Report on consultation for the Whole System pilot in the Abingdon area

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1. About NHS Oxfordshire

NHS Oxfordshire is a Primary Care Trust (PCT) and serves a population of around 630,000.

We are ambitious about improving the health and wellbeing of local people. NHS Oxfordshire intends that, by 2013, the people of Oxfordshire will:

- be healthier, particularly if they are vulnerable or live in our most deprived communities
- be working with NHS Oxfordshire to promote physical and mental wellbeing and prevent ill health
- be actively supported to manage their health and care needs at home when this is appropriate
- have access to high quality, personalised, safe and appropriate health services
- get excellent value from their local health services

Oxfordshire is the most rural county in south east England and has a large geographical area to cover as well as a diverse population to serve. The population of Oxfordshire ranges from a predominantly older, white population in the rural areas to very ethnically diverse populations in Banbury and Oxford city where one third of the population are students.

NHS Oxfordshire works with our communities and our partners to improve health in the area and to make sure that local people’s needs are being met. We also work with organisations from the voluntary, private and community sectors so that we can make sure that the organisations providing health and social care services are working effectively.

Area covered by NHS Oxfordshire
Oxfordshire PCT serves a population of approximately 630,000 and covers the areas of Cherwell Vale District Council, Oxford City, South Oxfordshire, Vale of White Horse District Council and West Oxfordshire District Council.
2. Executive summary

2.1 Introduction
The whole system pilot was launched in November 2010. As part of the consideration of the pilot it was agreed that there would be an engagement programme with key stakeholders and with members of the public. Engagement started in early November and data was collected until mid January 2011.

2.2 The engagement process
During the engagement process we undertook the following activities:
- A briefing was sent out to all the local stakeholders.
- A press release was sent out locally.
- An engagement questionnaire was launched.
- Meetings were arranged with local groups.
- In depth interviews were conducted with local people.
- Over 200 people were contacted about the consultation.
- Questions were raised during the consultation.

2.3 Key finding from the consultation
Information gathered has been recorded in two ways. The findings from the questionnaire and the narrative responses which are a collation of the comments in the questionnaire comments, concerns raised in meetings and views and issues raised during the in-depth interviews.

Strong preference for being able to access local services was expressed in the questionnaire. Respondent also told us they were happy for their information to be shared when necessary and that GP practices offering follow up care to patients with long term conditions was important to them.

The key issues raised have been grouped under the following headings and in order of priority.
- Transport and journey times
- Working together and skill development
- Consistency of standards
- Personal Information
- The needs of those with Parkinsons and other long term conditions
- Social care
- Joined up services
- Perceptions
Transport issues are raised in almost all the work we do in public engagement and were raised significantly in this work. Much of the concern relates to bus routing but also parking and rush hour traffic were raised.

There were real concerns about joined up working which cuts across several of the themes above. Particular mention must be made of the number of concerns mentioned about the way social care works. Respondents were also keen to be reassured that they would get the same quality of service wherever they are seen and others felt that part of this quality assurance lay in effective training and skilling up of professionals including GPs and district nurses.

The needs of people with long term conditions were also raised – both in terms of the care they receive in hospital and also in the context of how social care manages their long term need to make use of services.

2.4 Other information
Respondents made some helpful suggestions for how it might work in future and for some simple changes.

From all this a series of recommendations have been made which should be considered by the project leads for the next stage. Some of these relate to how we communicate for the next stage of the whole system pilot and others to some of the planning we need to undertake before the next stage.
3. Background

3.1 Whole System Pilot Project background:

The NHS in Oxfordshire faces a financial challenge of the order of £194m over the next four years if it is going to continue to meet the demand for its services whilst delivering the efficiency targets required financially. Society is changing so health and social care systems need to change to respond to rising demand from an ageing population, patient expectations and advances in technology and medicines.

The challenge is to maintain and improve the quality of care for all patients within the limited resources available. A new approach is needed if we are to secure improved outcomes for our patients within a context of growing demand, increasing complexity, and a backdrop of significantly tightening budgets.

The 'Whole System Pilot' proposes to develop and test in Abingdon and the Vale area of Oxfordshire, a health and social model of care and services for adults in Oxfordshire working in partnership with the public, patients and professionals in primary, community, mental health, learning disability, secondary and social care settings.

This project has emerged from the work of the 'Creating A Healthy Oxfordshire' Programme and will test the implementation of a significant proportion of this programme and the wider development plans in progress in health and social care organisations in Oxfordshire in a specific area.

