



the way ahead

A strategic framework for health and social care

Devon 
Primary Care Trust

Devon 
County Council

This is a summary of a much bigger and more detailed piece of work.

If you would like more detail on any of the sections that follow, please go to our website at www.devon.gov.uk/haveyoursay where the full document will be posted.

Or contact:

Devon Strategic Review Programme Office,
Dean Clarke House,
Southernhay East,
Exeter EX1 1PQ

Telephone: 0845 155 1012

E-mail: d-pc.strategicreview@nhs.net

This Strategic framework covers all of Devon except the areas within the Plymouth and Torbay local authority boundaries.

If you would like this in a different format such as large print, Braille or tape, or in a different language, please contact the council's Information Centre on 01392 380101 or email: info@devon.gov.uk

Contents

1. Setting the direction	2
2. In partnership	2
3. Important aims	2
4. Shared information about Devon	3
5. Making a real difference	4
6. Improving health and social care	
<i>Staying healthy</i>	8
<i>Birth and maternity</i>	11
<i>Children and young people</i>	14
<i>Urgent care</i>	17
<i>Planned care</i>	20
<i>Mental health and wellbeing</i>	23
<i>Long-term conditions and disability</i>	26
<i>Older people</i>	29
<i>End of life care</i>	32
7. Developing health and social care	35
8. From strategy to reality	37
9. Our commitment to you	39
10. Welcoming views	40

Introduction

In Devon, we have a tremendous opportunity to improve health and wellbeing, and a shared determination to achieve and sustain outstanding health and social care for the future.

Last summer, Devon Primary Care Trust and Devon County Council launched a joint strategic review. Together, we studied the health needs of the population and the way health and social care are used. We looked to see what we could learn from the best practice locally and nationally and, most importantly, we listened to people across Devon - people who use our services, carers, colleagues in voluntary organisations, clinicians, staff and many others. All this has shaped the thinking that we now put before you for your comments.

We have a clear picture of where our priorities should lie, and we have built this into a strategic framework for Devon. During the next five years we will:

- Put a great deal more emphasis on helping our population stay healthy
- Target extra support to deprived communities and people who need our help most
- Do everything we can to help children and young people have a good early start in life
- Shift much more care into people's homes and communities, making local care a reality
- Make a difference to care for people with long-term illnesses or disabilities and their carers
- Pick up mental health problems early on and keep the focus on therapy and recovery
- Make sure our services in Devon match the best

We know that actions speak louder than words, and many people in Devon have told us they want to see early results. Some changes can, and will, be made now without delay. Others will need more planning and consultation, but we will be pressing ahead with a major redesign during 2008/09 and beyond.

We will do this in partnership. We are confident that, together, we can achieve better health and wellbeing in Devon, and continue to improve the experiences people have when they use health and social care services.

We would like to express our sincere thanks to the people who have contributed their time, energy, commitment and expertise in helping us complete the joint strategic review. We believe the outcome of this work, and the impact it will have in the next five years, will demonstrate the absolute value of all of the help we have had so far and hope to continue to receive in the future.

Dr Kevin Snee
Chief Executive
Devon PCT



David Johnstone
Director of Adult and Community Services
Devon County Council



Anne Whiteley
Director of Children and Young People's Services
Devon County Council

1. Setting the direction

We know we can make a difference and create even better health, better care and better treatment during the next five years.

Our joint strategic review has given us a wealth of information. During the summer of 2007 we:

- Reviewed past feedback and listened to the present views of people who live and work in the county
- Found out more about our population and the health and wellbeing needs in Devon's communities
- Looked at a range of care and types of services, and related these to national strategy and best practice

As a result, we are now ready to set the direction for health and social care for the future.

2. In partnership

At the centre of our approach will be strong and sustained partnership working, not only between Devon Primary Care Trust and Devon County Council, but with all sorts of organisations and individuals with an interest in health and social care. We know we can have a bigger impact if we:

- Seek out people's views so we can better understand what it's like at the receiving end for those who use health and social care services, and their carers
- Enable our population to influence planning and decision making
- Encourage and support collaboration among all those who provide health and social care
- Work side by side with the voluntary sector, recognising its invaluable expertise and contribution

3. Important aims

There are six core aims for health and social care in Devon. They are:

- **Health as good as it can be - prevention and early intervention**
- **Care as local as possible - and as specialised as necessary**
- **The best possible treatment - that is continuously improving**
- **The right support for people - with complex needs**
- **The most effective use of all our resources - for maximum impact**
- **A say and an influence - promoting partnerships in care**

4. Shared information about Devon

We now have much more intelligence about Devon, its population, health needs and the way we use health and social care. Detailed information is available about 29 Devon towns, including rural communities, and about many aspects of care. This information will really help us in the next steps of planning and improving health and social care.

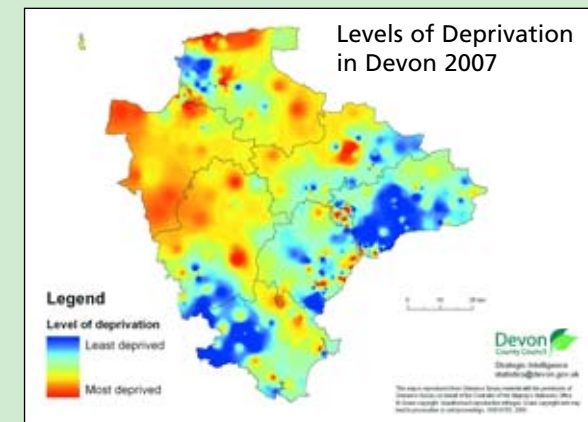
Our combined health and social care budget for Devon is about £1.5 billion. Resources are finite and need to be used wisely to make the biggest impact on health and wellbeing.

Nationally and locally, people have said they want greater emphasis on improving health and more care at home or nearby. New ways of providing care, new treatments and new technology now make this more possible. We will make a positive and timetabled shift in emphasis in the way we use our resources to achieve this.

In summary: Devon has a population of more than 750,000. It spans more than 2,500 square miles, is the third largest county in England and the seventh most sparsely populated. There are more than 6,000 births and 8,000 deaths a year but with people moving here the population continues to grow.

The numbers of 0-19 year olds are expected to fall by 2.5% in the next five years but numbers of more needy children will rise. The older population will grow by one third in the next 15 years – with an 8% increase in over 80 year olds by 2012. Already Devon has a higher proportion of older people (24%) than the south west as a whole (22%) and England (19%).

Disease prevalence in Devon is higher than for England as a whole for a number of conditions – including coronary heart disease, hypertension and cancer. The main causes of death are cancers and circulatory and respiratory conditions – but the picture varies among the 29 Devon towns. The towns also differ in many other ways – such as hospital admissions, use of care homes, and support at home.



Devon has generally good health when compared with the rest of the country, but this masks significant problems.

Twenty one communities in Devon are among the 20% most deprived in England. More than 50,000 people live in the most disadvantaged neighbourhoods in Devon. There is a correlation between deprivation and death. Today there is a gap of up to 18 years in life expectancy at birth between different communities in Devon.

5. Making a real difference

We are now able to set out 12 key strategic intentions for the next five years. We will:

◆ **Close the gaps that make people's wellbeing and life expectancy unequal**

In Devon, there is a difference in life expectancy of up to 18 years for babies born in different parts of the county.

We want every baby, child and young person to have the very best start in life and will do everything in our power to help them to be healthy, happy and safe. We also want to address the inequalities that affect all age groups and to work with our partners to tackle the impact of poverty, deprivation, and social exclusion. We want to support those who are most vulnerable and achieve high-impact change in Devon. We need to make demonstrable progress in narrowing the gap in life expectancy, targeting our attention to those groups and communities that need our help most.

◆ **Take positive action to improve health and wellbeing in Devon**

In Devon, we can make changes to the factors that contribute to poor health – such as obesity, alcohol consumption, poor housing, smoking, and lack of emotional wellbeing.

We want our population to be fully engaged in improving their own health. We also want to prevent problems where we can, and intervene early when people are ill. We need to provide better information and make it easier to get advice about health and wellbeing. We can do this through developing school-based hubs for children and young people and through local health and wellbeing contact points for adults and older people. We need to direct more of our resources to health promotion, early detection and intervention.

