NHS Oxfordshire Creating a Healthy Oxfordshire

Deliberative Event Report
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Introduction

Participate Ltd was commissioned to design, facilitate and report upon a large scale deliberative event on behalf of NHS Oxfordshire to engage with the public and patients in regard to its county wide programme – Creating a Healthy Oxfordshire (CAHO).

Reasons for a deliberative event

To provide insight (from stakeholders) to the CAHO programme team on the key challenges and opportunities facing the local health economy by:

- Identifying key challenges and opportunities facing local health services and the way in which they are delivered.
- Exploring with stakeholders the range of services which would change to deliver high quality sustainable services in the future.
- Facilitating the consideration of recommendations and provide feedback from stakeholders.

Deliberation

Deliberation is an approach to decision-making that allows participants to consider relevant information, discuss the issues and options and develop their thinking together before coming to a view (Involve/NCC 2008).

By adhering to the principles of a deliberative engagement process our events should:

- Involve discussion between participants
- Involve working with a wide range of people and information sources
- Have a clear task or purpose.

By adopting a deliberative dialogue approach our broad aim will be to reach an agreed view or set of recommendations through deliberation.

Report Content

The following report gives findings from each of the discussion groups undertaken at the event. The main findings section draws together the common themes from each of these activities and the key areas of note for NHS Oxfordshire.
Findings & Recommendations

Main Findings
To follow are the main findings extracted from all engagement activity i.e. a deliberative event with 100 participants.

As a Result of Deliberation Participants Felt Well Informed

![Bar chart showing the level of knowledge about the proposal to Create a Healthier Oxfordshire]

Sample Base: 75 pre event questionnaires, 60 post event

Figure 1 infers that 45% (27 out of 60 responses) of the participants felt that they knew a lot or a great deal about the proposal to create a Healthy Oxfordshire following deliberation. 33 participants stated that they knew a little and zero participants stated that they knew nothing post deliberation. Therefore, figure 1 infers that the majority of participants felt well informed to deliberate the proposed changes to healthcare.
Figure 2. To what extent do you agree or disagree that changes are needed to the way we provide healthcare in Oxfordshire?

![Bar chart showing responses to the question regarding the need for change in healthcare provision.]

Sample Base: 75 pre event questionnaires, 60 post event

Figure 2 infers that the overwhelming majority of participants (49 out of 60) either strongly agreed or agreed with the statement that changes are needed to the way we provide healthcare in Oxfordshire.
A Strong Agreement with Focus on Prevention

**Figure 3. How do you feel about encouraging people to take better care of themselves to prevent long term conditions where possible?**

<table>
<thead>
<tr>
<th>Options</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need more information before I can decide</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I'm not sure</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I think it's the wrong thing to do</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I think it's the right thing to do</td>
<td>53</td>
<td>71</td>
</tr>
</tbody>
</table>

Sample Base: 74 pre event questionnaires, 60 post event

Figure 3 infers that the majority of participants (53 out of 60) agreed that encouraging people to take better care of themselves to prevent long term conditions was the right thing to do. The group exercises give further qualitative insight as to why the participants agreed with NHS Oxfordshire’s approach.

**We need to be cost effective and efficient**
Participants across all the groups felt that there was a need to reduce current waste and cost inefficiencies. They recognised that there was less money available and money that was available, needed to be spent in cost effective ways. They also felt that due to economics and demographics, there was an increased demand on services.

**Taking Responsibility for Own Health**
The groups felt that the challenge was on the population of Oxfordshire to find out information and take responsibility for their own health. They also felt that more education was required for patients to manage themselves in order to keep out of surgeries when it is not required.

**Self Care With Support**
Across all groups, the concept of self-care was perceived as good although many participants expressed that some patients might not be skilled or confident enough to manage it themselves. It was also taken into account that there are those groups of patients who are unable to self-care. Many participants agreed that patients would need a
lot of support and motivation. They also questioned how to empower patients and change their mindsets as well how to identify those people who really do need support.

**Can GPs Provide an Enhanced Level of Care?**
Many participants expressed concern at the ability of their GP to deliver an enhanced level of care as opposed to care available in a hospital. They also voiced concern at their lack of confidence in GPs and their relevant training for such a task. Participants also queried GP specialisms and limited scope for them. How patients would be made aware of these services and specialisms was also a concern.

**Concerns about Health and Social Care Working in a More Integrated Way**
Many participants expressed positive views about Health and Social Care working in a more integrated way but they also expressed a lot of concerns surrounding skill levels, funding and sharing records. They also were very concerned about staff skill levels, support regarding workload and issues of security.

**Accessing and sharing Your Care Record**
Participants positively discussed Health Care teams having access to and sharing records, provided standards were adhered to and security was considered. They also felt that a good IT system and security was important as was the relevance of staff accessing the records.

**Information and Education for Patients to Help them Use Hospital Less**
Education and better communication were considered to be important factors to participants when considering helping people use hospital less and leave earlier, if appropriate. They also felt that clearer guidelines were needed on when to use A&E and what services pharmacies offer.

**Concern Regarding Changes That Have To Be Made**
Concern arose regarding the size of the task and why the changes needed to be made with some participants expressing doubt that specialist services could be moved into the community. They suggested the pilot schemes might be an effective way to monitor outcomes.

**Recommendations**

**Further Engagement is Required**
We strongly recommend that further engagement is undertaken across Oxfordshire to further explore the areas for change and to involve people in the decision-making process. It was evident from the engagement activity that people clearly understood the NHS is facing financial challenges, but those who had not been previously engaged were unaware that NHS Oxfordshire will now have to make critical decisions regarding investment in service areas.

**Build Awareness of Self Care and Prevention**
It is evident that the engaged participants felt that patients would need lots more support and motivation to point out how, why and when to self care along with better education on
prevention and certain lifestyle choices (for example healthy eating and smoking). We suggest more targeted, relevant approaches to help identify those who do need support.

**Communication Regarding Enhanced Care and Proposed Changes**

It is important that patients have access to information regarding where and how to receive the best care out of hospital in order to use resources effectively. Reassurance and clarification are also needed to alleviate fears and misconceptions regarding capacity and skill set of specialist services within the community.

**Feedback**

As people have given their time to be engaged in activities, they in turn like to know what has happened to the insight they have given. We strongly suggest sending a feedback summary of this report to all those who have been involved in this engagement activity.
Project Background

Background

NHS organisations and Oxfordshire County Council are working together to ensure they can provide high quality sustainable health and social care services in the future. Society is changing so health and social care systems need to change to respond to increasing demand, patient expectations and advances in technology and medicines.

The challenge is to ensure the highest quality care for all patients within the finite resources available. As a whole health and social care system they need to improve the quality and value for money of health services provided in Oxfordshire in a way that will keep the system in financial balance. This will involve redesigning the wide range of health care services currently provided throughout Oxfordshire. The Creating a Healthy Oxfordshire (CAHO) programme will lead to services being delivered in new ways with increased emphasis on self-care and healthy living and bringing care into the community. In order to achieve this, the programme has been divided into five workstreams to address different areas, these include:

- **Self-care and Patient Responsibility** - helping people to help themselves, prevent ill-health and hospital admissions.
- **Primary Care** - developing GP and associated services in the community
- **Integrated Community Service Provision** - integrating health and social care teams in the community to ensure patients can access the right treatment when they need it.
- **Acute Care** - reviewing delivery of hospital care and bringing care closer to home, when it is clinically appropriate.
- **Disinvestment** - reviewing the provision of services and treatments that are shown to be clinically ineffective and inefficient

Each workstream has a dedicated programme lead to develop and implement different initiatives to deliver the CAHO programme. The workstream leads report to the CAHO Programme Board which has Chief Executive membership from all NHS organisations in Oxfordshire as well as the County Council.

Staff, GPs, clinicians and healthcare professionals are being encouraged to get involved in the CAHO programme to ensure decisions are based on clinical evidence. However, involvement of the public is essential to the successful delivery of the CAHO programme. The ‘Revision to the Operating Framework for the NHS in England 2010/11’ has also introduced new tests for the reconfiguration of services which the NHS needs to adhere to. The framework emphasises the need for public and patient involvement in the work we do.

The tests will require reconfiguration proposals to demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base; and
- Consistency with current and prospective patient choice
As such an area of work underpinning this transformation project is how the NHS and Council keep the public informed of the work and involve the public in the decisions to be made about changes to treatments and health and social care services in the county.

**Communications and Engagement Objectives**

The overarching aim of this strategy is to ensure that communications and engagement activities support the goals of the CAHO programme. As well as ensuring the views of staff, patients, carers and the public are taken into consideration in the commissioning, development and provision of services.

1. To deliver effective communications and engagement through partnership by:
   - The local NHS and County Council working together to ensure consistency of message and activities.

2. To build awareness and understanding of CAHO with public, patients, staff and stakeholders by:
   - Using the appropriate means of communications for the requirements of the audience.

3. To build continuous and meaningful engagement with clinicians, healthcare professionals, the public, patients and carers to influence the shaping of services through the CAHO programme by:
   - Utilising existing internal two-way communications channels with staff (developing where necessary).
   - Developing channels with primary care to ensure involvement in the programme.
   - Using a wide variety of methods and approaches to communications and engagement.
   - Working closely with seldom heard groups to ensure they have a voice.
   - Facilitating the engagement of stakeholders in meaningful and productive debate.
   - Using our stakeholders to extend our reach to patients and public.

4. To provide insight (from stakeholders) to the CAHO programme team on the key challenges and opportunities facing the local health economy by:
   - Identifying key challenges and opportunities facing local health services and the way in which they are delivered.
   - Exploring with stakeholders the range of services which would change to deliver high quality sustainable services in the future.
   - Facilitating the consideration of recommendations and provide feedback from stakeholders.
Event Objectives

The following event objectives have been agreed in regard to the Creating a Healthy Oxfordshire programme:

- Source feedback from the public on proposed CAHO initiatives
- Source ideas from the public on provision of different types/models of care
- Explore with the public the range of services which could change to deliver improved outcomes and better value for money
- Raise awareness and educate the public in the challenges facing the local NHS.
**Participant Recruitment**

Effective recruitment is a crucial element to the success of a deliberative event. Participate will advise on the best methods of recruitment but it will be undertaken by NHS Oxfordshire. Most commonly, recruitment will involve some or all of the following methods:

- Postal and online recruitment
- Face-to-face recruitment for certain profile groups, especially the hard to reach
- Involvement of established citizens panels/jurys/user groups
- Discussions with gatekeeper community groups
- Local advertisements
- Incentive schemes
- Involvement of local network groups such as LINks.

**Agreed Approach**

In order to reach a wide range of participants the PCT has recruited participants via invitation. Invites have gone to:

- Patient groups affiliated with NHS provider organisations
- Councillors representing the public from areas throughout Oxfordshire
- Joint Health Overview and Scrutiny Committee
- Lay people affiliated with the Oxfordshire Health & Wellbeing partnership Board
- Local Involvement Networks representatives
- Public members of the Oxfordshire Council of Voluntary Organisations
- Registered public on the PCT’s Talking Health Public Involvement online database (292).
Details of Deliberative Event

Background
The public deliberative event was held in October 2010 in order to gather insight to help shape and influence NHS Oxfordshire’s project to Creating a Healthy Oxfordshire. 94 members of the public attended the event.

