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Vale of York
Clinical Commissioning Group

Big Conversation Engagement Event

Healthwatch Assembly. Priory Street Centre, YO1 6ET.

Thursday 3 August 2-4pm

Below are the verbatim comments raised at a public and stakeholder engagement event. They are arranged thematically.

The session was led by Phil Mettam (Accountable Officer) and Dr Shaun O'Connell (Joint Medical Director- Planned Care and Prescribing)

Access to primary care

- Lots of people can't get access to their GP so people are going to A&E and are being admitted.
- My GP recommended that I go to A&E to be seen and I did attend and they referred me back to my GP
- Have experience of GP referring to A&E, then A&E referring back. A "ping-pong" effect.
- Access to GPs is getting worse; it won't be long until patients have to pay for prescriptions and denying patients operations. In future this will lead to privatisation.

Rurality and local services

- Are you suggesting that community based-care is financially better for you? Because it's better for you and it's something we all want, it's what the patients want, this should save more money.

- Is advocating care at home just because of the cost saving? Using a community MS Nurse would be one way of making a huge financial saving.

Mental Health

- As a proportion of overall budget, mental health spending has decreased.
- The percentage of budget from the 1st year on the slides to the last year has gone down, is this proportionate?
- Extra funding of mental health professionals great, but funding is coming from within the existing budget. So not net gain. Difficult for CCG to manage funding with this in mind.
- Concerned about lack of skills in improving quality of life for those with special needs. Will this be improved?
- Additional funding for Mental Health Services coming from an existing budget, how is the CCG expected to manage funds when the secretary of state is moving funds from pot to pot.
- When Archways closed, there was an attempt to join up health and social issues. Delayed by structural issues.
- A lot of problems led to poor management of the closure. Compare this to the Council's closure of elderly homes which was managed alongside the voluntary sector.
- The problem was that the closing of Archways wasn't managed, nobody knew it was happening, we all found out through the press. CYC manage closure better with consultations which was better than how the NHS handled Archways closing.

Communication, signposting and navigating the system

- Need better signposting, knowledge is power, educate on conditions, provide knowledge on what is available

- A local signposting helpline would be a great idea. Only those with local knowledge are aware of the various options/alternatives.
- Paraceteomol chart on presentation. Reason for people going to supermarket for paraceteomol is because they know it is there. Recruitment of clinicians based on signposting would be an idea.

Prevention and education

- Can we predict how demand will change with time?

Length of time spent in hospital and discharge

- If the model is the same as 5 to 10 years ago how are A&E admittances going down? surely it shows that the model is working?
- Are the instances of consultants referring onto other consultants a national problem or is it local to York?
- Will you continue to allow consultants to cross refer? This will be driving the costs up and the patient may be attending appointments unnecessarily, if you ensure that they refer back to the GP they can then apply their broader knowledge to decide the best course of action saving money on unnecessary referrals.
- Is there a link with NHS England promoting specialisation, and greater internal referrals?
- If you allow continuous cross referral, then patients don't benefit.
- If less people are attending A&E but more are admitted, does this not mean those in need are attending A&E (those who should be there)?
- Does greater A&E admission not mean failings in primary provision?
- Is it just a York situation of consultants doing large amounts of referring to other consultants?
- 50% of your budget goes to the hospital

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Voluntary services in the community