3.2 Whole System Pilot Project Objectives

- To have access through one contact point, clearly understood by citizens, patients, their families and carers and health and social care staff with minimal use of eligibility criteria for access to individual services to be available at the time of need.
- To have a clear focus upon self care, prevention and care closer to home.
- To offer a wide choice of services delivered locally.
- Services are flexible and can respond quickly to changes in local need and better anticipation of such changes at a local level.
- To provide integrated pathways of care and targeted improvement work so that all services perform to high standards.
- To enable partnership and integrated working between local people, NHS and non-NHS providers focused on delivering local services to local people.
- To make sure that effort is made at every opportunity to bring services out of acute centres/hospitals and into community facilities or delivered
directly into peoples own homes (including early supported discharge and admission prevention).

• To ensure that opportunity for cost improvement and efficiency gains will be realised by focusing productive programmes and improvement plans in localities. These will provide the opportunity through improving quality and safety to improve cost effectiveness between and across teams in localities rather than by service lines alone.
4. Engagement

4.1 Introduction

An engagement programme was started at the beginning of November:
- A briefing was sent out to all the local stakeholders including MPs, councillor’s staff side and local medical committees. (Appendix 2)
- A press release was sent out locally. (Appendix 3)
- An engagement questionnaire was launched on the Talking Health pages on the NHS Oxfordshire website. (See para 4.3)
- Meetings were arranged with local groups to discuss the pilot.
- In depth interviews were conducted with a small number of local people. (See separate report)
- In all over 200 people were directly contacted about the consultation and provided with information.
- Questions have been raised throughout the consultation and these are listed at Appendix 1 together with our responses.

4.2 Methodology

Stakeholder briefing
The stakeholder briefing was prepared and agreed to be sent out before the start of the engagement. It was sent out to over 900 individuals and organisations.

Stakeholders contacted included: HOSC (this also included an informal meeting with Chair & Secretary of HOSC), Oxfordshire MPs, Local Involvement Networks (LINks), Local Medical Committee (LMC), Chair/Leads of Patient Groups associated with NHS orgs in Oxon, the Strategic Health Authority (SHA).

Press release
A full press release was sent out at the beginning of the pilot. This was reported by the following: BBC Oxford website [http://www.bbc.co.uk/news/uk-england-oxfordshire-11726917](http://www.bbc.co.uk/news/uk-england-oxfordshire-11726917) BBC South Today, BBC Radio Oxford
Following a meeting with the Town Council it was reported by the Abingdon blog 'This Abingdon'.

Engagement questionnaire
The questionnaire was launched via the NHS Oxfordshire on-line consultation tool Talking Health and was also made available in a paper version which was distributed at the meetings attended during the process. Twenty nine
members of Talking Health were directly invited to join the consultation. They were selected both by the area they lived in (Abingdon and surrounding post codes) and their interest and preferences. It was agreed that we would open a wider consultation for the next stage of the project.

In all 26 people registered to join the consultation and 20 responded to the questionnaire – 15 on paper and five on-line. A further 130 were given the questionnaire and supporting papers at meetings and local GP surgeries contacted over 50 people with details of the project to invite them to take part in the in-depth interviews.

Local meetings
A range of organisations and local groups were contacted during the process with a request to attend meetings already being held. An information pack containing the same information as had been made available on-line was prepared and distributed at all the meetings attended. Meetings were arranged with the following groups:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Numbers in attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinsons Society</td>
<td>12</td>
</tr>
<tr>
<td>Abingdon residents’ forum</td>
<td>18</td>
</tr>
<tr>
<td>Abingdon Town Council</td>
<td>20 (including one journalist and three members of the public)</td>
</tr>
<tr>
<td>Dorchester lunch club – week 1</td>
<td>23</td>
</tr>
<tr>
<td>Dorchester lunch club – week 2</td>
<td>16</td>
</tr>
<tr>
<td>Marcham village residents group</td>
<td>10 (20 were unable to attend due to snowy conditions but received the full information pack) 99</td>
</tr>
</tbody>
</table>

In addition we promoted the pilot at a health promotion event held by Marcham surgery which was attended by 40 visitors where we had direct engagement with 10 people.

At each meeting we recorded concerns and issues raised and these were compiled into a brief report on each meeting.

In depth interviews
A consultant conducted in depth interviews on our behalf and over a one week period met with eight people – a mix of carers and potential service users. The consultant had a specific brief to explore in depth as follows: “To capture, understand and identify how those who might be affected by these services (and/or their carers) view the change, capturing their hopes, fears and preferences.”

Those interviewed were identified by two main methods. A letter was sent out by surgeries involved in the pilot inviting their patients to take part – two
people came forward from this invitation. A further six were identified during the process of engagement with groups.

