CS/13/11
Health & Wellbeing Scrutiny Committee
6 March 2013

Devon County Council

Rural access to health

Refresh

Health & Wellbeing Scrutiny Committee

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INTRODUCTION

1 More than half of the population in Devon live in rural areas. Healthier, safer, calmer lifestyles, close-knit and supportive social networks, clean air and green spaces, peace and tranquillity describe the idyll of country living. But limited transport options and employment opportunities as well as less immediately available services present some people with sometimes insuperable challenges. In September 2009, the County Council's Health & Adults' Services Scrutiny Committee had established a task group to review access to health services in rural areas under the following headings:

a) Transport
b) Remote Care
c) Accident & Emergency (A&E)
d) Community Hospitals
e) Maternity Services
f) Discharge planning and delayed transfers of care

2 In February 2013, two members of the original task group, County Councillors Debo Sellis and Andy Boyd, followed up on how the group's original recommendations had been implemented. Following the publication of the "future of community hospitals" task group report (report number CS/12/23) in September 2012, members decided not to review the section on community hospitals as part of this exercise.

3 A number of follow-up reports had been submitted to the Committee following the publication of the task group's original report: "Developing Midwifery Services: Feedback and Next Steps" to the Committee in September 2010, an update on the implementation of recommendations to the Committee in March 2011 as well as a further update to the scrutiny chairs and vice chairs in March 2012.

4 The members focused their investigation on how people living in rural areas can overcome obstacles in accessing health care and looked at a number of areas, including transport and outreach services, workforce supply, appropriate training and so on. They invited and reviewed contributions from

- the County Council's transport coordination service,
- the County Council's social care commissioning team,
- public health,
- NHS Devon's strategic development lead,
- NHS Devon's Eastern locality commissioning lead,
- a GP locality lead,
- the South Devon and Torbay Shadow Clinical Commissioning Group's commissioning lead, and
- the midwifery and patient care lead at the Royal Devon & Exeter NHS Foundation Trust.

5 The members would like to thank all the expert contributors who participated in the process, for the detailed evidence they gave to the task group, for their time and effort and continued commitment to helping to shape this review and recommendations for improvement.

6 This document will supersede the original task group report to the Health & Adults' Services Scrutiny Committee in March 2010 (report number CX/10/36).

FINDINGS

7 The rural access to health task group published a number of recommendations in their March 2010 report relating to transport, remote care, accident & emergency provision, community hospitals, maternity services and discharge procedures. In the following sections, the progress against the original recommendations will be explained, and new findings and corresponding recommendations will be presented. A list of the original findings as well as their progress is documented in the appendix.

8 In 2010, NHS Devon published a Rural Health and Wellbeing Strategy which has since informed a number of actions within local plans, notably local health improvement plans and locality public health plans at the district and borough council level. A number of funding bids have drawn on the recommendations to inform their submissions e.g. Active Devon's Active Villages programme and the Community Council of Devon's "home grown community owned" (hogco) project. Further health needs assessments have also been undertaken in order to inform future plans, e.g. covering farmers' health. The public health team will lead a strategy review and refresh from April until July 2013 and Devon is scheduled to host the national Rural Health and Wellbeing Network Conference in October 2013.

TRANSPORT

9 In 2010, the task group was concerned about people living in rural areas who have no transport of their own and how they can access services. They recommended coordination between the County Council, the NHS and community transport providers and establishing consistent support for the latter. These objectives have been progressed amidst the turmoil of fundamental NHS reorganisation.

10 The partnership agreement between NHS Devon, the County Council and the community transport sector covering the provision of consistent information via the single points of contact (SPoCs) has been strengthened. Individuals not eligible for non-emergency patient transport services (PTS) can access travel information via the SPoCs. Resource arrangements for the SPoCs had been clarified and members were reassured that this was a key priority while to date there has been less of a need to fund actual journeys. Existing NHS staff transferring to the new clinical commissioning groups will ensure the continuity of the agreement.

Recommendation 1: Devon County Council, the Health & Wellbeing Board, clinical commissioning groups and hospital trusts to continue to recognise the importance of public and community transport in relation to:

- providing access to healthcare services,
- maintaining access as healthcare delivery changes, and
- physical and mental health benefits which derive from public transport and connectivity, in enabling active and fulfilling lifestyles;

and to incorporate this into priorities and spending plans in order to ensure that access to healthcare is possible for all Devon residents.

