Health & Care Transformation in Oxfordshire

Report from the Developing Community Hospital Options Stakeholder Workshop held on 22nd September 2016

1. Purpose of report

The purpose of this report is to present the feedback drawn from the stakeholder workshop held on Thursday 22nd September 2016 at the Kassam Stadium in Oxford.

It describes the event, outlines key themes, and identifies concerns and issues expressed during discussions both following a presentation and during facilitated table discussions.

This report will be presented to the Transformation Board and considered by the project group which is developing a pre-consultation business case for any proposed changes to community hospitals.

2. Background

A wide ranging Health & Care Transformation stakeholder event held on 6th June in Oxford signalled the start of a public conversation about what health care could look like in 2020/21 - how it could improve health and wellbeing in Oxfordshire, and improve the quality of care people receive while being financially sustainable.

The conversation has extended across Oxfordshire through a series of drop-in roadshows, held in various localities. These events have provided an opportunity for people to find out more about the challenges being faced in Oxfordshire and ideas for possible new models of care. Public feedback gathered at these roadshows and through an online survey will be used to further inform and shape plans.

The workshop held on the 22nd September was part of this conversation. Its purpose was to further develop the themes explored at the previous stakeholder event on 28th July, which included presentations and discussions about ideas to bring care closer to home from integrated community hubs - a new way of thinking about community hospitals.

The 22nd September workshop looked specifically at community hospital inpatient services and fed back how the Transformation programme's Integrated Care for Frail Older People and Urgent and Emergency Care for the General Population Workstream has been developing the options for the future of community hospital inpatient services. There was particular regard to urgent care and rehabilitation services; the impact of travel and access for patients, families and carers; and thoughts and feedback on what further information is required for the formal public consultation scheduled to begin in January 2017.

3. Summary of Key Points Made By Stakeholders for Consideration by the Community Hospitals Business Case Project Group

3.1 Comments on the issues around delivering rehabilitation of high quality, though in fewer places

- Problems of access and public transport to fewer centres
- Shortages in workforce numbers to support more people in their own homes
- The need for better discharge coordination
- Support for unpaid carers

3.2 Comments around the characteristics of a good home care package

- Access to good quality information about the care options available
- Joined up working by the key agencies
- Support for elderly carers
- More local diagnostics

3.3 Other issues

- Recruitment and retention of high quality staff especially to senior clinical roles such as geriatrics and specialist GPs
- Need for more multi-skilled staff
- Costs of larger rehabilitation centres
- What will be the role of primary care in these services?
- Need to ensure there is up to date information on voluntary/community networks in local communities
- Where does palliative and end of life care fit into this model of care?
- The process would benefit from getting people who have experienced the care to talk about their experiences (good and bad) as this is a powerful tool to help with the system redesign
- Patient representatives should be on all workstreams.

4. Event

Stakeholders who had attended the stakeholder events on the 6th June and 28th July were invited to participate in the workshop on 22nd September. Those who attended included

representatives from organisations across health, voluntary and community sectors as well as patient representatives from the Oxfordshire localities.

The workshop was led by a team comprising:

- Pete McGrane, clinical director for Older People's Services, Oxford Health NHS Foundation Trust
- Lily O'Connor, divisional head of nursing, Oxford University Hospitals Foundations Trust Hospitals
- Dr Barbara Batty, Oxfordshire Clinical Commissioning Group
- Dominic Hardisty, chief operating officer Oxford Health NHS Foundation Trust

The event agenda started with a presentation about how best to provide care and support to support frail elderly patients, the role of community inpatient beds to help deliver this model and the options being explored for the number of sites where community inpatient beds could be located. At the heart of the options being explored is the need to prevent people being unnecessarily admitted to acute hospital or using A&E services because we can't offer a better or more local alternative. A copy of the presentation is available in appendix b.

After the presentation, attendees were invited to ask questions for clarification before heading into table discussions.

