Forest of Dean Health Forum
West Dean Centre, Bream
Tuesday 5th April– 7.00-9.00pm

Minutes

Attendees:

Albert Weager chair

Norma Smith

Barbara Jenkins

Di Martin Councillor (FoD /Cinderford TC)

Jan Baynham committee

Lynn Teague FODCAB (Minutes)

C. Smith CCG

Margy Fowler GCS

Mary Thurston Friends of Lydney Hospital

Tony Midgley " " "

Brian James " " "

Angela Davies " " "

Julia Butler (HWG)

Roy Sharma CCG

Roger James Councillor (FoDWD PC)

Don Pugh councillor (Lydney TC)

Peter Jackson FoD governor at Glos. Hosps.

Doug Battersby

Jane Macbean (Coleford HC PPG)

Judy Berry (Great Oaks)

Mary Matthews (Bream Ladies)

Eileen Elsmore (Coleford TC)

Clive Elsmore " "

Terry Hale (FoD councillor)

Peggy Jordan

Hilary Bowen (Barnwood Trust governor)

1. **Expert Panel :**

- Dr Frank Harsent - Chief Executive Glos Hospitals
- Andrew Telford - Community Services Manager -2Gether Trust
- Stephanie Bonser - Operations Manager - South West Ambulance
- Candace Plouffe - Chief Operations Officer – Glos Care Services
- Mandy Hampton - Head of capacity - Glos Care Services
- Stuart Lane - Locality Manager - Arriva Transport
- Jenny Bowker - Associate Director, Strategy and Planning - Glos CCG
- Margaret Wilcox - Commissioning Director: Adults & DASS
- Hannah Williams - Health and Social Care Commissioning Manager – CCG

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1. Welcome and Introductions

Albert welcomed members and introduced the Expert Panel. He went on to explain the focus of the meeting and that we would be inviting questions that focused on Person Centre Care inviting **Hannah Williams** to open the meeting by talking about the work going on with the End of Life Strategic Board. Hannah explained that there was a lot going on both nationally and in Gloucestershire where this was a priority. The new strategy awaiting sign off by the Board and once made public would be made public through Health Watch. Strategy to include working in a joined up way across Health and Social care including working with the Voluntary sector to shape services and ensure patients have good experience of End of Life care with the patient at the centre of all services. There are several work stream groups whom are working together to identify gaps, including Access to Palliative care, Hospice at Home Services. It was recognised that staff at all levels would need access to good education and training in order to ensure a 'good patient journey' with adequate joined up support services to enable them to 'die at home' if this was the patients choice. The goal is to develop a module for End of Life Care including support for families and carers ensuring everyone has the right to the death they would like.

What is happening in other areas?

Frank Harsent –it was recognised that society needed to break the taboo around conversations around death to work together to give people choices around the way they want to die. He acknowledged that there are currently staffing issues around palliative care and there are plans to expand in this area.

Mandy Hampton and CandacePlouffe Glos Care Services to explain how they were supporting Commissioners with focus on

- access to training for nurses
- Improving information to assist patients journey
- Providers – How will it work in the Community
- Ambition to provide a clear pathway whether in hospital or at home with adequate support liking Community Nurses, Therapists, Equipment and Social Care

Andrew Telford 2gether Trust

Talked about mental health and support services for those with dementia, learning difficulties and severe mental health issues. Agreed that services were somewhat stuck and needed to expand no links already in place with Cruise/Bereavement aftercare. Agreed needed a partnership approach with CCG.

Judy Berry Great Oaks Hospice asked about training for nurses and Health Care workers and whether staff would be released from duties in order to attend and access training.

Hospice at Home service has limited availability. Social Care is a big issue, packages of overall care not currently available. How will this be addressed.

Margaret Wilcox asked for examples and stated that National Level of Care only fund substantial and critical care. CCG were working closely with community sector and third sector on more preventative work.

It was pointed out that funding had decreased to less than a third in three years

The panel need to take into consideration situations in nursing and care homes.

- Elderly friends/no package in place
- Education for employers and employees
- Pharmacy service – access to drugs – not always available out of hours

- What's happening regarding children's services – current strategy is over 18's only, more work to be done on transitioning between children and adult services-plan to tap into work and services already being done

Dr Roy Sharma – Pathway from Patients point of view
The Chair asked for an explanation of the patient journey from the patient's point of view.
Dr Sharma explained that admission would only happen after consultation, usually only 10% of patients are sent to hospital reasons for this being twofold a)diagnosis; b)cause then assessed at hospital for further treatment or sent home. The single point of access (SPA) would be checked for availability of beds which may determine which hospital client is sent to. The SPA is based at Edward Jenner Court and staffed by clinicians with a vast clinical knowledge and linked to the Ambulance Trust. A member reported how excellent she had found this service when suffering a Deep Vein Thrombosis- as she was fast tracked through the treatment process, with appropriate transport and the cause of the clot was also looked at.

Frank Harsent went on to explain that Assessment/Diagnostics is part of Emergency Ambulatory Care. GP's are placed in A & E to triage those who self-refer. In 8 years A& E services have seen an increase of 50% in patient footfall. However once at hospital after treatment there is not transport provided to take you home.

Admission into Acute Care- is managed through the older people's liaison service – elderly are assessed by an Old Age Physician through front door access. 90% of those patients accessing A & E are discharged home after initial diagnosis and treatment. The remaining 10% are discharged into other services after their period of care in hospital, this may include home with a rehabilitation package/care package and medication. Admission into Residential home. A & E staff are not trained to decide where patients should be sent next. Joint team working with Social Care team, Community Nursing teams and complex care teams are linked in to decide patient progression. Problems with complex dementia patients.