Event Date: Friday 29 October 2010
Start and Finish: 10am to 4pm
Venue: The Oxford Centre, 333 Banbury Rd, Oxford, OX2 7PL

The following schedule details the agenda for the event:

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td>Registration &amp; refreshments</td>
</tr>
<tr>
<td>10:30</td>
<td>Welcome: Sonia Mills, Chief Executive of NHS Oxfordshire</td>
</tr>
<tr>
<td>10:40</td>
<td>Format of the event:</td>
</tr>
<tr>
<td>10:45</td>
<td>Group Introductions: Introduce yourself to your table companions</td>
</tr>
<tr>
<td>10:50</td>
<td>Agenda and expectations</td>
</tr>
<tr>
<td>10:55</td>
<td>The ‘Case for Change’: Catherine Mountford, Director of Strategy and Planning, NHS Oxfordshire</td>
</tr>
<tr>
<td>11:10</td>
<td>Group Exercise 1: Understanding the ‘Case for Change’</td>
</tr>
<tr>
<td>11:30</td>
<td>Staying Healthy: John Morgan , Chief Executive, Oxfordshire Learning Disability NHS Trust</td>
</tr>
<tr>
<td>11:45</td>
<td>Group Exercise 2: Understanding staying healthy</td>
</tr>
<tr>
<td>12:05</td>
<td>Your Local Services: Alison Westmacott, NHS Oxfordshire</td>
</tr>
<tr>
<td>12:20</td>
<td>Group exercise 3: Understanding your local services</td>
</tr>
<tr>
<td>12:40</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:10</td>
<td>Welcome back &amp; New groups</td>
</tr>
<tr>
<td>13:15</td>
<td>Health and social care working together: Philippa Muir, NHS Oxfordshire</td>
</tr>
<tr>
<td>13:30</td>
<td>Group Exercise 4: Understanding health and social care working together</td>
</tr>
<tr>
<td>13:50</td>
<td>Urgent and specialist care closer to home: Joanna Paul, NHS Oxfordshire</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>14:05</td>
<td><strong>Group Exercise 5</strong>: Understanding urgent and specialist care closer to home</td>
</tr>
<tr>
<td>14:25</td>
<td><strong>Coffee Break</strong></td>
</tr>
<tr>
<td>14:35</td>
<td><strong>Chief Executive Panel</strong>: Question Time</td>
</tr>
<tr>
<td>15:10</td>
<td><strong>Post-event questionnaire</strong></td>
</tr>
<tr>
<td>15:15</td>
<td><strong>Next steps</strong>: how we will use the information gathered today</td>
</tr>
<tr>
<td>15:25</td>
<td><strong>Close – Thank you for attending</strong></td>
</tr>
</tbody>
</table>
**Deliberative Event Findings**

The following pages outline the following:
1. Results of the pre and post event questionnaires
2. Insight from Exercise 1 – The case for change
3. Insight from Exercise 2 – Staying healthy
4. Insight from Exercise 3 – Your local services
5. Insight from Exercise 4 – Health and Social Care working together
6. Insight from Exercise 5 – Urgent and specialist care closer to home
7. Insight from Exercise 6 – Capturing knowledge – why things have to change

1. **Feedback from the Pre and Post Event Questionnaires**

In order to ascertain an aggregate feel for the levels of knowledge and perspectives of participants pre and post the event, each participant was requested to complete a pre and post event questionnaire by hand. Please note although 94 participants attended the event and completed pre-event questionnaires, not all participants completed post-event questionnaires.

**Fig 1. Of the following statements which one best describes how much you know about the proposal to Create a Healthier Oxfordshire?**

<table>
<thead>
<tr>
<th>Options</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know nothing</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>I know a little</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know a lot</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>I know a great deal</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Sample Base: 94 pre event questionnaires, 60 post event responses

Figure 1 infers that 45% (27 out of 60 responses) of the participants felt that they knew a lot or a great deal about the proposal to create a Healthy Oxfordshire following deliberation. 33 participants stated that they knew a little and zero participants stated that they knew...
nothing post deliberation. Therefore, figure 1 infers that the majority of participants felt well informed to deliberate the proposed changes to healthcare.

**Fig 2. To what extent do you agree or disagree that changes are needed to the way we provide healthcare in Oxfordshire?**

<table>
<thead>
<tr>
<th>Options</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>10</td>
</tr>
<tr>
<td>Agree</td>
<td>36</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>21</td>
</tr>
<tr>
<td>I don't know</td>
<td>6</td>
</tr>
</tbody>
</table>

Sample Base: 75 pre event questionnaires, 60 post event

Figure 2 infers that the overwhelming majority of participants (49 out of 60) either strongly agreed or agreed with the statement that changes are needed to the way we provide healthcare in Oxfordshire.
Fig 3. How do you feel about encouraging people to take better care of themselves to prevent long term conditions where possible?

<table>
<thead>
<tr>
<th>Options</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need more information before I can decide</td>
<td>2 (Pre), 3 (Post)</td>
</tr>
<tr>
<td>I'm not sure</td>
<td>1 (Pre), 4 (Post)</td>
</tr>
<tr>
<td>I think it's the wrong thing to do</td>
<td>0</td>
</tr>
<tr>
<td>I think it's the right thing to do</td>
<td>53 (Pre), 71 (Post)</td>
</tr>
</tbody>
</table>

Sample Base: 74 pre event questionnaires, 60 post event

Figure 3 infers that the majority of participants (53 out of 60) agreed that encouraging people to take better care of themselves to prevent long term conditions was the right thing to do. The group exercises give further qualitative insight as to why the participants agreed with NHS Oxfordshire’s approach.
Fig 4. And how do you feel about moving more services out of hospital to be provided by GPs and clinics in the future?

<table>
<thead>
<tr>
<th>Options</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need more information before I can decide</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>I'm not sure</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>I think it's the wrong thing to do</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>I think it's the right thing to do</td>
<td>24</td>
<td>23</td>
</tr>
</tbody>
</table>

Number of responses

Sample Base: 76 pre event questionnaires, 59 post event

Figure 4 shows that 23 out of 59 (39%) felt that moving more services out of hospital to be provided by GPs and clinics in the future, was the right thing to do. Pre the event, 27 out of 76 (36%) felt they needed more information before they could decide whereas after the event this figure reduced to 15 out of 59 (25%).
Fig 5. Overall, how do you think people rate the quality of healthcare provided in Oxfordshire?
(where 1 is very poor and 10 is excellent)

Sample Base: 56 responses

Figure 5 shows the average rating is 6 out of 10 (where 1 is poor and 10 is excellent), when participants were asked to rate the quality of healthcare provided in Oxfordshire. This rating was the same pre and post event. Any rating of 6 to 7 is seen as good, which infers that the participants feel that the healthcare provision in Oxfordshire is good on the whole.
Figure 6 infers that the majority of participants (34 out of 79) attended the event to have their say about proposed changes to the services. This finding coupled with 26 participants stating that they wanted to find out more about what is happening to local services and 16 participants stating that they wanted to meet other people and discuss changes to services, infers that the participants held a genuine interest in becoming informed and being involved in the decision-making process in regard to service changes across Oxfordshire.
Fig 7. Post event questionnaire
To what extent do you agree or disagree with the following statements (Where 1 is strongly disagree & 10 is strongly agree)

<table>
<thead>
<tr>
<th>Options</th>
<th>Average response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today’s event gave me a good opportunity to express my views about how we can Create a Healthier</td>
<td>5</td>
</tr>
<tr>
<td>I had a good time at today’s event</td>
<td>5</td>
</tr>
<tr>
<td>Today’s event has made me feel more involved in the work of the NHS</td>
<td>5</td>
</tr>
<tr>
<td>I would definitely come to another event like this one</td>
<td>5</td>
</tr>
</tbody>
</table>

Any rating of around 5 is seen as satisfactory, therefore Figure 7 infers that the participants felt that they had a satisfactory opportunity to express their views about how we can create a Healthy Oxfordshire, they had a good time at the event, they felt more involved in the work of the NHS and they would come to another event like this one.
Fig 8. Post Event Questionnaire

How good or bad do you think we have been at the following?
(Where 1 is very bad and 10 is excellent)

<table>
<thead>
<tr>
<th>Options</th>
<th>Average response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explaining things so that people could have their say</td>
<td>5</td>
</tr>
<tr>
<td>Running a good discussion at the event</td>
<td>5</td>
</tr>
<tr>
<td>Making you feel welcome</td>
<td>6</td>
</tr>
<tr>
<td>The care and attention taken when inviting you to attend the event</td>
<td>6</td>
</tr>
</tbody>
</table>

Any rating of around 5 or 6 is seen as satisfactory to good, therefore Figure 8 infers that the participants felt that the organisers were good at making them feel welcome, giving care and attention to inviting them, running a good discussion and explaining things so that people could have their say. This finding infers a good satisfaction rating for the overall management of the event.
2. Insight from Exercise 1 – the case for change

Following a presentation in regard to the need for change in Oxfordshire, participants were asked to undertake discussions on the following questions:

- Why do they think services need to change?
- What challenges do they think the population of Oxfordshire face?
- Do they agree with the case for change?
- What, if anything, would you like to know more about?

Findings from Exercise 1:

Why do you Think Services Need to Change?
The following common themes emerged from the discussion in regard to what the participants felt needed to change.

We Need to be Cost Effective and Efficient
Participants felt that there was a need to reduce current waste and cost inefficiencies. They recognised that there was less money available and money that was available, needed to be spent in cost effective ways. They also felt that due to economics and demographics, there was an increased demand on services.

- We need to be realistic on our demands
- It has to reflect financial reality
- Consider the current financial crisis and cuts
- Things could be done better
- Stop opening / closing / opening services, it’s wasting money
- Some services are badly run and inefficient
- Need to offer what we already are but more efficiently

Must be Easier to Access Health Services
Participants felt that more education was required in terms of access to health services and that access could be easier than it is currently.

- Access to GPs and hospitals depends on where you live and transport issues
- The Out of Hours GP services do not reflect need or provision
- Services must be more accessible
- We need more knowledge
- More education is needed, where to go, how to be ‘healthy’

Preventative, not Reactive Services
Participants discussed preventative services rather than reactive. They discussed the role of the individual and the community. They felt that more needed to be done to improve lifestyles and that patients should take responsibility.

- Community needs to help improve healthy lifestyles
- Resources are needed to empower people to help themselves
- Look at increasing investment in preventative services including the voluntary sector
- Increasing knowledge of patients particularly via the internet
Lack of self responsibility

New role of GPs and Government intervention
Participants talked about the Government and the new role currently being faced by GPs. They acknowledged that finances were limited and that change was necessary.
- The Government says the NHS has to change
- Government pressure
- Policy and economic cuts, there is no choice
- Pushed through too quickly, no consultation
- Commissioning complex

What challenges do you think the people of Oxfordshire face?
The following common themes emerged from the group discussions.

Education of the Population
The groups felt that the challenge was on the population of Oxfordshire to find out information and take responsibility for themselves. They also felt that more education was required for patients to manage themselves in order to keep out of surgeries when it is not required.
- People are not aware of the cost of healthcare
- Information is needed for patients and the public
- Need to know how to access specialist advice
- More awareness of appropriate services
- Moral education
- Education around self care
- Health promotion and prevention is vital and it needs to be culturally appropriate

Transport, Accessibility and Location
The groups discussed transport, accessibility and location as challenges to the people of Oxfordshire that must be taken into account. They noted the difficulties in balancing community services with resources needed to support it.
- Consider transport services in rural areas
- We want more community services but we don’t have the facilities or transport in the community
- Difficult to provide services locally especially specialists locally in a rural county
- More first stage services locally and transport for patients to start accessing them
- For city areas hospital might be closer to home
- Balancing viable services against individual need e.g. transport (demographic issue)

Higher Expectations, More Demand, Less Resources
The participants recognised that patients had higher expectations of care coupled with higher demand due to increasing and ageing populations. The participants were also very aware that less resources were available, particularly financial resources.
- People are too dependant on statutory services
- People need to change their expectation of services, a cultural change
- Less resources available, especially for social services
- Increasing elderly population, heavy strain on resources
- Increasing financial demand on public spending
- Question – How does the student population affect healthcare? E.g. mental health, sexual health, higher demand?
- Unrealistic expectations by patients

**Expertise and Knowledge of GPs vary**
Participants discussed their concern at placing all the responsibility for care on GPs, who are already over-stretched. They talked about using specialist GPs and how was this going to be feasible geographically.
- Lack of confidence in GPs to deliver ‘all’
- GPs need to change, so many illnesses to cover
- Specialist GPs needed
- Difficult to provide services locally especially specialists locally in a rural county

**Do You Agree with the Case for Change?**
The following common themes emerged from the group discussions

**Don’t Agree with Change for the Sake of Change**
Some participants expressed concern regarding the case for change and appeared to need reassurance that the changes were justified and necessary.
- There is a case for some change
- We must retain what is good
- Concern about GP commissioning
- Is there a point asking this question?
- Yes for change, but not the way (it’s being done)
- Not sure, need to know more about change to what
- Change is forced on us
- Need to define change
- Have been dissatisfied with previous change
- Have issues with consortia, will costs escalate?

