



Tuesday 6th November 2007

Notes from Bristol Workshops

Workshop 1

The group was chaired and scribed by Phil Morgan from The Care Forum .The representative from the Bristol PCT was Mark Woodcock.

Q. I would like to ask a question about health inequalities. The prospectus sets very wide and quantitative targets and I am worried that there is the danger of the preventative agenda being submerged by the treatment and care path to produce short term results. If you are about effecting sustainable change in for example teenage conception rates, then one must influence any number of psychosocial elements.

MW. Have you any suggestions about how we could deliver a more effective service?

Comment:

Monitoring conception rates are not good enough, they do not get to the crux about why this happens. There are a number of organizations who are working with young people about the causes. You need to work with community based groups who work with families and young people. The education of young men and contraception for example.

Q. Strokes- Those of us who are working in this field find it difficult to deliver the stats that the PCT are demanding. The emotional support that we give is recognized as being vital to the recovery of stroke victims both in terms of time and level of recovery but these things are difficult to measure. It would be useful to have these debates with PCT to develop monitoring that works for everybody and some recognition of this sort of work. The current focus is very much on what happens in the acute phase of the stroke. I would also echo what has been said, that the demands of the system to achieve targets actually works against that aim. What is not particularly useful is bald facts and figures.

A. What we would be useful is that if you recognize shortfalls –let us know what they are, this level of detail is important to us so that we can use it to frame the future direction of cash.

Q. I am shocked that Mental Health is not right at the top of your agenda. Reports from GP,s are that they are swamped. This is an area that the VCS can help with and has great expertise in . The social model of mental health has a vital part to play in community work and in general preventative work.

Q. I work in South Bristol – we have lost beds and 16 nurses which has resulted in us having to send patients to London which costs huge amounts of money and has detrimental effects on the patients themselves.

A. Firstly I hope that GP's have this conversation with us. I would hope that there can be some flexibility within the £50 million budget to manage the system better.. Secondly I have to say that I am surprised that the out of area placements are still happening. Also Health Scrutiny is looking at mental health this month.

Q.(Bristol Mind) It is now officially recognized that depression and anxiety are now the top ailments. I am worried about the way services are being commissioned- there is an assumption that there is only one way of doing things. The sector are still perceived as the amateurs because the commissioning criteria are dominated by the medical model. For example the CAMS services are not being commissioned openly and intelligently, Bristol Mind have not been approached at all about it. As usual the VCS will get the crumbs and will not be considered for the main stream services.

A. I recognize that is easier to look at the bigger established services.

Comment : Again this is the myth that the VCS are small and incapable of running major services . there are many examples where this happens. In children's services you only have to look at Barnardos and NCH . In learning difficulties, Mencap and so on. The Federation of Voluntary Providers in Southwark is a model of small VCS organizations running a wide range of community services within an umbrella organization. Some Housing associations have turnovers which would dwarf the PCT budgets. We can do it.

Comment (WRVS) I agree. If you look at the targets for the reduction of people who go into care homes there are any number of successful VCS schemes throughout the country. Are you looking at any of these when formulating your prospectus?

A. I doubt it . but I would be interested to hear from you we do need to look at imaginative ideas. Please get in touch. The 49 targets are already resourced in terms of money but the way that they are going to be delivered is yet to be decided.

We have some concerns about some of the targets for example the 2 hour target may well be counter productive and encourage people to go to A&E rather than to their GP's.

Comment ; This may have something to do with the fact that some people find their GP's difficult to access. Some appear to be a law unto themselves. Maybe we should be considering why people access the services they do and those they do not. It is time we thought of hard to access services rather than hard to reach groups/ people

A. The position on with GP'S can be difficult because of their contractual relationship with the NHS.

Q. (Age Concern) I feel that there is a great deal of scope for working together. For example on falls prevention access to foot care and health inequalities. However my question is how do we feed our information/proposals into the framework.

A. The key is to know the right person. That is to say the commissioning lead. Contact them, they will be glad to hear from you.

Care Forum- We did a who's who a little while ago but no doubt some of the information will have changed. Could you let us have an up-to-date list to put on our website?