Advances in medical care means that life expectancy has increased significantly it is likely that GRH have at least 24 patients 100+.

Stuart Lane from Arriva care explained the booking system for transport services – explaining that online booking system works best and pre-planning is key. Patients are booked time slots and Arriva have an hour window with pre-booked discharge. If the booking is made on the day this time slot expands to 4 hours this can sometimes mean patients don't go home on the day of discharge if this is later in the day as a judgement needs to be made as to whether it's suitable to send someone home late at night.

Mandy Hampton explained that community beds working together throughout the hospital trust, though effort are made to place people In their own communities sometimes lack of availability of beds sometimes means patients have to transfer between areas. The plan is to work with multi-disciplinary community teams to enable smoother transitions and adequate support in place.

There is often a delay in discharge due to waiting for pharmacy. This will be speeded up with the introduction of electronic prescribing which means Doctors can authorise drugs from any location via a handheld electronic device. Due to be introduced this year.

Jenny Bowker– CCG explained that as part of the Community Health Review they are looking at patient pathways and joined up services. Consideration being given to primary care and how this needs to change. What needs to be in place through joined up services.

Stephanie Bonser -South West Ambulance Trust. Ambulance services now fully integrated, fewer patients now end up in A & E. 60% treated in own environment, 40% admitted.

Time related illnesses –Stroke, Heart Attack, Trauma are conveyed to the hospital with most specialist clinicians.

SPA –Care pathways constantly evolving to ensure quality of care.

Team working for End of Life Care including Macmillan available Monday to Friday

SWAT is involved in the forest review looking at paramedic services recognising gaps in provision. 90% work within and are passionate about their local community and know what works well.

Reduced d/c part of 7 day working group to provide best care 7 days per week.

Cardiology will be offered in Cheltenham 7 days per week. 3 hour window to treat.

Young Persons Mental Health Services –

Young persons with challenging behaviour more effort needed to engage with carers team, escort carer relative.

A & E multi –discipline. Learning Disability Liasion nurses at GRH- medical needs assessed first

Community hospitals deal with minor injuries only. Children links with wards, District Nurses, therapist teams – speech/language, physiotherapy, occupational. Arrangement joint visits.

Andrew Telford 2gether Trust – Many areas need improvement and development. Can often be complicated due to fragility child often complex issues. Clear guidance needed so Nurse liaison role critical. A&E are great at this.

Greater emphasis on transitions from child to adult services.

Recognition that early intervention important.

Learning Disability – generally need longer term care over 50% of those in residential care from out of the County, this makes future planning more difficult as funding doesn't always follow patient. This makes it difficult for Commissioners when planning services.

CAM children's services no local beds on one occasion nearest bed was in Edinburgh. Poor services nationally in children's services, children often have to travel long distances.

Different conditions

Care is always taken with those with severely challenging behaviour to ensure appropriate methods and appropriate escort are in place when planning transport, crews are trained.

Who is Responsible for continuity of care and in charge of process upon discharge

Communication for ongoing care.

GP responsibility once patient is home Doctor Sharma explained that communications are good between hospital and GP.

Needs to be a partnership between professionals and patients.

Frank Harsent said that there is more emphasis on patients to follow up on advice following their discharge and chase appointments etc.

A member gave an example of someone who had a broken ankle and was discharged with little information and promised an appointment within a month. She chased GP after five weeks and did get access to the appropriate help.

Tony Midgley Friends of Lydney Hospital
Faster response is needed for authorisation to provide equipment and services funded by the Friends. Some improvements have been made but still significant delays in system- better communication is needed between those at consultant level and the ground.

Hilary Bowen

Problem raising specific concerns – she gets blocked when she is trying to raise general concerns rather that specific to a patient. Unable to put the question due to those at the other end wanting details of specific cases.

3 issues with Ambulance Trust

1 Health watch

Care homes/Public need education when to dial 111 or 999. People put off dialling 999 in an emergency as feel they must go through 111 leading to delays etc. Request for publicity campaign to highlight this issue.

Community Teams – Frank Harsent

Greater emphasis to be put on teams working within small populations 30,000in rural communities – Proposal for community teams to be based around GP practice. Teams to include Community Nurses, CPN, Social Care and Therapists teams.

Plan to build specialist teams to deal with chronic conditions e.g lung disease, diabetes. Changes to disease pathways . Models to be developed to support community teams to enable patients to remain in their own homes and communities

The question and answer session finished with a presentation to Frank Harsent who is retiring at the end of the month.

Albert then invited everyone to enjoy refreshments and cakes and network with each other.

2. Apologies

Linda Vaughan Forest Health Forum Committee
Jim Spiers
Farooq Ismail 2gether Trust
Chrissie Johnson

3. Future meetings:

May 3rd – Elisha Kyne British Red Cross – Elisha will give a talk on the first Aid Courses available

June - CAMHS or FSS

July – Event at Lydney Community Centre

Chairs Report to the Forest of Dean Health Forum, Tuesday April 5th. 2016

Attended the first part of the GCS Care event at the Guildhall, Gloucester, with secretary,

Linda Vaughan. (March 1st.)

Left this event early to attend a meeting of the Blood Transfusion committee at Gloucester Royal.

March 2nd part of a dementia care inspection at the Dilke Hospital. I was most impressed with the quality of care and specialist training provided and, also with the general hospital environment.

Monday March 7th part of a Patient Led Assessment of the Care Environment (PLACE) at Gloucester Royal. Our group looked at ED, external environment and out patient areas. The group was generally satisfied and reported so.

March 7th went on to Sandford EducationalCentre, Cheltenham, to attend the Venous Thromboembulism Committee (VTE).

Thereafter all activity restricted due to illness.

Albert Weager Chair