Healthwatch Staffordshire

# Conversation Staffordshire Events

STP Events in Staffordshire

Joanne Darrant
2-8-2017

# Contents

## Conversation Staffordshire Context

In December 2015, the NHS outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

Healthwatch Staffordshire role is to act as an independent voice of local people, championing quality health and social care and ensuring that voice is heard when changes that will impact the local population are in progress. Through effective engagement to gain service user feedback, we can raise awareness of key issues affecting our local health and social care services and recommend improvements. There are five key work streams that cover Staffordshire, these include:

- Focussed Prevention
- Enhanced Primary and Community Care
- Simplifying the Urgent and Emergency Care System
- Effective and Efficient Planned Care
- Reducing the Cost of Services.

In order to support the development of the STP, Healthwatch Staffordshire organised 8 Conversation Staffordshire events around the county during November and early December. A total of 250 members of the public who attended the events with a further reach of 54,200 and 1,813 people directly engaging with the events and discussions via social media.

It's important that the public are engaged with changes that occur to the NHS Service not only because "*the public is seen to have a larger role as co-producers of service and innovation*" (Hartley, 2005) but because "*The NHS belongs to the people.*" (NHS, 2013)

## Discussion

There are a number of enabling work streams for the STP in which individual research activities are taking place. For the Conversation Staffordshire events, the STP programme decided that the following areas were suitable for public discussion and captured the 5 workstreams of the Staffordshire and Stoke on Trent STP:

- Digital
- Mental Health
- Prevention
- Primary and Community Care
- Planned Care
- Urgent and Emergency Care.

This report will provide a summary of those discussions and the comments that came from them. These events took place **before** the publication of the Sustainability and Transformation Plan.

It must however be noted that some themes for discussion were not discussed at all events since participation was based on public interest.

### Promoting the Conversation

Healthwatch Staffordshire promoted these events in a variety of ways. A cohort of 2300 Healthwatch members were reached via email and 6000 posters and flyers were distributed across Staffordshire. We engaged with the public about the events using social media, our reach and engagement over the course of these events was as follows:

| SOCIAL MEDIA | REACH | ENGAGEMENT |
|---|---|---|
| **TWITTER** | 45,700 | 1,383 |
| **FACEBOOK** | 8,600 | 430 |
| **WEBSITE** | 1,609 | n/a |

This means that our total social media reach was 54,300 and our total engagement over social media with the public was 1813.

## Conversation Staffordshire Events

The table below details the number of people who attended each event that were members of the public.

| LOCATION | NUMBER OF ATTENDEES |
|---|---|
| **NORTH STAFFORDSHIRE (BIDDULPH)** | 43 |
| **SOUTH STAFFORDSHIRE (CODSALL)** | 16 |
| **STAFFORD** | 51 |
| **NEWCASTLE UNDER LYME** | 11 |
| **LICHFIELD** | 28 |
| **TAMWORTH** | 35 |
| **EAST STAFFORDSHIRE (BURTON)** | 30 |
| **CANNOCK** | 36 |
| **TOTAL NO OF ATTENDEES** | 250 |

Each event was attended by a number of panel members enlisted from various organisations within the NHS, County Council and independently chaired by Healthwatch Board Members. Panel members took questions from the public about the STP and related issues. Please see the Appendix for a list of panel members and the Questions and Comments Section of the report which gives a themed overview of questions posed by the public at each event.

A presentation was delivered by Penny Harris (Programme Director) about the STP. This outlined the challenges faced by the public and the health and care system in Staffordshire, both in terms of health outcomes and financial stability, this formed the backdrop for the following discussions.

Figure 1 details the challenges faced in our health and care system with regards to Health and Wellbeing

