onenortherndevon

Workshop #1

10th September 2021

- Objectives
- Participants
- Agenda
- Key Points
- Agreed actions

CO-DESIGNING FUTURE CARE & SUPPORT IN NORTHERN DEVON

Welcome

Introduction, participants, objectives

Workshop #1 objectives

1. To understand what matters to older people living with frailty, their families and carers and how they would feel best supported to live healthy, independent lives
2. To understand what matters to clinicians and other professionals in delivering care and support to older people
2. To understand the barriers to delivering the care and support identified
3. To understand the current provision
4. To understand future demand and risks
5. To consider what current and future enablers may be available

Who attended Workshop #1?

People from: older people's groups, patient participation forums, hospital doctors and nurses, GPs, physiotherapists, occupational therapists, voluntary groups, councils, community nurses, home carers, commissioners of hospital care, domicillary care and transport services, older people's mental health services, carers organisations

Older people's groups

Carers groups

Local (housing) Authorities

Secondary Care

Voluntary & Community Sector

Health & Social Care Commissioners

Primary Care

Transport Commissioners

Independent Care Sector

Community nursing and Therapy

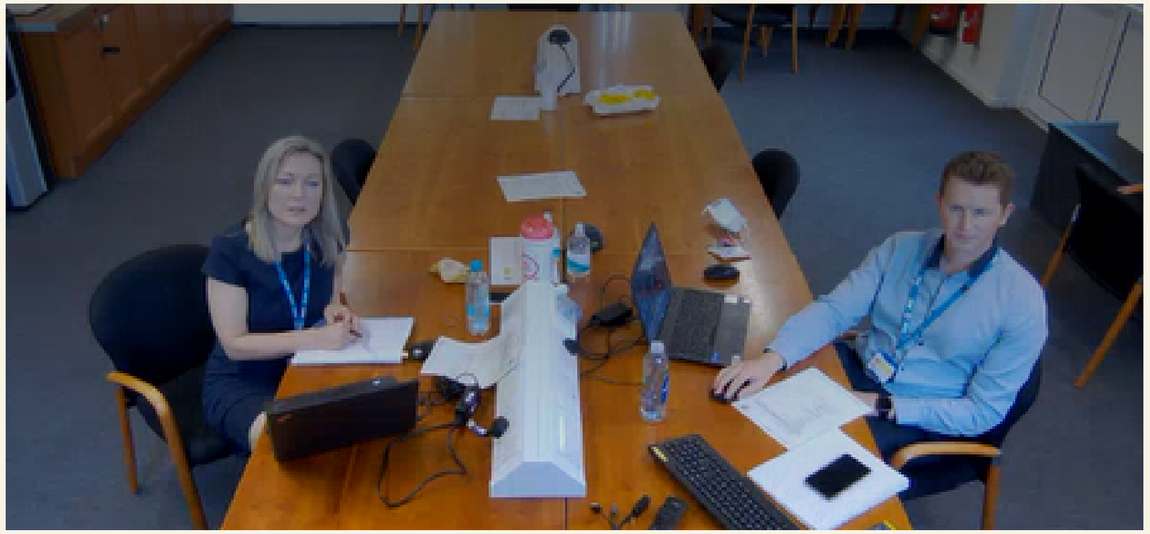
Understanding the context

The national picture

Introductions & objectives of Workshop #1

Andrea Beacham expressed appreciation that colleagues were spending 3 hours to be here, demonstrating the importance to everyone that we work together to make sure older ones in our community get the best care and support.

OND has been asked to facilitate this work in recognition that so many organisations have a vital role to play in supporting older people. They need to be part of the solution and therefore the design.



Andrea welcomed Dr Anita Donley, working with Grant Thornton on NDHT's “Our Future Hospital” programme. Anita is an ex consultant physician in acute medicine and care of older people, and has worked in Devon for 26 years.

The steering group were introduced along with the design framework and intended outputs for Workshop 1: to understand what matters to older people and those providing support, understand the current provision, identify needs, constraints and opportunities with the aim to take a 'design brief' to Workshop # 2 in November.

2. Understanding the context

NHS Long Term Plan

Anita Donley:
Agenda says I'm starting with the NHS Long Term Plan but instead I'm going to start with a short sentence from the Social Care Future Blog which sums up what communities are and the power of communities in delivering health and care:

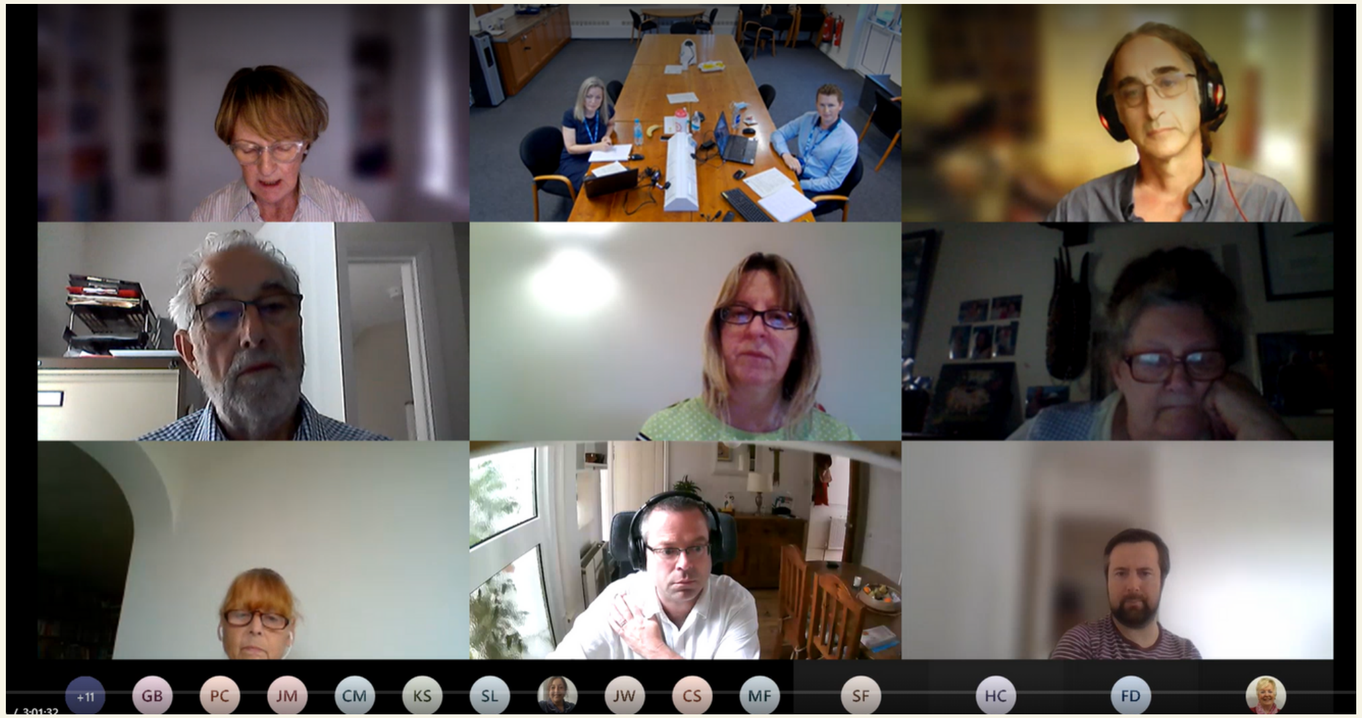
We all want to live in a place we call home with the people and things we love in communities where we look out for one another doing the things that matter to us

So the starting context for your work is your One Communities and One Northern Devon and the work you're going to do at this level.

But it would be missing an opportunity to not place the work you're doing in a context both regionally and nationally that allows you to achieve the aims you want

Understanding the background context

NHS Long Term Plan & 5 Year Forward View - one of early statements about integrated care - had 3 aims: integration of primary and secondary care; physical and mental care and health and social care. Each integrated care system responded and in 2019 plans were submitted to NHSE from each of the STPs (now ICS's) to say what their strategy was in line with the recommendations for the 5YFV and the next paper - the Long Term Plan. Older people's services were part of that and in today's agenda you will find reference and examples of this.



Current context

Health and Care bill going through parliament at committee stage. ICSs will become statutory bodies with duties and responsibilities in law. Locally there is NDHT's Our Future Hospital programme and the clinical strategy that supports it.

