# Health & Care Transformation in Oxfordshire

# Report from the Stakeholder Workshop Held on 28th July 2016

## 1. Purpose of report

The purpose of this report is to present the feedback drawn from the stakeholder workshop held on Thursday 28th July 2016.

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 Health & Care Transformation stakeholder event held on 6 June 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, improve the quality of care people receive whilst being financially sustainable.

The conversation has extended out 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 28th July was held as part of this conversation. Its purpose was to gather feedback on any possible options for community inpatient services; discuss the criteria that might be used to assess any option and gather views on other services and where they may be located.

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

### 3.1 Comments on the current list of possible options

- Many felt the one site option would not give best or equitable access
- Although the six site option was questioned in general, and one group ruled this out, others felt it should not be excluded at this stage
- A suggestion was made that a 'sub option' should be considered, based on the Henley RAACU model, which could enable more sites

### 3.2 Location of sites

- Concerns were expressed about the accessibility of the Churchill – not just for those travelling into the city but for city residents accessing the site by car and public transport
- Witney was suggested as a location in the West, although it was recognised that the site would need to be expanded
- The Milton/Didcot (Science Vale) area was suggested as a location for a south site
- Overall, the discussions identified key factors to be considered when choosing locations for sites – including basing any configuration on GP clusters, access, demography and travel time (rather than distance) e.g. "*I don't think it's about location but providing the best place for patients' needs to be catered for*"

### 3.3 Benefits criteria

- There was a clear view expressed that outcomes and experience should be separate measures – stakeholders wanted to see the clinical evidence to measure outcomes and to understand how any options would improve patient experience
- Prevention was a key theme that emerged in the discussions – including its pivotal role in delivering the Five Year Forward View, enabling community hospitals to be better utilised to support prevention, helping to reduce demand and enabling patients to be seen as a whole person.

### 3.4 Other services and issues

- It was noted that an understanding of where other services would be based (the bigger picture and context) was needed to better comment on possible options and location
- Points were raised about the role of Social Services in the consultation and the presence of key staff at events
- The need to better accommodate the needs of patients with learning disabilities and autism was raised – both in terms of the design of buildings as well as the provision and delivery of services
- Suggestions were made about the need to have patients stories that clearly describe the benefits of new models of care and services

## 4. Event

Stakeholders who had attended the stakeholder event on the 6th June were invited to participate in the workshop. 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 team comprising:

- Pete McGrane, Clinical Director for Older People's Services, Oxford Health NHS Foundation Trust
- Anne Brierley, Operations Director for Older People's Services, Oxford Health NHS Foundation Trust
- Dr Barbara Batty, Oxfordshire Clinical Commissioning Group
- Dr James Price, Oxford University Hospitals NHS Foundation Trust.

The agenda (see appendix A) started with a presentation about the model of care 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.

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 – this was so that people on each table could discuss and debate the questions directly with members of the clinical workstream responsible for developing the model of care.

Each table was asked to discuss the following questions:

1. Are these options the correct ones to work up in detail to put forward to consultation? Are there others we should be working up? Are there any on the list we should be excluding and why?
2. For each option, which locations do you suggest we should consider?
3. What are the key issues we need to take into account in terms of other services that could be within local hospitals or other locations?
4. What are the criteria that should be used to assess the benefits of any option?

## 5. Feedback from Table Discussions

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

**Question 1:**

**Are these options the correct ones to work up in detail to put forward to consultation? Are there others we should be working up? Are there any on the list we should be excluding and why?**

All options were considered – the most consistent feedback about any particular configuration was the one site option, which many felt would not give good access or would bring care closer to home. Likewise concerns were expressed about the feasibility of a two site option. Although some of the tables the need for six site option, there was a general view that, although probably not a workable solution, this option should not be excluded at this stage.

One group did identify another possible option – that of a RACU type model as seen in Henley, which could be delivered across a larger number of sites.

| **Points raised** |
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| The option looking at one site does not seem good in terms of access for patients across the county - clinical or operationally |
| Why are 6 sites on the list if you need to have a population of approximately 200-250k to make them viable? The group accepted that this should be worked up |
| Looking at 2 options onwards you start to get into issues around accessibility |
| Looking at 4 options and above you then need to start to question workforce and financial viability of delivery |
| Looking at the population breakdown 3 seems reasonable |
| It looks like the Horton is a done deal? I'm not sure that six sites is right – why so many? |
| I don't think you can have one or two site options. It takes me 1.5 hours to get from Hook Norton to Oxford. |
| Could there be a sub option to include more sites based in the RACU model that was 5 days a week? |
| It seems to me that three site option seems more favourable i.e. north; middle and south |
| I don't think two is possible, and you can't have just one site if it's in Oxford City. Six seems unrealistic |
| One site isn't "local" – doesn't feel like a *community* hospital |
| One site – there would be access issues. Would it lead to inequalities? |
| In an ideal world, you would have six but we need to strike a balance |
| Could we have diagnostics on sites other than the big three or four sites? |
| Those counties with one site for this, where are they? |
| If you talk care closer to home, then you need 6 sites |
| We should look at all options |
| Are people coming from the local area? Who need the community hospital services, e.g. older people, younger people needs? At the moment it looks like you need four based on where the need is. |

**Question 2:**

**For each option, which locations do you suggest we should consider?**

The overriding theme in response to this question was the issue of accessibility and travel time, and subsequent availability of parking when on site.