**Agree Change is Necessary**
Some participants expressed support for the case for change commenting that the current system was inefficient and over bureaucratic. They commented that the change could be an improvement and an opportunity for agencies to work together.
- This is a time of opportunity and we shouldn’t panic
- Agree with change because LA and PCTs are inefficient and overly bureaucratic. The central approach is not sensitive to communities.
- We don’t have joined up health and social care
- This is an opportunity to improve community services
- We need better prevention
- Specialist services don’t always have to be in hospital
What, if Anything Would you like to Know More About?
The following common themes emerged from the group discussions.

More Information on the Proposals
Participants had various specific questions regarding more information on the proposals.
- Are there any alternatives?
- What isn’t going to change?
- Does the PCT have full freedom or are there idealogical constraints?
- Need more information on individual services
- What is happening to NHS Direct?
- Could we use hospices differently to support a growing, older population?
- Need more information and education about services
- How GPs will ration budgets?

Needs Further Communication
Participants discussed that more communication and engagement was needed. They also wanted an understanding of any communication carried out. They also discussed how other agencies would be involved.
- Needs more discussion with communities
- Communication between professionals and organisations – electronic / paper / other methods
- How council will work with NHS to make it happen
- Want to know more about how people and service users are consulted
- Explaining, talking to people about how the health system works and what the changes will mean
- Understanding routes or communications

Understanding New GP Commissioning Consortia
Some participants discussed the new GP commissioning consortia and expressed a lack of understanding of how it will actually work.
- What will be the GP commissioning roles?
- How will GPs ration budgets?
3. Insight from Exercise 2 – staying healthy

Following a presentation in regard to self-care, participants were asked to undertake discussions on the following questions:

- What are your feelings about self-care?
- How do you feel about prevention and empowering patients to manage their health?
- What would we need to take into account when placing greater emphasis on self-care?

Findings:

**What are your Feelings about Staying Healthy / Self Care?**

The following common themes emerged from the group discussions.

**Fine If People Can do It But…**

Participants discussed the fact that although generally the idea of self-care was good, many people would not be skilled or confident enough to manage it themselves. Many participants agreed that patients would need a lot of support and motivation.

- It will be a culture shift for Health Care professionals, it needs good customer service
- It’s a no-brainer
- With support, it is a good idea
- How are you going to encourage people to become empowered and change their mindset?
- Some people cannot manage their own self-care
- Might fail with poorer educated groups
- How do we identify people who really need support?
- People who are not healthy or who have a severe illness cannot self-care

**Patient Information and Education is Essential**

Again, many participants felt that the idea of self-care was good. However, access to, and availability of information was essential. They also expressed that patient education was vital.

- Education is needed across public / patient groups (all ages)
- National messages. The FAST campaign was a good example
- Need to build it into children’s education
- Re-education on attitudes is needed
- Prevention education is important e.g. cooking healthy food
- Think of different ways to educate, there is too much emphasis on guilt
How Do You Feel about Prevention and Empowering Patients?
The following common themes emerged from the group discussions.

Prevention Is Better Than The Cure
Many of the groups agreed that prevention was better than the cure taking into account education and knowledge, for example smoking and obesity. Some participants suggested the use of incentives and that a more holistic approach was required.

- Needs a co-ordinated approach from organisations and industry e.g. food
- People need to want to help themselves
- People need to support primary care to address this issue e.g. obesity and smoking
- There is evidence to suggest that when incentives are offered, this encourages empowerment. For example, GPs offering to fund obese / overweight patients to go to Weight Watchers
- Need to research what is effective and invest in early preventative methods
- Why should money be spent on people who have chosen a particular path, for example, smoking?

Health Professionals Need to Listen More and Work With Patients.
Participants talked about what patients felt was required from health professionals regarding prevention and empowering patients. They felt a more personal approach to patients was required coupled with enough assessment time.

- Need NHS staff to be responsible for people who can’t chose or decide and help them as if they were a friend
- Treating patients as individuals and looking at prognosis and whole picture of need
- More holistic and personal
- Time to give complete assessment of patient
- Listen to patients
- Treat people as individuals

Great Idea, People Need to Take Responsibility
Many participants expressed positive ideas surrounding the idea of prevention and empowerment. They also felt that people needed to take responsibility for their own health.

- Expectations must reflect a different approach – personal responsibility
- Not a new idea, get on with it!
- People need to be aware of impact of actions and take responsibility
- Empowering patients is a good thing
- I feel happy / passionate about this
- Empowerment is necessary for achieving the goal of self-care

Danger of Leaving Patients to their own devices
Some participants expressed concern regarding prevention and empowering patients.

- There is a danger of leaving patients to their own devices
- Patients and the public will need help to navigate themselves
- Some people don’t want to be empowered
- People can make decisions that are not necessarily in best interests of health
What Would We Need To Take Into Account When Placing Greater Emphasis on Self-Care?
The following common themes emerged from the group discussions.

More Dialogue, Communication, Support and Education
Many participants held the view that in order to place greater emphasis on self-care, it was important to communicate effectively with patients as well as educating and supporting them.

- More dialogue – statutory bodies
- Better communications
- Take into account patients’ views
- More education
- Information about consequences
- Appropriate information
- Safety net when things go wrong
- Surgeries need to be approachable – no judgemental behaviour
- Does the lady in the case study understand why she needs to change?
- Sign-posting to appropriate services

Consider Bureaucracy, Rural Deprivation and the Need for More Staff
Participants discussed other elements to take into account regarding placing greater emphasis on self-care. They were concerned about the current levels of bureaucracy, the impact of rural deprivation and the need for more investment in terms of staff, especially nurses.

- Access more nursing rather than clinicians but still have access to clinicians
- Public Health departments get back to public health!
- Be aware of gaps between NHS and Social Services – have seamless service
- Social determinants can affect health
4. Insight from Exercise 3 – your local services

Following a presentation in regard to Primary Care, participants were asked to undertake discussions on the following questions:

- What are your feelings about primary care? Prompts for questions include:
  - How do you feel about receiving an enhanced level of care at your GP practice?
  - How far would you be willing to travel to receive that care, if it was provided at another GP practice?
- What would the health service need to take into account when placing more emphasis on people using enhanced services at their GP practice?

Findings:

How Do You Feel About Receiving An Enhanced Level Of Care At Your GP Practice Rather Than Travelling To Hospital?

The following common themes emerged from the group discussions.

GPs Not Necessarily Well Informed / Lack of Confidence In them

Many participants expressed concern at the ability of their GP to deliver an enhanced level of care as opposed to care available in a hospital. They also voiced concern at their lack of confidence in GPs and their relevant training.

- Great idea but it depends on the willingness and expertise of GPs and the availability of the professional’s time
- Do they have facilities and specialisms e.g. mental health?
- Depends on the GP
- How will patients know the specialist GPs?
- More education for GPs on treatment of various communities – equality
- Limited scope for GPs to offer enhanced services
- Not happy with concept of GP specialist – not experts and not full time
- Experienced GPs with more training would be better
- Lack of confidence in GPs
- Concern about GPs incorrectly diagnosing and bringing a delay

Problems Can Arise If Staffing Isn’t There

Some participants discussed the pitfalls of staffing problems regarding enhanced level of care at a GP practice rather than travelling to hospital. For example, holiday and maternity cover and out of hours provision. There would also be greater pressure on GPs and increased demand for nurses.

- Out of hours services needs to be extended to evenings and weekends
- Use nurse practitioners more but may not identify all the problems
- Issue about ensuring consistency and quality of care when services are more diffused
- For this to work, people have to have confidence that clinicians are fully trained, can spot early symptoms and will refer you to specialist services when needed
- GP and practice nurses need to be trained – specialisms
• GPs must recognised limits and have more input and advice from specialists
• High confidence in A&E

**How Practical, affordable and Suitable is it?**
Participants discussed the pros and cons of enhanced levels of care at the GP practice, asking specific questions regarding practicality, cost and suitability.
• What if the hospital is closer?
• Should have better technology
• Patients will have better relationships with GPs
• Suitability of practice premises – will have to be phased
• Sounds lovely but how practical and affordable is it?
• Rural practices will need a different approach
• Avoid postcode lottery
• Will the surgery be properly equipped?

**How Far Would You Be Willing To Travel To Receive That Care If It Was Provided At Another Practice?**
The following common themes emerged from the group discussions.

**Depends On Public Transport**
Participants had varying opinions on answering this question but the key theme was access and public transport. An indication figure taken from all the responses with a specific answer indicates approximately up to 30 minutes or 15 miles away.
• Would go to ‘the ends of the earth’ for the right care
• Depends on options available to support patients accessing services
• Well funded community transport
• Issue is not distance, but ease and cost of journey, especially via public transport
• Depends on public transport
• Need to ask people in rural areas, homeless people and other disadvantaged groups how they feel about travelling

**Consider the Mobility Of Patients and The Type of Care Required**
Participants acknowledged that patient mobility and the type of care required were important issues that needed to be taken into account when considering travelling distance.
• Depends on condition and ability
• Older people couldn’t travel far, costs etc
• Issue for those in care homes, can’t travel
• Depends how ill you are
What Would The NHS Need To Take Into Account When Placing More Emphasis On People Using Enhanced Services At Their GP Practice?
The following common themes emerged from the group discussions.

Needs To Be Properly Equipped
Most of the participants concluded that enhanced services at their GP practices would need to be properly equipped, the building would need to be good and more nurses would be required. There would also need to be better out of hours provision, good transport links and good aftercare services.

- More nurse practitioners and better use of them
- Need an improved out of hours service
- Availability of diagnostics
- Have a good range of expertise within a practice
- How is all this going to be incorporated into an already stretched system?
- Capacity of GP practices, can they deal with increased numbers?

Need to Support GPs with Staffing, Funding and Training to Provide Enhanced Services
Participants discussed the need for support for GPs regarding staff, funding and addition training if required.

- GPs must be willing to do this
- NHS consultants will need to travel to people and GP practices
- Good training of practice staff
- Core GP service should not be eroded
- GPs sometimes unable on certain conditions to assist
- Increase training for GPs
- Costs and rewards to the practice, is it worthwhile?

Patient Information and Education on Enhanced Services
Some participants felt that more information and education was required for patients regarding enhanced services. They also felt that patients would need specific information regarding where to go.

- Have not fully comprehended what enhanced services are
- Need patient education and information
- Selling the ‘idea’ to the public
- The public need to understand why it costs more to go to A&E then they might not go
- Giving enough information about who’s doing it and what will happen. Not just a leaflet
- Knowledge on what services are on offer
5. Insight from Exercise 4 – health and social care working together

Following a presentation in regard to Integrated Community Service Provision, participants were asked to undertake discussions on the following questions:

- What are your feelings about integrated community service provision?
- What would we need to take into account when placing greater emphasis on integrated teams?

**Findings:**

**What are your Feelings about Health and Social Care Working in a More Integrated Way?**

The following common themes emerged from the group discussions.

**It All Sounds Good But Will It Work?**

Many participants expressed positive views about Health and Social Care working in a more integrated way but they also expressed a lot of concerns surrounding skill levels, funding and sharing records.

- Health and Social care are totally different
- Concerned about levels of skills and knowledge staff will have and issues of security
- Concept is good, care co-ordinator role is too large, will they be able to manage their load?
- Need integrated funding mechanism, model sounds expensive. Future scenario assumes resources available
- Staffing – will there be support for more integration?
- How does this fit into personal budgets in social care?

**How will it be Managed?**

Participants expressed concern at how Health and Social Care working in a more integrated way would be managed and structured. They also said they needed more information on what the exact plans were.

- Concerned about how it will be run, not sufficient information to make a judgement
- Needs more public consultation
- In mental health it works current, but what would happen in the future?
- Must have an integrated (single) management structure
- Jointly managed, jointly run and jointly owned
- Need a co-ordinating role with knowledge of all services and what is appropriate

**Needs More Emphasis on Voluntary Sector and role of Family**

Some participants that the voluntary sector needed to be considered within the model and also the role of family and carers.

- Needs more emphasis on voluntary sector and community
- Next of kin should be included in the model. Power of attorney in cases of dementia. GPs bound by confidentiality and family role is crucial
- More support for carers
No sense that voluntary sector is part of this project as an equal partner

What Would We Need to Take Into Account When Placing Greater Emphasis on Integrated Teams?
The following common themes emerged from the group discussions.