- Third sector (Age UK) rely on City of York Council (CYC)and the CCG for contracts. CCG have cut transport funding across the sector. This means extra demand can't be accommodated, and either cutting staff numbers or charging service users. Cuts given at a poor notice, and even prior to this they hadn't risen to meet rising operating costs. Happy to do as asked, but it isn't currently possible.
- Age UK and other support workers have training in case of falls and calling an ambulance wouldn't always be needed. This support has been rejected; voluntary organisations in many areas could save money.
- Trustee of Age UK: Biggest charity CYC & CCG contract to expedite patients being transferred back home but we are having funding cut , how can we pay for this care and follow this plan when you are cutting our funding, where are we going?
- You cut our budget 3 months into the year, there's been no uplift in 10 years, our costs have gone up but finding just keeps being cut. We've been saying for years about the benefits of social prescribing and you told us it couldn't be done, that you couldn't be seen to be favouring one charity over the others, now you want help?! We are annoyed and frustrated.
- Regarding your pyramid model, if you are going to stick with it, you start at the bottom, you focus your attention on the 3rd sector if you want the model to work you have to build the foundations, currently 0.17% of total budget on the voluntary sector, this isn't good enough.
- Voluntary sector needs to be clear about what it can offer, and a breakdown of what this could save (ie: fewer A&E appointments). Need to shout from the rooftops , sector currently too mostly. Localism is mostly happening due to the

work of people within it, forms the bedrock. NHS England has to be shown this evidence to influence both locally and nationally.

- MS Society – Community based care is better for us, it's difficult for us and other vulnerable patients to travel, this is the better option and should save more money.
- Trying to plan for changes in delivery but change of the kind we want we need to know that that there will be time for any changes to bed in, if this is going to work in the long term it needs the commitment.
- With the "pyramid model", work needs to start at the bottom (third sector). This is currently very small part of healthcare in York, but funding has been cut.
- Trying to change in line with demand is difficult with short termism of funding. This is how the national system operates.
- Should have MPs advocating/pushing this cause. Subtext of meeting seems to be to manage expectations.
- Collaboration of organisations puts health needs above the needs of the organisation
- We will need stronger evidence to champion at a national level.
- You are managing expectations – subtext for a system that's going to have to change, this is a political challenge, it needs to come from the top.

Quality of care and the future of the NHS

- You are already determining operations based on BMI, you are denying patients surgery.

Workforce and capacity

- Concern over patients with complex health care needs, we need to bring in the skill to help these people, there is currently no specialist care, we need to try and bring this in as quickly as possible from the north.

Technology

- Third route to respond to those who fall in their home is using technology like a fall detector.
- People with Autism may need a more visual approach for communication; there must be some options suitable for these patients to allow them to be comfortable.
- Patients with Autism with mental ill health who are written off as too much trouble – Skype would allow patient to be seen comfortably
- Older people don't always have computers and those that do may not wish to use them this way.
- I think if we were to go down this route it would need to be a robust system, not everyone has a support network, and those that don't feel comfortable having appointments through technology may be left behind and alienated. The vulnerable may become even more vulnerable, if you did this it should not be a blanket approach it should be robust and an option giving choice but not a blanket approach.
- Need to bear in mind when signposting, that not all have access to a computer. There needs to be a robust system of recognising those (with dementia for example) to safeguard them and allow face to face patients. Needs to be flexibility and choice in the appointment system.
- It would also depend on GPs and nurse practitioners really knowing their patients, which is a big thing, all GPs would have to be really familiar with patients.
- Introducing of phone or e-consultation relies on GP's and nurses knowing the circumstances and needs of their patients. Large effort would be required to familiarise with patients.
- For some groups, a different form of appointment could meet their different communication requirements (eg: visual for those on the autistic spectrum).

Have heard clearly how some of these patients are written off by clinicians as difficult to engage with. A different setting can provide reassurance and an alternative.

Waste and duplication

- People on eight paracetomol a day could save the local health economy plenty if they could buy at supermarkets, but this isn't presently allowed.
- Dr David Unwin- Winner of Innovation Award through reversing disease, and so reducing prescribing. However the benefit of this hasn't followed the patient.
- Your slides show 2 examples for headache which is emotive but not realistic if you are on 8 a day but are not permitted to buy more than 32 a day, if they need more then this isn't particularly cost effective for all patients,
- The cited examples are over simplified models, these figures will result in incorrect figures and this will eventually result in even more cuts.

