AGENDA ITEM

REPORT TO THE HEALTH AND WELLBEING BOARD

25 JUNE 2014

REPORT OF HEALTHWATCH, STOCKTON ON TEES

REPORT ON ACCESS TO HEALTH SERVICES IN STOCKTON ON TEES

SUMMARY

1. This report provides some insights into the way in which residents of Stockton on Tees gain access to care and what can be the stumbling blocks to gaining access. It is not comprehensive in its coverage of all the issues but does show the feedback that Healthwatch, Stockton on Tees has received over the past year when helping people find the right service in a timely way and suggests some ways of improving the system.

RECOMMENDATION

2. The Health and Wellbeing Board is asked to note the conclusions included in the report and be aware of it in future discussions on service delivery

INTRODUCTION

3. The issues of access to service are complex and multi-faceted. Aspects of them have been examined in some detail nationally and locally and yet there remain uncertainties about the way in which people make use of services, the choices they make about which to use especially in emergency, how well access is achieved and whether some users are at a disadvantage when seeking service. Improvements in research, delivery of services and advances in technology have all served to make the availability of treatment and cure far greater than previously but have the location, distribution and management of service delivery kept up with these changes?

4. The publication of a national report “Transforming Primary Care” (appendix 1) and the report of the local Adult Services and Health Select Committee “Review of Access to GP, Urgent and Emergency Care” (appendix 2) has been really helpful in identifying both the problems faced by the services but also the patients or potential patients. Both reports have identified actions to change the way services are delivered. In the case of the national report the changes are more likely to have an indirect impact on access to services in that a large group of patients should need less urgent access but the use of resources to provide the changes may mean that there is less for the basic service. Attempts have been made to avoid repeating anything said in either report.

5. We are able to rely on the two reports as a basis for this report but hopefully add several new or developed insights into how services might change to reflect the needs of the wider public.

BACKGROUND

6. Access to service has long been a challenge to the NHS as it has been unable to cope with the demand placed upon it. Controls on the flow of patients have been inevitable and the NHS has used waiting times and lists among many tools to achieve this. It has always been necessary to determine priorities and the nature of the NHS means that deciding who has priority is not only a strategic task but a day to day one in every A&E and GP practice.

7. The local report by the Select Committee has documented in some detail the services available to the patient when in urgent need. Most require the patients or those close to them to make a choice as to whether to use any service or which to choose if they believe the illness is important enough. It is only in some ambulance cases where that choice is taken out of the hands of the patient or other person. In effect the patient is expected to make the first attempt at triage and then decide which service matches the need they have identified. Is it fair to expect this to be the case but is there any concrete evidence to suggest that they make poor judgements? A review by the College of Emergency Medicine published in May and based on data collected in March found that 15% of a sample of 3000 who attended an A&E could have been treated in the community (other reports have estimated the figure between 10% and 40%). It was even suggested that there should not be any concerted attempt to redirect such patients and the Patients Association said that patients have been wrongly criticised for abusing A&E, adding weight to the argument that patients should not be blamed for the vagaries of the NHS systems.

HOW THE PATIENT DEALS WITH ACCESS

8. Patients with chronic or long term illnesses are probably the most familiar with how to use the various services offered by the Health Service as first ports of call. If the proposals within the NHS report on Primary Care are fully implemented those patients will receive a service more geared up to their needs and less prone to the complexities of gaining access. In other cases, it is often those who make decisions on the part of others who have the greatest difficulty in deciding what to do, whether to use a service and which one. It is this issue of doing the initial triage that adds further pressure to the presence of the illness itself. For those who have access to the technology they may well make use of the many websites available or they might well contact 111, in some instances because they will feel that they are not “troubling” anyone. The time of day will also influence decision making but more because of the concerns that “normal services” are not available at that time.

9. Contacting 111 should give some comfort to those making the decision but they still have to get into the system recommended. Assuming you have transport or judge that you can justify an ambulance, gaining access to an A&E department is straight forward as you simply join the queue. The speed at which you receive treatment is directly related to how serious your illness is and how busy the service is. There is some evidence that the 111 system can

send people to the wrong service or at least make a different judgement in triage than the receiving service.