**Personal experience**
We also had one very detailed and thoughtful response from an individual member of the public who has had considerable experience of health systems world wide, in a professional capacity, and long term personal experience of disability and the issues arising. This will be referred to later in this report.
4.3 Main findings from engagement

4.3.1 The Questionnaire
The summary results of the questionnaire are included at Appendix 4

<table>
<thead>
<tr>
<th>Q1 Whenever possible your care will be provided in Abingdon Community Hospital or in locations in the Abingdon and Vale District or in your home. Please tell us what you think of this.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I would prefer to go to the Oxford Radcliffe Hospital for my care</td>
</tr>
<tr>
<td>☐ I want to have all my care in Abingdon/Vale as long as it is possible</td>
</tr>
<tr>
<td>☐ I would like to be able to go to the Oxford Radcliffe Hospital until I am stable and then have my care in Abingdon/Vale.</td>
</tr>
<tr>
<td>☐ I do not think that it makes any difference to me where I have my care as long as I am treated in the best way possible.</td>
</tr>
<tr>
<td>☐ I do not know.</td>
</tr>
</tbody>
</table>

Two people said they would prefer all their care to be at the John Radcliffe Hospital and one did not know. All the others were happy for some or all of their care to be provided in Abingdon.
When asked to prioritise options the two most important issues for respondents were that their family are informed (25%) and to go to their local community hospital for treatment (23%). One person did not want their information to be shared and only one thought the option to go to the John Radcliffe was important to them.

When they were asked to weight the options that might be available respondents rated GP practices offering follow up care to support patient with long terms conditions as most important. They also gave high weightings to
organisations working together, community support being in place and a system which meant not having to go into acute care if they were not well.

Q4 Social workers and health professionals will be working closer together to find solutions to support the care and needs of local people. As part of this, we are looking for information systems to become more joined-up so that up-to-date patient information is available to support patients as they move from one service to another.

All the respondents thought it would be acceptable to share their information though (20%) felt it would be important to have the opportunity to give permission first. No one objected to their information being shared.

Q5 Would you rather be assessed and treated in your local community hospital or at a larger hospital like the John Radcliffe Hospital?
When asked directly to choose between treatment in a local community hospital or a large acute hospital 80% either stated no preference or preferred a local community hospital.

4.3.2 The narrative themes
There were some strong themes which cut across all the engagement approaches. The comments and issues below are drawn from the questionnaire, narrative responses, the individual interviews and the meetings with individuals. These are listed below in order of strength of feelings and range of mentions.

- Transport and journey times
- Working together and skill development
- Consistency of standards
- Personal Information
- The needs of those with Parkinsons and other long term conditions
- Social care
- Joined up services
- Perceptions

Transport and journey times
The more convenient location was welcomed by many for a variety of reasons. However some of the respondents live outside the immediate catchment for Abingdon Hospital and for them the distances to treatment were a concern. This was particularly raised by respondents living in Faringdon and Wantage – these respondents saw Witney as their likely local hub.

Abingdon is not a transport hub so, although for some patients (such as those living in Marcham) it was a welcome location, for those receiving daily treatment and not living on a route into Abingdon this could mean a difficult journey.

For example several members of the Dorchester lunch club mentioned a particular concern about the problem with getting to Abingdon. There is no direct bus service so it would mean a bus journey into Oxford and back out again – for these people the journey to the John Radcliffe (JR) already takes two hours because of the need to change buses in Oxford. At certain times of day due to the traffic issues in the centre of Abingdon it can take an hour to reach the Abingdon hospital by car from Dorchester. There was a universal preference at the lunch clubs for a service being provided by Wallingford Hospital.

One of the respondents mentioned the stress of making journeys for her frail husband and welcomed the move of services nearer to her home.

“I do not ever want to go into hospital because he would not be able to get there and it would worry me. He could not sit on the bus all that
time. If they use Marcham road more perhaps that would not be a problem. It’s the journey all that way.”

Concerns were also raised about parking at Abingdon. It was felt that it was usually possible to get a parking space at John Radcliffe but difficult at Abingdon. The lack of dedicated disabled parking at Abingdon was also raised as an issue.

A question was raised about patient transfer – it was commented that transfer by ambulance from the John Radcliffe has been known to involve waits of 13 hours. What reassurance is there that this issue has been dealt with for this pilot and any future role out? (See Appendix 1 for a response)

During one meeting the volunteer transport coordinator for Abingdon was present. He advised that the transport patterns for their users had changed significantly over the past few weeks (this was about five weeks into the pilot). Until he spoke to me he had no idea that services had been moved to Abingdon. He was unable to arrange a meeting with the drivers because it was too near to Christmas but on other occasions it might be helpful to meet with this voluntary section in particular because of the effect on the way they provide services – particularly their potential to do several short journeys to Abingdon rather than one long journey to John Radcliffe.

