HSJ LOCAL briefing

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MID DEVON COMMUNITY ENGAGEMENT

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Community concern about the closure of services at Tiverton hospital in Mid Devon led to the creation of a project to look at the future of the hospital's services in partnership with the public. The NHS Confederation has led an event with the project group which trialled the use of a future thinking methodology with the public for the first time.

Context Northern Devon Healthcare Trust took on responsibility for running the hospital under transforming community services. However, a number of other NHS organisations also provide services there. Contracts for community services must be retendered by 2016.

Outcome There appears to be much agreement between commissioners and the lay members of the project about what health services need to do in future, which is positive. However, there is still a lot of work to do with the wider public in Tiverton and across the rest of the county.

The lie of the land

There has been a hospital in Tiverton in eastern Devon for more than 100 years. The current building was built under a private finance deal with a capital value of £10.4m by Mid Devon primary care trust and was officially opened in 2005.

While Northern Devon Healthcare Trust has overall responsibility for the hospital, and runs a 24 hour minor injuries unit there, a number of other local NHS providers also use the hospital. Royal Devon and Exeter Foundation Trust provides orthopaedic surgery, runs the maternity unit and delivers endoscopy and other diagnostic services.

Devon Partnership Trust uses the hospital as a base for some of its older people's community mental health services and until recently had inpatient beds. The hospital, which serves a population of about 70,000, also houses a GP surgery and is used by local GP out of hours cooperative Devon Doctors. Nevertheless, significant parts of the hospital are currently standing empty.

Northern Devon acquired the hospital on an interim basis, along with 11 other community hospitals in the east of the county, in 2011, when PCTs were required to divest themselves of community services under the transforming community services programme. There is a feeling locally that Northern Devon did the county a "favour" in taking on the hospitals from Devon PCT when no one else wanted them as the need to change the model of community hospital provision was well known among local NHS bodies.

The contract for community services must be reprocured by 2016 and is likely to go out to open procurement. Northern Devon's foundation trust application has been delayed twice and still requires "commissioner convergence". At the time of writing, the two sides had gone to arbitration in a bid to reach agreement over their contract for 2013-14. HSJ understands the shape of future of community services is an area of continued discussion.

Northern, Eastern and Western Devon Clinical Commissioning Group is England's biggest CCG in terms of budget, with an annual income of £1.1bn. Originally three separate shadow CCGs, they came together so they could viably carry out commissioning tasks in house.

NEW Devon CCG retained the three localities, each of which has its own chair and chief officer, and is committed to developing local services in partnership with the community. In November last year it agreed a set of principles to patient and public engagement, which stipulate that patient and public engagement should be "endemic" within the CCG and the patient and public voice is equal to that of the professionals.

How did the community get involved?

Concern about the closure of services at Tiverton and District Hospital, including the maternity unit in 2010 and the suspension of inpatient services at the Devon Partnership-run Melrose Unit on Christmas eve that year, generated a lot of local interest. A number of local residents got involved in discussions about keeping the hospital open.

The Melrose Unit had single room inpatient facilities for up to 12 patients with dementia so its closure added to the proportion of the hospital that was not being used. It is often referred to locally as being "half empty". There was also concern that the minor injuries unit was often being forced to close overnight due to staff shortages.

Tiverton GP Frank O'Kelly, in his then role as Devon PCT GP lead for strategic development, was asked to lead a project to maximise the use of the hospital – the Tiverton Patient Centred Care Project was born. He invited members of the group that had loosely formed following the closure of the Melrose Unit to get involved.

Although willing, and becoming increasingly concerned about the hospital, the individuals involved did not feel they had a mandate to speak for the whole community. They called a public meeting to which they invited representatives from local community groups and other relevant organisations. Approximately 50 people attended and 20 agreed to play an active role in the project, including a number of local councillors; the Tiverton and District Health Service Choice group was formed.

Chair of the group Bob Deed is Mid Devon's cabinet member for community wellbeing and a retired City banker. He describes the issues at Tiverton as a "microcosm of the national health service". He said: "It has a number of different health service providers and they seem not to work seamlessly together. Governance is a major issue. The public, when they walk through the hospital door, believe the NHS to be one organisation."

The minor injuries unit

As part of the care project, the hospital's League of Friends conducted a survey of local people asking them about their use of the hospital and which services they saw as a priority. More than 1,000 people responded to the survey, which identified the minor injuries unit as the most valued service.

