ROCHDALE BOROUGH COUNCIL

NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

Design Week Sessions

STARTING WELL	**2 design week Sessions plus a Children's and Young People event**
DATES:	**8 September 2015** **9 September 2015** **11 September 2015**
PRESENT:	**Jan Reynolds (Rochdale Borough Sexual health and Contraceptive Services)** **Asma Akhtar (Rochdale Solutions)** **Kelly Dawson (CVS Rochdale)** **Paula Flint (PCFT)** **Carla Wilson (Kingsway Clinic)** **Mohammed Sarwar (MAMC)** **Jane Hodgkiss (Barnardo's)** **Donna Livesey (link4life)** **Fenella Fowkes (Croft Shifa Health Centre)** **Karen Kenton (HMR CCG & RBC)** **Simon O'Hare (HMR CCG)**

General Comments:

a) Communities helping themselves
b) ' community' needs to be agreed across partners/blended and multi skills - One brand idea, single co-ordinated response including core elements in all job descriptions across all child & family services - Home start Model
c) Work with adult care – roles older people as supporters/mentors etc.
d) Current support - Family Nurse Partnership - 5 ways to wellbeing - FAST
e) Babies can't wait work' with adult services

f) attachment
g) Early intervention around maternal depression
h) Every family at tier 1 (universal early help) allocated a mentor regardless of need. Involvement dependent on need
i) Single assessment - CAF becomes a family assessment framework
j) Get rid of age restrictions within agencies
k) Remove targets that are unhelpful (e.g. children's centre reach)

New Ideas:

a) Locality hubs – adults and children, multi-disciplinary teams/ Localities defined by need - SPOE/a – a 'duty' type system. Must have people to speak too immediately who provide a response/Family co-ordinators, navigators, key workers/ Team around Family
b) Peer supporters at huge scale
c) Develop an 'expert parent programme' and use peer supporters/Mini social enterprises in communities
d) 'Generic' workforce at 'tiers 1-3' (universal & target early help)
e) Use transitional funding to test something out – core skill set & competencies (e.g. attachment, emotional & mental health), family workers. Work with an HEI to develop & provide training. Include community roles – peer supporters, community champions etc
f) Introduce REACH into general assessment practice
g) Develop concept of expert patient programme
h) Build on winter pressure clinics for minor illnesses
i) Implement full GM EYNDM
j) Co-ordination of PSE in schools and what is taught
k) Single point of access/entry – at each locality/ Access to support – not a referral, automatic support -Sign posting – for patients and professional
l) IT co-ordination to allow knowledge of the whole family to be passed between agencies

LIVING WELL	**1 Session**
DATES:	**7 September 2015**
PRESENT:	**Jenifer Connolly (RBC PH Registrar)** **Mary Chadwick (PCFT)** **Nicky Morris (RBH)** **Khalid Bashire (BME Heywood and Middleton)** **Sam Evans (HMR CCG)** **Julie Murphy (RBC)** **Mark Wynn (Rochdale Circle CIC)** **Jan Reynolds (Rochdale Borough Sexual health and Contraceptive Services)** **Tariq Khandoker (CVS Rochdale)** **Penny Strickett (Rochdale & District Mind)**

General Comments:

a) Making people more self-sufficient – encouraging independence
b) Clarity regarding responsibility for funding

New Ideas:

a) Integrated Pathways – easy access to all services

AGEING WELL	**2 Sessions**
DATES:	**7 September 2015** **9 September 2015**
PRESENT:	**Michelle Warburton (RBC PH)** **Margaret Wilson (Patient Representative)** **Margaret Whalley (Ageing Well)** **Becky Begum (Stroke Association)** **Mark Wynn (Rochdale Circle)** **Mai Wan (HMR CCG)** **Shirley Waller (link4life)** **Debbie Kinsella (Rochdale Circle CIC)** **Shirley Fisher (PCFMark Wynn (Rochdale Circle CIC)** **Michelle Warburton (CVS Rochdale)** **Nazia Rehman (Rochdale Solutions)** **Becky Begum (Stroke Association)** **Margaret Wilson (Ageing Well)** **Margaret Whalley (Ageing Well)** **Steve Taylor (PAHT)**

General Comments:

a) The key to ageing well is lifestyle
b) Too many services work in silos
c) Older people prefer the personal approach they do not favour electronic means of communication
d) Education should be about consequences of not changing as well as benefits of changing, highlight the link between lifestyle and death.

