



Darlington LINK Newsletter

SPECIAL EDITION ANSWERS AGM 2011

Special Edition Answers AGM 2011

Response to Questions raised

LINK

Local Involvement
Network

Make your voice heard and
have your say in Health &
Social Care in **Darlington**.



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Responses from questions raised at the LINK AGM May 2011

Darlington LINK held its 3rd AGM on Wednesday 11 May 2011 at the Dolphin Centre. At the event, round table discussions took place giving people the opportunity to raise questions about the presentations and the future of health and social care. The presentations were from Elaine O'Brien (Darlington Borough Council) gave information about the new Intermediate Care Plus Strategy. This was followed by Dr Harry Byrne and David Gallagher who gave a presentation on the GP Consortia and the Health and Wellbeing Board.

The minutes for the meeting and the presentations can be requested from the LINK office.

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Questions compiled on the evening

- With there being an increased direction on care in the home how does the fact it has been stated there will be no additional funding for external nursing tie in with this?

I am not aware of this. Additional funding has been allocated to pilot Care Closer to Home from the Foundation Trust; supporting earlier hospital discharge.

- Will there be a postcode lottery within the NHS as areas look to balancing budgets?

The challenge for the NHS is to ensure that local needs are identified, prioritised and dealt with. This might mean some variation to meet local health needs, but within a national system. There will be priorities as there are now and difficult decisions to be made there are greater as there are now but opportunities for patients to have a say in setting priorities, making those decisions and sharing responsibility.

- If certain areas have higher incidents of a disease that requires more costly medication does this mean that other services will suffer or will additional funding be available?

As with the previous answer, the key to this is ensuring that local health needs are addressed, rather than always looking for additional funding. This does mean that we make more effective use of funding already available.

- What happens to the funding if there is a surplus at the end of a financial period will it roll over or will there be a 3 year financial period which allows for better financial management?

Some parts of the NHS already do this – mainly foundation trusts. We currently have a five year plan which is reviewed annually. It is hoped that more local clinical and patient involvement and input will enhance the effectiveness of that annual review.

- Will there be more scope for alternative therapies within this new commissioning process?

As with any treatment or therapy, this will depend on there being a demonstrable need for which they are proven to be efficient and effective.

- Will there still be patient choice and will this still be available for out of area treatment?

Patient choice will continue as now with patients having a choice of where to have planned treatment.

- What are the plans for musculoskeletal services in Darlington?

Development of a “Musculoskeletal Triage Service” with the aim of delivering a comprehensive, joined up streamlined pathway of care and to deliver care by the most appropriate practitioner to patients with all manner of musculoskeletal problems.

- Who will monitor the care being delivered to people?

Levels of care are monitored by the organisations which provide services. They are also monitored by regulators including the Care Quality Commission and people who commission the services (the PCTs at the moment). Any services provided for the NHS need to meet minimum quality standards.

- People are concerned that GP Surgeries will not be able to take on new patients, cover patients who are financially costly?

While we realise this can be a concern, nothing in the proposed changes to the NHS should affect this either way. Practices and organisations use “risk sharing” arrangements to help manage more costly cases, such as specialised services.

- How are you going to let everybody in Darlington know about the new local authority policies to keep people in their own homes?

People are informed through publicity, leaflets in Council reception points, libraries, health setting and voluntary organisation etc., Adult Social Care website and information at point of contact to Adult Social Care. Councillors are also informed through reports.

- When people go into private nursing homes they lose their access to PALS. They also seem to lose access to Advocacy (on Site) can you contract out to homes which do provide these safe guards and move if possible. People who are forgetting things have need of regular contact from advocates they know and trust?

My understanding is all the homes have access to advocacy services. In addition the need for advocacy is covered in safeguarding meetings.

- Because of the financial element attached to the changes will that affect patient and doctor time to consult?

We don't anticipate any reduction in consultation times. Freeing up clinicians time to undertake the new role is a recognised challenge and the financial element attached to the changes exists to facilitate the development of the additional time needed.

- I'm concerned about the authority of the none elected quango monitor. E.g. they can select the elected governor and have joint responsibilities for commissioning without any responsibility?

