Draft
South Reading
Patient Voice Minutes

NHS South Reading Clinical Commissioning Group

Date	25th February 2015
Location	Reading Community Learning Centre
1. Introductions and Apologies Present	Carol Munt - Milman Road, Lister John MacDonald, UHC Tom Lake, Pembroke Surgery Shaheen Kausar, Chatham Street Douglas Dean, Westwood Road Surgery David Bales,, Longbarn Lane James Penn, Milman Road, Dr Lister, Laurence Napier-Peele Christopher Mott, Milman Road, Dr Kumar Martha Klein, London Street Michael Fairfax Tony Sawyer, Pembroke Ade Osgood Sofija Opacic (Visitor from Nw Reading)
Apologies	Libby Stroud, Pembroke Surgery Joan Lloyd - BMHUG sec. - Reading Mental Health Partnership Boa John Missenden, Milman Road, Dr Kumar Catherine Williams, Healthwatch

2. Hospital At Home - Kate Turner, Project Manager, Berkshire West Federation

Kate Turner had joined the Hospital At Home project 8 weeks ago. She had had experience with both acute and community care management.

Hospital at Home is a pathway using services that already exist but making sure that services are robust enough to allow patients to come home earlier or without being admitted to hospital. TS: Are social care involved? KT: They are involved when necessary. They are at the table in making sure that the pathway works robustly for the patient.

We start when the patient arrives at A&E and is deemed not to need admission but does need strong support at home. E.g. a patient with cellulitis can have IV (intra-venous) antibiotic at home if living with family or other carers etc. Alternatively the patient may be admitted to the Medical Decision Unit from A&E and then be deemed suitable for the Hospital At Home pathway or even be deemed ready for the Hospital at Home pathway after admission to the main wards of the hospital. It is then up to the patient and carers. If patient and carers choose Hospital At Home they may go home with up to 5 days of strong support.

To enable the strong level of support there is evidently a need to enhance community services

Monitoring and medical supervision are key to making this work.
TS: Does this address bed blocking? CM: Not directly, it switches in well before that. This is a scheme to ensure that patients that don't need admission or who don't need to be in hospital any longer can be treated at home.

There are distinct training needs for the community nurses who will be delivering the strong support

at home. Community nurses needed to have training with IV antibiotics.

TS: Can the GP arrange for this care - or the paramedic?
KT: In the first instance they will go to A&E and it is the A&E consultant who will decide that they are suitable for the Hospital At Home pathway.

TS: Will this include social care (which is chargeable to those that can afford it)? Someone to prepare or deliver meals.
CM: If family or social care are involved then they will see that people are fed and watered etc but if for some reason they are not involved then the Hospital at Home would arrange this - there would be no charge.

MF: The patient normally recovers better and with less risk of infection if at home.

SO: Where is the funding coming from?

KT: The funding is from existing services, but the CCG has added funding for extra posts and training.

SO: What about the GP? KT: The consultant is in charge until the patient is discharged from the Hospital At Home pathway and handed back to the GP. And there is a nominated key worker for all aspects of care.

CM: In Oxford the GP is involved.
KT: There is no one model. In some places it is very high-tech with a lot of equipment available to be placed in the home during treatment, in others not so much.

SO: I have looked at the GP contract and realised that there are many things that GPs don't do.

CM: This is a pathway that comes in when the patient is in A&E. The patient is under the supervision of a hospital consultant.

JM: What if your IV pump packs up?

KT: You or your carer would contact the Health Hub. The Health Hub has a single number and is the single point of contact for all patients on the Hospital at Home pathway. The hub will contact the key worker or the most appropriate professional to respond 24/7. Five years ago there were many points of contact for the Berkshire Healthcare Trust service (mental health and community nursing) - now there is a single Health Hub for all community services provided by BHFT with a single telephone number to access it. This is used when discharging patients from the acute hospital. A single number for all BHFT services, manned 24/7 by clinical and admin staff. This also 'leads to the mental health single point of contact. Westcall, the out-of-hours GP service is co-located with the Health Hub.

CM: You see there is little knowledge of the Health Hub among patients. LNP: Most are not aware of the global nature of the services provided by BHFT.

KT: The Health Hub is usually called by health professionals. When the patient is on the Hospital At Home pathway the paperwork has the Hospital At Home number on it. The Hospital At Home staff will decide on a response.