e) Messages from providers and commissioners need to be consistent, at the moment they are confusing, e.g. one minute low fat, low calorie foods are the healthy way to eat, the next it is fatty foods. It is not clear what 5 portions of fruit and veg are, do potatoes count or not?
f) Social Isolation is a major issue
g) Current system reliance on care homes – poor mixed quality support
h) Socail Housing adaptions – grab rails help in the home

New Idea

a) There should be one point of contact for all services
b) A one stop shop for all services should be developed that does not just signpost but also facilitates entry into services. This should be a person or persons not an electronic system. This will enable potential service users ask questions in a more intuitive way.
c) Whole life education from early years to old age because people can change lifestyle at any time. It is important that messages are delivered in the right way for the audience. Younger people prefer social media whereas older people prefer the personal touch.
d) There needs to a recognition that most people need to belong to a community of some sort, whether geographical or of interest. Providers and commissioners need to recognise the importance of building communities. Employ Community Development officers
e) Social isolation – knowledge of what's going on in local areas how do they find out?
f) Clubs – what can you do to help - Housing associations men in sheds walking sports activities
g) Pubs/Hairdressers – how can they help tap into private sector change in culture – link to nails as well
h) End of life – increase people's awareness of advance decisions see dignity in dying website. Enables people to say what level of life preserving intervention they want.
i) Use care line differently – safe and well checks on fire service in their new role
j) Take paracetamol of prescribing – people should buy it
k) Look at waste linked to prescription products that are unused and sent out
l) Regular carers when care needed smaller care companies that are more personal
m) Comprehensive information services eg; Circle health and wellbeing events – getting information is a minefield
n) Want a conversation about conditions not just given information
o) Social Enterprise taxi service – know the rivers not for profit
p) Self-help blood pressure readings but show people how to do it
q) Targeted proactive – managed by clinician other than GP
r) Medication support system for people to take it
s) Pharmacy technician review everyone over 65

t) Create a more united approach to volunteering
u) Lunch clubs/social isolation – but not the traditional type in people's homes or local café
v) Meets with schools – use schools to help with OAP technology
w) Neighbourhood watch for health not just crime
x) Shift from residential provision target care in the community and how all services could link to support individual
y) Development of extra care
z) Need more support for carers
aa) Podiatry in the reablement offer
bb) Social enterprise for toe cutting
cc) CIF social investment for falls prevention

NURTUING A SOCIAL MOVEMENT FOR CHANGE	**1 Session**
DATES:	**11 September 2015**
PRESENT:	**Wendy Meston, Director Public Health (presenting & Chair)** **Andrea Goodall (HME CCG)** **Mark Wynn, Director (Rochdale Circle)** **Chris Woodward, (Petrus)** **Liz Varey, (Petrus)** **Becky Begum, Stroke Association)** **Chris Larkin, Stroke Association)** **Lindsay Thompson, Manager (various services),** **Steve Blezzard, Rochdale BC)** **Andrew Fry, HMR CCG)**

General Comments:

a) The biggest issues in the borough: loneliness and isolation.
b) There was an acknowledgement that there was a miss-match between what residents expect and what we can achieve
c) The timing of messages is important - whether you absorb the message will depend upon relevance to your time/phase of life.
d) some of the most vulnerable residents in the borough and currently undertake healthy lifestyle education - the challenge is how we integrate services
e) There are also issues with regards to accessibility to services - it is confusing to professionals working in the borough, so very difficult for residents, especially those that are vulnerable.
f) There is a need to look at people's perceptions / expectations
g) The general public doesn't understand/need to understand how complex the NHS/ health system is

h) Contract structures are a major barrier - targets have changed to tariffs, but need to be incentivised to outcomes**.**

New Ideas:

a) Target services required and bring in for ease of access.
b) Use our visible champions to promote campaigns and raise awareness
c) Nurture community bottom up - look at assets, infrastructure, where is the community strong and utilise
d) Communication and marketing - stop scatter gun approach. Pick out a few issues and do them well.
e) Demand and expectations - be honest
f) Engage staff to become advocates
g) focus on change to lifestyles and behaviours
h) Very high profile champions - identify community leaders/ organisation leaders or community service users
i) Nurturing around health equalities - remove commissioning barriers (contracting/finance that force functions)
j) Consistent message throughout Greater Manchester when we are not delivering something
k) Secondary care perceptions around risk - deflecting back to Primary Care and how you turn around as a society
l) Where you build in diagnostics and diagnosis - very expensive in primary care - how do we get it right and quickly to secondary care
m) Focus on mental wellbeing is critical
n) Develop a holistic approach to Mental Health and Physical Health