Worried That ‘Anybody’ Will Be Sent In
Participants expressed concern regarding the quality of staff used when using integrated teams. They were worried that although the contract may be fulfilled, the staff used would not have the right skill mix.

- Skilled, trained professionals doing the work
- There must be training of integrated teams and on an area basis
- Better paid, better supported workers
- Skill development – multi-skilled with clear lines of accountability
- Issue around adequate staffing and funding
- Terms and conditions of staff not aligned
- Retention of employment rights

Clarity of What Services to be Provided and Good Communications Throughout
Some participants felt that they need more information and clarity on what was to be provided. They also felt that communication was key throughout the whole process.

- Continuity of care
- Joined up communications strategy
- Very hard to understand how these services will be commissioned
- Clarity of what services to be provided and eligibility criteria
- Concerns about what future commissioning framework will look like
- One authority overseeing it?
- Accessibility and co-ordination, role of local authority? Who controls ultimately? Measure / monitor outcome?
- Essential to communicate throughout change

Funding and Patient Confidentiality
Some participants discussed the financial implications of integration and questioned how the budgets would be allocated. There was also concern regarding access to patient records and confidentiality.

- Payment for social care, how will this work with integration?
- Access to patient records versus patient confidentiality
- Cost implications
- Getting that balance right between sharing information and maintaining confidentiality. Different levels of security ‘need to know basis’.
- Whose budget? Joint pooled?
- Integrated access to records is important if it is to work but maintain confidentiality
6. Insight from Exercise 5 – urgent and specialist care closer to home

Following a presentation in regard to Hospital Care, participants were asked to undertake discussions on the following questions:

- What are your feelings about bringing certain aspects of care out of hospital?
- What would we need to take into account when placing greater emphasis on moving some care out of hospital and into the community?
- How do we help people use hospitals less and leave them earlier if appropriate?

Findings

What Are Your Feelings About Bringing Aspects of Care Out of Hospitals?

The following common themes emerged from the group discussions.

In Favour of Bringing Aspects of Care Out of Hospitals but Concerned About Resources

Many participants expressed positive views regarding bringing aspects of care out of hospitals, however there was concern regarding availability of resources and that the proposal was ‘papering over the cracks’.

- Will medical staff be redeployed?
- Will there be specialist GPs in community hospitals?
- You are just moving the problem
- Is it financially efficient?
- Pilot looks good but what is the cost?

Should Have Adequate Facilities and Resources and Be in a Good Location

Participants discussed the need for adequate facilities and resources coupled with a good location.

- If it is rolled out it needs to be local
- Proper facilities for the ailment
- Should be in every significant community
- Need to ensure that specialist service and knowledge is available if this is to happen
- Will there be a specialist GP in community hospitals?

What Do We Need to Take into Account When Placing Greater Emphasis on Moving Some Care Out Of Hospital and into the Community?

The following common themes emerged from the group discussions.

Need Appropriately Trained and Skilled Staff

Participants expressed that appropriately trained and skilled staff was an important consideration when moving some care out of hospital and into the community. They also felt that this would enhance trust and confidence levels for the patients.

- Ensuring there are the right level and quality of services
- Good training and support for all the professions involved
- Availability of specialist equipment and trained operators
- Resources and knowledge in place locally
• Need to ensure that people can get access to the right specialist
• Contradictory to what has been done before, is it a reversal of policy?

Loss of Services, Opening Hours, Access and Transport
Participants talked about their concerns around issues such as loss of services, opening
hours, access and transport.
• Need assurances that shifts to community don’t shut down services
• Opening hours / access still not enough
• Take transport and access into account
• Consider location of services in community
• How quickly can support be provided in a crisis?
• Have regard for public transport issues. Location of bus routes

What Are Your Feelings on Health Care Teams Having Access to and Sharing
Your Care Record?
The following common themes emerged from the group discussions.

Shouldn’t Be a Problem if Standards are Adhered To
Participants positively discussed Health Care teams having access to and sharing records,
provided standards were adhered to and security was considered.
• Needs good IT system, could be costly
• All staff are ethically bound
• Need clarity about which professionals
• Need reassurance there is good security of records
• It could be open to corruption
• People / Healthcare professionals should only have access to what they need to
know

What about Confidentiality and Consent?
Confidentiality and consent were considered to be important factors to participants.
Important issues were raised such as patients with dementia and transparency and trust.
• General consent from patient
• Who makes the decision on behalf of people with mental health problems or
dementia?
• Importance of relevant people having access to information can outweigh
confidentiality
• Transparency and trust
• Should be shared with NHS unless people have opted out
How Do We Help People Use Hospital Less and Leave Earlier if Appropriate?
The following common themes emerged from the group discussions.

Education and Better Communication
Education and better communication were considered to be important factors to participants when considering helping people use hospital less and leave earlier, if appropriate. How and when to use A&E and pharmacies were also seen as unclear.
- Education of patients about their condition
- Re-educate public / patients / carers
- Clearer information of when to use A&E
- Confidence in aftercare
- Understanding what services pharmacies can offer
- People should be educated that the services are there

Enhanced Recovery Programme and Improve Morale
Helping patients recover and improving their morale were seen as key points to consider by participants. They also felt that there was pressure to make patients leave hospital too early.
- Good level of service in the community for LTCs
- Preventative measures
- Pathway to health
- Improve morale
- Better and quicker care plans
- Pressure to make patients leave hospital too early – tick in a box, makes the figures look good

Use Voluntary Sector, Community Resources and Family
Using other non-hospital resources were deemed to be important by participants as many felt these resources were underused.
- More family and community support
- Empower and involve voluntary sector more
- Utilisation of proven, existing services in the community e.g voluntary
- More community service resources but may not be cheap!
- More backup and early intervention at home
- More people receiving care at home
- Help people use hospital less, staff in community like OTs look at care in home environment. More holistic. Education. Managing expectations – too much demand
7. Additional Questions:

As the day drew to a close, participants were asked to respond to two final questions:

1. Is it clear why health services in Oxfordshire need to change?
2. What are your feelings on the changes we have to make?

Findings

Is It Clear Why Health Services In Oxfordshire Need to Change?
The following common themes emerged from the group discussions.

Yes – Feel Clear Why Service Feels It Needs to Change
Many participants agreed that after the presentations, they did feel it was clear why health services in Oxfordshire needed to change.
- Need to do more with less
- Embracing technology and progress
- More individual responsibility
- Yes because of the White Paper
- Yes – money
- Yes, but not clear how
- Economic and demographics

Feel Less Clear Now
Some participants expressed that they were less clear on the reasons for change after the event.
- More confused after event
- Not clear why changes are needed, we don’t need to change everything
- Nothing about quality, only about funding / money today
- Today has ignored implications of the White Paper
- Not entirely, costs are not clear
- Sceptical

What are your feelings on the Changes We Have To Make?
The following common themes emerged from the group discussions regarding feelings on the changes.

Apprehensive – Why Is Change Needed?
Concern arose regarding the size of the task and why the changes needed to be made. Some participants were doubtful that services could be moved into the community while some expressed some scepticism.
- Huge piece of work
- Could impact us badly or we might benefit
- Seen it all before...
- Why are you asking? Seems mind is already made up
• Very doubtful specialist services can be moved into the community
• We do not need cuts and rationale
• Who says they have to make changes?
• Will there be enough support?
• Long way to go before population is convinced that the changes are for the good of the population!

Have Not Made Good Use of the Scenarios – No Economic or Outcome Information
Some participants expressed doubt, scepticism and opposition to the proposed changes. Some said they needed more information and that relevant pitfalls hadn’t been addressed.

• Changes are mainly logistic but things that really need to change were not discussed
• Can’t treat health in isolation – too much happening too soon
• Changes should be piloted and judged on quality outcomes, not satisfaction
• Need more detail before forming an opinion
• Opposed – changes are political, geared towards privatisation, wholesale orientation towards competition in markets – inappropriate
• Risk assessment would be good on all proposed initiatives
• Pitfalls haven’t been addressed

Funding
Some participants expressed concern regarding funding and reduced budgets.
• Budget is in the driving seat!
• Conflicts between the plans and the improvements and the smaller budget
• To achieve this with less money is going to be difficult
• At no point has the cost of change been addressed
Appendix 1: Detailed responses from group exercises

The following is the detailed responses from the group exercises:

Exercise 1

Question 1: Why do you think services need to change?

- We don’t necessarily accept the need to change – leading?
- Not allowed to have a deficit
- They need to change because of money we are told
- Imply not efficient, not meeting needs of population at present
- 10% in output and 100% in input (over 10 years)
- Duplication of effort
- Not joined up
- Few community based services
- Commissioning complex
- At different levels
- Difficult to join up services
- Too many managers, not enough case workers
- Oxfordshire not the worst by a long way
- Before you move people out of hospital beds you need to have a proper care plan and community services in place
- Transport – rural area and even in City to some health facilities (e.g. City Centre to Churchill)
- Pressure on GP services
- Patients need and want to see person best qualifies to treat them – that may be a hospital specialist. Also need to be where diagnostic facilities are available e.g. skin cancer
- Good community care is not the/a cheap option (at least not always)
- Outreach at Community Hospitals would be a good option
- Need to offer what we already are but more efficiently
- Need to respond to change e.g. technology
- Money
- Inefficient – some are badly run, waste
- More complex illnesses
- Lack of self responsibility
- Gap in health education
- People living longer
- Policy, and economic cuts = no choice.
- Ageing population
- Not fault of NHS – but change to structure does not help (cost)
- Pushed through too quickly – no consultation
- More education needed – where to go, how to be “healthy”
- To save money – as we have less money
- Technical & scientific & medical progress create need for change – These are expensive
- Need to be cost effective
- Need to be efficient – Health care professionals
- Focus needs to be on communities re: change not Oxon wide
- Economics and demographics
- Patchy provision – not focused on local needs (lack of availability)
- Pockets of deprivation
- Changing nature of healthcare – technology
- Must be easier to access health services – hospitals, GPs – depends on where you are and transport issues
- Need to be realistic on our demands

- Preventative not reactive services
- New role of GPs
- Maintain health in the population
- Services need to identify people earlier
- Community needs to help improve healthy lifestyles
- Resources need to empower people to help themselves
- To utilise new technologies
- Has to reflect financial reality

- Because the OOH GPs Services do not reflect need or provision
- Outcome is the increase in A&E visits
- Look at the increasing of investment in preventative services including the voluntary sector
- No mention of the need for efficient and effective partnership working between health and social care and voluntary sector

- Demography + and increased aspiration (ageing population) individual requirements not generic
- Technology
- Consider locations
- Current financial crisis / cuts
- Access to global facilities
- Increasing financial demand on public spending
- Increasing knowledge of many patients – internet (within various groups)
- Things could be done better
- Oxfordshire population specific
- Centralisation versus rurality
- Chaos within the change
- Arbitrary cuts
- Older population – heavy strain on resources
- Generally healthy population – less money
- How does student population affect healthcare; mental health, sexual health, higher demand?
- Drives up housing costs for healthcare workers
- Agree need for change
- Role of local authorities
- How will the transitional period be managed?

