Changing Times: What does it mean for you?

A report of Healthwatch Shropshire's Annual Event
Tuesday 16th September 2014
Old Chapel Community Centre, Cross Houses

Introduction

Healthwatch Shropshire was delighted to welcome over 80 people to our annual event at the Old Chapel Community Centre in Cross Houses, including associate members, volunteers, members of the public and representatives of statutory, voluntary and community organisations.

The event aimed to address the current changes to health and social care in Shropshire and what the impact of these changes will be. It was intended to spread awareness and help people's understanding of how and why decisions are made about health and social care services.

Speakers' presentations

The first section of the afternoon consisted of brief presentations from the speakers about changes in their area of work.

Councillor Karen Calder, Shropshire Council: Health & Wellbeing Board

The Health and Wellbeing Board has a number of statutory responsibilities including the development of a health and wellbeing strategy, commissioning health services and holding health care providers to account. Healthwatch Shropshire has a seat on the Board.

More information can be found here:
https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=217

Dr Bill Gowans, Shropshire Clinical Commissioning Group: NHS FutureFit

NHS FutureFit is working towards improving acute and community hospital services in Shropshire. It is focussing primarily on the hospital services provided by Shrewsbury & Telford Hospital NHS Trust and Shropshire Community Health NHS Trust. Healthwatch Shropshire is represented on the Programme Board as well as on the various workstreams.

More information can be found here: http://www.nhsfuturefit.co.uk/

Kerrie Allward, Shropshire Council/Shropshire Clinical Commissioning Group: Better Care Fund

The Better Care Fund aims to transform integrated health and social care. It consists of a local single pooled budget to incentivise the NHS and local government to work more closely together.

More information about the Fund in Shropshire can be found here: https://shropshire.gov.uk/committee-services/documents/s3946/3%20Better%20Care%20Fund%20Report.pdf

Stephen Chandler, Shropshire Council: The Care Act

The Care Act 2014 has reformed the way care and support will be delivered. It has created a single, modern law that makes it clear what kind of care people should expect. It includes a standard minimum eligibility threshold and a cap on individuals' financial contribution to care.

More information about the Act can be found here: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

Question & Answer session

Jim Hawkins from BBC Radio Shropshire did an excellent job of hosting and facilitating the interesting and lively question and answer session which followed the presentations.

The following is a summary of the questions and answers. It is the most accurate representation that we are able to provide from the recordings available. Healthwatch Shropshire can not be held liable for any errors.

Q1. My concern is the assumption that GPs are going to be integrated into the changes to the health service despite being overloaded already.

Dr Gowans: Primary care has to be part of the mix; it's the major care provider. One of the reasons they are snowed under is that the system isn't working properly and when you feel snowed under, you become disenchanted and resistant to change. There needs to be a conversation that persuades you that it needs to be changed and the problem is that it takes energy. There will come a point where change is necessary. Finally, GP commissioning is changing and the CCGs [Clinical Commissioning Groups] are being asked if they want to, in the first instance, co-commission GP services with NHS England. That will give them leverage to change. There's also a new GP federation that's just been formed which, from a business perspective, brings together the majority of the Shropshire and Telford practices. The federation will try and represent the interests of practices as a unit rather than 66 separate ones.

Q2. The phrase 'community resilience', what exactly does it mean?

Cllr Calder: My interpretation is that it's about personal responsibility. It's having that conversation about taking responsibility for yourself, for your health, for your actions. Community resilience is asking communities to be more responsible for themselves. People who make the wrong choices will still be taken care of. We're not going to change people's minds overnight, this is a long term solution.

Jim Hawkins: It's all very well saying to people you need to take responsibility for your health, and then they don't. Where does that leave us?

Cllr Calder: In the same position we are now and the system is teetering isn't it?

Jim Hawkins: So how do we stop it teetering? How do we make it work reliably?

Cllr Calder: Where we can make the change and make the difference is with our younger people.

Q3. How can Stephen Chandler feel that it is the right decision to move elderly, vulnerable people away from their home and family to somewhere miles away where they don't know anyone, just because of financial reasons?

