NHS
South Lincolnshire
Clinical Commissioning Group

South Lincolnshire Clinical Commissioning Group Commissioning Intentions

Public Engagement Report

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This report has been produced in line with South Lincolnshire Clinical Commissioning Group (CCG) commitment to ensuring the public and patients are fully aware of their local services and have the opportunity to comment on; ask questions or leave patient experience or feedback, and giving them the voice to question our coming year's activities.

This information will support towards a wider project where the CCG will be meeting with a number of stakeholders to determine next year's priority areas and has commenced this year's cycle of commissioning intentions.

Last Year's & Current Priorities

In July 2013 and 2014 we spoke to stakeholders, patients and the public to look at the current priorities for SLCCG and what work we had been carrying out to achieve these, and to look at whether these areas were still relevant to the local population and to meeting set aims and objectives.

During 13/14 patients told us the things important to them:

- Preventative services
- Care delivered locally
- Patients seen quickly
- People encouraged to take responsibility for their own health
- Make communication between organisations better
- Treat patients with compassion and support them and staff to get involved

This informed our commissioning priorities for the following two years SLCCG continues to take these forward and improvements have already been seen in areas such as:

- Revising pathways of care to support care close to home –Peterborough Hospitals now provide chemotherapy in Spalding Community Hospital saving patients and their carers travel.
- Movement to best practice in referral and patient management – SLCCG have continued to roll out Pathfinder tool and now look to improve usage across the CCG.
- Expansion of patient choice through Any Qualified Provider (AQP) where market conditions indicate this represents good value for money- AQPs have been successful and increased local provision has already started in ophthalmology, community surgical treatments and physiotherapy.
- Cancer Pathways review – Certain cancer pathway are being reviewed to make sure the reliance upon hospital care is retained at a necessary minimum, whilst at the same time working to support the longer-term 'survivorship' work to support and empower patients and their families to feel more confident once their active cancer treatment has ended.
- Improving End of Life Care – As part of county-wide work, we are focusing on the palliative and end of life care that patients currently have to make sure the patient, their families/carers receive the right level of

support to plan ahead more, when this is at all possible. When this is not possible, we are improving the communication and working relationships between our local services in our community to avoid any unnecessary delays to ensure our patient and carer experiences are as positive as possible.

- Improving patient access and experience for Mental Health and Learning Disabilities – SLCCG has secured Cantab mobile an app that is used in primary care to diagnose patients with dementia enabling patients and carers to proactively access support services and plan for future needs, recently commissioned dementia management support for Stamford neighbourhood team and looking to expand. A CAT car has been commissioned via EMAS. The car will respond to urgent calls received by the call centre for patients who have fallen but after assessment over the phone do not need hospital admission. The Car is staffed with a paramedic and Emergency Care Assistant who will attend the scene and provide a full assessment. They will also ensure that the patient is taken home or to a place of safety. If hospital attendance is needed the crew will call for an ambulance to convey the patient to hospital. Also a Triage car is currently in the pilot phase, managed by EMAS the car is staffed by a Mental Health Nurse and a paramedic. The car will respond to all urgent calls which do not require an A&E admission. Early results show good rates of both diversion and outcomes which do not result in use of policy custody or admission to hospital. The Crisis Concordat Declaration has been written and signed up to by the main stakeholders. This is a whole community approach to Mental Health Care.
- Review of Diabetes services to improve community access. Following the patient involvement meetings of March 2014 and the internal review of Diabetes Services patients informed us they wanted local access to services; peer support and more education to self-manage. The implementation of Neighbourhood Teams will support in more localised services. In addition we secured additional funding to run 4 interactive educational sessions to encourage innovative ways to manage diabetes, the sessions will cover various topic including dietary advice, physical activity and managing the condition.

