

Future Forum Engagement Event
VONNE/Regional Voices, Sunderland 20th October

Future Forum Listener: Prof. Jimmy Steele

Also Present: Claire DH

Community & Voluntary Sector organisations represented:

Arthritis Care	North Tyneside LINK
Afasic	Parkinson's UK (NE)
Carers' Federation ICAS	Ray Brown VOLSAG
CVA Blyth Valley	Redroof Community Engagement Services
Darlington LINK	Stockton North Area Partnership Board
Groundwork NE	Streetwise
Gateshead CAB	Sunderland LINK
Living Streets	VONNE
MENCAP	
Mental Health Care	

Public Sector contributors:

Gentoo Housing Group	North Tyneside Council
Hartlepool Borough Council	Stockton Borough Council
Jobcentre Plus	

Information

The group felt that GPs were ill informed about the range of services provided by local community and voluntary groups that could support them in caring for patients. There was a view that a significant number of visits to GPs were as a result of anxiety and links with local voluntary & community organisations could be strengthened to offer alternative non-medical responses to mental distress. The group suggested that this responsibility should be shared across practice staff including receptionists, practice managers and allied health professionals. It was felt that more needed to be done in building the "practice profile" to map local voluntary & community services alongside identified needs.

The group expressed concerns in relation to information standards and how this was preventing voluntary & community groups from sharing information about their services. Implication of the standard varied considerably across GP practices, hospitals and clinics. This was considered to be a significant barrier to providing information about local VCS services. "you can't get anything into a GP's surgery or hospital ward unless it has an NHS sticker on it..."

There were still concerns that the NHS was not getting the basics right. Numerous examples of communications were cited that were inappropriate/insensitive to previously identified access requirements or just simply ineffective. There should be more use of “visual learning” and provision of information in languages in other than English. The group gave an example of how text reminders in community languages had significantly improved attendance at clinics and reduced missed appointments.

When people are required to attend hospital or clinics, there should be greater clarity about “what is going to happen to me”. Photos/pictures of waiting rooms, consulting rooms, and visual learning are important to developing clear communications and allaying fears. Middlesbrough’s work on domiciliary care/personalisation was considered to be good practice in this area.

There was support for the “patient passport” where details of medical conditions, caring responsibilities, access requirements could be stored once, and accessed by health and social care professionals. One example could be a website that patients could securely log into, to upload data about themselves that they were happy for health & social care practitioners to be able to access. It was noted that we currently supplied this information for banking and finance details – so it wouldn’t be a great shift to enable this for health information. The group expressed concerns with transfer of patient records between hospitals and health trusts. It was acknowledged that this has improved but there were still too many incidences of lost or missing records that delayed treatment.

If choice and personalisation is to be increased, then it is vital that there is significant investment to improve communications/information. This equally applies to supporting residents/patients understand and make informed choice, and professionals learning to clearly articulate choice. There were concerns that Any Qualified Provider would make service integration even harder, with more relationships & data sharing implications.

It was felt that more needed to be done to clarify what services were available where. The increase in walk-in centres, was an example quoted where pharmacies were unable to provide advice about local provision and patients were required to return home, dig out leaflets/look online if they were lucky enough to have internet access, or try their luck with NHS direct to find out what options were available to them. Effective signposting from pharmacies and other allied health professional was seen as key to improving information flows. There was broad agreement that it was difficult to find out about what was available at your GP surgery and what you needed to go somewhere else for – i.e. was there a GP with a specialism in muscular skeletal work at your local practice, do they have a diabetes clinic etc.

Information on transport options was considered to be poor and routinely out of date. It was felt that this had been compounded by reductions in support for bus routes from local government.

The group shared examples of one GP practice that had a very pro-active approach to learning from complaints – disappointingly there were also examples of where older people felt intimidated and were reluctant to complain for fear of reprisal & ongoing poor care/treatment. The work of local PALS was considered a strength and concerns were raised about how this would link with HealthWatch in secondary care. There were concerns that there would be two systems running concurrently, when the ambition for HealthWatch was a single consumer champion for wellbeing & health.

The group noted that there were not places on Health & Wellbeing Boards for Community & Voluntary sector representatives (other than the public/patient voice represented through local HealthWatch). The group felt strongly that this should be strengthened, and become mandatory.

It was felt that services should be communicated through a range of health and non-health professionals. Using Housing Association staff who regularly visit residents was quoted as one “non-traditional” way that information about health& social care could be disseminated.

Information sharing and information collection was seen as a barrier to joined up services. The fact that HES data, even in a suitably aggregated, data protection compliant form, is not readily accessible to non NHS staff and does not include housing tenure was seen as a barrier for a housing association being able to understand more about the health needs of their customers – a high percentage of whom live in areas of multiple deprivation and have a long standing illness or disability.

Educating and training of health and care professionals

Importance of multi-discipline training i.e. bringing professions together as they are being trained, community nurses, physiotherapists, General Practitioners, Social Workers, future directors of public health. Even if twice a year, students met with other professions, maybe in a community venue, hosted by a voluntary & community organization, it would be invaluable in giving students a context to their learning and a greater understanding of what happens in the “real world”.

