Northumberland Clinical Commissioning Group – Patient Forum Feedback – 11 July 2015

Introduction

The third CCG Patient Forum event took place on 11 July 2015.The event was well attended by 25 patients, 11 CCG staff and 6 service providers. The patient forum steering group were involved in planning the event and, as the last forum was held in Morpeth, decided to hold the event closer to Alnwick. Shilbottle community hall was selected as the building was purpose built in 2010, close to the A1 and had excellent facilities.

Service providers represented at the event included Northumbria NHS Foundation Trust (NFT), Northumberland, Tyne and Wear NHS Foundation Trust (NTW), Northumberland Carers Centre and Healthwatch Northumberland (Northumberland County Council were invited but were unable to attend). The NFT stand provided updates on the specialist emergency care hospital in Cramlington, leaflets were available from NTW about mental health services, and Healthwatch and Northumberland Carers had general information available.

The event included a range of brief presentations, including a CCG update, the purpose of the integration board testing panel (presented by Cllr Scott Dickinson and Cynthia Atkins) and an overview of the vanguard programme. Consultants Robson Brown also held an interactive session on developing NEAS's mission, vision and values statement.

Following the presentations there were a series of workshops. The workshops were conducted against a vanguard backdrop under the heading, developing a Primary and Acute Care Service (PACS). Feedback will be used to inform the development and design of services. These workshops followed on from an engagement event that took place in Hexham in April, which was also PACS themed. Feedback from this event was summarised during the presentations to help both inform the audience and provide a start point to the workshop discussions:

- GP services (extending access to primary care)
- Community services
- Hospital services in Northumberland

Each workshop focussed on 3 or 4 key questions. Notes were taken by facilitators at each of the table discussions and additionally attendees were asked to complete feedback and evaluation forms about the event.

Feedback

The following feedback was received from the table discussions:

GP services (extending access to primary care):

1. *What makes 8am-6pm GP access work for you?*

- Non-working adults ability to access appointments = great
- Discriminatory against working people
- Patients choose to access other professional (pharmacy/chiropractor)
- DNA's – why do we see large numbers in some practices? – these affect access for others
- Perception and expectation of patients can sometimes be unrealistic
- How the practice is managed can affect ability to access appointments
- Leave number for a call back method of access – positive feedback
- More collaborative working across practices would be good e.g. Wooler/Alnwick
- Ability to book ahead – a preference for this to continue
- Sharing information across all health and care professionals should happen for every patient
- Access to professionals
- Online booking – positive feedback from those who use this now – need option for those patients who don't have internet
- Blyth Acute Service – liked – is there potential to expand this to weekends?
- Problem accessing named GP and Locum Dr's have limited / varying expertise
- Not appropriate for all patients as core working hours plus travel makes core hours inappropriate/problematic
- Some practices have 8am-8pm on certain days (usually only 1 day per week) – this is liked by working adults
- Registration of new patients not dependant on current staffing radio
- Some telephone consultations not appropriate as cannot visualise problem
- Wait for weeks for appointment
- Role of pharmacy important to signpost and give advice and alternative treatment
- Technology important to access primary care information about patients
- Telephone consultations have improved services - this alternative access is valuable
- Problem with availability of appointments, need more GPs or other professionals to share the workload
- Variable across the geographical area ; some areas have no problem with appointments
- Urgent appointments always accessible but only in some practices – not consistent

- Some expectations are unreasonable by patients i.e. wanting to access a particular GP
- Organisation of practice does not facilitate good access to services i.e. practice nurses etc.
- Scope to improve rapid access to services i.e triage to practice nurse etc, however language refers to GP access.

2. *What would make access outside these hours work for you?*
   - *When would this be best offered?*
   - *Where would this be best offered? (e.g. hubs?)*

- 45 GP Practices – do we need all of these all of the time?
- Some practices have later evening appointments which are good
- Telephone access would be beneficial/alternative to accessing Primary Care in practices
- On Call/ Out of Hours System not widely known
- Service improvement dependant on size of practice/ scope for availability and access
- 24 hour access to Primary Care at walk in services (but need to improve continuity of care)
- Not having access to patient information difficult for OOH service: important to improving sharing of information
- Later evening and weekend appointments would be good
- Access to GP practice nearer to where people work
- Access to GP at an alternative place
- Access to a nurse practitioner
- Need improved accessibility to patient records
- 24 hour walk in access – new Northumbria sites are great for access for minor issues
- Clinical urgency / triage system important
- Walk in centres in more localities 24/7
- Urgent referrals to be seen at end of surgery;
- Extended core hours for all staff/professionals not just GPs
- Problem with transport if need to access out of area unit/practice – need to consider public transport issues with this
- Geographically close practices to work closely together rather than two separate units
- Patient expectations need to be addressed i.e. urgent access available but will

see any GP

- Evenings and Saturday mornings would be useful for remote areas
- Weekends – transport difficult – any doctor – alternative methods don't always work for everyone
- Dr First need everyone's ability to access
- Appointments differ in current extended hours across practices – can we get these to work the same?
- Reception – managing urgent dedicated urgent appointments
- Triage – access urgency requests
- Evening appointments – for certain groups who can't access in day
- Access to speak to someone would be good out of hours
- Home visits – 24 our access – information shared with all professionals

