

## Appendix 1

### Better Care Fund consultation – service user, public and provider engagement

#### **1. Better Care Fund consultation conducted by Healthwatch December 2013 – January 2014**

Healthwatch Rotherham was commissioned by Rotherham Health and Wellbeing Board to conduct consultation to undertake consultation with the local community and engage the community in the envisaged transformation of services.

The aim of the consultation was to:

- Seek views on how local people think things are working at the moment
- Get views and ideas on how we could do things better
- Ensure local people in Rotherham know about this activity

The survey was completed by 42 people between 31<sup>st</sup> December 2013 and 14<sup>th</sup> January 2014.

Of the surveys completed:

- 25.6% strongly disagreed and 18.6% disagreed some of the time, that there needs as a person were assessed and taken into account. The results show that the participants views were evenly spread across agreeing and disagreeing.
- 27.9% strongly disagreed and 18.6% disagreed some of the time, that professionals involved did not talk to each other and work as a team
- 32.6% strongly disagreed and 30.2% disagreed some of the time, that they were told about other services available and local and national organisations
- 32.6% strongly disagreed and 16.3% disagreed some of the time, that when something was planned, it happened without chasing it up
- 27.9% strongly disagreed and 14.0% disagreed some of the time, that when moved between service there was a plan in place for what happened next
- 27.9% strongly disagreed and 23.3% disagreed some of the time, that they had systems in place so that they could get help at an early stage to avoid crisis

The survey demonstrated that:

- Services are not co-ordinated around a person or family – users and carers do not feel central to decision making and assumptions are made regarding an individual's needs based on previous diagnosis
- People do not talk to each other and there are problems with communication between the patient/service user, family and carers, health and social care services, GP, private companies, housing and all services involved in the persons care. No evidence of joined up care. Good examples of joined up care mentioned included Lifeline, Mental Health Crisis Team and Portage services
- People believe that services require chasing up and agreed actions are not completed – in some cases uncertainty about referrals and what happens next
- Customers and service users are unclear of expectations regarding the service they should receive
- Lack of information provided about local and national services and organisations
- Information and education needs to be improved:
  - People feel trapped in the system falling between services
  - People are given conflicting information

- No clarity on who the person or the department is that is looking after their health and social care needs
- Not having their needs been looked at as a whole person or assumptions being made due to a diagnosis
- Waiting for services/referral to respond with appointments taking too long
- Individuals have a good experience of services when there has been a dedicated key worker or professional
- Level of distrust regarding providers in health and social care
- More nurses and better community care are required to prevent the number of people going into residential and nursing care

Recommended areas for improvement:

- Communication:
  - Service contracts to be drawn up with the service user and carer regarding what is expected by each party and the consequences of failure to keep to the contract
  - Extended usage of emails from professional to professional including service users and carers
  - Health and social care staff working within the same teams with same leadership
  - Key workers to stay involved in a person's care when needed to hand over to a new team/service until the service user/carers needs are fully understood
  - Carers to write their own daily notes on their observations in an everyday setting. This can be used when care is reviewed
  - Acceptance of private assessments to avoid duplication, this should be accepted by statutory services
  - From the beginning of journey consent to share a customer's details should be sought. This could be included in a service contract
  - Decision makers to encourage challenges and to provide a clear rationale for decisions
- Reduce the number of people going into hospital and residential care:
  - Provide information on local and national services, with a quality indicator – extend home from home to provide signposting to private providers on how they get quality checked
  - Use community, family and friends to help
  - Extend roles eg porters to handover patients between wards, community nurses to monitor IV drips
  - Specialist teams to work with GPs to raise awareness and support them to understand the effects of specialist issues
  - After care to be provided for carers eg help to arrange funeral and coming to terms with adapting to not supporting the person they cared for

## **2. Views of the Customer Inspectors – January 2014**

During January 2014 12 RMBC customer inspectors were asked a series of questions focussed around the proposed vision health and wellbeing vision including the 4 priorities, experiences of health and social care services and views on what needs to change to make services better. Key headlines are as follows:

