A meeting of the Patient Council will be held on **Wednesday 29 January 2020 at 6.00pm** at Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY

AGENDA

ITEM	SESSION	LEAD	TIME
1.	Welcome and apologies	Chair	6.00pm
2.	Update of the previous meeting held on 27 November 2019	Chair	6.05pm
PRESENTATIONS / QUESTION & ANSWER (Q&A) SESSIONS			
3.	Refreshing our End of Life Care (EoLC) Strategy for adults in Barnsley -Presentation followed by small group discussion and feedback (please see attached pre-read information in preparation)	Siobhan Lendzionowski - Lead Commissioning and Transformation Manager for Long Term Conditions; Cancer and End of Life/Palliative Care Dr. M. H. Kadarsha – GP and CCG Governing Body Member (to be confirmed)	6.10pm
GENERAL			
4.	Any other business	Chair	7:25pm
5.	**Date and time of the next meeting:** The next meeting will be taking place on Wednesday 26th February 2020, 6.00pm at Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY **Future meeting dates for 2020:** Wednesday 25th March 2020 Wednesday 29th April 2020 Wednesday 27th May 2020 Wednesday 24th June 2020 Wednesday 29th July 2020 ***No meeting in August***		7.30pm Close

For enquiries please contact:
Angela Musgrave, Secretariat Team Leader & Executive PA
Barnsley CCG, Hillder House, 49 - 51 Gawber Road, Barnsley, S75 2PY
Call 01226 433742 or email angela.musgrave@nhs.net

Pre-reading for Barnsley Patient Council Members

29 January 2020

Refreshing our End of Life Care (EoLC) Strategy for adults in Barnsley

Speaker

Siobhan Lendzionowski – Lead Commissioning and Transformation Manager for Long Term Conditions; Cancer and End of Life/Palliative Care

Background

We are currently working with our Health and Care partners across Barnsley to refresh the current Barnsley End of Life Care Strategy for adults.

When we talk about End of Life, what do we mean?

End of life care is defined by NHS England as care that is provided in the 'last year of life'; although for some conditions, end of life care may be provided for months or years.

The most recent NICE (National Institute for Health and Care Excellence) Guidance End of life care for adults: service delivery, published: 16 October 2019 states:

End of life care includes the care and support given in the final weeks and months of life, and the planning and preparation for this. For some conditions, this could be months or years.

This includes people with:

- ***advanced, progressive, incurable conditions***
- ***general frailty and coexisting conditions that mean they are at increased risk of dying within the next 12 months***
- ***existing conditions if they are at risk of dying from a sudden acute crisis in their condition***
- ***life-threatening acute conditions caused by sudden catastrophic events***

What do key national guidance documents suggest is needed?

NHS England is working with the government and partners across the health and care system to deliver the 'End of life care commitment' announced by the government in their response to the independent review on choice in end of life care.

