talking Change or Parity of Esteem staff be included?

- Regarding Mike's struggles and 'needing extra support' it may be that the voluntary sector can offer support here by providing practical support such as help with the garden, housework or dealing with incoming post and responding to requests for payment rather than more specialised health care? The Solent MIND model is a good one since those people providing support are trained to support people with particular mental health issues rather than being trained to provide a generic peer support service.
- The qualitative standards provided in secondary care mental health will be more guaranteed than the service that might be offered to people with (perhaps complex as well as) multiple needs from generic peer supporters recruited by the voluntary sector.

- The NHS could provide support relating to vulnerable adults, safeguarding and child protection by working more closely with social care services (in localities?)

Notes end.
Siobhain McCurrach 13.4.18