Working together and skill development
Several people expressed concerns about capacity – particularly of district nurses to take on this load and wanted to know more about staffing arrangements. Doubts were also raised about the skill mix of GPs – it was felt that more specialist GPs would ensure a more successful outcome for the project.

“Would prefer more "specialist" GP's in the community. It is not possible for GP’s to have the depth of knowledge or expertise in all branches of medicine. How can they possibly keep up to date with everything?"

Consistency of standards
There was a wish for reassurance that consistency of quality and standards would be maintained for those using services.

“Providing it is on a par with the JR* with modern, easily accessed diagnostic equipment.”

However there was a concern that for some group of patients with long term their condition needs to be understood as well as their presenting health problem when they are in contact with health professionals. So there would need to be reassurance that those providing healthcare would be able to recognise the occasions when the underlying health condition needs managing as well as the presenting condition. This would ensure that the
underlying condition was not neglected to focus on a presenting problem thus accelerating symptoms of the underlying condition.

There were also questions raised about how the out of hours service would respond to this as it develops. The point was made by two people at one meeting that they had used out of hours, failed to get a responding call from a GP and finally gone into A&E – though this would not have been needed if the call from out of hours had come in a timely manner. If this is to be a resource for times when out of hours is in operation issues like this need to be resolved.

In another case a patient reported an experience of locum GPs which had indicated really poor local community knowledge and little understanding of rural issues. It was suggested that this could work against such a localised system of care.

NB Both these concerns have been raised directly with the relevant departments/commissioners.

**Personal Information**

One question in the questionnaire was about holding of personal information. This is also being addressed as part of the informatics survey which has recently finished. Of the respondents to the report no-one objected to information being shared – though some preferred it only to happen with direct permission. However several commented that security of information held was very important. There were also concerns raised about how joined up information held actually is.

> “When all services have appropriate instant access to combined medical and social data, then we can think about moving forward. It is a good strategic goal, but “pie in the sky” over the next 5 years.”

> “I have been to hospital a few times over the last two years and every time a nurse spends about an hour writing down detail that I know are available in my files on the web, WHY?”

Another member of the public commented that he found it very depressing during his wife’s illness to have to keep repeating the same information wherever they went in the health service. Others referred to the problems that may arise from transferring treatment from JR to Abingdon when all the paperwork is currently held at JR.

**The needs of those with Parkinsons and other long term conditions**

Some issues were raised at the meeting with this group which are specific to those with Parkinsons but may also apply to others with long term conditions. One patient reported that he requires absolutely regular medication to maintain his health sufficiently so that he can walk. He normally self
medicates and manages this well. However when taken to hospital he had to have an extensive argument with the nurse to persuade her that he could continue to self medicate and that the ward rounds would not meet his specific needs which mean that medicine dosage is very time sensitive. It was suggested that staff should have access to advice from specialist nurses to help them to manage and understand this type of situation.

Because in general medicine dosages can make a significant difference to wellbeing over relatively short periods of time symptoms arising for the Parkinsons could be misleading in assessing the patient’s general health and the presenting health issue.

Another individual reported being hospitalised because of assumptions made about his presenting condition when he knew that the cause was something to do with his long term condition. His view was not taken into account.

Social care
Several responses as above referred to weaknesses in the social care system. They mentioned concerns about lack of services poor quality services and ‘dropping out of the system’. See also the ‘joined up services’.

Joined up services
There was a strong response from one individual who has given permission for his response to be reproduced. He is particularly concerned about the lack of joined up thinking which can lead to long and frustrating waits for individuals who have long term conditions or needs.

“I am just one of a growing number of patients who face an exasperating task in managing their own clinical needs but are constantly frustrated by the circuitous route one has to follow to get professional help in terms of management. This farce impacts on the NHS policy to make clinical management simple and cost effective and demands a rethink.”

In particular he mentioned a recent problem with the occupational therapy team at Oxfordshire county council who had closed his case and would have to reopen it which would mean a wait of weeks or even months. As the problem was with a pressure sore he could not wait that long. However the story continued…

“Another with the same agency suggested I contact the tissue viability nurse who in turn told me the referral had to come from my GP who then contacted the wheelchair service which then referred me back to a district nurse. At that point I was referred back to the tissue viability nurse.”

His hope is that this kind of issue will be tackled by the change in the system.
“...to reduce the impact of an aging population out of the bed blocking and costly side of the balance sheets, then some serious rethinking needs to happen to stop the revolving agency referral circus so that elderly and infirm people can cater for themselves with adequate and low cost applications.”
Perceptions
There is still some perception that the hospital in Abingdon is “where people go to die”. That may mean that some people will have unnecessary worries about going to the hospital for treatment.

