NHS
Portsmouth
Clinical Commissioning Group

"YOUR BIG HEALTH CONVERSATION"
Progress report – September 2017

1 INTRODUCTION

During February and March the three clinical commissioning groups (CCGs) serving the Portsmouth and south east Hampshire area began the "Your Big Health Conversation" process.

The engagement activity is designed to support the development of new systems of NHS care both within Portsmouth, and across the wider local health economy. However, the engagement in the early part of 2017 was very explicitly intended simply as 'phase one' of a longer process. The initial phase was intended to do two specific things – to begin a 'plain English' conversation with local people about the challenges facing the NHS in this area and the likely consequences of those challenges, and secondly to start the process of gathering feedback about potential changes to services in the future.

It is important to note that this process is not a formal public consultation, and does not currently relate to any specific decisions concerning service change. The feedback received to date is intended to inform the next steps, but does not dictate them.

2 ENGAGEMENT TO DATE

A survey was developed to be disseminated across the local area. The questionnaire was available online, and hard copies were distributed.

The survey was promoted in a variety of ways – it was prominent on the websites of all three local CCGs, it was promoted via social media, and news media, and also through a network of contacts in the city – partner organisations, stakeholders, GP surgeries and Patient Participation Groups, and other patient and public representative groups.

3 WHO RESPONDED

Across the whole local health system – the areas covered by the CCGs serving Portsmouth, Fareham and Gosport, and South Eastern Hampshire – there were a total of 1,950 responses. Of those, 311 were from people reporting that they were resident in the PO1 – PO6 area.

Of that group, almost 32% were aged under 45 (a notably higher proportion than was the case for the sample as a whole), and only 19% were aged over 65 (far lower than the overall sample). Only 24% of the Portsmouth respondents were male (35% across the full sample), 89% described themselves as white (94%), 24.5% described themselves as having a disability (20%), almost 38% reported that they cared for an adult friend or relative (37%), and 28% said they had dependent children (17%).

4 FREE TEXT RESPONSES

The scrutiny panel has previously seen the quantitative results from phase one, in a paper submitted for the June meeting, which was augmented by a very superficial textual analysis which only looked at the frequency with which words and phrases were mentioned. What follows is a broader assessment of the qualitative ('free text') responses – these questions were a mixture of two types of questions: stand-alone enquiries seeking people's views on a particular topic (for example what the priorities should be for mental health services), and also "Why do you say that?" prompts for people to explain the reasons for giving a particular response to a previous question.

What should the local NHS do differently?

The most common response was also perhaps the least surprising – many people tended to see this question in terms of resources, although not necessarily purely financial resources. "We need more staff", "Waiting times need to be shorter", the need for more or longer appointments were a recurring theme.

Fewer people referred to wanting specific changes to how services could be accessed, although for a minority this was key – "more walk-in clinics", more appointments at weekends and evenings were the most common responses here.

Another notable theme was the declared preference for local, community based care services. Many respondents saw this as a 'good' in itself, but there was also a sense that people felt that strengthened community services were valuable because of the potential impact they could have elsewhere in the system – especially in terms of easing pressure on the acute sector.

Although the overall numbers were small there was a discernible subset of people who felt that charges should be considered – either for people "misusing" the system by missing appointments, or for people from overseas. Again, only a small number cited a need for better staff behaviour/attitude, relatively few people made unprompted references to the need for better mental health care, and some people felt that money needed to be redirected from back-office/managerial staff to frontline teams.

"Why do you say that?" (Whether the NHS should focus more on community services, on acute services, on mental health services, or does not need fundamental change).

Echoing a theme from the earlier question, and a frequent theme throughout the survey, people expressed the view that a greater emphasis on community services had a beneficial impact across the whole of the local health system. People talked of community services "easing pressure" both in A&E specifically, or hospitals more broadly. There were also repeated references to "bed blocking", and the perception that investment in the community would reduce that number of people unable to leave their inpatient ward – both in terms of getting people discharged from hospital more quickly, but also in terms of how community-based services could stop people needing to be admitted in the first place.

A smaller group just felt that primary and community-based care was the natural, and best, place to invest regardless of wider considerations. People felt that it should be the "first port of call" as a matter of course, and that hospitals should be a last resort, not the default option.