- Needs change
- Doctors should have the initiative and authority to prescribe products regulated by
FSA i.e. food supplements etc rather than just medicines
- Changing demographics
- New possibilities arise – knowledge and techniques
- More accessible
- Government says it has to
- We pay for, therefore we have a right to demand change – not an agreed principle
- Need to look at other forms of evidence not just clinical
- Need more knowledge

- Government pressure
- Demographic change
- Demand change
- Need a better case for change – too global/big numbers – need to narrow down
- Privatisation pressure – changes dynamic, supposed to be for public good
- Some services need improving but some are very good
- Change should be continuous and evolving
- Stop opening/closing/opening services – waste money
- Change costs too much
- Integration is needed across organisations

- Waste and inefficiency
- Patients don’t always turn up for appointments
- Too much travel to appointments
- Patients wait to be seen at their appointment
- Could services be provided as one stop shop

**Question 2: What challenges do you think the people of Oxfordshire face?**

- Self-care and responsibility is a challenge as there is not the support in the community to help this. There was emphasis on this being parish or local community support to help with self-care rather than formal/statutory services
- Needs to be much more support and services provided in GP practices as the local provider/support of health care
- Empowerment of patients/public is essential for making the changes
- Aging population – in rural area
- 2015 >85 outnumber <5
- Different language spoken
- Want range of LTG. Does one size fit all??
- Need to look at Public Health initiatives – not lecturing
- Health promotion and prevention vital and it needs to be culturally appropriate
- Where is the funding – it sounds expensive?
- Where is the ‘expert patient’?
- Carers – need respite
- If people are being kept out of hospital it may increase need for respite care
- Understand financial benefits of carers
- 1oz of prevention is worth 1lb of cure
- Need to check personal circumstances
- Day centres (voluntary, cheap) have an important place in keeping people out of NHS
- COPD is jargon – it won’t engage people (this is just an example)
- Don’t medicalise problems
- Creating A Healthy Oxfordshire
- Increased expectation(resulting from generally good health)/CF low expectations
- Need to understand how to manage ourselves – so keep out of surgeries when not needed
- NHS to use voluntary sector more effectively
- Address inequalities
- Address rural/city
- Address women/men
- Address BME communities
- Address literacy
- Balancing input so that areas of high need get higher input
- Balancing viable services against individual need e.g. transport (demographic issue)
- Resources to patients
- Aging population
- Less money generally – NHS and individuals
- Lack of family support – families spread out/people living on their own
- Cost of living in Oxfordshire – housing
- Not being able to access the right services
- Education around self care
- Lack of education
- Rural and city issue
  - Needs
  - Awareness of context
- For city areas hospital might be closer to home
- Deprivation, rural deprivation
  - Access to services, despite wealth area.
  - Critical mass issue
- More resources for carers – can’t change without
- BME pop challenges - access
- People are not aware of cost of healthcare
- People have higher expectations and more demand
- People too dependant on statutory services
- People need to change expectation of services – cultural change
- Challenge is for population to find out information
- Challenge is also for Health workers and system

- Expertise and knowledge of GPs – varies – different for some conditions

- Transport/accessibility
- Information for patients and public
- Primary care – needs to know how/where to access specialist advice (local!)
- Lots of different service providers
- Reliance on voluntary support – community cohesion
- Change and timescale – culture change takes time

- Getting older
- Housing – affordable and lifestyle
- Less resources especially for social services
- Already badly served for inpatient mental health services outside Oxford
- Transport services - rural areas
- ID of dementia – need extra training
- Unemployment having an effect on health

- Reduction of services
- Voluntary sector cuts and Local Authority cuts
- The commissioning/tender process not transparent
- Lack of confidence in GPs to deliver “All”
- Increasing elderly population
- We want more community services but we don’t have the facilities or transport in the community
- Population taking responsibility for their own health e.g. obesity
- More awareness of appropriate services
- Moral education
- Confidence – need to gain it in NHS and in ourselves

- Fragmentation of services
- Unrealistic expectations by patients
- Wealthy area = high demand
- Transition population
- Medicine changes so quick patients can’t keep up/informed of choices
- GPs need to change – so many illnesses to cover
- Specialist GPs needed

- Plan for now and longterm as population needs change
- Difficult to provide services locally especially specialists locally in a rural county
- More ‘1st stage services’ locally and transport for patients to start accessing them.
- NHS and social care work together
- Where can we save money in existing services?
- Need for better rehabilitation to support people leaving hospitals

**Question 3: Do you agree with the case for change?**

- Must be for the better
- Agree there’s got to be change – more efficiency, more working together – all sectors not just health
- Cut backs
- importance
- Not much choice but balance of cash between services
- Specialist services – don’t always have to be in hospital
- Need investment in LTCs
- Don’t agree with change for sake of change
- We have an aging population etc – means more demand
- Time of opportunity – ‘shouldn’t panic’
- Yes! Because LA and PCTs – inefficient, overly bureaucratic – central approach not sensitive to communities
- Not necessarily pace of change though!
- We don’t have joined up health and social care – opportunities to join up training
- X-boundary working must improve
- Case for some change
• Must retain what is good
• Concern about GP commissioning
• Not if it reduces MH services
• Is there a point asking this question?
• Issues with consortia – will costs escalate
• Yes for change not for way
• Not sure – need to know more about change to what
• Change to make more effective and efficient
• Opportunity to improve community services
• Mixed
• Change forced on us
• Need to define change
• Have been dissatisfied with previous change
• Absolutely
• Need better prevention

**Question 4: What if anything would you like to know more about?**

• Impact on clinical outcomes of patients following changes & impact on patient choice
• How are we balancing demographic issues e.g. geography, high need against provision and need
• Explaining – talking to people – how the health system works, what the changes will mean
• Difference in money spent between cost and administration
• About the basic level of service people can expect – lack of transparency
• Open and honest if mistakes are made – value of an apology – sorry!
• Learn from mistakes and from experience
• How GPs will ration budgets
• Understanding routes/or communications
• Are there any alternatives?
• What isn’t going to change?
• Would like a map of medical services in Oxford
• How services are proposing
• To discuss across and with communities
• Open thinking
• Does PCT have full freedom or are ideological constraints?
• Communication between professions and organisations – electronic/paper/other methods
• Understand new GP commissioning consortia
• GP commissioning roles
• How council will work with NHS to make it happen
• How to reduce bureaucracy
• More about individual services
• What is happening to NHS Direct?
• Could we use hospices differently to support a growing older population?
• More information about services
• More education
• More about how people / service users are consulted
Exercise 2

**Question 1: What are your feelings about staying healthy/self-care?**

- Empowerment and knowledge is essential for self-care
- What would the savings be?
- Can encourage patients but can’t force them
- This is already happening
- Brings several issues for one person together
- Encourage people to list symptoms/issues prior to appointment with doctor
- Essential for country and you
- Unrealistic – unless there is enough support and education – including medical services
- Life can take over – neglect own health
- People who are not healthy/with severe illness can not self care
- Must be able and willing
- Must be informed – education
- How we identify people who really need support.
- Think of different ways to educate – too much emphasis on guilt
- Self-care needs to be legitimate part of the health system
- Too often seen as a bit on the side
- Role models are an important tool
- Patient information is essential
- Will be culture shift for Health Care professionals – needs good customer service
- Fine if people can do it but people may not be able/skilled/confident to do it
- Good neonatal services could prevent LD needs for self-care
- What point will patients be able to get ‘more direct’ care? – specific to tele-health
- Clarity needed about ensuring patients know/understand when help is needed
- How to manage self-care to ensure people are informed properly and can understand what they need to do
- Support might need informal networks
- Individual focus – not one size fits all
- Education across public/patient groups (all ages)
- Support/advice on how to look after yourself – before people get ill
- Holistic approach
- Taking responsibility
- National messages – FAST (good example)
- Use modern technologies
- Does this cover respite for carers?
- Do it – it is a no brainer
- Personal, not personalised
- Personal health plan must have support – sympathetic care
- With support it is a good idea
- Why did the example start at 60?
- This should be about preventative care! And evidence based
- How are you going to encourage people to become empowered and change their mind set?
- Generally good idea but gap exists. No mention of personalisation.
- Shapes services available.
- Personalisation open to abuse
Different choices
Some people cannot manage their own self-care
Varying education – reduce demand for health services e.g. transport budgets and cycling. Better integration of services – health, transport, education.
Assumes that everyone wants to be healthy – is it a priority for all?
Good pilots are essential to test equipment / ideas (no waste at end of process).
Too much control
 Might fail with poorer educated groups
 How to motivate everyone? Some people don’t care enough about their health
2 groups of people:
 o Interested, with capacity
 o Not interested – focus on these? Educate?
Monitor/evaluate progress.
Important to have confidence in professionals
Education important
Concern about cost of tele-health
Sounds like common sense
Need to persuade people to take personal responsibility – need to know at that time where to get information and help when need it
Need to build into children’s education
Tragic people need to be empowered to look after selves – need self discipline, responsibility
Not one size fits all for prevention or treatment
PHPs should be able to include wider support e.g. food supplements, exercise
What happens to GPs if we have PHPs?
Re-education on attitudes needed
Good idea
Gives quality of life
Does this include un-preventable conditions like dementia?
Staying healthy starts before you are ill. Could have book to help monitor own care. Information e.g. blood pressure (patient held record)
But patient needs to know what to do with the info
But need to remember those without mental capacity to self-care
Very positive approach. Group welcomed the plans and agreed some caveats:
 o Need to make sure impact of health condition is considered – for example emotional, mental health impact
 o Prevention should include skills to prepare and cook healthy food
 o Importance of 1:1 support and education
 o Plans should include short term changes to help people cope with health problems AND longer term cultural change to encourage healthy living
 o Take into account importance of motivating people to learn to self care and maintain this
Will these plans work for everyone – or mostly for middle class people who are already motivated?

**Question 2: How do you feel about prevention and empowering patients?**

is necessary for achieving the goal of self-care
Must make sure pooling resources
Good health not just an NHS issue e.g. police (antisocial behaviour), housing (noise
quality)

- Would like to see more holistic care – for Mary with smoking and stress
- Are we doing enough to prevent Mary from starting to smoke?
- Empowering patients is a good thing
- Empowering through education – not lots of leaflets, consultations etc
- Time – to give complete assessment of patient
- Listen to patient
- Treat people as individuals
- Prevention is different to self-care. But there needs to be information and more targeted information.
- Empowering – people can make decisions that are not necessarily in best decisions of health.
- More holistic and personal
- Ethical decision – why should money spent on people who have chosen particular path i.e. smoking?
- Passionate
- NHS could improve staff health with a good Occupational Health service – preventing illness
- Need NHS staff to be responsible for people who can’t choose/decide and help them as if they were a friend
- Health care professionals need to listen more and work with client patients
- Prevention better than cure
- Too much choice isn’t a good idea
- Treating patients as individuals and looking at prognosis and whole picture of need
- Danger of leaving patients to own devices
- Need to be patient centred – not patient led
- Opportunity: CDW, Outreach, Health promotion advocates – need capable people!
- Needs a co-ordinated approach from organisations/industries e.g. food
- Patients/public will need help to navigate themselves
- Expectations must reflect a different approach – personal responsibility
- Not a new idea – get on with it!
- People need to want to help themselves
- Public need to support primary care to address this issue e.g. obesity and smoking
- There is evidence to suggest that when incentives are offered this encourages empowerment. i.e. GPs offering to fund obese/overweight patients to go to Weight Watchers
- Focus the spending on what evidence shows methods that work – preventative
- Need to research what is effective and invest in early preventative method
- People with Mental Health issues feel isolated – they are good at self-care
- There are issues with technology and machines bleeping – especially mental health patients. This cannot substitute the personal element and this includes the elderly
- Why spend lots of money on self-inflicted illness e.g. smokers
- Who decides? Could be a cause of keeping fit e.g. climbing
- But may be reasons why they are doing this e.g. behavioural/environment
- People need to be aware of impact of actions and take responsibility
- Some people don’t want to be empowered
### Question 3: What would we need to take into account when placing greater emphasis on self-care?

- Sign-posting to appropriate services (including on-line signposting)
- Support from voluntary organisations
- Networking and local support groups/community involvement/support
- Buddying – pairing people who have long term conditions with those newly diagnosed to help support and share experiences

- Support when I need it
- Surgeries need to be more approachable – no judgemental behaviour
- Is this the support she wants?
- Is she willing to change?
- Does the patient understand why she needs to change?