JP: The Royal Berks Hospital (RBH) has a bad reputation for record-keeping due to their problems with their computer system. Will this affect Hospital At Home?

KT: We are not using the RBH system - we use the AdAstra system as used by Westcall and community services - community nurses will have to update both Adastra and RIO.

MK: I understand that most patients don't use the Health Hub number themselves but that it is there as a backup for Hospital At Home patients if they need it.

SO: Does this cover mental health patients?
KT: That is up to the consultant - there are no pre-conditions and only paediatric patients (babies, children and young people under 18) are excluded.

JP: How do we review best practice from the rest of the country?
KT: We have good networks - there is some really good work there - but we cannot always replicate it because we don't have the right services in place.

CM: Cornwall is an example. Not based at A&E - the team goes out with the ambulance to the patient. Of course that is more rural. The system has to adapt to the local conditions.

TS: How many patients could we handle? KT: About 1600 per year across West Berkshire.

SO: Is this for older people? KT: Not necessarily - but not paediatric cases. Often older people need more than five days treatment and might not be suitable.

TS: Could they be end-of-life patients?
KT: They could be on this for 5 days and then back onto their palliative pathway.

LNP: Has this started?
KT: We are expecting to start in July and will be testing the pathway and building up the numbers. The patients and staff will tell us what we need to change. We want to be seeing patients flowing through it by September.

LNP: Is this being done in East Berkshire?
KT: No - and services in other areas may need to be different. We will share our learning with East Berkshire when they are ready.

CM: This has come about because the professionals have looked at the real needs of patients being admitted. Similarly dialysis at home is being looked at elsewhere.

JP: I read about use of agency nurses in Berkshire. Will you be using agency staff? Will there be a funding problem?
KT: No - we need stable, known staff at a higher grade to deliver this care and they will not be agency nurses.

CM: In other areas it has been proven to be cost effective.
CMott: This was important for the CCG.
TL: In answer to a question many months ago the cost was estimated by the CCG at £120 per day but I suspect that there was not much evidence behind this.

MK: Could you go from any hospital ward to Hospital At Home?
KT: Yes - and the patient would be handed over from their existing consultant to the Hospital At Home consultant.

SO: Will the family be asked to monitor? Report?
KT: Communication with the family is fundamental. The family or other carers will have to consent.
KT: There will be many more suitable for the pathway than capacity allows. So only those who want this will get it. The responsible consultant will be a geriatrician - either the community geriatrician based at RBH or an acute hospital consultant.

JP: Will there be a web page for the consultant to use in the virtual ward round?
KT: That is on the AdAstra system. And they will talk to the nominated key worker. And they can see the tele-monitoring outputs.

SK thanked Kate Turner for a very interesting talk. Kate Turner offered to return to the group when the pathway was up and running.

3. Beat the Street 2015, Katherine Knight, Intelligent Health Ltd.

Katherine Knight: We will be running the Beat the Street programme in Reading again this year - this time on a wider basis and we are currently planning and arrange the details.

I am from Reading, living off the Oxford Road. Intelligent Health Ltd, who provide Beat the Street, is located on the Reading University campus. Dr William Bird has designed the programme to get a whole community doing more activity.

Last year Beat the Street was funded by the two Reading CCGs. 15,000 took part. 12% had long term conditions such as diabetes, hypertension (high blood pressure) or lung disease. and their activity levels increased by 18%. RBC Public Health is also contributing this year. We are hoping this will become a 3 year programme.

The reason for running the programme is that physical activity is beneficial for 23 medical conditions, it is the single best medical treatment and is of course, very cost effective..

130 Beat Boxes were placed around Reading last year - one in the Reading museum caused a big increase in attendance and other public institutions are asking to host a Beat Box this year.

There will be 200 Beat Boxes in 2015 - and the locations in South Reading CCG area will range down to Whitley Wood and up to the Town Centre - also covering walking routes for children to school.

In 2014 the recruitment through schools was more effective than through GP practices but we are hoping that GP practices will promote the programme more this year. We are asking for all GP practices to actively take part. To run adverts on their screens. We will be writing to about 50,000 patients with long term conditions or pre-diabetics. 18,000 cards will be distributed through GP practices. The emphasis is on enjoying Reading and getting out and about. We are working with the Reading Chronicle and will have lots of banners in town. The target is to cover 500.000 miles. Every child in school will receive a parent pack. We are working closely with the health walks person for RBC (Philip Burbidge 0118 937 5192). We hope to organise walking groups based in GP practices.