Figure 1

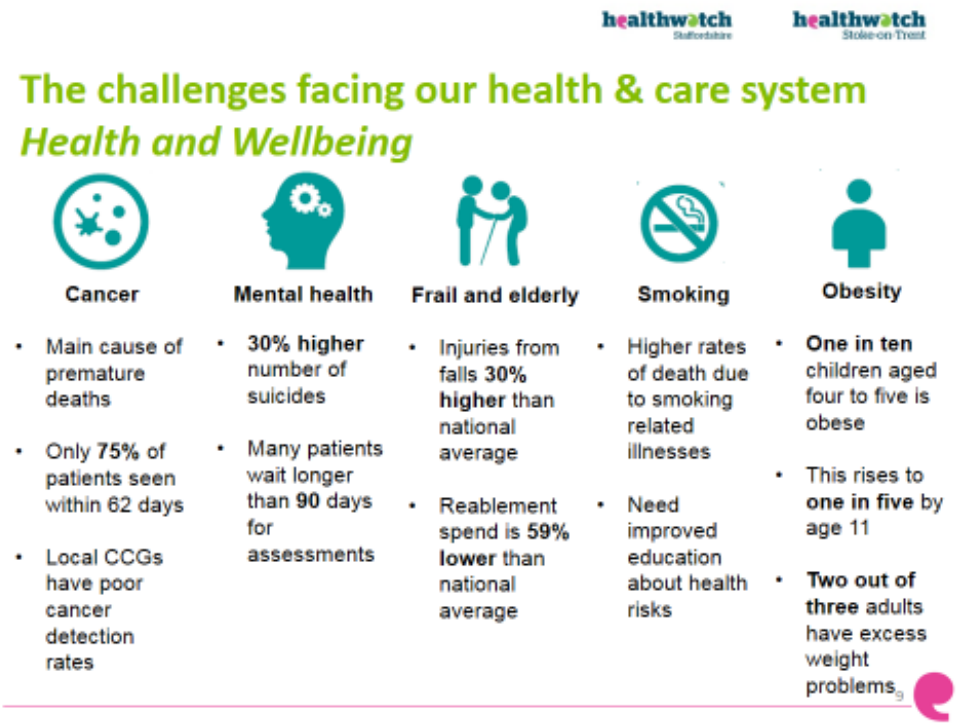


Figure 2 details challenges in relation to quality of care

Figure 2

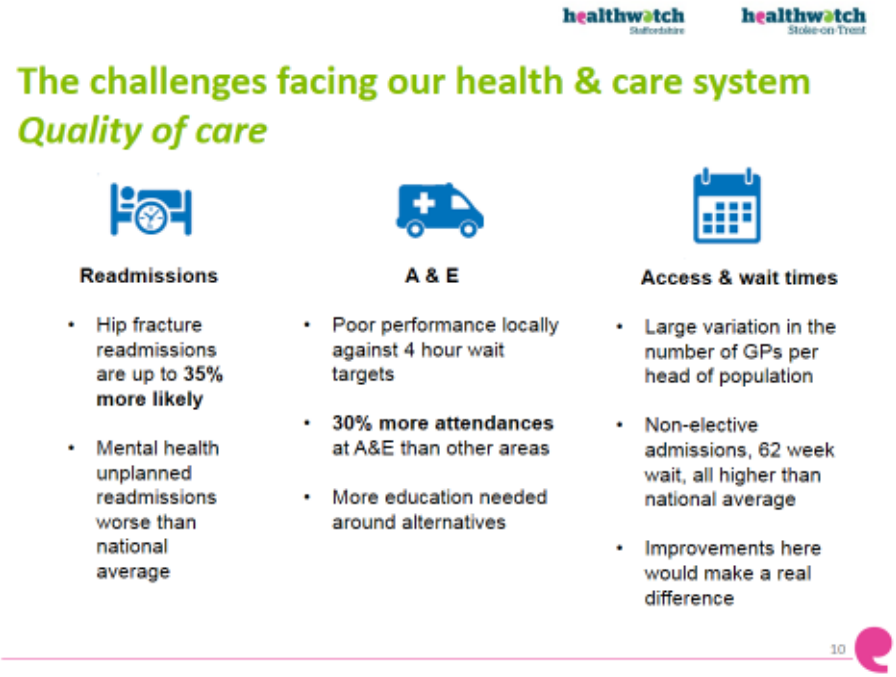


Figure 3 details the financial and efficacy challenges currently faced that was presented by the programme director during the events.

Figure 3


The following section provides a detailed summary of the key themes that emerged from the content of the table discussions across all 8 events.

## Discussion themes

### Digital NHS

Discussions around a Digital NHS took place in both Codsall and Tamworth. It was accepted that digitisation would take place within the NHS, but there were concerns.

Accessibility was an issue in both of the discussion groups, there were concerns that not everyone has access to IT. Even when accessibility to IT was not a problem, digitalisation may not fit all groups of people, for example, individuals with sensory impairments or learning difficulties. Apps needed to be designed to be easy to use but their usefulness to monitor weight, sleep patterns, as an

alarm on a smart watch or as a way to empower people to self-manage conditions was acknowledged.

> ***Phones to send in results to specialists e.g. diabetes- empowering people to self-manage. Blood pressure self-care/ communications tool to share results*** **Codsall**

The need to be consistent in branding digital services across the NHS was discussed, as was the need for information from reliable sources as one contributor stated in a discussion around data quality.

> ***Good information in- good information out; bad information in- bad information out- be aware"*** **Tamworth**

However, there were concerns about shared digital records, these included being clear about who has access to it, its uses, the security of the data and the impact on being able to access services across boundaries. There was an acknowledgement that whilst not appropriate for everyone, technology could be utilised for interactions with patients such as Skype follow ups, texting appointment times or tailored health information messaging. There was also concern about capacity issues for staff to "double run" services in the transition phase.

### Mental Health

Discussions around Mental Health provision took place in 7 of the 8 events. The discussions covered access to services and how the GP was the gatekeeper and that this wasted valuable GP time. Suggestions for improvements were a way to self-refer to services without having to be referred via the GP each time or to have Mental Health Nurses embedded in GP surgeries so that they can see patients without the need for GP referral.