Stephen Chandler: In considering moving someone we look at the individual and we look at the factors that you've described. We look at how easy it will be to retain those networks. But if, at the end of the day, we believe that we can meet that person's needs, which is our legal responsibility, in a way that still maintains the quality of life then we do that. It doesn't happen very often but it does happen. That's because as a local authority we only have a finite amount of resources and we have to make sure that we're using those resources as effectively as we can. It's a very difficult and emotional subject. At best, we do this work with little disruption. We appreciate the impact that a move has.

Q4. You said there's lots of new things in the Dementia Strategy for Shropshire. I didn't spot many and I'm not aware that there's anything dramatic to address the needs of people with dementia to live well.

Kerrie Allward: I'm not an expert on the dementia strategy. I can provide information in detail about what's in the dementia strategy and what it is that we're looking to do. Was there something in particular that you were looking for?

Questioner: I'd like to see more funding put into early diagnosis and support.

Stephen Chandler: We will not deliver more of the same with less money. So you will have heard Dr Gowans, Cllr Calder, Kerrie Allward and me talking about the transformation that's needed. GPs are not going to be able to manage with an increased amount of work unless we, all of us, the local authority, you as a patient, GPs themselves, all consider what change is possible in order to ensure that the needs people have can be met. So what we've got to do, and a resilient community will do this, is provide signposting, information, advice, networks where people can find out the answers that enable them to resolve those problems.

Dr Gowans: The issue that GPs have is that there's an assumption that when you make a diagnosis you automatically refer somebody to a memory clinic. Memory services cannot sustain the numbers involved and there's evidence that only a certain proportion require specialist services. Secondly, dementia is a long term condition and if long term conditions are managed in fundamentally different ways, you have a bedrock of care that's community based and does make a difference, upon which you can build specific dementia services.

Q5. Will Minor Injuries Units be open 24/7 under NHS FutureFit and will they have x-ray?

Dr Gowans: Basic diagnostic facilities will be available in urgent care centres. A core offer will include plain x-ray and ultrasound. They will be open a minimum of 16 hours but if it's only open 16 hours there will be people on site to make sure that you get triaged if you turn up and you need to go somewhere else for urgent care. You'll be transferred as part of the urgent care network and you may be sent to the emergency centre. It is conceivable that there will be other services open 24/7 but the networking of urgent care is the key issue.

Jim Hawkins: So people who haven't got an urgent problem will go to the emergency centre. Isn't that exactly the type of problem you're trying to iron out?

Dr Gowans: No because triage will be done clinically and if you don't need emergency centre care you won't be sent there. For example you could be

diverted to GP out of hours services if they still operate separately. If they don't operate separately you will have the availability of a GP 24 hours a day thus providing a 24 hour service.

Q6. When is mental health going to have the same consideration and discussion around services in Shropshire?

Cllr Calder: It is an ongoing discussion and one of our priorities. We've got a paper coming next month to the Health and Wellbeing Board looking at the IAPT service (Improving Access to Psychological Therapies) and is there another way that we can deliver services at a lower level. When somebody goes to a GP surgery and it's going to take some time to get an appointment with the IAPT service so the GP prescribes, there's got to be a better way of doing it. Again we come back to looking at what we've got within our communities already, including in the voluntary sector.

Dr Gowans: Mental health services are intimately involved in NHS FutureFit so the representatives from various levels of mental health care have been at our meetings. If we have one emergency centre there should be a mental health assessment unit co-located with it. With regard to urgent care centres there is a clamour from the mental health services to position their community mental health teams in the same unit and to learn to work together. What we all know is that if we went back 40 or 50 years we wouldn't have set up mental health services separately from physical health services.

Jim Hawkins: What about crisis teams? What about paediatric mental health?

Dr Gowans: There has been a big move to reduce the number of mental health beds and in its place put crisis teams or the equivalent into the community to avoid admission. Back to the same issue: the bedrock of care that's available as a resource to the crisis team is limited and they have only a few beds to admit people in to. They need to be integrated into the remainder of care. So keep them but actually integrate them into the broader team. Paediatrics is a particular issue. The bottom line is it's under resourced and we have a big problem with transition care for going from childhood to adulthood. Currently one of the reasons for that is the CAMHS service [Child & Adolescent Mental Health Service] is not connected to the rest of the system and has been subject to a major overhaul in an attempt to make it work better and be more efficient. We are not there yet.

Jim Hawkins: People between 16 and 18 years old, at the moment they don't have anywhere to go?