11 A number of successes can also be celebrated. For example, in recognition of recommendations aimed at improving the support available to voluntary transport providers, voluntary drivers can now be issued with standard parking permits at the acute hospitals. Members recognise that transport planning and access considerations should form an intrinsic component of any activity undertaken by public sector commissioners and providers, including public health, and that clear policy decisions are needed in order to further improve access to transport and the flexible use of vehicles and drivers. This matter becomes particularly pertinent for rural primary care surgeries where home visits to patients who do not have access to transport does not represent a good use of professionals' time.

Recommendation 2: Devon County Council, the Health & Wellbeing Board, clinical commissioning groups, public health and hospital trusts commit to working closely and effectively in partnership to identify and act on opportunities to achieve savings which can result from collaborating on vehicle utilisation on non-emergency NHS transport, and consider recycling savings to ensure access to healthcare is maintained as service delivery changes.

12 A new contract for more flexible non-emergency patient transport service (PTS) solutions will be tendered for during 2013 or in early 2014. Progress against the original recommendations regarding the full coordination of transport services may seem slow but a collaborative approach towards robust planning once the new contract has been agreed will ensure appropriate arrangements for the long term.

Recommendation 3: To continue to recognise, support and value the benefits of the Devon Health Transport Partnership, supporting the community transport sector to provide access to healthcare, in the new structures from April 2013.

13 Careful consideration should also be given to where people are housed with regard to access to services near homes and where new developments take place. This should be reflected in the district councils' local plans and local development frameworks.

CARE IN RURAL AREAS

Telecare

14 The health and social care system is undergoing fundamental changes, including the establishment of centralised, specialist services, but also the development of more service provision closer to people's homes. One mechanism whereby people can monitor their conditions and live independently for longer is telecare. A new county-wide telecare service commenced on 1 January 2013. The contract will run until 31 March 2014 and will deliver as a minimum the following improvements as a result of commissioning from a single provider:

- installation of telecare following an agreed referral within two working days from April 2013, an improvement from the previous 19 working days,
- support from the new provider to determine the best telecare solution to meet the clients' identified outcomes, an improvement from support to staff not being commissioned in the past,

- a wider range of telecare equipment will be available, including standalone technology solutions, an improvement from telecare equipment connected to a control centre being available only.

15 While the new service has been commissioned to meet the need of those eligible for social care services from the County Council under Fair Access to Care criteria; it will also be available to those who wish to self-fund and purchase their own telecare services. The County Council's commissioning approach of telecare services alongside wider community equipment and minor adaptation services is currently being reviewed. The Council will, in the coming months, explore the opportunities of self-assessment for equipment and adaptation services, including telecare, which will continue to see more choice and access to services for those who are able to self-manage and fund these low level preventative services.

16 The innovations team in the South Devon and Torbay Shadow Clinical Commissioning Group's area is developing a system together with pharmaceutical companies which sends interactive text messages to patients, utilising technology people have already got, e.g. mobile phones.

Integrated support at home

17 The Devon-wide 24/7 integrated community nursing and rapid response services were established in November 2011 and January 2012 respectively. The services integrate community nursing and personal care staff whose primary focus is providing the necessary support in people's homes to prevent unnecessary admissions to hospital.

18 The virtual ward and hospital at home pilots have also been further developed over the past three years and are helping to avoid admissions successfully. As part of the virtual wards in South Devon and Torbay, for example, patients at risk of admission are identified and proactively case-managed employing a coordinated and holistic approach, meaning a patient's physical health, psychological wellbeing and social, personal, spiritual as well as environmental needs are being supported through integrated working between general practice and the wider community teams. Virtual ward meetings usually take place once a month in GP practices where intelligence from the integrated teams is utilised to identify patients at risk and to proactively support them. During 2011/12, £1.3million of section 256 funds[1] were invested in home-based intermediate care, including more therapists, spot purchasing of short-term care home placements, recruitment of hospital discharge co-ordinators and short-term additional staff to clear social care assessment backlogs.

19 A different approach is employed in Exmouth, East Devon. The local hospital at home scheme admits and discharges patients for a limited amount of time onto their virtual ward with a limited amount of beds. Patients are more actively managed receiving daily input from a team of healthcare professionals under the leadership of a consultant.

