NEW HEALTHCARE SERVICES FOR HENLEY

A new way of delivering health care and support is being introduced for people living in Henley and those registered with an Oxfordshire GP practice - the care that will be provided to patients in their own homes and at the newly developed Townlands hospital is called ambulatory care.

What is Ambulatory Care?

Ambulatory care enables patients to be seen earlier and closer to where they live. Patients are assessed, treated and, if needed, provided with rehabilitation support, without having to be admitted to hospital. In the case of Henley, ambulatory care will be provided within patients' own homes and at Townlands hospital.

At the heart of Henley's ambulatory care services is a consultant/GP led service called a Rapid Access Care Unit (RACU) at Townlands. As well as the Unit, there will be a wide range of community-based care and support from by an integrated team of health and social care staff.

The ambulatory care services that will be provided in Henley are not emergency services. Clearly there are times when patients should be admitted to hospital for serious health problems such as suspected strokes, cardiac chest pain or significant head injuries. This will still be the case – patients will always be taken straight to a main acute hospital (the Royal Berkshire Hospital or Oxford University Hospitals) if this is the best place for them.

Why is Ambulatory Care Being Introduced to the Henley Area?

By identifying and dealing with problems sooner, the NHS is much more able to help keep people well and out of hospital for longer. As well as providing earlier diagnosis and treatment locally, ambulatory care means patients will receive any follow up care or longer term support in their own homes or through local follow up appointments.

It is often the case that people who have an unplanned stay in hospital are frail, older people. They generally have more than one long term condition, often including dementia, and have been admitted to hospital because they have developed a problem or their condition has worsened. Their stay in hospital is sometimes because there aren't the services available locally which can give them the shorter, same day treatment they need within their local community.

The experience of clinicians looking after this group of patients is that, once an older person is admitted to hospital for treatment, it is important to make sure that their stay is only as long as it medically needs to be. Otherwise, their patient's overall health tends to deteriorate and the original problem that they were first admitted to hospital for is made worse by other health problems. More often than not, the end result is a longer hospital stay and the need for more complex care and support for that person when they are discharged from hospital.

What is the Rapid Access Care Unit (RACU)?

The new Rapid Access Care Unit (RACU) will be based at Townlands and will provide the ambulatory care that we have just described.

The unit will be open seven days a week, from 8am to 8pm, 365 days a year with a Consultant/GP on site every morning, Monday to Saturday. It will offer next day appointments, although the unit will be able to accommodate same day appointments if there is a particular medical requirement. Patients attending the RACU will be assessed and then, depending on their needs, receive diagnostic tests or treatments such as intravenous antibiotics all on the same day.

A consultant or lead GP will run appointment clinics each morning, Monday to Saturday. They will see patients who have been referred to them by GPs, paramedics, out of hours services, community based staff (such as district nurses), local hospitals or out of hours services.

This lead clinician will be supported by a team of health and social care professionals who have a range of specialised skills and expertise, such as nurses, community nurses, physiotherapy and occupational therapy practitioners, social care coordinators, hospital and mental health staff. All staff working at the RACU will be trained in dementia care.

The service will be available to people living in Oxfordshire although we expect that the main users of the unit will be those patients registered with the five Oxfordshire GP practices in and around the Henley area (The Bell Surgery, Red Cross Road Surgery, The Hart Surgery, Sonning Common Health Centre and Nettlebed Surgery).

The RACU will support patients who are over the age of 18; although the health needs of the local area mean that the majority of people who are likely to be helped by the RACU will be over the age of 65.

As well as receiving same day assessment and treatment, if it is needed, patients who are discharged from the RACU will receive follow up care at home or come back to the unit for follow up appointments or to be seen by other services such as the diabetic nursing team, the heart failure nurses or speech and language therapy.

What Sort of Follow-Up Care is provided?

There may be times when the RACU medical team decides that a patient would benefit from a little more time under the care of the Unit's medical team before they can be discharged home. In these situations, a patient who needs this extra care will be admitted to what is known as an intermediate care bed.

Intermediate care beds will be available in the Orders of St John Care Trust (OSJCT) home, which will also be based on the same site as the Townlands hospital. Anyone who is admitted to one of these NHS commissioned beds will be looked after by appropriately trained nurses and be overseen by the RACU medical team. The beds will be in individual rooms, which are likely to be located together within the care home.

In addition to admission to the care home from the RACU, these intermediate care beds will be available for patients who no longer need care on an acute hospital ward (such as the Royal Berkshire or Oxford University hospitals), but who would benefit from some additional support and care to further their recovery and maximise their independence before going home.

We expect that we will need to have up to eight beds available at the Orders of St John Care Trust home with the ability to increase that number to 14 beds if demand increases.

In the majority of cases, if a patient needs any further follow-up care, this will be provided to them in their own home. This is because clinical evidence has shown that people recover and gain their independence more quickly if they are provided with rehabilitation services tailored to their own needs within the familiar surroundings of their own home.

If it is better for patients to receive treatment and support in their own homes, what sort of services would I receive?

Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust and Oxfordshire County Council are working together to deliver local services delivered by one team of health and social care staff (known as an Integrated Locality Team). This Integrated Locality Team would operate as part of the ambulatory care service.

The type of services that could be provided would be tailored so that they meet a patient's particular health and care needs. Because these services will be provided by an integrated team of health and social care staff, they will work together to deliver your care – meaning your care should be more joined up and better coordinated.

The Integrated Locality Team will include:

- District nurses
- Physiotherapists
- Occupational therapists
- Older people's mental health nurses
- Palliative care matrons
- Social workers
- Reablement staff

Importantly, the RACU will have its own social care coordinator who will make sure that patients have suitable packages of follow-up social care. If a patient, who has been seen by the RACU team, is already receiving social care support, this will continue and, where appropriate, will be extended or altered to ensure their needs are being met in the best way.

What will this mean for social care at home?

Clinical evidence shows that staying at home or leaving hospital quickly is better for people. It reduces the risk of infections being picked up in hospital and enables them to retain their independence which is something people have said is important to them. It also promotes quicker recovery.

Care packages are stopped when someone goes into hospital and their discharge can be delayed as they wait to have their package restarted. By remaining at home the continuity of care will not be lost.

By receiving care from a locality team made up of health and social care staff, patients and their family and friends (their informal carers) will often see the same staff. This will lead to a greater rapport between them and staff and will mean people do not have to keep repeating the same information to different care providers