> ***GP is in the middle of a lot of access points- MH nurses in GP practices- say you need an appointment with a GP first- waste of time and resources.*** **Lichfield**

There were concerns around capacity, with acute beds not being available and residents having to access residential support long distances from home and therefore away from family, friends and support networks. This was also mentioned with regards to children's placements.

> ***There is very little provision for children- beds are a long way away, they can be as far away as 200 miles.*** **Stafford**

Capacity continued to be a theme when discussions moved to community provision with comments such as:

> ***Community services seem very stretched. There's no flexibility.*** **Tamworth**

> ***Ongoing needs link up with community team. But there isn't enough community provision.*** **Stafford**

There was also concern across most of the areas about cuts to services that people saw as vital.

> ***Peer support groups, community based groups have all been cut. These are important services.*** **Codsall**

> ***Money seems to have been pulled out of all preventative/lower level support services.*** **Tamworth**

There was a consensus that education played a key role in reducing stigma and ensuring a wider understanding of mental health issues. It was said that this should start in schools and the workplace but also that GP's needed education too.

> ***"GPs don't always know enough to be able to provide adequate support."*** **Stafford**

One solution was a more "joined up" approach to providing services. Comments from the public suggested that a more holistic approach to people's health was needed. This approach needs to take into account both physical and mental health needs and communication between services so people don't "*Slip through*

*the Net"*. One participant in Tamworth commented that patients need health passports so that all services that people attend know about their history and the care they have received.

Prevention was also a big discussion point. Participants felt that providing access to support groups early on could prevent hospitalisation therefore saving money in the long term. Other comments included the reliance on carers and voluntary services, which have led to pressures and a need for support.

> ***Support for carers- NHS far too reliant on carers who are sometimes forced into situation.*** **Cannock**

> ***There is limited support available and more people accessing voluntary sector services but little resources.*** **Lichfield**

> ***"We need better carer's assessments and specialist carer support"*** **Newcastle-under-Lyme**

> ***"There is an over reliance on volunteers to fill gaps"*** **Burton upon Trent**

The general discussion was centred on the value of carers in society and that if more time and money was invested in supporting family/friend carers, they would save the NHS and social care services a great deal of money in the long run.

### Primary and Community Care

Discussions around Primary and community care focused on access to GP services and the need for more flexibility. Participants highlighted the importance of easy accessibility to GP's, particularly for people who find it difficult to travel.

> ***"We need easy access to GP services – being able to register and services being flexible such as late night opening."*** **Newcastle-under-Lyme**

Continuity of care was also raised; there were discussions around relationships not being developed or maintained through not being able to see the same GP. There was a concern that locum doctors didn't have the same knowledge of patient history and wouldn't

have time to read your medical history before a consultation. The public said that people 'get tired' of stating their history time and time again to different doctors. Other comments included providing access to the same GP for individuals with chronic conditions.

> ***"A lack of continuity with GPs and being able to see the same GP means that relationships are not developed or maintained."*** **Newcastle-under-Lyme**

There was a recognition that there was a need for a culture change not only amongst the community but for services too. These comments stated that while the population need to learn how to live more healthily and how best to utilise the services available, the professionals needed to break the 'disease centred approach' to healthcare and embark on more joined up working. This entails not only incorporating other specialisations within the GP practice but also requiring closer working relationships between CCGs/Trusts and county councils.

> ***"Need for more joined up working between providers; County Council and NHS"*** **Stafford**

> ***"Behaviour and culture change - educating people about what's available."*** **Codsall**

> ***"More education. People don't know what clinicians do. They just want to see GP or A&E doctors."*** **Biddulph**

Cuts to services was also widely discussed, from questions arising about the impact of the planned closure of community hospital beds to the proposed closure of pharmacies and impacts of closures of other health services.

> ***"I'm interested to know how ready primary and community care are to deal with the closure of the community beds in North Staffordshire."*** **Newcastle-under-Lyme**

> ***"Respite care from the NHS has been lost. It was every six weeks and it enabled families to keep going and also gave an opportunity for medical staff to pick up on and deal with any emerging health issues. Therefore, preventing an emergency admission."*** **Newcastle-under-Lyme**

It was stated by a member of the public that they felt a lack of money was causing the STP. Finance was a recurrent theme in the various locations, where participants stated that they were concerned about the lack of transparency around how money is being spent and how senior management were being paid too much.

It was suggested that people would be willing to pay more tax if there were guarantees that the money was spent on the frontline of services. It was suggested that if money was not spent, that services would be unable to meet the health needs of the population. It was however suggested that Doctors and Nurses who were newly trained should commit to working in the NHS for five years post training.