We understand that the role of Monitor has now been changed and that it will encourage joint working between NHS and Partner organisations something that most professional bodies have been pressing for and would welcome.

- Will it encourage GP specialists to enhance NHS services?

Yes potentially if they will help address local health needs and priorities.

- If it doesn't work what happen?

We need to try it and see. Setting things up before the PCTs close down will help make sure this done carefully.

- If voluntary community sector are so valued why haven't they got an automatic place on the well being board?

They have at the moment through Healthwatch. It is also possible that local health and well-being boards have other representatives.

- How are you going to find the care workers if some are being made redundant?

Where care workers are needed they will be either transferred from areas where there is less need or purchased from the independent sector.

- What support is available for GP's and Services supporting conditions such as cancer?

There are opportunities to develop and enhance some of these services. There are opportunities to use support, including finance linked to GP pathfinder work which includes work on cancer and end of life.

Do we have any single handed GP's in Darlington?

No

- GP – Patient experience – any solutions to GP concerns about this?

We would emphasise the need for us to strengthen our relationship with patient representatives as we proceed – important for our patients to be assisted in developing a greater understanding of the challenges we face and encourage true participation and sharing of responsibility for setting the agenda locally.

- Is there any financial support for the GP Commissioning?

There is some funding to set up GP consortia and to provide management support to them. Ultimately, when the PCTs close down, some of the funding they use to commission some services will be transferred to the GP consortia. In Co Durham and Darlington we are starting already to give the GP's responsibility for some aspects of this funding this year.

There is also practical support in the form of our staff skills and expertise from the PCTs, some of whom have been aligned to directly support the GP's and the development of the consortia.

- For conditions that have a low prevalence for example multiple sclerosis, how can voluntary sector organisations and people affected by these conditions most effectively support GP consortia in knowing what are the most effective services to commission?

The consortia will need to develop mechanisms to engage and listen to patients, the public and patient groups as part of their planning for services.

- We are just past the (10 Year) half way point in the NSF for long term neurological conditions. How can we work together to ensure that the quality requirements continue to initiate innovative services development and this is not lost in this time of change?

This will be one of the many challenges for the new consortia, who will look to build at what has gone before, including work such as this.

- Assessment of individual need - Who will do the assessment? i.e. which discipline / who will provide? E.g. joint budget? All assessments to one panel? One family stream? One point of access. Intermediate care is free – after 6 weeks reassess?

The Intermediate Care Plus Strategy advocates an integrated approach to intermediate care and work is progressing for the health and social care teams to work closer together. Assessments will be carried out by the most appropriate person or jointly. Intermediate Care is free but where people need ongoing social care support they will be assessed financially in line with the Councils Fairer Contributions Policy.

- Patient involvement – through healthworks and patients on the GP board?

Partly, but there is a need to engage with local people to understand their needs and experiences to plan for the future. This might be done working with local authorities and the voluntary sector and utilising their expertise and experience.

- Financial implications for patients?

By trying to ensure effective use of services to meet local health needs we will try get as much quality care for local people in a system which remains free at the point of access.

- More joint workings with patients and staff?

Hopefully – see last but one answer.

- Presentations gave mixed messages?

We tried to be clear but recognise that in changing times (nationally) we need to keep on updating to avoid any mixed messages. It's difficult to respond to this question / comment without knowing the specifics.

- Need more information about patient choice?

Patients currently have choice of where they receive services in accordance with the NHS Constitution.

- Funding?

Please see answer above relating to funding consortia.

- Specialism's and research?

We are keen to develop local expertise and enhance the skills and knowledge of our local clinicians where that best meets the patient priorities that have been identified. By developing a closer working relationship between practices we will also be able to tap into the shared databases of practices that will improve our ability to identify local need more rapidly and accurately and that may also facilitate local research though research is not an immediate priority of the developing consortium at this time.

- If individuals are going to be nursed either in a care setting or at home – some care providers use a lot of agency staff – who monitors their training?

All independent providers are monitored by Care Quality Commission and if there is a Local Authority contract the contracts team monitor on a regular basis.

- Why are specialists allowed to operate in both NHS settings and private?

This is a national issue and probably relates to a limited skilled workforce.