The Tiverton Choices group picked this up and considered five options for the future provision at the minor injuries unit, which commissioners agreed could be provided and afforded financially. Significantly the group discounted two of the proposals, including one for a 24 hour doctor led service, after looking at data collected as part of the Tiverton Patient Centred Care Project; this showed there were just 238 attendances between 1am and 7am during the whole of 2011.

Dr O'Kelly cites this as an example that the community can be trusted to make sensible decisions about use of resources. He said: "For far too long we have told [the local population] what they need.

"If you go out and engage people on local issues they will be brave enough to look at the costs and say 'it

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is too expensive to keep the minor injuries unit open overnight when it is only seeing one or two people'."

During February this year the Choices group went out to consult on three options: the status quo of nurse led care, 24 hours a day; nurse led care from 6am until midnight; or doctor led care, open from 8am until 10pm. Of about 1,600 responses, 87 per cent were in favour of the doctor led option.

However, nearly three months since the consultation closed there is little sign of any changes to the service and, what's more, both Northern Devon Healthcare Trust and the CCG have expressed reluctance to implement it.

The local NHS argument is that putting more doctor cover into the minor injuries unit will duplicate work that should be done in existing primary care, and that any changes to provision at the hospital need to be made as part of a wider strategy for community services across the Eastern locality rather than on an ad hoc basis.

Historically GPs from Tiverton practices have provided the doctor cover in the minor injuries unit under contracts with Northern Devon for 23 hours a week so the increased cover would equate to an additional 25 hours.

Dr O'Kelly is a partner in Clare House surgery in Tiverton, which provides GP cover; some believe he has a conflict of interest in the minor injuries unit work. In response Dr O'Kelly points out he was leading the work as a PCT employee and set up a separate group to consider the minor injuries unit project, of which he was not part in order to maintain his "probity".

Dr O'Kelly, who is not currently involved in local commissioning after coming second in the election for chair of NEW Devon CCG, says the per head payment his practice receives reflects the fact that some primary care work does end up at the minor injuries unit.

"What I'd love to do is just accept patients want a decent service. They have paid for it, they have a right to it," he said.

However, many, including some members of the Choices group, feel the public's trust is at stake. Councillor Deed said: "Experience has shown the public, within Mid Devon, that a 'consultation' over a proposed closing of a ward on a temporary basis results in that ward remaining closed permanently.

"Having spent 18 months on the Tiverton project and having consulted twice with the public on what they want and need, if we don't have implementation of the public's overwhelming choice for an enhanced urgent care provision shortly, we are going to lose the public support. It will be seen as just more of the same.

"The NHS cannot ask the public to keep responding to consultations and then not actually take any notice when they respond."

Coming together

It was against this background that the NHS Confederation bought together members of the Choices group and key local NHS figures with an interest in Tiverton hospital for a "scenarios" event.

The methodology was developed by NHS Confederation chief executive Mike Farrar and others during his time as chief executive of the NHS North West Strategic Health Authority, but this was the first time it had been used with a group that included members of the community as well as NHS professionals. The Confederation was initially invited by Dr O'Kelly, who had used the methodology on a leadership programme.

Over 24 hours participants considered four future scenarios and discussed what changes they would need to make now if they were to be prepared for these futures.

Deliberately extreme and bordering on dystopian, the scenarios are designed to be "just possible" versions of the next 15 years, not predictions of what will happen. They are polarised between a UK in which health and social care has been all but privatised and one in which the community has taken control; and between a system focused on treatment, cure and care, and one most concerned with prevention and improving health and wellbeing.

The futures were constructed, in part, by analysing how the health and social care system might react to five key change drivers:

- the ageing population;
- reaching the limit of the welfare state;
- possibilities introduced by new technologies;
- increasing consumer sophistication; and
- the "exhaustion of traditional methods of containing costs".

Participants had mixed expectations about what the event, which ran from 4pm one April afternoon until the same time the next day, was designed to do. Many from the community expected a more detailed consideration of Tiverton hospital while those from the NHS were clearer it was to be more strategic.

Participants were each allocated a scenario and spent a number of sessions considering it in a group. The groups were then mixed up into new formations and asked to come up with a bold vision for the future, setting out what changes they would need to make immediately, and in the medium to long term, in order to make it happen.

Common themes included more personal responsibility, more integration and more community ownership and involvement. One senior NHS figure present commented on the "maturity" of the debate.

NHS Confederation chief executive Mike Farrar, who attended the event, said it had provided some "important pointers about the potential of communities getting involved proactively rather than reacting to things like hospital closures".