◆ **Shift the balance from acute hospitals to community care wherever this is possible**

In Devon, the majority of hospital care takes place in the larger, acute hospitals - from outpatient appointments, hospital admissions, urgent care, day treatments and diagnostics.

We intend to change the way we use the acute hospitals in Plymouth, Exeter, Torquay and Barnstaple and bring significant proportions of urgent and planned care into more local settings. We know, for example, that about 90% of current outpatient appointments take place in acute hospitals, but many do not need the complex and specialist facilities those hospitals afford. To provide care more locally, we will develop our community and primary care services, allowing acute hospitals further to reduce waiting times and deliver increasingly specialised health care. Bringing care closer to home is also important in services for people with dementia, mental illness and disabilities.

◆ **Develop and use real alternatives to residential care**

In Devon, we know that over 50% of our adult social care budget is spent on 24% of service users living in care homes, yet we know that more people would prefer to be cared for in their own homes.

There is evidence that spending social care resources on care in the community improves people's lives - and makes sense financially, too. Yet more than half of Devon's social care spending is on residential care and some people are cared for outside Devon, many miles from their families. We need to make a steady shift in this pattern and provide responsive, individually-tailored support in people's own homes and communities, using integrated teams to help with a range of needs, including housing. This approach applies equally to services for children and young people.

◆ **Avoid people receiving appointments or treatments that don't have clinical value**

In Devon, we estimate that each year more than 15,000 outpatient appointments are attended when they are not really needed, and that more than 250 operations are performed that don't really help. People from poorer backgrounds are also more likely to have these unnecessary interventions.

These appointments and treatments disrupt lives and use valuable NHS resources that could be better spent on more helpful care. According to national guidance and research, some follow-up outpatient appointments and some surgical procedures do not actually lead to clinical benefit for all patients. We want to make sure that only those who will benefit are given these appointments or treatments. We will in the future provide care on the basis of best evidence-based practice. We want to become a national leader in getting this balance right for our population.

◆ **Deal with the hidden waits that can make people's lives more difficult**

In Devon, there are almost 100 people waiting for electric wheelchairs that could dramatically improve their lives. Without our taking action, those joining the waiting list today would wait at least three years. Young people with special needs and adults who require assessment are also facing lengthy waits.

We are already making care and treatment easier and quicker to get, and we are working to drive down waiting times for social care assessments and reviews, outpatient appointments, diagnostic tests and surgery - beyond national expectations. But there are also hidden waits that often go unnoticed. We are currently addressing the provision of wheelchairs with the help of people who use the service in Devon. We will continue to address this and other waits that are not currently measured but can have a big impact on people's lives.

◆ **Continue to improve the results or outcomes of the care people receive**

In Devon, there is already much good practice, but we are striving to keep improving the results people get from their care, and to avoid problems in that care.

We want to ensure everyone receives the very best health and social care, with the most up-to-date treatment and the most effective approaches. We need to meet all national guidance, standards and targets, and get the best possible results for people in their treatment, survival rates, and experiences. We need to deal with the things that worry people most, particularly MRSA and other hospital-acquired infections or inappropriate treatment. We also need to keep improving safeguards and make sure that vulnerable people are free from the risk of abuse. We will set clear standards for our providers of health and social care, and have a strong system for measuring results.

◆ **Enable people to choose where they die, whenever this is possible**

In Devon, 8,000 people die each year. National studies tell us that 56% of people would prefer to die at home. In Devon, over a three-year review period, only 20% of those dying did so in their own homes.

There will always be deaths in hospital, especially in emergency situations. But many people expecting to die have time to make plans. We want to give these people a choice of where they would prefer to be when they die, and to ensure they have real confidence that this choice will be respected and delivered. In Devon we have many very good elements of care and highly-skilled and sensitive services for people at the end of their lives. But we have found gaps. A particular lack here is in out-of-hours nursing that could really help people who are dying to stay at home. This will be given our early attention.

◆ **Integrate and co-ordinate health and social care**

In Devon, health and social care are already well integrated, with joint management arrangements and jointly-commissioned services.

We want to build on our success in integrated working and move to a new era of co-ordination and collaboration, not just through our health and social care commissioning partnership but with all our other providers of care, support and advice. Joined-up working was raised as a central issue in our consultations and our response is to re-focus our commissioning to give greater co-ordination and continuity. This will need a new style of relationships. It is also central to this that we further strengthen our partnerships with the voluntary sector.

◆ **Make sure people have a say in their own health and social care in the future**

In Devon, there are many examples of people having a say and influence but we know there is so much more we must do to engage people.

We want to put the people who use our services, and their carers, more in control over what happens to them. This will mean providing better and clearer information, active support to enable people to care for themselves, and systems to ensure people have a choice in their treatment. We also want to build clinical, staff, public and community engagement in our commissioning. Through our joint strategic review we have met many people who have real interest and expertise. We want to continue with these relationships into the future to help us ensure we are responsive to the needs of our population.

◆ **Take positive action to include and support people who are often overlooked and excluded**

In Devon, there are people who could benefit most from the results of this strategic review who may not be able, or sufficiently confident, to comment. We need to recognise this when making decisions.

We want to promote an inclusive approach to health and wellbeing, to care and to engagement. This means we want to ensure that the voices of people traditionally overlooked, left out or disadvantaged are properly heard. These people may include young people caring for relatives, black and minority ethnic groups, travellers, people with disabilities, homeless people, prisoners and people with mental health problems. We will need thoughtful engagement and action to make sure we are acting to improve their experiences of health and social care.

◆ **Achieve best practice, best performance and best care**

In Devon, there are many examples of good performance in achieving health and social care standards and targets, but there are also opportunities for further improvement

We want to reach a position where we achieve and exceed national and local targets and are always well prepared for any challenges and emergencies, such as major incidents or pandemic flu. Between health and social care, we now have shared strategic intelligence and a stronger partnership infrastructure. We intend to continue to develop this and achieve world-class health and social care commissioning for Devon. Our pace of change will be rapid, with major system redesign in 2008/09 ready to make the maximum impact in the years ahead.

During our joint strategic review we have also looked more specifically at the detailed changes we need to make.

We have done this under several headings:

Staying healthy



Planned care



Mental health and wellbeing



Birth and maternity



Long-term conditions and disability



Older people



Children and young people



End of life care



Urgent care



The following pages outline our proposals and intentions for each of these headings to achieve continued improvement in health and social care.

Staying *Healthy*

To achieve 'health as good as it can be' for Devon we intend to:

Work in active partnership to reduce the inequalities in health across Devon, and focus more of our attention and resources on helping people stay healthy

We know:

- Making a real difference to health will require a strategic shift from a health and social care system that uses most of its time and money dealing with acute and episodic illness to one that actively promotes prevention and avoids unnecessary intervention.
- There is wide variation in people's behaviour when it comes to health. One in five people on GP registers in Devon smokes. Smoking is a well-known risk factor in many diseases.
- Childhood obesity is a recognised problem, and more than 52,000 adults in Devon are recorded on GP registers as clinically obese. These figures are likely to be an under representation of the true picture.
- The alcohol needs assessment indicates that more than 18,000 people in Devon will have an alcohol dependency, with many more drinking to hazardous and harmful levels. Alcohol is believed to lead to 35% of all accident and emergency attendances nationally. In Devon, 16% of hospital admissions last year were related to alcohol consumption.
- Sexually transmitted diseases are continuing to rise in Devon, especially in the 15-26 age group, and we need more comprehensive sexual health services to address this problem.
- Poverty, deprivation, poor housing and homelessness have a major impact on health and life expectancy and must be tackled, with particular attention to the 21 priority communities in Devon that are among the 20% most deprived nationally.
- Dental health is important to people. We have improved access to NHS dentistry, but we need to achieve year on year improvements through our longer-term strategy on improving oral health.
- There are things we can do to improve physical and emotional health and prevent health problems for the population, including carers. Many people have told us we must prioritise the ambition of 'health as good as it can be' for Devon, with a particular focus on improving children's health.