> ***People would be willing to pay more tax if they could guarantee it would be spent on the ground*** **Biddulph**

> ***Needs to be more money- services will not meet needs otherwise*** **Biddulph**

There were also concerns about whether there is infrastructure in place to be able to cope with changes and that maybe the step up/step down model wasn't suitable for all localities. (The step up step down model is now called My Care My Way – Home First, it is designed to reduce the time elderly people spend in a hospital environment in order to maintain independence and reduce the 'functional decline in instrumental activities of daily living, mobility, physical activity, and social activity' (Kortebein P, 2008).

*Step up/step down model- the whole infrastructure- how is it going to work?* **Newcastle-under-Lyme**

*Decision making feels like it is a knee jerk reaction without the infrastructure in place* **Newcastle-under-Lyme**

*"Rural areas are not between 30-70,000 people. This model doesn't work with small communities. Rural communities might be grouped with others- not enough patients to impact services."* **Biddulph**

Concerns arose around the pressures on the system and that changes will lead to GPs taking early retirement. There were concerns about staff retention with a lack of new GP's and a failure to retain nursing staff. Solutions provided were a rotation system, job swaps or buddy systems.

*"Difficulties for hospital and G's to recruit new staff"* **Burton upon Trent**

*"Why would anyone want to be a GP- take on the business and all that when you can be a locum?"* **Newcastle-under-Lyme**

*"A newly qualified nurse can go to acute and stay there. When would rotation happen? Use job swaps and buddy systems"* **Newcastle-under-Lyme**

There were concerns that people would be transferred from hospital to care home, instead of to a community hospital and that this would lead to the patient not receiving the therapy and support they would otherwise receive to get them 'back home'. There was an acknowledgment that social care needed extra resources and that this was impacting on acute settings. Resolutions to this issue were better signposting and self-care/management of chronic conditions. The impact of digital service and a single patient record for primary and community care was acknowledged stating that avoiding duplication will undoubtedly reduce costs.

## Focused Prevention

One of the STP's five priorities is focused prevention, this concerned tackling the top 3 health issues of obesity, smoking and diabetes as well as addressing health inequalities.

One of the key discussion was around changing the mind-set of the public, from cure to prevention. It was agreed that what was needed was a:

> ***Mind set change – all focused on prevention*** **Lichfield**

There were some innovative suggestions about how this could be achieved such as:

> ***Tax reductions for having health lifestyle choices*** **Cannock**

> ***We need incentives to make people willing to change?*** **Newcastle-under-Lyme**

Other avenues were looking at community based skills workshops.

> ***cooking skills, employability skills.*** **Stafford**

There was an understanding that it was the pressures of modern life and that it was down to

> ***Work life balance- inactive jobs- lack of time to cook or exercise.*** **Stafford**

Education was a key area to start the change in thinking. It was suggested that this was the role of community nurses, although the education was needed to be conducted alongside, to promote healthy lifestyles and an awareness of health issues. Additionally, education should not only be about healthy lifestyles but to educate the public about the options when needing health services aside from the hospitals. It was also stated that there was need for intergenerational work (i.e. working with a whole age range of people from children to the elderly).

> *Health education in schools- educate parents through children- eating; mental health; exercise"* **Cannock**

> *Need to change the view that hospital is the place to be* **Newcastle-under-Lyme**

> *Education in schools- made engaging, stimulating and challenging.* **Stafford**

> *Education- start in schools.* **Tamworth**

There was a concern that the messages were not reaching the seldom heard groups, with particular difficulty engaging with BME groups and Eastern European communities. This was where Healthwatch was seen by the public as a vital option, having evidenced some success in this area in the past. Encouraging people to exercise was seen as important to the prevention of problematic health issues. Subsidised healthy food and gym referrals, as well as developing public spaces such as parks for outdoor gyms were suggested as ways to encourage this.

> *Positive schemes e.g. GP gym referral schemes, subsidise health food.* **Tamworth**

> *Use of parks as outdoor gyms* **Cannock**

> *LTC's GPs should be encouraging people to go to Gyms and clubs rather than current methods of healthcare* **Burton upon Trent**

There was a concern that if the money was spent on prevention, it would reduce the funding for medical interventions. The reduction in funding from the government had led to partnerships that were now in competition for funding, impacting on their ability to work together. It was argued that there was a need for more effective spending to cut wastage. Suggestions for incentives to encourage healthier lives included ideas such as encouraging companies to

look after their employees' health as well as providing tax breaks to individuals who look after their own health.

> ***"Early intervention prevents pounds down the line."*** **Cannock**

> ***"Partnerships are now in competition for funding rather than working together"*** **Stafford**

> ***"They should incentivise with Tax breaks for looking after yourself."*** **Tamworth**

Questions arose around the issue of resources; were they sufficient and where should they be directed.

> ***"Put resources- post hospital care (community bed, residential care home, domiciliary care)"*** **Cannock**

> ***"Resources available to prevent admissions to hospital. i.e. community and voluntary sector support. Third sector partnerships, churches and charities."*** **Stafford**

There was a consensus about the need for joined up working and the belief that organisations were currently silo working, and there was a need to work together to avoid duplication.

