



Working
together for a
stronger NHS

NHS
Listening Exercise

Pause, Listen, Reflect, Improve

Your details	
Name	
Organisation	Plymouth Local Involvement Network (LINK)
Organisation type: e.g. individual, Trust, patient organisation etc	public/patient organisation
Email	info@plymouth-link.co.uk
Telephone	01752 202407
In which region are you based? (South East, South West, London, East of England, East Midlands, West Midlands, Yorks & Humber, North West, North East)	South West

CHOICE AND COMPETITION

How can we best ensure that competition and patient choice drives NHS improvement?

We are interested in your views on this area, including:

1. Which are the types of services where choice of provider is most likely to improve quality?	<p>Plymouth LINK has received much feedback about difficulties in getting a service from primary care providers and would recommend that improving choice should begin here. Often, as the gatekeepers to further services and follow-up, GPs are the first point of contact. Many people who have contacted Plymouth LINK have not been able to register at a surgery they would like, or are unable to find a new GP or find that they cannot remain with a trusted GP due to a house move. Removing GP boundaries will allow patients to exercise choice and control and highlight the professionals who offer a better service – patients will vote with their feet.</p> <p>Introducing choice in providers will improve competition and with it quality and a focus on meeting patients' needs/customer care.</p> <p>Choice of provider should also be available where patients are travelling out of area for specialist services. This is especially important where patients are away from home due to feedback we have received that raises concerns about the impact on families and carers when a patient is treated out of area. The impact may be financial or even prevent patients from having people to support them. Choice would allow people options which can consider transport, parking, and who they know in that area, which will improve the patient's experience of treatment and quality.</p> <p>The logical priorities must be for services that can be delivered by a broad range of suppliers, i.e. only brain surgeons can perform</p>
--	---

	<p>intricate brain surgery, whereas in the case of frequent changes of a wound dressing, then the skill required is less intense and thus in theory service providers should find it easier to meet the demand. Thus those demands which can currently, in theory, be dealt with by more than one source should be the priority.</p> <p>It might be unlikely for a patient in hospital to choose a different setting for tests, but choice may also reflect the practitioner as well. Patients should have the right to choose who performs tests, scans, measurements, etc. Plymouth LINK has received feedback from different cultural communities that a certain gender of professional has been requested and not available. Women often prefer women doctors and staff who are trained in working with learning disabilities may be the choice of patients with learning disabilities. Through feedback, the main challenges would seem to be lack of compatible systems for different service providers, and lack of understanding of other services. We are always surprised that even in one of our health trusts that services are not aware of each other. Services need a universal system that holds records on local people that can be accessed by all. Services also need to update knowledge of other services locally and the directory previously mentioned could help this. Joined up services requires a change in culture and should form part of a services contract, monitoring and registration to ensure a proactive approach.</p> <p>Unless choice is written into the legislation, it will be difficult to enforce organisations to uphold the principles and hold them to account. Basic requirements should support a patient to choose the service they want and for that service to receive the patient where possible. Legislation should also expect services to make reasonable adjustments to be accessible to local people. (info etc.).</p>
<p>2. What is the best way to ensure a level playing field between the different kinds of provider who could be involved?</p>	<p>Plymouth LINK is aware locally that different providers offer different levels of service, which vary in terms of how patient centred the service is. A provider fitness test for NHS services will help to ensure consistency. Based on LINK feedback, the criteria should focus on the accessibility of the service, how well it caters for the needs of potential patients, staff training in equality and diversity and patient focus, continual evaluation of patient experience and service response to patient feedback, monitoring of diversity of patients using the service and how the service meets the needs of the demographics of different patients/local area.</p> <p>Every provider should be subject to and able to evidence that they are fit for purpose, strategically relevant and offer a patient centred service. In the Third sector, all sizes of organisations are subject to the same funding constraints, quality assurance and monitoring. This should also apply to providers of health and social care. An "any willing provider" directory should be established, as this will encourage providers to be competitive and offer a good service.</p>

