**Walsall Together Service User Group**

**Minutes of Meeting held on**

**21st September2021**

**Present:**

Andrew Green Walsall Together Service User Group Chair  
Nazima Esscopri Ethnic Minority Community Development Worker  
Paul Ryder LGBT Sparkle  
Jayne Dragon LGBT Sparkle  
Emma Van Dun Senior Healthy Lifestyles Specialist  
Agnes Wallwork Expert by Experience, Walsall Resident  
Phil Ellet Walsall Resident, Service User  
Shaz Akhtar Transforming Communities Together, Walsall  
Paul Higgitt Senior Engagement Lead, Healthwatch Walsall   
Teresa Tunnel FACE Walsall  
Lynn Gamble Walsall Resident, Service User   
Agnes Wallwork Expert by Experience, Walsall Resident  
Cllr Ian Robertson  
Linda Beasley Zebra Access  
Kelly Mind Kind Projects

**In attendance**

Michelle Beddow Communications Lead for Walsall Together  
Rachel Barber Blackcountry CCG, Lay Member  
Michelle McManus Acting Head of Transformation, Walsall Together  
Natalie Harding Blackcountry and West Birmingham CCG   
Gemma Harris Walsall Healthcare NHS Trust  
Frank Botfield Digital Lead, Walsall Together

**Agenda Item 1.**

**Any declarations of interest**

**Agenda Item 2.**

**Apologies**

Kim Green Service User, Walsall Resident  
Janet Davies Brownhills Community Association

Naresh Hargun Walsall Resident, Service User

**Agenda Item 3:**

**Minutes from the Previous Meeting – 15th June**

Agreed as a true record

**Agenda Item 4.**

**Action Log**

PH shared the action log with the group.

A service user agreed that the action log should be reviewed but for noting purposes only.

**Agenda Item 5**:

**Walsall Together Update**

1. Walsall Together Update

5.a. Presentation by Michelle McManus

Michelle McManus gave an in-depth presentation around how the intelligence from both the respiratory and cardiology engagement report for potential service changes. Michelle also gave an update on the direction of travel for social prescribing.

There were some service user views that communication with social prescribing needs to be enhanced and for service users to be supported to access the right support. Michelle explained that social prescribing means a lot of things to different people and that partners ambitions are to have a case or link worker that works with people for a period.

**Action:** For the presentation to be made available on the Walsall Together website for wider dissemination.

**Action:** It was agreed that a future agenda item around Social Prescribing.

The Walsall Together programme team used the intelligence from the respiratory and cardiology reports in order to highlight the engagement work identified the following areas for action:

* Support Group
* Social Prescribing (access to self-help and support)
* Referral to IAPT
* Personalised Care Plans
* NHS 111 giving access to local services other than ED
* Pulmonary Rehab – many people find it is too hard so drop out
* MDTs for respiratory conditions

**Proposed Plans highlighted are:**

* ***Support Group & Social Prescribing & Referral to IAPT:*** this will be taken through our Resilient Communities workstream to agree how to activate this
* ***Personalised Care Plans:*** patients will be seen by Case Managers who will agree with the patient an individualised care plan and then get additional support from Respiratory Specialist, locality Multi-Disciplinary Team (MDT), or Specialist MDT as required.  Patients would be given the numbers to escalate themselves to as first point on contact [e.g., Respiratory Nurse in hours and Care Navigation Centre (CNC) out of hours]
* ***NHS111:*** for those people who seek support via other agencies, there is a need to provide local alternatives for care other than A&E and GPs – this could be via the CNC
* ***Pulmonary Rehab:*** there is the potential to follow up patients who do not want the face-to-face rehab programme, and offer them a self-initiated programme which could be followed up via the CNC
* ***MDTs:*** we need to get the MDTs functioning and push Respiratory patients through this and get the Consultant MDT to consider conditions other than COPD

**Cardiology**

**In relation to cardiology the proposed plans are:**

Community services working with specialist consultant cardiology at Walsall Manor to

