

Question Time Re: The Future of the NHS Part 2 Event Report

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Details of Questions 1 to 11 Posed to Panel Members

Written questions from local people about health and social care for the above event will be as follows:

- 1 **Question posed by Doncaster LINK's ICE Group.** How will patient choice be met by the Clinical Commissioning Group (CCG) and how will CCG ensure that services being commissioned are what patients would choose?
- 2 **Question posed by Miriam Shores.** How do things stand with regard to the changes that are proposed around GP Consortia locally?
- 3 **Question posed by Pat Thompson.** Do you think acute services will take precedence over non acute long term treatments ie MS, Rheumatoid Arthritis, Stroke Rehab etc which are seen to clog up beds?
- 4 **Question posed by Rita Holdsworth.** Regarding patient choice - how far will this go? Will a patient be able to choose one provider for say a diagnostic scan and another provider for say the recommended operation?
- 5 **Question posed by Rita Holdsworth.** Who will manage, co-ordinate and hold the CCG accountable at a local level?
- 6 **Question posed by Richard Brocklehurst.** What is the panels view on the long term funding of social care in the UK? Do you agree with the proposals to limit the cost of funding of your own social care, but how will this funding gap be filled – are we all to take out insurance?
- 7 **Question posed by Dot Head.** National screening programmes ie mammography and bowel cancer are currently funded through the PCT. How are these programmes going to be managed under the new arrangements and who will ensure these programmes are continued at a local level?
- 8 **Question posed by Sheila Barnes.** Mental health and learning disabilities. With the proposed changes to commissioning of services, patient choice and 'Any Qualified Provider' is any future threat to local service provision anticipated and can any preparatory actions be undertaken to ensure stability of those services?

- 9 **Question posed by Doncaster LINK's Executive Board.** Sustainability of local acute hospital services. With the prospect of 'Any Qualified Provider' and possible reduction in revenue, will the services currently provided at DRI be sustainable and is there any possibility of the local hospital facilities being taken over by any private company?
- 10 **Question posed by Doncaster LINK's Executive Board.** Ensuring accountability and client safety. When private companies are engaged in the provision of client care in the domiciliary setting, who is responsible for standard setting, monitoring and accountability and how can that be assured?
- 11 **Question posed by Brian Button.** Does Joan Beck think more or less disabled/sick people will be left without help in their home under this new assessment criteria?

Details of Open Forum Questions Posed to Panel Members

Question. If a patient living in another area wanted to have their operation in Doncaster would their transport be paid for?

Question. Loneliness is a problem faced by many old people. Getting to the doctor is also a problem. How would an old person get to their doctor's surgery? The heart nurses provide a good service going out to see patients. Is there any consideration for a nurse practitioner to go out to see elderly patients? This could potentially sort out issues of loneliness, medication hoarding and bed-blocking. (Dorothy Head – LINK Member).

Question. Isolation is a problem would a visit from a health professional help eradicate that? (Dorothy Head – LINK Member).

Question. Literature is produced in various languages, but what about people who are deaf, as they also may have reading difficulties? (Representatives of Doncaster Deaf Action Group).

Question Time Re: The Future of the NHS Event Part 2

11th November 2011



Introduction

Doncaster Local Involvement Network (LINK) held their Question Time Re: The Future of the NHS Part 2 event on 11th November 2011 at Castle Park, Doncaster. The event was an opportunity for residents of Doncaster to have questions answered by a panel of professionals based around the future of the NHS.

Members of the Panel

The panel consisted of 5 professionals as follows:

Roger Greenwood	Chair Person – NHS Doncaster
Madeleine Keyworth	Chair Person – Rotherham Doncaster and South Humber Mental Health Foundation Trust (RDash)
Lynn Rothwell	Director – Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH NHS Foundation Trust) deputising for Ron Calvert, Chief Executive DBH NHS Foundation Trust
Joan Beck	Director of Adult and Community Services – Doncaster Metropolitan Borough Council (DMBC)
Dr Eric Kelly	Interim Chief Executive – Doncaster Clinical Commissioning Group (Doncaster CCG)

Chairing the event was Sheila Barnes, Doncaster Local Involvement Network (LINK) Executive Board Chair Person.

Responses to Questions from Panel Members

Question 1 posed by: **Dorothy Head (Doncaster LINK Information Communication and Engagement (ICE) Group.**

How will patient choice be met by the Clinical Commissioning Group (CCG) and how will CCG ensure that services being commissioned are what patients would choose?

