LymeForward Health and Wellbeing Group

Outline of gaps, weaknesses and concerns regarding current provision of local health, care and support services

January 2018

We trained hard, but it seemed that every time we were beginning to form up into teams, we would be reorganised.
I was to learn later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation.

Caius Petronius [circa AD 65]

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This document attempts to describe the perceived gaps in health and care service provision within the area of Lyme Regis, Charmouth and surrounding villages. It notes areas of apparent weakness within the services already provided, and identifies more general concerns among local people.

It incorporates perceptions obtained by the CCG during its local engagement exercises in the spring and summer of 2017, as summarised in its 'Engagement feedback report' of October 2017, combining these with the evidence acquired by LymeForward's Health and Wellbeing Group in researching its own reference document on the 'Current provision of local health, care and support services' (January 2017).

The issues identified cover a broader range than just the current CCG focus on re-commissioning the Alternative Provider Medical Services and Community Services contract with Virgin Care. This is because, from the public's eye view, health and care services are all one experience.

Underlying all that follows is one clear theme:

Many patients report their confidence in, and good experience of, the services they receive. That is because –

almost without exception, the professional and volunteer people who provide our health and care services locally are caring, hard-working and do a very good, often outstanding, job.

In taking the strengths of the system and its people as read, we do not take them for granted, and trust that they will continue. But this exercise is about improvement, so must focus on what needs improving.

For the positive experiences of patients are balanced by too many accounts of inadequate or inaccessible services.

This is because those excellent professional staff labour under challenges of inadequate resourcing, relative professional isolation, and over-complicated management systems that combine to reduce their potential effectiveness and efficiency in serving our population.

Given that the health and care services nationally suffer from inadequate funding, it is all the more important that service provision is carried out in a streamlined, economical and waste-free manner, emphasising 'on the ground' impact above all other considerations.

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References in the text to 'Baseline Survey' are to LymeForward's 'Current provision of local health, care and support services' which complements this document.

1. Mental Health Services

(See also CCG Feedback report, pages 10, 11, 12 & 13)

Poor mental health frequently leads to problems with physical health. Slow intervention upon the early signs of mental health issues risks worsening those issues. For these reasons, the weaknesses in local mental health services for young people top our list of concerns: they allow greater human suffering to develop, while ultimately incurring much larger financial costs in treating the worse mental and physical health conditions that have developed.

The overall impression is that much good work goes on, but that there is simply not enough of it, with consequent deleterious stress both on those with mental health issues and those who help them.

Children and Young People (see also Services for Children and Families, page 2)

- Services are significantly under-resourced. The intensive work that is carried out touches only a relatively small proportion, those the most challenging, of the needs that exist.

- The threshold for referral to CAMHS is high. As a result, early-stage mental health issues fall to hard-working individuals and teams of other professionals, who are not necessarily trained in dealing with psychological and social problems: to the already-over-stretched child health team of health visitor, school nurse and nursery nurse; to staff of the Children's Centre, West Family Partnership Zone and Action for Children; to support teachers in the schools; to family liaison; to GPs … While these all do their best, there is no fixed focus or coordinating lead to maximise the effectiveness of their efforts.

- Liaison between GPs, school staff and CAMHS is erratic: the school is not always aware of students referred via a GP to CAMHS, nor is it always informed when CAMHS closes cases. Similarly, communication between school and social workers / police could be better in both Dorset and Devon: it is difficult to speak person-to-person, with over-reliance on email and form-filling.

- The result is an 'early intervention' gap for young people below the CAMHS and social services thresholds; yet effective early intervention is the key to minimising the call on such services.

- Referrals to CAMHS usually involve a significant delay of 6 weeks or more.

- While some CAMHS appointments are made at LRMC or through home visits, in other cases young people have to travel to Dorchester. For those using public transport, this means the loss of a day's schooling.

- CAMHS specialist services (Eating Disorders, EIS, Learning Disability) are all based in the far east of the county; the SWIFTS service is based in Dorchester.

- Social work support, especially critical for those in Child Protection or 'Looked after', is limited due to shortage of staff and time.