> ***"Communication across sectors needs to be key to STP, people currently working in silos, they need to avoid duplication and share best practice"*** **Burton upon Trent**

Again, it was suggested by a member of the public that this was a role for Healthwatch to align groups and ensure that duplication is avoided and that each group's voice is heard.

The lack of social care services was seen to impact on people's health, with a further lack of support put in place for community care. Additionally, it was also stated that there was no support for families and informal carers. Effects of this were that more people ended up in A&E than there should be.

> ***"Lack of support for families and informal carers. Can't get required funding, criteria changing meaning more people end up in A&E."*** **Cannock**

As a part of the prevention approach, resources need to be channelled in the right areas to ensure there are no inappropriate uses of services.

### Planned Care

Discussions on Planned Care took place in 5 of the 8 locations. Discussion around the appointment system took place primarily in Burton upon Trent. Suggestions were made that appointments could be combined to reduce the number of trips made to the hospital. It was suggested that check up's and follow up's should be triggered rather than given across the board.

> ***Need for follow up appointments - ring up if needed a follow up appointment, rather than an appointment no matter what.*** **Burton upon Trent**

It was also suggested that there were difficulties chasing up appointments and communicating with the team responsible. Reminders needed to be texted to patients, and a suggestion that follow ups could be carried out by Skype or telephone as this technology was already utilised for some patients. Appointments too far in the future caused anxiety. Some felt that DNAs were a result of poor communication within the system whilst others felt that charging for missed appointments may be a way forward.

Looking to others for best practice examples was suggested as an opportunity to become more efficient.

> ***"Need to look at best practice from peers further afield to see how we can change. Provider Trusts generally recognise need to do things more efficiently but don't know how and aren't incentivised to change."*** **Cannock**

There were concerns that beds become blocked due to unplanned admissions and that there were

> ***People in beds that do not need/want to be there*** **Tamworth**

The challenges that the NHS were faced with were acknowledged not least around ensuring staff were aware of growing populations and their needs as well as ensuring their continued flexibility;

> ***They need to make sure that teams aren't so specialised they can't provide another service/procedure if their demand drops- keep an eye on the levels of demand*** **Cannock**

It was also reported that there is a requirement to ensure that discharge needs are addressed when planning an episode of care and that Hospitals without emergency facilities are more likely to have less cancelled appointments because.

> ***Easier to plan and stick to the plan*** **Cannock**

There were questions around the future of local services such as the Sir Robert Peel and Samuel Johnson hospitals. Planned Care it was argued should remain in local areas as

> ***People will want to be admitted to their nearest site as wellbeing of having visitors cannot be underestimated.*** **Cannock**

Voluntary services were seen as crucial to supporting discharge for those patients who do not have an existing support network.

### Urgent and Emergency Care

Discussion around Urgent and Emergency care took place at 3 of the 8 Conversation Staffordshire locations. There were questions around whether the urgent care centres were always at full capacity and if more capacity was the answer. It was suggested that education was needed to manage expectations regarding urgent and emergency care access.

> ***There's a perception that if they go to A&E they will see a consultant for their particular ailment more quickly but they won't, they'll see an A&E doctor*** **Biddulph**

Community triage was suggested as it had a significant positive impact on Urgent and Emergency Care. It was queried whether 111 was used correctly and suggested that during the night A&E was the only option considered.

> ***Not sure that 111 is being used as much as they could- not understanding the difference between 111 and 999 but if in doubt 999- elderly concerned/vulnerable.*** **Codsall**

There needed to be;

> ***Alternative places other than A and E for 111 to send people.*** **Burton upon Trent**

Suggestions were that out of hours GP's could be embedded into community hospitals and that this may alleviate the strain on A&E. It was acknowledged that

> ***Staff are challenged but strive to provide great care*** **Burton upon Trent**

However, community services have diminished and so it was reported that a focus was needed for primary care and effective signposting. Suggestions to enable more effective triaging were to enable Skype and smartphone triaging for 111. Alternatives were to utilise existing resources in each area.

> ***Utilising what we have in each area- existing clinics- used differently. Based on local insight i.e. what they go in for- skill the centres appropriately.*** **Codsall**

The defining question though is

> ***What is it that we are trying to fix in urgent care - who do we not want there i.e. A&E; walk-ins*** **Codsall**

## Concluding Note from Healthwatch Chief Executive

Healthwatch Staffordshire welcomed the opportunity to deliver these events to ensure that the public are aware of the Staffordshire and Stoke-n-Trent Sustainability and Transformation Plan. Our health and care services are under severe pressure, and we believe it is right both that there should be a longer term plan to address the financial and service quality challenges outlined. We also believe that this plan should be informed by the public who use these services – we all have a stake in the future of health and care in our county and city, and, as the people who use these services, we often have the best view of how they can be developed and improved. It is also vital that we understand the financial constraints that exist, and the changes in practice that affect how care is best delivered, and I am really glad that these events started the conversation with the people of Staffordshire – we now need to make sure that conversation continues and Healthwatch Staffordshire is committed to supporting that process. We welcome any comments from the public about this report and will use feedback to help inform how we ensure that happens, and the future development of the plan which has now been published and can be found here.