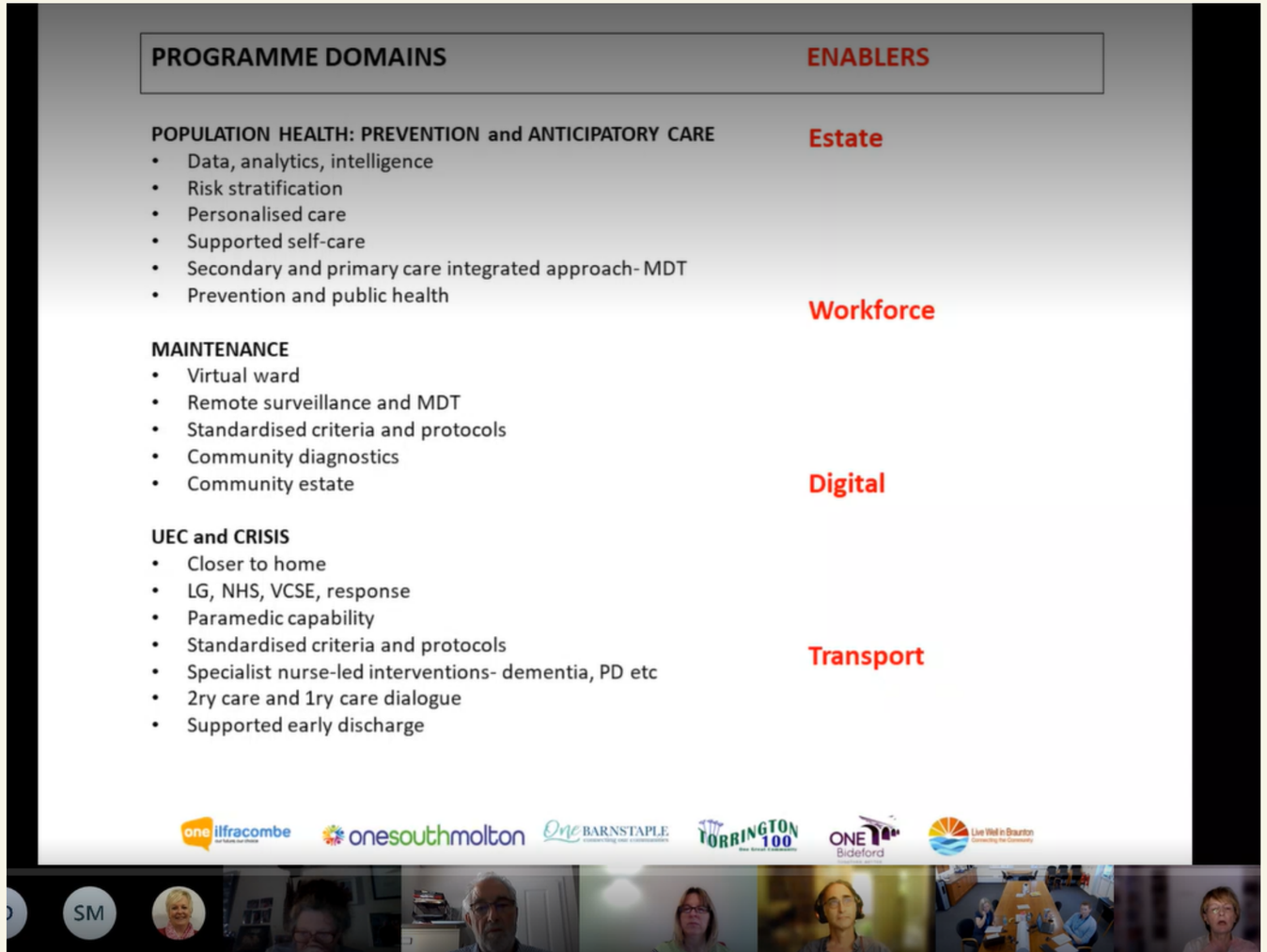
Emerging themes from NDHT Pathway workshops

NDHT's clinical strategy is being written in the context of how will clinical care be transformed in order to provide much more emphasis on keeping people closer to home, in their own communities, promoting good health and wellbeing.

We'll be discussing today prevention, public health and living well before thinking also about how to anticipate a crisis.

We looked at what interventions could be game changers - realistic, high value, high impact, proven.

Things that were discussed and agreed by the clinicians in the workshops as enablers were:
Estate - Workforce - Digital - Transport

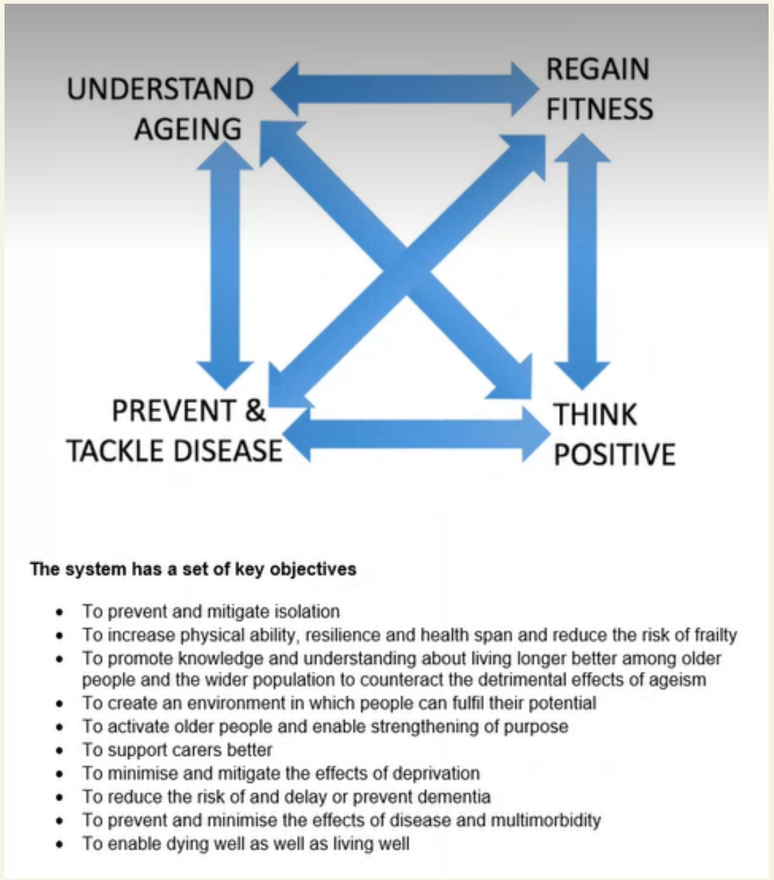


Understanding the context

Prevention & population health
National, Devon & Northern
Devon examples

Prevention and population health: Live Longer Better

Kay provided information on this national prevention model which is based on the concept of risk reduction.



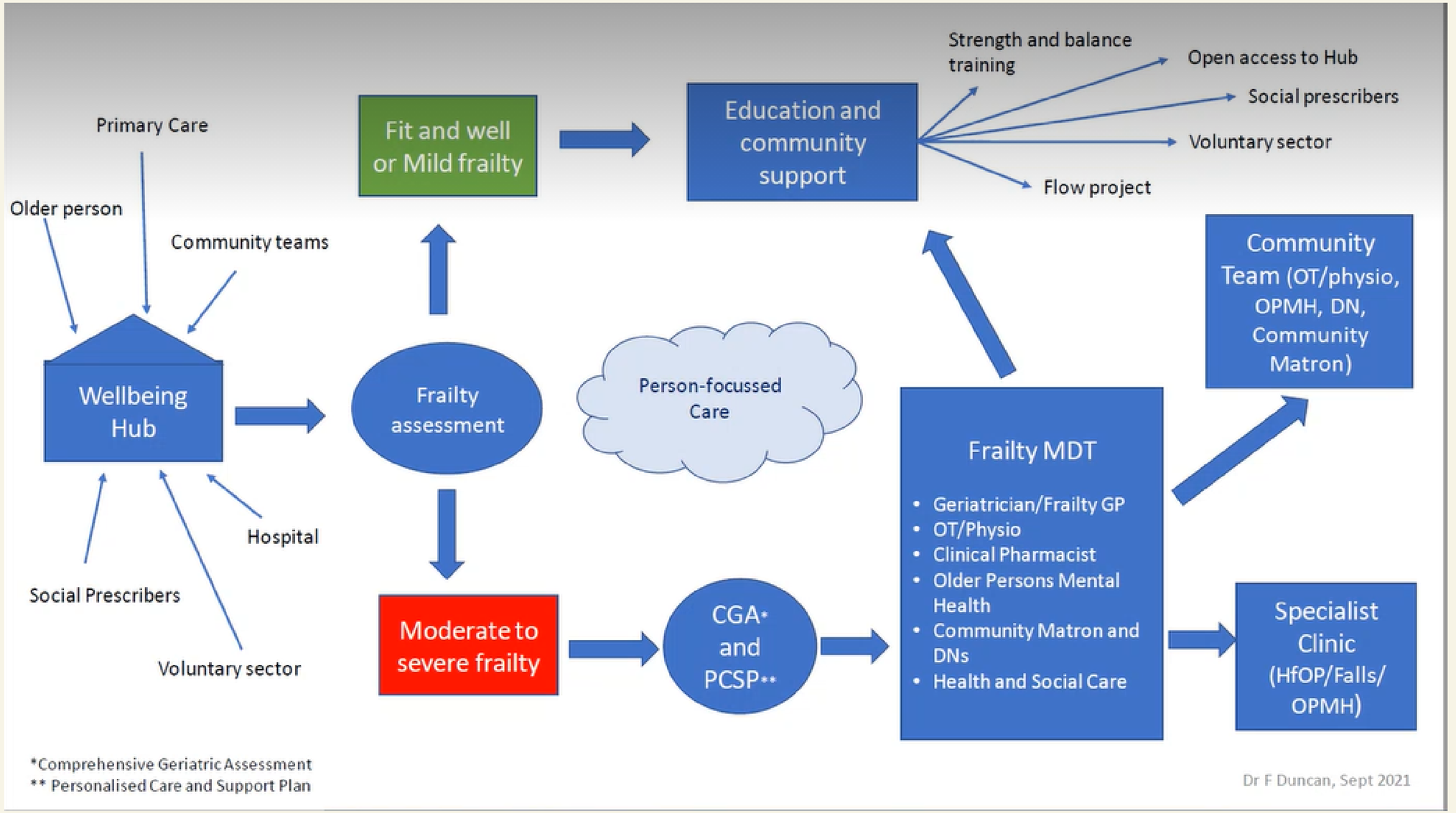
Key quote from Sir Muir Gray - "knowledge is the elixir of life". This uses the data we have to introduce education across the system at a very early stage to try to educate people and workforce around ageing, mental and physical fitness, understanding disease including dementia, also the positivity of going into older years and the positive benefits older people can provide to society. It's about upskilling with skills and resources and is an offer to our system.