Adults and Older Adults

Mental health services for adults appear to be systematically arranged, well-managed and flexibly organised at the lower levels of need. However, for those with serious mental illness there are problems, with people complaining of poor access to help. There are certainly inadequate facilities for those needing help away from home.

A particular concern is that three registered mental nurse posts, totalling 2.0 wte, are vacant, while a review, without public consultation, is being undertaken into the service provision and pathways. The funding available for those posts is lying unused at a time of scarce resources across the mental health landscape, and uncertainty about future arrangements remains.

2. Services for Children and Families

This is an area of great concern.

- Family isolation is a characteristic feature for many young families in the area.
- Services are fragmented: GPs, midwives, health visitor, school nurse, nursery nurse, DHUFT nursing staff, West Family Partnership Zone, National Childbirth Trust, Children's Centre, Action for Children, pre-school, schools, student support teachers, family liaison officer, ELSAs, therapists, educational psychologists, CAMHS and its affiliate organisations, children's social services, Child Protection and a host of volunteer groups … The Probation Service seems strangely absent.

  All do their bit, and their best, and it is a wonder that the system hold together as much as it does. But this fragmentation has a cost:
  • too many vulnerable children and families are falling through the cracks;
  • emotional neglect, in particular, is not picked up sufficiently early;
  • the system is hard for families to understand, particularly with frequent staff changes, which leads to disengagement;
  • too much professional time is spent on paperwork and on trying to coordinate with other bodies.
- The team of school nurse, nursery nurse, health visitor and family liaison officer have insufficient hours to meet the demands that they face.
- School catchment areas extend into Devon and Somerset (almost half of all Woodroffe students are from outside Dorset) with their different procedures for accessing services, safeguarding and child protection, etc. Thus both school staff and other involved professionals must engage with many different systems, services, agencies and people – a major extension to workload.
- The threshold for referrals to the children's social care team is high, at levels 3 or 4 of the child protection hierarchy via the MASH. It is felt that this situation mirrors that of the threshold for CAMHS with mental health issues: too many medium-stage issues become over-reliant on teachers, family liaison, and the family workers of the West Family Partnership Zone, with longer-term human and financial costs.
- Case conferences are normally held for administrative reasons in Dorchester, which makes family engagement less practicable. They should be held locally in the interests of families.
- The future of the Lyme Regis Children's Centre is uncertain. It feels an increasingly-neglected and under-promoted outpost of Bridport, yet the child health team at LRMC regards it as a vital point of contact due to its location within the town and its propinquity to St Michael's School. This team emphasises that the families to whom they relate need familiar faces and familiar places, rejecting professionals, however skilled, 'parachuted' in from outside the town. They believe that the Children's Centre is under-used, even though they, the midwives, and the NCT all describe extra use they could make of it for clinics, drop-ins and courses. The paucity of current service at the Children's Centre adds to the isolation for mothers and young children, in contrast with the relative vibrancy in Bridport and Beaminster.
- St Michael's School is concerned that the squeeze on school budgets, if it continues, will put most at risk those important elements of provision outside the 'core' work of classroom teachers and teaching assistants – such as the ability to buy in external support services, make use of family liaison help, or to release time for ELSA activity. If that makes it harder to nip potential problems in the bud, the human and financial costs later will be considerable.
- Poor parenting skills are of of growing concern. St Michael's School is extending efforts to engage positively and effectively with parents, and to develop parental support for the standards required in school – an increasingly testing task. Courses in parenting skills exist, though not in the immediate locality, but fail to recognise that for many parents the idea of working in a group, or in an institutional setting is not appealing; new ways of facing this challenge are needed. Individual follow-up after these courses are taken is inadequate.
- Child Protection procedures look well organised. However, the midwives note the value of their participation in the regular multi-disciplinary team meetings held at Bridport Medical Centre by the Safeguarding Lead there, as midwives are often the first professionals (and the ones most likely to have the confidence of families) to spot potential problems. They regret that similar arrangements are not made in this area.

3. Health Prevention / Early Intervention

(See also CCG Feedback report, page 13)

Emphasis on health promotion, preventative measures and early intervention has made little apparent headway in the LymeForward area.

