

**LINK Stewardship Group**  
**Thursday 22<sup>nd</sup> September 2011 6.00 – 8.30 pm**  
**Large Conference Room HQ Building**

<b>Attendees:</b>	<b>Apologies:</b>
Chris Boote (Chair)	Lois Lloyd
Barry Lucas (Vice Chair)	Gennifer Gomez
Geoff Marks	Carol Rose (left early)
Dot Throssell	Joe Dunn (Vice Chair)
Peter Woodley	Karen Morse (Host Team)
Sue Kelley	
John Miskelly	
Sally Parker (Patient & Public Involvement lead)	
Amanda Plunkett (Sentinel Board member)	
Vicky Shipway (Host Team)	
Christine Breckell (Minutes)	

<b><u>Agenda Item</u></b>	<b><u>Action</u></b>
<p><b><u>Welcome and Introductions from Chair</u></b>            CB welcomed everyone to the meeting, and in view of the amount of business on the agenda began running through the minutes of the previous meeting.</p> <p><b><u>Minutes of last meeting and matters arising</u></b>            The following amendments were requested to the minutes:            Page 3 paragraph 5 re: the re-definition of 'Never Events' at the hospital. BL informed the group that the 6th event recorded <u>would</u> have been included under the previous recording system.</p> <p><b><u>Matters Arising:</u></b></p> <ul style="list-style-type: none"> <li>- Page 3: <u>HealthWatch development</u> - CMc had provided a response from the local authority to the funding consultation, to be considered by the SG as an agenda item later in the meeting.</li> <li>- Pages 5-6 <u>Cardiac nurse recruitment</u> – at the last meeting JD was to collect further information on this subject; as he has been unable to attend, this subject will be raised at the next meeting. DT expressed concern at the drive to reduce hospital beds as both the hospital and home treatment teams are both working at maximum capacity, and there is uncertainty about the capacity of care in the community to pick up reductions in hospital care.</li> <li>- Page 6: <u>Stroke unit at Mount Gould</u> – A briefing giving more information has been sent to the stewardship group to explain the situation, but the impact of the changes is unknown.</li> <li>- AOB: <u>Problems contacting social services</u> – this had been raised at the LINK Liaison meeting, and more information was going to be obtained from the steward concerned for CMc to investigate further. A general discussion took place amongst the stewards</li> </ul>	

about the length of time one is left on hold, that a response varies depending on the options you choose and the fact that there is only an answer-phone message at evenings and weekends. The group agreed that access should be 24/7. It was suggested that the number and options be tested.

- AOB: Complaint – this had now been concluded and the recommendations made are an agenda item.

The minutes were then accepted as an accurate record of the meeting – proposed by DT, seconded by CR.

### **Urgent agenda items from stewards**

No urgent items were raised.

CB then welcomed SP and AP and invited them to speak to the group about the plans Sentinel has to involve patients and public in making healthcare decisions. SP explained her role in working with the PCT commissioners to enable the GP consortia to take over the function of commissioning services in 2013.

### **Sentinel plans to involve patients and public in making healthcare decisions**

SK informed SP that the entire presentation was not accessible to anyone with vision impairment, particularly white writing on a coloured background, and there was too much information on each slide. SP thanked SK for the guidance, and informed her that the format would be changed.

SP then began the presentation by explaining the 5 elements to be considered in commissioning a service: patient experience, clinical effectiveness, value for money, safety of services, and mandatory requirements.

SP then explained the principles to be followed when involving the public in commissioning decisions:

- People are partners with the health service.
- The public must be made to understand when things are compulsory.
- Information needs to be accessible and easy to take in, to maximise effectiveness: professionals must realise that not everyone has access to the internet, or can process written information easily. There must be several different formats.
- People need to know and see the influence they have made upon decisions.
- Public input is of benefit to those being involved, so that it is rewarding to participate.
- It is vital to provide good communication – there must be demonstrations of how decisions are reached, to enable the NHS and its partners to take action as part of the decision making process.
- The systems set in place for participation must be strong, robust and easily understood.
- The system must be vibrant and continuous, involving dialogue to know what works for the public and patients.

The important message for the public is ‘No decision about you without you’.

