Appendix 8 - Questions and Answers

Topic 1: Dementia and intermediate care

Question: What form of support is there for older people? – This appears to relate to 2 aspects – delivery of intermediate care and support for those with older people with mental health issues. Re dementia services – “Concern that if services are reduced/location changed what about transport issues”

Response: Intermediate care is short term input to prevent admission into hospital or long term care and to support intensive rehabilitation following discharge from hospital.

In Oxfordshire last year, the PCT commissioned intermediate care in mental health services. This covers registered and non registered practitioners working in every intermediate care team across the county. They work with patients and their carers in designated intermediate care beds and in their own homes to ensure effective rehabilitation in the physical, cognitive and social elements of people’s life.

This is an area of development highlighted nationally in the soon to be published national strategy for dementia, so in Oxfordshire we are an early adopter and we will have a full team in place by April 2009.

On discharge from intermediate care, patients who require on-going input will be transferred to the older people community mental health team that is an integrated health and social care team.

Topic 2: Support for brain injured children

Question: What support is available for brain injured children?

Response: Community Health Oxfordshire has teams of therapists and nurses delivering co-ordinated packages of care with our colleagues in Oxfordshire county council – schools, support staff and specialist services. Supporting discharge from hospital and return to school for school aged children.

Topic 3: Stroke services

Question: Will the quality of stroke services remain the same if away from acute hospitals and will there be specialist staff?

Response: All stoke services as they are developed will be delivered in line with the national stroke strategy, the Royal College of Physicians and NICE guidelines that will ensure quality of care. There will be stroke specialists within acute and community settings. The PCT has commissioned additional stroke specialists outside of the acute setting this year to deliver improved capacity and quality in stroke rehabilitation. This development will continue into 09/10.
Topic 4: Mental Health

**Question:** Should mental health not be the job of the mental health trust?

**Response:** Not entirely no. We have over 17 contracts with voluntary organisations who deliver mental health services and we envisage that mental health services will be delivered by an increasing number of agencies in the voluntary and community sector.

Topic 5: Finance

**Question:** Clarify how funding for the PCT works – how we get what we do from government?

**Response:** The PCT is financed directly from the Department of Health through a funding allocation which it calls down on a monthly basis. The allocation is based on a national funding formula. Oxfordshire presently receives more funding than the latest formula suggests and is therefore likely to receive less than average growth over the next few years.

**Question:** How will inflation at 5%-10 % (as the government prints money) affect the main actions of the strategy?

**Response:** The NHS funding is now confirmed for 2009/10 and 2010/11 at just over 5% increase per annum. Inflationary pressures during this period will have to be managed primarily by the providers of healthcare through additional efficiency savings.

Topic 6: Strategic position

**Question:** How does this plan fit into all the other strategies that exist as there is no reference to all the other initiatives taking place? – refers to county plan 2030 and ‘Your Vale – your future working together for a better Vale, a strategy for sustainable communities 2008-2016'.

**Response:** The PCT has worked closely with the County Council on preparation of this strategy to ensure that there is good synergy between the County’s plans and our own. This has ensured, for example, that we have shared objectives around older people and deprivation, and that our strategy will deliver Local Area Agreement (LAA) 2 targets.

The PCT’s Partnerships team lead work with each of the districts over the last year and a half as they have developed their strategies. Planning has been based on the Oxfordshire Public Health Strategy which included specific analysis of health needs in the Vale and other districts and which was worked on collaboratively. We also work with the Vale and other districts through the
Health and Well-Being Partnership, Children’s Trust, Community Safety partnership and all the officer groups.

We have not specifically referenced all the District Council Sustainable Community Strategies in developing the strategy, but will consult with the Public Health staff to seek their views on how best to ensure alignment.

We also remain happy to come and talk to Officers or Members at the District Council about our plans and how they affect the Vale, if that would be helpful.

**Topic 7: Motor Neurone Disease**

**Question:** Very vague information given at the Strategy Meeting and in the document. We would like exact details on:

1. How the PCT and social services work together to keep people with a terminal illness (like MND) in their homes, with appropriate and affordable level of care (this does not seem to be working).
2. Why the NHS Continuing Care Scheme does not seem to be working well in Oxfordshire.
   - A. Why is it not offered to people?
   - B. Why is it not explained that it is not means tested?
   - C. Why does it take so long? District Nurse Assessment Committee --> Another Assessment --> Finding and Appropriate, possibly 24 hrs care package.
   - D. With MND, this needs to be thought about by GP/DN soon after diagnosis and put into place very quickly as needed. Discussed with MND centre at the JR. Could we have some statement that could be circulated to our members?” (from Oxfordshire branch of the Motor Neurone Association)

**Response:** the PCT and social services will:

- Set up jointly funded services which can provide sitting services to give carers breaks from caring - this will enable them to care for longer overall
- set up jointly funded carers breaks to give carers a longer break from caring
- set up services which are able to deliver social care e.g. getting shopping or doing household tasks as well as deliver health needs such as getting out of bed/ helping with personal care in order to help people stay at home longer
- set up health services which will be able to provide nursing care at home to dying patients to support carers/ provide appropriate level of care/ keep patients safe and comfortable
- services to be delivered will be well planned in advance including crisis and contingency plans in order to ensure that emergencies which arise have been foreseen and planned for. Forward planning for emergencies means ensuring adequate access to pain relief and other palliative care medicine out of hours; access to equipment to keep people at home, rapidly (e.g. commodes) and that possibilities such as
carers illness have been thought through and planned for (e.g. admission to community hospital).

All of the above are aimed at keeping people within the community, helping them be cared for and die in the place of their choice and keeping them out of acute hospital which is the place least likely to be appropriate for dying.

*The above services already exist to varying degrees across Oxfordshire but we are now planning to introduce all of them comprehensively across the patch ensuring equitable access for all patients.*

Future planning
With regard to MND we are at the start of a project to look at neurological conditions and the work stream will focus on reviewing current service availability for a whole raft of neurological conditions of which MND will be one.

The work programme will be as follows:
- Review current services and funding
- What are the gaps?
- What do voluntary sector offer
- What is the gold standard evidence of best practice nationally?

The ultimate goal is to design a clinical pathway which will best meet the needs of all these individuals. There will be some common themes that link into the end of life project

This work is very much in its infancy. The PCT is still trying to meet with stakeholders, having met with Rachel Marsden from the MS centre. We are looking at developing a project brief and work programme and using the Neurological Alliance as our user engagement reference group. We are aiming for a first meeting in March 2009.