	<p>Currently most people are aware of the reputation and effectiveness of various hospitals, consultants etc through word of mouth and the experiences of others. No system will ever totally replace this as people will always talk about extremes of experience. Other than that the current bar for most people is travel. Whilst the reputation of one particular hospital etc might be far better than others, if individuals cannot see how they and their families can get to the hospital it will remain an option they cannot and will not access. Thus wherever possible service provision needs to be geographically widespread, as many people would probably prefer to wait and be seen locally, than travel many miles just to be seen sooner.</p> <p>In order to encourage GP consortia to commission choices for patients, they need a clear picture of existing services (what is working well or not, including a picture of the area they are commissioning within/numbers, demographics, needs of local populations). Identifying new services to commission needs to be supported by patient/local feedback which can be provided by local HealthWatch.</p> <p>Feedback should come directly from patients using/recently used the services being considered. An overall picture can be gained from local HealthWatch and complaints/PALS can offer insight as well. As a matter of course services should ask patients to evaluate their services and questions about choice could form part of that evaluation, supporting a picture for GP commissioners. Plymouth LINK highlights that people are often unaware of what to do when they do not receive a good service. It is a service's responsibility to promote routes for PALS/complaints/ HealthWatch and check that patients are happy with their service and that they have received choice. This information should then go back to GP consortia/ Health and Wellbeing Boards/Commissioning Board to inform future provision. Patients who are able to voice their lack of choice should be offered choice.</p>
<p>3. What else can be done to make patient choice a reality?</p>	<p>See also above answers.</p> <p>Plymouth LINK supports the opportunity to extend as much choice as possible to patients. Most illnesses have a wide range of options for treatment (self-management, medication, holistic, invasive, alternative) and patients should be made aware of the range of options, even where they step outside the medical model, for example, we are aware of the success of local acupuncture services for pregnant women at the hospital.</p> <p>Feedback to Plymouth LINK shows that people are not always able to get the service they would like, for reasons such as location, access, information or just not knowing what is available. There seem to be barriers to choice and control. Giving people choice and control needs to try to remove these barriers, which needs to start</p>

before first contact with a service. Personalised care will require individual involvement in their treatment pathway at every stage and will have a significant impact on resources.

Discussions in Plymouth LINK about Choose and Book and specialised commissioning have highlighted possible inequalities where people have to travel to access a service. For people on a low income, travelling to a provider or being visited by family to support their treatment or recovery will be difficult. This impacts on a need to go out of area for a specialist service but also limits choice for people where the choice may require travel. In these circumstances, the process will not be a fair one; subsidising travel/accommodation or paying for families on low incomes may help to address this.

Plymouth LINK is receiving increasing feedback about mental health services, with lack of information about what is available and how you can access it a key issue. Improving choice of mental health service provider will be determined by the information available to inform choice. As a possible future role for LINKs (as HealthWatch) an information point will play a key role to achieving this. Feedback also highlights issues returning to services and availability of mental health services. Improved choice will allow patients to re-access services after discharge and work with those services that offer a more patient-centred approach. This in turn will put added pressure on some services.

Patients often tell the LINK that they worry about whether complaining will affect the treatment they receive. Patients are loyal to services if they have been helpful in the past and fear the consequences of making waves. If information about options are regularly available at admission, appointments, in discussions, etc., and discussed with patients, it will help to create an environment where choice is possible. This will have big implications for healthcare staff and how they embrace and promote this principle. Services need to work together (on compatible systems for a central database) to share information and allow a seamless transition between services. Care managers will need to access services from health and social care which, from feedback, are often at odds about funding. Staff will need training and support to facilitate this new way of working, as well as information sharing. Feedback often highlights that health professionals are unaware of what other services are available and the directory which will enable emergency services to allow choice could be shared across all services.