We will:

- Work in partnership with all the agencies and groups that play a key part in improving health and wellbeing. This will include our Local Area Agreement (which sets shared priorities for the area) for 2008-2011 and beyond. We will provide clear, accessible information and high-profile messages to specifically-targeted groups.
- Promote supportive community social networks for health and wellbeing through local contact points, such as Children's Centres and school-based hubs for children and young people, and use our developing community hospitals to support people to lead healthy lifestyles.
- Implement evidence-based policy and practice on health and wellbeing, including improved access to immunisation and screening.
- Make health checks and advice more accessible in local venues such as GP practices, pharmacies and in local community hospitals as their role develops.
- Improve prevention, early diagnosis and high quality treatment for those diseases that result in long-term conditions, with a greater use of self-care approaches, more support for carers (including child carers) and early intervention in primary care.
- Make changes to sexual health services to achieve rapid access and targeted intervention for those most at risk.
- Develop alcohol intervention services with ease of access and early intervention to reduce hazardous and harmful consumption, particularly targeting those who are at serious risk through alcohol dependency.
- Start acting now on a planned and appropriate shift of resources into improving health. This will mean ensuring that our workforce expertise is used where there is the greatest need and opportunity to make a difference.

We will achieve:

- A significant impact on improving health so that by 2013 there is: a clear downward trend in childhood obesity; an increase in fruit and vegetable consumption to the highest levels in England; improved levels of physical activity; a continued cut in smoking to levels that are the best in Europe, with smoking in manual worker groups being equal to those in non-manual worker groups; and a reversal of the present upward trend in sexually transmitted disease.
- Speedier access to health care in alcohol services, integrated sexual health services (including 100% access to genito-urinary medicine appointments within 48 hours on any day of the week by 2009), and comprehensive services, including harm reduction, for all forms of substance misuse.
- A health inequality reduction strategy which aims to narrow the gap in life expectancy at birth within the county by up to 5% in the next five years.
- A reduction in mortality rates from cancer in people aged under 75, to a level of less than 100 deaths per 100,000, and sustained performance in reducing deaths from heart disease and stroke, beyond the national target of 65 per 100,000 for people aged under 75.
- A shift of 5% of our resources into improving health over the five year period.



Case study

Janet has asthma and suffers pain in her back and knees from arthritis. She knew that losing some weight would help her.

She lost three stone with the support of her GP and dietician, but then she found that the weight stopped coming off. She felt stuck.

Her dietician recommended the 'slimming on referral' scheme. This paid for her to join one of the local Slimming World groups and to go to a course of 12 weekly sessions.

Janet started to lose weight again and was so successful with the group that she was funded to attend a further 12 sessions. Janet lost another stone and has now lost a total of four stone.

Since she lost this weight, Janet's asthma has stayed under control and the pain in her back and knees from arthritis has also improved.

Losing weight and keeping weight off means changing the habits of a lifetime - but Janet is now confident she is on the way to better health.

"I'm grateful that I was given the help to get me on the right track. I have started eating more healthily, and losing the weight has given me the confidence to join a swimming exercise group."

Staying healthy How it can be...



Birth & Maternity

To ensure healthy pregnancies and healthy starts in life we intend to:

Emphasise the normality of childbirth and ensure women have information, education and choice. We will pay particular attention to those who are more vulnerable, so that we promote healthy pregnancies for all women and healthy starts for every baby.

We know:

- Effective health and social care at this early stage is of fundamental importance to improve the long-term health of the population. Information and education before pregnancy, then co-ordinated care throughout it, are key to this - especially among those who are more vulnerable.
- In Devon there are more than 6,000 babies born each year, and public health statistics indicate this will rise slightly in some parts of Devon but fall in others over the next 10 years. The percentage of Devon women giving birth at home is more than double the national rate of 2.14%. Teignbridge and West Devon are national leaders with 14% of all births being home births.
- For mothers having their babies in hospital, the length of time they stay varies from 1.5 days in some parts of Devon to 2.4 days (the seventh highest in England) in others. In Devon, about 10% of all women and babies transfer to a second hospital as part of their care.
- National direction emphasises choice, access, safety and continuity of care with the option of home birth, birth in local facilities under the care of midwives, and birth under the care of a consultant when this is the most appropriate.
- The integration of midwifery care is important to ensure co-ordination and quality across the whole team involved in birth and maternity care. At present, arrangements for this vary across Devon.
- Births to teenage mothers account for 6.2% of all births in Devon. Smoking during pregnancy is higher in younger women in Devon, with almost a third of all teenage mothers smoking at delivery.
- Breastfeeding initiation rates are similar to the national rate overall but there is a 10% variation in uptake across Devon. Even when deprivation is taken into account the variation is still high. Breastfeeding is known to be strongly associated with positive health outcomes.

We will:

- Ensure high-quality care before pregnancy with easily-available advice and information for all, with targeted support for those who are more vulnerable and at risk. Women will have direct access to midwives or maternity professionals for all aspects of their care.
- Ensure arrangements are in place to guarantee mothers a choice, promoting continuity and safety in maternity care, with home or midwife-led birthing centres at the heart of this choice.
- Clinically integrate community midwifery, including birthing units, with specialist obstetric services so that we achieve high-quality care and continuity across the whole span of care, from home birth to obstetrician-led care.
- Maintain the links between midwifery and primary care and extend the links with children's centres as they are developed in Devon, to achieve the best possible support.
- Develop services so that midwife-led birthing facilities can also provide clinical assessment, and so that women can have scans, routine appointments and admissions without delivery all in one place, as close to their homes as possible.
- Support mothers who are young or otherwise more vulnerable, to ensure the best possible care and start in life for every Devon baby. Learn from research and best practice to make sure we get this right.
- Ensure the most effective use of midwifery skills and more use of support workers, for example to promote breastfeeding. Review the key roles of staff providing parenting support to ensure attention is targeted on those who would benefit most.

- Require those who provide services to demonstrate they are implementing relevant national guidance and to supply reports on their performance in key areas such as Caesarean rates and breastfeeding initiation and maintenance.
- Involve users of the service and develop the role of maternity networks to achieve best practice.

We will achieve:

- The national guarantee of choice in maternity care, accompanied by an increase to 10% of babies born at home and 30% being born in maternity units by 2013.
- Where births take place in hospital, women and their babies will be supported to return home as soon as possible, with the length of stay at the national average or below by the end of 2008, and transfers to a second hospital for maternity care reducing by 50% by 2010.
- A teenage pregnancy rate of less than 20 per 1,000 by 2010, and a minimum 50% reduction in the under 18 rate in all areas of Devon by 2013.
- An improvement of 25% by 2010 in the numbers of mothers breastfeeding at six weeks, a reduction in smoking rates during pregnancy to no more than 5% by 2013, and a reduction in Caesarean section rates by 1% a year for the next 5 years.
- A clinically-integrated and co-ordinated midwifery arrangement in every part of Devon from April 2008, so that every woman having a baby experiences a service that provides maximum quality and continuity of care.

Case study

Matthew and Jo Jones, from North Tawton, went to Okehampton Hospital for the birth of all three of their children. This is Jo's account.

"I had our first child at Okehampton's old hospital. It was a good experience. When I became pregnant again I was invited to look around the new hospital. I liked the relaxing atmosphere and modern surroundings there. It wasn't until the big day itself, though, that I really appreciated what it had to offer.

"From the time I arrived I was treated like I was the only mother on the ward. I was given all the help I needed to make me feel at home; a single en suite bedroom, refreshments on tap and the help and support of staff 24-hours a day.

"When little Isaac popped into the world it wasn't only me and my husband he saw, but also our midwife, Heather. After the birth, she and other staff always found time to help me to breastfeed. They gave me space to be with my new baby - and time to rest.

"When the day came to go home, I knew where I wanted to have my next baby. A few years later, I returned. And I couldn't have been any more pleased when Heather once again handed me another member of our growing family."

having a baby

How it can be...