The decision making process used by Sentinel was then defined:

- Assessing needs
- Deciding priorities
- Designing tools to meet needs
- Accessing service providers and involving patients and the public
- Review needs and see if anything needs changing.

SP explained that Sentinel is very keen on diversity, and are eager to explore different

SP

approaches to access different points of view, such as art. Sentinel also recognises that commissioners are not necessarily the best people to talk to minority groups directly, and therefore plans to involve groups with established relationships with minority groups to gather their views.

The possible level of public and patient involvement was then explained, with patient representatives sitting on the Board, a patient experience review group, patient representatives on steering groups, and support being provided to them at all levels to enable them to be effectively involved. A wide range of mechanisms and communication methods will be provided to allow diverse needs to be accommodated.

The plan is for the process to be phased in over a 3 year period, with the focus in Year 1 being on consultation with Sentinel's partners, development of an effective infrastructure to support the new organisation, the formal arrangements with partner organisations for partnership working e.g. expense payment procedures, provision of interpreters etc., and a continuous dialogue with partner organisations.

Having finished the presentation, SP asked for any questions to be referred to AP, as an established Sentinel board member.

AP confirmed that the clinical commissioning group in charge of community services must be a statutory body under new healthcare arrangements.

AP was unable to confirm which services are being commissioned by the clinical commissioning group and which are not, but explained the benefits of the new system of getting health professionals to work together. The Referral Management Centre has been set up to assess the needs of a patient and the venue where treatment can be given most effectively. Consultants are beginning to sit in the Referral Management Centre, and suggest the best healthcare pathway for patients, which is effective in ensuring that the most serious cases are given priority in arranging consultant appointments and referring patients back to their GP where appropriate.

Plymouth City Council is also working in partnership with Sentinel, which will result in 'joined-up' healthcare, with social services, the hospital and Sentinel working together and considering money and cost in terms of pathways other than health or social care. Stewards asked if locally commissioned services would be nationally commissioned in future. AP replied that some specialist services e.g. cancer treatment may be regionally commissioned due to cost and some regional services will be prescribed by the government.

GM described the funding arrangements and associated difficulties for the Derriford Learning Disability group (currently financed by 3 funding sources) and asked if this would change to a regionally funded service. AP was unable to answer, but promised to supply the information to LINK. CB added that he thought that service users would be involved.

The NHS commissioning board will be responsible for commissioning primary care services (such as doctors and dentists), and will have a special commissioning group to commission regional services. The clinical commissioning group will commission everything else, including the hospital.

CB pointed out the failure of the vision that local care centres would provide all services under one roof because various health services would not work together. AP acknowledged this, but countered it by saying that staff and services which will be impacted by the changes will be involved in a partnership approach to avoid this.

JM commented that it would be vital from the outset for Sentinel to manage public expectations in its strategy to describe the service changes to prevent disappointment and disillusionment. JM foresaw problems if Sentinel asked the public what it wants as it will be very likely that the wishes of the public will be incompatible with what is possible.

DT applauded the plans for health and social care providers to work closely together, but

AP

raised 2 points:

1. Social services and health service computer systems are currently incompatible
2. Health services provide care at the point of need, whereas social services provide care based on financial assessment with a cost attached – how can these systems be made compatible?

AP answered that the national computer system has been dropped in favour of local systems being adopted, and that care package strategies are being worked on at the moment. Wider service meetings are now taking place with care service providers, but as yet nothing definite has been decided.

SK raised the following concerns about the new commissioning structure:

- How are territorial thoughts by agencies going to be managed to ensure they are effective.
- How the sizes of groups going to be managed
- How are the less articulate going to be actively engaged, instead of being overwhelmed by the more articulate members of the group
- How are lay people going to be effectively engaged

AP replied that change was going to take time to overcome resistance to change by some individuals within the health care system – this was already evident by the engagement of some consultants with the changes already in progress.

The plan for the other issues is to ensure that the right people are in the room to make decisions immediately, rather than hold general meetings.

SK asked how people with multiple needs will be treated as a whole person in order to see a consultant – JM commented that at a meeting he had recently attended that needs were assessed by a pyramid system which will ensure that multiple needs are covered.

