Community Services Redesign
Public Workshops Report
February and March 2019

1. INTRODUCTION

Extensive engagement activity has been undertaken to hear the views on how a new integrated model of community care changes the experiences of staff, family carers and patients and people who use the service. This work is part of the Better Care Together programme for Leicester, Leicestershire and Rutland (LLR), engagement activity

The services we are reviewing are:

- District nurses
- Intensive Community Support Service
- Domiciliary therapy (occupational therapists and physiotherapists
- Community hospital inpatient beds
- Care home reablement beds
- Primary Care Co-ordinators (discharge workers in hospital)

Research has been extensive and has included:

- Face-to-face qualitative interviews (n. 156)
- Online qualitative survey (n.66)
- Examined 22 existing reports in line with community services from research in LLR representing 4,300 people (patients, family carers and staff)
- Presented findings at six public workshops across LLR and captured further insights from 169 people (patients, family carers and staff)
- Presented findings at 3 workshops to capture insights regarding travelling communities, Asian family carers of people with learning disabilities and Hinckley Locality Patient Participation Group (PPG) – total of 21 people

This report should not be seen in isolation. In addition to this report, two others reports have been published. The first presents the findings of an examination of 22 existing reports in line with community services. A second report presents the insights of the Face-to-Face qualitative interviews and the online qualitative survey. It also shows the outcome of an examination of the qualitative secondary research in line with the 22 existing reports.

A total of 4,712 patients, staff, family carers and stakeholder insights have been considered and reviewed.

2. PURPOSE OF REPORT

This report presents the additional insights gathered at six public workshops held to share the findings of the research. It also includes findings from three workshops to capture insights from specific communities.

The six workshops were held across LLR and were attended by 169 people on:

- Monday 11th February 2019, 2.00pm – 4.00pm, Wycliffe Rooms, 27 George Street, Lutterworth, LE17 4ED
- Tuesday 12th February 2019, 6.00pm – 8.00pm – NSPCC National Training Centre, 3 Gilmour Close, Beaumont Leys, LE4 1EZ
- Tuesday 26th February 2019, 6.00pm – 8.00pm – Rutland County Council, Catmose House, Catmose Street, Oakham LE15 6HP
- Wednesday 27th February, 6.00pm – 8.00pm - Heartwood Conference Centre, Rothley House, Coalville Business Park, Coalville, LE67 3NR
- Tuesday 5th March 2019, Holiday Inn, 299 Leicester Road Wigston Fields, Leicester LE18 1JW
- Wednesday 6th March 2019, 2.00pm – 4.00pm, Leicestershire Voluntary Action, 9 Newarke Street, Leicester LE1 5SN

At the workshops we shared what we have learnt so far about experiences of community health services and what matters most to people. We also explained the work that has been happening to redesign community services and how all the insights are contributing and influencing our thinking about how services could look in the future.

The events were the opportunity for anyone who had an interest in designing future community services to get involved – staff working in acute or community settings, social care staff, domiciliary care workers, GPs, care home staff, patients and family carers receiving or with an interest in community care and people working in voluntary and community organisations. We also welcomed patients, family carers and health and care professionals who participated in the research.

During the event we worked together to hear what surprised people and what resonated with them. We also asked them what else we needed to consider when designing services and whether they felt that the insights so far aligned with the proposals for how community services should look in the future.

3. KEY THEMES AND SIMILARITIES

People attending the public events and workshops, after hearing the insights and business intelligence gather, were asked to express what resonated with them and what they found surprising.

In summary when sharing the insights from patients in hospital beds, people at the public workshops felt:

- Picture relayed by patients in their own home is mixed. Patients would prefer to stay in their own home, but their level of confidence is dependent on support from family and external agencies which can vary. People perceived that physiotherapy is not always safe in a home environment, due to space and consideration of general safety issues. People felt a night service is reassuring to make sure patients are comfortable, particularly when stepping from a hospital to home environment. Without this type of service people didn't know 'where you would go in the middle of the night.'

- Relations with services, including their GP is important. The inability to get timely appointments and to see the same GP is a frustration. Services not arriving on time and the lack of communication are all issues. People feel that an improved relationship with health and care services would give them more confidence.

