

Response to Better Health, Better Care Discussion Document South Edinburgh PPF – October 2007

We welcome the new Secretary for Health and Wellbeing and we are glad that she covers not only the NHS and all aspects of health, but also, sport, food safety and dentistry, social inclusion, equalities, anti-poverty measures, housing and regeneration and we value the insights that this will bring.

We endorse the approach laid out in the 2005 paper “Building a Better Health Service: Fit for the Future” where the shift is more towards delivering health care in a primary care setting and putting the patient firmly at the centre.

Moving on to each section of the Discussion Document:-

1. Improving Experience of Care

Our top priorities would be

- Setting out the standards every patient has a right to expect – including an additional standard giving patients the right to select a GP of choice within a reasonable range of their house. We would also wish to encourage GPs to extend opening hours – perhaps by opening later one or two evenings a week to help working people attend when they need to (with corresponding curtailment at the start of the GP working day).
- A new standard reflecting that it is imperative that patients in hospital must not be exposed to infection because of poor cleaning or nursing practices.
- Independent scrutiny within the process of major service change – in addition adopting routine publicly available audit of both community based services and hospitals.
- Increasing the patient, carer and community involvement and publicity for the delivery of local health services etc. This could be through the local PPFs, who could pull together information for their local communities.

Adopting set targets seems only to encourage clever ways to circumvent specific measurements. A better approach would be to routinely publicly audit both in primary care and in hospitals. Results from audit should provide the identification of problems and also encourage problem solving – and in making the results public, encourage public scrutiny.

2. Best Value

Best value is described as using public money wisely.

- One glaring issue that comes to mind is that the RIE at Little France uses pre-prepared meals from Wiltshire for its patients. Apart from the fact that the meals are not made fresh on the premises there is the question of trucks trundling up and down, which is inconsistent with the NHS’ responsibility towards the environment. We would encourage a full cost-benefit analysis for issues like this one.
- The scandal of healthcare associated infections (HAI) must be tackled on all fronts. Many patients are concerned about the poor quality of hospital cleaning services, which are often contracted out. What ‘contractual levers’ are ‘at our disposal’? Why are they not used to improve services? If the quality of cleaning services is poor (which many patients, nurses and doctors allege), why can the contract not be concluded and the cleaning taken back into an in-house arrangement where cleaners are responsible to the ward manager and are part of the ward team?
- Whilst we welcome the development and training of NHS staff and the broadening of skills, we hope there can be more attention paid to delivering training at the appropriate time in a person’s

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career. For example, one of our members was recently in an MBA class where 90% of the students were NHS staff (nurses – none of whom had any ward administration responsibilities, finance, and ambulance people) but **none** of whom had management roles. This is an expensive course – and could only realistically benefit the student if they had management experience and responsibilities. We need to consider urgently the training that is offered to cleaners (and other staff) about infection and the consequences of not adopting clear practices.

3. Taking Responsibility

While we endorse the approach of taking responsibility for our own health, we need to be careful about demonising people who are struggling with weight, tobacco or alcohol problems. Adequate and timely support is what is required, as well as good local facilities to encourage activities such as those available at Meadowbank Stadium and the Commonwealth Pool. Citizens of all ages from toddlers to older people can take advantage of the facilities and we need to keep and improve these.

For children, we suggest that chips should rarely be on a school meal menu. We also advocate that there is maximum playground space available to them and that school playing fields must not be sold off. Teachers/staff cars should not be parked on playground space.

In recognizing that dental services need to be strengthened (why was the Edinburgh Dental School closed?) we would have liked to see reference to the need for a substantive review of how these services are funded with a commitment to a significant lowering of charges.

It would also be very helpful to remove the unhealthy eating franchises situated within hospitals – a fast food outlet within the RIE for example.

4. Tackling Health Inequalities

The Ministerial Task force, due to report in May 2008, should provide interesting insights into how best to tackle these. We were impressed to learn of the range of targeted facilities offered in a SIP area within Edinburgh – and we hope that such facilities can be offered in all areas.

5. Anticipatory Care and Long Term Conditions

Long term neurological, developmental and mental health problems (as well as developmental disorders) all need to be explicitly recognised as long term conditions. We have a growing ageing population and therefore likelihood that there will be a need for specific programmes to be in place to help ALL carers and older people to cope more effectively with their increasing disability.

In particular we would advocate most strongly that we do not treat dementia as any different from any other long-term condition. It is an illness – usually quite distressing both for carer and the patient themselves – requiring respite and long-term care based on a single shared assessment.

We should like to emphasize that respite care may be needed in a range of circumstances and for a range of conditions and there must be such services available to carers to allow them to continue to care and to maintain their own health.

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Whilst we welcome the commitment to abolish prescription charges, we would like to see an audit of the prescribed drugs which are not used to inform medical professionals so that ways can be devised to encourage best use of drugs.

6. The Best Possible Start

It makes sense to target help and advice on children, particularly those in deprived areas – a fresh fruit shop in all communities would be a good start along with safe places to play. Stringent enforcement of the laws relating to the sale of alcohol and cigarettes would be welcome as would encouragement of supermarkets to keep alcohol sales within their alcohol displays (no cheap piled high beer or lager at the shop entrance for example).

We recognize that children who are carers for their older siblings or parents need themselves to have good quality help and care.

7. Continuous Improvement in Healthcare

We understand the attraction of pre-screening patients for MRSA or other high risk infections. We suggest that the screening is done at a time that allows the patient the opportunity to recover or get rid of the infection before admittance for surgery or treatment. Using MRSA screening as a delaying tactic for entering hospital must not become usual practice. Also, if we adopt these measures, then we need assurances that staff are also routinely screened. After all, they are the people that are the most likely to be in contact with the infections. We would also like to see no uniforms being worn to and from hospital by nurses, physiotherapists, etc.

We suggest extreme caution in the everyday use of near-patient testing becoming the norm. Diagnostics at a local level sounds attractive but experience indicates that unless those personnel using glucose meters, blood gas machines, or any other automated high technology analysers have a good scientific background and proper training and understanding about how the methods work, then patients can be at risk from being treated using erroneous results obtained from these methods. Far better to have tests done by experienced staff where quality control and audit are in place.

We note that NHS Boards are encouraged to achieve the ‘62-day waiting time target for cancer’. What does this mean? 62 days from GP appointment to end of treatment? To beginning of treatment? To consultation with cancer specialist? This must be clarified and there should always be room for the clinical judgment of the consultant. (In the case of suspected cancer there should be no more than 14 days from GP appointment to hospital consultation.)

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