Although there was little discussion during the formal sessions of the local detail, one group did include implementing changes to the minor injuries unit as an immediate priority, eliciting a commitment from a member of the CCG present that it would happen. Some participants described the event as having been "hijacked" by this issue and said the commissioners were "put on the spot".

Not everyone supported the methodology, complaining that too much time was spent looking at scenarios rather than finding solutions. The Choices group was generally positive about the event, although Councillor Deed said, at first, it had been difficult to "grasp where it was all going".

He added: "It got the group thinking. It was also extremely rewarding as both lay people and senior members of the NHS were working together. The Choice members heard and understood some of the NHS perspectives and discussions were wide ranging."

The future

Where there was discussion about Tiverton hospital there was shared frustration that the facility was currently underused and agreement from members of the community and the NHS that the empty space should be used for other community facilities.

One senior NHS source suggested

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any qualified provider procurement could be used to provide more services from the hospital.

Meanwhile, Dr O'Kelly would like to see a specification detailing services the hospital should provide drawn up in partnership with the community. With that having been done, the contract to run the hospital could then be put out to open procurement. The Choices group is keen to be involved in developing a specification, although not all members would be happy with an open procurement.

Councillor Deed advocates producing a business case for setting out what the community needs from the NHS.

"As the hospital has to resolve its governance issues, so the commissioners of all the various NHS service provision strands need to work together to establish what's needed in the community, and then deliver that integrated service within the overall funding available," he said.

The CCG is looking to "coproduce" a specification for community services across the east of Devon that must be retendered by 2016; it is planning community engagement events across the county to inform local residents about this. As such, CCG chief officer Rebecca Harriott says the CCG plans to talk to the Choice group about whether to go ahead and implement the changes to the minor injuries unit or whether to be "slightly more ambitious".

She added: "We are trying to get the balance right between looking at services on a community or town basis and across the whole of Devon."

Ms Harriott, who was previously NHS Devon's director of commissioning development, found the scenarios event a "helpful" way to encourage people to think differently, "partly because of the scenarios but partly because of the mix of people around the table".

"There was a breadth of solutions coming forward, for example the idea of campuses in Devon that bring together NHS, leisure, education and social care," she said.

NHS England's Devon, Cornwall and Isles of Scilly local area team medical director Graham Lockerbie is also interested in the idea of health and social care campuses. He thinks these could fit well with Devon's historic configuration of dispersed market towns, each with their own community hospital. He argues that making use of these "tribal loyalties" to develop community-wide strategies could help win local buy-in for reconfiguration of services.

"If you're going to take a community facility like a well-loved community hospital away, you have to make sure you put something well loved in its place," he said.

Happily ever after?

The experience of engaging the community in Mid Devon demonstrates the possibilities and the limitations of such involvement. From a single-issue group, the Choice group, following regular meetings, has become interested in the wider strategy for health services across the community and well informed about the issues at stake.

Some members privately accept the CCG's argument about not making changes to provision at the minor injuries unit at this time, but there is real concern about losing the rest of the public. This highlights how the often glacial pace of change in the NHS can be frustrating for members of the public who have given up their time to make a difference.

Lessons learned

The formation of the Choice group by invitation seems worth replicating in a bid to get wider representation and a broader range of voices involved. As well as the "usual suspects" of local politicians and activists, the group also has some professionals among its members such as the local Age UK chief officer.

Allowing the Choice group to lead the consultation on the minor injuries unit and offering people specific, easily understandable options to choose between appears to have given it an added legitimacy.

The scenarios event was mainly viewed as useful by participants. The process of considering more abstract futures rather than the specifics was useful in the strategic sense and in impressing on the community that its well-loved service is part of a much bigger complex system.

However, the event also provided a space for discussions about the nature of health service provision without some of the emotion that can attend consideration of specific services. Bringing together NHS professionals and members of the community as equals proved to be an opportunity to build respect as well as relationships.

Financial support from the NHS Confederation allowed the event to be held in the neutral space of a local hotel. CCGs may not feel this is an appropriate use of resources but it seems some level of investment is appropriate if commissioners are to be seen to be taking community involvement seriously.

The CCG's proposals for public engagement in the future strategy for community services are genuine and ambitious; whether this approach can win widespread public support for difficult decisions remains to be seen. What seems clear, however, is that involving people early on and being honest about the issues is essential, rather than presenting ready-made solutions that are then met with suspicion.