WIDER PUBLIC SECTOR REFORM/5YFV NEW MODELS OF CARE	**3 Sessions**
DATES:	**7 September 2015** **9 September 2015** **10 September 2015**
PRESENT:	**Darren Grive (Link4life)** **Jan Reynolds (Rochdale Borough Sexual health and Contraceptive Services)** **Michelle Warburton (CVS Rochdale)** **Paula Jones (PCFT)** **Shirley Fisher (PCFT)** **Pat Phillips (Care UK)** **Elaine Gansler (Barnardo's)** **Nadine Armitage (PAHT)** **Steve Taylor (PAHT)** **Mark Wynn (Rochdale Circle CIC)** **Ken Brearton (Care UK)** **Adam Levy (MCEP)** **Kim Marshall (Birch Hill Hospital)** **Mark Wood (Birch Hill Hospital)** **Steve Lenehan (Care UK)** **Paula Jones (PCFT)** **Steve Lenehan (Care UK)** **Elaine Gansler (Barnardo's)**

	Nadine Armitage (PAHT)

General Comments:

a) The focus should be at the start with the hospital activity being at the end point. Focus particularly on pre-pregnancy, schools to develop the heath of the population.
b) Need to look after our most vulnerable citizens better such as homeless, refuges, asylum seekers.
c) The Living well model has some good potential It could be particularly effective with Children and Young People.
d) There is a requirement to develop a cultural/behavioural change from cradle to the grave
e) Instead of a "one size fits all" change to "the suit is able to be tailored to fit this individual".
f) The Third sector offer good work and value for money - if we work together we can achieve more.
g) Health should be lower down the list of the priorities - if we focus on the contributory factors to ill health such as employment, housing, education etc. and prevention, there will be less impact on health.
h) Greater use of Care plans throughout a patient's life
i) Third Sector provision in specs going forward. Everything commissioned should have the third sector within the spec. We need to work on the ability to book someone into a voluntary sector activity directly at source.
j) New tools to link GP and third sector - community health portal?
k) CAMHS service is frustrated with the steps needed for them to support children and young people in the borough and would like to be involved in the management of support at an earlier/lower stage instead of dealing with a crisis later. They want the gateway conditions/steps needed prior to referral removed so that they could intervene appropriately without profound difficulties being experienced by the child and family.
l) It is the decision of the neighbourhood/township to develop where is suitable for services. There may be a need for smaller areas to develop other than the traditional township boundaries. There is a need to breakdown need and understand how different sets of individuals need/want services

New Ideas:

a) Shouldn't only be Doctors/Health Care Professional to refer. There is a need to develop a single referral number so that issues can become shared and made everyone's problem and everyone can sign post to social care and health
b) child obesity clinics
c) What we need to develop is a personally tailored holistic offer for the Rochdale Borough.

END OF LIFE	**2 Sessions**
DATES:	**7 September 2015** **10 September 2015**
PRESENT:	**Celia Walsh (Rochdale & District Mind)** **Pat McDonald (Rochdale Circle CIC)** **Karan Youngblut (CVs Rochdale)** **Liann Rearden (Kingsway Clinic)** **Alice Davies (PAHT)Andrea Goodall, (HMR CCG),** **Sheila Downey, (Rochdale BC)** **Rob Kilvington, (Rochdale BC)** **Mui Wan, (HMR CCG)** **Shirley Fisher (Pennine Care Foundation Trust)**