Prevention and population health: Devon Integrated Care of Older People - iCOPE

Fiona highlighted a model led by Dr David Attwood, GP & frailty specialist in West Devon. It helps healthcare professionals detect declines in a person's functional ability and to deliver interventions to delay the progression of frailty. Everyone over 65 is assessed for frailty every 1-2 years in primary care. Depending on where they are stratified, there will be a different intervention. Fit and well are sent an annual communication - lifestyle advice, community support. Mild frailty tier are also referred for social prescribing, falls prevention etc. Moderate frailty have a Comprehensive Geriatric Assessment. Severe frailty, as well as the above, have advanced care planning.

Step1: Create patient groups with high frailty prevalance	Step 2: Programme Primary Care IT to fire a popup if patient in a high risk group so that clinicians opportunistically diagnose frailty	Step 3: Evidence-based interventions (where evidence exists)
High frailty prevalence groups: 1. Patients needing home visits 2. EFI score 'severe frailty' 3. Age >90 years 4. Patients with dementia 5. Patients in carehomes 6. Patients with difficulty mobilising noted by HCA/nurse on routine bloods or QOF reviews	Severe frailty n=13,750 (5.5%)	1. Code as severe frailty 2. De-prescribing 3. Pragmatic Comprehensive Geriatric Assessment (CGA-main focus is examining patient goals, enabling patients to achieve goals and advance care planning) 4. Exempt from QOF (if appropriate)
	Moderate frailty n=22,000 (8.8%)	1. Code as moderate frailty 2. De-prescribing 3. Consider advanced care planning 4. Clinically led CGA (main focus is keeping people happy, healthy and independent for as long as possible 5. Exempt from QOF (if appropriate)
	Mild frailty n=20,250 (8.1%)	1. Code as mild frailty 2. Refer for social prescribing/goal orientated care to target things like loneliness/bereavement etc 3. Strength and balance, Tai Chi, Yoga classes
	Fit and well n=194,000 (77.5%)	1. Send letter that is adapted from NHSE/AgeUK "Practical Guide to Healthy Ageing (2015)" and adapted to locality assets

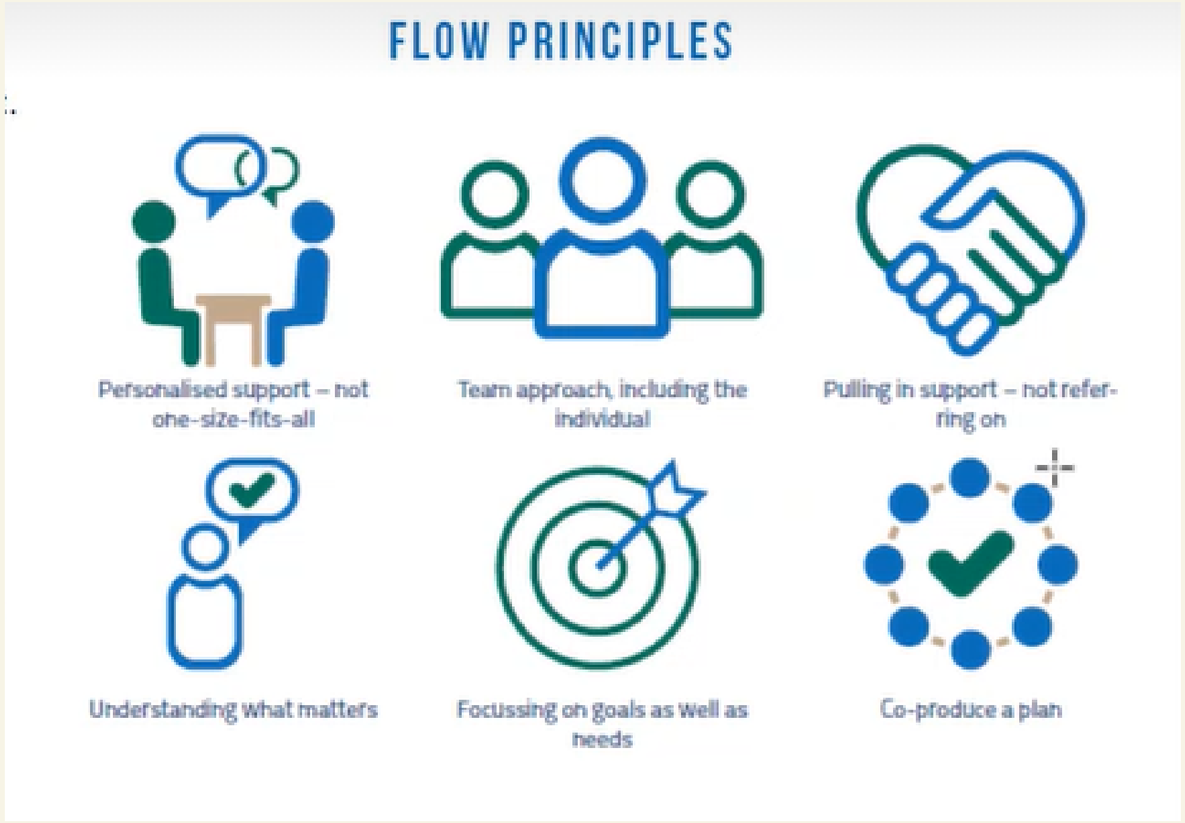
Prevention and population health:
Draft Northern Devon - Older Person's Wellbeing Pathway



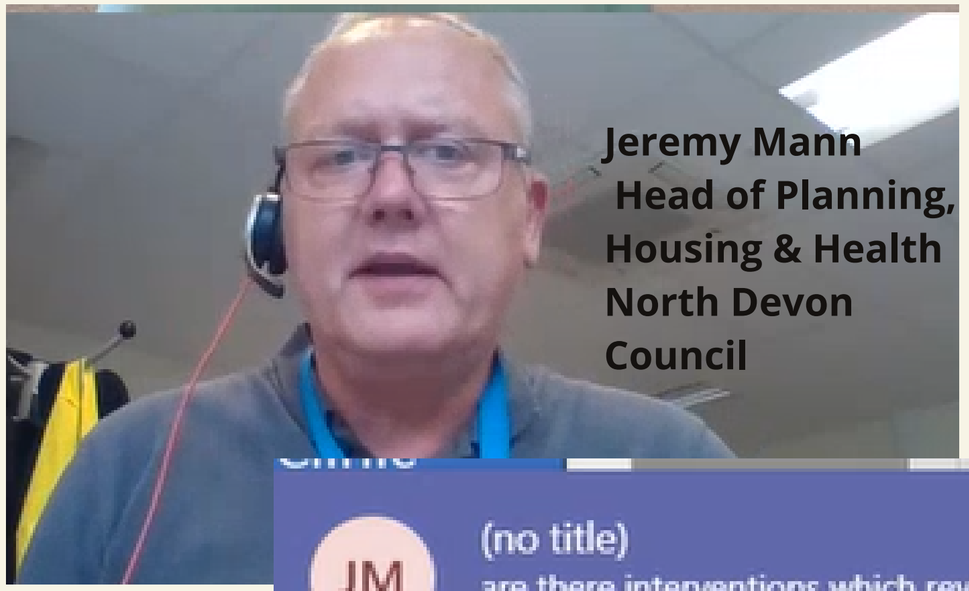
Fiona described a draft model based on discussions in the steering group, her clinical work with older people and existing models from elsewhere. Ideas to stimulate further discussion.