10. Both 111 and A&E use triage processes to assess urgency. However GP services do not have a clear and focussed way of doing so. Typically patients seeking urgent appointments are making contact alongside those seeking revisits for various reasons but mainly a check-up at a specific time in the treatment cycle. Some may have a very legitimate reason for seeking an appointment but they also know that it is not in any way urgent. The proposals in the DH report will go some way to setting up care packages for a range of patients that will allow appointments to be predetermined as with prevention regimes. There will remain many patients who seek access to service and currently struggle with the systems GPs have in place which are supported by appointment software set up to control available slots rather than fit patients into them by order of priority. These same systems have to cope with potential patient choice of GP, a requirement that often cannot be met for urgent cases but is clearly a disadvantage for both patient and GP where time has to be spent getting up to speed when the patient is less well known. Issues brought to Healthwatch reflect these problems and patients cannot understand why the process has to be so restrictive. The greatest criticism is the way in which patients are told to ring early morning to get an urgent slot only to find the number regularly busy or the slots gone. Indeed there can even be difficulties setting up appointments in the longer future often because individual GPs control their availability. The notion of charging for the initial appointment has some merit, it is argued, in that it might control misuse. It might also place a greater emphasis on customer care by GPs. Were it to replace the charging for prescriptions it could well be putting the costs up front rather on the treatment where patients are perhaps unfairly penalised if they are more ill than others.

11. The introduction of the facility to speak direct to a GP at this first stage or to get a phone call back or the "Doctor 1st" system is a welcome development assuming it gives consistency and the correct outcomes. It needs to be matched by a flexible booking system that allows urgent cases to be seen throughout the day. Patients are beginning to expect services arranged in the same way as commercial organisations. Many are gearing up in their own homes to take measurements of standard health signs, e.g. temperature, oxygen levels, blood pressure, pulse. They are expecting to be able to get advice electronically because they know what capability technology has. While patients with long term conditions have monitoring kit at home, how long will it be before that extends into all homes? Will the old fashioned systems now in place cope with such change or embrace it?

12. The walk in centre clearly provides a useful alternative for mainly GP services. There is no evidence that it has a big impact on A&E attendances. Equally there seems little impact on GP attendances though this is difficult to show either way. Perhaps it does provide a much better triage system that redirects patients elsewhere. Its siting probably restricts its use, with a central Stockton site being more convenient.

13. Access to secondary care other than through A&E is reliant on the referral processes in place usually through GPs. However feedback suggests that there are concerns about these systems. Choose and book may well give figures for an out-patient wait by hospital to allow

choice of hospital, but gone are the figures by consultant and access to a chosen doctor. There are no figures for in patient wait when, for surgery, that can be the more important time. There are even suggestions that the times given are not accurate and the actual wait is much longer. A further frustration links into opticians and dentists where their ability to refer can be restricted. It does seem perverse that an optician can't refer to an ophthalmologist but has to do this through the GP (who knows little about the eye problem) adding time to the patient's wait.

13. Feedback about access to opticians and dentists inevitably features the costs and how they can restrict people making use of such services. Often people do not appreciate the wider health implications of failing to take care of teeth and eyes and base their judgement on whether to take up services often on cost. In the case of dentists there remains the frustration that it is often difficult (without travelling) to gain access to a dentist providing NHS care. Perhaps this shows how charges can be a disincentive to receiving care.

WHICH GROUPS ARE DISADVANTAGED?

14. Some very specific work with focus groups to consider eye health services and other health services have shown how difficult it is to ensure that the specific needs of those with disability or from an ethnic background are met. It is here that concerns that people don't even attempt to use services arise and thought has to be given to how best to provide services and make their existence well known. The difficulties people face when attempting to gain access to services and actually attending them are well known but the implementation of changes to help are very patchy

ALTERNATIVE WAYS OF PROVIDING SERVICES AND SELF HELP

15. Alternatives to the way traditional services are provided are growing and over the past few years have included the Walk in Centre and 111. At the same time social prescribing has grown in use. Stockton Services Navigation Project, managed through Pioneering Care Partnership and therefore linked into Healthwatch, is receiving 200 referrals a year. These referrals come from GPs and other professionals, very few (10%) are self-referrals. Users are signposted into a wide variety of services, some health related, many managed by charities or social enterprises. The number of services to which users are referred has grown to 40, none of which are conventional NHS services.