General Comments:

a) There is a need to examine for the reasons why a situation has become a crisis. Most people choose to spend their last hours/days at home and families are not aware of how hard the last few weeks/days may be and how difficult it can be both physically and emotionally to support a loved one to die at home.
b) On the whole the service responds well, but when a family starts to struggle the intervention is often not quick enough.
c) The Advanced Care Plan should inform all parties of what the patient's wishes are, but often this is left too late in the patient's journey
d) we are risk adverse which may result in Clinicians putting the decision for further treatment onto the patient
e) there needs to be some flexibility as to the most appropriate support on offer
f) We need to understand and reflect other culture and religion thoughts and beliefs.
g) Hydration in the community is a big issue
h) There is a need to examine for the reasons why a situation has become a crisis. Most people choose to spend their last hours/days at home and families are not aware of how hard the last few weeks/days may be and how difficult it can be both physically and emotionally to support a loved one to die at home.
i) On the whole the service responds well, but when a family starts to struggle the intervention is often not quick enough.
j) The Advanced Care Plan should inform all parties of what the patient's wishes are, but often this is left too late in the

patient's journey

k) we are risk adverse which may result in Clinicians putting the decision for further treatment onto the patient

l) there needs to be some flexibility as to the most appropriate support on offer

m) We need to understand and reflect other culture and religion thoughts and beliefs.

n) Hydration in the community is a big issue

New Ideas:

a) it would be beneficial to offer an earlier opportunity to start the ACP process

b) undertake patient audit going forward on their journey

)

Supporting Families	**2 Sessions**
DATES:	**7 September 2015** **8 September 2015**
PRESENT:	**Shirley Waller (Link4life)** **Jan Reynolds (Rochdale Borough Sexual health and Contraceptive Services)** **Asma Akhtar (Rochdale Solutions)** **Kelly Dawson (CVS Rochdale)** **Lisa Reyburn (Kingsway Clinic)** **Elaine Gansler (Barnardo's)** **Charlotte Marshall (PAHT)**

General Comments:

a) whole family issues and therefore pick up all of the issues one for safety of staff but 2 so that a full picture is available and this would include GP, hospital, children's social care, adults social care, charities, local groups. Signposting of families.
b) No point of contact in specific incidents where Link4Life had to go to tell staff at NMGH of the child's issues and then when he was transferred to Birch Hill this was all lost so had to go to BHH to repeat the info. This shows the need for a single system.
c) Housing providers are seeing more low level MH needs in adults due to debt etc. and therefore this impact upon the children.
d) When supporting children you end up supporting the adults too.
e) Family nurse partnership is open to women less than 19 at 26 weeks gestation but this is only offered to 100 women due to concentrates. There is a randomised control test which is due to publish any time. In the US this has had a big effect but they do not have the community system of free healthcare we do but KK states that the anecdotal evidence is strongly supportive of this
f) Working with children excluded from school and you find that they are not valued within the family and therefore have low self-esteem. Teaching cooking skills, parenting, communication. Bowlee schools project. Wrapping services around a family both adults and children and health and social care. Debt, housing issues, domestic violence, literacy, numeracy. All links to

police and other public services. Linked into first 1,000 days and how this impacts and also how do you identify these patients. Home start team are good at identifying patients who are needed. Link into SLT and getting children into this. Parenting classes but in accessible environments that will pick up people who would not normally attend i.e. just not at a sure start centre

g) Extend offer to up to 25 for emotional health and wellbeing as the threshold for adult emotional health and wellbeing is much higher and therefore at 19 these patients can just disappear / not be able to access services anymore and therefore they are not supported.
h) Helpful workforce who will not say it's not me but will support / hand off to colleagues / signpost
i) Family goals, single purpose and a number of goals on the way. This has to be their goals as they are more likely to stick to it / work at it / achieve if it is there's and they have ownership
j) Need to invest early with children. Asylum seekers, language skills. Refugees who have food vouchers but do not have money to get to hospital appointments or to get to the supermarket to use them.
k) Due to cheap housing stock we get more than we export esp from London and these are the most vulnerable of society and therefore are highly labour intensive
l) Families can be moved or choose to move and therefore they may not be known to services where they go. This has an impact on the children as they cannot build up networks, relationships.
m) Children are living longer with far more complex conditions due to advances in medicine
n) Public health cuts, community centres new funding and 65% of the funding comes from PH therefore what impact will this have upon these services? Health smart did a piece of work (c£250k) but the work did not go anywhere or lead to anything.
o) Do projects need to be innovative or should they grow with the children as they grow up
p) Need to look at everything we do and assess what is actually making an impact rather than saying we have always done this
q) Assessment of where the best use of the money is i.e. stop adult prevention and beef up children's prevention and just treat the results in adults.
r) Local counselling services are not very good and do not respond to the whole needs i.e. lady with agoraphobia referred to counselling in Littleborough but after intervention did this via phone as she would not travel to Littleborough now 3 years later she is working as a nursery nurse in a surestart centre after retraining
s) Rochdale play association – possible funding cuts that could stop these