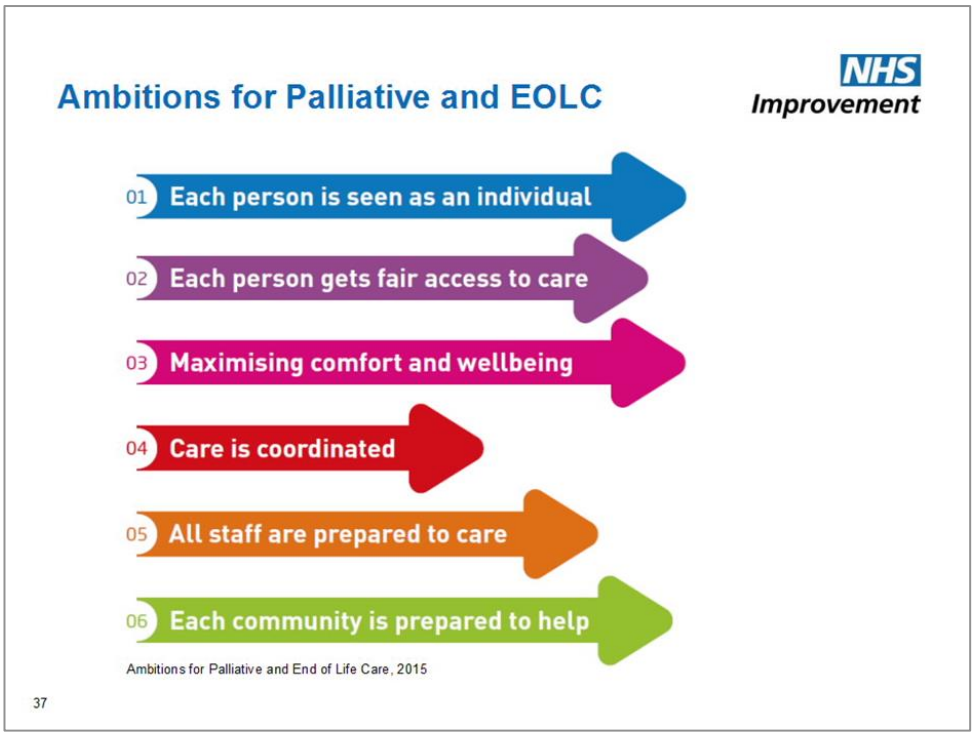
The government's six commitments, which closely align to the ambitions for Palliative and End of Life Care (described later), are made to the public and aim to end variation in end of life care by 2020. They are:

- honest discussions between care professionals and dying people;
- dying people making informed choices about their care;
- personalised care plans for all;
- the discussion of personalised care plans with care professionals;
- the involvement of family and carers in dying people's care;
- a key contact so people who are dying know who to contact at any time of day.

What does this mean for the individual and their family/ carer?

1. That a deteriorating condition is recognised
2. They have personalised planning - leading to coordinated action - offered for treatment, care and support
3. They can access high quality experience anywhere anytime
4. They are cared for by staff who know what they are doing
5. Timely access to medicines, equipment, etc. is available.
6. They feel safe physically and emotionally
7. Their Family/those important to them are supported

The Ambitions framework was developed by a partnership of national organisations across the statutory and voluntary sectors. It sets out the vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.



Shaping our local strategy refresh

A key part of the work to refresh our local End of Life Care Strategy is to gain feedback from patients, carers, staff and members of the public in relation to their experiences of accessing and delivering end of life care across the borough.

As patient council members, we would very much value your views and input to this this work. At the next meeting following a short presentation, we would value your views and feedback in relation to the following questions;

1. Would you feel comfortable discussing end of life with those closest to you and can you tell us why?

2. How do we as a local health and care community in Barnsley make it easier and more comfortable for local people to discuss death and dying earlier?

It would be really helpful if you could have a think about the above questions in advance of the meeting and where appropriate discuss these with your fellow GP Patient Group members and/ or your friends and family.

Your input will help us to directly shape this work going forwards.

Other ways to have your say

We understand that for some people this is a really difficult and emotive subject to discuss openly so there will also be the opportunity for people to provide their views and feedback privately via the patient and carer survey which can be accessed via the get involved section of the CCG website at www.barnsleyccg.nhs.uk/haveyoursay from 17th January onwards. It should take you no longer than ten minutes to complete the survey and all responses will be kept anonymous.

Thank you in advance for your support and we look forward to seeing you at the next meeting.

Minutes of the Barnsley Patient Council meeting held on Wednesday 27 November 2019 at 6.00pm in the Boardroom, Hillder House, Barnsley CCG, 49/51 Gawber Road, Barnsley, S75 2PY.