Concerns were raised about the accessibility of the Churchill both for those patients travelling in from outside the city and across the city itself. It was felt that Witney offered potential but that the site was not big enough and possibly doesn't offer opportunity for expansion. The South Milton/Didcot was also identified as a potential location, particularly given the large scale growth identified.

As well as location-specific comments, the groups discussed what factors could be used to assess site location – travel time (rather than distance), demography and areas of population growth and the catchment of the new GP clusters were all considered to be factors that should be considered.

| **Points Raised** |
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| Can you work out locations/options on distance travelled? |

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| Time of travel, rather than miles? |
| Parking is a factor |
| Public transport time and availability e.g. Faringdon to JR served by bus. Bus to Churchill only available from park and ride. |
| Think about locations with greatest growth – presumably if new build you could put them anywhere accessible and don't need to worry about the older estate. |
| Look at options based on demography, travel time |
| Difficult to compare locations and where they should be - old people in the south doesn't mean old people forever. You need to look at population demography for the next 5 – 10 years so you can anticipate need. |
| Access and travel time important for locations, as much as location number |
| Aren't GPs clustering, so could sites be built around these clusters rather than the localities? Sites have to be able to be reached by carers on a bus route – often the carer themselves is elderly (a lot of children of elderly parents live away) |
| I don't think it's about location but providing the best place for patients' needs to be catered for |
| Is it a given what site it would be within the City? The Churchill is dreadful to get to |
| Economies of scale is what it's about – you need to clearly explain the pros and cons i.e. you will get better care, better outcomes and experience, more joined up care but it will take you 20 minutes longer to get there. I think people would travel for a different type of care. |
| If the Horton was made more attractive would also be more appealing |
| Difficult to truly consider this without considering and understanding what the models of care look like about and below the local hospital model, so you can factor in areas such as access to diagnostics etc |
| Locations Witney for West offers potential but the site is not big enough and don't think offers opportunity for expansion |
| South Milton/Didcot for a location particularly when you bear in mind the large scale growth identified there and links to Science Vale area. Also has good transport links, but there was acceptance that this may need to be a new build |
| For the North - population changes to Bicester may create issues particularly if wanting to avoid city |
| Banbury is not going to change |

**Question 3:**

**What are the key issues we need to take into account in terms of other services that could be within local hospitals or other locations?**

The groups raised a number of considerations to be borne in mind, from ensuring the needs of patients with autism or learning disabilities are met through both services and building design and ensuring parity of mental and physical health.

| **Points Raised** |
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| New buildings have to be planned with the needs of autism in mind. Many patients aren't able to access services – there is need to skill up the workforce. For example, clinicians and nursing staff need to understand sensory issues e.g. lighting. Autism and LD affects the patient experience. |
| A new build is very slow –what can you provide while you're waiting for a new build? People need to understand the limitations |
| Will people get access to more services in new community hospitals than they do currently? |
| Have the community hospitals as more than a medical centre, but also social support around things like falls prevention, stopping loneliness, drop in preventative sessions. |
| Raising the awareness for the family about this new model and getting access to the GP/primary |

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| care fits with this as this will be key for patients |
| Access for patients and equitably |
| No differences indicated with models of care for ethnic minorities - suggest that these groups are consulted to take this into consideration |
| Ensuring parity of mental health and physical health services |
| More consideration of self-care and the prevention theme |
| Questions around the provision of specialist palliative care needs how does the model provide support in for clinician's friends, family etc for this area? |
| What role do local hospitals have from an education basis to members of the public? (possibly comes under primary care through things like social prescribing) |
| Needs to be an element of future proofing |
| Ensuring the clinicians are fully engaged and bought into the process |
| What about day case provision? |
| What about the resilience of this models with care homes |
| Learning disabilities have not been particularly well addressed previously and needs to be improve |
| Lots of things need to stay at locality level: MIU, urgent care and community teams. Primary care and other services should be working together. Mental health should be as or more local as outpatients access. This should also apply to preventative measures in mental health. |
| End of life care. |

**Question 4**

**What are the criteria that should be used to assess the benefits of any option?**

Many comments were on the theme of patient experience and separating this out from outcomes. This extended to using the ability of any options to help with the prevention agenda and changing disease patterns.