The table discussions were each led and facilitated by the workshop team –so people on each table could discuss and debate the questions directly with clinical workstream representatives responsible for developing the model of care.

Each table was asked to discuss the following questions:

1. **What do you think the issues might be in delivering rehabilitation of high quality, though in fewer places?**

2. If we are delivering more care at home, what would the characteristics of a good home care package be?

1. Feedback from Table Discussions

This section describes the key themes and issues raised – it includes a brief general summary, along with detail of the comments provided.

Question 1:

What do you think the issues might be in delivering rehabilitation of high quality, though in fewer places?

The groups raised a number of points for consideration, from concerns with transport access and how care will be provided to people at home, to the staffing of services, and the impact they may have on timely rehabilitation.

Points raised
Opening times and transport access. Not all people can drive and/or pay expensive parking charges.
If beds are concentrated in one place, parking will be an issue. There is already an issue getting volunteer drivers because of problems parking and waiting at acute sites.
Time in rehabilitation, and timely rehabilitation e.g. timely physio available following a fracture.
If more care is provided at home there will be real challenges as equipment and staff is scarce.
A small number of intensive places may mean more breaks in care.
A better structure of district nurses or equivalent is required to deliver care at home.
Discharge decisions need to take account of people's circumstances.
Arguments for closer to home include the upskilling of local GPs and clinicians.
The model of care for community hospitals keeps changing. How can rehabilitation be designed if you are unsure what the model is?
As healthcare gets more efficient at enabling people to get in and out of hospital more quickly, people need a little more looking after, especially if re-enabling them to get home. These should be more local for friends and family to visit and to get people re-engaged with their local communities.
Needs, and in parallel, the number of beds, changes from week to week, so it is difficult to predict the size of the rehabilitation required.
Demand is due to rise by 17%.
Poor communication and a lot of mistrust within the public that health services are not being transparent.
There needs to be better discharge coordination. HealthWatch found that there were seven different professionals involved in discharge often from different authorities.
This is pushing more people to have their care at home. Won't there still be the same number of people needing care?
Concern that people receive rehab for around eight weeks and primary care picks up the burden.
Lots of people don't know how to access care without the support of their GP practice.
What about retirement villages? They will have huge impacts.
Support to patient carers.
Ensuring that patients are equal partners in the discussions and develop a holistic model to take account of future needs.
Having a better understanding of what's currently available across the different locality. Therefore scoping all services including those provided by the community and voluntary section, and getting buy-in from them.
The how, what, and why the changes will take place will be a major issue for the public, and needs to be taken into consideration.
Staffing of the services – concern that the new models are very dependent on GPs.
How the staff for these services have continued professional development and a career

Points raised
portfolio type environment.
Accommodation for staff.

Question 2:

If we are delivering more care at home, what would the characteristics of a good home care package be?

The overriding theme in response to this question was collaboration. The groups brought up the points that key agencies and families need to be more joined up with better communication, patients need continuity of care at home, and a contact plan would be useful to families and the emergency services.

As well as collaboration, the groups also discussed involvement of the voluntary sector, appropriate staff training, and providing services that enable and empower people to look after themselves.

Points Raised
Involving and supporting the voluntary sector to provide domiciliary care and support.
Making sure that everyone knows what care is available in their areas and who to talk to.
Reviewing care packages in a timely manner to ensure that crises don't build up.
Ensuring that people feel they have a life to live.
Providing a service that enables people and think of their outcomes in terms of returning to independence as far as they can.
Better communication across the programme and joining up of key agencies.
Early planning before discharge.
Patient led goal setting and delivery should also involve the clinician. Also important that it is ensured that the patient has understood the agreed goals.
More responsive and person centred, with more flexible agencies.
Ensuring that a multidisciplinary team approach provides a rewarding environment.
Changing the terminology from carer to e.g. support team worker, to ensure proper recognition is had. Primary care should identify carers so that GPs can have this information when they are visited for an appointment.
Making sure that families and the support team are included in the model.
An effective escalation system.
Advance notice of when you will receive a visit.
Support for elderly carers who may also fall ill.
Continuity of care at home – the current problem is that individuals receive up to four or five visits a day, all from different people which can be very confusing.
Thames Valley Police highlighted the importance of an available contact plan so there is one central place they can go to check whether an individual is receiving treatment.
A point of contact for carers – what happened to the carers' strategy?
More diagnostics available locally or via GP surgeries.
Ensuring that those with mental health problems and learning disabilities don't slip through