A. Yes.

Comment; (Bristol Mind) I am quite cynical. I personally put in a huge amount off my unpaid time into things like the LIT CSIP and am consistent in the things that I talk about but I just see Commissioner making the same mistakes carrying on commissioning the same old services largely. There appear to be no sanctions against the service providers or the commissioners. This would not happen with the VCS. If they fail to meet the terms of their service level agreement they cease to have a contract. The PCT must challenge better and use the power that they have.

A. This is something that the PCT is working on. Historically the accountability has been upward and we are trying to alter this.

Comment Services will only seriously improve by a more joined up approach between the sectors.

Phil drew the workshop to a close and thanked everyone for their contribution.

Notes workshop 2

Workshop with Stephen Boardman, Strategic Development Manager, Bristol PCT

Q. The consultation document should have been sent out much earlier. It is long and difficult to absorb.

Disabled people are not included in their own right.

A. PCT staff looked at the number of disabled people and how their needs are met. Our data is not good. We have started a new piece of work to look at this.

Q Are you saying that staff are not consulting with disabled people – they won't get it right unless they do.

It would save money and time if you involved disabled people and organisations.

Should consult with disabled people before producing the document.

Old and disabled people are at the bottom of the heap.

A. Christina Grey in the PCT is taking this work forward.

Q PCT board agreed to the document. They would have undertaken an impact for equalities. I can't accept this

The NHS needs to look at the community as consumers.

Q North Bristol Trust and C difficile – we will say it is not safe to use unless there are proper plans for improvement.

What about Standards for Better Health?

You are commissioning what you believe the community wants not what they do want.

Q Where is NHS Annual Patient survey – there is no information for us to decide where to go for treatment. What about local needs assessment?

A There will be a report to board mid November on C difficile. It will be on the website. Standards for Better health is on the website.

The needs assessment will be picked up in the submission to the Strategic Health Authority on 30 November – it will be published and it will provide evidence of what the PCT is doing.

Q There is a difference between information and consultation. This feels like information. There is very little about unpaid family carers. Acute care is moving into community – this will put pressure on carers. Loss of beds will also put pressure on carers

If you don't support carers you could find you have dual hospital admissions – with carers needing treatment as well.

Q Point 34 on page 17 refers to a reduction in care home placements. Again if you are doing this you must support unpaid carers. You need to support carers in your strategy.

Q I would challenge Bristol Council re provision for home care. If you discharge to unpaid carers you need to ensure they get support from services.
We need more joining up of services

A I think we have made a mistake in the language used in this document. The vast majority of services will be for older, disabled people. The first section is on coronary heart disease – and most people are 65+. We have just not used the words 'older people'.

Q. You have to provide care in the community systems in advance of these changes to make sure people can be looked after.

Q Pt 46 is '100% of older people with mental health needs should be accessing services'. In order to do this you have got to identify people with mental health needs. What are your plans for identifying these people.

Q Incidents of depression amongst unpaid family carers are high.

Q Point 36 refers to people who are at risk of admission – from when?

A From time of assessment, - within next 12 months.

Q There are insufficient assessments currently how are you working to get joint assessments?

Q. Joint commissioning has got nowhere . There has been little progress in Bristol council working with the PCT. It is different from South Glos where for example there is a joint HIV Strategy

In this document there is no mention of sexual health or HIV. It appears only in the context of teenage pregnancy because this is a government target – HIV isn't.

Sexual health services are appalling

A We are under pressure from government to hit sexual health targets.

Q Consultation in Bristol is always very short – we are given these papers just to rubber stamp them – nothing changes. There is limited money for social care and the voluntary sector provides most of those services.

Q What does the PCT see as the role of the voluntary sector?

A We have not mentioned the voluntary sector as provider in this document. But we will use the contestability framework as a way of changing service provision and innovating. Currently tendering for Children and Adolescent Mental Health Services – looking to third sector providers to provide services. Other than that we will commission from voluntary sector as before eg commissioning specific services such as stroke services in the voluntary sector.

Q Why are mental health plans concentrated on older people (points 46,47)

A Demography, increasing numbers of older people

Q But it completely leaves out younger people with mental health issues.