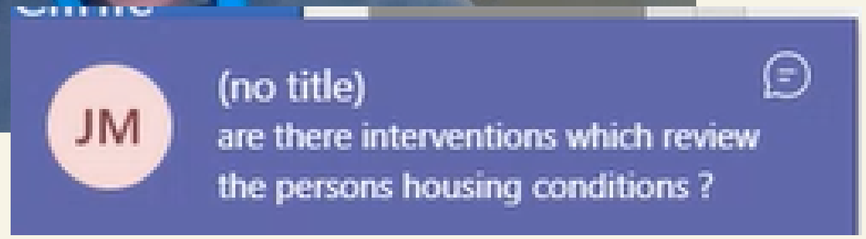
Prevention and population health:
Primary Care Flow - a Northern Devon model

Dr Hassall described Northern Devon's model for delivering person-centred care which is part of the population health management programme. It involves the lead professional having a 'What matters' conversation with the person, co-production of a set of goals and the introduction of a Flow Co-ordinator who brings together a 'team around the person' to address those goals. It particularly supports patients with complex needs as it offers a joined-up approach. Dr Hassall was confident there was a role for this approach within the framework of care for the elderly and frail and we would encourage all practitioners to have a proficiency in Flow.



Questions to the panel





Jeremy Mann asked whether a person's housing is reviewed in any of these models, saying it seems an obvious intervention, in the scheme of the other things proposed in the iCOPE model, to ensure a person's property is warm and free from hazards.

Dr Hassall replied that housing frequently comes up as a problem with patients. With the Flow model, the housing officer would be part of the Team around the Person. Good progress has been made with housing in the patients he's been involved with. And although Flow doesn't deal with the housing crisis it can provide the needed data about the effects of poor housing on a person's health.

"Not everyone who is frail is elderly and not everyone who is elderly is frail. There's a psychological impact of being labelled frail. I know because I was copied into a letter from a consultant to my GP that described me as a 'frail gentleman' and I got upset about that because I don't consider myself frail... it has a psychological impact. I'd like to move away from the term ... it's more about 'at risk' and identifying those risks. So my question is 'Is everyone working to the same criteria when they identify someone as 'frail'?' Is there a national template? Moderate and severe? Or is up to each individual?" - George Kempton

Dr Fiona Duncan responded that frailty here is being used as a medical term to identify people at highest risk of adverse outcomes such as falls, admissions to hospital etc. There are recognised tools for the assessment of frailty - probably the Rockwood Frailty Score is the most common standardised tool used across the board.

Dr Kay Brennan agreed wth George that you can be frail in your 40s and it's a starndard of mental and physical resilience is how I think about it. But we do need to think about ageism and we need to challenge as a group - it's a good way to start a debate.

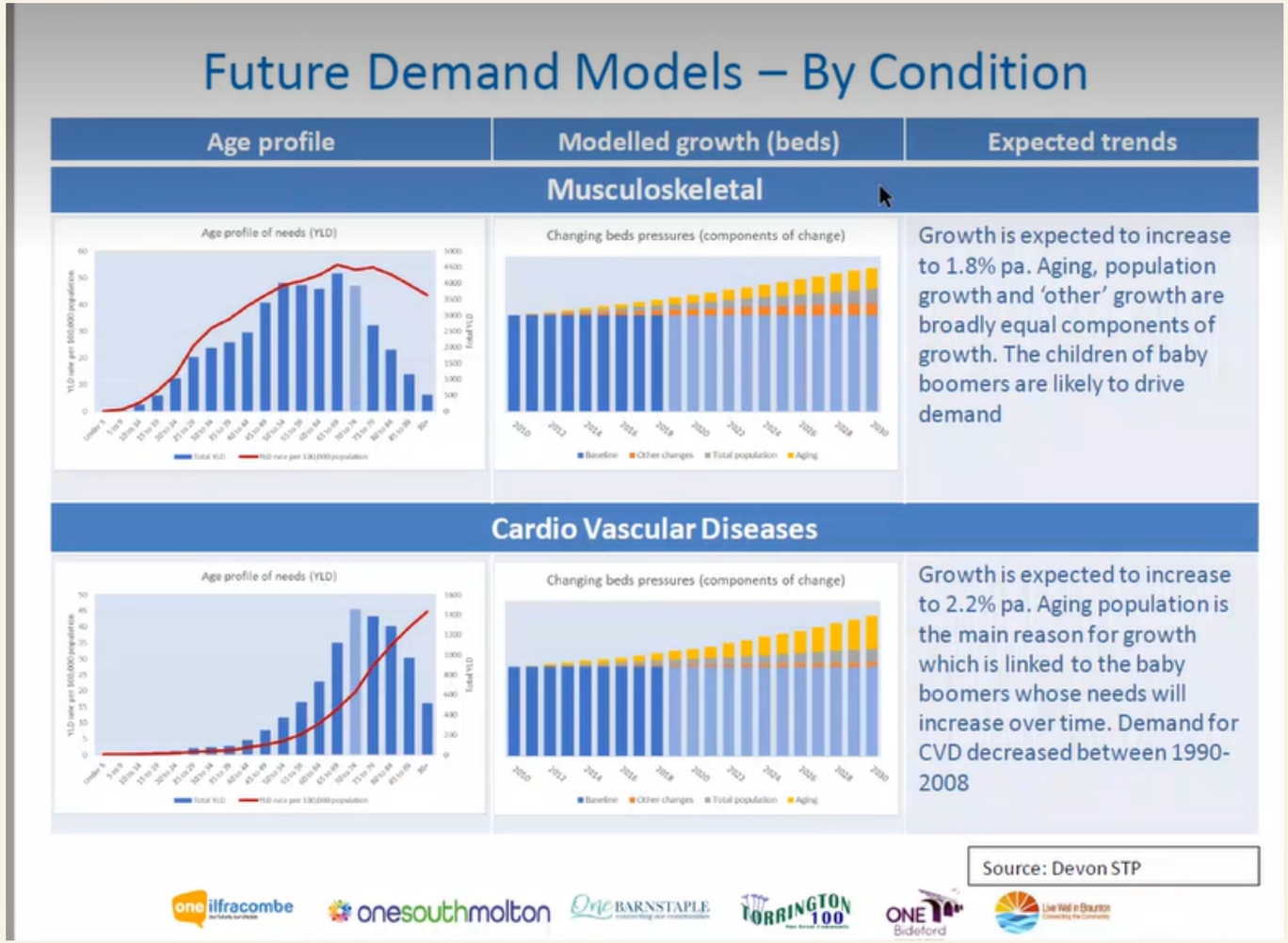
Dr Anita Donley added that getting a flag which says frailty isn't necessarily a lifelong thing. "I could become frail if I break my ankle and get pneumonia even though i'm a relatively healthy person and I could need quite a lot of support if my physiological responses were hampered but that need not necessarily be lifelong. Really important point."

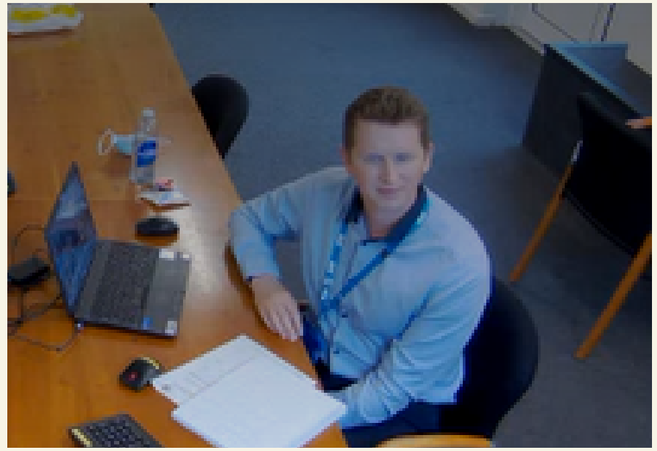
Richard Blackwell from SWAHSN agreed it's an important issue and said the more we go into population health management and risk stratification we are going to start labelling people quite early so we need to find a way to do this without people feeling stigmatised but explaining that it helps us guide you to the right services.

What we know about the local position

Population demographics, survey results, service map, case study

What we know about the local position: Population demographics for Northern Devon





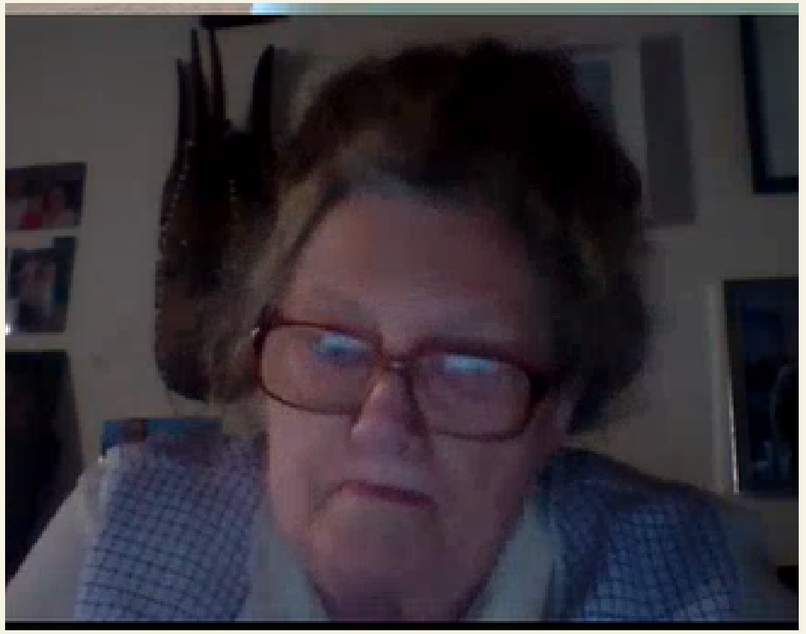
Question: do we take into account the increase in visitors in the summer months and the shoulder months? Yes Matt confirmed that seasonal variation has been considered when developing the clinical strategies. Anita added that the seasonal increase was more related to physical injuries, sprained ankles from walking on the coast path etc rather than an increase in frail, elderly attendance.