There is also a perception that services have not worked well together in the past so may not in future. There was also a concern that respondents had had previous experience of, for example, being told they were entitled to intermediate care but that they would not get because there is no money.
5. General support
Many of those spoken to welcomed this move as a step in the right direction and despite doubts and reservations few people said they thought it was wrong or could not work at all.

“I have answered this questionnaire from my mother’s perspective. We had cause to use the Abingdon Unit recently when she became unwell and the care was excellent. Massive loads of tests, liaising with cardiologists at JR re her September heart attack. Back next day for follow up tests, results and referrals. I couldn’t fault it. A friend of mine also had cause to use the unit and was also most impressed.”

Another patient commented that the care at the JR was very efficient but impersonal and welcomed this change to what he felt would be a more personal service.
6. Suggestions made by respondents
Throughout the consultation suggestions were made by respondents about how changes could be made or managed.

- Medical advisory cards to be held by those with long term conditions.
- Training of GPs on the specific needs of particular groups such as Parkinsons.
- A homecare model that includes medication prompts by phone for those who can self medicate but may find it difficult to remember.
- Introduce a system for unused medical supplies which are still packaged to be returned for someone else to use.
7. Key learning

- We should make sure we have engaged with all the relevant voluntary sector organisations in the area before launching future work. This is particularly important where our work may mean changes to behaviour of the service users such as the change in preferred journeys identified by the Volunteer transport service in Abingdon.

- We need some engagement with the public to explain telehealth more thoroughly than we are able at this stage. Particularly to quash the myth that they would need a computer at home.

- We need to clarify the diagnostic skills of GPs in this context. There was a view held that GPs are not suitable diagnosticians.

- We should provide responses to some of the questions raised which did not have responses in the consultation paper.

- The development of the consultation documents for the next stage should take note of and include reference to the issues raised here.

- The learning from the informatics engagement which has been running concurrently should also be taken into account in relation to holding of personal records.

- We need to ensure good quality supporting background information when we are addressing a new concept – such as telemedicine.

8. Glossary

Some abbreviations have been in the quotations – these are as follows:

Marcham Rd  Refers to Abingdon Hospital
JR  Refers to John Radcliffe Hospital
Appendix 1

**Questions raised**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will this service respond to increasing demand?</td>
<td>The teams have been scaled to meet with predicted demand and we will be reviewing this on a regular basis. Flexible working across community services (Hospital at Home, District Nurses, Case Management, EMU and Enablement / Social support) helps mitigate any peaks and troughs in demand.</td>
</tr>
<tr>
<td>There is trust in the service at the JR If I have been having regular day care there would I have the same team supporting me in Abingdon?</td>
<td>The team at Abingdon is led by a consultant from the John Radcliffe. They have access to a wide range of general and specialist support services across Oxfordshire.</td>
</tr>
<tr>
<td>How are district nurses being trained for this role?</td>
<td>Hospital at Home nurses are – dedicated team of nurses with a range of experience and expertise – some from Hospital background / others district nursing, specialist community nurses etc.</td>
</tr>
<tr>
<td>Will there be more district nurses in a time of cutbacks?</td>
<td>A small team of district nurses have been recruited for this pilot stage.</td>
</tr>
<tr>
<td>This seems to involve a high dependency on district nurses. Will there be more district nurses to cope with this?</td>
<td>In this urgent care pilot new services put in place over and above DN’s to support patients escalating health needs. There will be DN’s over and above the normal complement for longer term support.</td>
</tr>
<tr>
<td>What about the care offered at the NOC and the Churchill – is that included in the pilot?</td>
<td>The pilot is focusing on urgent care and most of the NOC’s work is elective (planned). Focus in on alternatives to admission and or early supported discharge. Patients can be pulled home from either NOC or Churchill but tend to come from the Emergency Assessment Unit / Emergency Dept.</td>
</tr>
<tr>
<td>Transfer by ambulance from the John Radcliffe has been known to involve waits of 13 hours. What reassurance is there that this issues has been</td>
<td>Pilot scheme now has a dedicated one person vehicle for movement of patients across from ORH / Abingdon or from home into services in</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Would prefer more &quot;specialist&quot; GPs in the community. It is not possible</td>
<td>Many health issues such as minor illnesses and long term conditions (e.g. diabetes, emphysema), can be managed by the team at your own GP</td>
</tr>
<tr>
<td>for GPs to have the depth of knowledge or expertise in all branches of</td>
<td>surgery. Some practices are also contracted to provide additional services for their patients; for example minor surgical procedures</td>
</tr>
<tr>
<td>medicine. How can they possibly keep up to date with everything?</td>
<td>such as injecting joints for pain relief, removal of toe nails and removal of certain types of cysts and lumps.</td>
</tr>
<tr>
<td></td>
<td>Not every GP practice currently provides these additional services but these services are suitable to be provided in a GP practice.</td>
</tr>
<tr>
<td></td>
<td>At the moment, if you are registered with a practice that has opted not to provide a service you need, you may have to attend an acute</td>
</tr>
<tr>
<td></td>
<td>hospital to get treated. In the GP practices that do not offer these services, one of the things NHS Oxfordshire are thinking about</td>
</tr>
<tr>
<td></td>
<td>doing is sending patients to a different GP practice that does offer this service, just for this treatment when it is needed.</td>
</tr>
<tr>
<td>What is telecare/telemedicine?</td>
<td>Telehealth or telemedicine is a new monitoring system will allow patients to update nurses on their health via remote devices in their</td>
</tr>
<tr>
<td></td>
<td>own home and empower them to be more actively involved in their own treatment and care. The detailed monitoring will act as an early</td>
</tr>
<tr>
<td></td>
<td>warning system so that patients can be treated before their condition deteriorates.</td>
</tr>
</tbody>
</table>