Staff training in Equality & Diversity issues should be mandatory for all working in health and social care, to improve awareness of possible issues. Assessment, treatment and care planning should include discussion of patients' individual needs on this area and the impact on further healthcare. Information should be formatted to meet the needs of the patient (languages, audio, etc.). Patient needs

	<p>should then be communicated to all services involved. Plymouth LINK has received quite a lot of feedback about difficulties accessing health services, despite the legal requirements of services under equal opportunities legislation.</p> <p>Patients need information and reassurance about their right to choice and control. Our contact with different communities shows that the accessibility of information, services, staff approach are key barriers for people for whom English is not their first language, asylum seekers and refugees for instance. Feedback from older people highlights an attitude that they need permission to speak out and don't want to make a fuss. A consistent and positive response to people making a choice will support them to make them again. The community and voluntary sector need to work more closely with health services in order to support choice and control for the people they work with. As opportunities and developments in health services occur this should be communicated to the wider community and voluntary sector as a matter of course. Commissioners should discuss organisations offering roles in supporting healthcare choices in the new system and the potential impact on service provision and on funding to support the community and voluntary sector to do this.</p> <p>Based on issues that have come to Plymouth LINK, time spent sharing the same information with different healthcare professionals at different stages of treatment is a cost issue and accessibility of travelling to services will also rise if people are to have more choice. New IT systems and patient records that can be easily shared/travel with the patient will support the first point. Increased costs for travelling will require varying budgets but improvements may see savings which can be used in this area.</p>
--	--

PUBLIC ACCOUNTABILITY AND PATIENT INVOLVEMENT

How can we make the NHS properly accountable to the public, and make sure that patient involvement is at the heart of its decision making?

We are interested in your views on this area, including:

<p>4. How can we ensure commissioning decisions are made transparent to the public, and that commissioning consortia engage fully with patients, carers and communities?</p>	<p>Commissioning decisions can be transparent through open communication via the established networks and media in the local area. GP consortia need a robust communication strategy to involve and communicate with people on an ongoing basis - including needs analysis, commissioning intentions, how they work, outcome of involvement and how commissioning decisions have worked out.</p> <p>In order to engage as fully as possible, GP consortia need to show commitment to involvement which can be done via:</p> <p>* a strong presence on GP boards or decision-making groups</p>
--	---

	<p>within the consortia - not a token seat, but a strong presence with voting rights/a say;</p> <p>* comprehensive mapping of patient groups, communities, carers, etc. and contact with those groups. GP consortia need to develop a working protocol on how, when and why they will engage and who will be responsible.</p>
<p>5. How can we best ensure that the NHS commissioning budget, held by the new NHS Commissioning Board, is allocated transparently and used with proper accountability to the public at local level, and Parliament at a national level?</p>	<p>See also answer to question 4.</p> <p>Clear communication from the NHS Commissioning Board to Health & Wellbeing Boards who then have responsibility for spreading information wider into the local area.</p> <p>A patient seat at the NHS Commissioning Board could be from HealthWatch England.</p>
<p>6. Are we doing enough to make sure the NHS at local level has the freedom it needs to take locally-based decisions?</p>	<p>Feedback to Plymouth LINK highlights the importance and need for improved partnership working and pathways through services (both health and adult social care). Discussions at Health and Wellbeing Boards with partners across trusts and a strong patient voice will allow for valuable discussion of service and commissioning needs of a city/area. These discussions could ensure that priorities for budgets (both public health and other) take a wider perspective and help to ensure a patient's journey through the healthcare system is improved.</p> <p>It should be mandatory for local authorities to provide or commission all services which will need flexibility to respond to local needs. Local authorities will, however, need to work with GP commissioners, health providers, HealthWatch and others to ensure that commissioning works in partnership. There needs to be accountability. This could be to Health & Wellbeing Boards, where needs assessment (including those relating to public health) are developed. Patient and public transparency and involvement in monitoring use of grants will add assurance to local people that there is some accountability (either via Health & Wellbeing Boards and HealthWatch involvement or another route).</p>

CLINICAL ADVICE AND LEADERSHIP

How can we ensure that advice and leadership from NHS staff themselves on improving services and tackling patient needs are at the heart of the health service?