- West Dorset is the one part of the county that does not have a Locality Health and Wellbeing Board under the auspices of Public Health Dorset.
- Apart from Dr Sue Beckers's regular, and extremely good, articles in the Charmouth magazine 'Shoreline', there is little evidence of the GP Practices taking high profile initiatives to promote healthy living.
- Regular individual health checks and large-scale screenings do not appear to take place as often as could or should be expected.
- This area has a number of Independent-minded people who struggle on alone and refuse to see a doctor; this a challenge to the community as a whole.
- Practice newsletters (where they exist), websites, and local media rarely carry health promotion messages from the local services.
- LiveWell Dorset has no record of engagement with any client from this area.
- In the 20 months between April 2016 to Oct 2017, My Health My Way had 23 referrals from postcodes DT 6, 7, 8, of which just 3 were from DT7.
- In both those cases it could be that user-unfriendly websites are unhelpful; but managers in both organisations comment that there appears to be little if any promotion of their services by clinical professionals; one noted that "we need the surgery to drive referrals" while another proposed co-location of service within a local Practice.

4. Elderly Care: frailty / palliative / end of life

(See also CCG Feedback report, pages 10, 11, 13, 14 & 15)

- The local need for frailty and palliative care is not being met; as the amount of solitary living for the elderly increases, so too does this gap in provision.
- No local GP Practice holds the Gold Standards Framework for Palliative Care.
- The shortage of intermediate care / step down beds is severe.
- The 'hospital at home' service is insufficient, with no night service (unlike other parts of the county).
- Families report problems in applying for CHC or FNC funding: the process is complicated and protracted, eligibility assessments are often poorly conducted, and payment unduly delayed.
- Home-care services whether privately or publicly funded are hard to obtain. Family carers need more help with coordinating and obtaining the range of services they may need, and report a lack of respite care and financial support, as well as difficulty in finding suitable care help. Unsupported family carers, often themselves elderly, can risk their own health breaking down with consequent additional burdens on the system.
- Not having a single palliative care provider either for inpatients or in the community leaves gaps in provision; it creates confusion and complications for patients and their families attempting to coordinate a smooth transition between different settings, services and providers.
- Care planning and signposting of services is too often reactive and crisis-driven, insufficient to navigate the unnecessarily complicated pathways and enable people's wishes to be respected.
- Weldmar Hospice Trust has only one nurse covering West Dorset, and thresholds for care are high. Marie Curie nursing service appears to be under-used for lack of referrals.
- For patients with conditions other than terminal cancer, there is little provision outside or within hospice care.
- The only hospice for West Dorset is the Weldmar Hospice in Dorchester, with a high threshold for admission. When patients are discharged once stabilised, greater pressure falls on community settings to provide adequate palliative support.

5. Hospital Discharge

(See also CCG Feedback report, pages 10, 11, 13 & 15)

- Many local patients report inadequate arrangements when discharged from hospital, particularly in terms of the liaison between the hospital and the GP or relevant community medical and social services.

- Although multi-disciplinary team meetings for this purpose are held regularly at each Practice, too many patients fall through one or more gaps between GP, community nurses, OT, physiotherapist and social services.

- The problem is most acute with discharges from Exeter RD&E, and particularly in cases of a patient registered with a local (Dorset) GP but resident in Devon or Somerset: responsibilities across the borders are unclear, with coordination between Dorset medical services and Devon or Somerset Social Services difficult.

6. Adult Social Services / Social Care / Care at Home

(See also CCG Feedback report, page 11)

Keeping people in their own homes or in the community, rather than in hospital, is an ambition that faces difficulties in this the Lyme Regis and Charmouth area.

- Only six NHS 'rehabilitation' beds are available, in Lyme Regis Nursing Home, as a 'step-down' facility.