20 In order to further coordinate and integrate services in the future, all assets within an area – i.e. facilities, skills, competencies and communication – should be pooled

[1] Section 256 of the National Health Act allows Primary Care Trusts to enter into arrangements with local authorities to carry out activities with health benefits.

together and deployed flexibly, especially in rural areas. For example, community hospitals are currently staffed even if beds are empty and patients are supported by different services depending on whether they are well or unwell which does not contribute to their continuity of care or professionals' skills development.

21 The recent developments in remote patient care address this dilemma. Although there is a level of professional risk involved in keeping patients at home, integrated teams do benefit from supporting patients remotely under specialist consultant leadership because healthcare professionals can cater for more complex needs independently which develops their clinical competencies.

22 But community teams need to be further integrated if a "total place" approach is to be employed, including GPs, community nurses, community matrons, community psychiatric nurses (CPNs), physiotherapists, occupational therapists, social care professionals and voluntary sector workers and so on, and they need to maintain a high degree of visibility and communication, i.e. every team member needs to be aware of ongoing activities. NHS commissioners are currently in the process of re-specifying contracts with a view to re-tender services in 2015.

Recommendation 4: To support the further development of asset-based care, i.e. the flexible deployment of resources across an area to achieve the best outcomes for patients.

Discharge planning

23 The virtual wards facilitate a patient's journey before and after admissions to hospital and while it was reported that discharge planning functions well, better post-discharge support could be achieved so patients feel safe and supported. For example, a current pilot with the Red Cross ensured that patients' homes were prepared for their return, e.g. the heating was turned on and the refrigerator was filled. Following discharge from the Eastern Locality's orthopaedic ward, patients also receive phone calls within twelve hours to monitor their progress.

Domiciliary care

24 As highlighted in the task group's 2010 report, shortfalls in domiciliary care still seem to be resulting in delayed transfers of care, which occur when patients are medically fit to be discharged but keep occupying acute or community hospital beds because follow-on care cannot be arranged. It was reported that patients with more complex needs, e.g. stroke patients requiring double-handed care four times a day, struggle to access care in rural areas. NHS funding could be used to increase payments where this might assist providers but there appeared to be a problem with provider capacity in some areas.

25 In April 2012, the County Council introduced a new Framework Contract for Personal Care and Community Based Support. When submitting their tenders, providers were invited to quote both rural and urban prices so that the costs of providing care in rural areas could be more accurately reflected. They were also required to confirm that they could offer a service across the whole of the geographic area for which they were applying. When arranging care packages, the agreement with service providers is based on needs assessments. Having regard to the assessed needs and the number of people to visit in a given area, the provider

determines how best to arrange their staffing rotas. This is more challenging where more complex, e.g. double handed, care is required.

26 Providers, especially in some parts of Devon, find it challenging to respond to demand. Providers who are part of the Framework contract have the option to sub-contract from other providers if they need additional capacity and a number of them are also increasing their own staffing to better respond to need. Providers have reported an increase in the complexity of care packages, particularly in relation to hospital discharge, which is often requested at short notice, and end of life care. The Council is monitoring the situation carefully and will be looking at solutions with the Framework providers and NHS partners during 2013.

Recommendation 5: To recommend to the new Council to review the commissioning and provision of domiciliary care services.

MATERNITY SERVICES

27 Maternity services in Devon are provided by the Northern Devon Healthcare NHS Trust, the Plymouth Hospitals NHS Trust, the South Devon Healthcare NHS Foundation Trust as well as the Royal Devon & Exeter NHS Foundation Trust. However, one particular service change had dominated the debate in 2010.

28 In April 2010, community maternity services covering Exeter, East Devon, Mid Devon and parts of West Devon transferred from NHS Devon's provider arm to the Royal Devon & Exeter NHS Foundation Trust. Following extensive public engagement and scrutiny involvement throughout that year, the service was restructured to be consistent and reliable across the localities. Maternity support workers now staff the low-risk birthing units in Honiton, Tiverton and Okehampton 24 hours a day, complemented by an on-call midwife cover and the assistance of infant feeding coordinators. The Trust had managed to fill all its vacancies.

29 The Trust had achieved UNICEF's Baby Friendly status in 2012 as the first service to do so in Devon, guaranteeing consistency of information provision and staff training. This means mothers who give birth in the community get the same level of (breastfeeding) support as those in the acute hospital. The Trust had also attained level 2 of the clinical negligence scheme for trusts (CNST), which assesses maternity clinical risk management standards at least once in any three year period.