Children & Young People

We intend to achieve for children and young people the following, in line with the goals of the Children's Trust:

*Be healthy, stay safe,
be happy, enjoy and achieve, make a positive
contribution, achieve economic wellbeing for children
of all ages and ensure the best of care
when this is needed.*

We know:

- In Devon there are more than 164,000 children and young people. Projections indicate the numbers of 0-19 year olds will fall by 2.5% in the next 5 years.
- There are numerous laws and guidance to ensure every child has every opportunity to get the very best start in life. Improving the health and wellbeing of Devon's 164,000 children and young people has been raised time and again as a priority within this review.
- There are significant inequalities that must be addressed. In Devon, 20% of children and young people live in low-income households, and on average around 0.4% are looked after by the local authority at any one time.
- More than 4,000 children in Devon have special needs. The largest proportion of children with special needs is in the 5-14 age group.
- Obesity is one of the most serious and growing health challenges for children and young people and we must act now to reverse the rising trend.
- Substance misuse and sexual health are important features of children's and young people's health. In Devon, sexually transmitted diseases are increasing in the 15-26 age group, affecting young people as they move into adulthood.
- Nearly one third of teenage mothers in Devon were smoking at delivery.
- Immunisation rates for children by their fifth birthday are higher in Devon than the national rate, although this masks a big variation in immunisation uptake in different parts of the county.
- In Devon last year, 290 in every 1,000 children attended accident and emergency departments. More than 79,000 children and young people attended outpatient appointments, and more than 33,000 were admitted to hospital.
- There are gaps and variations in children's and young people's services, particularly in the time they wait for assessment, access to primary care mental health workers and speech and language therapy.
- The needs of disabled children have been identified as one of five key priorities for the NHS this year.

We will:

- Address inequalities in children's health in Devon, focusing on children most at risk of poor outcomes due to deprivation, disadvantage and poverty - and providing opportunities for parents to get support, work, training and childcare.
- Ensure parenting information is available to everyone and achieve high-quality parenting support for those most at risk, including children of young parents, with a consistent service across Devon.
- Recognise the important needs of the 2,000 young carers in Devon, and make sure there are systematic approaches to identifying and supporting young people in this role.
- Develop single points of access to multi-disciplinary and multi-agency teams based on evidence of what works best in improving outcomes for children.
- Improve access to children's and young people's services by commissioning more co-ordinated services through a smaller number of providers.
- Develop an integrated health, social care and education services approach for 0-5 year-olds, with children's centres as the focal point for effective integrated working and local support.
- Complete our consultation with families and children with special needs, finalise our model of education, support and care for Devon, and implement it as early as possible.

We will achieve:

- Continuous improvement in services for children and young people, to the point where we get a 'good' performance in the Ofsted 'Be Healthy' ratings by 2008/09 and 'outstanding' by 2013 – meaning young people themselves will rate the service highly.
- Improved support for children's emotional health including one primary care mental health worker in each multi-agency team by 2011, and an impact on bullying, evidenced by feedback from children and implementation of anti-bullying policies in schools.
- A fully-integrated Child and Adolescent Mental Health Service across Devon so that children and young people get access to the services they need, with a 20% reduction in children being admitted to specialist inpatient services by 2010.
- Continued improvement of services for children and young people with special needs and disabilities, with an agreed system of co-ordinated care implemented in the next 12 months.
- Teenage pregnancy rates of less than 20 per 1,000 by 2010, a minimum 50% reduction in the under 18 rate in all areas of Devon by 2013, and a reduction by 50% in the percentage of teenagers smoking at delivery within the same period.
- Parenting support for the first two years for those families assessed as most vulnerable, including young parents.
- Reduced attendances for children at acute hospitals, with a 10% reduction in hospital admissions, and a shift of 20% of children's outpatient appointments from acute centres to locations closer to home within five years.

case study

Consider this young vulnerable adult living in Devon. "Martin" was a persistent young offender who was looked after by the local authority and had been permanently excluded from school. His parents were substance misusers and he was a substance abuser himself.

Over the two years after he left prison, all agencies worked together with him in a co-ordinated way. On his release from prison, he got support from the county Youth Offending Team, and a place on a Devon County Council inclusion programme to continue with his education, since he couldn't go to school.

The EDP substance misuse service offered him a treatment programme. And he was assigned a social worker to oversee and review his welfare and progress.

With the help of the young people's agency Connexions, "Martin" won a place at college. He is now in his second year at a mainstream college, getting himself some qualifications. He has not offended for nearly a year and has stopped taking drugs.

He sent a text to his former foster carers saying:

***"Two years ago in prison
One year ago on tag
This year having a drink with
a college friend at home."***

Children's and young people's care how it can be...



Urgent Care

For people in need of urgent advice, diagnosis, treatment and care we intend to:

Ensure there is clear public information on how to get help in an urgent situation with easy access to the most appropriate level and quality of care and treatment – at home or as close to home as possible.

We know

- In Devon, some of our urgent care services have been greatly developed in recent years. Our ambition is to build on this with a truly collaborative approach to urgent care.
- More than half a million people a year contact the health and social care system for urgent attention. That may be by calling NHS Direct, going to a GP or minor injuries unit, contacting social care and support providers, attending an emergency department, or calling an ambulance.
- Well over half of those attending for urgent care appointments in Devon go to emergency departments in acute hospitals, with the others going to community hospitals, walk-in centres and GP practices.
- Some urgent situations are predictable and could be avoided altogether with improved education, prevention strategies and care planning.
- Our attention to urgent care must include effective urgent responses for people with mental health crises. This needs to be done through co-ordinated working between organisations.
- More people could be supported outside emergency departments and closer to home if we had effective services in community locations. We have clinical commitment to developing integrated urgent care centres in Devon.
- This approach would help reduce the burden on emergency services and emergency departments, releasing capacity for them to care for the patients who most need their specialist help.
- For example, the most recent national audit of stroke services identified a need in Devon to improve the speed of access to diagnostic tests, thrombolysis and interventional care, with a clinician driving forward these improvements.

We will:

- Ensure uncomplicated routine minor injuries care is available in the daytime in people's own communities, delivered to a Devon-wide standard and specification, and involving clinicians and local people in deciding the most suitable setting for this care.
- Establish new integrated urgent care centres in key locations across Devon. These will offer comprehensive high-quality care closer to home for urgent (but non-life threatening) problems that require diagnosis such as x-ray and early medical attention. In combination with emergency and other urgent care, this will mean urgent care will be accessible within 20 minutes' drive time of most communities in Devon.
- Develop outreach capacity from these centres, for example through rapid response vehicles and services visiting people in their own homes when this is appropriate.
- Establish rapid and direct clinical access to specialist opinion and diagnostics in acute care, to enable more care to be managed in primary and community settings when this is appropriate. Rapid access will include effective arrangements for rapid scanning and thrombolysis for stroke.
- Provide access to urgent care through a familiar contact number and with consistent assessment across Devon, so that in urgent situations people can be confident of a similarly high-level response, whatever the time of day and wherever they are.
- Establish advance care plans for people with long-term conditions or complex disabilities who are at risk of requiring urgent attention. We will have clear arrangements in place to get the right help for them and their carers in a crisis, wherever possible at home or close to home.

- Conduct and sustain a public information campaign to help people avoid urgent situations and to provide advice on the most appropriate place to go for treatment, care and support - as close to home as possible.
- Do everything we can to ensure that active health and social care support for older people, people who are terminally ill, carers and more vulnerable people is well planned. To avoid needless emergency admissions or attendances, we will ensure appropriate home care support is available – for example 24-hour nursing and emergency plans for carers.

We will achieve:

- A shift of at least 30% of urgent care activity out of acute settings by 2013.
- A reduction of 33% by 2013 in the numbers of people attending emergency departments who are subsequently followed up in that department or admitted for acute hospital care.
- Reductions in the time that elapses between someone arriving in an urgent care setting and the completion of their treatment. We will do this ahead of the national requirements, by 2009, when our ambition is that 98% of people attending emergency departments, urgent care centres and minor injury facilities will be discharged or transferred to an appropriate care setting within two hours of arrival.
- Emergency responses so that by 2010 all people who have suffered a stroke will receive a scan within three hours, seven days a week, as well as a Devon-wide improved performance in the annual national stroke audit.

Case study

Mrs S, who is 86, lives alone in a small village on Dartmoor, five miles from Okehampton.