- Those are frequently 'bed-blocked': patients entitled to financial support from Social Services, who are ready to move to a non-NHS bed within the Nursing Home, to another Care Home, or to their own home with support, are often unable to do so because of lengthy delays by DCC Social Services in arranging the funding package: while the target average for stay in an NHS bed at the Nursing Home is 6 weeks, some patients have waited a year or more for financial arrangements to be organised. This delay effectively takes the NHS bed out of use for another patient needing NHS rehabilitation.

- The availability of Continuing Health Care funding for those eligible is not sufficiently well publicised or understood, nor is enough assistance with the application process on hand.

- Privately-financed care at home is difficult to come by. Page 34 of the Baseline Survey lists a number of providers, none based in the immediate area. Travel distance for carers employed by an agency is a disincentive to taking on commitments unless they live nearby.

- The Baseline Survey, pages 36 - 38, indicates a reasonable choice of residential care and nursing homes for those who can afford to fund their own care. In all cases, people relying on Social Services funding are accepted, but only if they can find top-up payment from their own or third-party resources, which is not always possible.

- The very experienced social worker employed by Virgin at LRMC is retiring at the end of March 2018, with loss of her accumulated knowledge and understanding of local needs. The over-stretching demands on community nurses, OTs and physiotherapists (see the following page) also affect the social worker's job. We are concerned about the lack of information about arrangements for her replacement: operating the system from Bridport will not be appropriate.

7. Community Services

(See also CCG Feedback report, pages 10, 11, 12, 13 & 14)

Provision of community services has significant current weaknesses. Some are listed on other pages referring to specific services, such as mental health provision and services for children and families. General concerns include the following.

- Staffing levels are seen by local people as having always been inadequate for their needs. The common view is that staff are stretched too thinly with insufficient professional support.

- The CCG's Feedback report noted shortage areas in mental health nursing, occupational therapy, community nursing, podiatry and palliative care.

- That situation is now worse: all three Registered Mental Health nurse posts were vacant at the end of the year; podiatry and occupational therapy were vacancies being covered by locums; the school nurse is leaving in February 2018.

- The intended transfer in April of the school nurse and health visitor posts from Virgin to DHUFT, whatever the justification in itself, has by its poor handling unsettled the wider team of professionals, including those in related non-clinical fields, and is having a damaging effect on the critical area of work with children and families.

- The 'hospital at home' service does not seem able to match the demand; in particular, the lack of a 'night sit' service is widely remarked by other professionals in the field.

- Provision of palliative and end-of-life care is inadequate (see page 3).

- The CCG's Feedback report included observations, which from their wording could have come from clinical staff themselves, that the service is characterised by:
  - lone working, professional isolation, and limited clinical supervision and support;
  - too much part-time employment;
  - vulnerability to sickness and leave;
  - vacancies being left open for too long;
  - frequent staff changes making coordination harder.

- Those points stem in part from the fact, one that greatly concerns local people, that the service is on its own, disconnected from the rest of Dorset; the long-term implications for professional strength and development are severe.

- Some patients at the Lyme Bay Medical Practice and Charmouth Medical Practice are not sufficiently aware of the community services provision at LRMC and that they have an equal right of access.

- It is unclear to what extent the range of community services, as described in the published sources, are all actively and coherently managed as a single unit.

8. Professional, Third Sector and Volunteer Support

(See also CCG Feedback report, pages 13 & 14)

The continuing reductions in funding to health and care services, and increasing financial strain on charitable and other 'third sector' bodies, make it essential that volunteer support for on-going personal health and care needs is available, accessible and well-integrated into professional service provision.

