Shaftesbury, Gillingham, SW Wiltshire and Somerset Community Services Reference Group

Bringing care closer to home in North Dorset

Background

A public engagement reference group has been set up to involve local people in the development of community services for Shaftesbury, Gillingham, South West Wiltshire and Somerset, following Dorset's Clinical Services Review. The reference group brings together representatives from various organisations including Healthwatch, town councils, patient participation groups, the Save Our Beds and mental health campaigns, Westminster Memorial Hospital League of Friends, council of governors and the voluntary sector with health and care professionals from Dorset HealthCare and the clinical commissioning groups for Dorset, Wiltshire and Somerset. The group is chaired by Dr Simone Yule, a partner with the Blackmore Vale practice, who, as lead GP for the North Dorset locality, sits on Dorset CCG's governing body. It can co-opt additional members if required from time to time.

The group has met twice. At the first meeting in January we made sure that we had the right representatives at the table and at the February meeting, provided members with information to make sure everyone had the same level of knowledge about how plans for health and care are being developed in the area. The main presentations are summarised in this bulletin.

Improving care for frail and elderly patients

Sara Froud, Dorset HealthCare's Locality Manager for North Dorset spoke with passion and enthusiasm, as she outlined how change is being driven forward in Shaftesbury and Gillingham and how real improvements in patient care are taking place by using existing resources differently.

Sara explained how the new RACE (Rapid Access Clinic for Frail and Elderly) service works. It started in mid-November last year, running alongside the previous outpatient clinic at Westminster Memorial Hospital, Shaftesbury.

Already enjoying early success, by mid-January 12 new patients had been seen, all of whom were kept out of hospital.

RACE can see three new patients per week plus three follow-ups depending on need. Patients are seen by various health professionals working as a multi-disciplinary team (MDT) which can include occupational or physiotherapy, health care assistant (HCA), medicines management, a consultant geriatrician and an advanced nurse practitioner (ANP).

A similar service is due to start for South West Wilts patients in mid-March. Dorset HealthCare and Salisbury Hospital are working in partnership and are trialling this for three months so Wiltshire CCG can decide if it wishes to continue and support the service using its own staff.

Sara described other improvements to services which are being developed.

These included:

- the recognition and early identification of frailty and an ambulatory care service, which aims to provide same-day outpatient care and treatment for people who were unwell but do not require hospital admission
- the Shaftesbury locality hub, which brings professionals together in one location as a 'virtual ward', including the Intermediate Community Rehabilitation team (community therapy team), Health and Social Care coordinator, adult social care staff, Older People's Mental Health team, Community Matron, District Nurses and primary care staff. This provides co-ordinated and responsive multi-agency intervention and care; proactive case-management for a people with chronic and long term conditions; enhanced primary care team support to local GP practices and partnership working with acute hospitals to speed up discharge
- supporting care homes
- development of a GP extensivist role, with special skills in caring for elderly patients
- a Parkinson's Disease specialist nurse
- increased access to primary care
- development of the minor injuries unit to meet new standards for urgent care from December 2019.

"Ten days in hospital (acute or community) leads to the equivalent of ten years ageing in the muscles of people over 80."

Transforming primary care

Dr Simone Yule introduced the North Dorset Transformation Plan, which sets out plans to meet some of the challenges facing primary care and to improve local services, with greater focus on patients.

Dr Yule explained how, traditionally, too much emphasis had been placed on treatment in hospitals and not enough on community services (where most care takes place) and prevention. She said that change was needed to meet the demands of a growing elderly population – many of whom were living with complex needs; a diminishing workforce and strains on the health and care system which could not be allowed to continue. She added that North Dorset has the second largest elderly population in the county.

Dr Yule described the main areas of work being tackled by the transformation project group. These include:

- harmonising computer systems across community services, nursing homes and general practices, allowing patient records to be shared and easily seen by different services; encouraging patients to contact services online; using Skype and other electronic systems for some medical consultations such as dermatology (skin complaints) and the Dorset Care Record
- using new workflow systems to free up more time for GPs to spend on patient care and training 160 members of staff to signpost patients to the right place for care (this may or may not be the GP)
- creating economies of scale by sharing administration support and training across practices
- introducing new roles to work in primary care, which will help take some of the pressure off of GPs. This includes nurse practitioners, pharmacists and pharmacy technicians, paramedics to do home visits and physicians' assistants
- changing the ways in which care is provided (known as 'new models of care') such as providing more proactive care for patients with frailty and long-term conditions, and managing demand for services on the same day
- improving access to primary care by working together with Dorset HealthCare staff and introducing bookable appointments in the evenings and at weekends at the community hub.