Urgent Care Practitioners (UCPs) and emergency response

- In the slide showing Ambulance vs. UCP, are the Urgent care practitioners the ones based at the hospital that go out in the car?
- What is the time response of the UCP?
- In my opinion the UCPs are not fast enough, we've had to wait over 4 hours because they were in Easingwold, my husband couldn't breathe as he has emphysema.
- That slide isn't accurate, there are fast responders, and YAS will also often ring the GP
- Your slide states that the UCP will leave an instruction for carers to contact the GP the next morning, who are the carers? Who's paying for these carers? Not all patients have carers, there are many elderly patients who have no

family or support, we can't rely on patients to have support at home, and we don't want patients being left alone at risk.

- There is an obvious 3rd option other than Ambulance and UCPs and that is to use technology and warden services, we should be making the most of the services on offer who can attend to patients quickly.
- Where are UCPs based and what are the response times? Have experience of a very long wait in Easingwold. Could be the difference between life and death.
- Fall example cited may be a bit misleading, before 7pm ambulances often call the GP rather than referring straight to A&E.
- What happens if people don't have carers, sending for UCPs rely on someone to report? Is hard to quantify how many people may be in this situation and what the gap in care is.
- UCPs are very qualified, but people don't fully understand their role.
- Regarding fall slides on presentation, the home from hospital service if support worker goes in and sees someone on the floor they will press the 'be independent button' who will phone for an ambulance, you need to look back, you need to look at what we all do, and then you can work out how to make savings, each sector will have worked out where you can make savings.

Finance

- Have you got to make £40 Million of savings over the upcoming 2 years? Do the Trust have an awareness of the financial situation and a contingency for this?
- Have you got to make £40 million savings in the next 2 years? Are these conversations relevant with this in mind?
- You can't believe the hospital aren't aware, they must have some contingency plans in place

- By rationing operations, this is a step towards privatisation. Future seems to be budget being balanced because services not being provided.
- What doesn't add value is the marketisation of our health service, all those private providers are taking in profits which are going into their shareholders pockets and not being reinvested back into the system
- Do you have predictions of how much costs will change or do you have to work it out?
- Models cited can be oversimplified and savings can only be made by cuts. Marketisation and money entering into the private sector does not benefit the NHS. EG: Wheelchair provision.

Importance of feedback

- Is anyone listening to these comments, is anyone writing it all down?
- Do we only get 15 minutes to speak at the end of the presentation?
- We do need the opportunity to feedback at a national level we will need this to influence local and national long term change

Other comments

- If you have someone who is overweight, then operations are safer if you lose weight (clinician). More common sense needs to be applied though to painful/urgent cases. Difficult for those who are not articulate to get a review. People are individuals not statistics.
- There needs to be more common sense applied – I've seen cases of a patient losing 5 stone before the new rules came in but struggled to lose the rest, luckily the patient fought but any other patient who perhaps wasn't as literate or capable of fighting the system will lose out.
- Suggestion by attendee for everyone to read an article in Yesterday's (2/8/17) Guardian newspaper on page 30 about Accountable Care System: Playing ball – future of joined up care.

- Let's be aware of the elephant in the room, we shouldn't have to accept this, we need a political push, get involved with our MPs.
- One attendee still waiting to response from Julian Sturdy to letter on local health.
- To help us out we all need to be speaking to our MPs, would encourage you to speak to elected members of your local council

Main themes from the engagement session:

- Voluntary sector could perform a much big role, and provide much greater efficiency. As part of the discussed "pyramid" system, this needs to be the first area of focus however resources currently allocated are insufficient.
- Third sector contracts make up very smaller part of health expenditure, too much focus on cuts here while avoiding bigger areas of cost.
- Needs to be a national movement behind this, involving MPs and other elected representatives.
- UCPs may not be fast enough at responding. Not all people have the carers to be able to stay at home.
- Appointments in other forms (phone, internet) can be a way to engage with hard to access groups such as those on the Autistic spectrum.
- However face to face appointments must still exist and clinicians will need to be more familiarised with their patients.
- Cross referrals within hospital environment excessive.
- Experiences of being bounced between GP and A&E.

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