- Falls and deteriorating health are frequently mentioned as a cause of crisis. Low points people feel should be improved to help service users to manage in their own home include assistive technology and home adaptations. Also improved and timely communications from services, improved relationships with staff and a better language/cultural understanding. The language used was of particular importance, whether used on the telephone, face-to-face, in leaflets or online. Certain services being called one thing if you live in the city and something else if you are in Rutland or Leicestershire is confusing. Where people live on a border, there is the added complication of different services and terms in other counties. The different terms used across health and social care was also found to be unhelpful. People were also confused regarding what constituted a 'crisis', which was felt to mean different things to different people.

- Patient can be left feeling stressed and socially isolated. They would like to do the things they were once able to do or at least have the best mobility they can. Socialising, involvement in external agencies are important. Mobility is everything and having support to enable people to keep busy and as physically active as they can are seen as important to improve both physical wellbeing. Physio and occupational therapies are seen as particularly important. People in the workshops were surprised that mental health was not an integrated part of the community services redesign. They felt that a more joined up approach to services supporting good physical and mental health would prevent more people from having an emotional breakdown, particularly those people who are coping with a long term physical condition. People also saw social prescribing as a support service for patients and their family carers.

- The importance of good communication throughout all stages of the patient journey resounds throughout the insights. It is essential for patients to feel confident, cared for and supported.
- The need to feel supported is also essential to recovery and wellbeing and discharge is seen as a really low point, particularly if it is late in the evening. People gave experiences of sorting out medication at the point of discharge as feeling chaotic.
- People demonstrated their reliance on support while in hospital to aid successful recovery, particularly from physiotherapists and occupational therapists, other hospital staff, friends and relatives. They also relied on this support when they return home.
- Community hospitals are seen as an important part of patients' treatment closer to home, although some patients were unsure why they were in a community hospital and what treatment they could expect. Some people were concerned that reducing community hospital beds in LLR could result in more people using beds across the borders.
- Border issues and rural v urban solutions and transport issues are also of concern.

In summary when sharing insights from family carers, people at the public workshops felt:

- Entire pathway of care is a low point and for people in the workshop was felt to be a key area that needed to be considered. People want services which are reliable and appropriate to their situation and allow them to support their loved one. They report difficulties in getting the help they need and frustration around the processes, including decision making and discharge. Getting further help at times of crisis was a challenge for some.
- Providing care at home is described as simply waiting for the next crisis to happen. This was enhanced for people supporting a family member with dementia, also for people caring for a loved one with a learning disability. Carers felt that these conditions were not always understood and they shared experiences of staff supporting patients with physical conditions being over whelmed by the mental condition.
- There were mixed relationships with services and staff. People did not always receive consistent information and were not involved and kept informed. People felt that having information appropriate for carers all on one website would be useful.

- People from Asian communities felt that some staff were going into their home with a cultural bias, intensified by lack of a translator or interpreter. Trust and empathy breaks down through a lack of understanding.

- The caring role resulted in emotional stress for carers, such that they did not feel that they could take holidays or have breaks.

- Areas of concern were falls, getting help when their loved ones' health deteriorates and administering painkillers. Where the patients also has a mental health condition, carers want stronger links to mental health services and to their GP practice, particularly around medication.

- Neighbours and friends play a vital role and want to be differentiated from family carers. People gave examples of supporting a neighbour or friend, particularly when patients have no family around them. They shared experiences of communicating with services when they are perceived as having no 'permission' to help their friend or neighbour.

- People also want more recognised involvement of voluntary and community sector in a formal capacity, rather than a voluntary one.

In summary when sharing insights from health and social care staff, people at the public workshops felt:

- Building good relations/working together with patients/families are important. Trying to involve patients in their care, can be challenging where patients/ family disagree or don't understand care available. Time/ workload pressures reduce ability to develop good relationship with patients/ families including too much documentation for staff to read and note. Providing emotional support is rewarding, but more guidance, training and time is needed.

- Relationships with other services significantly impact on the care given. Good working relationships with other teams are important - where teams work well together/trust each other the outcomes for patients are improved. Quality of relationships varies, but are improved where individuals know each other. The issues people describe between services are poor communication, lack of awareness of services/ referral criteria not clearly understood. Relations with Social Services can be a particular issue. Staff shared experiences of cultural differences including different service criteria. Also how services talk 'a different language'. Different terms are used to describe the same thing. Once this is understood across teams, barriers are lifted. People suggested that interdisciplinary training opportunities across social care would be beneficial.