- Do you agree with the vision? 100% of customers surveyed said Yes it is very needed
- Do you think the 4 priorities are the right ones to focus on? 100% of customers surveyed said Yes
- What is your experience of health and social care services?
  - There has been a long wait for hospital appointments. They have cancelled on me three times and then I have had to chase things up myself
  - From my experience departments do not speak to each other
  - Communication is poor eg between GP's, district nurses and the hospital. There has been lots of confusion between appointments and information being faxed from one department to another has caused me a lot of upset
  - I can't fault my home care. It is brilliant and they communicate with each other
  - The Council needs to provide the care again, rather than contracting out. If it wasn't for carers I would be in a home.
  - I am not an unwell person, but when I have needed medical assistance it was there and quickly
  - Direct payments difficult to manage eg timesheets, paying for carers etc.
  - I have a friend who has had a need for social care and has been involved in making all the necessary decisions about her care and she was happy.
  - My sister was in a care home. The care she received was very good. They were brilliant. I think you need to know that your staff are people that really care and not just in it for the money. Can't fault the private home care or the council residential home care at all
- What needs to change to make services better?
  - Some people are too proud to admit they need care when they are having a tough time so they refuse it. We need to be able to put care in place for a person even when they say no. the council need more power to be able to do this
  - Better communication between all services to ensure joined up working. Customer should not have to chase services up. More focus needed on the client eg better training and better communication within the NHS particularly your own doctors.
  - Better care services available in the home and more staff to cope with demands so people can remain independent
  - Better after care is needed. You are just left to it once services are put in place. There needs to be more support available for people. Services are just too difficult to access
  - More accessible information needs to be available to people. I had to find out about what services were available to me, no one told me
  - So much care is external to Council and they don't know what is happening most of the time
  - There needs to be consistency of same workers. Too many services are cut back which means people have different workers and feel unsafe
  - Long waiting times for GP's - It's at least 2-3 weeks before you can get into the doctors and you can get worse in that time

### **3. Better Care Fund provider consultation – January 2014**

Emails were sent to 305 social care providers in Rotherham inviting them to take part in a survey around issues related to the Better Care Fund. 7 questions were asked:

- How do you think that the Council and Health could work together better?
- How could the Council and Health work together to offer more support to people to help them live independently in their own homes and communities and keep people out of hospital?
- How could the Council and Health together better support local organisations to provide services that prevent people from reaching crisis point and having to be admitted to hospital?
- What services should the Council and Health stop commissioning and/or start commissioning to support people to live independently in their own homes, manage their own care and keep out of hospital?
- Given the opportunity, how could your business / service better support people to remain independent in their own homes?
- How might your organisation support a 7 day redesigned service to support patients being discharged at weekends and prevent unnecessary hospital admissions at weekends or “out of hours”?
- Given the opportunity, how might your organisation improve the patient or service user experience?

See embedded below the responses to the questionnaire:



The questionnaire also asked providers if they wanted to attend a round table discussion on the Better Care Fund. 9 providers responded positively and the meeting took place 28<sup>th</sup> January 2014 at Riverside House.

Following a presentation that explained the Better Care Fund, the attendees were asked to discuss the following questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
- What practically could be done to prevent people going into hospital / staying too long in hospital?
- How do you want us as commissioners to change?
- What are the gaps / what does the future look like?

Below are the notes taken to capture comments on each of the questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
  - Equipment is key – much lower cost than acute services and prevents people from deteriorating mentally and physically and getting into a downward spiral where they then need an acute service. But equipment and adaptations need to be provided quickly before cases become critical.
  - There are some great funds / grants already in existence but not always marketed and fully utilised. Eg Motability Scheme where people can trade in their Mobility Allowance for a car which can then be driven by the SU, or parents, carers, PA etc. Eg Disabled Facilities Grant which is used to adapt properties. Eg NHS Costs to help people access hospital appointments.