- Pages 23 and 31 - 33 of the Baseline Survey details several support groups, partly or wholly volunteer-led and staffed, which are locally-based.
- The Baseline Survey also identifies many such groups which are based in Bridport, Dorchester or even further east. Given the paucity of public transport, access to these is difficult if not impossible for the majority of those who could benefit.
- Those groups that do operate within Lyme Regis and Charmouth are often failing to draw in sufficient clients for sustainable viability, even where it is clear that the known needs are substantial. Dorset REACH, for example, an important and professionally-run service recently established in Lyme Regis, reports low numbers of clients, which could eventually lead to the loss of a vital service locally.
- The mismatch has varied causes. Insufficient signposting and encouragement from the professional services, including GP Practices and community services staff, is one of them. This may come from lack of knowledge about local support groups, or from failing to recognise the role they can play in sustaining health and preventing relapse. Recently, some encouraging signs have emerged that this problem is being acknowledged.
- Across the professional services more broadly, coordination of knowledge and of opportunities that should be signposted, is still inadequate. Just for example, do front-line clinical staff, social workers and probation officers all share the same understanding of what help is available for the young unemployed, and how to help potential beneficiaries to access it?
- Conversely, there can be a confusing overlap of services with similar objectives. It is unclear where the distinctiveness lies within and between, for example, My Life My Care, the SAIL multidisciplinary approach, and POPP. Too many cooks ...
- Professional services such as LiveWell Dorset and My Health My Way do not have significant presence or impact here. Many charitable services, such as Cruse Bereavement Care and the Red Cross, have no presence.
- Professional support and training for volunteers is limited, which adds to the challenge of recruiting and motivating volunteer support.
- Expanding and sustaining volunteer groups is currently a function that falls by default to LymeForward, which receives no funding from health and care sources to do this even though such groups play an important part in enhancing health and care, not least in helping to reduce the demands placed on professional health and care services.

9. Locally-based tests, diagnostics and clinics

(See also CCG Feedback report, pages 10, 11, 13 & 14)

- While basic tests and diagnostic procedures, and a good range of the most common clinics, are carried out locally, it is still necessary to travel to Bridport or Dorchester for many such processes, pre-operative assessments etc – even when these could be conducted in Axminster.
- Given the age profile locally, and the ongoing reduction in public transport, this is becoming a serious problem and a disincentive to self-care.

10. Out of hours provision / Minor Injuries Unit

(See also CCG Feedback report, pages 11, 12 & 13)

- The MIU is reported to average 2 cases per day. Given that the service is led by the practice nurses at LRMC, with whom half the residents of Lyme Regis and Charmouth are registered, we have reason to believe that this may not be an accurate figure.
- The service is, however, in the words of one clinical professional, 'the best kept secret in Lyme Regis'. Our research confirms the truth of that comment: its existence and the facilities it offers are too little known in the area.
- Protocols limiting services from the MIU reduce its potential and leave a staffing gap in the 'excluded' areas between about 4.30pm (when most nursing services have finished in the GP Practices) and 6.30pm when the Out of Hours service begins. This timing of services can cause difficulties to patients with urgent needs, while plugging the gap currently falls to GPs.
- During the holiday season, Lyme Regis and Charmouth are full of visitors; there are no First Aid points that can help with minor injuries. The nearest alternatives to the MIU at LRMC are at Axminster Medical Centre (open 9.00am - 5.00pm weekdays only) which itself is not well publicised as an MIU, and Bridport Hospital (9.00am - 6.00pm daily).

11. Emergency Response

(See also CCG Feedback report, page 13)

- Anecdotally, residents believe that the First Responder service operated by the local Fire Service team has reduced, an impression borne out by the drop in call-outs from an average of 350-400 per year to the recent 100-120.
- This drop is said to be the result of a revised SWAST triage system making greater use of volunteer Community First Responders. This policy is questioned locally, because the Fire Service team is well-known and respected; people have great confidence in its First Responder service. There is particular concern that the new, fragmented system may work to the disadvantage of our Fire Service function and to the interests of the volunteer fire crew, neither being in the interests of the community.

12. General Practitioner Medical Services

(See also CCG Feedback report, page 12)

Questions of the future structure and provision of GP services are beyond LymeForward's scope. Our focus in reviewing services has been on wider community health and care services, with the role of GPs as part of that provision being touched on in earlier pages.

However, the following points have been raised by patients:

- Lyme Regis Medical Centre lost two excellent GPs when the contract was awarded to Virgin, and for several years the GP staffing was thin and locum-dominated, with little continuity of care.
- While the GP staffing has been more settled of late, some patients feel that they have to wait an excessively long time to make a GP appointment: this can be two to three weeks or more for their preferred GP, and often little less for any one of the established GPs.
- In expanding the use of online communication, and of electronic systems for matters such as repeat prescriptions, GP Practices must recognise that many of their elderly patients are unable to manage this form of communication.
- Inadequate procedures for repeat prescriptions, as between LRMC and Lloyds Chemist, are a frequent cause for concern and on occasions have risked real danger.