We are interested in your views on this area, including:

7. What early action is	No response
-------------------------	-------------

<p>being taken in your area to improve quality of services through clinically-led commissioning? What is working well?</p>	
<p>8. How can commissioning consortia best engage and take on views from across the range of health professions in taking their commissioning decisions?</p>	<p>If the consultation process is handled properly, all stakeholders will have their input.</p> <p>Consulting health professionals should be twofold:</p> <ol style="list-style-type: none"> 1) on an ongoing basis through feedback and network channels a seat at decision-making groups/boards; 2) as needed in response to specific decision making. In this case health professionals (alongside patients, carers, etc.) should be involved in identifying issues, feeding into plans and monitoring the outcomes. <p>Not all health professionals will want/need to be involved in all commissioning decisions, but it should be good practice to identify who is affected/all stakeholders/staff, services, patients, etc., how to communicate with those affected and begin the consultation process at the earliest opportunity.</p>
<p>9. What more could we do to ensure that commissioners collaborate to join up services to fit around the lives of patients and carers, and the particular circumstances of certain conditions?</p>	<p>Plymouth LINK has strongly advocated for improved partnership working between health and social care services. Integrated services should begin with commissioning and commissioners should have regular contact with each other, especially for health and social care commissioning plans. Consultation and decision making should happen in partnership with health, social care, patients and services.</p>

<p>EDUCATION AND TRAINING</p>	
<p><i>How can we make sure that NHS staff in the future have the right skills to meet changing patient needs? Are the arrangements we have proposed for education and training the best ones to ensure this?</i></p>	
<p>We are interested in your views on this area, including:</p>	
<p>10. Will the proposed changes to the education and training system support the aims of the modernisation process?</p>	<p>No response</p>
<p>11. How can health</p>	<p>Work force development for health professionals needs to be a</p>

<p>professionals themselves take greater ownership of the education and training of their own professions, whilst meeting the needs of healthcare employers?</p>	<p>balance between clinical knowledge, legal requirements and also developing a culture/ethos that best serves the patients. Plymouth LINK is starting to inform some of the training of health professionals based on the issues raised by people in the city.</p> <p>It is a fundamental requirement for health professionals to have awareness of the cultural, communication and diverse needs of its local population.</p> <p>Patient involvement in professional training is a powerful tool and is important to illustrate the patients' experience. Staff should also have awareness of good practice in patient involvement to embed feedback and continuous improvement.</p>
<p>12. How can we ensure that the values of the NHS are placed at the heart of our education and training arrangements?</p>	<p>See above answer.</p>
<p>13. How can we best combine local and national knowledge and expertise to improve staff training and education?</p>	<p>Where possible use patients within training to highlight personal experiences of treatment and pathways.</p>

OTHER FEEDBACK

Is there any other feedback you'd like to give us?

Please send your responses via email to:

nhsfutureforum@dh.gsi.gov.uk

or via post to:

**NHS Modernisation Listening Exercise
Room 605, Richmond House
79 Whitehall
London
SW1A 2NS**

There are more chances to have your say with events running in every part of the country over the next two months. This will give people a chance to get involved – from specific events for NHS staff, to others involved with the NHS, and those already involved in making change.

Comments should be received by **31st May 2011**. However, the NHS Future Forum would be grateful to receive responses as early as possible so that they these can help shape their initial advice to the Prime Minister, Deputy Prime Minister and the Secretary of State for Health by the end of May.

Summary of the Listening Exercise

The comments you submit in response to the NHS Listening Exercise will be considered as part of the extensive period of listening, reflecting and improving led by the NHS Future Forum. The Forum's first task will be to report to the Prime Minister, the Deputy Prime Minister and the Secretary of State for Health on what they have heard.

Confidentiality of Information

1. We manage the information you provide in response to these engagement questions in accordance with the Department of Health's Information Charter.
2. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
3. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
4. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.