Torrington Community Cares: Meeting local needs
Staff and stakeholder engagement and involvement report

Appendix 10

Healthwatch Torrington 200 report recommendations and response

Summer 2014

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www.torringtoncares.co.uk

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Northern, Eastern and Western Devon Clinical Commissioning Group Formal Response to Healthwatch Devon 'Torrington 200' Report

Thank you for the recommendations you suggest as a result of the Torrington 200 survey. We would like to respond to each in turn.

1. Further work

1.1. Healthwatch Devon to continue work across Devon with providers, CCG, volunteers and community representatives, to promote and support co productive involvement in an engagement process which would be tailored to each community, including:

· service planning and consultations

· developing processes to enable people to be involved in evaluating need

· advocating for community voice.

The Northern Locality of the CCG and Northern Devon Healthcare Trust wholeheartedly support this recommendation. It is essential that we engage with all our stakeholders in designing, developing and evaluating the services provided.

We recognise that all our localities and neighbourhoods are different and have different needs and views: therefore our approach to the engagement process needs to reflect this.

We also welcome Healthwatch's role in supporting and promoting the community voice, perhaps not only at times of change, but as a litmus test for public opinion, or initiating a conversation with Health and Social Care organisations themselves.

There is a real opportunity for us all here to reflect on the systems and processes of all our organisations to promote collaboration and develop more systematised working relationships together.

2. Dialogue and Communication

2.1. This is an opportunity to improve information and communication as to the nature and location of “bed based” care following acute emergency or elective care episodes.

This survey has indeed demonstrated there is a lack of clarity about how ‘beds’ are used in both Health and Social Care. This lack of clarity in the public domain means that community medical inpatient beds are being confused with residential and nursing homes, palliative and respite care.

We are confident we have communicated information about the model of care described in Torrington Community Cares throughout the process, but it is apparent there has been a lack of understanding with some members of the public, despite best efforts to communicate clearly and effectively.

A record of all our engagement activity is available on the Torrington Community Cares website as a draft version covering the first four months of the evaluation period.

From this recommendation, there are two key pieces of learning. One is that we need to find further ways of informing the public about our services routinely and not just during an engagement exercise. The second is that in opening any specific engagement, it is essential that we find a way of ensuring facts are communicated and clearly understood at the earliest opportunity.

3. Health Needs Assessment

3.1. Health Needs to be demonstrated as specifically aligned to the population.

3.2. A distinction to be drawn in reporting between normative or comparative need and the felt and expressed needs of the community.

3.3. The current expectations of the Torrington community in relation to clinically assessed need appear to be at odds with felt or expressed need. An explanation within needs assessments in plain English of clinical/normative/comparative need as well as those felt or expressed by people may help understanding of the position health services must take in relation to modernisation, finance and changing demographics.

We have found this observation and the subsequent recommendation particularly useful. Articulating the difference between normative/comparative and felt/expressed need is something

we could articulate more clearly our conclusions and actions to address health inequality following a review of the Joint strategic Needs Assessment JSNA.

However, it also draws our attention to the emotional aspect of change and the impact changes in health and social care can have on a community over and above the clinical or service delivery change.

We are sure that this application of theory will now be routinely embraced both in the way we approach engagement work in the future, but also how we assess the impact of potential change and endeavour to mitigate negative impact when and where we can in our service planning. The reality of the current economic and financial situation will mean that further changes to health and care service delivery will be inevitable.

The other learning from this is that in future engagement exercises, we need to be careful to articulate clearly the difference between health provision, social care provision and private or charitable provision and make explicit those services we have ability to change and those we do not.

4. Systems and Processes: Quality and Safety

4.1. The public expressed confidence in the safety of bed based care, but the public perception of Enhanced Home Based Care was that it was less safe. Clinical systems and processes in place to mitigate any risk, whatever the model of care should be more clearly explained.

4.2. Patients should feedback about quality in real time without fear or favour. Complaints and compliments need to be acted on in an accountable and transparent manner.

4.3 Information about the Patients Advice and Liaison Service and Healthwatch Devon should be routinely available to those receiving home based care and services in the community.

Safety:

In terms of providing reassurance on the safety of the service, there is a challenge in presenting complex health care data in a way that is easily interpreted by the community.