One Saturday morning she called her neighbour – she was feeling very weak and her heart was racing.

Her neighbour phoned the out-of-hours doctor service where the call was assessed as urgent. The nearest doctor was already out visiting other patients, but when told of the case he contacted ambulance control and arranged for a paramedic in a rapid response car to go to Mrs S's home and assess her condition. He made this choice, rather than calling a 999 ambulance.

The paramedic arrived within 10 minutes and examined Mrs S. He discussed his findings by phone with the out-of-hours doctor and they decided she should go into hospital.

They agreed the local community hospital in Okehampton would be the right place; the out-of-hours doctor arranged the bed and paramedic the transport.

Mrs S was dealt with quickly and received the care she needed close to her home, without the distress of being taken to a hospital many miles away.

Urgent care How it can be...



Planned Care

For people who need pre-arranged clinical assessment, diagnosis or treatment such as outpatient appointments, x-rays and tests or surgery we intend to:

Develop a service where much more planned care is available closer to people's homes and outside acute centres, with a system that promotes choice, independence, convenience and timely access to care.

We know:

- In Devon, the vast majority of planned care (for example more than 90% of outpatient appointments) takes place in acute hospital settings, but the national approach is for significant proportions of planned care to take place in appropriate non-acute facilities closer to patients' homes.
- There has been progress in providing planned care in community hospitals – as well as in independent sector mobile facilities and units – but the numbers are small when we look at the true potential for change.
- In some countries, the majority of outpatient appointments take place outside hospital, and care models such as polyclinics are being actively promoted as a way forward for planned care.
- There is a strong local desire, expressed by GPs and the public, to have more routine diagnostics, outpatient appointments and day surgery in appropriate community locations.
- There are new and different workforce roles that can support this, for example among specialist nurses and therapists as well as medical staff. Developing these roles, with direct access to consultant listing where needed, can lead to real improvements in the patient experience.
- There is the opportunity to reduce planned care altogether. National information, based on best practice clinical guidance, indicates that many appointments and some planned treatments are not clinically necessary.
- Reducing unnecessary appointments and creating alternatives to acute hospital care will help reduce delays in treatment and increase patient choice - both central planks of national policy.
- For some highly specialised treatments, there is increasing national clinical guidance to ensure the best possible outcomes can be achieved. There is a general move towards greater specialisation and centralisation for these treatments, for example in cancer treatment.

We will:

- Continue to improve the speed and convenience of access to diagnosis and treatment through our work towards 'no-delays' and through measures to improve choice and booking systems.
- Prevent avoidable appointments, both by promoting self-care and through early intervention with people with long-term conditions.
- Introduce the 'local' element to as much planned care as possible, even when the procedure necessitates acute hospital care - for example by making pre-assessments available in community and primary care to avoid needless journeys for people.
- Introduce new roles in primary care, such as specialist physiotherapists and other clinical specialists, to provide early assessment - with direct access to diagnostics and consultant listing as appropriate. This would reduce steps in the system.
- Develop local care centres for planned routine clinical assessment and treatment, within 20 minutes' drive time of the majority of communities in Devon. These would provide a local choice for routine planned care such as outpatient appointments, diagnostic tests and day surgery.
- Ensure every Devon town has an appropriate level of enablement clinics for people with long-term conditions or other risk factors, offering education, advice, and more opportunities for self-management and social support.
- Continue to develop primary care with the enhanced roles of GPs and pharmacists and extended opening and access arrangements.
- Avoid needless care and its consequent impact on patients and resources, through a wide public awareness programme. We will also clearly specify a requirement for best practice from all those who provide services.

We will achieve:

- Improved quality and value by achieving the level of the top 25% in England in terms of productivity for outpatients and surgery, eliminating more than 45,000 unnecessary follow up appointments and 750 unnecessary surgical procedures in the next three years.
- Rapid access to specialist clinical assessment and treatment in line with national and NHS South West targets, with an ambition to reduce delays beyond the current 18-week target by 2009.
- A reduction in repeat outpatient appointments for people with long-term conditions, through the impact of preventive clinics.
- A year on year increase in the percentage shift of outpatients, diagnostics and surgery out of acute hospital settings, and within a period of five years achieving:
 - 60% of routine outpatients in community settings
 - 40% of routine diagnostics in community settings
 - 60% of routine day surgery in community settings



Case study

Eunice Hann, who is 78 and from Tiverton, started losing weight and feeling unwell about three years ago. It turned out she had a gastric problem, for which she needed surgery. For the regular drug infusions she now needs, she goes to Tiverton Hospital, saving her a journey into Exeter.

"Since May of last year I have been going to my local hospital in Tiverton every two weeks for an infusion to help with my digestion - with only very occasional appointments with the hospital team at the RD&E Hospital in Exeter, for them to keep an eye on me. I feel I'm mainly looking after myself with support from my daughter. On my very rare 'bad days' I take plenty of rest and eat very carefully. I couldn't have had better care at any price and must say the staff at Tiverton Hospital are excellent and so dedicated.

"I am a real enthusiast for local services and plan to keep using them long into the future."

Planned care how it can be...



Mental Health & Wellbeing

We will actively promote mental health and wellbeing in the population and commission services that enable recovery and independence. We intend to:

Engage community partners to establish services where early help and self-care support is available in primary care settings, with access to talking therapies and individualised care. This will work alongside high quality and responsive specialist care, with the focus on recovery.

We know:

- The adult population in Devon is approximately 614,000. Surveys suggest that, at any particular time, 1 in 10 adults in the south west will have a mental health problem, and 1 in 14 will have a significant problem likely to require treatment.
- We can expect there to be about 7,300 adults with autistic spectrum disorder in Devon, of whom half will have high functionality autism or Asperger's syndrome. People with autistic spectrum disorder are particularly vulnerable to problems such as anxiety and depression.
- People with mental health problems risk social exclusion and reduced access to mainstream care. Their carers also risk additional health problems as a result of their caring responsibilities.
- There is an agreed vision for mental health and wellbeing in Devon established by current service users, carers and voluntary sector representatives, alongside commissioners and providers from statutory services. This advocates active promotion, prevention, self-help and early action in primary and community care, to complement a recovery focus in specialist care.
- National statistics suggest that more than 90% of adults requiring treatment can have their needs met in general practice. However, more specialist care has traditionally been promoted.
- 'Commissioning for a brighter future' describes psychological talking therapies for depression and anxiety disorders as providing the most cost-effective and appropriate treatment in the least invasive manner as close to home as possible.
- Plans are in place for multi-disciplinary networks of care to: promote mental wellbeing and enable people to receive care and treatment as quickly as possible; provide care and treatment at home, and in hospital in times of crisis and acute illness; promote recovery, to help people regain as much independence as possible.
- Too many people are being managed in specialist services and residential units outside Devon, and too few receiving early and ongoing management and support in primary care. As a consequence there is an over-reliance on a bed-based and institutional model of care and under-provision of appropriate community alternatives.

We will:

- Actively promote mental health and wellbeing for the adult population, directing more of the overall investment to achieve the strategic priorities of improving health, using early intervention to support service users and carers, and improving social inclusion.
- Address the issues that contribute to mental ill health by working with a wide range of partners to target attention to the most disadvantaged and at risk, including those with black and ethnic minority heritage, new mothers and people within the criminal justice system.
- Support the development of models of care that emphasise self-management and self-directed care, primary care, psychological therapies, and health and social care at home or as close to home as possible. This will require a continued shift to ensure less of a bed-based focus to enable more resources to be dedicated to effective care close to home.
- Ensure this continues to be backed up by a responsive specialist service that promotes a focus on recovery and social inclusion for individuals.
- Ensure all services are based on need and that people are not disadvantaged due to age, disability, ethnicity or the complexity of their problem, condition or disability.
- Ensure there is a positive, effective transition from children's and young people's services to adult mental health services and older people's care, so that people receive the right care throughout.
- Actively engage service users, carers and members of the public in shaping the future of mental health and wellbeing services and challenge stigma and discrimination.
- Promote continued improvement of services based on a model of commissioning for fairness, safety, quality and equity.

