MEETING:	Patient and Community Assurance Group (PCAG)	
MEETING DATE:	Tuesday 20 November 2018	
VENUE:	Civic Centre, Ashby Road, Scunthorpe, North Lincolnshire	
TIME:	17:00 – 19:00	

PRESENT:		
NAME	**TITLE**	**ORGANISATION**
Janice Keilthy *(JK)*	Lay Member, Public and Patient Involvement and Chair of the PCAG	NHS North Lincolnshire Clinical Commissioning Group (CCG)
Kirsten Spark *(KS)*	Engagement Manager	NHS North Lincolnshire CCG
Heather McSharry *(HMc)*	Lay Member, Equality and Inclusion	NHS North Lincolnshire CCG
Clare Linley *(CLin)*	Director of Nursing and Quality	NHS North Lincolnshire CCG
Chloe Nicholson *(CN)*	Quality Manager	NHS North Lincolnshire CCG
John Anscombe *(JA)*	Community Member	N/A
Helen Condliff *(HC)*	Community Member	N/A
Jon Harper *(JH)*	Community Member	N/A
Addison Potter *(AP)*	Youth Council Member	North Lincolnshire Council
Angela Treadgold *(AT)*	Advocate	Cloverleaf Advocacy
Carol Lightburn *(CLig)*	Chair	Healthwatch: North Lincolnshire
Susan Oliver *(SO)*	Chief Executive	Humber & Wolds Rural Action
Rae Twidale *(RT)*	Project Co-ordinator *In attendance from Item 4.0 onwards.*	Westcliff Community Works
IN ATTENDANCE:		
Geoff Day *(GD)*	Interim Director of Primary Care *In attendance for all items*	NHS North Lincolnshire CCG
Jane Ellerton *(JE)*	Head of Strategic Commissioning *In attendance for all items*	NHS North Lincolnshire CCG
Clare Smith *(CS)*	Patient Experience Manager *In attendance for the notes*	NHS North Lincolnshire CCG
APOLOGIES:		
Alex Seale *(AS)*	Chief Operating Officer	NHS North Lincolnshire CCG
Sheila Girling *(SG)*	Community Member	N/A
Peter Hinks *(PH)*	Community Member	N/A
Jamie Pugh *(JP)*	Youth Council Member	North Lincolnshire Council
Carrie Butler *(CB)*	Delivery Manager	Healthwatch: North Lincolnshire

1.0 WELCOME, APOLOGIES FOR ABSENCE AND QUORACY

JK welcomed attendees to the fifth formal meeting of the Patient and Community Assurance Group (PCAG). Apologies for absence were received and noted as above. It was noted that the PCAG was quorate to proceed.

2.0 DECLARATIONS OF INTEREST

JK reminded members of the need to declare any interests relevant to any items on the agenda.

Name	Agenda No	Nature of Interest/Action taken
Angela Treadgold	4.0	AT advised that in her role as an Advocate for Cloverleaf Advocacy, she was aware of a number of complaints relating to pain services.

Resolved: Declarations of interest were received and noted, as above.

3.0 MINUTES AND ACTIONS FROM THE PREVIOUS MEETING ON 18 SEPTEMBER 2018

The minutes of the meeting on 18 September 2018 were taken as read, and accepted as an accurate record of the last meeting.

Actions from the meeting on 18 September 2018:

1. **Item 1.0: Welcome, Apologies for Absence and Quoracy**
   JK confirmed that the meeting on 21 August 2018 had been cancelled due to the number of apologies received from the proposed speakers.
2. **Item 4.0: PCAG Meetings**
   KS confirmed that she was in the process of preparing a PCAG Forward Plan with the CCG's commissioning team.
3. **Item 5.0: Proposals for engagement to inform the Dementia Strategy**
   Discussion took place regarding the local engagement to inform the Dementia Strategy. It was queried whether the use of online surveys provided representation of the population, as 38% of people did not access the web. It was agreed that there was a need to ensure the surveys were shared with the appropriate stakeholders, including voluntary sector organisations, to maximise response from the general public. It was suggested that contact should also be made with the following organisations:
   - Dementia Action Alliance.
   - North Lincolnshire Community Wellbeing Hubs.
   - North Lincolnshire Museum

3.1 North Lincolnshire CCG Governing Body: Public Question Time

JA queried the decision that had been made by the CCG to cease asking questions at the CCG's Governing Body public meeting. JA questioned the decision, as the CCG was promoting wider engagement with the local population, but was then stopping the opportunity for members of the public to ask questions. JK stressed that there would be opportunity for members of the public to engage with the CCG at future events that were planned for 2019. A variety of other ways to ask questions and provide feedback to the CCG are highlighted on the CCG website.

