

Appendix 3 – Notes taken at consultation meetings

Hart Surgery and Nettlebed Surgery Patient Participation Groups – 12 May 2015

Questions:

- Why do patients in the RBH end up in Wokingham and Newbury and not come back to Henley?
- How does OCCG buy beds?
- What is the timescale and cost?
- Abingdon has beds to support its model, 2 wards with 20 beds and 14 beds, why can't Henley?
- Where will the Maurice Tate room go? Its not in the current floor plan!
- Is this a fait accompli?
- What is the decision timeline to know what services there will be?
- Can we have maternity, in patient services?
- Why can't we have clinics on 2nd floor and beds on 1st floor

Agree:

- Agree with outpatient clinic model
- People want to be in their own community

Disagree:

- Disagree with no beds, not going to get away with 5 beds
- Concerns
- Carers/family can't visit in areas outside of Henley due to poor transport
- Not enough staff to do domiciliary care
- Angry that someone said the hospital in its current configuration would close in 2 years
- Lack of information on a transition plan, if there had been a transition plan this would have given reassurance.
- Would have preferred to have the proposals presented to them by a GP
- 2nd floor could be used for more beds – concern it can't as there is no emergency exit – therefore beds would need to be on 1st floor

Comment

- Henley Standard was silenced
- 14 beds currently means you have the staff to continue with this model
- Car parking has not been addressed
- War memorial money – where has this gone?
- Concern about Sue Ryder pulling out

- Concern that you are building to current plan
- Can't run shot gun over us
- GPs have mixed views, not involved in discussions, knew about proposals when the public did

Henley College Students – 15 May 2015

- Concern that as a child being treated in the Minor Injuries Unit (MIU), it is scary to be around the adults and older people – can there be separate waiting areas?
- Please put a clock in the MIU waiting room
- Shortage of nurses, need more as they are not paid well
- 14 places at university for 500 applicants – not enough training of new nurses
- A & E needs a customer service person – reception should do this
- Mental health services – gap in provision, 1 in 10 students have a mental health problem
- Drop in clinics at the new hospital for students
- Idea of home care is good but need a balance on how community teams are then spread
- Health visitors have to do a lot of driving, may be better to see more people by making them come them
- Travelling for clinical teams is an issue
- Drop in for general services and mental health
- Family planning – make this a more anonymous service
- Better use of technology for younger people, use face time/skype

Goring and Woodcote Patient Participation Group meeting 19 May 2015

- The concept is excellent but is it deliverable? What about the infrastructure and parking? Getting from Goring to Henley can be difficult so perhaps we could have a similar facility in Wallingford?
- You are assuming people have cars – Henley is really hard to get to on public transport so I go to the RBH (Royal Berkshire Hospital)
- There is a lot of supposition in the plans. You must look at the practical aspects. How will the GPs cope? The recruitment and retention of GPs is already an issue.
- It is good for us to be involved in how it develops because patients do have treatment at Henley
- Will there be respite care bed? Who is the Order of St John?
- What if a patient needs longer than three days in a bed? There needs to be a plan
- How will it tackle delayed transfers of care?

- Surely you need more than 48 hours to get a social care package together?
- What about the Henley GPs? Are they on board?
- Where will the 14 beds that are in Peppard ward go?
- How will people access this new service?
- What kind of capacity will it have? How many patients will be seen?
- I'm happy to see the opportunity for free text to be written but I don't like the first question in the questionnaire.
- I would like the service to be more locally focussed. Not just Henley-centric
- Where will the Integrated Locality Teams be based? Will they have capacity?
- What about Berkshire? What about people who are registered with an Oxfordshire GP but live in the West Berkshire Council area. Our GP has examples and this has been raised before where there are issues about social care staff getting out into Goring to give care.
- We hear horror stories about carers and the lack of them. Will there be enough social care packages?
- What will the Order of St Johns element be?
- If the RACU is only open three days a week, what about weekends? What happens if someone comes in on a Friday and needs care?
- What about 24/7 working – has this been taken into account? Will it see private patients?
- What about the second floor? What's happening? Will there be specialist clinics? Lots of people do choose to have treatment at Henley and it will be nice to have that flexibility

Questions and answers from the public consultation event held by Oxfordshire CCG on 21 May 2015 at Phyllis Court, Henley on Thames.

The following is a transcript of the question and answer session held at the start of the consultation event. Questions were asked by members of the audience to a panel comprising:

David Smith Chief Executive Oxfordshire CCG

Dr Andrew Burnett, Urgent Care Lead at Oxfordshire CCG

Pete McGrane, Clinical Director at Oxford Health NHS Foundation Trust

John Jackson, Director of Adult Social Services at Oxfordshire County Council

- Q. We are here because we will be short of beds. I was in Wallingford Hospital and it taught me to walk in ten days, but that could not be done at home so I think the whole proposal is ridiculous.**
- Q. Henley is an acute hospital and is supposed to be 18 beds and is now four step down; what does that mean? We were promised 18 beds but why is it down to four?**
- Q. Where is Peppard Ward going now? The care they gave a woman was absolutely wonderful. You can't get rid of beds. The care the woman patient is getting now is done privately I thought it was NHS? (on the Peppard Ward).**

A. (Pete McGrane) However, aspirational we are, there will be patients who need to be admitted to hospital. There is, however, a challenge for us – it is easy to admit somebody to a hospital bed and that is never more evident with patients who have got physical and cognitive impairment. We know there will be a need to admit people even through the Rapid Access Clinics when it is not safe to keep them in their own homes. All our aspirations should be to keep people in the lowest intensity setting possible. Our aspiration will be to use the beds in Wallingford extensively. Our aspiration during the transitional phase we will be suggesting we use the beds in Wallingford to deliver care.