13. Transport and access

(See also CCG Feedback report, pages 14)

- Page 41 of the Baseline Survey illustrates the practical and financial difficulties for people needing access to services. For some, such as those in the further reaches of the town, in Charmouth and in surrounding villages, even reaching medical centres, dentists, chemists and support groups can be problematic.
- Access to clinics, therapists and hospital appointments in Bridport and Dorchester, particularly for those reliant on public transport, can be a major undertaking – sometimes such a daunting prospect as to cut them off altogether from services that they need.
- The continuing reduction in public transport services, both absolutely and in terms of frequency, exacerbates the problem.
- Many local people ask why more use cannot be made of services in Axminster, which is the most accessible of the towns outside the local area. In the holiday season, access to Bridport can be extremely difficult.
- Essentially, too few of the available health and care services are located in, or periodically operated from, this immediate locality. Local people hear the CCG's commitment, in its Sustainability and Transformation plan, that "We want everyone to have an equal standard of care regardless of ... where they live" and that "more of our services will be provided closer to home, with improved access seven days a week", but are as yet unconvinced.

14. Cross-border Issues

(See also CCG Feedback report, pages 10, 11, 12, 13, 14 & 15)

Of the 8,949 registered patients at the three Practices, 964 live in Devon and 81 in Somerset.
Of the 1,040 students at the Woodroffe School, 543 live in Devon and 54 in Somerset.
Those figures demonstrate why cohesion of services across the borders of the three counties matter so much. Currently, there is little evidence of cohesion, and too many examples of artificial barriers.

It has not in the time available been possible to track policies through all the individual services shown in the Baseline Survey, though we imagine that knowledge is held centrally in some form.

A few examples are illustrative.

- Some services accept clients on the basis of Dorset GP registration irrespective of county of residence; some others do not accept clients from outside Dorset even if they are registered with a Dorset GP. Social Services, for example, draw strict county demarcations.
- Many residents are unclear about their 'right to choose' for hospital referrals: some are not given options when they are entitled to them; in some case the online 'Choose and Book' service appears to limit choices unreasonably.
- The Dorset Care Record and its Devon equivalent appear not to be integrated, creating difficulty for patients and clinicians with a patient being treated across the boundaries.
- A similar discontinuity seems to apply to the protocols for some test results.
- Patients living in, say, Devon but registered in Dorset, if discharged from, say, Exeter RD&E fall into the remit of community GP and nursing services in Lyme Regis but Social Services in Devon; care planning in such cross-border discharges often fail to be effective.
- The midwifery service will follow mothers across the county boundaries, but when a mother's care is passed on to the health visitor protocol demands transfer to the health visitor of the other county service.
- The West Family Partnership Zone does not receive live birth data about a family living in Dorset but registered with a GP outside the county.
- Devon offers little in the way of parenting programmes so, for example, residents of Uplyme registered with a Dorset GP ad to the demand when a Dorset waiting list already exists.
- Professionals such as student support staff at Woodroffe School, the school nurse, or the health visitor, when required to handle child safeguarding matters, have to deal with multiple different agencies, people and procedures in different counties. This adds significantly to workload but does not always seem to be recognised by management in drawing uptime allocations.

15. Coordination of Services

(See also CCG Feedback report, pages 10, 11, 12, 13 & 15)

- The separation of social care from health provision, regarded nationally as a problem, is particularly severe in a rural area with restricted services. The bed-blocking at Lyme Regis Nursing Home (see page 4) is one simple illustration of the weakness: with so few 'step-down' beds available, it makes no sense for the budget-control in one organisation to hamper the delivery of service in another. Similarly, the frailties of the hospital discharge arrangements demand a unified health and care approach.
- On a lesser scale, the small community services team at LRMC comprises staff commissioned by the CCG and by Public Health Dorset (as well as by Social Services). The different CCG and Public Health contracts mean that the employment basis of the school nurse and health visitor differs from that of other staff; this has had severe consequences for the integrity of the team.
- Although the community services contract is held by Virgin, as demonstrated on page 45 of the Baseline Survey there is much involvement 'round the edges' of Dorset HealthCare. This makes seamless provision less likely.
- Residents often report that communication between GPs and other parts of the service, and between different clinicians and therapists within community services, feels inadequate. Patients are unhappy at having to repeat their accounts several times over to different staff as they move through the system.