We will achieve:

- Improved understanding of mental wellbeing promotion and reduced stigma and discrimination within our local population - with fewer people and families assessed to be at risk of losing their jobs, accommodation, financial security or social networks due to their loss of mental health.
- Consistently strong performance on national targets, including a reduction in deaths from suicide to no more than 8 per 100,000 by 2010.
- Improved opportunities for self-directed care, to the point where all people newly-diagnosed with mental health problems have access to this care by 2013.
- An increase of 30% by 2010 in the proportion of people with diagnosed mental health problems receiving care in primary settings, closer to home. This will be accompanied by a comparable reduction in the use of specialist and institutional forms of care.
- An increase of 20% in the number of older people with mental health needs accessing services.
- Increasing levels of satisfaction among service users, carers and staff, from average to above the national average, as measured by discovery interviews, involvement activities and surveys.

Mental health How it can be...

Case study

"Adam" had been using mental health services for a while, and from time to time was really unwell. He was introduced to a new idea, aimed at giving people with mental health problems more control over what should happen to them during those bouts of acute mental illness. He filled in a 'wellness recovery action plan'.

"I initially thought the idea was a waste of time. After all, I already knew the signs I showed when becoming unwell, what skills I had and when to use them – what was the point in writing them down?"

"However, when I looked through the plan I realised it contained so much more than skills and when to use them. It gave the opportunity to state what I did and didn't want to happen when I became too unwell to know, rationally, what was happening, the chance to say who I wanted to be involved in my care, and what I found most useful to do for me when I was unwell. Basically it gave me the chance to write my own care plan. It was great.

"...It gave me a rational voice to use in the times when I was deemed too unwell to know what was best for me."

Long-term conditions *and disability*

For people with long-term conditions and disabilities, and their families or carers, we intend to:

Create a model of care where individuals have maximum control over their own care, with individual plans that promote wellbeing, independence and choice, and with timely and appropriate care when this is necessary.

We know:

- One in three people in the UK has a long-term health condition. They are likely to see their GP more frequently, be admitted to hospital more often, attend more outpatient appointments, and be more dependent on social care services than other people.
- There are links between lifestyle and the incidence of some long-term conditions – obesity, for example, increases the chances of type II diabetes. So it is important that care for long-term conditions starts with education and prevention.
- Better detection through earlier diagnosis will give us the opportunity to intervene earlier where possible, slowing the progress of the condition.
- In Devon just over 2,700 people with a learning disability are recorded on GP registers, though the actual prevalence is likely to be significantly higher, and the numbers are expected to rise. People with learning disabilities often find it difficult to access routine health checks and screening, and experience additional health problems associated with complex disabilities.
- In 2004, the Devon Best Value Review considered needs and developed an action plan for making change. The Devon Strategic Partnership group for physical and sensory disabilities and acquired brain injury has been reviewing and revamping this plan to make further improvements and to clarify effective ways of engaging the people who use the service.
- There is considerable opportunity and value in a person-centred approach, ensuring the person with the disability or long-term condition is as well informed as possible and is supported to take control of their own care and the decisions made about it.
- Many problems associated with long-term conditions and disabilities can be more effectively managed by planning care in advance, and ensuring timely access to monitoring and advice tailored to their specific condition.
- Access to integrated and co-ordinated care and help to retain independence also play a central role, particularly for people whose conditions are more advanced and who require more support up to and including complex care management.

We will:

- Actively promote prevention and early detection, with better information and advice as part of our approach to staying healthy. We will ensure people with learning disabilities, and others with long-term conditions and disabilities who are more vulnerable, have health action plans based on comprehensive health checks.
- Extend significantly the availability of self-care - developing the skills of staff, and supporting a range of schemes such as peer trainers, information prescriptions, the use of monitoring technology in people's own homes to pick up vital signs, and self-management training courses.
- Develop plans for high quality disease-specific advice, diagnostics and monitoring where this is required, to support early intervention and the best possible disease management.
- Promote an approach to care that helps people retain as much independence and quality of life as possible. We will use effective advance planning and care plans to reduce the need for repeated outpatient appointments and admissions to hospital.
- Help people with wide-ranging or more complex needs remain at home by actively managing cases and giving additional support such as intermediate care, rapid response, wheelchairs, home improvements, or equipment and technology. We include a recognition that added support – such as advice on benefits or housing matters – can make a real difference.
- Pay close attention to the needs of carers, recognising that they themselves need care and support. We will make sure that carers' emergency plans are in place so they know what will happen to the person they care for should they themselves fall ill.
- Implement plans to develop services for people with long-term conditions – setting up complex care teams across Devon, establishing the planned new renal dialysis unit, considering the next steps for neurological care and rehabilitation, and completing our review of the wheelchair and equipment services.

We will achieve:

- Access to self-care by 2010 for everyone newly diagnosed with a long-term condition who would benefit from this.
- Individual plans by 2008 for everyone with a long-term illness or disability who is assessed as requiring this.
- Health action plans for everyone with a long-term condition or disability (with people with learning disability as our most immediate priority) by 2010.
- Reduced outpatient appointments, hospital admissions, lengths of stay and use of residential care for people with long-term conditions and disability, leading to:
 - A 30% reduction in emergency bed days by 2010, with a 20% reduction from 2006/07 levels in admissions of people on primary care long-term conditions risk registers
 - Achievement of the top 25% performance nationally in admission rates for people with identified conditions
 - Devon's becoming a national leader for supporting people in their own homes by 2010.



case study

Alex Nesbitt has had diabetes for 30 years. He joined an Expert Patient Programme, designed to help him manage the problems associated with living with a long-term health condition.

"I have had Type 1 diabetes mellitus since 1978. As my system does not produce any insulin at all, I have required up to five injections of insulin daily for a considerable part of this time in order to remain alive and well.

"Then a breakthrough – I heard about a local Expert Patient Programme in Exeter. Over six weeks this course provided support for individuals, all with a variety of long-term conditions, led by two tutors who themselves had continuing conditions.

"I now live a very changed life. Hypoglycaemia is a very rare event and my blood glucose levels, while not quite normal, are much more stable. I have lost 6 kg (just under a stone) in weight and feel significantly healthier. I keep in touch with some of the expert patient group of individuals. Two of us have become volunteer lay tutors for the Expert Patient Programme.

"If you have a long-term condition, do strongly consider joining a course."

Care for long-term conditions how it can be...



Older People

We will transform our care of older people and intend to:

Implement a comprehensive plan of health and social care that reaches the heart of the challenge in older people's care and improves the lives of the growing number of older people in Devon

We know:

- People over 65 make up more than 20% of our population, and the number is likely to grow by one third in the next 15 years. In the next five years alone, the number of people aged over 80 will rise by 8%. More than 16% of households consist of pensioners living alone.
- There are 73,000 unpaid carers in Devon and 11.9% of those aged 65 and over are providing some level of unpaid care. These carers need proper support.
- National strategy emphasises more active attention to promoting healthy ageing, with screening, early intervention and advance care planning before needs become more acute.
- Where care is needed, the emphasis must be on supporting independence and care at home or as close to home as possible – with a shift away from institutional care.
- Too many older people are still admitted to hospital or care homes when they would prefer to remain at home. We need to develop intermediate care, extra-care housing and rapid response services to provide more care in people's homes.
- In Devon, hospital admissions due to falls are 14% higher than the national average. Hip fractures account for more than 260,000 hospital bed days costing £7 million, as well as the associated distress and disability. There is a national target to reduce falls and hip fractures by 15% by 2010.
- The South Devon stroke service has won awards for its model of stroke care. However, similar models still need to be introduced Devon-wide, and there is much to be done to improve the speed of access to scans and thrombolysis.
- The Dementia UK report identified that one in 20 people over 65, and one in five over 80, are affected by dementia. In Devon, estimates indicate that more than 12,000 people will have dementia, rising to more than 17,000 in 2021. Devon has a strategy based on a review conducted by the Sainsbury centre for mental health in 2005 which promotes: greater integration and co-ordination of care, earlier detection of dementia and support in primary care, a shift in spending towards effectively-supported home care and less reliance on residential and hospital care.