PRESENT:

Chris Millington *(Chair)*	Barnsley Clinical Commissioning Group Lay Member for Patient & Public Engagement
Ben Cox	Park Grove Medical Centre PRG
Philip Watson	Patient, Hill Brow Surgery
Margaret Lindquist	Walderslade Surgery PRG
David Brannan	Victoria Medical Practice PRG
Alan Higgins	Barnsley Hospital Public Governor
Alan Jones	Hollygreen Surgery PRG
Janet Neville	Patient, Rotherham Road
Adrian England	Healthwatch Barnsley and Monk Bretton PRG
Jan Eldred	The Kakoty Practice PRG
Margaret Sheard	White Rose Surgery PRG
John Gessler	Hoyland Medical Centre PRG

IN ATTENDANCE:

Jacqui Howarth	Service Manager for Right Care Barnsley and the Acorn Unit
Jayne Sivakumar	Chief Nurse, Barnsley Clinical Commissioning Group
Emma Bradshaw	Engagement Manager, Barnsley Clinical Commissioning Group

APOLOGIES:

Colin Wilkinson	Park Grove Medical Practice PRG
Terry Kendall	Penistone Group PRG
Elaine Staley	The Kakoty Practice PRG
Mark Smith	Healthwatch Barnsley
Tom Sheard	White Rose Surgery PRG
Lynne Craven	Hoyland Medical Centre PRG
Ian Batty	Kingswell Surgery PRG
Val Batty	Kingswell Surgery PRG
Phillip Morris	Royston PRG
Mel Dyke	Patient, Roundhouse Surgery
Garth Heyworth	Wombwell Surgery PRG
Alan Curtis	Patient
Gill Partington	Ashville Medical Centre PRG

Agenda Item	Note	Action	Deadline
PC19/11/01	**WELCOME AND APOLOGIES**		
	The Chair welcomed everyone to the meeting and apologies were noted.		

PC19/11/02	**MINUTES OF THE PATIENT COUNCIL HELD ON 30 OCTOBER 2019**		
	The minutes of the previous meeting held on 30 October 2019 were approved.		
PC19/11/03	**AN INTRODUCTION TO RIGHT CARE BARNSLEY**		
	Jacqui Howarth, Service Manager for Right Care Barnsley and the Acorn Unit and Jayne Sivakumar, Chief Nurse for Barnsley CCG delivered a presentation which provided an introduction to Right Care Barnsley. <u>What is Right Care Barnsley?</u> Right Care Barnsley (RCB) is a multi -award winning care navigation single point of access centre for local health and care staff in order to help ensure that local patients across Barnsley receive the right care, at the right time, in the right place. Its functions are care coordination and brokerage of the correct level of care and the team are based on the Barnsley Hospital site. They are co-located with Patient Flow Team, Hospital Social Services Team and Discharge Case Managers The service is open 8am to 8pm, seven days per week includes bank holidays Calls which are all recorded, go through a call management system this allows them to prioritise GP's and Emergency Department staff and they can audit activity Outside of operational hours (8pm to 8am), referrers can dial the same number and the system will divert the call to the site flow matron or the Community Crisis Response Nurses. RCB are commissioned under an Alliance contract between the owner (Commissioner = Barnsley CCG) and the providers who deliver the service (Barnsley Hospital NHS Foundation Trust (BHNFT) and South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) All parties have signed up to the same aims and objectives which are; • to prevent unnecessary emergency hospital admissions and to,		