Responses to Question 1 From:

Dr Eric Kelly (Doncaster CCG)

Dr Kelly said the recent White Paper has increased patient choice. Front line commissioners and GPs have knowledge of what patients need and what is available in the system and will listen to what patients say. Doncaster CCG has a structure in place which includes the 5 localities of the area. Each GP practice has been encouraged to start a patient participation group whereby patients are invited to feed in what services are working and where the gaps are. Information from these groups is then fed back up to the CCG. The Department of Health has proposed the way forward for CCGs – there will be a place on the Doncaster Board for LINK to represent. The CCG is accountable to the Local Authority's Shadow Health and Well Being Board – chaired by Councillor Patricia Schofield – who hold CCG accountable and make sure that commissioned services are what the people of Doncaster want and need – this is a careful balancing act.

Joan Beck (DMBC)

Joan stated the GP Commissioning Strategy is based within the Joint Strategic Needs Assessment, where such information as areas of deprivation, typical life expectancy etc are detailed. HealthWatch also has a place on the Health and Well Being Board.

Madeleine Keyworth (RDash)

Madeleine informed attendees that RDash chairs several geographical areas – they ask the question “what would patients choose regarding Mental Health and Learning Disabilities?” These are often vulnerable people, who cannot speak for themselves, so how do we know what the patient's needs are? RDash has a Counsel of Governors which includes Service Users, and Carers (some of them are present here today) who give insight into what it is like to be a patient. For example, if a Service User goes to see his / her consultant, and it is not the usual consultant, we should let them and their

carer know this beforehand, so they know what to expect. It is essential to listen to people and give them what they want where possible.

Dot Head further added - how can you find out about patient services?

Dr Eric Kelly (Doncaster CCG)

Dr Kelly replied that Patient Participation Groups are encouraged within all GP practices and that the Government funded these groups. He advised people to go into their own local practices and ask them for information.

Question 2 posed by: Miriam Shores (Doncaster LINK Member).

How do things stand with regard to the challenges that are proposed around GP Consortia locally?

Responses to Question 2 From:

Roger Greenwood (NHS Doncaster)

Roger said that most of this had been covered by Dr Eric Kelly within the structure of the CCG. He went on to say that Doncaster is already ahead of other areas within the South Yorkshire Board of the Primary Care Trust (the CCG is accountable to this Board). There has been a series of challenge meetings and a delegation made that the Shadow Health and Well Being Board will be responsible for monitoring the CCG.

Dr Eric Kelly (Doncaster CCG)

Dr Kelly stated the CCG has been pro-active in taking clinical commissioning forward. The initial Board was set up in March / April 2011 and all GP practices in Doncaster have signed up. The Board has been through a series of confirm and challenge meetings. CCG has been given £400 million of NHS money to work with. Once this paper has gone through parliament, it will be compulsory for all GP practices to be signed up with the CCG.

Question 3 posed by: Pat Thompson (Doncaster LINK Member).

Do you think acute services will take precedence over none acute long term treatments i.e. MS, Rheumatoid Arthritis, Stroke Rehab etc which are seen to clog up beds (Pat is concerned regarding the waiting lists for hip / knee replacements, bunions etc and if they will be put on a back boiler).

Responses to Question 3 From:

Lynn Rothwell (DBH NHS Foundation Trust)

Lynn responded by saying the maximum waiting times for an operation from GP referral to actual procedure is 18 weeks. No patient will be treated above others. Some acute patients will be given a priority due to their high needs.

Madeleine Keyworth (RDash)

Madeleine said the NHS and Social Services are working together, investing funds to support people who are not in acute care but wanting to remain in their own homes. This investment is going into such services as Step Up / Step Down care to enable patients to leave hospital but have the extra support they need to live in their own homes. Each patient is treated as an individual.

Dr Eric Kelly (Doncaster CCG)

Dr Kelly stated we are working jointly on a long-term conditions agenda, the population is getting older – keeping people well at home is part of the agenda. For example, on the old system a hip replacement patient took 12 to 18 months to get their operation from paper referral to procedure. Now a GP does an electronic referral and the procedure is carried out within 18 weeks. The Government target is 18 weeks and this will remain in place. At Doncaster Royal Infirmary it often takes a lot less than 18 weeks.

Question 4 posed by: Rita Holdsworth (Doncaster LINK Member).

Regarding patient choice – how far will this go? Will a patient be able to choose one provider, for say a diagnostic scan, and another provider, for say the recommended operation?

Responses to Question 4 From:

Lynn Rothwell (DBH NHS Foundation Trust)

Lynn said this is possible in theory but not recommended, as it is more beneficial to keep with the same consultant. If this pathway is chosen, it would take longer and feel like the patient has been let down.