A Telehealth management box
Appendix 2

Stakeholder briefing

Briefing: Whole System Project

Background
Whilst funding for the NHS will increase in the next three years – it will increase at a slower rate than previous years. The impact of this is that the NHS in Oxfordshire faces a financial challenge of finding efficiencies of £179m over the next 3 years if it is going to continue to meet the demand for its services within tightening budgets. Society is changing so health and social care systems need to change to respond to rising demand from an increasing older population, patient expectations and advances in technology and medicines. The challenge is to maintain and improve the quality of care for all patients within the finite resources available. We are doing this in a number of ways:

- improving productivity within the NHS locally, so doing the same but more efficiently and using staff to maximum effect;
- reviewing clinical evidence and ensuring patients are offered the most clinically appropriate treatments and stopping the provision of ineffective treatments
- and through system transformation - changing the way that healthcare is delivered, for example, providing more care in the community to stop hospital admissions and supporting people to look after themselves better.

All NHS organisations in the county along with the Local Authority are working together to address this through a programme of work called ‘Creating a Healthy Oxfordshire’

From this work a proposal for a ‘Whole System Pilot’ has been developed which will test a new health and social care model of urgent care that aims to provide care closer to home for patients who might otherwise have gone to hospital, to facilitate quicker discharge if a patient has been in hospital and requires support when they leave and to enable patients to look after themselves more effectively when they get home.

The proposed model of care will treat patients in a different way which will reduce costs associated with hospitals stays and importantly improve the patient’s experience. At the same time providers of health and social care will be more integrated to meet the needs of patient’s in the community.

The pilot will be tested in the Abingdon area starting in November and if successful it will be rolled out across the county next year.

What does this mean for patients?
Adult patients can expect to see a range of different services in the pilot depending on their level of need. These include:
• Access for them, their carers and their clinicians to training which will help them to live more independently after an episode of illness.

• Personalised care plans – patients will work with a health care professional to develop and agree a care plan with that will help them to live well with their condition.

• Using technology (telehealth) to monitor conditions – patients will have technology installed in their own home to monitor vital signs remotely. This might be short term to measure blood pressure or heart rate, or could be longer term for a patient with Chronic Obstructive Pulmonary Disease to learn to manage their blood oxygen levels. The readings would be accessed remotely by a health or social care professional. The system allows signs of deterioration to be identified and an appropriate response to be made very rapidly if the measurements fall outside individualised pre-set limits.

• The introduction of an Emergency Multidisciplinary Diagnosis and Triage Unit (EMDTU) operating Monday to Friday 08.00-18.00 based in Abingdon Community Hospital. The EMDTU will give urgent care patients access to speedy investigations and diagnosis in the community. Patients would be referred via their GP, the ambulance services, emergency departments, medical assessment units and wards at Oxford Radcliffe Hospitals NHS Trust and community health care professionals (including the Hospital at Home service). The EMDTU would make the clinical decision whether patients referred to them for urgent care needed to go into an acute or community hospital or if they could have their care at home via Hospital at Home community based services. The EMDTU would also help to facilitate early supported discharge from acute hospitals.

• The introduction of Integrated Community Teams comprising health and social care staff, with a dedicated Social worker attached to Abingdon Hospital, working together to meet patient’s needs in a community setting.