Dr Yule outlined some of the improvements to prevention services across the area (Prevention At Scale) which are being made by the NHS services, local authorities, Public Health Dorset and voluntary organisations working together under a Strategic Health and Wellbeing Group. Prevention services aim to promote wellbeing and stop people becoming ill in the first place.

North Dorset has the second largest elderly population in the county.

Local examples include the appointment of a Health and Wellbeing Officer; health and wellbeing checks at the Gillingham and Shaftesbury Show; 'walking for health' and 'mile map' schemes based at local general practices; exercise referrals; and monthly drop-in sessions for carers called My Time.

Dr Yule also explained that North Dorset was one of three localities in the county currently piloting a national scheme called Primary Care

Home. Primary Care Home will help to support the long-term future development of local GP services by strengthening the workforce through closer working between partnership organisations and the voluntary sector; using technology to help deliver clinical care; and promoting more personalised care through, for example, greater self-management of long-term conditions by patients, more prevention and less medicalisation.

Care at Home in North Dorset

Nichola Arathoon, principal programme lead with Dorset CCG, explained some of the plans in place to address a perceived gap in the supply of domiciliary care – required by people who can still live at home but need help with household tasks or personal care – and demand, especially for people who want to die at home (end of life care or EOLC).

Nichola, who worked as a physiotherapist at the WMH, said this means that people were waiting too long in hospital for care services to be available and longer waits for care in the community. "The results are untimely discharges from hospital with a risk of readmission; people being admitted to hospital unnecessarily; and people at the end of their lives dying in hospital when they don't want to".

A 'task and finish' group, which brings together people from health and social care services, has been set up to explore what is happening now and look at how home care and reablement – services which help people to adjust to physical or mental illness by learning or re-learning daily living skills – can be provided differently by bringing them into community rehabilitation/nursing teams.

The aims of the project are to reduce the number and percentage of:

- delayed transfers of care
- referrals to reablement services
- patients readmitted to hospitals, and to
- increase the number of end of life patients supported at home.

In a separate presentation, Nichola reminded the group of the process and outcome of Dorset's Clinical Services Review (CSR). Following consultation, the recommendation for a community hub without beds in Shaftesbury was revised and the CCG's Governing Body decided "to maintain a community hub with beds in Shaftesbury, whilst working with the local community on a sustainable model for future services based on the health and care needs of this locality".

Nichola confirmed that the current proposal was for 12 beds for Gillingham and Shaftesbury, and that discussions were taking place over a further four beds for South West Wiltshire patients. How and where these beds might be sited has not yet been agreed.

Wesminster Memorial Hospital

Ian Tait, Project Director, Estates and Facilities, at Dorset HealthCare, highlighted some of the concerns about the feasibility of the current building at Westminster Memorial Hospital.

Whilst clinical services continue to be delivered to a high standard at the hospital, Ian said that a survey carried out on the site in 2014, found that the building was in poor physical condition and space was under-utilised.

He said that a total of almost £1.5m had been spent on maintenance to date, which was an overspend of £239,000 on the original estimate from 2014. To prevent further deterioration, maintenance work is being carried out as efficiently as possible. However, the building no longer conforms to the standards for health buildings. It is also a listed building, which restricts work that can be done.

South West Wiltshire and Somerset

Dr Andy Hall, Lead GP for South West Wiltshire, outlined Wiltshire CCG's plans for services for patients living in the Old Sarum area of the county. Dr Hall said there was an emphasis on breaking down organisational barriers to care, including geographical boundaries and exploring services that worked best for patients.

This included working closely with Dorset HealthCare to provide improved access and outpatient services from Shaftesbury; providing an Urgent Treatment Centre; moving towards 8-8 hours/seven-day working; using step up/down community beds and spreading examples of good practice across the community.

Susan Glanfield, Deputy Commissioner, confirmed that Somerset CCG is at the early stage in its own clinical services review and would be working flexibly with Dorset and Devon.

For more information please contact
hannah.white1@nhs.net