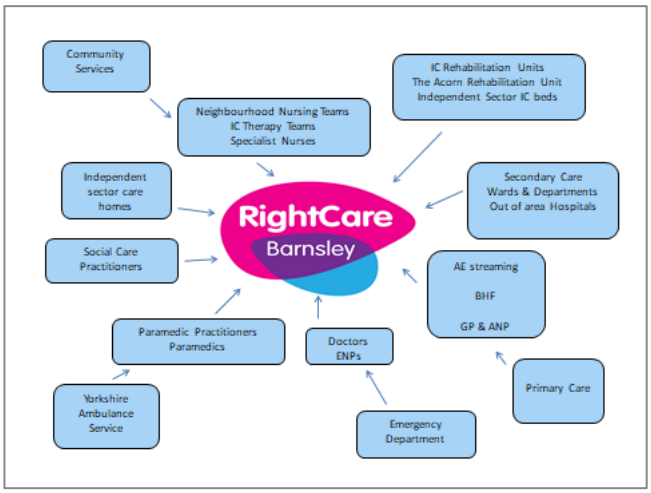
	• reduce length of stay in hospital whilst waiting discharge support and also emergency readmissions Their mantra and mission statement is **Right Care - Right Place - Right time** RCB initially launched in February 2015 <u>How has the service been developed and what role does it play locally?</u> The RCB Service has been developed over the last 4 years as new phases have been implemented Phase 1 (incoming referrals) - started with them taking referrals from GP's for medical people with medical conditions, potentially requiring hospital admission within 24 hours The role of RCB is to find suitable alternatives to hospital admission, keeping patients at home if possible, and if hospital is required avoid the Emergency Department unless clinically indicated this is a requirement. On average RCB take 640 referrals of this type per month (peak in July this year of 737 just on this type of call) RCB is staffed by a team of experienced Nurse Practitioners with a background in acute (hospital based) and community care. The nurses carry out a clinical assessment over the phone with the referrer taking history including clinical observation, sepsis screening, and completing an ambulatory care score. RCB will investigate different systems used by the hospital, community and social services for relevant information to inform the decision on suitable placement or service. If hospital intervention is required they will utilise appropriate ambulatory care, out-patient clinics or specialist services such as the BREATHE (Respiratory) and Frailty teams. This phase has developed over time and RCB is now taking referrals from any health or social care professionals for patients who require intervention urgently to avoid potential admission or further deterioration, and medical and surgical type referrals. They are in the process of extending to Gynaecology		

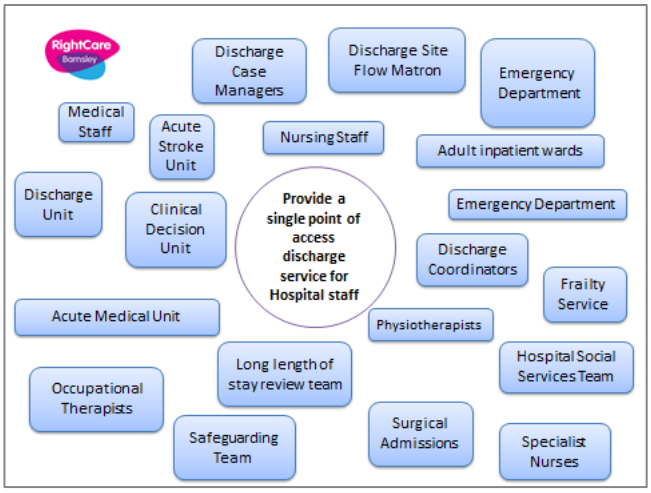
	with plans to also bring Orthopaedics on board. The service reports on how many referred patients they have provided an alternative to hospital admission and the average for 2019 so far is 29%, with a peak last month (October 2019) of 38% The next two phases (in relation to discharge referrals) were around reducing the length of time patients spend in hospital waiting for the next appropriate place or service. RCB take approximately 420 referrals from the hospital wards and departments per month for patients needing another service in place so they can be discharged or to avoid admission from our Urgent Care areas. The role of RCB is to activate the onwards referrals to social services, intermediate care, reablement and community services. They ensure the referrals have been accepted and monitor response against locally agreed and national timescales. Where we have identified gaps or challenges we have introduced new ways of working to improve the admission, avoidance and discharge processes Every morning RCB chair a situation reporting (sit-rep) conference call with our partners where any issues, challenges or difficulties are identified and discussed and we work together to find a solution to minimise delayed transfers of care. All the partners are proactive, they cooperate with each other and focus on the patient and what the patient needs – they use appropriate terminology recognising that every delayed transfer of care is a patient in the wrong place at the wrong time. It is very much a team effort but it's coordinated by RCB because they have the whole system overview. In December 2017, Barnsley's new Intermediate Care Service was launched. This Service is also commissioned as an alliance between Barnsley CCG, BHNFT, SWYFT Community services and Barnsley Healthcare Federation and Barnsley Council. RCB manage the intermediate care bed based elements of the service. They also are the single point of access for the intermediate care services from primary care, community or secondary care (including other hospitals where their role is to avoid unnecessary hospital admissions or to reduce length		