There will be prizes - it is an eight week challenge - a team prize - and donation to Royal Berks Cancer Centre if we reach the target of 500,000 miles covered.

On 4th July there will be a Beat the Street street party.

Arts organisations are involved.

MK: How do these boxes work?
KK: Like an Oyster card - tap your card and it beeps and flashes. Boxes are half a mile apart and your journey from one to another is recorded if it takes less than an hour.

CM: You are dependent on the practice manager at a surgery.

TS: Why would I want to do this? Would this grip an adult?

KK: Some do it as fund-raising for their community. No one motivator - we have to feature several.

SO: It is important to bring in people with learning difficulties and mental health problems. Contact relevant organisations - e.g. Mencap, Berkshire Carers.

JP: How about a poster in the Jackson's Corner window?

Any further suggestions - contact Katherine Knight.

4. Minutes and Matters Arising

TS: Spelling problem "chkechs".

SK: It is unfortunate that we don't have a representative from Reading Healthwatch.

KS: Need to contact Mandeep because Catherine Williams - PPG lead - cannot make Wed evening meetings usually. LNP: Healthwatch are recruiting volunteers - perhaps one would attend..

CM: Need to ensure that if a volunteer attends - then they are prepared and briefed to discuss Healthwatch's reports and activities and able to take away actions.

SO: We need accuracy and depth on Healthwatch activities. Healthwatch are producing a toolkit for patient groups.

CJBM: It would have been helpful for Catherine to have been here. Catherine is taking over the work with PPGs - the detail would have been useful.

CM: The CCG spent £50,000 on Healthwatch PPG work with what outcome? They should be sending someone to our meetings.

SO: Continuity with a Healthwatch staff member is useful.

The minutes of the last meeting were approved.

Patient Engagement Christopher Mott

I wrote a short paper and hope it has been circulated (Generally - yes - SO - no).

- The PEG (Patient Engagement Group) exists for arranging and planning patient engagement events and activities and considering the outcomes. With two separate bodies for South Reading and North and West Reading it has been difficult to persuade stakeholders bodies to send a representative - especially as many of the events are actually conducted in common. As a result it has been decided to have a single body for the two Reading CCGs.

  First meeting 14th April 15.00 - 17:00pm. Chaired by NW lay board member for PPE - Wendy Bower. Alternately chaired by NW and S lay representatives.

- Concern was raised by Cathy Winfield at the South Reading CCG board that the South Reading Patient Voice did not have a clear link with the South Reading practice Patient Participation Groups (PPGs) To maintain the support of the board I think that we need to bring people in so that there is a clear link.

  We need to formalise this and put it in our constitution.

  The NW area Patient Voice is a committee of the chairs of the PPGs at the practices. We might see it as closed and hierarchical. Let's rejoice in our openness to people interested - but recognise that we need to have a closer link with PPGs.

  TS: Constitution says members are not representatives or chairs of PPGs.

  SO: What data do Healthwatch have about PPGs.

AOB

SK: Laurence Napier-Peele has resigned as vice-chair. Let's thank him for stepping up when he did and for exercising the functions of vice-chair. There will be an election at the next meeting.

Laurence also requested that our programme should be planned a year in advance - we can consider this also at the next meeting if desired.

CM: Can I report on a Good event for Thames Valley Patient Engagement at Oxford. Tony Sawyer

has written notes which have been circulated. Healthwatch arrived half way through. Patient Participation groups were keen to exchange information.

Mark Stone spelled out the challenges for patient engagement - widening representation - by age, by clinical need, by ethnicity, by affluence and deprivation.

He wanted to eliminate the postcode lottery (why - six models of PPG in Oxfordshire)

And suggested groups should get representation on decision making bodies.

SO: I am the lay representative on the Primary Care Board for West Berkshire - making policy on primary care for West Berkshire.

SO: What vision do we have for patient voice?

DD: I said to my practice manager that you have not got a statistically representative set of people on your email mailing list. Most of the cited results are of doubtful validity.

Close
The meeting closed at 8:00pm.