NHS
Haringey
Clinical Commissioning Group

CCG network meeting – Tuesday 8 September 2015

Feedback report

Introduction

Like last year, we wanted to use September's Network meeting to help us think through some of our commissioning intentions. Commissioning intentions are developed every year. They describe the changes and improvements to healthcare that the CCG wants to make for the year ahead and what services the CCG expects to commission to achieve these changes. Our commissioning intentions will always fit within the context of our wider strategy, five year plan and objectives.

At September's meeting we chose two areas to focus on: intermediate care* and musculo-skeletal services in Haringey. Network members heard some short presentations about why we are looking at these services and then had the opportunity to discuss some key questions and give us feedback. We will feed back to Network members in March 2016 about how we have used what members told us.

This document summarises the discussions and feedback heard from Network members at September's meeting.

***Definition of intermediate care:** *"Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system – community services, hospitals, GPs and social care."*

Musculo-skeletal (MSK) service discussion

Issues identified through the case studies and actual experiences

- The general view was that a waiting time of six weeks for first appointment was too long, particularly as the condition has an impact on his livelihood and business.
- Inconvenience of having to be referred to an occupational therapist a few weeks after being seen by a physiotherapist. The service should have been more responsive to the needs which are directly or indirectly related to his condition from the first instance.
- It was considered as an inconvenience for the patient to be seen by the GP prior to the specialist. The representatives empathised with the long time for first

assessment, as well as the time it may have taken to be seen by the GP (usually two weeks).

- The patient having to be assessed multiple times was seen as an inefficient route of care.
- Not clear if there was any follow up from specialists after patient was discharged.
- Based on actual experience, information sharing amongst professionals needs to be better across services. In this case partial test results were sent to the physiotherapist, resulting in the wrong treatment being given.
- *Long referral delays are common and people get lost in the system* - root of the problem is believed to be that the MSK system is fragmented to the extent that GPs don't always understand which service to refer patients to for what. When patients have their first consultation, it's clear that the service isn't appropriate and they're bounced back to their GP. The more transactions there are, the longer patients have to live with their symptoms, the more likely people will give up and go to A&E and the more likely patients will become lost in the system.
- *People often receive referrals for the wrong treatment* - example was made of someone with frozen shoulder being referred for physio, which was inappropriate and made the condition worse. The patient then went back to the GP who just prescribed anti-inflammatories. It wasn't until 3rd or 4th visit that the patient was referred to a specialist and given the right treatment.
- *People are not given support for long enough* - examples were cited of people completing their therapy (usually 6 weeks) and discharged from care before having fully recovered
- *People aren't given enough support by therapy services* – for example, many physio patients just get print outs of exercises to do but there is little additional support or checking to make sure they're doing them.
- *The aspirations of individuals aren't always taken into account when MSK packages are put in place* – for example, an older lady who had an accident and needed to go to hospital. Previously dancing had been a really important part of her life, despite the fact she was older, so she was keen to recover sufficiently to carry this on. However there was an automatic assumption that she would not need that level of mobility. It took a lot of persuasion to get the right treatment to help her make a full recovery.

<u>Suggestions for improvement</u>

- A need for more integration / collaboration amongst specialists and a shorter, more straightforward referral process. It would have saved time if the patient had been referred straight to the occupational therapist by the physiotherapist instead of having to go back to his GP for the referral.
- A multi-disciplinary assessment team that can wholly assess patients in the first instance.
- The representatives agreed in principle that a central hub for accepting and triaging all MSK referrals would be beneficial for the patients.
- There was a lot of discussion about how patients would access the 'central hub' for MSK appointments. Consideration was given to setting up a direct access for patients with chronic, recurrent conditions- negating the need for seeing the GP before the specialist assessment.
- Community pharmacist, urgent care and A & E services perhaps could directly refer patients to the 'central hub'. The hub will then triage and assess whether or not the patient is eligible for the services.
- The integrated service provider should have access to patient records so that they can fully assess whether or not the patient is suitable for the services.
- Introduce short cuts into services such as ones which accept self-referrals.
- Falls clinic could be an extension of the MSK integrated service.
- Educating patients about preventative care at the same time as treatment.
- More publicity about what services or treatments are available.
- Linking in with other services.
- A better system might be for GPs to immediately refer patients to an MSK specialist (assumed to be either a matron or nurse with special interest) for a consultation. This could be done either:
  - Remotely using technology e.g. skype etc… - or
  - Via a roaming specialist who visits GP practices

This specialist would then have access to the full range of different MSK and diagnostic services and could refer appropriately.