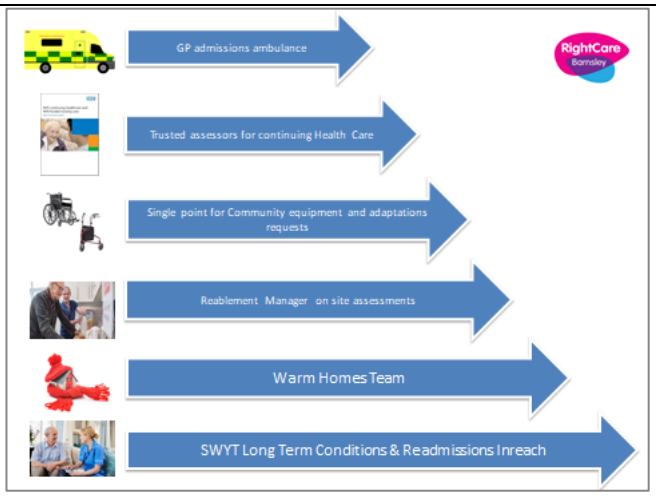
	of stay in hospital). To do this they have to maintain an effective flow into and out of the intermediate care beds and services - so they manage discharge from the different elements of the intermediate Care service using much the same approach as the discharge processes from the acute wards and departments – activating referrals to the appropriate onward service, monitoring response and timescales, trouble shooting and escalating where there are delays or barriers. They co-ordinate approximately 100 referrals in and 100 referrals out of the intermediate care bed based units per month, performance and outcomes is good with patients spending less time in the bed based rehabilitation units, better outcomes demonstrated on the outcomes measure and more patients returning to their own home following the intermediate care episode. The latest phase to be implemented is RCB support to Care Homes using skype nurse assessment. Implementation started at the very end of January 2019 in 3 Care homes and has been implemented in 17 care homes so far. The role of RCB is to avoid unnecessary GP visit and hospital admissions, and to support the care homes staff to treat residents in the home. The service is not for repeat prescriptions or 999 calls – it's for everything in between. Every morning the RCB nurses make a call to the care homes to say they are here, is there anyone you are worried about, anyone who is unwell? Most of their referrals come from this proactive morning call although the care homes can ring them any time during their operational hours if they become concerned about a resident. The nurses will take an initial screening and triage assessment over the phone to rule out emergency or 999 situations they then advise the caller to take the tablet to the resident and will log onto the skype screen to carry out the face to face assessment. A lot of their referrals are handled by giving advice and support, some on-going monitoring over a few days, perhaps contacting GP for script. A GP visit is only requested if necessary and the outcome of the RCB assessment is documented on system one (GP electronic system) or shared electronically with the GP practices who do not use system one.		