Dr Gowans: Correct and that needs to be fixed.

Q7. NHS FutureFit suggests that wherever possible patients should be discharged and that follow up support and care should be provided at home. Is there sufficient investment in social care for this approach to work?

Stephen Chandler: Kerrie Allward talked about some of the work that's being done around integrated services which helps people get out of hospital but provides them with support in their own home for a period of time. We've had less funding in the local authority, like every other local authority, so we've been transforming the way we support people. Where there's an alternative way of supporting people which doesn't have such a high demand on resources we use that way. This means that for people who do need a higher financial level of support it's available. We are working very closely with the NHS, both the CCG and the Community Trust, to make best use of the pound.

Q8. Has the panel addressed the fact that in the future carers who are 60 plus are still going to be in work?

Stephen Chandler: The Care Bill does talk very clearly about the responsibilities to carers in supporting them to remain able to be employed. That's a very good thing in relation to the carer who wants to remain in work. It is a challenge for us in how we're going to fund the bit that the carer was doing.

Kerrie Allward: When we're planning and transforming services, it's an issue we are aware of and it will be factored into our plans.

Q9. Quite a lot's been mentioned today about resilient communities and the role of the voluntary sector, particularly around preventative services. We

can't continue to do that with less money. Any redesign has to think about how the voluntary sector can be adequately resourced if the expectation is it will pick up a lot more.

Stephen Chandler: I agree completely. The return that we get from the work that carers do is phenomenal. Behind that is the return that we get from the voluntary sector and the work they do. Every pound that we invest in the voluntary sector goes so much further than some of the traditional models. So it is about how we can redesign the offer that the voluntary sector does, with the voluntary sector at the heart of that.

Dr Gowans: We all know that because of, whatever you want to call it, austerity or possibly even some choices we've made around taxation, we are all struggling to fund and provide the services that we all think are needed. We can go so far by trying to reorganise systems, we can try and relieve people who are submerged and help empower them to think differently and work differently, we can change the relationships that we have with each other so that we feel that we're working together and not against each other. However, at the end of the day, will that be enough to satisfy us all? The decision making process is going to be difficult, we will not fix this in anything less than 5 to 10 years and we may need a change in government policy to do it. So one of the reasons I want to have good relationships with all of you is so that you can help us make these really hard decisions.

Cllr Calder: I just wanted to reemphasise the value that we place on the voluntary sector. That is illustrated by the fact that they have a seat on our [Health and Wellbeing] Board. We have confidence in what the voluntary sector's delivering at the moment and their capacity, ability and commitment and I don't think we should ever underestimate that.

Q10. Could Stephen Chandler say a bit more about how he sees this new relationship with the voluntary sector working?

Stephen Chandler: There are really good examples of where that relationship I've described is already working. There are examples right across the county where the voluntary sector is embedded as the centre point of communities. They're the place communities know that they can go to get answers. They're also the organisation that will say to us "We know you're doing things differently. We can do some of what you've been doing historically because we are confident to do that. Wouldn't that allow you then to free up your resources so that you can ensure that they're focused on meeting the needs of some of the more complex individuals that perhaps in the past may have had to wait a longer." There are

other parts of the county where the relationship with the voluntary sector isn't so rubust.

Q11. When are health and social care going to define the 'communities of Shropshire' and how are they going to work with them?

Stephen Chandler: Communities can be anything from a few people to large geographical areas. Communities are based upon individuals, interests and priorities, so are many different things. The challenge is not trying to find one size that fits all.

Jim Hawkins: How do I know if my community's resilient or not?

Stephen Chandler: If something challenges you in your life, do you know where to go and is it local? Perhaps you're becoming less mobile. Perhaps you're feeling a little bit isolated and lonely, perhaps you need some advice. Do you know where to go in your local community or do you feel that the only place you can go to get that help is either the GP surgery or I'd better ring the Council. There could be a resilient community around you, but because you're not aware of it, it's not resilient for you.

Cllr Calder: Heather Rodenhurst [Shropshire Libraries] is part of a work programme to expand what libraries do. Libraries are there in our communities. In Oswestry we went to a meeting last year about prescribing for health. You've got GPs who, rather than just giving a pill out, would say go and read this book. Libraries are points of contact for many people.