- More information should be given at assessment stage – even when people don't fit the criteria or eligibility. Signposting to community services at this point would be key to preventative action.
- Crisis (mental health) often occurs at night, when a person may call an ambulance – need to have mechanisms in place to support this person without the need for hospital.
- What practically could be done to prevent people going into hospital / staying too long in hospital?
  - Better identification of people at risk. With better communication between agencies it will be easier to identify people who are vulnerable but not currently in receipt of any support
  - Not enough manpower at weekends. All work is geared towards a Mon- Fri week. There is no point in any one organisation working out of hours – the whole system needs to change as all the links need to be in place.
  - More step up and step down beds would be useful. Can we not work with our better performing care homes to provide this?
  - Meal service available as part of care package for a short period of time, would provide a proper meal, and a visit to help a person settle back at home after a time in hospital.
  - Not having appropriate equipment/services/medication support in place often delays discharge, but most services (for equipment etc) close at 5pm – there needs to be more out of hour services, not just 7 days.
  - Carers need to feel confident about the care package and support which the person requires after being in hospital
  - All support services (that provide equipment/social care/dom care etc) need to communicate and work better together.
- How do you want us as commissioners to change?
  - Reduce bureaucracy – example given of it being very common to experience delays in receiving a commode. People have to talk to different agencies, repeating their story and experiencing delay. In the meantime they reduce their liquid intake, find themselves dehydrated. This can result in illness and/or a fall which then leads to acute services being required.
  - Help organisations link up and work together. Eg an LD provider did not know about Community Transport.
  - GPs are often first point of contact – commissioners need to work with GPs to ensure that preventative solutions are utilised eg Social Prescribing Service.
  - Transport is not always taken into consideration when planning DP packages – rendering the package useless.
  - Commissioners of health and social care currently work separately, need them to work more joined up and see the whole person (not just single issues in isolation).
  - Savings that could be made in acute/health sector through more focused prevention/social care support should be realised by all commissioners and money could be reinvested appropriately.
  - People often deteriorate quicker in hospital than if they were at home, if social care/support provision is put in place earlier they could be prevented from going into hospital – which then has a knock-on effect, because if a person does go into hospital their social care needs may be greater when they come out
  - In dom care, when a person is assessed as needing continuing healthcare, the dom care provider loses the person because the contracts are different for

CHC, this can cause distress for a person who is familiar with their carer and comfortable with their care package – change can be difficult.

- What are the gaps / what does the future look like?
  - There should be better education around health and social care. Don't wait until people are in crisis as then they are unable to take all the information on board. People should be taught to plan their health care in the same way that people plan their finances – early on and proactively. Awareness should begin in schools
  - People use A&E/hospital for the wrong reasons – need to raise awareness about the services/support available for people when hospital is not the most appropriate place e.g. people may call 999 as they know someone will pick up the phone – and there may be a stigma to other support, such as charity organisations
  - Marketing about support organisations needs to be targeted to those most likely to use hospitals inappropriately – often if they are lonely/want some company
  - There is no longer a sense of community – people's social needs are not met in their community. People often rely on things like day centres, and when they are gone, they lose touch with other people – people need to have this social interaction in another way.
  - People attending mental health day centres, don't want to get this interaction elsewhere, as through a day centre they meet with people they are familiar with and likeminded.
  - How do we engage people more in their community – it is cheaper to fund and support community groups to establish themselves and reach out to people in the area, than a social care/health care package or hospital.
  - We have created a dependent society, where things/services are provided to people, we need to encourage independence more and help people to engage in their community.

#### **4. Health and Wellbeing consultation – July – August 2012**

Consultation on the Rotherham Joint Health and Wellbeing Strategy took place between July – August 2012 to help shape the priorities. In addition a summary of the outcomes of the consultation were fed back at a VAR/LINK hosted event which took place on 24<sup>th</sup> July 2012.

The consultation was focussed around the proposed vision and priorities, how the priorities would be achieved and barriers to achieving these.