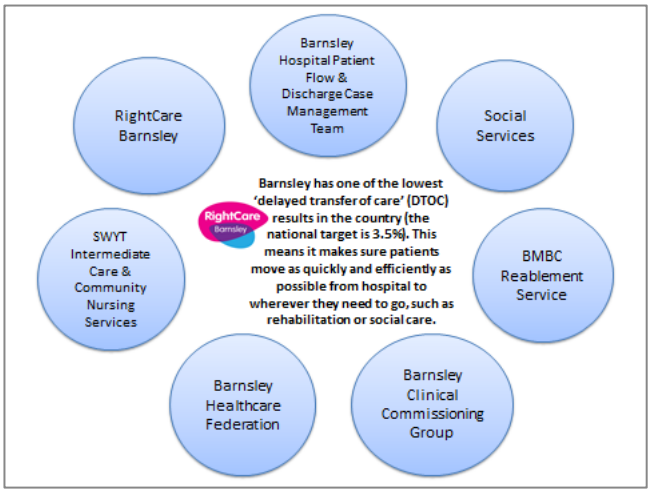
	Outcomes for this relatively new phase of the service are looking promising; GP visits were avoided for 73% of the referrals in August 2019. Tameside provide a similar service and, in Barnsley we are applying the same criteria used by them to measure avoided hospital admissions. In August 2019, 13.5% of the referrals we took were potential hospital admissions. Many of the referrals are resolved with advice, support, treatment and monitoring by RCB alongside GP input. RCB also refer to other teams and services such as Crisis Response Team, District Nurses, Specialist Nurses, Memory services etc. and they have brought some residents to frailty clinic for comprehensive geriatric assessment, investigation and commence treatment. There is lots of potential and whilst RCB rolls out to the 68 care homes across Barnsley they are already thinking about what else they could use the skype equipment for. On behalf of the members, the Chair thanked Jacqui and Jayne for their really interesting and informative presentation prior to inviting comments and feedback. In summary, the feedback received was overwhelmingly positive and members were really interested to hear such great feedback from a service which is truly tailored around the needs of the individual rather than the service. Members stated that it is a really positive development for both patients and staff in Barnsley which deserves all the national recognition that it has received and provides a shining example of true partnership working to ensure the right approach for all concerned. A brief discussion took place on how the foundations can be built upon and the service developed further going forwards as part of the work to integrate care locally. It was agreed to invite Jacqui and Jayne to come back to a future Patient Council meeting at the end of 2020 in order to provide a progress update on developments throughout 2020.		