Another suggestion was that undergraduates/trainees be offered non-medical mentors during their studies. This could be for example a trustee of a local charity, a chief executive or board member of a voluntary/community group, a director of a housing association. Their role would be to develop the understanding of the wider determinants of health and provide a local context & reality check.

The group expressed concerns about the extent to which those training to become health & social care professionals were representative of communities with the highest health needs. It was felt that more needed to be done to promote health & social care careers to those from communities with high health and wider inequalities, and support made available for those from deprived communities to succeed in their training/studies.

The group gave examples of stark differences in cultures/values of health & social care professionals and residents/patients they were working with. The importance of both empathy and compassion was stressed, and it was agreed that methods of assessing these qualities in initial recruitment and throughout training was essential. The group heard an example from Parkinsons UK (NE) who ensure that people with Parkinsons are a key part of all recruitment and decision making throughout the organisation.

There was concern that the professional role of “health education” had been significantly eroded. There is no national strategy/overarching framework for health education. There are no national occupational standards for this role, nor a competency framework by which staff can be trained/assessed. It was felt that this important area of work would be further put at risk in the transfer of public health to Local Authorities.

Improving the public’s health

There was concern that the government’s increased drive for “personal responsibility” to improve individual’s health was happening at a time when many of the programmes and support services previously in place to enable those with the highest health inequalities to make the required lifestyle changes were being removed. There was particular concern in relation to levels of physical activity – the loss of the free swims initiative for example. There was also concern that community projects that included sport and active recreation were losing financial support from Local Authorities and Primary Care Trusts as a result of cuts in public sector spend. There was evidence of sport and active recreation being given low priorities by local authorities in the North East and examples of proposals to sell off community athletics and tennis facilities.

The group considered weight management to be a top priority and noted that while considerable investment (and success) had happened in smoking cessation, there was little support for people who wanted to lose weight.

There is a culture of risk aversion across the NHS which prevents people being able to do “the thing that will be most effective” because there are procedures and protocols to be followed. The differences in needs of communities and individuals varies greatly: e.g. geography, rural deprivation, older people, parents with young children. We must give professional space to innovate and be flexible to meet the individuals’ needs, not make individuals fit round the system.

The group heard examples of how social prescribing was working in some parts of the region (e.g. Sunderland) but that take up from GPs was patchy. Many did not see this as a core part of their work – yet the group considered that a holistic approach to wellbeing & health was essential to tackle the region’s entrenched health inequalities. The group felt that there was still too much reliance on the “medical” model of care, and that this needed to change. If GPs are acting as “health advocates for patients”, this must be in the spirit Marmott and be developed as a “wellbeing & health advocate”.

There was support for building health & social care services around other public services e.g. schools, jobcentres etc. It was felt that this way you might be able to target those who traditionally don't visit GPs and often present "late" with serious health conditions.

In relation to performance of health organisations, it was considered that more needed to be done to enable informed choice and that the reality of what choice was actually available should be more clearly articulated. For many parts of the North East, choice of facility is effectively not there – the nearest facilities for many are over 75 miles away and inaccessible by public transport.

The digital divide was considered to be another area that compounded health inequalities, with those with greatest health needs often unable to access the information they need to make an informed choice about their care or treatment.

Joined up services

Real concerns in relation to short term funding, and the loss of targeted public sector deprivation funding (e.g. Neighbourhood Renewal Fund) that supported a number of community voluntary organisations. Also, restructure and clustering of PCTs makes them further from local communities and worries are that this will lead to a reduced understanding of small geographies' health needs.

There were concerns expressed at the pace of change of the coalition's health policy, and the assumption that everything that the previous administration had in place was unsuccessful. Much of the good work in service integration happens as a result of partnership working and relationships based on trust, this takes time to develop and seconds to lose. The group recognised the need to innovate and seek service improvements but urged caution in change for change's sake.

There was a strong view that the voluntary and community sector was vital point of pre-entry and post-completion of many NHS health services and this role was not clearly recognised in proposals for change. Many small scale projects make a significant improvement to people's lives and reduce reliance on NHS services.

There was a concern that the increase in competition, coupled with spending reductions, would by default lead to price winning over quality & outcomes. Examples were quoted where national contractors had won contracts for services previously delivered by grants to the third sector, e.g. A4E delivering services that the local CAB used to deliver, and then the CAB receiving an influx of people seeking help with forms that A4E have issued, but wouldn't help service users complete. Not only did the local CAB lose out on the contract, they then had extra (unplanned and non-resourced) work to do to support local people deal with the changes!

In discussions on pathways, there was a concern that many “started too late i.e. at the NHS and not in the wider community” and “finished too early i.e. on discharge from the NHS, not out into the community”. There were specific concerns that the Welfare to Work agenda was not sufficiently integrated/joined up with Health & Social Care.

Finally – recognition that actually, despite our long list of improvements – services had improved and there were some great examples of health & social care across the North East.