What we know about the local position: Survey results analysis

There was a recognition that there was a much smaller proportion of older people that had completed the survey compared to professionals and carers. The Steering Group had agreed that we would try to address this by resourcing some of the Community Developers to do some targeted engagement with older people to ensure the voice of older people is built in to this phase.

Carole McCormack-Hole, Devon Senior Voice, Barnstaple PPG said she'd had some paper surveys so had been able to speak to people while they'd been filling in the survey. Unfortunately because of covid, they emphasised the lack of opportunities to be social. I spoke to people who hadn't actually been out of their door for 18 months.

Loads of groups like diabetic groups, U3A groups that provide this help with social isolation just haven't been meeting. It's right now that people are desperately suffering from not doing something for 18 months and because they haven't done it, they're not likely to do it, like playing bowls, if they haven't done it for all this time they've lost the skill to go and do it, so right now we have more of a problem of loneliness because of their self-isolation.



Anita said this was a really critical point and commended that this programme of work picks this up - as part of the Live Longer Better principles. There will be an opportunity in the next phase of the survey to pick up on whether that trend is diminishing or persistent as a consequence of what's happened in the pandemic. We are seeing nationally a massive increase in the need for mental health services around anxiety and depression in all ages and the workforce.

Anita highlighted some issues raised by service users:

"There are issues highlighted around continuity and transition of care. We know from international work that things go wrong at transitions of care, when people move from one setting to another so whether it's from home to a care home, or from home to hospital or from hospital back into the community - those are risk areas.

And then there's continuity within a service - lots of different doctors in hospital wards having to say the same thing multiple times over. This very poignant comment from the person whose husband has alzheimers disease - that complex set of needs - in this instance not met."

Service Users - Feedback where care and support could have been better

"Hospital discharge left me feeling very anxious"

"Lots of different doctors in hospital wards. Confusing with no direct feedback to patients"

"I put up with problems because I feel I am a burden to the GP - more GPs if it would make it easier to see"

"My husband has Alzheimers. We jumped through hoops to get help. 2x2 hours sitting service was all that was offered while I did shopping etc. It was no help at all, my husband agitated and unmanageable for hours afterwards. Gave up after 2 sessions"

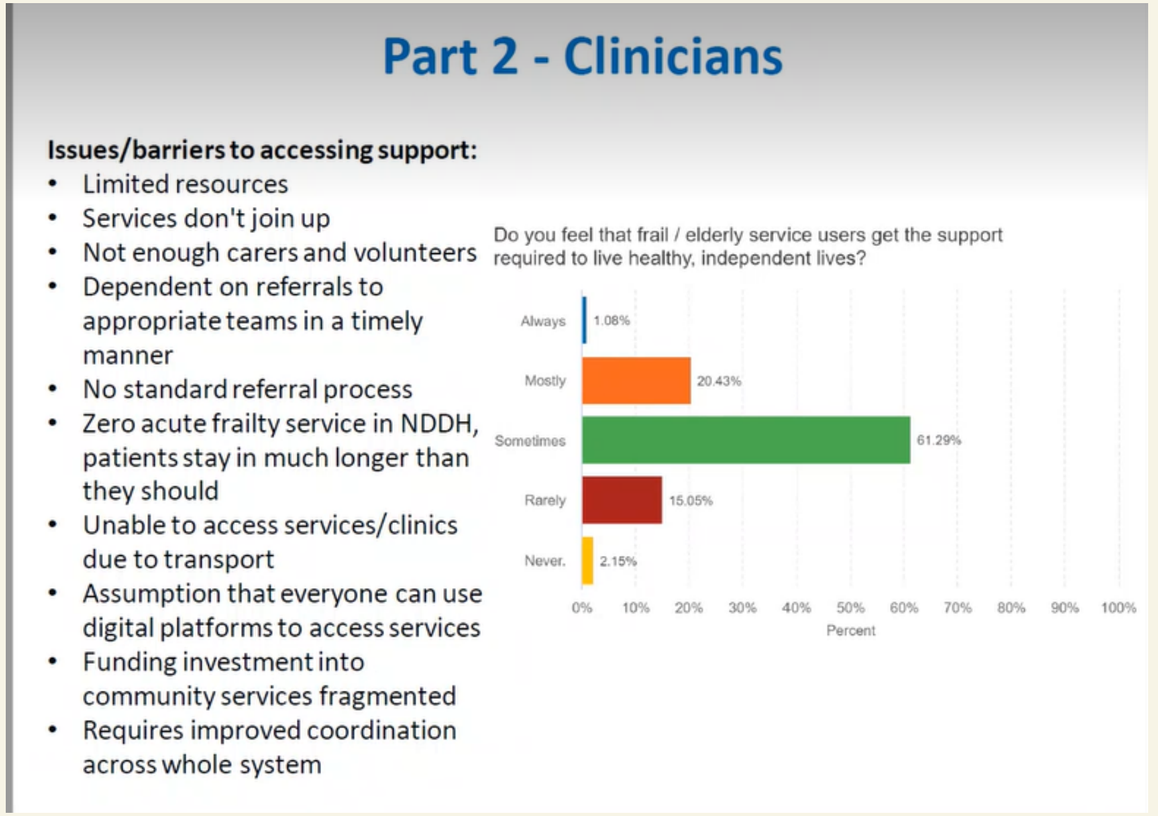
"Paying £60 a year to have prescriptions delivered due to limited pension. No local family members to help out"

"Was asked to take a 93 year old to hospital as an ambulance wasn't available. Had to wait in A&E for 30 minutes to be triaged - he was in his pyjamas, shaking and being sick every few minutes"

Anita highlighted some issues raised by clinicians:

"Comments reflect a feeling across the clinical workforce that we could do better - services don't join up - that's a comment from both sides of the bed.

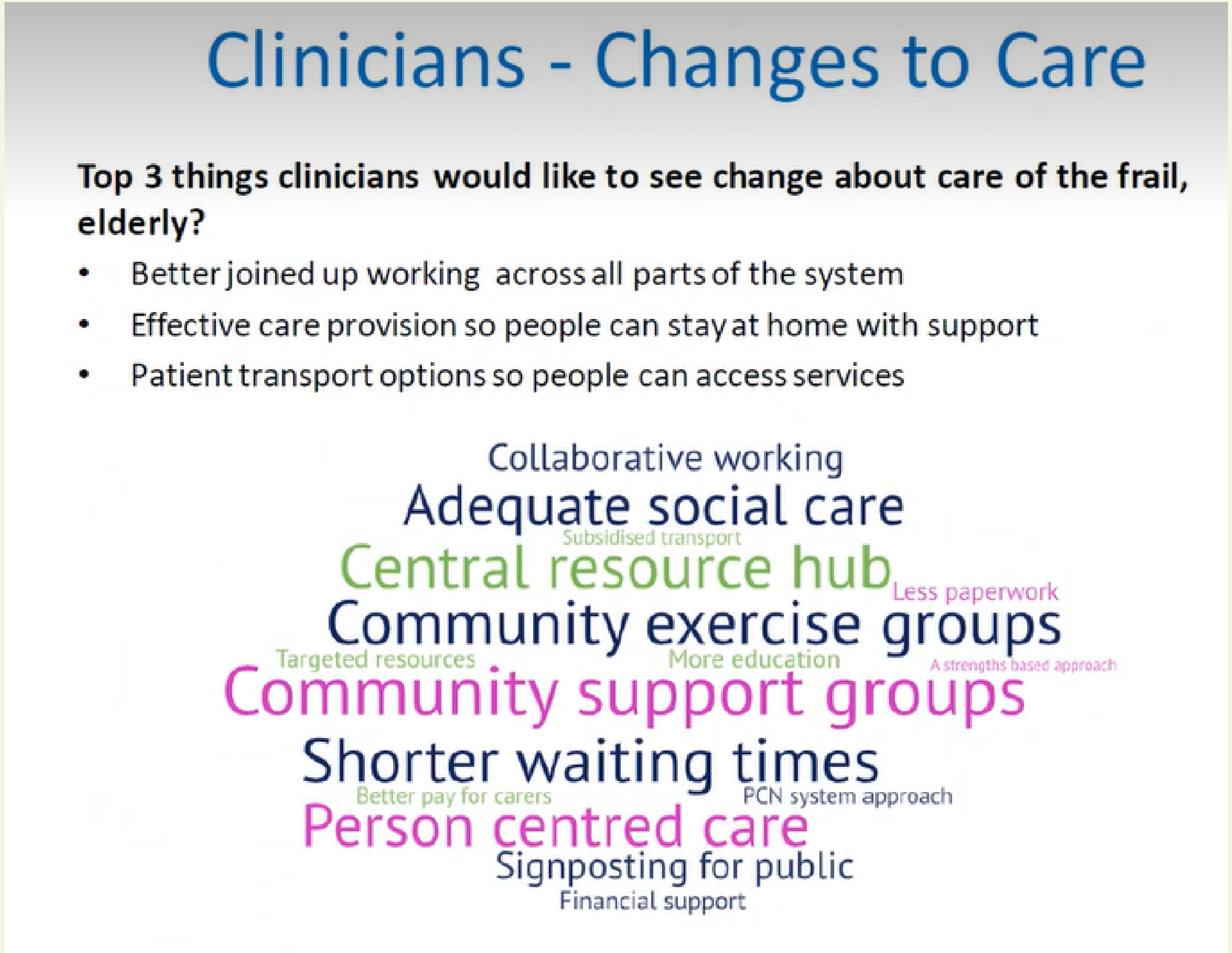
It's important to recognise the position in NDHT - the difficulty in recruiting a further specialist to add to your current team, which is quite small, of specialists in geriatrician medicine and the impact having a community geriatrician can make - if you have the right numbers of them - is huge and very important. The other aspect is around mutual support across the acute care provision and the health and social care provision in the community working with new partners including the RD&E.