> Isabelle is a single parent who looks after her youngest daughter who has severe learning difficulties. She has been on anti-depressants but has not found them helpful. Since her referral to the service she has been able to stop taking the drugs. She now enjoys leading health walks and attends classes at the Arc. She is looking to volunteer to use her skills and experience to help others. She says "Since I've become socially active I no longer need to take the anti-depressants and feel much happier. I am making new friends and feel better in myself. I am much more patient with my family and we have a better relationship and enjoy time together more".

16. Other similar organisations exist, that help people find a service suitable for their needs, some funded and run by charities or social enterprises, others funded through public money

and augmenting existing conventional services. There are some services to which these agencies can refer people that could be regarded as typical health services especially those in the mental health area. However they cannot give the user access to most health services and the user is not monitored within the auspices of the NHS, the GP often not knowing what has happened.

17. There is undoubtedly good work being undertaken by many of these organisations however there is not in place a recognised audit system to see whether the user gets satisfactory and comparable results.

18. For minor health related issues it has long been accepted that the local pharmacist can provide good advice and often guide a patient to the right drug without recourse to other services like GPs. This is being encouraged and will provide a useful service for minor problems. However the pharmacist is limited in how they can take action by what drugs are available over the counter.

19. Independently minded people are increasingly seeking to look after their own health usually by seeking proactive ways to avoid preventable illness but also by finding self-sufficient ways of caring for themselves when ill. Building on this so that more people, who might normally be dependent, feel comfortable in dealing with health issues themselves relies on much better knowledge and raised confidence levels. The obvious danger is that people try to go beyond their knowledge and are only seen by an expert when matters have got worse. This is a growth area especially if actively supported and information sources are vital. They will serve to help a person take the initiative as well as guide them through the options within the NHS should they choose to make use of them.

20. Other changes may well be on the horizon. Single Point of Access may prove valuable but it difficult to see how it could possibly provide a consistency in advice and, more importantly, how it will avoid people simply being passed on to the next step in health care. The other area of interest is the development of the Summary Care Record which should facilitate the passing of information across the various sections of the NHS. However it seems unlikely that it will be able to cope with gathering information about those how make use of alternative services. Perhaps the arrival of a patient held summary record on electronic card might facilitate matters. Given the worries about sharing information it might be a long time before such transformation is possible.

CONCLUSIONS

21. Building on the proposals made by the Select Committee, we would suggest that the following be considered when developing services further:-

- All agencies should seek to educate the public and patients about what matters in their health care so they can understand their own environment and risks and make good judgements about how to take care of themselves and how to use services. This could start at school as part of the drive to improve prevention generally.
- Specific care needs to be taken when educating those who are less well able to understand or how have particular health difficulties

- Professionals need more education themselves on how best to deal with those unable to make themselves heard
- Much better information should be available to allow patients to navigate through health care systems. Such systems get progressively more complicated and the map therefore needs constant updating and simplification. Patients must know what to expect when they make use of services and the necessary documentation must be written from the patient's viewpoint. Again this is especially vital for those less well able to understand.
- The ongoing modification of systems alongside clinical change must take into account the patient's viewpoint and become more user-friendly. This seems especially important in GP services.
- Self-help in the prevention of avoidable ill health, the care of minor ailments and the use of alternative care systems is to be encouraged but there needs to be more freedoms given to allow this to flourish. Conversely a better audit system is needed to ensure good value.
- Information sharing is vital to ensure that all, who need to know about a patient's care, actually do so. However the scope of this should be understood as the system grows both within and out-with the NHS family.

FINANCIAL IMPLICATIONS

Not applicable to this report

LEGAL IMPLICATIONS

Not applicable to this report

RISK ASSESSMENT

Not applicable to this report

CONSULTATION

This report has relied to some degree on the experiences of residents but this has not constituted a consultation as such

Name of Contact Officer: **Natasha Judge**

Telephone No:

Email Address: **natasha.judge@pcp.uk.net**

Name of Contact Officer **Joanne Shaw-Dunn**

Telephone No:

Email Address: **joanne.shaw-dunn@pcp.uk.net**

Name of Contact Officer **Tony Beckwith**

Email Address: **anthonybeckwith@hotmail.com**