# Appendices

## Location Panel Members

2nd November 2016 – Biddulph Panel Members

| Name | Position | Organisation |
|---|---|---|
| **Will Taylor** | Independent Chair | Healthwatch Staffordshire |
| **Penny Harris** | Programme Director | Together We're Better |
| **Rob Lusuardi** | Director of Operations and Delivery | South Staffordshire and Seisdon Peninsula CCG |
| **Steve Fawcett** | Medical Director | North Staffordshire CCG Governing Body |
| **Dr Bill Gowans** | Medical Director | Together We're Better |
| **Dr Richard Harling** | Director for Health and Care | Staffordshire County Council |
| **Sally Parkin** | Clinical Director for Partnership and Engagement | North Staffordshire CCG Governing Body |

9th November 2016 – Codsall Panel Members

| Name | Position | Organisation |
|---|---|---|
| **Robin Morrison** | Independent Chair | Healthwatch Staffordshire |
| **John Macdonald** | Staffordshire and Stoke on Trent STP Chair | Together We're Better |
| **Andrew Jepps** | Interim Care Commissioning Lead | Staffordshire County Council |
| **Dr Paddy Hannigan** | Governing Body Chair | Stafford and Surrounds CCG |
| **Dr Bill Gowans** | Medical Director | Together We're Better |

14th November 2016 – Stafford Panel Members

| Name | Role | Organisation |
|---|---|---|
| **Will Taylor** | Independent Chair | Healthwatch Staffordshire |
| **Penny Harris** | Programme Director | Together We're Better |
| **Dr James Shipman** | Medical Director | Staffordshire and Stoke on Trent Partnership Trust |
| **Paul Simpson** | Director of Finance & Deputy Accountable Officer | Cannock Chase/SE Staffs & Siesdon Peninsula/ Stafford and Surrounds CCG |
| **Tracey Shewan** | Interim Director of Nursing and Quality | North Staffordshire CCG |
| **Dr Richard Harling** | Director for Health and Care | Staffordshire County Council |

21st November 2016 – Newcastle under Lyme Panel Members

| Name | Role | Organisation |
|---|---|---|
| **Yvonne Buckland** | Independent Chair | Healthwatch Staffordshire |
| **Stuart Poyner** | Chief Executive | Staffordshire and Stoke on Trent Partnership Trust |
| **Dr James Shipman** | Medical Director | Staffordshire and Stoke on Trent Partnership Trust |
| **Marcus Warnes** | Accountable Officer | North Staffordshire CCG |
| **Andrew Jepps** | Care Commissioning Lead | Staffordshire County Council |
| **Dr Ruth Chambers** | Clinical Chair | Stoke on Trent CCG |
| **Dr Mark Williams** | GP | General Practitioner |
| **Caroline Donovan** | Chief Executive | North Staffordshire Combined Healthcare NHS Trust. |

22nd November 2016 - Lichfield Panel Members

| Name | Role | Organisation |
|---|---|---|
| **Will Taylor** | Independent Chair | Healthwatch Staffordshire |
| **Penny Harris** | Programme Director | Together We're Better |
| **Helen Scott-South** | Chief Executive | Burton Hospitals NHS Foundation Trust |
| **Robert Flinter** | Deputy Director of Health and Care | Staffordshire County Council |
| **Dr Bill Gowans** | Medical Director for 'Together We're Better' | Together We're Better |
| **Dr John James** | Chair Governing Body | South East Staffordshire and Seisdon Peninsula CCG |
| **Tracey Shewan** | Interim Director of Nursing and Quality | North Staffs CCG |
| **Dr Gulshan Kaul** | GP | General Practitioner |

28th November 2016 – Tamworth Panel Members

| Name | Role | Organisation |
|---|---|---|
| **Yvonne Buckland** | Independent Chair | Healthwatch Staffordshire |
| **Andrew Donald** | Accountable Officer | South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG, Cannock Chase CCG |

| | | |
|---|---|---|
| **Helen Scott-South** | Chief Executive | Burton Hospitals NHS Foundation Trust |
| **Robert Flinter** | Deputy Director of Health and Care | Staffordshire County Council |
| **Dr John James** | Chair Governing Body | South East Staffordshire and Seisdon Peninsula CCG |

30th November 2016 - Cannock Panel Members

| Name | Position | Organisation |
|---|---|---|
| **Robin Morrison** | Independent Chair | Healthwatch Staffordshire |
| **Penny Harris** | Programme Director | Together We're Better |
| **Andrew Donald** | Accountable officer | South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG, Cannock Chase CCG |
| **David Loughton CBE** | Chief executive | The Royal Wolverhampton NHS Trust |
| **Dr Bill Gowans** | Medical Director | Together We're Better |
| **Dr Mo Huda** | Governing Body Chair | Cannock Chase CCG |
| **Dr Richard Harling** | Director for Health and Care | Staffordshire County Council |
| **Dr Johnny McMahon** | Clinical Lead – Cancer and End of Life Care | Together We're Better |