Anita highlighted what clinicians wanted to see changed:

"Better joined up working - so that's integration between primary and secondary care, mental health and social care.

Care closer to home so people can stay at home and transport ... so with each of these there's a synchronicity between what the clinicians and service users are saying"



Anita highlighted the 3 key themes that were identified across all groups who engaged in the survey:

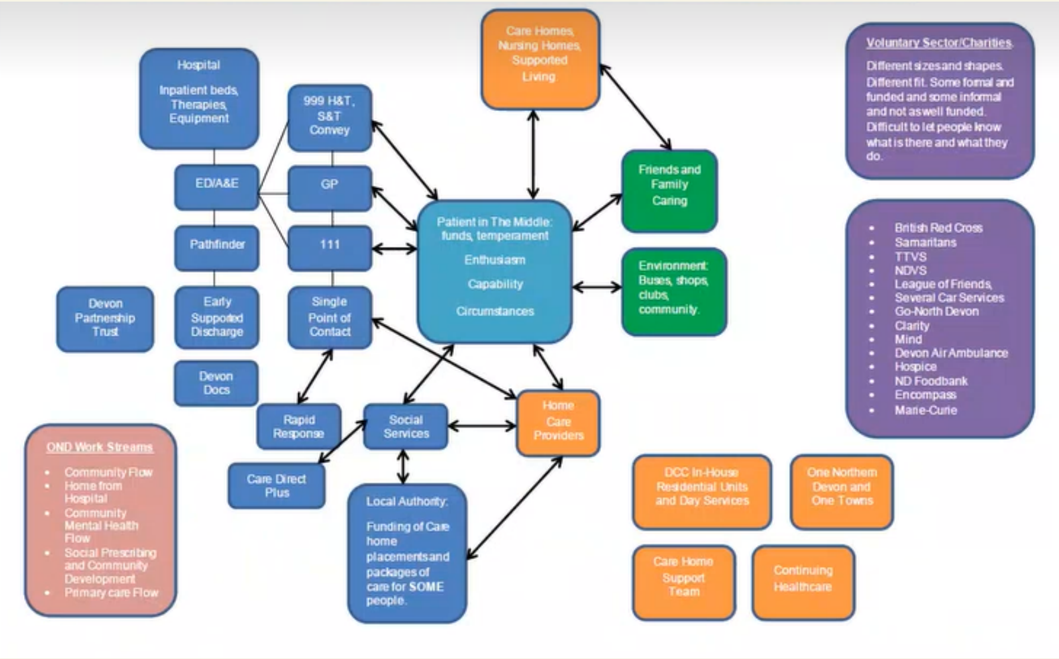
What we've heard...

The survey has identified the following key themes across all respondents:

- Improved access to transport to enable older people to attend appointments etc.
- Support is needed for lonely and isolated older people especially in rural areas
- Services need to be joined up and information need to be accessible

Moses Warburton, Devon Clinical Commissioning Group said this is one of the simplest maps he's seen and it's quite chaotic. When you're a professional in the NHS and you're having difficulty navigating all the arrows, how much more difficult for the patient, who doesn't have this map in front of them trying to work out who they should be talking to.

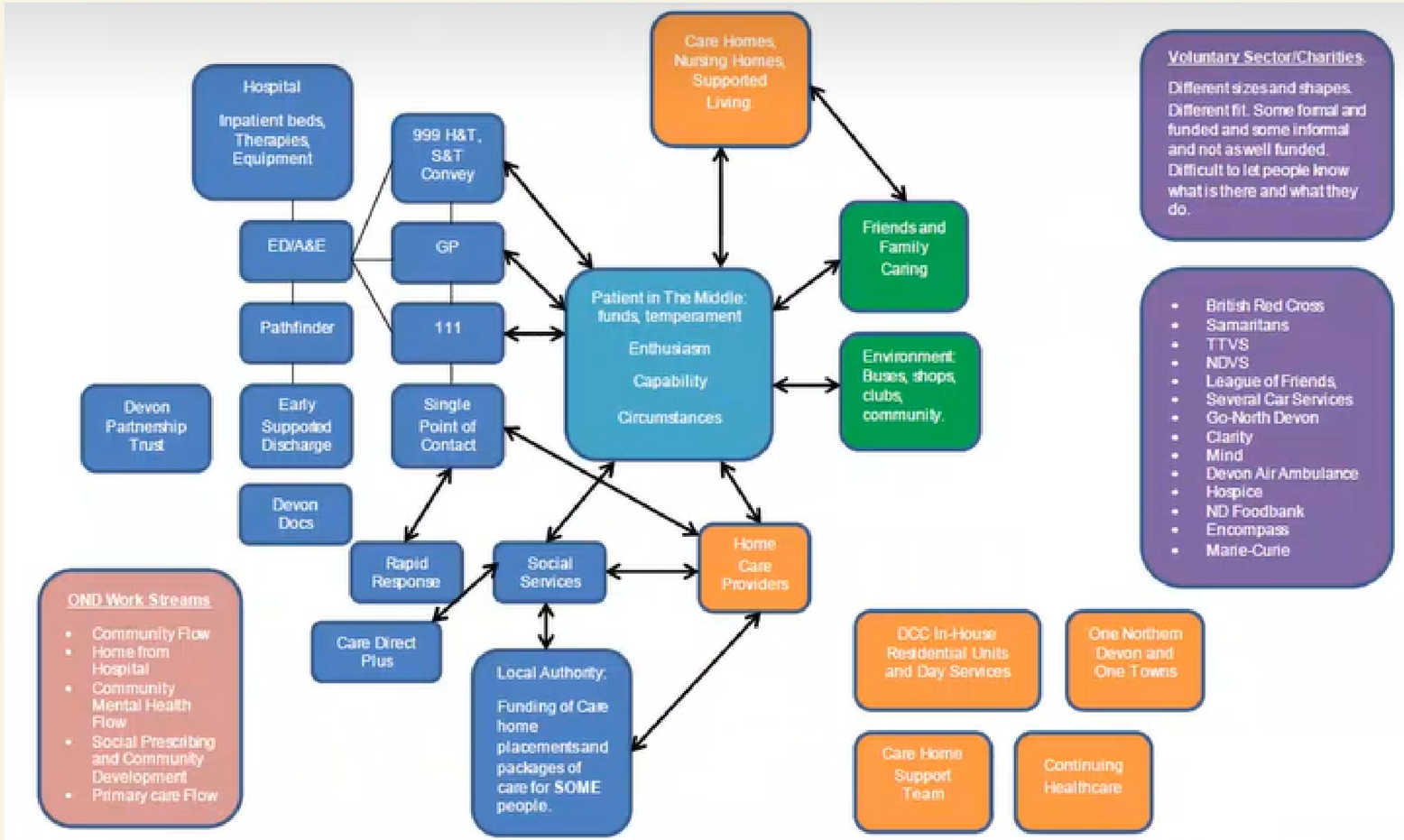
The public sector boxes in blue on the left include local authority who hold some of the purse strings around care home commissioning and packages of care. Then urgent care, so 999 - hear and treat, which means they will end the call with advice (about 14%); see and treat where the ambulance sees the patient and conveys to ED or other options (about 39%).



None of it is static - all boxes have development plans and opportunities - part of the campaign this year was that if you come on holiday and feel unwell don't contact the local services, contact your GP back at home, because now you can, 18 months ago you couldn't.