Other areas the CCG has progressed on during 2014/15 are:

- **ENT** – Procurement during 2014/15 has secured a minor ENT service bringing appropriate services into the community, creating better access for patients and carers.
- **IBS / IBM management** –Faecal Calprotectin testing for the diagnosis of IBS / IBS in order to reduce the requirement to send patients to secondary care for invasive diagnostic testing has been introduced
- **Stroke prevention** – Identification of patients with Atrial Fibrillation using GRASP –AF Tool is currently being rolled out across the CCG practices. Patients identified at risk of a stroke using a CHADS2 scoring system are then prescribed anti-coagulation to reduce the risk of a stroke.
- **Chronic Heart Failure management** – To increase the number of patients on Heart Failure Registers prescribed ACE Inhibitors to reduce hypertension. All South Lincolnshire CCG GP Practices were offered the opportunity of 'up skilling training' on the management of heart failure. 8 out of 15 practices participated in the training. The CCG are now in the process of rolling this training out to the rest of the practices.
- **Dementia Strategy** – Review of services to improve and increase support and levels of intervention for patients and carers. Key achievements in 2014/5 were the launch of the Cantab Mobile which is a tablet based application that can be used by any health care professional to help in the diagnosis of Dementia. The Delivery and Development Manager has also undertaken the Dementia Friends training and will become a Dementia Champion and will encourage others to participate in the Dementia Friends Scheme. The focus in 2015 will be working with GP Practices who are within the bottom quartile of screening rates to encourage them to utilise the tools that are available to screen patients for Dementia, therefore optimising their Dementia Diagnosis rates.

Public Engagement Process

Following the success of last year's approach to engagement with patients and the public, the CCG has undertaken specific local engagement that has supported us to reach a wider audience including those individuals who, at this moment in time, may not necessarily be accessing health services.

It is of great importance to South Lincolnshire CCG that as many members of the public are able to give their opinion and experience regarding their local services, and therefore took a number of different approaches in order to make the engagement as interactive; meaningful and useful to members of the community.

The CCG attended various events to advertise and seek opinion of the current (future) priorities and these included:

- 2 x Car boots in South Lincolnshire
- Spalding Market
- Carer's AGM
- Carer's Roadshow – Bourne
- Fire Station Family Fun day
- Bakkavor Pizza factory event
- Dementia Café at Tonic
- The Healthwatch AGM

At these events we asked the public to vote for the priorities they felt were still important and relevant and more work should be continued to support the population of South, and more importantly tell us if they felt anything was missing. These areas were pulled together from the areas patients had told us were important before and the work we still have yet to achieve as a CCG as well as incorporating the themes of the Lincolnshire Health and Care Programme. These areas are as follows:

- Mental Health: *continuing to support with education and learning for both patients and professionals to improve patient experience.*
- End of Life Care: *Continuing to improve end of life planning with patients; carers; families and friends.*
- Proactive Care: *Following on from our Chronic Heart Failure; diabetes and stroke prevention work. More education and learning for patients to better self-manage and better prescribing to reduce long term risks.*
- Neighbourhood Working: *Professionals working better together and locally for a better patient journey.*
- More Services at Local GP Practices: *Increasing the amount of services that are available at a GP practice.*
- Cancer Services: *continuing to improve local access to chemotherapy services.*
- Dementia Care: *focussing on earlier diagnosis of dementia and pathways of services after diagnosis.*

The events were held throughout July and August 2015 across the South Lincolnshire area. Information was taken that promoted healthy eating; keeping active; 111 information and safeguarding information. We also had tools for the public to vote which were quick and simple and therefore encouraged a higher number of people to take part. Some of the events we visited were discussion events, which enables us to cover feedback regarding our priorities and the Lincolnshire Health and Care Programme, the verbatim responses to these sessions can be found in the appendices.

Findings of Public Engagement

Over all of the events the CCG spoke to a total of 265 people, and this was broken down as follows:

2 x Car Boot Sales	61
Spalding Market	12
Carers Roadshow Bourne	22
Fire Station Family Fun Day	50
Carer's AGM	21
Bakkavor Pizza	67
Dementia Carer – Tonic	16
Healthwatch AGM	16
TOTAL	**265**

This figure encompasses a large number of people who may not regularly access local healthcare and therefore do not get the opportunity to comment regularly. A number of different approaches were taken to ensure that the engagement was undertaken in an inclusive manner.

The table below shows the split of the votes across all the events and how the public and patients saw which areas still needed improvement:

Healthcare Area	CCG Events
Mental Health: *continuing to support with education and learning for both patients and professionals to improve patient experience.*	**99**
End of Life Care: *Continuing to improve end of life planning with patients; carers; families and friends.*	**66**
Proactive Care: *Following on from our Chronic Heart Failure; diabetes and stroke prevention work. More education and learning for patients to better self-manage and better prescribing to reduce long term risks.*	**88**
Neighbourhood Working: *Professionals working better together and locally for a better patient journey.*	**43**
More Services at Local GP Practices: *Increasing the amount of services that are available at a GP practice*	**94**
Cancer Services: *continuing to improve local access to chemotherapy services.*	**96**
Dementia Care: *focussing on earlier diagnosis of dementia and pathways of services after diagnosis.*	**77**

These figures show that the public spoken to feel that, for the second year running mental health services do need the most of our attention moving forward, with particular attention needed around young people in the transition from children's' to adults' and mental health of working age individuals. Collectively feel that working in neighbourhood teams is something we should do automatically to ensure better patient experience.