Dr Eric Kelly (Doncaster CCG)

Dr Kelly added this is more likely to happen if the patient has their diagnostic done by their GP then an operation afterwards – they may go to another authority for their operation. However, it is a more seamless process if the same organisation does the diagnostic and the operation.

Joan Beck (DMBC)

Joan stated a good example of this happening would be - if a family carer lived out of the area the patient may choose to have their operation to be close to them for practical reasons.

Question 5 posed by: Rita Holdsworth (Doncaster LINK Member).

Who will manage, co-ordinate and hold the CCG accountable at a local level?

Rita Holdsworth stated the CCG is accountable to the South Yorkshire Cluster Board who will be monitoring performance towards 2013. Legislation insists that every CCG must have a governing body which must include 2 lay representatives as well as other defined members. It is the responsibility of the governing body to determine the efficiency etc of the CCG. Also, the National Commissioning Body accountability goes through this strand – it holds the CCG to account for the £400 million total given to Doncaster.

Responses to Question 5 From:

Dr Eric Kelly (Doncaster CCG)

Dr Kelly responded by saying there is accountability at different levels – with local authority colleagues via the Health and Well Being Board. This accountability goes right down to the patients. There are 44 GP practices in Doncaster. The Board members are made up of representatives based on their skills and competency. Patient participation groups are kept fully informed of CCG decisions.

Joan Beck (DMBC)

Joan further added the Health and Well Being Board are looking at which PIs (Performance Indicators) to use in order to judge the GP Commissioning Group. Within the NHS there are processes in place to ensure that patients are still getting the service they want from their GPs e.g. night time and weekend surgeries.

Question 6 posed by: Richard Brocklehurst (LINK Host Team).

What is the panel's view on the long term funding of social care in the UK? Do you agree with the proposals to limit the cost of funding of your own social care, but how will this funding gap be filled – are we all to take out insurance?

Responses to Question 6 From:

Joan Beck (DMBC)

Joan said she had been informed of/invited to a public consultation event to be held at the Carr House Centre on 21st November at 9.15 am and then again at 6 pm to hear the Government's proposals for future funding of social care. The country won't pay for the care it wants for the elderly, therefore the gap must be filled either via insurance or taxation. This is an urgent issue this country faces due to its continually aging population. We need to focus on prevention methods to the elderly becoming socially isolated; encourage participation in activities; drinking less; quitting smoking etc. We need to concentrate on:

- Future funding of social care
- Encouraging people to live healthier lives

Madeleine Keyworth (RDash)

Madeleine said we need to use our limited reserves in the most efficient and patient-centred way for example, One Team Working.

Roger Greenwood (NHS Doncaster)

Roger added there is a dilemma on how this should be funded. His personal view is that it is very sad that the NHS went through a phase of being target driven instead of being quality driven. Doncaster has a marker against it for having obesity and alcohol problems. It is essential to educate people to live healthy lives. There are current reforms in place which are working from the "bottom up" instead of previously where they worked from the "top down".

Question 7 posed by: Dot Head (Doncaster LINK Member).

National screening programmes i.e. mammography and bowel cancer are currently funded through the Primary Care Trust. How are these programmes going to be managed under the new arrangements and who will ensure these programmes are continued at a local level?

Responses to Question 7 From:

Dr Eric Kelly (Doncaster CCG)

Dr Kelly informed the group they are currently funded by the Primary Care Trust but they are national programmes. CCGs won't take on everything funded by the Primary Care Trusts, but screening programmes will still continue via NHS Commissioning Boards. There will be a national board

with local outposts – these will look exactly the same from the patient’s point of view and will be delivered locally as they already are.

Lynn Rothwell (DBH NHS Foundation Trust)

Lynn stated screening programmes are being expanded and supported to go forward.

Roger Greenwood (NHS Doncaster)

Roger said there may be a conflict of interest between Primary Care and the CCG as doctors are independent contractors.

Madeleine Keyworth (RDash)

Madeleine stated that, as a health community we need to encourage patients to take up screening processes – but it is ultimately their responsibility to do this.

Question 8 posed by: Sheila Barnes (Doncaster LINK Member).

Mental health and learning disabilities. With the proposed changes to commissioning of services, patient choice and “Any Qualified Provider” is any future threat to future service provision anticipated and can any preparatory actions be undertaken to ensure stability of those services?