We will:

- Shift the emphasis of all care to promoting control and independence, and making the most of new technologies to support people to remain at home.
- Build on the work done by Partnerships for Older People by continuing to develop care teams that can meet complex needs, making sure all older people can get the services they need.
- Actively promote older people's care nearer their homes. We plan to develop our community hospitals as integrated health and wellbeing services to promote healthy ageing, help people in looking after themselves, and to provide advice, clinical assessment and treatment.
- Ensure a range of appropriate housing options is available to older people by concluding a review of sheltered housing in Devon, developing extra-care housing in key market towns and developing housing support services tailored to individual needs.
- Seek the views of older people, working closely with the new Senior Council for Devon to enable older people to play a central part in health and social care decision-making.
- Pay close attention to the needs of carers, recognising that they themselves need care and support. We will make sure that carers' emergency plans are in place so they know what will happen to the person they care for should they themselves fall ill.
- Commission effective and high quality care for stroke, falls and dementia in line with best practice guidance.
- Build on schemes being developed in Devon to reduce the number of falls, including assessments of the risks and support through home improvement agencies. Everyone who falls should have access to a falls service before a decision to admit to hospital, unless there is an urgent or acute reason for the admission.

We will achieve:

- A reduction in emergency admissions to hospital for older people, as adjusted for population growth, to achieve:
 - 30% fewer emergency admissions to hospital caused by falls by 2010
 - A reduction in all admissions to hospital for older people by 10% by 2010
 - No delayed discharges from NHS hospital beds for non-clinical reasons by 2013
 - A reduction in the use of residential care for older people by 10% by 2013
- Improved access to care for people with dementia, with earlier diagnosis and more care at home or in the community, so that we will:
 - Narrow the gap between the recorded and the currently-estimated prevalence of dementia by at least 25% in the next five years
 - Increase by 10% the number of people with moderate to severe dementia who are helped to remain at home by 2013.
- Evidence of a change in approach to admissions to hospital, so that in the next two years at least 15% more people who require hospital care are admitted directly to a community hospital and complete their treatment there.

case study

Mrs "P" is 79 and lives alone in sheltered housing. Even though she'd had a comprehensive package of care worked out for her, she was frequently needing extra medical and social care help. She suffered from poor general health, complicated by depression and lack of motivation.

Among other things, Mrs "P" had suffered from cardiac failure, difficulties with taking her medicines properly, dehydration, and pain in her neck and back. She also had a history of falls. And she was isolated.

The multi-agency team looking after her gave her a lot of attention and encouragement and organised some important changes.

It found her the sheltered housing, and arranged for her own artwork to be put on display in her new flat.

Her medication regime was changed, so that she only needed to take her medicines once a day. Mrs "P" could manage that much better.

She was provided with a new chair that gave her proper support. That resolved her neck and back pain.

Mrs "P" is now medically stable, and is visited less frequently. She joined the library, visits friends, and enjoys her pictures – all helping her keep up her quality of life.

older people's care How it can be...



library picture

End of Life *Care*

We recognise that the last months, weeks, days, hours and minutes of life are a time of great need for people, and we intend to:

Ensure this is also a time of great care, with high quality, sensitive and co-ordinated support and services that do everything possible to give people choices and to support people who are dying and their families.

We know:

- In the three years from 2004 to 2006, just over 1% of the population of Devon died, with approximately 8,000 deaths a year.
- Of these deaths, 87% were among over 65 year olds. A small number, 0.6% of all deaths, were among people aged 19 and under, with the majority of these being in the 0-5 age group.
- National studies indicate that 56% of people surveyed would prefer to die at home, where this is possible. Devon figures show that 20% of deaths are at home. Too frequently, people are admitted to hospital in the last days or hours before they die. There is much room for improvement in enabling people to choose where they die.
- There is a forthcoming national strategy on end of life care, and ahead of this, there is a wealth of developing best practice guidance. This includes ensuring that people who have been identified as reaching the end of their life receive high quality evidence-based care using the national Gold Standards Framework.
- In Devon, there are already many excellent examples of high quality care; however there are variations in the availability of services – such as out-of-hours nursing - in different parts of the county.
- Our work with the range of organisations in Devon that provide care at the end of people's lives has highlighted a real desire to achieve the very best quality and choice of care for the future.

We will:

- Reduce the number of people being admitted to hospital in the last days of their life when they would rather die at home.
- Commission a comprehensive approach to care for people at the end of life that specifies co-ordination across all services. It will promote dignity, choice and freedom from avoidable pain, and support for families and carers as minimum standards from April 2008.
- Ensure consistent end of life care across Devon, for example in access to core services such as out-of-hours nursing, irrespective of where people live in the county.
- Extend best practice across all providers of end of life care in Devon, with the Gold Standard Framework applicable throughout.
- Build on the excellent practices already underway such as special patient messages to communicate wishes between different parts of the service, and develop arrangements for sharing and improving good practice.
- Ensure that supporting end of life care is a key role within the new complex care teams being developed across Devon.
- Develop local arrangements for end of life care, linked closely to outreach from specialist providers to bring assessment, clinics and appropriate palliative care services closer to home.
- Make sure vulnerable groups receive the right care and support at the end of life – for example people with learning disabilities.
- Have end of life care as a topic for wide and regular discussion to generate greater understanding and greater support for an aspect of life experience that is not discussed often enough.

We will achieve:

- A halving over a four-year period in the number of people being admitted to hospital in an emergency in the last days of their lives, to the point where people who have chosen to die at home have this choice granted, and the overall numbers admitted to hospital are also reduced.
- Every person in Devon clinically assessed as requiring end of life care receiving the best possible care, using the Gold Standard Framework of systematic evidence-based care in all locations by the end of 2008.
- No person dying in avoidable pain, and support for every person to die with dignity, sensitivity and support for families and carers. This will be measured by audits and feedback on aspects of care that are the most important at the end of life.
- Access to outreach end of life support in local centres across Devon by the end of 2009, to a point where this is available within 20 minutes' drive time of the majority of patients' homes.



case study

Mr 'Smith', who was 60 years old, was being treated in an acute hospital for the final stages of cardiac and renal failure. He was, sadly, going to die.

He was asked if he would like to go home to spend his last few days with family and have his care provided there. He and his family were very pleased to have this option.

Mr 'Smith' was offered a care plan to enable him to go home. It included full 24-hour support from the overnight team and community nurses. His key worker was a local district nurse who made sure he would be visited three times a day by social care staff, to give physical help and make sure the family had all the equipment they needed. Staff explained how his medications could be used to control his symptoms.

The out-of-hours service was given a 'special message' alert, so that the patient's and family's wishes were known to any clinician dealing with Mr 'Smith' overnight, and he wouldn't be admitted to hospital again.

Five days later, Mr 'Smith' died at home with his wife, children, grandchildren and his much-loved dog at his side.

End of life care how it can be...



7. Developing *health and social care*

This strategic framework launches a journey of development and improvement for health and social care. The notes below describe some of the differences we can expect as we move from our present arrangement and prepare for the future. In summary:

Primary care

The role of primary care will be extended, bringing care as close as possible to patients, service users, carers and local communities. General practice will play a key role in earlier detection and intervention for long-term conditions, disabilities and mental health difficulties. Pharmacies' roles in promoting health and supporting people with long-term needs will continue to develop, and the potential for dental and optometry services to support wider health improvement will also be explored.

Primary care commissioners, mainly local GPs, will lead the planning for future routine, non-complex daytime minor injuries care, working with local populations and strategic commissioners to decide the single most suitable and convenient location for this care in each community.

Integrated community services

Moves are already well underway to create integrated multi-disciplinary and multi-agency teams to support children and young people in the community (these teams being known as AXS clusters). Similarly integrated care teams are being created for adults and older people with complex needs. These teams will work closely with primary care, providers of services, people who use the services and with carers to develop the highest possible quality and range of care to support people to remain at home.

These teams will need strong connections with more specialist forms of health and social care to get the right skills to service users at the right time. This strategic framework begins to specify important roles for these new teams, including end of life responsibilities, early detection and support for dementia, assessment of the risks of people falling, and advance care planning for people with long-term conditions.