The free text responses did also reveal a number of concerns and criticisms. Most notable amongst these was the sense that people already felt dissatisfied with the way that the NHS – and particularly primary care – was currently coping with demands. Phrases like "I can't get an appointment now", and "we don't have enough GPs now" were not uncommon.

"Why do you say that?" (Whether the NHS should invest more in community services – even if that meant redirecting resources from acute hospitals – to reduce "bed blocking").

There were several similarities between the answers to this question, and the earlier question about whether the NHS needed to rebalance resources between community/acute/mental health sectors.

Once again, respondents demonstrated a basic preference for community-based care – in this context that is notable because the question explicitly set out the notion of a trade-off, that a greater focus on community services may accompany a reduction in the resources for acute hospitals. And once again, there were two distinct sub-themes – those who just saw community-based care as the best, most natural and sensible approach, and those who felt that a greater focus on services close to people's homes was the right option because of the impact it could have in lowering demand for care elsewhere kin the local system.

A minority of people explained their preference for hospital-based care, although few people saw this as a good in itself. Respondents were far more likely to endorse hospital-based care as the best choice in certain circumstances – "sometimes you need their expertise", or "some treatments just aren't available in the community".

There was a relatively small group of respondents who effectively disputed the choice that was being put before them. For this group, the NHS does not need to rebalance the way it spends its resources – it just fundamentally needs more investment. "You can't cut beds", or "hospitals need more beds, not less", or "the NHS needs more money", were typical comments from this group, alongside some others who felt "you need to have both" (increased investment in community and acute services).

"Why do you say that?" (How can the NHS reduce demands on GPs).

The responses suggest that, for a significant number of people, seeing only a GP is not necessarily the be-all and end-all it is often assumed to be. There were a large number of comments expressing the view that other staffing groups (nurses and physios were named in the question) were quite capable of giving people the care they needed: "nurses are highly skilled", and "other members of staff can help – it doesn't need to be a GP". It is worth noting that this group of comments significantly outweighed the number of people expressing the view that "it is my right to see a GP" if that is what they wanted to do.

There was a strong sense of frustration from some that too many people did not display enough common sense, or resilience, and that they needed to take more personal responsibility for keeping themselves well. "People just want instant fixes", "people just need to use more common sense", "people are too quick to go running to their surgery".

Importantly, very few people volunteered the view that pharmacies could play a greater role in offering people alternatives to their GP surgery – that is despite extensive efforts on behalf of the NHS to promote the role of the pharmacy as a key community resource.

"Why do you say that?" (Whether people would be prepared to receive some, specialist, care in larger regional departments rather than at their local hospital).

The most common answer can be summarised as "it's a no-brainer", as most respondents felt that the prospect of better care and better results outweighed the convenience of a particular service being close to home. For many, this was a straightforward truth, and although there was a small number of people who felt that caveats needed to apply – for instance, "there needs to be a limit, though…Southampton maybe, but Bournemouth would

be too far" – that was a more marginal approach. Other comments in this vein included "specialist care is going to be best – that's the point".

A smaller group of people favouring this approach also cited more practical concerns. There was, for some, the sense that – regardless of what might be ideal – it is simply impractical to expect all hospitals to have highly specialist teams working in all specialties. "It just isn't viable" and "you just can't have everything on your doorstep".

On the other side there were clear and understandable concerns about the potential prospect of some services being further away. This group can be very broadly divided into two – the larger group which sees greater distance as a problem in itself because of cost (particularly for those without their own transport), difficulty (especially for the frail and elderly), stress, and parking, and a second group which felt that more remote specialist departments would make it harder for friends and relatives to visit people in hospital. Comments here included "emotional support is part of the recovery process", and "people would be isolated".

There were also minor themes relating to specialisation being seen as particularly efficient for the NHS, and a relatively small number of comments to the effect that all hospitals should be the same, and should all specialise.

"Why do you say that?" (What do people understand by the term "seven day NHS").

Interestingly, although only about one-third of the sample had declared that they felt that all NHS services should be available, seven days a week, the most common free text responses on this topic related to the need for round-the-clock care to be available. "You get ill seven days of the week", or "illness doesn't stop at weekends" were typical of the views expressed on this subject.