Responses to Question 8 From:

Madeleine Keyworth (RDash)

Madeleine said that RDaSH provide mental health and learning disability service which must be paid for by elsewhere. As a provider they must ensure that these services are of a good quality, which will ensure that the commissioning groups who purchase RDaSH services continue to do so in the future. Services are continually monitored by patients, carers, Care Quality Commission etc. They welcome constructive criticism and ask that the public feed back to other patients, GPs etc so that they will continue to buy their services.

Dr Eric Kelly (Doncaster CCG)

Dr Kelly said as commissioners buy health services on behalf of the public, they must ensure that the highest quality services are provided and would encourage all patients to feed back to their GPs. Competition can help drive up the quality of services and also gives patients more choice.

Question 9 posed by: Doncaster LINK Executive Board.

Sustainability of local acute hospital services. With the prospect of “Any Qualified Provider” and possible reduction in revenue, will the services currently provided at Doncaster Royal Infirmary be sustainable and is there any possibility of the local hospital facilities being taken over by any private company?

Responses to Question 9 From:

Lynn Rothwell (DBH NHS Foundation Trust)

Lynn responded by saying many staff are asking the same thing. It is the intention to grow and develop which services they best provide. Some charities will be better at providing certain services. In the future they will work closer in partnership and with other organisations and concentrate on what they do best for a sustainable future.

Dr Eric Kelly (Doncaster CCG)

Dr Kelly stated that with regards to the Doncaster Royal Infirmary, it is important to the clinical commissioners and GPs that we have a high quality local hospital. On looking 5 to 10 years in the future, Doncaster Royal Infirmary will have a smaller base and concentrate on the things it does well. There will be links to the Voluntary Sector. The £400 million needs to be invested well in community services to give the people of Doncaster the best value and keep them well and out of hospital for as long as possible – partners such as the Voluntary Sector can help with this.

Roger Greenwood (NHS Doncaster)

Roger mentioned Centralisation Scheme – patients want to go where they will get the best treatment, he referred to the “Moving with the times” document. For example, can people be treated more locally instead of having to travel to Sheffield, as access and parking is not good there? This will be driven by the choices made by the people of Doncaster. The NHS must not lose sight of who the customer is.

Question 10 posed by: Doncaster LINK Executive Board.

Ensuring accountability and client safety. When private companies are engaged in the provision of client care in the domiciliary setting, who is responsible for standard setting, monitoring and accountability and how can that be assured?

Responses to Question 10 From:

Joan Beck (DMBC)

Joan said most providers of domiciliary care must be registered with the Care Quality Commission (CQC). Sole traders providing domiciliary care do not need to register – there is at least one of these in Doncaster. We can't only rely on the CQC – we need to ask whether providers are registered. There are national quality standards in place. Local authorities used to inspect domiciliary care providers and a better job was done back then. Things seem to change every couple of years with regards to monitoring domiciliary care. If care is provided by the local authority it is contract monitored – we are investing in this as it is very important that independent sector providers are kept on their toes. 2000 plus people in Doncaster are sampled to see what they feel about the care they are receiving. This information is shared with health colleagues. At the end of the day, it is down to the people in the community to ensure that care provided is up to standard and to report what isn't right and any potential safeguarding matters. Frequently we are complacent for people to have a really low standard of care, and don't do anything about it, we need to ask more questions and not turn a blind eye – it is our responsibility. We have national standards and contracts monitoring, but we need to take responsibility as individuals. Scotland is much further forward with this as all their workers involved in care must be registered. Care work is the fastest growing workforce in the country.

Question 11 posed by: **Brian Button (Doncaster LINK Member).**

Does Joan Beck think more or less disabled / sick people will be left without help in their home under this new assessment criteria?

Responses to Question 11 From:

Joan Beck (DMBC)

Joan responded by saying Fair Access to Care Services (FACS) is a national document – it means that everyone has the right to a Community

Care Assessment. People are categorised as low, medium, high and critical. This has been in place since 2002. Currently Doncaster is meeting all but the low level needs as these are being met in the community. Doncaster still provides for moderate needs – most other authorities only provide for high, and some only provide for critical. Doncaster is enforcing the FACS criteria and has previously been very lenient with customers, giving them the benefit if they are borderline cases. We are currently re-enforcing the FACS criteria.

Wellbeing officers are working in the community to create solutions. The biggest problem for people is isolation – they are completely self-caring, just lonely and the request for day care is common. Can the Council continue to provide this service? Other community services could be an alternative, for example, church luncheon clubs, pub quizzes etc. Transport has been identified as a problem for people to get to services. The Council has 5 members of staff looking at vulnerable groups and what community solutions are available. The solution must be a local community one. It feels good to give back to the community – i.e. voluntary services. Transport is the main problem.