SP said that the size of groups would be managed, and that a 'buddy' system could be used to support people to be engaged at meetings.

Due to time constraints, VS suggested at this point that any further questions be given to CAB outside of the meeting to be forwarded on to Sentinel for a response. VS will email all further queries to Sentinel, who will respond within 7 weeks to allow responses to be given to the stewards at the November stewardship group meeting, together with further information about care pathways.

SP and AP were thanked for their input and left the meeting.

VS

### **Stewards response to the consultation on HealthWatch funding options**

#### **Q 1. Is Option 1 or Option 2 preferred?**

VS had prepared flip charts showing the current funding for LINK and projected funding for HealthWatch depending on whether Option 1 or Option 2 is adopted.

Currently LINK receives £122,400 funding to carry out its existing functions. The added functions of advising, influencing and signposting are to be added.

VS suggested inviting PALS and ICAS to attend a future meeting to discuss the way forward, and cost implications.

VS

Option 1		Option 2	
Funding based on adult population numbers	£115,000	Funding based on social needs of local people	£142,000
None of the funding is ring fenced.			

CB informed the group that an Option 3 was discussed at national level, which includes people over 64, which Option 1 and Option 2 do not, but the Department of Health had

decided not. to offer it for consideration.

PW expressed the concern that if HealthWatch was centralised, then funding would be uniform. As it is, different regional councils will have different funding preferences.

CB pointed out that the LINK budget allocation had not been severely cut by Plymouth City Council, which had not been the case in other areas of the country.

JM commented that if a different funding allocation is made by regional areas and the over 64's are not considered in Plymouth, the city will lose out. However, the stewards wished to note that they believe Option 3 should known and be considered.

CB spoke about the current contract for advocacy services expiring in April 2013, and the need for local authorities to commission the services from that date. As the geographic areas covered by current regional advocacy services will get smaller as local services are commissioned; this will result in greater cost as economies of scale are reduced. The government has provided some extra funds to facilitate the changes. VS pointed out that the local authority may choose to pull all advocacies together and existing local advocacy groups such as the Highbury trust could be commissioned to offer a greater remit.

Stewards' answer: After discussion the stewards agreed that Option 2 was the preferred option, as it provided better funding to address the social needs of the city, and fits in better with the demographic for Plymouth.

#### Q2. Should there be a minimum fund allocation and should that be £20,000?

CB pointed out that there is a huge difference in the size of individual LINKs, and asked whether Plymouth should contribute to maintaining a minimum cost for smaller HealthWatch organisations in smaller areas. A minimum allocation for smaller LINKs is taken from other LINKs and is the equivalent of approximately £1000 for Plymouth. GM pointed out that the set up charges for all HealthWatch groups are going to be the same, and that size will be immaterial in that. SK asked whether Plymouth can afford to give away a sum of money, however small, as the over 64's will already be subsidised from Plymouth's budget. VS asked whether the money would be needed to set up brand new groups, or could be used instead to enhance groups which already exist. She also pointed out that groups such as the Isles of Scilly have high expenses, as representatives may need to use a helicopter to reach the mainland to attend meetings with outside agencies.

SK asked if the allocation will be reviewed according to changes in demographics, and if so, when would this occur. JM replied that as the money is to be phased in over a 3 year period, papers he had read have indicated that any review would take place after that time.

Stewards' answer: The group agreed that the answer should be yes, but only if the money is ring fenced so that HealthWatch received this entire amount and small HealthWatch organisations do indeed receive the £20,000 allocation.

#### Q.3 Any alternative suggestions to allocating funding.

Stewards' answer: Recommend that the formula including the over 64's be considered.

Complaints advocacy funding options were then considered.

Option 1		Option 2	
Funding based on adult population numbers	£46,191	Funding based on social needs of local people	£45,510
None of the funding is ring fenced.			