Moses highlighted that the green boxes are key but quite contentious, friends and family caring and the environment. Access to healthcare is only 11% of all determinants to good health and housing, for example, is a larger proportion. The voluntary sector and charities, still not sure we've included everyone. As a picture all boxes play a key part in looking after our patients, but we're not very good at measuring the pathways between the boxes.

Anita commented that this is one of the most important slides. The map is not integrated and joined up so at some point during this work you are going to have to allow a space come together as providers to consider how we can join up more effectively to make this more than the sum of its parts. Getting a grip on this at place level is very important.



Case study

Provided by informal carer - interviewed 25th August 2021

> “I was a cleaner for Janet (not real name) who was in her late 70's. She had been in hospital with a COPD related issue, became very poorly and was in hospital for about 2 weeks. When she came home she was extremely frail and was advised that she could be an ‘end of life’ patient. This, fortunately, was not the case as time progressed.”

A few issues came up after she returned home from hospital:

- The first was that the clinicians were talking to her about discharge and what she needed to do, but she didn’t understand what they were telling her and had no-one else there to help with this.
- The ambulance crew dropped her off very quickly, most likely due to time constraints.
- Carers were organised to visit 4 times a day. However, the first carer wasn't due to arrive a few hours after discharge which meant Janet couldn’t get out of her chair to use the toilet or commode during this time.
- There had been a discussion about her using pads for incontinence, but this didn’t materialise as part of the discharge. I had to go to a local super market and pick these up for her without knowing exactly what to get.
- The notes from hospital weren’t very detailed.
- When it was highlighted that Janet was sleeping in her reclining chair, the district nursing team were really helpful and a hospital bed was sourced within a few days.

cont'd ...

Case study cont'd ...

- I picked up all the medication for Janet and created a list for the carers. This was used for approximately a week before a senior carer visited and reviewed he medication list. Finding out about medication blister packs was an issue as well.
- Janet was told that she would be visited by the hospice, but this didn't happen.
- An oxygen machine was delivered but there was confusion about the bottle size and oxygen delivery volume. The hospital notes were different from what the Oxygen Team suggested.
- It was a very complex process to go through to get larger incontinence pads - these were required as the smaller ones were leaking. The process involved the carer weighing the used pads to request the larger ones. This posed a dignity issue for the elderly person and also time wasted by the carers.
- Incidences of time pressures of carers / nursing staff put before the dignity of the elderly person.
- There was generally a lot of confusion in the first few days after discharge. This was compounded by the fact that there was no family member / companion present to make notes of the instructions for the first few days.
- I didn't know where to go for information - a central information hub for elderly services would have been very useful.

Suggestions from informal carer following this experience:

- Not giving important care information to frail elderly people on discharge as their recollection will not always be reliable.
- If a family member / companion aren't available, there needs to be a care coordinator to make sure everything is in place for when a frail elderly person arrives home.
- A central hub to contact for information about services available for frail elderly people that can be accessed.

Co-designing care & support

What have we learned about what we have and what we need?J

Population health: prevention & anticipatory care

Data, analytics, intelligence
Risk stratification
Supported self-care
Secondary and primary care integrated approach - MDT
Prevention and public health

Maintenance

Virtual ward
Remote surveillance and MDT
Community diagnostics
Community estate

Urgent and Emergency Care & Crisis

Closer to home
Local government, NHS, VCSE, response
Paramedic capability
Standardised criteria and protocols
Specialist nurse-led interventions - dementia, PD etc
Secondary care and Primary Care dialogue
Supported early discharge

Enablers

Estate

Workforce

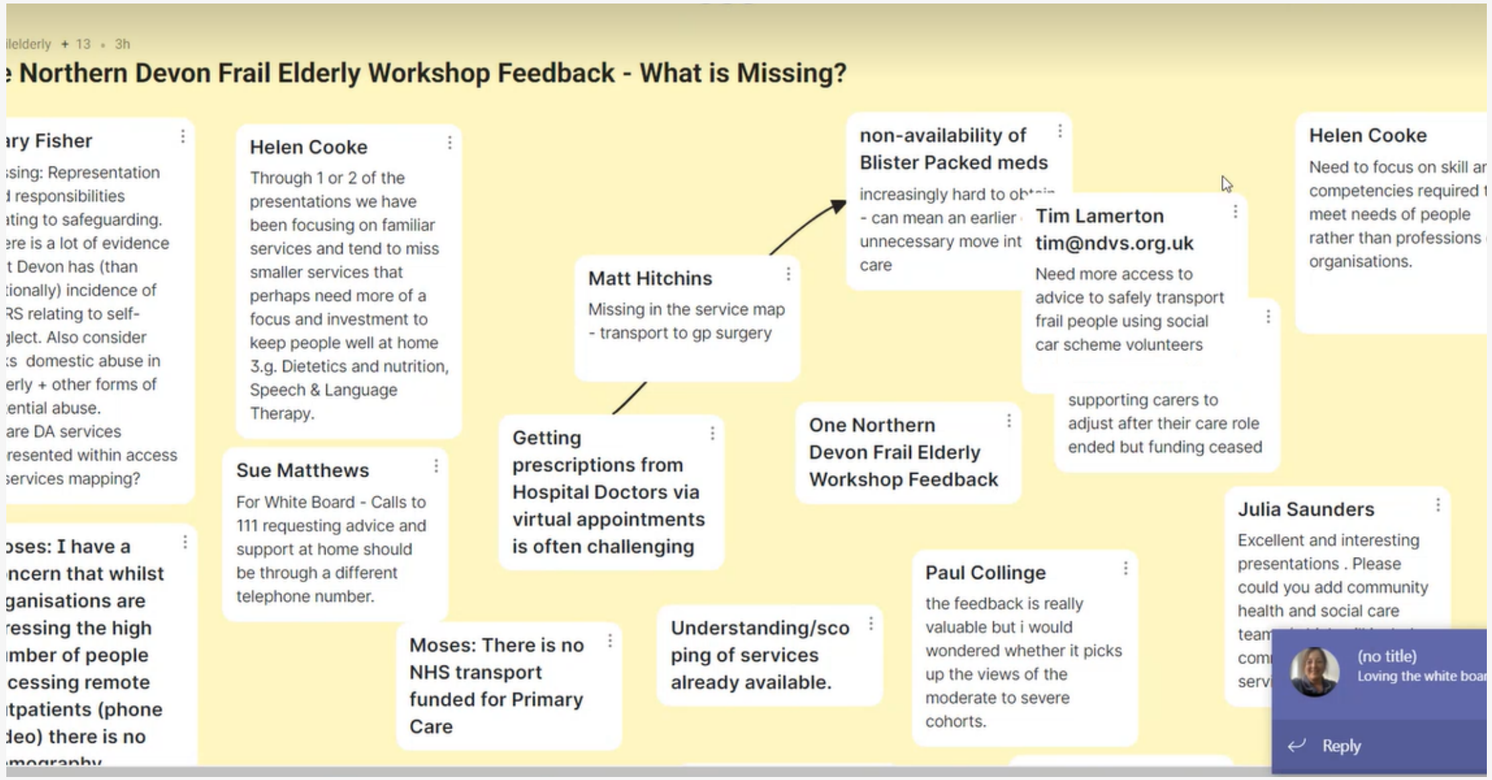
Digital

One Communities

Transport

Workshop participant interaction

What have we missed?



Following the presentations that outlined what we had discovered so far from the research, workshop participants were asked to add anything they felt was missing: in general, from the service map or in terms of what was needed in Northern Devon. Feedback is shown on the next 3 slides: Service Map, Needs & Additional Comments This additional feedback will be added to 'What we learned' phase.

What we know about the local position – What do we need to add to the Service Map ?

Transport

Missing in the service map - Transport to GP surgery.
Karen Rose - Add to service map - Ilfracombe & District Community Transport Association and Holsworthy Rural Community Transport Association. These community transport groups have larger accessible vehicles alongside the voluntary car schemes mentioned by Tim Lamerton.

Safeguarding

Mary Fisher: Representation and responsibilities relating to safeguarding. There is a lot of evidence that Devon has higher (than nationally) incidence of SARS relating to self-neglect. Also risks of domestic abuse in elderly plus other forms of abuse e.g. are DA services represented within access to services mapping?

Age UK Devon's Information & Advice Team

Sophie Littlewood: Missing from the service map is the work undertaken by Age UK Devon's Information & Advice Team, which focuses on key areas of support (health & social care, money, housing and signposting into local services) and our benefit uptake work.

Dementia support workers

Fiona Duncan - Missing from service map: Dementia support workers (they work within the Primary Care Networks and also alongside OPMH).

Community health and social care teams

Including community nursing

Dental services

Where do Dental services fit in and how are they accessed when NHS dentist not available?