4.0 MUSCULOSKELETAL (MSK) AND PAIN SERVICES

JE presented Item 4.0, advising that the CCG currently commissions a range of services to manage patients with MSK problems and chronic pain. The services are provided by both hospital and community based providers, and there is some duplication of service at present. It was highlighted that in 2017, NHS England

launched an Elective Care Programme for MSK which set out a number of requirements:

- Clinical assessment and triage of all MSK, chronic pain and rheumatology referrals – to get patients on the right pathway quickly.
- Introduction of First Contact Practitioners – physiotherapists based in primary care to reduce demand on GP time by rapidly assessing, diagnosing and treating lower level MSK problems.
- Use of standardised referral forms to improve the quality of referrals.
- Services provided by multi-disciplinary teams to provide more holistic interventions.
- Use of shared decision making and self-management approach to help people understand their own condition and take responsibility for their own health and wellbeing through lifestyle change.

At present, the CCG commissioned services do not fully comply with the model, therefore the CCG is currently working to address the issues through the development of a new model. JE confirmed that the CCG has reviewed previous engagement feedback in relation to the services and has developed a service specification for an integrated MSK and Pain service, which reflects the national requirements and feedback from patients. JE advised that PCAG members were asked to consider the content of the report and assure themselves that the developing MSK and Pain model reflects the feedback obtained from patient and public engagement.

Specific areas highlighted/discussed:

- Services close to home.
    - People only want to go to a hospital if necessary, when the care they need cannot be provided in the community.
- It was agreed that people should be empowered to self-manage, but to ensure that there is easy contact with the service when needed, so that they can feel safe, supported and in control.
    - It was highlighted that there was a need to utilise the technology available (Skype and on-line consultations).
- Access to peer support.
- Services in the community need to be supported by transport links and/or patient transport.
- Waiting times locally were a concern, which resulted in people paying for private treatment.
- There was a need to work with local groups and voluntary sector groups around pain management.
- Next steps: Key elements of the service.
    - Single point for referral, using electronic referral, advice and guidance requests.
    - Standardised referral form and process.
    - Offer extended hours opening to improve access.
    - Clinical triage of all referrals to ensure the patient sees the most appropriate clinician/team.
    - Service is provided by a multi-disciplinary team including doctors, nurses, physiotherapists and pharmacists.
    - Service includes psychological support to patients to address the psychological impacts of MSK and chronic pain problems and address mental wellbeing.
        - It was highlighted that MSK and chronic pain can lead to social isolation.
    - Service includes assessment, medication review and treatment including procedures.
    - Provide access to diagnostic tests.

- Utilises Shared Decision Making, involving and informing patients and their carers about the options available to them along the MSK, Pain and Rheumatology pathways.
- Focus on self-management, supported by 1:1 consultations and group sessions with each patient having a personalised management plan.
- Delivered in the community, with patients only referred to hospital when the care cannot be delivered elsewhere.
- Ensure that the most appropriate community-based treatment is offered based on clinical need, but where secondary care intervention is required; the surgical conversion rates are comparable with national benchmarking.
- Choice at the point of onward referral to secondary care or more specialist services.
- Improve waiting times in line with national constitutional targets.
- Build partnerships and collaborative working between organisations delivering various aspects of care along the pathways, including voluntary sector.
- Integrate with lifestyle change services, e.g. health trainers, weight management, exercise groups.
- Rapid access back into service where a patient experiences deterioration in condition.
- Discussion took place regarding the statement *'GPs are not good at diagnosing and sometimes put it down to age. A patient being told to manage their pain without medication is not well received. Asking to see another professional should not be seen as an issue'.*
    - JE confirmed that the statement was what the CCG had been told by patients.

- Waiting times for pain treatment.
    - JA advised that the waiting list for pain services locally was one of the longest in the country, and highlighted that he was aware of some patients who had not received any pain treatment for 25 weeks.
        - It was confirmed that the local hospital based pain service was experiencing long waiting times for pain treatments. Discussion took place regarding patient choice and alternative provision.
        - It was highlighted that the maximum NHS waiting time for non-urgent consultant-led treatments was 18 weeks from the point of referral to the first definitive treatment.
        - AT stressed that patients often found it extremely difficult to go elsewhere for treatment, and if they did attend appointments out of area, it was often extremely difficult to be seen locally again, without being placed to the bottom of the waiting list or discharged.
- Peer support.
    - It was queried how the support would be 'built in' to the service specification.
- Single point for referral.
    - HC queried if 'private' physiotherapists would have access rights to the electronic referral system and whether they would know how to access the pathways.
        - JE stated that unfortunately private physiotherapists would not have access to the referral system. Referrals would be made by a patient's GP.
- Multi-disciplinary Team (MDT).
    - Discussion took place regarding the service being provided by a 'team'. It was queried whether a patient would be seen by a specific clinician or one particular person, and who would make the decision to discharge a patient.