• The introduction of a Care Co-ordinator role within Integrated Community Teams to ensure there is continuity of care for the patient and to ensure they are supported to undertake their care plans.

• There will be more capacity for outpatient rehabilitation services at Abingdon Community Hospital.

• A new base for longer term therapy provision, assessment for falls and balance groups at the Wellbeing Centre – in Audlett Drive, Abingdon.

• The introduction of a day case management unit at Abingdon Community Hospital to support blood transfusions, rehydration and intravenous antibiotic administration as required. For example an elderly patient with a severe urinary tract infection could be treated as a day patient, at present they would need to have their treatment undertaken in an acute hospital.

• The implementation and integration of the Hospital at Home service and case management in nursing homes – starting in Abingdon from 1st November 2010. By Christmas, this will enable patients in nursing homes or at home to be monitored remotely with the use of telehealth systems and for health care professionals to step in and treat patients where necessary to avoid admittance to hospital.

How will the pilot be evaluated?
Over the next three months, NHS Oxfordshire and partners will be engaging with the public, patients, carers and health and social care staff to seek feedback on the pilot. This will include on-going discussions with Oxfordshire’s Local Involvement Network and the Joint Health Overview and Scrutiny Committee; looking at patient experiences; feedback from public on the piloted services and assessing clinical outcomes for patients using the new services.
Hospital at home enables a step change in early supportive discharge, where, unless there is sound clinical reasoning for on-going monitoring as an in-patient, patients would move to care outside hospital. Hospital inpatient teams would be encouraged to use new telehealth support to enable this move to take place.
News Release

XXX November 2010

NHS AND SOCIAL CARE WORK TOGETHER TO TEST NEW MODEL OF CARE
FOR PEOPLE WITH URGENT CARE NEEDS

NHS Oxfordshire, along with health and social care partners in the county, will be testing a new way of supporting people when they need urgent care (urgent care is any health service support you may need which is unplanned). This approach aims to provide care closer to home for patients who might otherwise have gone to hospital. It will also help by making the discharge quicker if a patient has been in hospital and requires support when they leave. The pilot will be tried in the Abingdon area starting in November and if it is successful the service will be available across the county next year.

The proposed model of care will see patients treated in a different way which will help reduce hospitals admissions and importantly improve their experience. At the same time health and social care staff will work more closely together to meet the needs of patient’s in the community. Adult patients will see different services depending on their level of need.

One of the services to be tested is an Emergency Multidisciplinary Unit (EMU), which will operate from Monday to Friday 08.00-18.00 based in Abingdon Community Hospital. This is a new service which will give urgent care patients access to speedy investigations and diagnosis in the community. Patients would be referred via their GP, the ambulance services, emergency departments, medical assessment units, wards at the Oxford Radcliffe Hospitals NHS Trust and community health care
professionals. The EMU would make the clinical decision whether patients referred to them for urgent care needed to go into an acute or community hospital or if they could have their care at home via ‘Hospital at Home’ community based services. The EMU would also help to aid early discharge from acute hospitals for patients who need more support.

Sonia Mills, Chief Executive of NHS Oxfordshire said: “Whilst funding for the NHS will increase in the next three years – it will increase at a slower rate than previous years. At the same time society is changing and we are seeing more demand for health and social care services – we have an increasing older population within Oxfordshire, patient expectations are increasing and everyday there are advances in technology and medicines. This means that there are more demands being made on the pot of money we have.

“For us to meet the demand for services within tightening budgets we need to change the way that healthcare is delivered. This new approach will help us do this by providing urgent care in a different way that gives tailored care to patients, supports people to look after themselves better in the community or in their own homes and helps reduce hospital admissions.”

The pilot will be tested over the next few months, during which time NHS Oxfordshire and partners will be engaging with the public, patients, carers and health and social care staff to get feedback on the new services. This will include looking at patient experiences, getting feedback from patients and assessing clinical outcomes for patients who use the new services.

For more information about the consultation please XXXXX
Appendix 4

Questionnaire results

1) Wherever possible all your services will be provided in Abingdon Community hospital or in locations in the Abingdon and Vale district or in your home. Please tell us what you think of this.