Personalised Care Team:

- HOPE
- Health Coaching

Community Therapy MDT:

OT, PT, Speech & Language Therapy, Intermediate Care, Dietetics & Nutrition (tend to miss the smaller services which need investment to keep people well at home)

Equipment Services:

e.g. - For discharge
- Maintaining independence
- Wheelchair prescription

Access to DFGs - LA/Environmental Health

Community Pharmacy

What else is needed in Northern Devon? (in addition to the data/feedback so far?) **1/3**

Tim Lamerton: The aim to reduce the need for transport is a good one. **The physical and mental needs of those that still require transport** will increase and **more support will need to be given to community transport** to help meet those needs (fewer, but more complicated and challenging journeys). **Please do talk with us the North Devon and Torridge Car Forum about how to achieve this. (Volunteer transport).**

Need more access to **advice to safely transport frail people using social car scheme volunteers.** There is a network of Community Transport providers across Northern Devon and always an invite to chat with them. Is it possible at a future time to add **more detail about community transport to primary and secondary care services?** And the **transport needs of frail people?**

Moses Warburton: There is **no NHS transport funded for Primary Care**.

There was previously a voluntary sector group **supporting carers to adjust after their care role ended** but funding ceased.

Hannah Hopkins - **One CGA with clear problems and goals** (patient's, not the professional's) that is **accessible to all** services so we can provide joined up, seamless care.

Increasingly hard to obtain **blister packed medications** - Can mean an earlier or unnecessary move into care.

·Getting **prescriptions from Hospital Doctors via virtual appointments** is often challenging.

What else is needed in Northern Devon? (in addition to the data/feedback so far?) **2/3**

Education at/ before the hub level/in care homes.

Consideration of **carers** in all pathways.

Community **health coaches** as part of any model

Treatment/support of **alcohol dependency** - often an underlying issue which impacts on effectiveness/take up of any offered interventions

Better understanding of the term **frailty -** de-stigmatise it - make it clear it's a clinical assessment, not necessarily permanent or related to age - or use another term that people don't find offensive, describing as having frailty rather than 'being' frail may help. Frailty is generally characterised by issues like reduced muscle strength and fatigue. Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and a 50% for those aged over 85.

Ability for people, communities and professionals to be able to **share information** about older people - highlighting risks, highlighting needs to enable communities and professionals to be able to respond to the needs of the person.

How to establish who needs what & target them with that intervention. Not everyone needs interventions to combat loneliness but what indicators could identify who does? We don't need a 'one size fits all' it needs to be targeted at different groups

Interventions should include reviewing a person's **housing conditions**

What else is needed in Northern Devon? (in addition to the data/feedback so far?) **3/3**

Gordon Back - older people's mental health lead at DPT described a conversation with a carer - the wife of a gentleman with dementia. She was relaying the stress it caused her to not have had the conversations with her husband about what his wishes were for his care. **She didn't have the conversations earlier on with him when he was able to communicate his wishes**. Gordon sees this a lot - the person's dementia is advanced so the family and professionals involved are exposed to great deals of stress as they can't know what the person's wishes are. How do we communicate to the population - it applies also to physical and frailty issues - to encourage people to get involved sooner in their planning?

Sue Matthews - the **Who I Am documentation** can help with this. A lot of people moving to Devon to retire don't do the proper planning for their retirement, getting everyone to complete the Who I Am and what's important to me would help rather than just those in receipt of care.

Issues around **funding smaller charities**

Using our **community hospitals more as hubs**, particularly around those who aren't digitally enabled, they could be supported by volunteers

Could we learn from Children's Services? They have a **go-to place where concerns are collated**

Don't forget **Social Prescribers**

Anita felt some themes were emerging around how to deliver person-centred care, focus on sub-cohorts, advanced care planning

This feedback has been added to the research analysis which will help inform the Design Brief

Additional comments on the virtual 'whiteboard' ...

Going forward there are going to be more pooled budgets. What are we doing with the professional associations to encourage not relying on personal relationships to work together. We need a commitment across professional associations to be flexible in their professional approach and not defensive to their own professional area.

Controversial question but how do we distinguish between the 'needy' and the 'wanty' when allocating services, and who makes that assessment.

I have a concern that whilst organisations are stressing the high number of people accessing remote outpatients (phone video) there is no demography attached and the people using them are the people find accessing appointments the hardest.

What happens if we have a different model of care?

“Need to also think about what you stop doing. If you can displace activity that is taking people away from their homes for such things as eye tests, cataract appointments, hearing tests, hearing aid clinics, community rehabilitation and reposition it so it's out in the primary and community space rather than in the secondary care provision then the resource should follow that and then you could begin to see how you could shift things at place level, you could agree that this was a priority and if the ICS decided to devolve a certain amount of budget to you, you might say - these are our priorities, this is what we want to do.”

Dr Anita Donley

What could we build on in our system to address needs?

> Interesting that the "real" case study tied in well to the principles of the FLOW project - a discharge coordinator or keyworker bringing in appropriate teams would have helped for this sort of complex case especially when there is no family member to pull things together.
>
> Dr Julia Saunders

> We have community hospitals - community rehabilitation already happens in those so it's not about bringing it out of acute - it's already there. These could also be used more as community outpatient hubs. We also need to build on what we've learnt about consultant video consultations - needs further development to do it well and help people access it. Anything that can be done virtually should be done virtually, anything that needs to be face to face should be provided locally so that you only have to go to the acute for what's needed such as diagnostics.
>
> Nicola Kennelly

What could we build on in our system to address needs?

Hannah McDonald talked about the seven **One Communities** in Northern Devon that are part of the One Northern Devon system infrastructure. They are **local partnerships** made up of residents, health and social care professionals, councils and other statutory services and the voluntary sector. Each One Community has **engaged with their communities to understand what is important** and what the local priorities are, we've matched this with local population health data - such as the Joint Strategic Needs Assessment Town Profiles so that this informs their delivery plans. So each One Community is different in what it's doing - the Community Developers in each One Community work closely with the PCN social prescribers to understand where the gaps in provision are and try to fill them. We are currently trying to further develop our **'Community around the Person'** response - similar to our 'Team around the Person' in our Flow work but where communities can contribute to supporting individuals more systematically.

Final workshop comments - what do we need to build into the new model?

Person-centred care/shared decision-making

I would like to know how we will ensure shared decision making - Putting the Person First. Not just clinical decisions

I would like to be part of the decision making when dealing with my health.

I would like outcomes to be the main consideration for defining a person's care needs, rather than just tasks and units of time. This would be either for a hospital discharge or more beneficially before a crisis point is reached

I want my views as a patient / service user to be listened to

Easy access to advice for carers & professionals

I would like to have simple link to advice and support whilst caring for friends and relatives (be it equipment or care advice).

I would like a quicker way of accessing all the different information available to me about the input of other H & SC professionals

I would like there to be a single point of access (?? hub) for older people, their carers and healthcare professionals to access support, information and advice

I want to know who I can talk to about what's available for me to go to in my community.

Awareness of self-neglect

I would like to see more work done locally raising awareness of risks of self-neglect in elderly frail and reduce associated risks. I would like to like to raise more awareness around risks and overall health consequences of domestic abuse in the elderly frail. I would like more accessible and flexible support for carers to prevent carer breakdown and risks to patient in that.

Workforce

I would like to have timely access to carers, to enable my patients to be safely cared for at home (if that is their preferred place of care)

I want easy to access care and support to prevent deterioration and escalation.

I would like rapid access to care to get people home ASAP.

Local self-help, support & prevention

I would like to see local self-help/support groups, with signposting, to maintain independence for individual SUs. They want to share their experiences and info.

I think we have such a fantastic network of partners in Northern Devon that getting key messages and education resources out on focused areas of prevention could really help support self-care and increase health span of our population better connect partners so they know what is out there to refer / signpost to.

I would like some funding to be able to provide more community based social groups and a befriending service to tackle social isolation

I would like us to focus on the prevention - we are already dealing with the top of the triangle as best we can and we never get out of it when we start there because we are not addressing reducing the demand

I would like to be able to signpost my patients to more community based social groups - e.g. something similar to the memory cafes but for people with mild frailty.

Greater community networks to enable people to remain / improve independence and not be reliant on health and care services.

Community hospitals

Lets make better use of the community hospitals as a hub to provide direct and virtual care. Also consider one stop clinics to reduce transport/travel

I would like to learn more about the Teignmouth Hub and community involvement in supporting the local residents.

Pro-active planning

I would like to ensure the proactive planning for housing needs of older people in the refresh of the Local Plan.

I would us like to start to understand (and address) the human factors that get in the way e.g. reluctance to talk with patients/people about plans for the inevitable deterioration of their condition.

Next steps

Actions agreed

- Add additional services highlighted today to the Service Map
- Add the needs highlighted today to the theme needs in each theme (in addition to the survey results)
- Circulate the NHS definition of 'frailty' so we have a shared understanding of what we mean by the term
- Form sub-groups for the prevention and anticpatory care domains to report back to the next workshop with their priorities that should be in the Design Brief
- Get more detailed information about some of the themes that arose from the survey - second survey asking for some specifics around what the issues with transport are and targeting more older people.