the net.
Technology, such as a pedometer, help carers identify if there are reductions in activity, and could be used for other aspects of care.
Appropriate training for staff.
Physical health nurses knowing how to assess someone's psychological needs

2. Other Issues Raised

The discussion at the workshop covered a number of other themes, which have been captured below:

Key Themes	**Summary of issues**
Staffing and recruitment	• What are the barriers stopping geriatricians or specialist GPs being attracted to Oxford Health Foundation Trust roles? • Need to break down professional boundaries and have more multi-skilled staff. • Need to use the workforce better, including voluntary sector resources (people and facilities).
Emergency Multidisciplinary Unit (EMU)	• The EMUs provide excellent service, but not at scale - having more of them in the future? • Making services such as the Witney EMU 7-day instead of the existing 5-day service.
Technology	• Use of technology to help with communication to staff and the public. Potentially looking at the use of a helpline, website, FAQs.
Bigger picture	• How are political agendas factored into discussions and acknowledged? • The prevention agenda needs to be raised. • Need to ensure we are sharing learning and best practice from other successful models e.g. Cotswold GP pilot. • Be clear of benefits of proposals – don't focus on what is being 'lost'. • Public information and education are really important. • Need to be able to explain the whole pathways to patients to understand the journey at an individual level – including opportunities for self-management.
Costs	• How much will it cost to run the larger rehabilitation centres? • Like to see funding for extra care beds in local facilities like the six in Faringdon. • What will it cost to have care at home? Surely the cost gets passed onto the patient who gets cared for at home rather than in hospital?

Key Themes	Summary of issues
	• Money to follow patient and pathway. Ensure that there is not a disconnect between these e.g. disinvestment by council in one part of the pathway and another stakeholder wanting input in another part of the pathway.
Primary care	• If GPs were giving the message then that would be more credible than the providers. • How are you working with primary care? Are you planning for an increase in demand? • The primary care work stream has asked PPG groups what contribution they can make to help patients in practice use services differently e.g. use of care navigators.
Voluntary sector	• The voluntary sector is really good at developing relationships. • Need to ensure there is up to date information on voluntary/community networks in local communities.
Patient empowerment	• Ensuring that patients are equal partners in the discussions and develop a holistic model to take into account future needs. • Need to manage expectation – need to consider not just the patient, but the expectation and understanding of the family and carers.
Communications and engagement	• The process would benefit from getting people who have experienced the care to talk about their experiences (good and bad) as this is a powerful tool to help with the system redesign. • Patient representatives should be on all workstreams, not just some.
Palliative care	• Ensuring end of life care is accommodated within the service models. • There needs to be something in Wantage that can provide respite and convalescence closer to home.
Social services	• Where are the discussions with the County Social Services? • Need to break down the barrier between health and social care.

AGENDA

Oxfordshire Healthcare Transformation:

Developing Community Hospital Options

9.30am	**Welcome and introductions** • Aims of today's workshop • What are we currently working on? •	Pete McGrane Clinical Director, Oxford Health NHS Foundation Trust
10am	**The emerging model of care to support frail elderly people** • Our vision and model of care • What would need to change • What else do we need to consider? • What are the options being explored?	
10.30am	**Table discussions** **1.** What do you think the issues might be in delivering rehabilitation of high quality, though in fewer places? 2. If we are delivering more care at home, what would the characteristics of a good home care package be?	
11.40am	HOSC briefing	Diane Hedges, COO Oxfordshire CCG
11.50am	Wrap Up and Next Steps	Pete McGrane