- Staff suggest that IT support can help closer working between services, e.g. the referral process, but can reduce team working. Job satisfaction is important. They want their work valued and feel they are making a difference.

- They feel stressed and tired, particular if short staffed, have high caseload or are doing a lot of travelling across LLR to see patients. Job is made easier by supportive colleagues and leaders who work well together and good relationships with other teams.

- They worry about having evidence that a new model of care will work, whether new staff can be recruited and whether there is the money to recruit staff. Staff want better communications and involvement about proposed changes. They also described the need to win hearts and minds as being a big task, so that the fundamental direction of travel is clear for staff and they are on board.

In summary when sharing insights from care home and domiciliary care staff, people at the public workshops felt:

- A mixed resonants. Particular low points in the care pathway are around relationships with other health and social care staff and involving the person in decisions about their care.

- Co-ordination and providing physical and emotional support is an area of concern. Time factors sometimes prevent this to be considered equally.

- Some people did have concerns about using care home beds as reablement beds. They felt is could cause patient anxiety if they had not chosen the home and they may see it as permanent rather than temporary. Also some people perceived care homes as variable in quality.

- Integrated services, good communication and involvement and team working between agencies/care homes is important particularly the reablement assessment.

4. WHAT ELSE WE NEED TO CONSIDER WHEN REDESIGNING COMMUNITY SERVICES

In the second part of the public workshops, we shared the proposals relating to the redesign of community health service. People were asked to tell us, how they felt they aligned with the insights and business intelligence. We also asked them to tell us what else we need to consider.

- Some staff shared work they had done in other areas:

  “I did this in Warwickshire – they put all teams together in one building, but you went off and did your own work as usual. They [staff] were out of their comfort zones – dividing peoples’ professionalism.”

  “Care as seen by specialists not just generalists.”

People had ideas for consideration to improve information sharing and communication:

"One-stop-shop to track patients, carers or GPs. Telephone number of people who know what is happening generally between health and social services."

"Community forum on line."

"First contact plus style service for health services – falls, pain, podiatry, physio etc."

- People wanted a review of the GP service model – particularly the appointment system.

"More than one item, my GP refuses to listen."

- The zero suicide ambition model was suggested as something to look at.
- People felt more support to help carers prevent 'crisis', signposting to self-help was important.

"Mobile carer college offering free courses in the areas, similar to recovery college."

"Lasing Power of Attorney to be considered in the care plan and also wills and consent forms."

- People asked for more information regarding community services financial model, to gain assurance that we have the resources to deliver the new model of care to patients.
- People were also interested in understanding what the ratio of clinical and care team numbers to patients is needed to deliver the quality of patient care needed in the new model.
- People suggested widening the integration of the model to include some voluntary sector organisations.
- People also wanted to see end of life care fully integrated into the community services model
- People felt that there were challenges with services across borders:

"Needs to be more understanding between patients and GPs about referrals out of the county and the implications. For example, systems don't talk to social services and discharge is appalling due to communication."

"Border liaison officers work with Burton and Nuneaton hospitals to improve relationship."

- People wanted us to recognise the interdependencies across services including services outside of NHS and social care:

"Prevention especially mobility – how are community services integrating with prevention – particularly active Rutland and voluntary groups?"

“Join up with education – prevention/good health. Educate young at school.”

“I have worked in mental health and stroke and a lot of services overlap – need to address diet, mobility, smoking – there has to be a better way to address this.”

“Lead time as prevention is so long – you often don’t see impacts immediately – don’t focus on short term. Invest for the future.”

“Why not consider Multi-disciplinary Team – including police.”

- People were concerned about increasing population size and increase in the number of new homes being built.

  “Different numbers of population – demographically will the number of staff be considered?”

5. The way these insights are used

Better Care Together partnership wish to thank patients, carers, staff and the public for their time in sharing their experiences of health care and talking to us about what matters most.

The insights and business intelligence contained in this report and the first two reports published are supporting the development of the options and shaping the model of community care in Leicester, Leicestershire and Rutland.

Additional information can be found at: http://www.bettercareleicester.nhs.uk/

Consolidation and Engagement Report (September 2018)

Qualitative Interview Report (January 2019)