We continue to publish all data on the safety and quality of service in the home-based care model on our website: www.torringtoncares.co.uk and offer to post copies on request.

As well as data, we have also sought to express and communicate the safety and quality of the service via patient questionnaires and patient stories.

We acknowledge the recurring and powerful theme of safety in your report: that the “hospital bed” with attendant 24/7 staffing holds a tangible reassurance. In contrast, unless one has experienced it, it is much harder for the public to conceptualise the very individually-tailored care and support packages that are now possible through enhanced home-based care that bring improved health and social care outcomes, particularly in maintaining independence.

On reflection, the concept of “needs” described in recommendation 3, (divided in to “normative” and “felt”) could equally apply here, where the clinical understanding and definition of risk does not tally with the public’s concept of risk.

Over recent years, NHS providers are experiencing real difficulty in staffing small community hospitals and supporting staff to maintain their clinical competency with seeing so few patients; across the CCG there have been examples where hospitals have had to close due to lack of staff, but these issues are not always obvious to the general public.

We might also refer this back to recommendation 2 regarding communication and how we can promote a dialogue emanating from the same baseline of understanding, and providing a platform for challenge and debate about the issue of safety and quality.

We have begun to address the issue of communication and safety through gathering and publishing patient stories and will be developing this work further.

Feedback:

We are confident that our frontline staff ensure patients are aware of the Patients Advice and Liaison Service (PALS) and Healthwatch Devon, and we have systems and processes in place across both organisations supporting these, reporting to the highest level. Again, both organisations also have Complaints and Compliments systems and processes, reporting at the highest level in both organisations.

Indeed, the Northern Devon Healthcare Trust has started issuing patients with business cards with key contact and feedback information to ensure patients are encouraged to offer their thoughts.

We also have a “Live chat” facility linking directly to PALs which can be found via a link through the CCG website for signposting and general questions.

However, we value the observation that there can be reluctance to use these feedback mechanisms, supported by some evidence from the survey that the public may feel that to use these services might jeopardise their care.

Information:

The availability of consistent information and well-publicised feedback mechanisms is a concern that we take very seriously in the Northern Locality and NDHT

In light of this recommendation and the learning we have taken from the patient experience and patient story reports we have committed to develop a leaflet which explains the model of care to the residents of Greater Torrington. This will include information on NHS and social care, signposting to the voluntary sector support groups. As with all patient leaflets we will describe the feedback mechanisms and encourage people to send their feedback via complaints, PAKS, patient opinion and/or Healthwatch Devon.

5. Service Change

5.1. Respondents recognise the importance of the hospital as an outpatient facility and the potential for it to be further developed as a base for additional services and community provision. However, the majority who took part in this survey do not wish this to be at the expense of the inpatient beds.

Further dialogue needs to continue. Clear accessible evidence about need should be available to support decision making. Essential services which cannot be a subject for negotiation need to be clearly differentiated from areas upon which engagement activity may be expected to have an influence

We would fully accept that further dialogue needs to continue and we are endeavouring to present the engagement evidence to which you allude through the Oversight Group for wider dissemination.

We also would fully support the delivery of additional services in to Torrington and its parishes that meet the health needs of the local residents of Torrington. We are developing plans which aim to move more 'NDDH' outpatient services and specialties to Torrington where it is safe and efficient to do so. These plans came from the community's suggestions and are all undergoing feasibility studies so we can confirm to the community how we progressed their ideas.

We would also agree with your point that "*Essential services which cannot be a subject for negotiation need to be clearly differentiated from areas upon which engagement activity may be expected to have an influence"* and we will reflect on whether the conversation document "Meeting Local Needs" makes that clear for the public.

In the spirit of honesty and taking all your other recommendations in to account, we would not as either commissioner or provider be able to say that the beds at Torrington hospital are or indeed for some time have been by definition "essential services" to either Health or Social Care and in economically constrained times will have to come under scrutiny as all public office is at this present time.

Northern, Eastern and Western Devon Clinical Commissioning Group and Northern Devon Healthcare Trust (NDHT) would like to thank Healthwatch Devon and their volunteers for the time spent supporting the 'Torrington 200' and look forward to working together on future projects.

Northern, Eastern and Western Devon Clinical Commissioning Group
24 March 2014