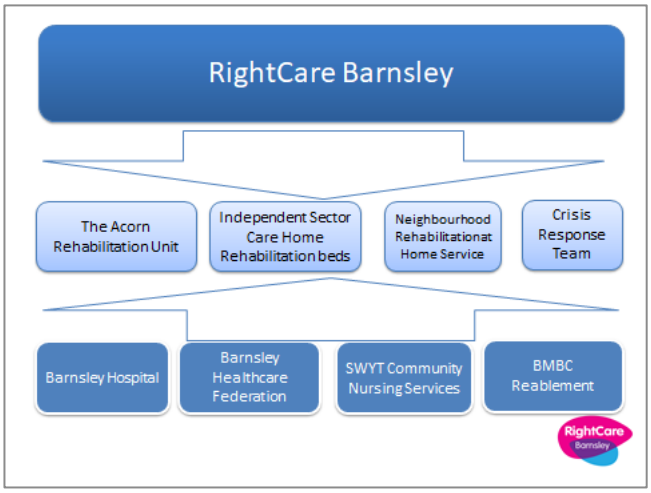
Presentation Slides

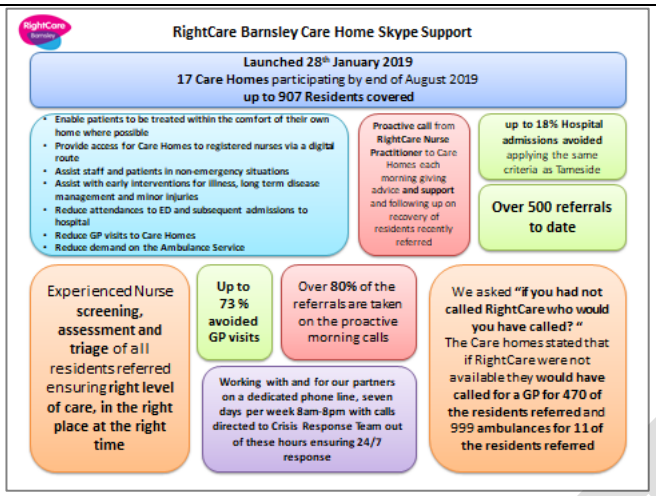




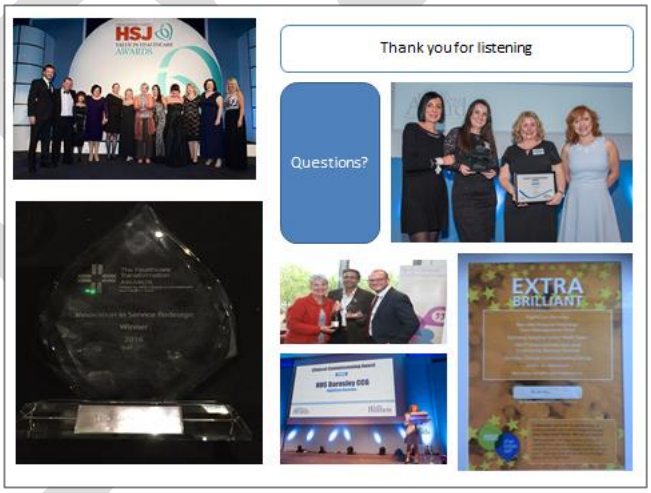

GP admissions ambulance
RightCare Barnsley
Trusted assessors for continuing Health Care
Single point for Community equipment and adaptations requests
Reablement Manager on site assessments
Warm Homes Team
SWYT Long Term Conditions & Readmissions Inreach


RightCare Barnsley
Barnsley Hospital Patient Flow & Discharge Case Management Team
Social Services
Barnsley has one of the lowest 'delayed transfer of care' (DTOC) results in the country (the national target is 3.5%). This means it makes sure patients move as quickly and efficiently as possible from hospital to wherever they need to go, such as rehabilitation or social care.
SWYT Intermediate Care & Community Nursing Services
BMBC Reablement Service
Barnsley Healthcare Federation
Barnsley Clinical Commissioning Group


RightCare Barnsley
The Acorn Rehabilitation Unit
Independent Sector Care Home Rehabilitation beds
Neighbourhood Rehabilitationat Home Service
Crisis Response Team
Barnsley Hospital
Barnsley Healthcare Federation
SWYT Community Nursing Services
BMBC Reablement
RightCare Barnsley


RightCare Barnsley Care Home Skype Support
Launched 28th January 2019
17 Care Homes participating by end of August 2019
up to 907 Residents covered
Enable patients to be treated within the comfort of their own home where possible
Provide access for Care Homes to registered nurses via a digital route
Assist staff and patients in non-emergency situations
Assist with early interventions for illness, long term disease management and minor injuries
Reduce attendances to ED and subsequent admissions to hospital
Reduce GP visits to Care Homes
Reduce demand on the Ambulance Service
Proactive call from RightCare Nurse Practitioner to Care Homes each morning giving advice and support and following up on recovery of residents recently referred
up to 18% Hospital admissions avoided applying the same criteria as Tameside
Over 500 referrals to date
Experienced Nurse screening, assessment and triage of all residents referred ensuring right level of care, in the right place at the right time
Up to 73 % avoided GP visits
Over 80% of the referrals are taken on the proactive morning calls
Working with and for our partners on a dedicated phone line, seven days per week 8am-8pm with calls directed to Crisis Response Team out of these hours ensuring 24/7 response
We asked "if you had not called RightCare who would you have called? "
The Care homes stated that if RightCare were not available they would have called for a GP for 470 of the residents referred and 999 ambulances for 11 of the residents referred


RightCare Barnsley
Discharge to Assess (D2A)
Care Home Beds
Or
Homefirst D2A


HSJ
Thank you for listening
Questions?
EXTRA BRILLIANT

PC19/11/04	**ANY OTHER BUSINESS**		
	The Chair thanked members on behalf of the CCG for the enthusiasm shown and their commitment to Patient Council throughout 2019 and wished everyone present all the best for the upcoming festive season.		
PC19/11/05	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Patient Council will be held on **Wednesday 26 February 2020 at 6.00pm**, in the Boardroom Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY.		