<table>
<thead>
<tr>
<th>Option</th>
<th>Results Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would prefer to go to the Oxford Radcliffe Hospital for my care</td>
<td>10% (2)</td>
</tr>
<tr>
<td>I want to have all my care in Abingdon/Vale as long as it is possible</td>
<td>35% (7)</td>
</tr>
<tr>
<td>I would like to be able to go to the Oxford Radcliffe Hospital until I am stable and then have my care in Abingdon/Vale.</td>
<td>25% (5)</td>
</tr>
<tr>
<td>I do not think that it makes any difference to me where I have my care as long as I am treated in the best way possible.</td>
<td>25% (5)</td>
</tr>
<tr>
<td>I do not know.</td>
<td>5% (1)</td>
</tr>
</tbody>
</table>

2) When we are planning your care which of three of the following are the most important to you?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like to know that my family would be informed straight away if I had a problem</td>
<td>25% (14)</td>
</tr>
<tr>
<td>I would like to have care in my local community or home that means I am less likely to need unplanned care</td>
<td>11% (6)</td>
</tr>
<tr>
<td>I would like to be sure that the voluntary support I have is treated with the same importance as the health and social care I need.</td>
<td>7% (4)</td>
</tr>
<tr>
<td>I want to be sure that everyone involved understands the issues that are important to me.</td>
<td>13% (7)</td>
</tr>
<tr>
<td>I don’t want to have to keep explaining my situation to different people.</td>
<td>13% (7)</td>
</tr>
<tr>
<td>I would like my situation to be private and not shared with other departments who are involved in my care.</td>
<td>2% (1)</td>
</tr>
<tr>
<td>When I need to go to hospital I would rather go to my local community hospital for my treatment.</td>
<td>23% (13)</td>
</tr>
<tr>
<td>When I need to go to hospital I would rather go to the Oxford Radcliffe hospital for my treatment.</td>
<td>2% (1)</td>
</tr>
<tr>
<td>Other (please add your idea here)</td>
<td>5% (3)</td>
</tr>
</tbody>
</table>

3) Please tell us what you think would be the best ways of helping people to use hospitals less and leave them earlier. Using a number from one to ten please tell us how important each answer is. One means it is least important ten means it is most important.

<table>
<thead>
<tr>
<th>Option</th>
<th>Results Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs doing more diagnosis in their surgeries rather than sending people to big hospitals for diagnosis.</td>
<td>14% (141)</td>
</tr>
<tr>
<td>GP practices offering follow up care to support patients with long term conditions which need monitoring such as heart failure or diabetes.</td>
<td>17% (172)</td>
</tr>
<tr>
<td>Community support put in place when it is needed.</td>
<td>16% (163)</td>
</tr>
<tr>
<td>Organisations working together to help people to stay in the community.</td>
<td>16% (164)</td>
</tr>
<tr>
<td>A helpline I can use when I need to get local information and advice</td>
<td>14% (139)</td>
</tr>
<tr>
<td>A system which means that I do not have to go to an acute hospital if I am not feeling well enough to stay at home.</td>
<td>16% (159)</td>
</tr>
</tbody>
</table>
Using telecare or telemedicine to help us to manage the care of patients in their own homes or in care homes.

**4) Social workers and health professionals will be working closer together to find solutions to support the care and needs of local people. As part of this, we are looking for information systems to become more joined-up so that up-to-date patient information is available to support patients as they move from one service to another.**

For example this will mean that you will not have to keep repeating the same information and your details will be passed between professionals with very strict protection of your information.

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am happy for my information to be shared in this way.</td>
<td></td>
<td>60% (12)</td>
</tr>
<tr>
<td>I would only want this to happen if I have given my permission first.</td>
<td></td>
<td>20% (4)</td>
</tr>
<tr>
<td>I do not want to have to give my permission first I just want it to happen.</td>
<td></td>
<td>10% (2)</td>
</tr>
<tr>
<td>I think this will improve my care.</td>
<td></td>
<td>5% (1)</td>
</tr>
<tr>
<td>I don’t believe this will make any difference to my care.</td>
<td></td>
<td>5% (1)</td>
</tr>
<tr>
<td>I would be unhappy for my information to be shared in this way.</td>
<td></td>
<td>0% (0)</td>
</tr>
<tr>
<td>I would only be happy for this to happen in an emergency but not at other times.</td>
<td></td>
<td>0% (0)</td>
</tr>
<tr>
<td>I do not have a view on this</td>
<td></td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

**5) If we can meet your urgent care needs with a service to the same standard, would you rather be assessed and treated in your local community hospital or at a larger hospital like the John Radcliffe Hospital**

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would prefer to be assessed and treated in my local community hospital and at home</td>
<td></td>
<td>70% (14)</td>
</tr>
<tr>
<td>I would prefer to be treated at a larger hospital like the John Radcliffe Hospital</td>
<td></td>
<td>20% (4)</td>
</tr>
<tr>
<td>I do not have a preference</td>
<td></td>
<td>10% (2)</td>
</tr>
</tbody>
</table>

**6) Do you have any other comments on this if so please put your thoughts in the box?**

This question has been answered 10 times.