A summary of the findings from the consultation were as follows:

- The vision and 6 priorities were the right ones, however the following suggestions were made regarding what needs to happen and change:
  - Priority 1 Prevention and early intervention:
    - Commissioning process to redirect services to prevention
    - Collaborative working and investment needs to be made into the VCS
    - Face to face/person centred approaches are important
    - Requires a shift and pooling of resources
    - Consideration to be given regarding how people who need services are reached
  - Priority 2 Expectations and aspirations:
    - Need to be clear - tailored standards required and communicated

- Although this priority is important it should be cross cutting across the strategy
- Training of staff required to ensure they know what is available
- Improve partnership working
- Develop different ways of getting information out to people
- Priority 3 Dependence to independence:
  - Collaborative working and investment needs to be made into the VCS
  - Better promotion and use of community transport to help people access services
  - All staff need to be aware of services available to signpost individuals
  - Simpler patient pathways required
  - Support which an individual receives should decrease as an individual becomes more dependent
  - Use of telecare is crucial to support independence
- Priority 4 Healthy lifestyles:
  - Accessible information is required in different formats
  - Small pots of funding required to make things happen
  - Better sharing of resources is required
  - Motivation is different for different people, need to look at behavioural changes
- Priority 5 Long term conditions:
  - Protocols required to share information from VCS
  - People are not always aware of voluntary and community groups available
  - End of treatment can lead to a feeling of abandonment, need to consider transition
- Priority 6 Poverty:
  - Need to improve job creation/entrepreneurship and improve take up of European funding
  - Carers often give up employment to provide care – flexible support is required
  - Workers need to be aware of what facilities are available to support people and improve skills
  - Funding needs to be more accessible
- Issues raised regarding some of the language used, suggested that some areas needed to be reviewed to ensure clarity regarding what was to be achieved and by when including priority 2 (Expectations and aspirations) and what this meant
- Felt that good partnership working would be required to achieve the outcomes
- Strong view that the shift from high dependency to early intervention was the right approach, however disappointed that the draft strategy did not refer to the VCS
- Concerns that not everyone could be treated through early intervention and enablement and that there should be plans in place for those that need acute care
- Comment made in relation to measuring success and whether any consideration had been given to what an undesirable outcome would be, if the outcomes were not achieved. Suggested that this needed to be built into the PMF.

## 5. Learning from customer complaints

Rotherham Council received a number of complaints between 2012-13 relating to Assessment and Care Management and Health and Wellbeing.

Strategic outcome	Service	Complaint
Prevention and early intervention, Dependence to Independence and	Home Enabling	Customer is not happy that their mother has to change care provider after 10 years. From in house domiciliary care to a private provider.

expectations and aspirations		
Expectations and aspirations	Hospital Social Work Team / Home Enabling	Customer was charged for care on discharge / assessment by Hospital Social Work Team as care was arranged via private provider rather than enabling care.
Expectations and aspirations	ACM – Older people	It was apparent that customer misunderstood information provided to them at assessment. This led to their care being reduced and for them to complain and challenge the assessment.
Prevention and early intervention, Dependence to Independence and expectations and aspirations	Assessment Direct/Enabling	Not happy with the assessment of their family member, how it was completed and the outcome as it left them without care. They did not want to go from 4 enabling calls to 0.
Prevention and early intervention, expectations and aspirations	Assistive Technology	Customer complained about the delay in equipment being ordered due to backlog of work caused by annual leave
Expectations and aspirations	Intermediate Care Netherfield Court	Customer complained that they had not been informed of falls suffered by a relative while in Intermediate Care
Expectations and aspirations	Unplanned Review	Customer complained about delays in assessment and submission to resource panel for a request to increase for customers mother
Expectations and aspirations	Home enabling	Customer complained about a missed call and the way a carer handled her mother
Expectations and aspirations	Unplanned Review	Customer complained about repeated unkept promises from a Social Worker to keep in contact regarding money owed for care
Expectations and aspirations, prevention and early intervention	Home Enabling	Customer complained about Missed calls from Home Enablers, the delay in sending out complaints leaflets and the lack of apology from the office in respect of a missed call