16. Communications

(See also CCG Feedback report, page 11)

- The Baseline Survey, on page 46, notes some unsatisfactory features of the basic information published by the three Practices and community services.
- Generally, the Practices do not publish routine newsletters for their patients, use email as a means of regular communication, employ their websites as effective ways of communicating, or make much use of public media.
- Leaflets and posters in Practice reception areas and waiting rooms are an important means of signposting other services for patients, but the presentation of this material is generally rather unsystematically arranged, often cluttered and confusing to use.
- It appears that some clinical staff are not always themselves aware of the range of services and support that should be 'signposted', or do not always take the opportunity to pass these on clearly to patients. Yet it is through one-to-one communication between patient and staff that the most effective signposting and referring can occur. Several ancillary services and agencies comment on apparent low levels of take-up in this area, attributing at least some of that to inadequate signposting and referral procedures. The result is that local residents are missing out on some services from which they could benefit.
- The Feedback report notes that 'People [are] not aware of all services available currently through lack of information'; it comments on the need for 'Patient education to enable them to access information, self-refer and access voluntary services'. Serious communication gaps certainly exist, which can be eliminated only through imaginative action on the part of the professionals, by putting themselves in the shoes of members of the public.

17. Monitoring and Quality Assurance

(See also CCG Feedback report, page 14)

- Although the health and care system has an elaborate superstructure of monitoring, inspection, quality control and scrutiny, this does not involve local people nor incorporate their direct experiences.
- Apart from Practice-based individual feedback mechanisms, which cannot be systematic, only the PPGs offer a way for residents collectively to offer ideas about strengths and weaknesses of services. Currently, and from the best of intentions, the PPGs are dominated by professional staff and do not act as effective feedback vehicles.

18. System Complexity and Change

(See also CCG Feedback report, pages 11 & 15)

(i) Commissioning, providing and contracting

The diagram on page 3 of the Baseline Survey only partly illustrates the complexity flowing from the number of commissioning authorities and provider organisations. This complexity has several negative consequences:

- lines of accountability are frequently blurred;

- the system is opaque to the public;

- it creates a degree of instability and confusion among professionals within and outside the system;

- it militates against the joined-up approaches to health and care that are widely acknowledged as imperative for creating a more effective and efficient service;

- the function, identity and accountability of elements within the system change frequently without due attention to the implications for public understanding and access;

- the complex contracting and re-tendering arrangements consume time, money, energy and attention that detracts from front-line services; this has done significant damage to staff morale in some areas of work locally, and to loss of good staff.

(ii) Locality structure

- 'Locality' is a useful way of framing services, but only if the 'locality' is geographically identical across all health and care bodies and defines similar components. Currently, it appears that the term 'locality' as used by, for example, the CCG, Public Health Dorset, social services, Dorset REACH and the West Family Partnership does not define the same thing, thus causing confusion.

- The CCG's Locality grouping of seven practices, while potentially a force for efficient professional sharing, does not as yet appear to have made much impact on service provision 'on the ground'. Its team concerned with the future of the contract for GP services at LRMC and Community services in Lyme Regis and Charmouth has not made contact with patient representatives here. The Locality group may be at risk of becoming another over-elaborate bureaucracy rather than a useful co-ordinating body able to eliminate wasteful overlaps.

- The existence of Jurassic Coast Healthcare Ltd is virtually unknown in the area it covers. Assuming that this organisation has a longer-term purpose beyond simply contracting for NHS Healthchecks, it would be helpful if that purpose were to be explained to local residents and to the registered patients of the Practices concerned.