3. *If you had excellent 8am-6pm access what would any extended access be used for?*

- Acute needs on a weekend mainly but some expectation of routine appointments too
- Access for working adults OOH in core OOH periods for routine things
- People's expectations would be to be seen for all purposes i.e. urgent/routine/non-urgent issues
- Weekend appointments utilised for sudden illness asset
- Variability of practice sizes problematic to the services that an individual practice can provide
- Flexible hours across 7 days rather than core hours of 8am-6pm
- Restrictions of all staff hours
- 24 hour home visiting/access

4. *Are there services currently provided in hospital that could be provided by your GP? Or gaps in current provision?*
   - *Planned care – e.g. monitoring*
   - *Acute care/ urgent need – e.g. A&E alternative*

- Minor injuries 24/7 (Alnwick/Berwick)
- More community sites to provide 24/7 care
- Routine treatment provided in Primary Care sites e.g. Chemotherapy etc and will improve patient confidence, more friendly environment

- Triage of patient appropriately when varying access to services available
- Access to care and communication important
- Speak to someone
- Distance
- Clinical triage – before sending to a centre or need to travel
- Using facilities and surgeries at weekends
- Working hours extend research core structure and how staff work
- 24/7 minor injuries
- Managing LTC – more locally
- More confidence then hospital

Community services:

1. *What skills, professionals or services do you think would be needed within a Community intensive care service?*

- There needs to be a single point of access to contact for professionals / patients / carers. The service needs to be 24/7 to ensure no time consuming wasted travelling
- Questions asked at initial point of access imperative to be accurate to ensure appropriate pathway
- Communication and documentation needed to ensure records of patient's details to include all previous events and be available to all professionals
- NHS number for patient to link into system when call made linking all records, etc.
- More skilled assessor / decision makers on telephone calls made and when at first intensive care service visit
- Professionals do a good job but they need support to feed results to them after tests etc.
- One person to co-ordinate services
- Need to address the fear of doing wrong thing and being blamed. Therefore there needs to be expert decision maker within the service.
- Presently two levels – GP/paramedics v home care. Need a level in between these.
- Ensure sufficient nurses are available in future to allow more time to meet patient's needs
- Care manager should be included more, ensuring continuity of service and communication.
- Auxiliary nurses could be used to carry out basic tasks – shopping, cleaning, cooking, waste etc.
- Still need a variety of people to provide care but they need to be co-ordinated.

- One patient had to stay in hospital because district nurse would not apply pressure bandage. Therefore need to maintain training for skills update
- District nurse to have more support in her task – should have diagnosis and
- treatment plan to work to.
- Knowledge of system / navigator
- Professional skills plus Interpersonal skills with compassion.

2. *Do you think a community intensive care service would enable people to stay at home, who otherwise would be admitted to hospital?*

- As admission to hospital is to ensure patient is safe, we need more community support. Also example where patients could be cared for at home is Intravenous antibiotics could be given at home and so avoid hospital visit
- Cases where patient gets anxious and needs someone to talk issues through with – this usually ends up with an ambulance but alternative is to get someone with appropriate knowledge to step in to avoid admission.
- On discharge from hospital, patient and carer for patient should be included in care plans for support at home (example – man caring for wife goes into hospital and extra carers are arranged for wife. On return home, social care not prepared to cook meals for him as care plan only for wife)
- Telemedicines service would mean district nurse has an IPad to communicate with GP or consultant e.g. community geriatrician. IPad could be used during ward round
- Patients do not want intensive care at home prefer to go to hospital but more sub intensive care and support should be provided at home.
- Management of LTC
- Co-ordination / communication across system
- Admission to hospital means risks obtaining other infections while in hospital
- Competent district nurse with smart phone should be able to deal with several patients.

3. *The intensive element of the service would need to be time limited what are your thoughts about this?*

- Possibly train carers who already have a lot of knowledge, to have the confidence to carry out certain tasks
- In the past used travelling wardens who were based in each locality and used to attend patients and resolve issues with social care. They were carers trained in mediation and health and safety etc., and need to be able to exercise judgement. They can contact GP regarding any event they attend to be noted for future reference.