- Patients could be referred to an assessment hub MDT consisting of (e.g.):
  - Exercise physiologist
  - Orthopaedics specialist
  - Social worker
  - Physiotherapist
  - Occupational Therapist
  - Podiatrist

- *Commissioning approach* - a framework approach is needed to allow several organisations to work together, rather than commissioning a single provider to deliver the whole pathway – which favours larger organisations. The current commissioning system especially disadvantages small voluntary organisations that can be extremely good at delivering specific components of a system. These small services should be much better utilised but aren't for the above reason. Hospitals, community services, private sector (e.g. gyms) and voluntary sector (e.g. Age UK) all bring different expertise and experience to a system.

Intermediate care discussion

Issues identified with service area (some based on actual experiences)

- Dementia pathway is not well established
- There needs to be a centralised place to do assessments, and continuity of care across the system. For example, patients would benefit from seeing the same physiotherapist in the community and hospital.
- Estates is an issue – patients can be discharged without a home to go back to, which is a concern particularly for vulnerable patients. There is a lack of dedicated facilities to look after patients.
- There could be better integration with voluntary sectors to provide support to patients who are discharged home. Voluntary sectors could be more integrated within the clinical care services.
- MDT teleconference could be linked more closely between hospital and voluntary services.
- Expand the MDT teleconference to other community providers to discuss patients which are frequent re-attenders. Expansion beyond the frail and elderly cohort of patients would be good.
- People don't know what services are out there.
- Big issue around care coordination - it's not clear who is responsible for coordinating care for patients. Nurses, therapists and care workers on the ground often don't have the tools/knowledge/experience to coordinate care and have to be task-focus.
- Inconsistent access to intermediate care and community service support – sometimes patients are discharged inappropriately with insufficient/no support.
- Better access if discharged from Whittington as community and acute services delivered by same provider. More difficult for patients being discharged from NMUH. Particular issues with patients discharged from hospitals outside Haringey.

- Slow response for community rehab teams – example given of a patient who has been treated at Guys and should have had extensive therapy – was not contacted by Haringey ICTT until a year after discharge.
- Particular issues for patients who have trouble communicating their needs – example given of a 70 year old patient who deteriorated rapidly. Was admitted to hospital but no system of communication was in place to tell families and explain how they can help.
- Support, information and advice for families is lacking.
- Particular issues around patients on multiple pathways – example given of a patient who had a stroke and then had a heart attack. Conflicting advice received, particularly around medicines.
- Services work but need to be delivered for an appropriate length of time, based on the patient's needs (not for a fixed period across the board).
- No follow up from physiotherapist after treatment for broken hip.
- Should remember disabled patients too, not just the elderly.

<u>Suggestions for improvement</u>

- Intermediate care (especially reablement) should be outcome focussed.
- Haringey needs more bedded intermediate care units.
- Intermediate Care strategy is long term and should therefore have a focus on using latest/emerging telecare and ICT.
- More individual centred care.
- A "wrap around" service where checks are made on whether basics are done, for example food, washing etc (i.e. reablement).
- A range of options need to be offered.
- Promote neighbourhood schemes, for example home visiting etc.
- Multi-disciplinary team to assess the patient in the first instance and put together an appropriate care package based on the patient's needs.
- Better access to support services in the community.
- Linking patients in with the relevant voluntary or community organisations for additional support.
- A more comprehensive initial assessment to cover social care issues. The right professionals need to be asking the right questions at the initial assessment stage.