New Ideas:

a) Improve Single IT system across all partners.
b) Single Point of Access for professionals or supporting staff
c) Single Point of Contact for a family so that if they have a problem they only have to call 1 person and then that person signposts them to the right place, places, services, support
d) IT systems so that health, social care, education etc. systems can talk to each other. Specifically adults and children's

systems reports to each other

e) Single brand i.e. all together as a single children's workforce and will signpost to services within rather than saying I'm not health
f) Co-location.
g) Single trusted assessment
h) Central Hub.24/7 access and knowledge of the service
i) Keyworker role that would cross cut both adult and social care but links to police, housing, debt / CAB, literacy and numeracy.
j) Parenting support.
k) SPOA and workforce development of staff
l) Solution focused interventions.
m) Prevention and early intervention
n) Short term initiatives using local forums rather than people from outside the borough as they know the area whereas those from outside do not.
o) Supporting people to change – health trainers and health coaches.
p) Working more creatively with the finances.
q) Expert patients programme – Expert Carers Programme

IN HOSPITAL CARE	**2 Sessions**
DATES:	**8 September 2015** **9 September 2015**
PRESENT:	Nadine Armitage (PAHT) Sarah Wiseley (PAHT) Simon O'Hare (HMRCCG) Jeanette Leach (HMR CCG) Rob Kilvington (RBC) Laura Fletcher (HMR CCG

General Comments:

a) Discharge processes – looking to pull HMR patients back to RI to be discharged and therefore common process.
b) The use of equipment day before is rising but SMc suggested that 2 -3 day LoS is what is driving this as the LoS is reducing and therefore the window is shortening.
c) Timing of discharges needs to be assessed and looked into i.e. older people being sent home on an evening or in the middle of the night when there is no support at home
d) A place of safety for patients to be between acute and home whilst legislative issues of discharge are resolved
e) Looking at a sub-acute facility but how do we fund this if capacity does not come out of the system?
f) Sort out patients going to A&E, especially at FGH and ROH, more robust triage. Sub-acute facility, convalescent nursing beds, sheltered housing.
g) Old HHH practice patients turn up and use UCC as a GP practice but the care is not joined up and there are not the proper safety nets in place
h) PAHT embarking on strategic service transformation plan which is based on Healthier Together and then takes this further.

This needs to be reflected in the locality plan. Linked into the co-location of ITS.

i) Discussions ongoing re changes to tariff.
j) Workforce planning – shortage of staff. Experience of staff who apply for jobs is not what it needs to be as most ANPs that are applying are just qualified. A GM ban on locums would help with the agency rates
k) Discharge co-ordination is key, need to look at transitional services between Hospital and usual place of residence. Co-location of staff is key
l) Social workers are from each locality not a single team embedded on each site and if they were on team then this would improve the process
m)

New Ideas:

a) Look to a model where equipment can be ordered in the morning and delivered in the afternoon
b) Use of 3rd sector. Hospital to home is for Emergency admissions do need to upscale this to go with planned care too.
c) Electronic record across all agencies, health, social and 3rd sector.
d) Housing – can have a massive impact upon speeding up discharge. A navigator style process who can identify landlords, sort out housing issues. Both frail elderly and chaotic lifestyles.
e) 3rd sector partnerships – key to this

OUT OF HOSPITAL CARE	**1 Session**
DATES:	**9 September 2015**
PRESENT:	**Shona McCallum (PAHT)** **Pat McDonald (Rochdale Circle)** **Paul Porlby (CEO Carers Trust)** **Barbara Bergin (RCSE)** **Mark Wynn (Rochdale Circle)** **Deborah Lyon (PAHT)** **Charlotte Booth (HMR CCG)** **Laura Fletcher (HMR CCG)** **Shirley Waller (link4life)** **Ken Brearton (Care UK)** **Adam Levy (MCEP)** **Paula Jones (PCFT)** **Sally Townend (Childrens OT -Callaghan House)** **Steve Lenehan (Care UK)** **Alison Hitchen (Care UK)**