December 2016 – Burton upon Trent Panel Members

| Name | Role | Organisation |
|---|---|---|
| **Yvonne Buckland** | Independent Chair | Healthwatch Staffordshire |
| **Penny Harris** | Programme Director | Together We're Better |

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|---|---|---|
| **Helen Scott-South** | Chief Executive | Burton Hospitals NHS Foundation Trust |
| **Tony Bruce** | Chief Accountable Officer | East Staffs CCG |
| **Dr Charles Pidsley** | Chair of Governing Body | East Staffs CCG |
| **Andrew Jepps** | Care Commissioning Lead | Staffordshire County Council |

## Questions Comments and Answers

### Planning and Strategy

1. How can an overstretched, failing system possible cope with more development/population increases or is it that the agenda is for the NHS to fail to justify privatisation? (Biddulph)
2. Will you be able to show me in five years' time that you have had a 14.8% increase in real terms- will it be in your accounts? (Newcastle under Lyme)
    - *A: Yes it is real- unless next year it is changed but 14.8% is what has been published.*
3. How does Staffordshire equate to place based approach to planning as suggested by the Kings Fund? (Biddulph)
4. Needs to be flexible - one standard plan with not suffice. (Biddulph)

### Public Understanding

5. How do medical professionals un-medicalise health for the benefit of the community? (Lichfield)
6. There is confusion over: walk-in centres; minor injury units; urgent care. (Biddulph)

## Mental Health

7. How can statutory mental health services adapt to make best use of the community and voluntary sector without putting undue stumbling blocks and restrictions in their way? The VCS has enormous local knowledge and expertise which could contribute greatly to preventative care. (Codsall)
8. (Combined healthcare). Staggered that alcohol is not included as one of the key challenges. Where are services commissioned by the local authority in what has been presented? Services are not represented in the system. (Newcastle under Lyme)
    - *A: Director of adult social services is a key representative on the STP. Prevention work with the STP sits with the LA. Alcohol is a huge issues.*
    - *A: Local authorities are in a very difficult position money wise. The NHS has done relatively well. Public health was ring fenced but this is no longer the case. It is now having to prioritise spending and prevention is being cut. LA will have direct responsibility for public health and we will have to work together.*
    - *A: A lot of money is being spent in the wrong places- there is a need to prioritise investment. How do we re-direct the money where we can't demonstrate outcomes? Alcohol is a priority.*

## Demographics of population

9. How do you get real meaningful engagement with a wide spectrum of people representing all sections of society including the hard to reach groups? (Homeless, drug users). Currently we seem just to be scratching the surface.
10. Housing Association- Approach to help people live well. We provide those services in the community- obesity, etc. - and access really vulnerable, hard to reach people. An opportunity to work with the NHS and wondered if you are applying the organisation/impact/service that could help the plan. (Codsall)

- *A: Previous role- signposting service. Have we mapped it? No. do we recognise the value of it? Yes.*
- *A: Local teams- as they mature would get into wider areas and have conversation with the voluntary sector. Stoke- provide heating etc for 20 people in poor housing. Need to be more innovative about bringing schemes together*

## Social Care

11. Care in the community is the biggest factor- not enough interest in community care service/domiciliary care/ better quality of life. Why don't we have a night care service? Why not 24/7 service? Who wants to go to bed at 8pm? (Codsall)
    - *A: It is difficult to provide for intensive are needs. Extra care scheme. Workforce capacity issues- challenge in finding people who want to provide home care and use people's time better for the provision of home care. Quality is important and there is a bit of good work going on.*
12. What will happen to 'step up- step down' model. Care homes not set up for that model like community hospitals? (Newcastle under Lyme)
    - *A: Relatively small number of beds- still going to be available- via flexing beds in Haywood. Step down in community beds or nursing homes.*

## Dental Health

13. Why is NHS dental referral provision postcode rationed? Why does the NHS not provide funding for patients too ill to attend the surgery to be visited by the dentist at home? (Biddulph)

## Financial support

14. Alzheimer's society and carer for relative with dementia- no mention of voluntary and community sector. Talk about holistic approach but no mention of 3rd sector support/provision and carers who provide huge amounts of support and care unpaid. Substantial element missing from holistic model and valuing carers and third sector and the work they do. (Codsall)
    - *A: Apology- part of relationship priority and not meant to be excluded on any level. Need to develop trust and established working relationships- partnerships rooted in the community to support service delivery.*
    - *A: Carers rights and responsibilities principle. Some things don't cost money but some do and we need to find a way to what we need to do but also save money.*