Heather Rodenhurst: I'm new in post as one of the leads for the library service for health and wellbeing. If you haven't been in your local library for a long time then there's an awful lot more you can access there than just borrowing a book. You can get information. If you can't access information, for instance online, libraries can help you.

Q12. How are you going to transfer best practice to other areas of the county, in particular Market Drayton?

Stephen Chandler: We have spent the last year testing approaches in different parts of the county. We started in Church Stretton. We went to Monkmoor, Oswestry and Wem. We wanted to make sure that we would find the different ways that would work in the various different areas. One of the problems we've had in the past is the public sector tends to apply one size. We will be getting to Market Drayton in the same way that we'll be getting to know Bridgnorth and Ludlow to explore the most apropriate models. I haven't got the timetable for Market Drayton.

Dr Gowans: My view of the fundamentals of change and the development of community resilience is about attitudes and relationships. That is what leads to responsibility. You don't wag a finger and tell people to be responsible. You empower them to be responsible. You actually stop being patronising as a professional and give people the power to change themselves.

Q13. Will there will be fewer NHS services and will people have to buy their own services unless they have very limited means?

Dr Gowans: There is no intention to change the concept of care delivered free at the point of delivery. There is an argument that people don't value things that are free but you can change attitudes and relationships so that people do value things that are given freely. There will be no reduction and there is no plan to introduce charging or any sort of limited service. Subsequent legislation could change that but that's not in our gift and nor is it in our domain to try and do that.

Q14. Dr Gowans was saying earlier that buildings didn't matter. They do matter because people have got to be able to get to the services that are offered from them. The clinical model says that the Emergency Centre must be co-located with Maternity & Children's Units and those have just been moved from Shrewsbury to Telford. Are you seriously considering moving them back again and unravelling that work, or is it likely that, however informally, a

decision has already been made that Royal Shrewsbury Hospital will close down?

Dr Gowans: The co-location that you describe is around the safest and most efficient, highest quality provision of services. The brief we were given was to start with a blank sheet. We know that political expediency, expense and all the other factors will need to come into the process once we begin to formalise the design. You said that buildings don't matter and misrepresented me by saying that. The clinical design process will take into account all of the competing interests. There will be a solution but I'm not going to get drawn into ultimate conclusions around conspiracy theories that decisions have already been made.

Questioner: You'll be aware, as a clinician, of the research that shows a link between the distance travelled to A&E and higher numbers of people dying. If we have a single Emergency Centre there may well be gains for some people in terms of more specialist care but there will be losses for other people in terms of death.

Dr Gowans: What you're describing has some truth but only if you put it in the context of the call to treatment time, not call to arriving at the door. There is an independent variable which says that if you go above 45 minutes for some conditions and an hour for another that there is an increase in mortality. But the main correspondence is the time to treatment and a prime example of that is stroke. Stroke, for people eligible, is the time to thrombolysis treatment on the ward not the time it takes to get somebody from an ambulance to the hospital. The second element of this is we need excellent relationships across the county because we have really tough decisions to make and the decision to have one Emergency Department and where to site it will need to be made for the common good and not the particular good.

Q15. Given that there is a drive from the Government to save money, my concern is that's what is driving the changes. Can we have faith in you that where you find areas where you cannot proceed without putting care at risk you will say so and refer that back to Councillors and politicians?

Dr Gowans: Personally if I think something is dangerous then I want the world to know and I don't want to be part of a service that is clinically unsafe. Money isn't the major driver. It's a big driver but the main driver for change here is that current services are unsustainable. Not because of money but because of workforce. Although money is linked to that, the quality of the services provided are more affected by the problems in workforce than they are by the lack of funding.

Jim Hawkins: What are the problems in workforce?

Dr Gowans: They are multiple. Recruitment and retention of clinical staff is becoming a major issue. There are some areas of absolute crisis. The recruitment of A&E Consultants is reaching a tipping point due to retirement; this is a national problem not just in Shropshire. The recruitment of acute physicians into the acute medical specialities is not far behind as well as GPs. The part time workforce dominates and the historic full time vocational training or care delivery is no longer a model that is relevant to us. A second concern is that GPs feel browbeaten. So do A&E Consultants. There are also managed more closely. They are less in charge of their own destiny and they feel less free to make clinically good decisions. That is one of the major areas that needs complete overall.