It addition to gaining the overall thoughts of the public we also asked for reasons as to why they felt these were important to them, this could be based on personal experience or known experiences of friends and/or relatives, or a professional viewpoint.

Some patient stories are historic in terms of time, however important to note that one bad experience can influence people in the long term, their view of the NHS and also the way in which they access care now albeit not in the correct way.

One resounding element that came from speaking with the public was that they wanted integrated health and social care and they wanted to use GP practices for more services and their local hospitals. People knew they would have to travel for some services, however accessing more locally and at more convenient times were very high on people's agendas.

Carers as well do not feel listened too. It is felt that they are invisible and that they are not included in the discharge process, if they are the main carer they need to know what is happening now and next. One concern that was voiced at the Carers Roadshow was about supporting new carers, and this was felt to be an area lacking that needed to be added.

The experiences/views are recorded below in the appendices verbatim, which gives the raw feeling to the data above. These have also been added to the patient experience logs and will be utilised by the CCG within their quality processes, where appropriate.

Areas that were not included but the public felt are important

Participants were also asked if they felt that there were any areas/ideas that we hadn't listed that they also felt were important. Preventative care was high on the agenda of the public including health education and self-management.

Additionally there were 5 other areas that were noted as being important to some of those who comments, these were wide ranging and are shown below:

- Mental Health Services:
    - *Transitional MH services from young people to adults (especially for Autism as there are a number of big life changes at the same time – helps to reduce self-harm.*
    - *This is the most important – how do you identify and work with working people with mental health problems*
    - *Does the CCG use "Together for Short Lives" Regional Action Group for MH, if not can we support to get one and support group?*

- Neighbourhood Working:
    - *Point of communication from GP referral – once in the system great, pre this in limbo (no diagnosis – no label)*

- Cancer Services:
    - *Can Chemotherapy not go on vans like retinopathy/screening etc. in supermarket car parks etc.?*
    - *Why doesn't South Lincolnshire CCG commission services from EPOC?*

One member of the public asked why there was no mention of women's and children's care in this consultation and felt that it is always forgotten, and this is not just relevant to the South. The Lincolnshire Health and Care programme was discussed and the patient was informed how this would form countywide work and changes and that it was a priority for all 4 CCGs in line with this project.

Conclusion

The public engagement for this year's commissioning intentions cycle clearly shows that mental health, especially in working age adults and young people aged 14-19 and accessing more services at the local GP are the most important areas to the sample of people we spoke too. Interestingly, in addition to the outreach work a proportion of the Annual Public Meeting included discussion around the mental health for younger people and especially those transitioning between children's and adults'.

The voice of patients and the public are very strong in south Lincolnshire and throughout the engagement they were extremely pleased with the progress and the changes that the CCG had undertaken, and felt their views were heard and they were told about changes.

Appendices

Appendix One: Carers Partnership Roadshow Notes (CI/LHAC)

Questions posed to Carers and Cared For (Bourne Salvation Army 30th July 2015)

How can we reduce A&E usage?

- Extra GP hours, more walk in centres.
- Better triage between patient and A&E
- Better education to migrant populations to not use A&E
- Carer information for these people (migrant population) as well
- Having nurses in workplaces, so you don't have to go to A&E
- Accessible information in different languages and formats (how not to end up in A&E but also what to do after you leave)
- A&E to general – need to decide which way to go
- Too many names for the same thing e.g. walk in centre/urgent care centre etc.
- More GP triage by a nurse to see if you need a doctor (by phone)
- More support for carers register, which GPs use it?
- Get GPs more involved and supporting change – for example where are they this evening?

How can we improve urgent care services?

- Doctors using technology more, to get more access to more knowledge – to decide there and then does this person need A&E? Is there another route?
- GPs need to know what other services are available, GPs don't know, education for GPs on what going on.
- Bourne surgeries have leaflets on services locally – they should use these more, they don't.
- Galletly is very good
- GPs should listen – don't all do that and not prepared to talk to carers
- Length of GP appointment should be longer may impact on wider situation – less A&E etc.