## 6. Customer Insight and service improvement (Continuous activities)

Rotherham Council has a strong, customer focussed performance management framework which tests services through customer experience on an ongoing basis. Techniques to gain customer insight and reality check services include:

- The Customer Inspection Service
- Customer Journey Mapping
- Customer Insight (quality checking calls, testing web pages)
- Mystery Shopping

This information regularly informs service improvements and helps to identify priorities for the council. For example, a recent Customer Insight Report which involved listening in to calls made by customers to the *Rothercare Service* identified that 4 out of 10 customers were not able to access the out-of-hours social care service due to no social worker being on duty. This highlights the need to improve our arrangements to ensure customers are provided with appropriate support out-of-hours and has fed in to our Better Care Fund Plan for action.

## 7. Local Account 2012/13

Customer insight is shared with the general public annually through our Local Account. This summarises how adult social care services performed in the previous year and sets out key priorities for the year ahead. The customer voice is prevalent in the account through 'you said; we did' statements and customer case studies. The account gives a balanced view of both achievements and areas for improvement.



Last year's account celebrates the Home Enabling Service which improved the customer's experience and outcomes during 2012-13. A total of 892 people were referred to the service, of these customers 42.8% resulted in being fully enabled to live in the community.

This was achieved by joining up more effectively with our partners (Hospitals, Social Workers and Therapists) to speed up the support provided for the customer. We have improved the national measure of how effective enablement services are with the numbers of people still living independently at home 91 days after discharge, from 85.5% to 86.7% which is well above national (81.5%) and similar council comparator average of 77.7%.

Customer quotes:

- *"Very satisfied helped me to get on my feet again. Thank you very much".  
"The service you all gave was amazing - we were so very grateful. Please pass on my thanks."*
- *"Very pleased with the care I received"*
- *"Very useful and a godsend under the circumstances. The carers have proved themselves cheerful, helpful and very obliging"*

Last year's account also evidences where existing integrated services have worked well together, for example Intermediate Care Services are integrated step-up, step-down facilities which support people to re-gain their independence and live in the community.

Customer quotes:

- *'This is a very good place, I have had a*
- *lot of help from pleasant people; I cannot fault it' (Lord Hardy Court)*
- *"I enjoyed my stay at Netherfield Court and would recommend it to anyone. Thank you" (RICC)*
- *"The service has given me confidence" (RICC)*

The account also sets out our future intentions to support more people to live independently in the community, by:

- reducing spend on residential care by a total of £4.880m
- decommissioning 30% of residential care and commissioning community based alternatives such as Extra Care Housing and Supported Living
- increasing the amount of joint funding into intermediate care - step up step down beds

The account evidences what progress has been made on this so far; In 2012/13 we placed 78 less people in permanent residential accommodation by expanding what works - our preventative intermediate care services.

Further intentions for 213/14 included in the Local Account, which support the delivery of the BCF include:

- Support more people to live in their own homes and reduce the number of people who need to go into a residential home
- Improve the experience of customers who want to access services and need advice and information, including out of hours
- Speed up the way we assess people when their needs have changed.
- Increase the number of services and support for carers

## 8. ASCOF Adult Social Care User Survey 2011-12

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services Responsibilities are required to take part. The survey asks service users about their quality of life and their experiences of the services they receive.

The survey is sent to those receiving services including service users in residential care, those who have a learning disability and those who use mental health services.

388 surveys were completed and returned.

- **Quality of life** - ASCOF Score 19.2 (Improved from 19.1 in 2011/12)

Overall the results are positive and RMBC are in the top quartile nationally however:

- 3.9% (15 out of 388) of people felt they had no control over their daily lives
- 7% felt socially isolated
- 5.8% felt they did not do anything valuable with their time
- 3.7% found it very difficult and 10.1% found it fairly difficult to find information and advice about support, services and benefits
- 2.6% don't feel safe and 18.7% do not feel that the care and support services which they receive make them feel safe

## 9. Personal Social Services Survey of Adult Carers in England 2012-13

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services responsibilities. The survey asks carers of service users about their quality of life and their experiences of services they receive.