        - JE advised that the service would be provided by a Multi-disciplinary team, including doctors, nurses, physiotherapists and pharmacists, with full team input regarding discharge.
- Clinical Governance/Assurance.
    - Discussion took place regarding the support services/self-help groups. It was queried whether the services would be monitored and covered by NHS clinical governance systems if they were providing a service for the NHS. It was suggested that services would have to have clear clinical governance processes in place to ensure the CCG were assured of quality and safety.
    - JE confirmed that the service would have to adhere to the National Institute for Health and Care Excellence (NICE) guidance and best practice.
- Funding.
    - Additional funding for voluntary sector providers was highlighted.
- Performance.
    - JE advised that Key Performance Indicators (KPIs) would be used to measure how effectively the service was achieving key objectives.
- Pathway.
    - Referral made.
    - Clinical triage of all referrals to ensure that the patient sees the most appropriate clinician or team.
- Discussion took place regarding the need for a patient to see a Consultant. It was recognised that a patient does not always have to see a Consultant, as another member of the multi-disciplinary team could be the most appropriate healthcare professional for the patient to see (e.g. physiotherapist, nurse or pharmacist).
- JH highlighted the use of complementary therapies. It was noted that complementary therapies were not mentioned in the report.
- Patient and Public Involvement
    - Discussion took place regarding the role of the PCAG to provide assurance that the CCG has carried out engagement with the wider community using a wide range of methodologies to gather information and views and inform decisions.
    - It was agreed that there was a need to ensure that the CCG puts the patient and patient experience at the heart of quality improvement.

Agreed Outcome/Action:

1. **The report was considered and noted by PCAG members.**
2. **Feedback from PCAG members was noted.**

5.0 'YOU SAID, WE DID': SHARING THE FEEDBACK FROM ENGAGEMENT ON EXTENDED HOURS GP SERVICES

GD presented Item 5.0 in relation to the feedback from the engagement process relating to the extended access to GP services.

Specific areas highlighted/discussed:

- HMc highlighted the use of the term 'game the system' on page 6 of the document. KS agreed to amend and use an alternative phrase.
- Transport links and patient transport for the extended access service was highlighted. It was noted that there was often limited transport available for patients living in rural areas, and transport was often not available in the evening.
    - It was highlighted that the CCG was working to ensure that the locations for extended hours were accessible and convenient. The plan

was to ensure extended access was delivered within each of the three care network areas.
    - It was highlighted that there was a Voluntary Car Service provided by the Humber & Wolds Rural Community Council between 09:00 and 17:00, Monday to Friday as well as the CallConnect service operated by North Lincolnshire Council. CallConnect is a unique bus service with no fixed timetable, but instead responds to passenger requests. Routes are different each day depending on the bookings made by passengers. Journey requests can be made by telephone or online. The service is designed to improve transport opportunities in rural communities where there is an infrequent conventional bus service.
    - GD confirmed that some GPs do still provide home visits, if required.
    - HC highlighted that England is one of the few countries to offer a patient transport service.
- GD confirmed that to date the service was working well and local GPs were requesting to work during the extended hours. It was hoped that the service would release more patient appointments during core hours, as some patients would choose the extended hours appointments instead.
- It was confirmed that GPs are paid to work during the extended access period.
- It was highlighted that if the report was to be shared with members of the public, it used clinical terms which may not be understood by a non-clinical person (e.g. triage, SystmOne, EMIS).
- JK asked if PCAG members were assured that the comments received during the engagement on extended hours GP services had been actioned by the CCG.
    - JA advised that he was not assured by the work undertaken.
- Discussion took place regarding the 'Care Navigation' role in GP practices, as it was highlighted that some patients were uncomfortable speaking to reception staff who were not clinically trained. Some patients may feel that non-clinical staff members were now able to make a 'clinical' judgment in relation to their care. It was queried:
    - What training was provided to reception staff?
    - Was it accredited?
    - Who provided the training?
    - Are there any practice governance/confidentiality arrangements regarding the care navigator roles?
- It was suggested that a private area should be offered to ensure patient confidentiality was maintained at all times.
- AT advised that the care navigation role was an area of concern for some patients.
- GD confirmed that all GP practice staff should ensure that patient confidentiality is maintained. It was suggested that any concerns regarding a specific practice should be forwarded to the practice for investigation and response.
- CLin queried whether there were any examples of good practice, where the care navigation role had been implemented successfully and worked well, which could be shared with other practices, if required.

Agreed Outcome/Action:

- **The report was considered and noted by PCAG members.**
- **Feedback from PCAG members was noted.**
- **KS to amend the report, as detailed above.**
- **An update regarding the Care Navigation role to be provided at the next meeting**.

6.0 MATTERS ARISING FROM THE MINUTES

Nothing discussed.

7.0 ANY OTHER BUSINESS

7.1. ACCESS TO MENTAL HEALTH SERVICES FOR VETERANS

JA raised concerns in relation to access to mental health services for Veterans, and queried how many Veterans in this area were receiving care. KS advised that she would discuss JA's concerns with the CCG's Armed Forces Covenant Champion and provide a response in due course.

Agreed Outcome/Action:

- **KS to obtain a response for JA in relation to mental health services for Veterans.**

8.0 DATE AND TIME OF NEXT MEETING

The next meeting will be held on Tuesday 15 January 2019, 17:00 – 19:00, at the Civic Centre, Ashby Road, Scunthorpe.

Future Meeting Dates	Time	Venue
19 March 2019	17:00	Civic Centre, Ashby Road, Scunthorpe

Signed: ……

Janice Keilthy
Chair of the Patient and Community Assurance Group, NHS North Lincolnshire CCG