Should A&E only be for patients with life threatening issues or after a serious accident?

- Yes fine – if somewhere else
- Johnson doesn't always have a service
- NHS Choices needs to be clearer
- What do we call all the services available – not clear
- 111 service is diabolical – use it and end up in A&E anyway
- EMAS staff say to not bother with 111 when they turn up
- We need to look at outcomes for patient that we want to achieve not what is easiest e.g. A&E
- Triage at A&E to separate people better
- Urgent and non-urgent differences, education for people and to manage expectation

Care in a Community Setting?

- Neighbourhood Teams – joint working, experts look at patients in a multi-disciplinary way, looking up the 2% to minimise A&E admissions
- Cohesive care is important not labels

What community service would you like?

- 80 year old widow who is carer for her 47 year old disabled son

- Emphasis on money – always filling in forms it is hours of my time
- Social education centre in Bourne, this has gone
- It is not as good as it used to be
- Professionals were on hand at centres, cohesive care
- Use spaces in services better
- Where does the money go when places sold, not re-invested for services gone from
- Better communication
- Need social care to work better and be quicker
- Just moving money around at the moment, not helpful to the person

Appendix Two: The benefits of integrated/neighbourhood team working to carers, discussion.

What would the benefits be to you, as a carer, if neighbourhood teams successfully brought professionals together?

- A quicker response
- Not having to repeat your circumstances over and over again
- More chance of follow up appointments
- Communication to be improved regarding power of attorney and medical power of attorney
- Not having to re-tell your story
- Professionals more aware of what each other can do and support they provide
- Potential benefits of co-location and community hubs
- Proactive approach means carer/patient isn't left chasing all the time
- GPs know what services are available, practice managers can signpost
- Telling story once
- Time limited support is not good
- What happens after the 6 weeks [free care from social care]
- More flexible approach from service providers
- Longer contracts - maintain good staff continuity
- Carer involvement in service in design and on the neighbourhood teams
- Single point of contact – quicker and easier
- Gives confidence in using different services
- Don't have to tell your story as much – less repetitive
- More personal – building a record of information – more time for the present issues to be resolved
- Save resources/time/travel – to provide more patient time/care
- Less stress for patient and carer

Do you see any challenges, as a carer, with integrated working?

- Having to repeat yourself as medical staff do not always communicate
- Communicating power of attorney and medical power of attorney are two different things, but in case of emergencies a close relative should be able to make decisions
- Communication of discharge
- Transport to be communicated better and the correct transport *transport member to be on neighbourhood team
- Bureaucracy
- Lack of connection between health and social care
- Different IT systems and info sharing protocols
- Ever decreasing pot of money
- Had to simplify
- Who is the first point of contact when multiple agencies involved, as organisations pass responsibility
- NHS needs to join up first too many layers – too much terminology
- Needs to be a leader of the neighbourhood teams to co-ordinate this
- Are they going to work together? E.g. professionals, agencies, hospitals
- Many may not want information shared – need to have security restrictions
- Being listened to as a carer and being involved

What do you think the overall barrier to success would be for neighbourhood teams?

- Funding
- Would other services be neglected?
- Professional institutionalisation
- Social vs medical jargon buster
- Hierarchy and leadership
- Cultural ethos is different in each organisation
- We have 'set' ways of doing things
- Promoting the service
- Clear language
- VCS orgs need to be able to access information when working with same clients – when involved with care – data protection – confidentiality
- Referral route
- Is the route to joined up working clear
- Managing contract outcome timescales
- Present multi-agency system contradicts itself
- Advertising services/support to have consistency with all services/areas
- Agencies working together
- Being cohesive
- Structure of agencies (including staff) will have to change
- IT systems and having contingency plans just in case

What else is important to carers that would support us to work better together?

- To take into account the carers point of view regarding the cared for
- To listen to carers
- Bring a neighbourhood team to the roadshows
- To be welcoming
- To enable the 'cared for' and the 'carer' to say their piece without being interrupted
- Feedback – more pilots – market research – run by communities
- Based on experience and not just money
- More effective PPGs
- Carers and Patients:
    - Discharge out of county
    - Communication
    - Home safe availability
- Being able to share information
- Not repeating yourself and being listened to
- Being part of a team as a carer
- Using carers journal to support the team