Q Voluntary sector services are not mentioned as a percentage of spending.

Voluntary and community sector and carers save PCT millions. But we don't see investment from the PCT. You have to support if you are going to extend home care.

Q Where do we get information on contestability framework?

Not everyone has access to internet.

Q. If you decommission services are there possibilities for the voluntary sector?

In prospectus you should identify plans for any decommissioning clearly.

Q The biggest problem is reaching people on health. The contact between NHS establishment and the customer is a problem.

A We have got to be more consumer focussed. We will collect more information on the patient experience.

Q There needs to be more emphasis on early intervention and preventative work. You should consult with the voluntary sector to find more about needs. Voluntary sector organisations reach people and know about needs. They understand overlapping issues.

Prevention pays - it is just difficult to measure.

Q. The voluntary sector covers areas the PCT doesn't cover. The voluntary sector can provide information.

A Katharine Hall from PCT is collating patient experience feedback and information – we are doing a big patient feedback survey.

Q Why haven't you heard of carers, disabled people, the voluntary sector. I worry that you are agreeing with everything people say. What are the barriers then and how will they be taken down?

A I'm saying the language was wrong using the medical model.

Q You are saying by cardiovascular you meant older people and disabled people

A. Our proposals are to improve outcomes, decrease health inequality. I accept that we haven't evidenced it well.

Q I don't think that the views of disabled people have been taken into account or that you have listened to them.

Q the response from the PCT on carers has been that this is GPs responsibility

A PCT has limited control over GPs.

Q GPs must have carers register. If GPs not providing proper service - get rid of them.

Q Carers register is part of GP contract but is very low on the list and doesn't attract much money so it is voluntary for GPs. What do they do with it once they have got it? There needs to be a service behind the creation of the list.

Q GPs don't see that carers health often deteriorates over time so you can have two impaired people. If you put supporting carers into prospectus as an aim we can see you are trying and can support you. There are good economic reasons for this.

Q Mental health and younger people – I am concerned that this is missing.

Bristol Workshop 3.

Facilitator: Babs William, Bristol PCT, commissioning manager

Q Target 46 on access is not a preventative service. Block of money from CSR for depression and mental health. Why only two targets for depression and mental health?

A There may be national drivers under mental health in addition to stretch targets.

Q Nothing on physical activity for mental health patients.

A The physical activity targets cover the whole population including people with mental health problems.

Q Access to counselling should be a big part of prospectus.

Q How has the link between health and housing been followed through?

A I don't know, but the joint public health director appointment provides the link to make this happen.

Q Reference to importance of housing on health needs to be included.

- Q We are asked to pay £40 for a supporting people reference from GPs in which we always make the link between housing and health, but our small organisation cannot afford to pay so we are now refusing to pay for references and assessments cannot be completed. GPs say 'fine'. Yet we contact GPs only if there is an ongoing health problem requiring support so it is not a lot of questions and can be done over the phone. Demand for payment has increased over the past 18 months, and there is inconsistency between practices. One GP compared it to a passport application. It is not comparable.
- A We need to look into this. It may be appropriate for another health care professional to provide a reference. The PCT needs to give the VCS guidance on how to raise these kinds of issues.
- Q More to do with GP contract.
- Q My understanding is that the PCT has very little influence over GPs.
- A PCTs set practice standards and monitor them. GPs commission for local population, PCT is responsible for the quality of that commissioning. We need to improve communications between VCS and PCT.
- Q As a supported housing provider a lot of what we do is related to mental health and physical health.
- Q Someone has to pay for the reference, so need to highlight the problem through the PCT/SHA/government in order to review arrangements. A Patient Advice and Liaison Service could take it up on your behalf.
- A GPs have to comply with certain standards but they are essentially under contract to the DH.
- Q There don't seem to be natural areas of responsibility for different conditions within the OCT management structure, and within commissioning too.
- A Moving into a new world of commissioning with buying power as close to patient as possible so giving GPs buying power so that it is community based with more patient choice. Healthcare wqokes are having to acquire a new skill set for a business environment to deliver DH 'world class commissioning'.
- Q A lot of people with chronic conditions know their hospital consultants and specialists better than their GP. So it is difficult putting the money with GPs when they are not providing or close to the service provision.
- Q Have many GPs taken up the request to keep lists of patients with different conditions?
- A I would have to find out. Quality and Outcome Framework allows payments for setting up lists, then reviewing outcomes for people on the list. There are practice-based registers, e.g. for all patients who have diabetes. It would be useful for providers supporting these patients. It is not the same as the Gold Standard. It is related to the GPs salary increase issues: more GPs achieved