General Comments:

a) Contracting process has resulted in a less robust hold over who provides what
b) How to make better use of local businesses for sign posting
c) Patients to become more responsible for own wellbeing
d) Link4 life presentations to work with patients with LTC
e) RBH working closely with tenants regarding personal safety and wellbeing

f) Vanguard sites interesting concept

New Ideas:

a) Providers to meet and discuss with patients the care required
b) Produce a map of services available
c) Merge providers to ensure holistic provision#
d) Link in with schools – football, dance, first aid, and MH – healthy eating initiatives
e) Change the name of Rochdale Infirmary to reflect its new purpose
f) Address ambulance system and transport as whole
g) Outpatients to be delivered wher possible in the community supporting the change of perception around hospitals

GMP, GM Fire, NWAS	**1 Session**
DATES:	**14 September 2015**
PRESENT:	**Ian Mello (HMR CCG)** **Ian Bailey (GMFRS)** **Mike Hynes (NWAS)** **Paul Monteith (NWAS)** **Lindsey Tarsell (NWAS)** **Alistair Mallen (GMP)** **Chris Hill (GMP)** **Chris Sykes (GMP)**

General Comments:

a) 40% of GMP activity involving Mental Health
b) Too much fragmentation between the three service (GMP, GMFRS, NWAS)
c) Drug and Alcohol services - issues raised – patients need to be managed adequately
d) GMFRS – a winter warmth service has been commissioned by RBC Public Health

New Ideas:

a) Extend street triage – good service
b) One frequent caller team across the three services
c) RAID is too short term needs to be with people longer
d) Produce a local PCSO model focussed on 3 services not just Police
e) 3 services would like to work with the frequent flyer service

MENTAL HEALTH AND WELLBEING	
DATES:	
PRESENT:	**Simon O'Hare (HMR CCG)** **Rob Kilvington (RBC)** **Dr Roy (HMR CCG)** **Chris Larkin (Stroke Association)** **Penny Stickett (Rochdale Mind)** **Mark Wood (CAMHS)** **Angie Hobson (PCFT)** **Mike Clarke (GMP)** **Niel wood (Rochdale Hornets Sporting Foundation)** **Juliet Monk (Age UK0** **Lynn Collins (Newbarn Ltd)** **Vigina Ncube (Blue Pits Housing Association)** **Donna Edgley (PCFT)** **Elaine Stott (link4life)** **Debbie Kinsella (Rochdale Circle CIC)** **Stewart Dobson (CVS Rochdale)** **Mohammed Sarwar (MAMC)** **Samina Arfan (GM CSU**

General Comments:

a) Lack of GP referrals to recovery republic.
b) Dealing with social isolation – how do you find these people?
c) How do we prove that voluntary services work? Move away from always being evidenced based and take patient / user feedback

d) Lighthouse project – funder went out and saw project and decided to use them.
e) Job Centres – too bureaucratic a process, no link to volunteering and looking to better themselves, it appears to be a tick box exercise and if have not made suitable number of applications in a week or month then they are sanctioned.
f) Kirkholt project discussed and the red tape involved

New Ideas:

a) Easy referral method – whether that be electronically or for other agencies to be able to cross refer to one another. A common IT platform
b) Single information portal link to above/ Single Point of Access – multi agency access to this with right information at the right time
c) Single key worker – but they need to have a basic set of skills to support
d) Use the life channel in practices to promote the MH pathways and encourage self-referrals
e) An app for showing where services are and how you access them.
f) Single key worker – but they need to have a basic set of skills to support /Single referral protocol – across GMs
g) Open referral system for CAMHS in or out – link to Home start and how they are being supported for patients that do not meet CA Energy clubs – work with parents and obese children to start the exercise process. Look at rolling this out for MH patients? Possible SIF bid. MHS criteria but do need support.
h) Use of CVS and Volunteer development agency.
i) Change culture to be more holistic

SOCIAL CARE	**1 Session**
DATES:	**11 September 2015**
PRESENT:	**Teresa Fielding (RBC)** **Steve Blezard (RBC)** **Mary Chadwick (PCFT)** **Carolin Brennan (PCFT)** **Shakila Hamid (Early break)** **Mark Wynn (Rochdale Circle)** **Yvonne Perry (HMR CCG)** **Paul Dillon (HMR CCG)** **Sam Evans (HMR CCG)** **Gillian Bishop (Link4life)** **Mohammed Sanwar (Multicultural Arts)** **Julie Taylor (PCFT)**