Wider support for people in the community

Wider support for people in the community will require more comprehensive access to individualised packages of care – using direct payments where people are given the resources to purchase their own care, technology to promote independence, intermediate forms of care and supported living. Further development of these types of support will play a key part in helping people to remain at home.

Developed community hospitals

Community hospitals have a pivotal role for the future and there is a real opportunity to make the most of these important assets. The vision is that community hospitals five years from now will manage and host a range of services, potentially from different providers, to deliver the most comprehensive care possible across Devon. There will be a mix of functions, with different hospitals having different roles, and all directed to providing a network of high quality care as close to people's homes as possible. The functions include:

Integrated health and wellbeing contact points/hubs in local communities providing information, advice and support.

Local care centres of excellence for people with long-term conditions and those who are otherwise vulnerable, with self-care support, monitoring and planned care such as routine clinics and treatments, eg blood transfusions. Outreach end of life care will also be a key role.

Direct admission facilities for inpatient care, enabling the entire hospital stay to be in the community hospital wherever possible, and enabling people with complex needs to be admitted for observation, rehabilitation and other forms of support.

Enhanced urgent care centres in a small number of hospitals, with extensive facilities and an integrated team approach including input from primary care, the ambulance service, out-of-hours doctors, acute care, mental health care and social care.

Centres for planned care providing routine outpatient appointments, diagnostics and surgery in designated community hospitals, bringing substantially more of these activities out of acute care and making them more accessible in local communities.

Other more specialist care, eg birthing unit care, renal dialysis and stroke care in designated community hospitals.

Changes in acute care

The model being developed shifts activity, wherever appropriate, out of central buildings and facilities and closer to people's homes. To achieve this effectively, the specialist skills and input of acute care clinicians will be a central part of supporting people to remain at home or as close to home as possible. We want to see acute and primary care clinicians and other health and social care staff working even more closely together to achieve the right expertise in the right location and at the right time for patients and service users. This mature form of integrated working will enable a joined-up approach

to quality, safety and access to care. Acute hospitals and other secondary care facilities will become more specialised, with greater capacity for rapid access and the potential to deliver increasingly complex care for the population.

Strengthened roles for the voluntary sector

There are many opportunities for closer partnerships and enhanced roles for the voluntary sector to reach into the heart of local communities, helping people to remain as independent as possible at home. We already have examples of extremely successful integrated working and intend to build on this, using the expertise of and compact (agreement) with our voluntary partners to improve health and wellbeing for Devon.

Sustained improvement

As well as the intentions and improvements we have described here, there are other opportunities for improving health and wellbeing in keeping with this strategy.

One area where we have already started work is in North Devon, considering how we can best address the specific health, wellbeing and access challenges to support this community. Similarly, there is detailed work underway on services for children with special needs and with improving care for people with dementia. We will report on these, and other developments that result from the strategic review, in the forthcoming weeks and months.

8. From strategy to *reality*

Commissioning for action

All of this will require highly-effective commissioning to bring about the desired improvements.

This means we will:

- Develop our partnership approach even further to support the shift in balance towards improved health and wellbeing, ensuring the intentions in this document translate into sustainable change.
- Work with the practice-based commissioners in Devon in shaping and establishing high quality and responsive services for the future.
- Clearly describe our expectations of those who provide health and social care, encouraging co-ordination among existing providers and the development of new providers where appropriate, to achieve highest quality care and services.
- Build on existing performance and, with our partners, use the new 'Vital Signs' indicators due to be published shortly by the Department of Health, to aim beyond national targets to achieve the very best for Devon.
- Continue to encourage the active involvement of patients, service users, carers, members of the public, staff and policymakers as we take the ideas in this framework forward, to make sure these ideas turn into effective action for Devon.



Effective and affordable

We now intend to bring the financial portfolio into line with our priorities. This will be achieved through our annual business planning, but with a five-year timetable for implementation. We need to recognise that resources are finite, and to achieve improvements we need to use them effectively. This includes, where appropriate, stopping activities that do not add quality and value.

We will need a two-pronged approach so that we commission the best care and services now, while at the same time achieving a strategic shift to improving health. This will require a planned timetable of high impact change and action for health and wellbeing, accompanied by a rigorous and sustained service improvement programme to shift the emphasis from acute care towards more care in people's own homes.



With a strong and reliable infrastructure

Successful service improvement will require a strong infrastructure to support improvement. Here we are looking at information, the workforce, technology and facilities.

We now have a vast amount of information about health and wellbeing, and about health and social care, at a Devon town level. This will help locally-based planning for the future.

We will now start work on developing our clear specifications for different aspects of care, including quality indicators and data requirements so that success can be measured.

The workforce is crucial to our plans, and across Devon we have highly-valuable skills and expertise. We intend to build on this and develop an approach where all of our workforce plays a central role in positively promoting health and wellbeing. People will also work in stronger partnership to achieve the best possible co-ordination of care, across the boundaries of services and organisations. There will be new roles and responsibilities, and a greater emphasis on improved health, self-care, choice and engagement.

The development of care at home and close to home will have an impact on how we use our buildings, and we will ensure high quality facilities with the right equipment in the right locations.

Technological advances present an opportunity for transforming care, and already we are involved in a pilot of mobile technology that is supporting more care at home. Picture archiving is in place in acute and community hospitals in Devon, meaning x-rays are transmitted rapidly from one part of the county to another, achieving faster results. We want to build on these examples and move forward more rapidly, with specific attention to shared records and web-based information systems for health and social care.

An active approach to improvement

We know that to make a difference we need to act, and to do this in a clear and planned way so that we can demonstrate progress and make sure the plans lead to real improvements in health and social care. Our five year plan will be published to follow on from this strategy, and will be updated regularly to show results.

9. Our commitment *to you*

Starting from January 2008 we will:

- Communicate the contents of this strategic framework widely and obtain feedback on the proposed future direction for health and social care.
- Consult with Devon Health and Adult Services Overview and Scrutiny Committee and, as appropriate, plan more in-depth consultation on specific issues.
- Sign off the strategic framework in the light of feedback in April 2008, launching a five year timetable for action with clear criteria for prioritising and monitoring the impact of change.
- Connect this timetable with health and social care business planning arrangements and the Local Area Agreement for Devon, ensuring year one actions are ready to start from April 2008 onwards.
- Identify areas for early implementation and action, publishing these on our websites and providing regular updates on changes as a result of this strategic framework.

In the first 12 months of this strategy these early actions will include:

- Developing the first of the new urgent care centres in Devon.
- Improving out-of-hours nursing arrangements to ensure these span the whole of Devon.
- Establishing a county-wide health and social care advocacy service to support people who are most vulnerable when they need care and treatment
- Taking steps to improve support for carers through greater partnership working with Devon Carers' Forum.
- Improving co-ordination and integration of records so that people need to tell their story only once.
- Strengthening key services to improve health, such as alcohol and sexual health services, and self-care and self-management programmes such as the Expert Patient Programme.
- Continue and accelerate action to shift appropriate outpatient, surgical and diagnostic activity into community settings.

10. Welcoming views – *promoting engagement*

Your views are important

Before we produced this strategic framework we gathered early views from people across the county. We would now like to build on this and continue to encourage the public, service users, patients, carers, staff and everyone else with an interest to help us shape the future of health and social care.

We will keep publishing details of what we will do, and when. We will keep inviting feedback.

Should a statutory public consultation become appropriate for any aspect of this plan, we will consult and be guided by Devon Health and Adult Services Overview and Scrutiny Committee. In the case of statutory consultation, this will follow Cabinet Office Code of Practice on Consultation (2004) and will be notified through posters, notices, letters to key stakeholder groups and articles in the media. For statutory consultation there will be a minimum of 12 weeks' written consultation and this will be notified separately.

Further information and updates

This document will be made available on both the Devon Primary Care Trust and Devon County Council websites and a shorter information leaflet will also be widely circulated. A timetable of discussion activities and events will also be available. Contact details for comment or further information are:

Devon Strategic Review Programme Office
Dean Clarke House
Southernhay East
Exeter EX1 1PQ

Telephone: 0845 155 1012

E-mail: d-pc.strategicreview@nhs.net

Devon 
Primary Care Trust

Devon 
County Council