quality targets than the government anticipated. All GPs complete a patient satisfaction plan. They get paid to run a survey, produce an action plan and deliver the services. Perhaps we could link with the lead on diabetes with your organisations.

Q Do they get more money for gaps in services identified?

A This would come through a different commissioning route.

Q Equality of access to counselling services is our concern. Will you be investing in this?

A We are looking for more partnership working, so that we can advise you on reconfiguring services to make them more culturally appropriate, e.g. stroke patients. We cannot support them all but we can help you to provide better services for them.

Q What impact are trainers having in the community? Where is the data? They could be important gatekeepers?

Q And who are these people? This is a communication issue.

Q Can you tell us how housing issues are being addressed?

A There is a lot of work going on that is not in this document. Planning, physical and environment strand is there and ties into the targets cited. Housing is one of the ones identified for work to make closer links.

Q How do we get involved with this?

A Contact me and I will link you up.

Q The other issue is access into housing problems that lead to back pain, etc. How to get housing adapted so people can use it properly?

Q Review of adaptations being done by the Council. The PCT needs to liaise and contribute to this.

A Spatial Strategy: city council consultation running now. It talks about house building plans. It would be worth looking at it.

Q What has happened to the Falls Project which has implications for resources and plans?

A Plans to extend it if resources allow.

Q When I look at % it does not tell me what I need to know – what are the actual numbers, what are the baselines?

A Work is being done on this at the moment.

Q With regard to targets, when will there be an action plan behind them?

A For some of them, the first action will be to agree the baseline.

Q Are the targets realistic? What analysis has been done? Is it available?

A Some of it will be but I don't know when. Perhaps a joint analytical report will ne out in January. The Joint Strategic Needs Assessment draft report will be out for consultation in Jan/Feb.

Q Are you doing anything on wheelchair access and assessment?

A Not specifically.

Q In Devon there is a 72-week waiting list for wheelchair assessment, and children are not being reassessed. Things are a lot better in Bristol. Wheel chair and equipment provision is crucial.

A One of the problems is that data is not collated. Need to do more work to bring together a picture for physical disability and learning difficulties.

Q Transition is another nightmare.

A This is an issue that is recognised by the PCT and the Council.

Q Funding is also an issue for longer living patients.

A We recognise this.

Q Why is nothing on CAMHS in the prospectus?

A Work is already going on. This prospectus is additional to what is already happening.

Q How much are you doing that is not toward a national target?

A Lots of care activity is not subject to a national target.

Q So if you have new national targets, what gets cut?

A Would have to take an informed decision, there is no rule book.

Q Is it the case that 15% of budgets are on prevention?

A Wanless Review looked at NHS activity, ageing population and disease trends and calculated that could not carry on delivering the same as now. He challenged the NHS to focus on primary and secondary prevention to reduce burdens on NHS at a later date. Btu people still get sick so finding a balance between prevention and quality of services is the issue.

Q Trying to flip around treatment to prevention but a meeting on this did not have outcomes and I don't know what is happening now.

A How we get wide stakeholder input into setting the direction of travel is an issue.

Q But 5% of the population has severe mental health problems and are using intensive services, but 75% are being neglected.

A That intelligence is vital and is why you need to be involved.

Q How do we disseminate these issues and challenges?

Q If I want to find out about plans for dementia services do I go to the Local Delivery Plan? There were NICE guidelines.

A Contact me and I can put you in touch with the lead officer.

Q Difficult when the national agenda is prevention but must not forget existing, necessary preventive services.

A They are both on the agenda.

Q Why is there not more on children and young people's needs/services?

Q Perhaps because the budget for CYP services is relatively much smaller than for the care for the elderly?