General Comments:

a) Procurement process a hindrance
b) The Locality plan must be for everyone
c) There is a danger that the HUBS will not be affective as cultural change is required
d) People are still working in Silos
e) Need to be less bound by risk aversion
f) Need to link to the development of community assets – community connection needs to be maximised
g) How do we ensure quality commissioning

New Ideas:

a) Hold a market day event

b) Signposting is essential
c) Education and engagement giving people confidence to self-manage and self-care
d) IT needs to be joined up
e) Need integrated commissioning
f) Develop an app for children for the management of diabetes
g) Community Champions key workers needed

PRIMARY CARE	**1 Session**
DATES:	**8 September 2015**
PRESENT:	**Julie Murphy, (RBC)** **Shirley Fisher (PCFT)** **Kate Hudson (HMR CCG)** **Jeanette Leach, (HMR CCG)** **Sarah Kershaw (HMR CCG)** **Andy Fry (HMR CCG)** **Sabrina Gawthrop (HMR CCG)** **Rina Escobar (HMR CCG** PC attendance.pdf

General Comments:

a) Estates issue – patients want easy access not to have to travel to a HUB
b) Secondary care integration issues – PBR issues
c) Amount of constant change an issue GPs need consistency for budget planning

d) Overall cost of medical training high
e) GPs have become to preventative should be diagnostic - preventative elements to be provided by other health care professionals
f) Media Bashing – discredits GP reputation negative public perception and does not encourage medical students to enter into GP training – NHS Choices a platform for negative comments with no ability for GPs to respond should be proactive – selling positives rather than negatives
g) HV and District nurses no longer in surgeries – service is disjointed
h) Full time locums and issue
i) 600/700 less trainee GPs in 2015 – National issue
j) Use the winter pressures model in the HUBS
k) Need medical social nursing integrated teams in HUBS
l) Locally services are disjointed, some GP practices are good but others are not. Some have moved with the times others have stood still.
m) The appointment system does not work, if you don't get through when you ring at 08:30 you don't get an appointment. This can have a knock on effect for employers with staff going on sick because they could not get a GP appointment
n) gatekeepers at reception are a problem
o) Are we at the stage where we needed a greater presence of less skilled staff to deal with specific conditions or issues?
p) Practices should hold cold and flu clinics over winter for all people not just high risk.

New Ideas:

a) Estates – best use of NHS buildings - sale of buildings to increase revenue.
b) Look at PAHT pharmacy opening hours – limited hours keep people in hospital – effects transport, social services etc. – need to review pharmacy availability
c) Contract reform required – red tape – GPs able to cover different practices
d) Working group to speak to speak to trainee GPs, employed for 5 years or soon to be employed - what do new GPs want? What would make becoming a GP in HMR more attractive? Speak to medical students??
e) Manchester University – 2 year prescribing course – trainee spends a day and half in practice – perfect for seeing patients with LTC, and supporting patient care plans. – But who would fund??? Medical training funding essential
f) PAHT to reduce jargon in patient correspondence - more patient friendly so GP appointments are not wasted trying to explain the hospital letters.
g) Patient Education/Possible charges for patients regarding inappropriate appointments e.g. DNAs and inappropriate second opinions
h) Physician Associates/ Pharmacists in surgeries – treating minor ailments and increasing GP availability but who would fund?

Funding required

i) All GPs to become salaried GPs employed by acute trust
j) Join up training practices - increased support with the aim of retaining trainee GPs once qualified and lock in contracts for 5 years
k) When an appointment is needed in advance you should be able to phone up and book one two weeks before needed. This would benefit patients with long term conditions Recruitment of GPs from abroad
l) Scrap the appointment system and have a triage nurse to see people arriving at surgery who decide if they need to see doctor, practice nurse, pharmacy or other service. Triage could be carried out by phone, on line or in person.
m) GP rounds in large workplaces to enable those in work to see a doctor. The employer could contribute to cost from savings made by less people being off sick.
n) Remove patients from practice list if they persistently fail to attend appointments without good reason and without notifying the practice.
o) Salary GPs and pay on the delivery of outcomes
p) 6. Forge closer working with GPs, pharmacists, opticians to deliver an integrated front end for primary care