- Ability of individual
- Condition (medical)
- Individuals acceptance of their condition
- Appropriate information
- Safety net when things go wrong
- Knowing where to go for help – in and out of hours
- Need to have a goof local GP service
- Importance of having an agreed written care plan
- Behaviour change
- More education
- Less judgemental
- Info about consequences
- More investment
- Better support from GP practice and P.C. nurses
- People go to A & E because they are not confident in primary care.
- Did not work in Wiltshire
- Time? Change needs time
- More dialogue – statutory bodies
- Better communications
- Groups – based from surgeries offering help and support in evening – out of hours support
- Funding of carers centres
- Public Health departments to get back to Public Health!
- Rural deprivation
- Lack of transport socialisation
- Access more nursing rather than clinicians but still access to clinicians
- Take into account patient views
- People’s varying ability to make the right choices
- Be aware of gaps between NHS and Social Services – have seamless service
- Social determinants can affect health
- Environment
- Communication
Exercise 3

**Question 1: How do you feel about receiving an enhanced level of care at your GP practice rather than travelling to hospital?**

- Would be very useful however for those with rare illnesses/conditions this may be difficult
- About 600 GPs in county, example of skin cancer; there are only 2 specialist GPs but there are experts in the hospital
- Outreach clinics from hospital will be part of the answer
- Ambulance crews phoning GPs will delay getting to patient
- Very much need to tie in with existing work on ambulance services e.g. Falls service (CHO), OCC Social Care
- Need to look at other models that are being discussed
- Need to reconsider Out Of Hours service model if this is to work
- Has to be access to patient records (new technology) but already wasted £20Bn on it
- We are worried about PCT’s level of knowledge
- No GP here
- This is branded as a public event but people here are already involved. It is unlikely to make any sense to members of the public when it comes to consultation
- Concern about GPs incorrectly diagnosing and bringing a delay
- Lack of confidence in Out of Hours
- Feel like more bureaucracy – filling in forms
- High confidence in A&E
- Great need to extend GP evening and weekend hours
- Difference between rural and urban practices
- Would feel comfortable going to GP for minor surgery etc
- Whether the surgery is properly equipped
- Is there after care if things go wrong?
- Lack of confidence in GPs
- GP and practice nurses need to be trained – specialism’s
- OK if getting right level of care for you
- Avoid post-code lottery – worried that changes to GP commissioning will increase this effect.
- GPs recognise limits. More input/advice from specialists
- GPs should behave less like private businesses. Issue of GP pay
- Difficult to answer; loaded questions
- What if the hospital is closer – spatially and geographically
- Pros and Cons – GP should know you as an individual, should have more and better technology. Better cost-wise for patients. Patients better relationships with GP.
- Patients might prefer hospital atmosphere, ‘some reflect in condition and presentation’
- GO Practice is key – A hub for local community services
- GPs not necessarily well informed
- Needs good IT system
- Many a slip between cup and lip
- Problems can arise if staffing isn’t there e.g. holidays, maternity leave etc
- Impossible for everyone to be the best – variation will occur
- Great – But! – depends on willingness and expertise of GPs (availability of
professionals time [Where/when provided])
- Confidentiality – some services (contraception) patients might prefer to access not at their own GPs
- Suitability of practice premises – will have to be phased
- Out-of-hours services needs to be extended to evenings and weekends
- Co-operative approach needed by GP practices
- Sounds lovely but how practical and affordable is it?
- We shouldn’t turn GPs into mini hospitals
- Wouldn’t work without bigger practices
- Rural practices will need a different approach
- Ideal if we can get there
- Out of Hours service still needs improving
- Question wording!
- Better service from GP i.e. especially out of hours
- Everyone agrees with enhanced level of care but not the model discussed!
- Meaningless question? – is GP good?
- Do they have facilities? Specialisms e.g. mental health
- Depends on GP
- Volume of patients
- Training of GPs
- Opening times
- How will patients know specialist GPs
- Education
- Quality of GPs
- More education for GPs on treatment of various communities, equality.
- What is the ‘standard level of care’?
- limited scope for GPs to offer enhanced services
- Possibilities and restrictions
- Not happy with concept of GP specialist – not experts and not full time
- Case for delivering more services at GPs but need access to GPs
- Issue specially in rural areas
- Needs to be partly across the county before you can start developing it
- Need more information about what is being proposed at GPs
- Debatable which level should provide which services
- Concerned may want to develop services that are convenient to the system no patient
- Concerned the system isn’t up to it
- Within travelling community hospital valued
- Only if made to work
- Experiences GP with more training would be better
- GPs may not have breadth of skills to do this and time
- Increases pressure on GPs
- More GPs would be needed
- Use nurse practitioners more but may not identify all the problems
- Local services better because they are less stressful to use
- Issue about ensuring consistency and quality of care when services are more diffused
- For this to work, people have to have confidence and clinicians are
  - Fully trained
<table>
<thead>
<tr>
<th>Question 2: How far would you be willing to travel to receive that care if it was provided at another practice?</th>
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<tbody>
<tr>
<td>- Living in a market town – there would be a reluctance to travel out of the town</td>
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<tr>
<td>- Travelling to other GPs – this might be a long was in rural area</td>
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<tr>
<td>- Presentations don’t make clear that everything won’t be delivered everywhere</td>
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<td>- Lack of continuity of care is a growing issue (salaried, part-time GPs etc)</td>
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<tr>
<td>- Need to ask people in rural areas, homeless people, other disadvantaged groups, how they feel about travelling</td>
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<td>- Cultural awareness training for GPs and use of language line</td>
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<td>- What’s the model for competitive provision of language line?</td>
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<td>- Vision should include centralised electronic record – would revolutionise care</td>
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<td>- Must be secure – retain confidentiality</td>
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<td>- City not a problem</td>
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<tr>
<td>- Rural – currently JR visit means a very long day for patients</td>
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<td>- Would look for cross county satellites taking into account need</td>
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<td>- Fresh pair of eyes may be good</td>
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<td>- Save time</td>
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<td>- Depends on public transport</td>
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<tr>
<td>- Depends how ill you are</td>
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<tr>
<td>- 20 miles max – need to get there and back</td>
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<td>- Will transport be included?</td>
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<td>- Cost – who’s paying – of transport and of procedure?</td>
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<tr>
<td>- Difficult to answer. Different things apply – rural/city areas.</td>
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<td>- Public transport issues</td>
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<td>- Free transport?</td>
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<tr>
<td>- Perhaps more specialists coming to you...(GP/hospital)</td>
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<tr>
<td>- Example of Southampton Community diabetologist visiting GPs – GP shadowing to learn.</td>
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<td>- Issue for those in care homes – can’t travel.</td>
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<tr>
<td>- Would go to ‘ends of the earth’ for the right care</td>
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<tr>
<td>- Wouldn’t travel to another GP – would expect a referral to a specialist – saves time</td>
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<td>- Essential to ensure standard of practice across all surgeries</td>
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<td>- Need to have adequate appointment time to raise all issues</td>
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<tr>
<td>- Mental Health</td>
</tr>
<tr>
<td>- 2 miles/20 minutes –depends on options available to support patients accessing services</td>
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<tr>
<td>- How will locality for enhanced services be defines? E.g. will patients be able to access GP services near their work?</td>
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<tr>
<td>- Dependant on public transport services – maximum 1 journey by public transport, no more than 30 minutes</td>
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<tr>
<td>- Mobility of patients is an issue too</td>
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<tr>
<td>- Advice centres at practices</td>
</tr>
<tr>
<td>- Patients will need access services at practices they are not register with</td>
</tr>
<tr>
<td>- Depends on transport available</td>
</tr>
<tr>
<td>- Depends if you live rural or urban</td>
</tr>
<tr>
<td>- Well funded community transport</td>
</tr>
</tbody>
</table>
- 5 miles or half an hour if you have access to a car  
- depends – who provides transport?  
- Depends on quality of care at destination  
- Distance – may be closer but can get there quicker by train than bus etc.  
- Can’t be specific on distance – variables  
- Depends on opening hours.  
- GP referrals – distance.  
- 3.62km and not a yard more – what does the question mean?  
- Depends on the issue of what transport is available and whether its available when needed  
- Depends on city/urban or rural  
- Issue for people that the further you travel the more it costs (in travel costs, time, difficult if you have children with you etc)  
- Service providers need to take into account transport and transport providers when commissioning/providing services  
- 15 miles  
- Depends on condition and ability  
- 10 mile  
- Demographic changes – older people couldn’t travel far, costs etc  
- One off, then might travel further, depends on frequency  
- Depends if drive, or public transport in your area  
- Issue is not distance, but ease and cost of journey. Especially via public transport.

**Question 3: What would the NHS need to take into account when placing more emphasis on people using enhanced services at their GP practice?**

- That the right services are available at the GP practice and communication between the practice and specialist/consultant at the hospital was joined up and up to date.  
- Increase provision, advanced communication course – long waiting list at moment – extend provision to GPS  
- More practice nurse provision to enable people to choose whether they want to talk to GP or nurse or perhaps to choose sex of staff they talk to  
- Community Health visitors – more and extend role  
- NHS e.g. NHS D, risk averse  
- Transport  
- GPs should know limits – clear referral protocols  
- Develop trust in other practitioners e.g. Nurse Practitioners with special skills  
- Specific information about when to go and where to go – online?

- Hours that GPs work  
- Confidence – in their experience – want someone who’s an expert in their field  
- Giving enough information about who’s doing it and what will happen. Not just a leaflet  
- Advantages and disadvantages  
- Choice  
- Knowledge what services are on offer  
- Adequate provision for after care  
- Knowing where to go for aftercare  
- Expense – to patient  
- Knowing who to contact for support/follow up care after discharge
- Costs – training, (on-going – needs to be up to date)
- Transport – how?
- Facilities?
- How GPs spend money? Has to be cost-effective
- How services will be allocated i.e. what GPs will be responsible for commissioning
- Does it address hospital effectiveness – effect on hospitals which might have been specifically developed
- Mental Health: important looked at as an individual – if not well done causes greater problems
- Needs to support GPs – Staff and funding to provide enhanced services and training
- Patient Information and education on enhanced services
- Don’t believe that presenter knew what case study actually meat or that the future provision example is correct, - rapid access clinic is not feasible, cost-effective/practical
- Have not fully comprehended what enhanced services are
- GP services need better integration, part of a ‘community centre’ focus (what are the best places to provide enhanced services?). Options include all other community services, example: Barton neighbourhood centre
- Enhanced services will need to be properly equipped
- Bring in promotion and prevention
- Part of specification for building new practices/health centres
- GPs must be willing to do this
- More Nurse Practitioners and better use of them
- Raise status of community nursing
- Need access to hospital as well
- Need an improved Out Of Hours service
- Availability of diagnostics
- NHS consultants will need to travel to people and GP practices
- Good training of practice staff
- Core GP service should not be eroded – GP core should still be holistic, not specialised
- How will this impact on our personal relationship with our GP?
- Look at not being able to make advance appointments
- Access to equipment and training
- Numbers of GPs
- GPs sometimes unable on certain conditions to assist
- Patients/carers
- Overcome the number of hurdles to access services – danger that there will be too many steps to overcome before treatment
- Increase training for GPs
- Needs to be an element of choice in GP practice
- Have a good range of expertise within a practice
- How is all of this going to be incorporated into an already stretched system
- Patient education and information
- Information for patients
- Accreditations for GPs – proof of ability (CPD)
- Costs and rewards to the practice – is it worthwhile?
- Who does additional admin?
- Standards for outcome
- User-led monitoring. Feedback.
- Transport
- Skills
- Access and availability (time)
- Patient immobility
- Capacity of GP practices – can they deal with increased numbers
- Some GPs may hang on to patient’s when they should refer on
- Communication
- Selling the ‘idea’ to the public
- Access – time and proximity
- Need the facilities – need location, timescale, capacity
- Catchment area
- Needs to make sure it doesn’t cost more than what doing before
- Quality needs to be maintained
- Flexibility
- GP practices needs to be somewhere patients have confidence in to go instead
- Need reassurance it will be a comprehensive package of care
- Integrated social care (access to their services)
- Support if GP not available e.g. NHS Direct
- What about sustaining e.g. GPs/staff go?
- Need to understand (public) why it costs more to go to A&E then might not go there
**Exercise 4**