1. Provide support to multi-disciplinary team (MDT) meetings
2. Provide support to community nurses and Allied Health Professionals (AHPs) – a contact for support when needed
3. Support to patients – access to clinic and home visits if needed

Four areas of focus:

1. Additional recruitment to community heart failure nurses
2. Procurement of V-Scanner, BP monitors and weighing device – to support diagnostics and monitoring for people who cannot attend clinic
3. Discharge of patients from acute care into community services
4. Streaming of patients from one stop heart failure diagnosis (OASIS clinic) into community services

There were also discussions around the frequency of the meetings and for these to be more regular. We have also agreed that the format will change in that there will be smaller focus groups taking place and Walsall Together update meetings.

The next meeting is scheduled for 20 October, and we are planning that the focus of this will be around Walsall Care Navigation Centre.

Walsall Together contract with Healthwatch to provide engagement on priorities that are agreed annually.

Original priorities – commenced August 2019

* + Respiratory
  + Cardiology
  + Diabetes
  + End of Life
  + Mental Health Outpatients
  + Healthy Child 0-19 services

We agreed to ensure we have closed the loop on the original priorities

**5.b. Update on Care Navigation Centre – Verbal Update from Gemma Harris**

Due to time constraint, it was agreed this would be a singe agenda item for service user to find out more about how this will work.

Andrew Green raised the question is there an engagement process in putting the care navigation centre in place.

Michelle McManus highlights that care navigation is core to the Walsall Together model. It will be a Walsall wide access point to help providers and service user navigate through the care system and that there was general consultation around the Walsall Together model a few years ago. It was initially around rapid response and for GP’s and nurses to help avoid hospital admissions. Through the COVID pandemic the care navigation system has been effective in helping co-ordinate care.

For people with long term conditions the aim is to give people direct access to the care navigation team. It is also for the Walsall Together Service User Group to help guide the progression and provide challenge.

**Action:** Paul Higgitt to arrange for a single agenda item at the next meeting around what is Walsall Care Navigation Centre.

**5.c. Keeping Patient Data Safe**

Verbal Update: Frank Botfeld, Digital, Data IT Lead for Walsall Together again due to time constraint gave a summary on shared care records and data safety.

It’s about providers and service users being able to navigate the system. There will also be opportunities for people to opt out of data sharing.

There were also comments about the challenges with Econsult and being able to access the right GP advice. Also, the issue on how it is saving data and sharing data.

**Agenda Item 6. Group Discussion**

User and Resident Feedback and Views

Andrew Green highlighted that this platform is the opportunity for people to share their views.

Michelle McManus highlighted that Walsall Together is a huge programme of change and that there is a journey to go on. Is this group about being involved in the decision-making process and design of services rather than just a forum for Walsall Together updates?

Walsall Together contract with Healthwatch provides engagement on priorities that are agreed annually.

There was discussion that having a focus on the provision and changes to mental health services. It is for the group and Clinical and Professional Leadership Group (CPLG) to steer engagement priorities that are in scope.

Michelle McManus gave an overview of CPLG and that the partners are to ensure that engagement feedback and intelligence is acted upon with CPLG. Michelle also explained that the Walsall Together partnership is not just about clinical pathways but social care and the wider determinants of health.

* Current priorities – agreed November 2020
  + Health inequalities including support for the development of a Population Health & Inequalities Strategy – what makes people happy and healthy?
  + Outpatients including virtual consultations
  + End of Life
  + Mental health community transformation – to inform future service provision in Walsall, aligned to the Health & Wellbeing Board review of mental health and wellbeing (IAPT, primary care mental health, support to adult and children’s integrated teams)

There were views from service users that the Walsall Together SUG has the potential for some targeted focus groups feeding into it. It seems that being able to summarise the Walsall Together programme is key but focused agenda items would be useful.

It was also noted that we have spent a great deal of time over last few months talking about diabetes, cardiology and respiratory, and that it would be good if we can focus discussion on the other key lines of enquiry.

**Agenda Item 7. Any other Business**

None

**Date and time of next meeting**: To be advised