30 The quality of the service also increased because all staff now benefit from consistent and continued professional development across the localities. All staff complete regular comprehensive and mandatory training. Midwives, for example, have been trained to perform the initial examination of new-borns after birth instead of paediatricians in order to facilitate more timely discharges. In addition, the maternity support workers are all qualified to NVQ (national vocational qualification) level and have completed further training in e.g. breastfeeding. All staff based in the community have also completed placements in the acute wards in Exeter in order to further develop their competencies and to embed a notion of working towards providing one service among all staff.

31 Senior management leads conduct monthly governance meetings in the localities where they review e.g. case loads, clinical outcomes and breastfeeding rates with the community teams, giving them an opportunity and a platform to raise any matters and further develop the service.

32 There is still an opportunity for women to stay overnight at the birthing units, e.g. following a transfer from the acute wards for clinical reasons or if the mother and baby experience breastfeeding problems. Antenatal appointments and parenting classes are provided as locally as possible, either at the community hospitals where the birthing units are based, at GP surgeries or children centres.

33 As a direct result of the service improvements, the birthing units have seen an eight per cent increase in births over the last twelve months. There now is a genuine choice for mothers to have their babies either in an acute hospital, at a midwife-led birthing unit or at home, if it is safe for them to do so, and the service improvements would not have been possible if the service had continued as a non-integrated model. The members satisfied themselves that the service had been successfully restructured and its quality had significantly improved. The annual Trust-wide maternity services survey was taking place during February 2013 and would soon be publically available.

34 In 2010, the Northern Devon Healthcare NHS Trust reported that it was facing challenges recruiting staff due to the problems associated with the large rural area it covers – such as the lack of affordable housing and the lack of employment opportunities for partners – but nevertheless managed to establish a workforce able to deliver the service safely. The Trust could not, however, develop its maternity and midwifery services innovatively without an increase in funding and improved staff/women ratios. The Royal Devon & Exeter NHS Foundation Trust is working towards sharing their learning with the Northern Devon Healthcare NHS Trust and the South Devon Healthcare NHS Foundation Trust and members suggested a Devon-wide review of maternity services.

Recommendation 6: To recommend to the new Council to conduct a Devon-wide review of maternity services.

CONCLUSION

35 In recognition of the challenges people living in rural areas face with regard to access to services, the rural access to health review was first undertaken in 2009/10. Following this refresh, members were impressed by the level of progress achieved and the commitment with which professional staff dedicated themselves to improving access to services in rural areas. Nevertheless, there is always scope for further development and improvement and therefore members presents the following recommendations for adoption as set out in this report:

1	Devon County Council, the Health & Wellbeing Board, clinical commissioning groups and hospital trusts to continue to recognise the importance of public and community transport in relation to: – providing access to healthcare services, – maintaining access as healthcare delivery changes, and – physical and mental health benefits which derive from public transport and connectivity, in enabling active and fulfilling lifestyles; and to incorporate this into priorities and spending plans in order to ensure that access to healthcare is possible for all Devon residents.
2	Devon County Council, the Health & Wellbeing Board, clinical commissioning groups, public health and hospital trusts commit to working closely and effectively in partnership to identify and act on opportunities to achieve savings which can result from collaborating on vehicle utilisation on non-emergency NHS transport, and consider recycling savings to ensure access to healthcare is maintained as service delivery changes.
3	To continue to recognise, support and value the benefits of the Devon Health Transport Partnership, supporting the community transport sector to provide access to healthcare, in the new structures from April 2013.
4	To support the further development of asset-based care, i.e. the flexible deployment of resources across an area to achieve the best outcomes for patients.
5	To recommend to the new Council to review the commissioning and provision of domiciliary care services.
6	To recommend to the new Council to conduct a Devon-wide review of maternity services.