## Joined up care

15. In hospital- had to wait for over a week for a social worker to arrange physio/care at home. Get more physio in hospital then on a care plan. (Codsall)
    - *A: Lack of joined up care. Challenge- put too much money into hospital care and need to invest in community care but there is no money left. Need to create the system that will save some money in the hospital. So need to set up community service/ double fund to then close the hospital service. Paradox is we can't access the money.*
16. Argument between NHS and Public Health over who is responsible for funding. Not just about substance misuse. Lack of trust that organisations can work together to sort it out. No confidence about the future. (Newcastle under Lyme)
    - *A: Looking at how to integrate services. BCF was supposed to do that before funding gaps. It means that there is a need to look at different ways of working.*

## Bureaucracy

17. Education/ health- great over burden and bureaucracy. Need to get back to basic principle to have a delivery of care rather than filling in bits of paper. Staff morale, patient, client. Anything that can be done to cut down bureaucracy, to save money. (Codsall)
    - *A: Simple care record, communicative*
    - *A: Partly cultural, regulation. Clinical bureaucracy- could be cut down. Paper chase across the patient pathway. Digital work stream is about reducing the flow of paper and increasing the flow of info. USA- 50% get results on-line- access their patient care records. Need to be more pragmatic and join up the system.*
    - *A: require change in legislation to go this. Basic principle- accountability has to take place and need to redress that.*

## Early interventions

18. Voluntary sector- early intervention and supporting people earlier not once they are in hospital. Work with people getting to live with sight loss and retaining independence. We get referrals too late as not an effective working relationship with GPs. If that was improved and would save the NHS money. (Codsall)
    - *A: GP practice is a mess at the moment. STP- enhance primary care- how do we build up capacity and do their prevention/ early intervention work aligned to primary/community care. Need to work much closer. GPs are overburdened.*
    - *A: Tell them how these relationships/connections should be made? Start again and look at how this works. Doesn't need referrals/ bureaucracy/barriers*

## Abuse of system

19. Abuse of A&E and post discharge social care by people not entitled to NHS care. Travel agent profiting from

local NHS. Wrote to previous Chairman but was dismissed. People are in corridors waiting because large numbers who are not entitled to NHS treatment are abusing the system. (Newcastle under Lyme)

- *A: If it is true would like to ensure that it doesn't continue to happen.*

## Hospital Closures

20. (Health professional and local resident) Proposed closures if local hospitals. Enforcement/CQC issues around outsourcing to private sector. How are you going to guarantee safety? Need reassurance. Good that Healthwatch are here. The NHS gets bad press- disappointed about bad media. Communities need to take some ownership. (Newcastle under Lyme)
    - *Chair: Hope that Healthwatch are able to put the positive side of the NHS as well as areas for improvement. Our Enter and View work helps to contribute towards measuring standards in care homes.*
    - *A: £38 million is spent on continuing healthcare within care home settings. There is robust commissioning and the new beds will be managed under NHS contracts in the same way. There are quality checks in place and the contracts are managed. There are 111 care homes in North Staffordshire and 4000 beds, we only commission a proportion of those beds.*
21. Who is taking clinical responsibility for those beds in regard to treatment including intravenous antibiotics, etc? (Newcastle under Lyme)
    - *A: Medical governance: contracts with GPS and an enhanced service with GPs being funded.*

## GPs

22. GPs visit once a week. They have pressure of running their own service without the extra responsibility. (Newcastle under Lyme)

- *A: Can only put people in a home if they can't get the level of care that they need in their own homes. If someone lives in a care home they pay for their own care or if they have continuing healthcare needs it is funded. Intermediate care needs are funded by NHS- short term assessment/intervention. Commissioned in similar way as in the community beds.*

### Prevention work

23. Sharing services- extended extra care- as clinicians can we educate staff in those to do prevention work. (Newcastle under Lyme)
    - *A: There is a work stream for prevention and there needs to be a shift to prevention. Teaching is absolutely fundamental. Specialist staff to empower others.*

### Long-term conditions

24. Expert patients panel: LTCs are managed but not cured. Large number in population have LTCs. With a relatively small amount of information people can self-manage. Links to prevention and enhanced primary and community care. (Newcastle under Lyme)

### STP

25. Public should have been consulted before now. How much genuine consultation can take place in the plan has already been written? (Newcastle under Lyme)
    - *A: When it has been published it will be possible to see that there are opportunities for genuine consultation.*
26. When will the STP be available in the public domain? (Newcastle under Lyme)
27. When are plans for STP going to be drawn together and published? (Newcastle under Lyme)

- *A: Before Christmas. Some LA's have already published. In the next couple of weeks once draft been submitted has been signed off.*

### Digital information

28. GPs putting information on the cloud- allowing access for patients and hospitals. If all GPs did that it would make information sharing easier. (Newcastle under Lyme)
29. (Clinician) Need for paperless communication. Been on the cards for so many years. If could get that right across the health economy would make savings.
    - *A: One of work streams is digital. Priority is shared care records. To be in place by April 2018.*

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