336 surveys in total were completed and returned.

- **Carer reported quality of life** – ASCOF Score 8.8 (Improved from 8.4 in 2009/10)

Overall the results are positive and RMBC are in the top quartile nationally. The majority of carers were also satisfied with the support/services they received however:

- 62.9% said that they did some things they valued with their time but not enough and 5.5% said that they don't do anything they value or enjoy with their time
- 56.8% said that they have some control over their life but not enough and 7% said that they have no control over their daily life
- 16.6% said that they have some worries about their personal safety and 2.1% said they were worried about their personal safety
- 36.5% have some social contact with people but not enough and 10.3% have little social contact with people and feel socially isolated
- 33.3% feel that they have some encouragement and support but not enough and 13.7% felt they have no encouragement and support
- 17.6% said that they had not been consulted in the last 12 months

## 10. Health Inequalities consultation – September 2011

The RMBC Public Health Team conducted health inequalities consultation with 426 people in September at the Rotherham Show. Key headline included:

- 41.3% of people felt that health in Rotherham had got worse and that the main contributors to this were unemployment, less money and increased costs of weekly

shops. Only 9.7% said that this was as a result of lack of health services and 20.9% as a lack of health choices.

- 52.5% of people thought that the NHS and Council should provide more information about eating healthy and 52.3% think that people should be encouraged to do more physical activity to improve people's health. However, only 29.6% of people thought that there needed to be easier access health services.

In addition a number of consultation focus groups were held and the problems and solutions suggested were as follows:

- Cost of living
  - Raise awareness of food schemes
  - Provide budgeting advice and support
  - Employers to offer flexible working arrangements
  - Teach people to cook from scratch
- Skills for life
  - Life skills are required not just employment eg cooking, budgeting
  - Provide parenting support
  - Provide opportunities for all abilities
  - Wider awareness needed regarding what is available
- Look and feel of Rotherham
  - Basic standard of housing and code of conduct for private landlords
  - Community engagement in town centre regeneration
  - Increased opening hours of shops and cafes
  - Presence in Town Centre – people, police, community wardens
- Health
  - There are confusing messages across services. Direct clear advice and support is required
  - Increase awareness of good health and prevention as there is a lack of self-awareness which impacts on behaviours
  - Standard core offer from GPs eg opening times and services
  - Offer support groups and raise awareness of what is available
  - Use of co-ops eg food crisis
  - Improve access to services
- Communities
  - Communities need to work better together/community integration
  - Improve communication about community groups and the value of these

## **11. Staff Consultation**

A number of workshops were held in autumn 2013 to map out the process from point of admission in to hospital to discharge to recognise where the points of interface are between health and social care and identify improvements to provide the patient with a better experience.

The workshops had good joint representation from health and social care, and a number of issues were raised about the way the current system operates. The key themes emerging were as follows:

Prevention:

- 'Patients circumstances and needs can change after the pre-assessment takes place (for scheduled care) resulting in patients requiring a bed following day surgery'
- 'A&E is a fall-back position for crisis teams'

- 'Criteria for services is not being applied flexibly resulting in patients being refused access'
- 'Lack of capacity in the community can result in (avoidable) admission in to an acute bed'

Delay in the system – delaying discharges

- 'Out of hours causes inappropriate admission and delayed discharges'
- 'Patients are referred to the Hospital Social Work Team inappropriately'
- 'Discharge planning is often not commenced until the day of discharge'

These issues will be fed in to the BCF Plan.

## **12. Patient Participation Network**

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the Network has identified the following priorities that could be addressed as part of the Better Care Fund Plan.

- Patients should be in the driving seat when it comes to their own care
- Services should be available 7 days/week
- There should be better education and information for people with long term conditions
- Social care, healthcare and voluntary services should work closely together
- More people should be treated at home Invest in community nursing services which are critical to home-based support