Cllr Calder: There's only a limited pool of nurses to recruit from and if you recruit for the acute sector, you're taking away probably from the private sector, your nursing homes and that then gives you a problem there. It's not just about finding nurses or doctors. One of the things that really made us all sit up and take notice was the Francis Report. The Health and Wellbeing Board receives assurances that we are compliant, that we have oversight of the services that our residents are receiving are safe. We also have our Scrutiny Committee, whose role is highlighted in the Francis Report, which plays an active role. Absolutely we would be shouting loud if we thought that services weren't safe.

Jim Hawkins: As the only politician on the panel, can you feed back to other politicians, can you feed back to party or government hierarchy?

Cllr Calder: If we thought that there was a case to do that we would. We have regular meetings with our MPs and I would be knocking on their door very loudly saying "We need help with this".

Q16. How can the Health and Wellbeing Board deal with the low staff morale which has been building up for a long time?

Stephen Chandler: The work and the role that social workers and nurses undertake has changed phenomenally over the years. One of the things we've done in the last 18 months is take away care management activities to allow the social worker to get back to doing that social work activity that they were trained in. We've done that by taking away lots of the bureaucracy. We're constantly looking at ways in which the practitioner can have their job made easier. If you were to walk into the Integrated Community Services team you would feel a real buzz because people are doing work that they believe has a real difference and a real impact. The NHS and the local authority are constantly being berated for things that we've got wrong. The trouble is the small few that get it wrong often have a disproportionate impact on the majority who get it right. We all have a responsibility to promote the positive work that professional staff do when they get it right.

Dr Gowans: Clinicians feel disempowered just as much as patients do. That disempowerment leads to disenchantment, loss of morale and all the other things you're describing. One of the aims of NHS FutureFit and the Health and Wellbeing Board, working in an integrated way, is to empower staff equally with empowering patients. It will take a while because, as you say, it's been eroded over 15 to 20 years.

Q17. Where can people go for independent, accurate and quality advice about the options that are available to them?

Carole Hall (Chair of Healthwatch Shropshire): People can call Healthwatch. We have an excellent former NHS librarian on our staff who is brilliant at providing a signposting service.

Stephen Chandler: There are lots of other organisations too that help people and can provide independent advice such as Taking Part and AgeUK. Also, if you disagree with the Council's decision you have the right to complain and if you're still unhappy you have the right to go the Local Government Ombudsman. I would encourage people not to go to the Ombudsman as the first line but to try and use some of those other resources to resolve or to get that advice.

Carole Hall: If someone doesn't want to ring Healthwatch, the public library service is an important resource.

Nicola Hawes (Wace Morgan Solicitors): Solicitors for the Elderly is a national organisation set up to provide additional, legal support to the public. There are many members of Solicitors for the Elderly in Shropshire.

Dr Gowans: We live in a world where there's too much information not too little. It's about accessing the correct information that's personalised. Simply setting up

more information provision in an indiscriminate way is not the answer. Part of the empowerment of patients is through care planning which should be done at the time of diagnosis, not when crisis intervenes. Part of care planning is knowing what to do when something goes wrong and who to call when you need help. Advocacy needs to be redesigned and renewed for the modern world. We live in a world of independence and valuing our freedom but we often need help and somebody to trust. There are levels of advocacy that need to be embedded in society from a casual "What do you think?" and 'my neighbour knows better than me', through to statutory authorities. These can link to your doctor's surgery.

Acknowledgements

We would like to thank our volunteers who collected and recorded people's questions, as well as those who helped us set up the event and pack up. We are grateful to the speakers for helping deliver this opportunity to the public, as well as to Jim Hawkins for his skilful hosting and facilitation of the question and answer session. We would like to thank members of the audience who asked questions. The answers given are a starting point in raising awareness of the people of Shropshire of the changes to health and social care services that will be coming.

Get in Touch!

01743 237884

enquiries@healthwatchshropshire.co.uk

www.healthwatchshropshire.co.uk

Healthwatch Shropshire
4 The Creative Quarter, Shrewsbury Business Park,
Shrewsbury, Shropshire. SY2 6LG

Follow us on Twitter @HWShropshire

Search on Facebook for: HealthwatchShropshire