Jan Shadbolt
County Solicitor

Electoral Divisions: All
Cabinet Member: Cllr Stuart Barker, Adult Social Care, Families & Post 16
Cllr Andrea Davis, Children, Health and Wellbeing

Local Government Act 1972: list of Background Papers: update on the implementation of recommendations to the scrutiny chairs and vice chairs, March 2012

Copies of this Report may be obtained from the Democratic Services & Scrutiny Secretariat at County Hall, Room G31, Topsham Road, Exeter, Devon, EX2 4QD or by ringing 01392 384383. It will also be available on the County Council's website at:

www.devon.gov.uk/index/councildemocracy/decision_making/scrutiny/taskgroups.htm

If you have any questions or wish to talk to anyone about this report please contact:

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APPENDIX

The rural access to health task group submitted the following recommendations to the Health & Adults' Services Scrutiny Committee on 11 March 2010:

	Recommendation	Progress
1	To achieve partnership working between the NHS, Devon County Council and commercial transport providers to ensure that health facilities become more accessible via public transport from communal focal points wherever practicable, including through collaboration in the new Local Transport Plan from April 2011.	Achieved: see paragraph 10 above
2	To identify existing post holders as rural health champions in each NHS trust in Devon in order to represent concerns and issues relating to the provision of rural health services in Devon, with strategic support within each trust.	Achieved: see report CX/11/27
3	To develop as a matter of urgency a coordinated approach between the County Council and all NHS trusts in Devon in the provision of patient transport.	In progress: see paragraph 12 above
4	To identify existing post holders in each NHS trust in Devon as lead officers to champion this piece of work within clear deadlines and to free resources through integrated use of County Council and NHS vehicles.	Achieved: see report CX/11/27
5	NHS Devon to consider the consequences of the withdrawal of NHS funding from non-medically eligible patients and the increasing numbers of patients requiring transport who do not meet the eligibility criteria.	In progress: see new recommendations 1-3
6	NHS Devon to stop using the voluntary sector to support budget cuts and cover gaps in transport provision without contributing to the core costs of voluntary providers where their services are used to replace services cut by the NHS.	Achieved: see paragraphs 10-12 above
7	NHS Devon and Devon County Council to recognise the invaluable and indispensable services provided by voluntary transport schemes and commit to productive partnership working between all NHS trusts in Devon, the County Council and community and voluntary transport providers in Devon.	
8	NHS Devon to establish and clarify what levels of consistent support voluntary transport providers can rely on in the future for providing travel to health appointments, in conjunction with current and ongoing funding support from Devon County Council.	
9	NHS Devon and all acute trusts within Devon to develop hospital access strategies and to provide up-to-date information about patient transport at hospitals and in primary care settings and to ensure that front-line NHS staff are familiar with single points of contact (SPoCs) and patient transport options and can provide patients with contact details for individual transport providers.	
10	To endorse proposals to integrate maternity services provided at the birthing units in Okehampton, Tiverton and Honiton with those provided by Royal Devon & Exeter NHS Foundation Trust.	Achieved: see paragraph 28 above
11	To endorse the proposed changes to the maternity care model, including the decrease in the length of stay and same-day discharge in the birthing units at Okehampton, Tiverton and Honiton.	Achieved: see paragraph 32 above
12	To recommend the Health & Adults' Services Scrutiny Committee to review the support available for isolated and/or vulnerable mothers in rural areas at an appropriate time in the future.	Not implemented as part of scrutiny work programme
13	To review the provision of antenatal classes in rural areas in order to avoid mothers being referred to classes in other localities and at inappropriate referral times.	Achieved: see paragraph 32 above
14	To improve professional development opportunities for midwives in rural areas.	Achieved: see paragraphs 30 above
15 a	To support the development of telecare services in partnership with alarm providers across Devon in order to increase availability for people who can self manage and fund telecare services.	Achieved: see paragraphs 14-16 above

	Recommendation	Progress

15 b	To call upon BT and other providers to ensure broadband access is made available to all parts of Devon by the end of 2010.	In progress via "Connecting Devon and Somerset" programme

Recommendations 16 and 17 not reviewed in view of recent future of community hospitals task group report (number CS/12/23)

18	To review discharge procedures and to report to the Health & Adults' Services Scrutiny Committee on the findings and improvement plans, including delayed discharges over weekends, joined-up admission and discharge planning as well as securing access to appropriate transport.	Achieved: see paragraph 23 above
19	To press for the provision of core community health services on 365 days a year.	Achieved: see paragraphs 17-22 above
20	To recognise and to have regard to the particular isolation of people with complex needs in rural areas.	In progress: see paragraph 24 and recommendation 5 above
21	To develop similar outreach facilities across all Devon districts.	Achieved: see paragraphs 17-22 above
22	To recommend to the Health & Adults' Services Scrutiny Committee that a report be requested on the implementation of the recommendations of the rural access to health task group in November 2010 and in 2011 and to keep the implementation of *The Way Ahead* under review.	Achieved: see regular update reports and this refresh