- Encourage people to use common sense
- If admitted to hospital for shortness of breath for say 2 days cannot do anything extra for patient
- Diagnosis of care is an issue – could carry out test at home and process results at hospital however risk of infection this way
- District nurse diary is full of routine visits therefore difficult to drop to deal with acute patient. Possibly split roles between urgent and routine to respond faster.
- People need to know about communication / documents involved – EHCP / SPN
- Efficiency and effectiveness not being compromised
- How intensive is intensive?

Hospital services in Northumberland:

1. *Overall experience of hospital services (in Northumberland): what works well, what doesn't work so well and how can we improve?*

- Day 3 of NSECH – blood service – well looked after every doctor in North excellent
- NSECH Bloods taken 6pm – results 9:45 – too long then admitted blood results fast
- Good MSK treatment
- Specialist cancers/stoma nurse – OOH access really difficult long drive from Hexham to Ashington OOA patient
- Slow information following consultant appointment – two week delay
- Wansbeck very positive and caring staff - but minor issues with individuals
- Inter department communications fragmented - a reoccurring issue
- Consultant report to GP (took 2 months) – not cost effective
- Areas for improvement – medicines management – communication across teams in parts of health systems, although new hospital in the main positive
- Appointments delayed by waiting letters to consultants and GPs
- Transport issues
- New hospital – initial pathway issues
- GP referral – pathway – info A&E less streamlined
- Out patients – seen consultant regarding drugs – over two weeks before back to doctors – communication across departments
- 16 months – cover wide – Wansbeck – palliative care chemo – OT/other services attitude – positive of older staff some minor issues but overall

positive waiting for medication a bit too long but minor – positive caring attitude – issues re inter dept communications – reoccurring – linked discharge and prepared for home – organisation of medication

- Wansbeck consultant letter to GP took too long (2 months) – Freeman letter quicker, leading to confusion. Systems not shared or compatible.

2. *Access to hospital services: making appointments, emergency access, what works well, what doesn't work so well and how can we improve?*

- Good prostate care – saw GP in Wooler – referred for further tests in Wansbeck or Freeman – seen within a week – back with results fine – 4 days appointments made 10 days after biopsy
- Medical records need improving – transfers lead to delays in making appointments
- Medical records – Wansbeck – NT entail (list in march) records not joined up
- Not enough switchboard staff – waiting too long on the end of the phone – need some reassured waiting longer than 5 minutes for an answer – and then automatically being being disconnected

3. *Base sites: Do you know where to go for what? Now that we have the new hospital in Cramlington, have we got the right services being provided in the right places?*

- Berwick and Wooler - neighbours use borders – cross border
- Cramlington walk in – confusing Comms – in news post leader
- Genuinely a good understanding of hospital triage
- Parking changed questioned
- Use of air ambulance quedtioned
- Confusion regarding cardiology pathways

4. Gaps: are there obvious gaps in services at the moment?

- Service –overall about right
- Individually – increasingly issues for rural communities
- Transport part of an issue
- Berwick what's available
- Accessing information is sometimes difficult

Potential implications for quality

Engaging with patients is an important way of obtaining soft information relating to the quality of services commissioned by the CCG. The feedback received at the CCG Patient Forum event is very helpful in providing an insight into the quality of services from the patient user perspective.

Summary points:

GP services:

- Access to GP appointments can still be a problem but there is variability across the county. There was a desire to improve access for working age adults but this didn't need to be every day, for example, some surgeries offer an 8-8 service one day a week. People were keen to explore more flexible booking arrangements such as online booking as long as alternatives were available for people without internet access. People do want 24/7 access to primary care services via walk in centres and hubs where GP practices work together across a geographical area but transport needs to support this and access to patient information is key. There was also a desire to increase the range of treatments available in primary care rather than always having to go to a hospital.

Community services:

- People were keen to develop a single point of access for community services with an effective initial assessment process. Again, access to information and communicating this was key. People felt more community input could prevent hospital admissions but continuity of care and care co-ordination was critical to the success of this. However people still wanted to be able to access hospital services when needed and don't always want to be treated at home. There was also discussion about the valued role of the District Nurses and the potential for them to support more urgent cases if they had more time and had the correct technology to support this (telemedicine).

Hospital services:

- People were generally content with the level of healthcare services provided however rurality and transport issues were a common theme. NSECH opening was well received although some initial pathway and pathology issues were experienced. Perhaps the key theme was the difficulties experienced by patients whose treatment crossed healthcare boundaries (primary/secondary in the main) and the delays caused by communication particularly between consultants and the GP. Encouragingly there appeared to be a good understanding of healthcare triage in Northumberland ie people generally knew where to go and for what.

Conclusion

The patient forum was a successful event, attended by well informed and willingly engaging participants. As the CCG moves forward on the Vanguard PACS front, this feedback is particularly timely in informing forthcoming work. It should be possible to feedback tangible progress on a number of issues at the next patient forum in 2016.