| **Points Raised** |
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| As well as economic and deliverable we need to think about how it *feels* to be at the point of care i.e. the patient experience. |
| Include outcomes, patient experience, prevention, impact on family |
| How much does the deployment of each model assist with the prevention agenda |
| Does any option adjust/tackle what patients have identified about their patient experience |
| Does it meet our current population health concerns? |
| Does it solve our health problems 20 years from now? |
| The affordability - clarification over what time this is affordable |
| What are the changing disease patterns and how will the model match up? |
| How much does the deployment of each model assist with the prevention agenda |
| Does adjust/tackle what patients have identified about their patient experience |
| Does it meet our current population health concerns? |
| Economies of scale is what it's about – you need to clearly explain the pros and cons i.e. you will get better care, better outcomes and experience, more joined up care but it will take you 20 minutes longer to get there. I think people would travel for a different type of care. |
| I think they all should have equal weighting |
| I think you should separate out clinical outcome and patient experience – you need a clear evidence base on clinical outcomes |
| I think travel shouldn't be as high as the other criteria |
| Need to take account of travel time as well as distance |

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| We need to be clear about the outcomes measures being used to assess the options |
| Effective use of staff time i.e. travelling between fewer sites |

## 6. Other Issues Raised

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

| Key Themes | Summary of issues |
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| Palliative care | • People who are dying who don't need a hospital bed, with no support at home, where do they go.<br>• We need to work with hospices. Around 4% of community hospital admitted inpatients need palliative care<br>• Hospices provide specialist palliative care and would be well suited to being sited near to community hospitals<br>• How do we bring together specialist and other clinical opinions together to make it better for people in the last months of their lives? |
| Support in nursing and care homes (intermediate care beds) | • What support should there be in nursing or care homes to ensure that there are local beds that relatives can get to (e.g. in Faringdon, 6 beds were removed which results in older people ending life in Banbury) |
| Primary care | • What is being done to tackle GP retirement rates?<br>• We need to understand what else is available and provided by primary care and you need to show you're not taking away services |
| Interface with social care and the role of Oxfordshire County Council | • We need some progress county-wide with joining up health and social care.<br>• We need to include models of social care and have social care representatives at this type of event<br>• Concern that any benefits in the new models of health care will be overshadowed by the County Council's cuts<br>• Why is the County Council only a consultee? |
| Use of technology | • Use technology and virtual teams to bring specialists into conversations about patients and reduce travel time<br>• The IT infrastructure needs to be considered |
| Understanding the bigger picture and wider context | • We need some case studies to show and describe the new patient journey. Describing the new journey and how it would work in each locality would be very useful<br>• You need to be able to tell the story of how what was traditionally provided in community hospitals can be done in the community<br>• How does this all fit with the other models for maternity, children's urgent care? |
| Recruitment and workforce | • Aligning medical/educational training and training recognition with the new models of care so that we have improved recruitment |
| Housing | • We need more intelligent design and support for the workforce<br>• School provision for the families of NHS workforce |
| The importance of prevention in the Five | • We mustn't underestimate the importance placed in the Five Year Forward View on prevention so that the patient can be treated as |

| Key Themes | Summary of issues |
|---|---|
| Year Forward View | a whole human being and help to reduce demand<br>• What role do community hospitals have to play in prevention?<br>• How will the space and services be used to best effect? |
| Treating people holistically/joined up and co-ordinated care | • We need to better understand the patient's lived experience, particularly if we are to deliver care in a patient's home. At the moment, healthcare is very reactive to problems and this has to change so that we can prevent the unnecessary consequences of the way we deliver care currently.<br>• It works best when there is one person co-ordinating that patient's care e.g. the lack of communication between GP and consultant. Any structure should be built around the GP and my experience has been that difficulties arise when that connection between GP and provider is lost |

# AGENDA

## Oxfordshire Healthcare Transformation: Developing Local Hospitals

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|---|---|---|
| 9.30am | **Welcome and introductions**<br><br>• Aims of today's workshop<br>• What are we currently working on?<br>• Questions | Pete McGrane Clinical Director, Oxford Health NHS Foundation Trust |
| 10am | **The emerging model of care to support frail elderly people**<br><br>• Oxfordshire's changing health needs<br>• How care is currently provided<br>• Our vision and model of care<br>• What would need to change<br>• What else do we need to consider?<br>• What are the options being explored? | |
| 10.30am | **Table discussions**<br><br>1) Are these options the correct ones to work up in detail to put forward to consultation?<br>• Are there others we should be working up? If so, why?<br>• Are there any on the list we should be excluding and why?<br><br>2) For each option which locations do you suggest we should consider?<br><br>3) What are the key issues we need to take into account in terms of other services that could be within community hubs or other locations?<br><br>4) What are the criteria that should be used to assess the benefits of any option? | |
| 11.30am | Key feedback from each table | Table facilitators |
| 11.50am | Wrap Up and Next Steps | Pete McGrane |