VS told the group that she had asked about the costs for PALS and ICAS, but had not

<p>received a reply yet. SK explained the existing charging scale for advocacy. JM said that the group needed to choose Option 2 for consistency, but ask for the money to be ring-fenced, and for Option 3 to be considered. CB expressed the concern that the increase in signposting people to agencies will increase the demand for advocacy services. BL asked what will happen to out of area people who ask for referrals – CB replied that we would signpost them to their own HealthWatch for assistance.</p> <p><u>Stewards' answer:</u> Option 2 is chosen for consistency, but the group ask for Option 3 to be considered.</p>	
<p><b><u>Review of work plan and priorities</u></b></p> <p>Due to time pressures, the review of the work plan was deferred until the next meeting.</p>	
<p><b><u>Current issues for consideration</u></b></p> <p>Two issues had arisen which the group needed to consider as a priority.</p> <ul style="list-style-type: none"> <li>- Primary care estates consultation – plans for primary care estates have been sent to LINK and VS has asked NHS Plymouth to report back on the action plan, so that LINK can monitor the situation. CB asked if a steward would take responsibility to oversee this and make sure that the actions were carried out – GM volunteered. VS will liaise with GM.</li> <li>- Response requested from Stewards about proposals for car parking at Derriford. A proposal has been put forward to charge blue badge holders. Various charging options were offered for consideration. SK pointed out that allocation of blue badges is not means tested and could therefore be unfair. JM suggested contacting PADAN for their comments, and after discussion the consensus of the group was that concessions might be more useful in the form of extra time being allowed to badge holders, rather than financial. Several members of the group suggested asking for more information before making a response, but BL informed them that the decision is being made within the next fortnight.</li> </ul> <p>The stewards were concerned about whether concessions will continue for regular users e.g. oncology patients. A suggestion was made that pay on exit machines be installed, for people to pay for what time they use; however SK pointed out that people with mobility problems have difficulty in using these machines. BL gave an explanation to the group that the bids for the parking tenders were based upon charging disabled badge users for parking.</p> <p>Since such a short time scale had been allowed to make a response, VS is to ask what current consultations have been conducted, as the email from Derriford mentioned information which was 2 years old being used to inform their decision. The hospital response to VS will be circulated to the stewards and the views of the group will then be collated and forwarded to the hospital.</p>	<p>VS</p> <p>VS/CAB</p>
<p><b><u>Complaint</u></b></p> <p>VS informed the stewards that the complaint procedure has now been completed and signed off by those concerned, and circulated a list of that were identified in the outcome letter. The recommendations on a review of a number of procedures.</p> <p>CB asked for a sub-group to lead on looking at the recommendations, since both he and VS had been a part of the original complaint. CB requested that he and VS also be a part of the group as well. It was agreed that BL would be chair, with JM and SK representing the stewards.</p> <p>BL and PW raised issues and serious concerns about the level of detail in the document. There were concerns that the details of the complaint were not shared. Without this information it was felt that the recommendations were not useful. VS recognised that details of the complaint have not been shared due to confidentiality, which some members of the group challenged. The group are aware that the complainant has</p>	<p>BL/JM/SK</p>

discussed the complaint with some members of the group. VS revealed that a complaints process is confidential and by sharing the detail, she would be acting against company procedures.

SK asked if a brief outline of the circumstances could be provided to give a context to the recommendations. VS agreed to look at the list again and try to put some context to the recommendations.

BL and PW asked about the independence of the investigation and handling of the complaint, and were reassured by VS, CB and JM that it was handled fairly and thoroughly, and Colebrook's procedures reflected those of other organisations.

The group also asked where the recommendations had come from and whether they had been agreed by the complainant. The recommendations came from areas raised during the investigation, from the complainant, the investigating manager, and also from VS and CB during the process.

The group looked at the recommendations and JM asked VS for confirmation that the complaint was signed off, which she gave. JM raised that the focus should be on reviewing LINK procedures to make sure they are robust and fit for purpose and that the group should not be confused by the recommendations listed but consider areas it feels are relevant.

BL voiced his concern at how the complaint had been dealt with before it reached Colebrook Housing Society level and CB agreed that it could have been more appropriately, although the complainant had not spoken to him or VS since the stewardship group meeting when the change in meeting times was agreed by the group.

The meeting was then concluded.

**Next meeting: Tuesday 18<sup>th</sup> October 1.30 – 4.30 pm**

**Steve Waite to speak re: new provider update and public involvement strategy.**

VS