**Question 1: What are your feelings about health and social care working in a more integrated way?**

- Sounds like utopia – reality is very expensive to make happen
- Relies on ‘Brokers’ to support – after not well trained, supported or paid
- Social care – people need to be assessed, some people don’t want to be assessed, what will happen to them?
- The question is it going to happen? Of course it is ‘mice’ but we don’t think it is realistic
- Fewer people are going into homes It’s not new e.g. social care workers transferred to the Mental Health Trust – some people think it will work, some thinks it doesn’t
- Note - The group did not like the question about their ‘feelings’, thoughts would have been better
- Long overdue
- Excellent plan
- Money – people don’t want to spend theirs
- No-one likes a pooled budget when it comes to it
- Needs more public consultation
- Is the present system so broke it needs fixing?
- Is integration going to work to the detriment of health – lowest common denominator
- Issue around case workload of care co-coordinators
- Good thing
- Issue around practical resources
- Issue around suitability of treating people in their own home
- Pooling budgets will allow for more efficient management
- Needs to be under a single structure to be truly integrated
- Will need more staff if people are going out to see people in the community
- Could save money by reducing bureaucracy of structure spend on care
- Need to make sure county council are involved if social care under county council structure
- Issue of security – sharing records
- Integration = good. But concerns as to how it will work over a boundary –
- Small place – sustainability issues.
- More detail about service as concerned about cost to provide care at home.
- Work in co-operation not competition – no internal market
- Work together – no fragmentation. Too many different NHS orgs
- Care closer to home but communities need to be reflect - rurality
- All sounds good – but will it work – Health and Social Care totally different
- Concerned about levels of skills and knowledge staff will have as have already excluded specialist nurses
- Concern over definition of ‘Health’ and ‘Social welfare’ – are there ‘hidden definitions’ that we aren’t being made aware of?
- Is the whole system reform biased towards secularism?
- Concept is good; care co-ordinator role is too large – will they be able to manage their load?
- Concern about care co-ordinator being a demotion of social workers
- Future scenario assumes resources available
- General assumption that integration is the way to go – not sure of this...
- Can’t be done on the cheap – budgets being cut even in voluntary sector
- Expectation that teams have been working together – 1. What is different about these plans? 2. What are the plans?
- By nature services are integrated – reality is funding introduces divisions – need integrated funding mechanism
- Need more emphasis on voluntary sector
- Focus needs to be on quality services in community
- Premises needs to be suitable to support integrated teams
- Hubs – district focus – satellite for services, different approach for rural and urban areas (issue with public transport)– merging GPs and Community Hospital premises
- Links to PHP and self directed support
- Staffing – will there be support for more integration? – are there issues with cover across services (multi skill, multi tasks)
- Potentially could be more expensive to run services in community – travel times for professional can be an issue, more time intensive
- Beneficial for patients
- Excellent
- Concern about how
- How?
- Not sufficient info to make a judgement
- Where will the funding come from?
- They are not funded in the same way so we need to go for a change!
- It should be a “single pot”!
- In mental health it works currently, but what would happen in the future?
- Must have an integrated (single) management structure
- If GPs are taking control – they do not have a holistic view
- Next of kin should be included in model
- Power of attorney – regarding decisions in case of dementia. As GPs bound by confidentiality family role is crucial.
- In principle a good idea
- Vol + community should be included in model.
- Communication – improve
- Different processes – discharge from hospital, homecare, GP.
- “out of hand”.
- Ward sister co-ordinates needs ie. Patient therapy
- Essential to have complete integration
- Jointly managed, jointly run and jointly owned
- Mental illness must be part of this and dealing with emotional need
- Take into account differences between funding Health and Social Care – how will this be dealt with?
- Mustn’t assume people have carer or social network – isolation must be addressed – need to look holistically
- Need to identify and break down barriers e.g. procurement issues
- Rebuilding capacity in the community is needed especially in rural areas
- Muddled thinking
- Specialist knowledge e.g. nurses are trained for a specific role
- How would this differ from current situation when social worker goes in
- Need a coordinating role with knowledge of all services and what is appropriate
- Integration gives more holistic care/info on a patient
More support for people that are carers

Principles OK, but high concerns about practical and logistical issues.
  - No sense that voluntary sector is part of this project as an equal partner.
  - Cost – model sounds too expensive.
  - How does it work when NHS is free at the point of delivery and social care is means tested?
  - How can voluntary sector take on this when its funding is being reduced?
  - How does this fit into personal budgets in social care?

Concerns about
  - Ensuring all staff have adequate training to take on different roles
  - Continuity of care and a familiar face to people receiving care
  - Frequent home visits can be reassuring for people and help monitoring of health

Will this be harder to achieve in rural areas?

Question 2: What would we need to take into account when placing greater emphasis on integrated teams?

Working in conjunction with GP practices and specialist to ensure continuity of care

Resources it will be a big issue

No involvement of hospital, only interested in emptying their beds

Social care budgets are being cut

Needs to think of patients whole care

Sounds like what people want

Think it will save money – it’s expensive

Compare with 1995 - care in the community – no money there and it didn’t work

Fewer people will go into peoples homes – bad for older people: need social interaction – which people will go in? – will they be able to do everything to an expert level

Care needs to be ‘needs’ led not system driven

E.g. children’s centre – not all families will go to children’s centres – need outreach to work as well

The whole group agrees, they felt most described was system driven

Needs to be accessible for people in Banbury, Oxfordshire is a long way away

Integrated health teams – one person able to deal with many conditions but also said community health merging with Mental Health Trust

Where is the logic in it?

Need more detail

Whose budget? – joint pooled

Won’t happen magically

Good enough paid carers don’t currently exist – recruitment issue, low pay – training and development

Integrated access to records important if it is to work

But confidentiality

Safety

Terms and conditions of staff not aligned

Professional boundaries – issues of status

Retention of employment rights

Communications x3 – essential to communicate throughout change

Not letting people drop through the net – also homeless people, moving around

Quality of staff – going into people’s homes, skills, attitudes, security
• Importance of accountability – complaints
• Speed of response – to complaints
• Communication between the two agencies proving the support
• Clear channels and multiple routes of communication
• Getting the balance right between sharing info and maintaining confidentiality – different levels of security ‘need to know’ basis
• Patient ownership/control of whole process
• Not just NHS and local authority car (friends, family and voluntary)
• How will the integration work between health and social care would one body be able to cope with both?
• Conflict between professions
• Patients don’t care where care comes from, want good care
• Issues – communities, logistics.
• 2 way engagement – community and acute care. Especially when GPs start commissioning communication to primary care
• GP time to engage in these issues
• Agree should work together
• Issue around adequate staffing and funding
• Multi-skilled
• Respite care important
• Cost implications
• Quality high priority – needs to be focus.
• Encourage voluntary sector.
• Worried that ‘anybody’ will be sent in – contract fulfilled but not with right skill mix
• Advocacy, if system doesn’t work for people, who advocates for them?
• Will it be NHS or ‘Private’
• Continuity of care
• Need resources for an independent advocacy service
• Plan needs to be included in training of health and social care workers
• Needs community engagement especially minority groups
• Payment for social care - how will this work with integration
• Need to monitor outcomes
• Transport
• Training to support culture change and for staff to mot work so directly
• Professional/peer support – challenge to maintain
• Communications strategy – joined up!
• Access to patient records vs. patient confidentiality
• What support can other areas (pharmacies) provide e.g. retail sector and equipment/​premises
• Equitable and transparent commissioning and tendering
• Fair representation of all stakeholders before strategic plan made
• Very hard to understand how these systems will be commissioned
• Data protection
• Strong evidence base
• Only fill in forms etc once is information sharing
• Skilled, trained professionals doing work
• Clarity over what services will be provided and eligibility criteria
• Real prevention of patients ill-health not just efficiency savings
• Should not only be about keeping people out of hospital
• Decisions must be made on what is clinically appropriate
• Concerns about what the future commissioning framework will look like
• Once authority overseeing it?
• For those living in the city hospital is closer to home
• Issues around public transport
• The move to GP funding is a golden opportunity to get it right!
• With professional support provided from the “area” the role of the social worker/occupational health are clearly defined and respected
• We would query the model with so much reliance on the voluntary sector – we must ensure there is a commonality
• More clarity on the meaning of community
• Definition of community
• There is a requirement for community to access GP services whilst in their place of work
• 24hr walk in Health Centres
• There must be clarity about the objective
• More emphasis on preventative measures
• There must be training of integrated teams and on an area basis
• Demolishing PCTs is not a good idea!
• Money
• Responsibility in future when GPs have the purse strings
• Accessibility and co-ordination
  o Role of local authority?
  o Who controls? Ultimately.
  o Measure/monitor outcome?
• May take up more time initially.
• Where does family come in? + community?
• Better paid, better supported workers
• Skill development – multi skilled
• Not working in silos
• Clear lines of accountability
• Need professionals to have time to get to know people and talk to them and treat them as if they mind about them
• Good coordination
• Good information on services available
• Patient centred, based on their needs
• Book/system (at home) that has all info on[patient name and contact – family member and contact- GP name and contact – Care/Support worker and contact – specialist service and contact number]. Info about patient for any service/carer that comes into contact with patient
• Patients need to be better at communicating needs/or might be proud/or not want to be a burden
• Meetings with all services there
• Communications between professionals need to be better – could use teleconferencing
• Placing budget with patient (if can mange well)
• Concerns for carers integrating, will they get the valuable respite?
Exercise 5

**Question 1: What are your feelings about bringing aspects of care out of hospital?**

- Positive if quality and safety is taken into account
- Need to ensure the specialist service/knowledge is available if this was to happen
- Don’t like ‘feelings’ in the question
- This is the way we should be going definitely – closer – more responsive – where people can visit
- Not without ‘experts’ – experts crucial to people
- Is the GPs IT all in place? So they are in communication with the hospital?
- They need to be – it can work very well
- But it can also work well having an assessment unit in the hospital
- Why have we closed down the assessment units in community hospitals in Oxfordshire?
- Mixed – looks like complex – will it work?
- Looks like moving from one hospital to another
- Future services in community are easier to cut
- Availability to spread county wide is limited (Partic Geriatric Care)
- Pilot looks good but what is the cost? Good if it’s done well
- Patient needs to feel supported
- Choice
- Depends on previous circumstances
- If not done well could be resource heavy
- Decision needs to be made on clinical basis and their support at home
- Need fast access to support if things go wrong
- Care pathway so people understand where to go, what will happen
- Constant process of monitoring and evaluating best care options
- How will it be cheaper? – useful to have cost detail. Community hospital vs. acute large hospital. Need more information.
- Locality – where? Should be in every significant community.
- Smaller towns = more multidisc units – one stop shop.
- Clarity on what is urgent very subjective.
- Return to what was working 15 years ago
- Should have adequate facilities and resources
- Agree in principle – a lot could be devolved especially where doesn’t depend on expensive technology
- What does ‘certain’ mean?
- In favour, but concern about resources
- Proposals feel like community hospitals with a coat of paint?
- How? – will medical staff be redeployed? – supervision issue for trainee (especially Doctors) – EWTD
- Will there be specialist GPs in community hospitals?
- Defines what can be provided locally e.g. specialist SNS like disabilities
- What is role for specialist nurses/AHPs and link to specialist support groups (Voluntary sector)
- Pathways must be clear for patients needing more complex/specialist SNS
- You are just moving the problem
- Needs to be very clear what is appropriate to do this for
• Should be being done now
• Is it financially efficient?
• If it is rolled out it needs to be local
• Suspicion it is not being done for the right reasons – for the good of the patient
• The examples in the presentation were poor – how do you affect behaviour change?
• It is not always safe to leave patients with certain illnesses at home. It is in certain circumstances a safer environment in hospital
• It could mean that certain GPs do not see enough of certain conditions to retain skills
• There is a need to keep patients in hospital at times. They are being sent out of county where wards locally have been closed (records etc are an issue and sharing info etc)
• Welcome
• Depends on what conditions are being in this way
• Good as can maintain family and friends relationships
• What about care of the dying?
• Need somewhere for people from Oxford
• Good in local area
• Why closed A&E Units in community hospitals, should stayed in local community
• Good, but need resources
• Funding is needed for this
• Support is needed for carers
• People shouldn’t rely on 999
• Good not to travel long distances

**Question 2: What do we need to take into account when placing greater emphasis on moving some care out of hospital and into the community?**