A smaller but notable group also made the case for seven-day cover, although clearly prioritised urgent care rather than routine services: "If it's urgent you need help whatever day it is, but if it's not so urgent it can wait until Monday". Fewer people still made the case for the importance of easier access for routine services, usually citing the difficulties that working people may have in accessing care and advice outside the traditional working day, or questioning why they should need to take time off work to get NHS help (or indeed, saying that they simply were not able to take time off).

Among those who were not advocating a more fundamental expansion of weekend services, there were two reasons which were most evident.

For many, it was simply not practical to talk about opening more services on Saturday or Sunday: "We don't have enough staff now", or "services can't cope as it is, so how are they supposed to do more?"

For others, the question itself was essentially considered to be redundant – they pointed to the fact that the NHS was already a 24/7 service. Typically these responses concluded: "The NHS already operates seven days a week", or "if someone needs care at the weekend there are enough services already".

This question was also interesting for what people *didn't* say. Although the national debate about seven-day services has focused largely on issues of safety and quality (particularly revolving around the specific issue of weekend admissions to hospitals, and associated mortality rates), that theme was raised by very few of the sample.

What are the biggest priorities for improving mental health care?

Unlike several of the other questions, this produced a relatively mixed picture, with no clear themes emerging obviously above others. Perhaps predictably, the issue of timely access was the most commonly-cited priority – both in terms of actual waiting times, but also in terms of more convenient access arrangements. People said that they wanted "shorter waiting times", and "quicker access to the support", as well as "more drop-in clinics" and a smaller number who wanted greater opportunities to be able to self-refer to get help.

Other themes were relatively evenly-spread. There were a number of people calling for more, local, inpatient and specialist capacity, but also a group which wanted to see a greater emphasis on community-based support, and more help to keep people living independently at home.

Perhaps surprisingly, the number of people simply calling for more resources – both funding, and trained staff – was relatively low, and there were also only limited numbers of people calling for a greater focus on early intervention, crisis response, and child and adolescent services. It should be noted that there were somewhat fewer substantive responses to this question, reflecting the fact that fewer people had direct experience of mental health services.

What should be the biggest priorities for improving social care?

This question had the lowest response rate, because of the relatively small number of people who have direct experience of social care services. However, it also produced perhaps the most unexpected findings.

The most frequently-cited response – by far – did not relate to the actual delivery of services at all, either in terms of resources, access, or quality. The most common response actually related to service integration. Time and again people called for health and care services to be more seamlessly combined – "pooled budgets", "closer working arrangements", "NHS and social care teams working together", and "make services more joined up" were common refrains.

Of the other responses, there were general calls for better, or more, help to support people to live as independently as possible within their own homes, and some people made the specific call for carers to be given more time to be able to look after people.

Among the more marginal themes there were those asking for carers to be better paid, to have better working conditions, and/or to be better trained, to enable a more skilled and motivated workforce.

5 NEXT STEPS

The findings from the first phase of the "Your Big Health Conversation" were never intended to support or endorse any particular decision or course of action – rather they were intended to support and inform further engagement work.

The findings to date suggest some interesting questions which need further exploration. For example, people may seem to be prepared – indeed perhaps keen – to see more services delivered close to their homes, but how does the NHS do that in the best way, and in a way which does best supports the acute sector to remain strong? How does the NHS balance local expectations (and national policy) regarding seven day services, against the resources available? How does the NHS acknowledge the apparent willingness of local people to see health professionals other than GP, but ensure that people feel they are getting the care that suits them, not the care which merely suits the NHS?

The next phase of Your Big Health Conversation will move away from the largely theoretical approach of the engagement work to date, and instead focus on presenting people with more tangible 'now and in the future' scenarios. It will set out to people how particular groups of people – for instance elderly people with several long-term conditions, parents with young children, someone who has recently been discharged from hospital – will currently receive their NHS care and support, and then sketch out how this might change in the coming years. The intention would be to capture people's views about each of the specific scenarios – what sounds attractive, and why? What is there which concerns people, and why? What needs to be considered, which perhaps hasn't yet been addressed?

The next stage will also mark a move away from relying solely on the web-based survey method of phase one, and seek to devote more energy to face-to-face interaction, with more proactive targeting of relevant audiences.

Initially the hope was that the second phase would begin in the summer, although this is now more likely to begin later in 2017. The expectation is that a further engagement phase (as a minimum) will still be required after the second phase is complete, to allow the NHS to set out in greater detail where the thinking has reached in terms of how the city's NHS may look in the coming years, and how people may access support.