- Doctors need to be more patient centred and communicate more effectively?

There is always room for improvement. Patients can help by feeding back when this doesn't happen. Every GP is subject to annual appraisal and one aspect of that process looks specifically at "relationship with patients". Feedback about performance both good and not so good is therefore both necessary and welcomed. Ways of easily delivering that feedback should be facilitated by practices, for example by patient questionnaire or correspondence to practice manager in the case of specific instances.

- Will GP commissioners be as committed to the role of very active voluntary sector in Darlington despite recent financial cutbacks (although GP budget not yet known)?

The emerging Consortium is keen to develop relationships with all of the other stakeholders in the Darlington locality including the Voluntary sector to ensure that we capitalise on what we see as our unique advantages.





County Durham and Darlington

Consultation launched on proposals for Hyper Acute Stroke Services in County Durham and Darlington

A consultation on proposals to consolidate hyperacute stroke care on a single site for people in County Durham and Darlington is launched on Monday 20 June 2011.

NHS County Durham and Darlington, the organisation responsible for commissioning health services for the local population is launching the consultation, which will run for 90 days until 11 September 2011.

NHS County Durham and Darlington is proposing that hyperacute stroke services are consolidated on one site to serve the local population. At the moment, the service is provided at the University Hospital of North Durham and Darlington Memorial Hospital by County Durham and Darlington NHS Foundation Trust, which runs both hospitals during normal working hours. The two sites work on an alternating week rota between University Hospital North Durham and Darlington Memorial Hospital to provide out of hours cover.

Hyperacute services are one of the most critical components of stroke care that patients need when they are at their most seriously ill. National standards say that these services should be available 24-hours-a-day, seven days a week, with patients being directly admitted to a stroke unit where there is access to specialist stroke consultants and where brain imaging and clot-busting drugs are readily available.

Significant improvements have been made to stroke services in County Durham and Darlington in recent years, with the introduction of thrombolysis, used to break up a blood clot, which can be the cause of some strokes.

However, doctors, nurse and managers have identified a number of urgent challenges which mean providing hyperacute services over the two hospital sites is not sustainable for the future.

As part of a review of stroke services across County Durham and Darlington, from emergency care to rehabilitation, it became clear that hyperacute services are where the most effective improvements can be made.

In order to safeguard hyperacute stroke services for the people of County Durham and Darlington, various options were carefully analysed by doctors, nurses and managers working in stroke

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services, with the help of patients, carers and a range of representatives from local groups and organisations. The details are included in the consultation document, which is available to download from Monday 20th June at www.haveasay.org.uk

In line with Section 242 of the NHS Act, NHS County Durham and Darlington will carry out a formal public consultation for 90 days so that people can have their say on the proposals. The consultation will focus on a range of options for the future of hyperacute services with the preferred option of a single site based at the University Hospital North Durham.

As part of the consultation, a number of public meetings have been arranged for local people to have their say.

Monday 11 July 2011 - 3.00 – 4.30pm
Sedgefield Parish Hall, Front Street, Sedgefield, TS21 3AT

Monday 18 July 2011 – 1.30 – 3.00pm
The Four Clocks Centre, 145a Newgate Street, Bishop Auckland, DL14 7EH

Wednesday 20 July 2011 – 4.00 – 5.30pm
Blackhills Community Centre, Derwent Street, Consett, DH8 8LS

Thursday 21 July 2011 – 1.30 – 3.00pm
The Greenhills Centre, Wheatley Hill Community Association, Wheatley Hill
DH6 3JS

Monday 25 July 2011 – 1.30 – 3.00pm
Durham Town Hall, Market Place, Durham City, DH1 1RH

Monday 22 August 2011 – 2.00 – 3.30pm
The Arts Centre, Vane Terrace, Darlington, DL3 7AX

Monday 22 August 2011 – 6.30 – 8.00pm
The Arts Centre, Vane Terrace, Darlington, DL3 7AX

Thursday 1 September 2011 – 2.00 – 3.30pm
The Witham Hall, Horsemarket, Barnard Castle, DL12 8LY

The consultation document is available to download via www.haveasay.org.uk or you can request hard copies by writing to:

Hyperacute Stroke Consultation
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