• Working better with emergency services
• Ambulance services need to be aware of the services
• Who is ultimately responsible for patients in integrated services?
• Need principle of responsible medical officer (RMO)
• Need to ensure that people can get access to the right specialist
• Mist be appropriate care – people must have access to all the services they need e.g. physio’s and Occupational Therapists
• Proper support for carers – ensuring existing services
• Have regard public transport issues. Location of bus routes
• What about people in south – RBH
• What about people in West – GWH
• What about people in East – BUCKS
• What about people in North – W’SHIRE
• Financial stability of JR once a Foundation Trust
• Access to specialist support
• Providing specialist support to local GPs, nurses etc, like FAQs on internet
• How quickly can support be provided in a crisis
• Support plan in place before person goes home/things go wrong
• Monitoring
• Can be more expensive to provide care in more than one setting
• Contradictory to what’s been done before. Is it a reversal of policy?
- Monetary and staffing support for GPs – concern support for future.
- Locations of services in community.
- Costs – logistics/facilities. Concern about duplication
- Integrated IT.
- Resources
- Anxiety of patient; people feel more confident in hospital
- Level of specialisation and how common condition will affect service provision
- Wrong timing; talking about cuts
- What about older single people living alone – how does tele-health work
- Very good early discharge planning
- Integrated IT.
- Resources
- Anxiety of patient; people feel more confident in hospital
- Level of specialisation and how common condition will affect service provision
- Wrong timing; talking about cuts
- What about older single people living alone – how does tele-health work
- Very good early discharge planning
- Good support systems in community - co-ordinators – brokers – packages – equipment, aids, beds
- Are patients ready/capable to handle level of information to help them make decisions about their care/health?
- Need appropriately skilled and trained staff
- Will further steps impact on patients needing immediate admission?
- Approve of pilot in Abingdon to rest this
- Need assurances that shifts to community don’t ‘shut down’ services
- Will there be a need for patient held records?
- Ensuring there are the right level and quality of services
- Must be safe
- Need to ensure no duplication/waste
- Must engage and use community/voluntary services
- Patients must be aware of what is available and how to access
- Supported where necessary when accessing services
- Impact on carers
- Good training and support for all of the different professions involved
- Opening hours / access still not enough
- Change the parameters of the test
- Proper facilities for the ailment
- Needs to be resourced
- Another pilot EMU for people in rural areas out of touch
- Some aspects can come out of hospital, some can’t
- Take transport and access into account
- Transport
- Availability of specialist equipment and trained operators
- Sufficient staff – with skills and experience – including admin staff
- Integration
- Trust and confidence
- What about people returning into the system?
- Minor injuries unit
- Adequate funding
- Resources and knowledge in place locally
- More beds in community hospitals
- IT resources need to be used better so patient info can be accessed across services
- Continuity of information
- EMU need to spot issues like if person cannot remember to take medication
### Question 3: What are your feeling on health care teams having access to and sharing your care record?

- Positive, however concerns over patient confidentiality and safety of information online from hackers
- Absurd to have to use motorcyclist to fetch patient notes – as we do now
- Who would have overall responsibility for patient records and overall picture and treatments
- Perhaps people should have a choice
- NHS records shouldn’t be shared with social services unless I have explicitly agreed
- Should be shared with NHS unless people have opted out
- People/Health care professionals should only have access to what they need to know
- Doubt over NHS IT systems
- Importance of relevant people having access to information can outweigh confidentiality
- Accuracy of data
- Patient control of information vs. need for medical information for clinician
- Transparency and trust
- People could judge on previous conditions (in medical notes)
- Good if there is security
- Integrated systems across health and social care
- Happy, but what about confidentiality
- ‘I haven’t read them, so I don’t know if they are accurate’
- Records may hold opinions that patients disagree with...
- Shouldn’t be a problem if standards are adhered to
- Information needed to support decision but who defines appropriate?
- Needs good IT system (failsafe) – could be costly – payment on outcomes...
- Patient expectation has increased – encourage choice but only where it suits system (e.g. choosing to go to A&E) How do we tackle this?
- Education
- Need to know who we are talking about
- Records shared need to be relevant, not just everything
- General consent from patient
- Who makes decision on behalf of people with mental health problems or dementia – capacity
- Need to know what is in them
- If this is volunteer led this could be an issue. There must be effective procedures in place to deal with this
- Especially to recognise allergies etc and spot serious conditions
- Training to specialist training for GPs and clinical staff
- GPs could get protective over budgets and may not want to refer to hospital
- Patients may have to fight to be referred to hospital
- Could be an issue with out of hours service referring to hospital
- Patient choice
- Services for SEMH – will those be maintained in the community?
- With consent
- All staff ethically bound
- One central system doesn’t work – or local system
- Must be with expressed consent
Question 4: How do we help people use hospital less and leave earlier if appropriate?

- Education of patient
- Support system in place in the community
- Ensure all services are available
- People should be educated that the services are there (needs to be from a young age)
- Should people be turned away if they attend inappropriately? Perhaps
- The alternative to hospital needs to be integrated
- Are they going to equip these places properly? Otherwise people will continue to go to the John Radcliffe
- Make sure quality of social care professional is good enough
- Outsources care adequate
- Make sure resources in social care are sufficient and appropriate
- Equipment and adaptations – assessment available/timely/suitable – Needs OT
  District and City councils
- All services should be culturally appropriate
- Specialist clinics in GPs
- More/better access to GPs
- Understanding what services pharmacies can offer
- Need high competencies in clinics etc outside hospitals
- Disparity between rich and poor
- Preventative medicine rather than curative
- Education for patients about their condition
- Wider dissemination about negative effects of processed food and the health benefits of healthy eating
- More family and community support
- Problems with tertiary care and lack of beds in nursing homes
- Less privatisation and more nationalisation of social housing
- How far do we take definition of health and well-being
- Empower and involve voluntary sector more
- Bad food, uncomfortable beds, slow ambulances!
- Re-educate public/patients
- Self reliant patients – limit choice!
- Good level of service in the community for LTCs
- Utilisation of proven, existing services in community e.g. voluntary
- Provide appropriate finances and support for carers
- People only shifted out of hospital where appropriate
- Enhanced recovery program
- Preventative measures
- Pathway to health
- Pressure to make patients leave hospital too early – tick in a box, makes figures look good, they then get re-admitted and hospital gets a black mark (Dr Foster)
- More community service resources, but may not be cheap!
- By recovering more quickly
- Tearing down the hospital
- More primary care orientated community hospitals
- Education of patients, carers, people
- Improve morale of patients
- Make sure patients ready to leave and social care in place close to home
- Better and quicker care plans
- More care homes, nursing homes etc
- More effective transfer of information to people that need to know
- More backup and early intervention at home
- Clearer information on when to use A&E
- More people receiving care at home
- Convalescent at homes
Exercise 6

Question 1: Is it clear why health services on Oxfordshire need to change?

- People agreed they were
- Economics and demographics
- Not entirely – costs are not clear
- Sceptical
- Would this be happening if the money weren’t going down?
- Yes – but not clear how - Cost in change.
- Cultural changes difficult
- Definitions – what is “closer to home”?
- Feel less clear now – more confused after event
- Clearer why service feels it needs to change
- Money!
- Need to do more with less
- Better services
- This is about social change on health provision
- Embracing technology and progress
- More individual responsibility
- Still a political focus re: change
- Not clear why changes are needed: we don’t need to change everything
- The meeting hasn’t clarified this – the reason services should get better
- Nothing about quality only about funding/money during today
- Yes – because of the White Paper
- Today has ignored implications of White Paper
- To save money
- Need more input from Social Services at events/presentations etc

Question 2: What are your feelings on the changes we have to make?

- Difficult
- It is a cultural change that will take between 7 years and a generation, how can it happen in 2 years
- More information for patients and training for staff required
- Change would be good but are they necessary?
- Pitfalls haven’t been addressed
- Concern that those in rural areas miss out – what about the smaller market towns?
- It could be very good if it works
- Conflicts between the plans and the improvements and the smaller budget
- To achieve this with less money is going to be very difficult
- At no point has the cost of the change been address
- Need to communicate the change
- Have not made good use of the scenarios – no economic and outcomes information
- Changes are mainly logistic bit things that really need to change were not discussed
- Budget is in the driving seat!
- Can’t treat health in isolation – too much happening too soon
- Apprehensive
- Huge piece of work
- Could impact us badly or we might benefit
- Sceptical (verging on cynical) – seen it all before...
- Change takes time!
- Also encouraged – some persuasive initiatives
- Don’t throw baby out...
- Lacking input from younger people and those we don’t usually involve
- Not enough focus on voluntary sector
- Not enough presence from LA
- Where was John Jackson?
- Commissioning is crucial, needs to be a balance to procurement
- Why are you asking? – seems mind is already made up
- Very concerned
- Very doubtful specialist services can be moved into the community
- Changes should be piloted and judged on quality outcomes, NOT satisfaction.
- Not hopeful
- We do not need cuts and rationale
- Who says they have to make changes?
- Long way to go before population is convinced that the changes are for the good of the population!
- Need more details before forming opinion
- No choice – everything affected as well as NHS
- Opposed – changes are political, geared towards privatisation, wholesale orientation towards competition in markets – inappropriate.
- Need to start again
- Mixed feelings
- Good time to start experimenting
- Need to coordinate changes
- Concerns – will there be enough support
- Risk assessment would be good on all proposed initiatives
- Use of technology important
Appendix 2: Graffiti Wall

We asked people to write their comments and thoughts about the Oxfordshire health system and Creating A Healthy Oxfordshire on a graffiti wall throughout the day.....

- The danger of moving services into the community is that they are far easier to cut (with no organised opposition) at a later date.
- Care in the community if done properly is not a cheap option.
- Why did the CEO leave so early?
- Plan services from the bottom up – talk to people in the communities about what will work there. One size will not fit all – need flexible, responsive approach.
- Extra services at GP surgeries should not lengthen or diminish the care pathway.
- The care of mentally ill people now comes under ‘Mental Health’ – This diminishes the needs and importance of mental illness.
- Voluntary Sector
  - Post 31st March 11 – cuts such that few of these organisations will survive!
  - How do we get linked into this work and using us as a part of the future model etc
- Governance
- Funding of Secondary Sector
- Interfaces
- Concern regarding Out Of Hours cover:
  - Competence
  - Information about me
  - Correct information about me
- Equality of access – Oxfordshire too big an area – needs to be defined in communities – and access to services thought through/provided accordingly.
- How will GP (Generalists) deal with specialist conditions?
- Are CQC or MONITOR fit for purpose? Doubt it!
- Self-care isn’t an option for severely ill people.
- Community services can be cut more easily than hospital services.
- Type of information leaflet that could support self-care can put in wallet (text needs to be bigger though!).
- How can you introduce Personal Care Coordinators in Health, at the same time as they are being severely cut in Social Services?
- Do people really want to live longer?
- Properly resources support for unpaid carers is essential for the delivery of all these initiatives.
- Community development and community infrastructure is a key part of health and social care delivery. Please recognise and involve community development agencies in planning services – and resource then to be part of the integrated care team.
- Use of voluntary sector.
- Considering refugees/asylum seekers and the wider BME communities.
- Language and cultural specific services.
Appendix 3: About Participate

Participate is a social communications consultancy which specialises in delivering consultation, engagement and research solutions for its public service clients.

As an Approved Partner of the Consultation Institute, Participate is one of only a few UK agencies which have been independently benchmarked against best practice principles to ensure our methods of engagement are comprehensive, transparent and meaningful.

We create specialist problem-solving toolkits for our clients that use a combination of dialogue methods, research and analysis to get to the core of behavioural patterns and understand what it takes to encourage people to take part and make a difference.

Participate’s strategic approach to problem-solving drills down into the core of what our clients need to achieve, adding value and supporting projects to ensure they are focused on outcomes rather than outputs.

Our services include:

- Stakeholder mapping and communications
- Consultation, engagement and research strategies, plans and reviews
- Implementation of dialogue methods including
  - Deliberative events and workshops
  - Focus groups
  - Quantitative surveys
  - New media and e-participation techniques
  - On-street engagement events
  - Facilitation of public meetings
  - Development of new techniques to meet the client’s needs
- Data gathering and analysis
- Reporting and recommendations
- Training and evaluation.

Our ethos is to deliver methods and approaches which meet the client’s objectives whilst ensuring that all work undertaken is inclusive and accessible to every stakeholder involved.

We believe that consultation, engagement and research are ineffective unless they are grounded in robust methodology, with a clear evidence base and a reason for people to be involved. That is why in addition to delivering projects that focus on supporting project outcomes, we also ensure all our methods of engagement are interactive, innovative and meaningful so that we create a desire in people to take part and make a difference.

More information about Participate is available by:

Visiting us at: www.participate.uk.com
Becoming a fan: www.facebook.com/ParticipateUK
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