Open Forum

Sheila Barnes invited questions from attendees, stating the session was not for individual / personal concerns but general questions only.

Question – If a patient living in another area wanted to have their operation in Doncaster would their transport be paid for?

Responses to Open Forum Question From:

Dr Eric Kelly (Doncaster CCG)

Dr Kelly said the public purse would not cover the transfer costs.

Lynn Rothwell (DBH NHS Foundation Trust).

Lynn stated if a GP refers a patient for an out of area operation the hospital will pick up the transfer costs.

Question – Loneliness is a problem faced by many old people. Getting to the doctor is also a problem. How would an old person get to their doctor's surgery? The heart nurses provide a good service going out to see patients. Is there any consideration for a nurse practitioner to go out to see elderly patients? This could potentially sort out issues of loneliness, medication hoarding and bed-blocking. (Dorothy Head – LINK Member).

Responses to Open Forum Question From:

Dr Eric Kelly (Doncaster CCG)

Dr Kelly said that Heart nurses (specialist community nurses) visit individual patients. Community Matrons do a similar role on a holistic level. These roles are based on health need and loneliness is not a health need. Lonely People can lead to hospital admissions so we need to find a community solution. Over £1 million each year is wasted on medicines which aren't

used. Practices have a strategy in place whereby when a repeat prescription is ordered, it is questioned whether the medication is genuinely required. They also aim to have a face-to-face meeting with the patient at least once a year to review their medication.

Madeleine Keyworth (RDash)

Madeleine stated many patients hoard medicine – they feel it will upset the doctor if they don't take it. Some pharmacists provide a medicines review service. As a community we have to report any excessive medicine hoarding. The pharmacist has to deal with returned medicines.

Question – Isolation is a problem would a visit from a health professional help eradicate that? (Dorothy Head – LINK Member).

Responses to Open Forum Question From:

Joan Beck (DMBC)

Joan responded by saying RDaSH is working closely with Doncaster Metropolitan Borough Council (DMBC) looking at pathways for patients. GPs will make one phone call to a team of health professionals who will discuss the patient to see which is the best pathway for them to follow. A patient may need support, but not necessarily acute care (hospital admission). Intensive support may be offered over a short period of time – this could be in a residential setting or in their own home. Home carers have key skills – they know their own service users and can often spot problems in the early stages. For example, a service user who becomes confused may have a bladder infection. If spotted early, this could cut down on hospital admissions. Over a 4 year programme, £4 million is to move from Health in to Social Care – this is to help cut down on people going in to hospital for acute care.

Roger Greenwood (NHS Doncaster)

Roger added that we need to reflect dignity as a whole and look at the standards of dignity and pride in Doncaster. A parish luncheon club may be the only time an elderly person sits down to eat with others. The community / society needs to stop this from happening. The current costs to the system are massive – that is why a reform is taking place. Would we have done the same things in hindsight? How more efficient can we be? We need to look at the service and redesign it. People need to become more involved and stop standing back.

Question - Literature is produced in various languages, but what about people who are deaf, as they also may have reading difficulties? (Representatives of Doncaster Deaf Action Group).

Responses to Open Forum Question From:

Roger Greenwood (NHS Doncaster)

Roger said that health education is very important, especially around obesity, alcohol, smoking issues etc. As a community we need to learn to treat things ourselves. Information needs to be produced in BSL (British sign Language) by the NHS.

Madeleine Keyworth (RDash)

Madeleine said the Trust has nurses who work with deaf patients, however, she takes the point that deaf patients need to be incorporated in the literature – an interpreter is required.

Roger Greenwood (NHS Doncaster)

Roger further stated that a document has been produced by NHS Doncaster as a commissioner – Roger will talk after this meeting to discuss improvements. He is also willing to go out to meet any groups to discuss improvements.

Joan Beck (DMBC)

Joan said DMBC have an interpretation service and have recently had a meeting with the Deaf Action Group and the Mayor and are now employing a part-time Well Being Officer to work with the Deaf Community to see how we can make services more accessible to the deaf community.

Summary

The main message which has emerged from the discussions has been the need for integration of services and community cohesion and the need to support each other. Sheila Barnes ended the meeting by stating that *'if health and social care services are not going as they should be, we need to shout up about it so things can change'*. Sheila also stated *'we also need to feed back when we are happy and getting an excellent service - let Doncaster be a flagship for excellent Health and Social Care'*.

Doncaster Local Involvement Network

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