It is proposed that the beds will be on Level 1. However, in our proposal we are suggesting that instead of using that (Level 1) as a bedded area we use it as an extended out-patient facility and we use it for the Rapid Access Clinics we want to run three or four times a week. The proposal is that we would work with colleagues in the care home so when it is open we use the beds in the care home for all those patients who cannot be safely looked after in their own home when we get to the fully developed Rapid Access model.

Q. How many beds?

A. (Pete McGrane) we anticipate it will be about 6 or 7 beds. All of our experience is that, when you develop an ambulatory model, as the experience of the people who are delivering it increases, they are more capable at managing patients in an ambulatory setting in their own home, and over time, the need for bedded care starts to reduce. To begin with it will need 6 beds.

(David Smith,) The plan is that the building is due to be handed over from the developer around November (2015) and the existing Peppard Ward from that date gets closed because that is the contract that was agreed – not by me – but by my colleagues. It pre-dates us. So, the proposal is that beds that are required will be provided by the Order of St John care home which will be on the same site but that won't be until six months later. So, the proposal that Peter has described is that, during that period, for those people that need a bed that care will be provided out of Wallingford. And, as soon as the care home is open that service will be provided at the care home. That is what is being built and we have to work with that. You may not like the idea that the ward is being closed but that is the arrangement that is happening with the developer.

Q. Have you got a contract with the Orders of St John yet for the 5 beds?

A. (John Jackson) We have not got a contract but there is a very good reason for that and you would lambast me if we had because we would have made a decision in advance of the consultation. We genuinely want to consult you on the proposal.

A. (Corrine Yates, Head of Communications and Engagement at South, Central, West Commissioning Support Unit) I am here tonight to help run the consultation and I can say hand on heart that everything that is being said here tonight is being captured and notes are being written by staff, and colleagues are responsible for pulling all that information together and writing a report. This is to ensure all the outstanding questions, the issues, themes and the things that are very important to people are very clearly stated in that report and are then passed onto Oxfordshire CCG for it to carefully consider those views as part of its next steps. I would say that everything you are saying hear tonight is being listened to and very careful notes are being taken.

Q. The ambulatory system you have described seems to me admirable together with the need for a smaller number of beds. What has been the experience of other such systems in this country or overseas?

A. (Peter McGrane) We have experience in the Abingdon Emergency Multidisciplinary Unit (EMU) for the last four and a half years and in Witney for the last 18 months of running a simpler type of approach and not a direct replication of what we envisage in Henley. We are heading off the crisis that occurs in patients which leads to the deterioration that gets them into hospital that requires a transfer to a community hospital setting and the type of recovery that we see after. About 80 per cent of the patients that come through those units are managed in a fully ambulatory fashion, they are managed in their own homes and for about 10 per cent of those patients who come through the unit, it is abundantly clear that their needs will mean they end up being admitted to hospital and a step up bed.

Q. What I wanted to know is what experience is there either in this country or overseas; we can't be the first to consider using this system, surely?

A. (Pete McGrane) There are a significant amount of models up and down the country that are doing exactly the same as what we are doing. From Newcastle and Lincoln, to a college in the West Country. A number of years ago, the Abingdon unit (EMU) attracted national attention through the *Guardian* Healthcare Awards for Innovation. And we have, for probably two and half or three years, had a very constant group of national and international people coming to see the unit and going back to deliver the same types of services. We are not at the cutting edge of healthcare for what we

are describing for Henley (Townlands Community Hospital). We are some way behind the curve in terms of what is happening across the country.

Q. Have you got an academic paper to what you are proposing?

A. (Pete McGrane) We have a significant partnership through the Academic Health Science Network, and our academic colleagues at Oxford University and Oxford Brookes University and we're looking at growing and developing the evidence that exists for this type of service.

Q. Can you refer to a paper that has already been written?

A. (Pete McGrane) Not off the top of my head.

Q. The money raised for the hospital was meant for 18 beds.

Q. Would you say Abingdon and Witney (EMUs) have worked very successfully?

A. (Pete McGrane) I think the experience has been positive, and how do you measure that? You measure it in a number of different ways. Patients who have been through that (EMU) increasingly report that it is a positive experience. Their needs are met without cause to escalating concerns and prolonged admission. The second thing that we have noticed is what happens in terms of emergency admission from that particular locality or area, and the second marker you'd be looking at is around excess beds which is the amount of time people spend in hospital. What we are seeing is that, when you concentrate on delivering ambulatory care, the non-elective admissions from that locality drop. And periods of time patients have to spend in hospital drops because you are able to get people supported in their homes than previously – that has been our experience of Abingdon.

I want to be really clear with you there is no point to start dressing this up as something as there are risks associated with this. I want to pick up on one point from Philip about re-admission rates. There is a really easy way to prevent readmission to hospital and that is by not discharging people from hospital. If we are serious – we are health users as much as we are health providers – about delivering ambulatory care we have to take a degree of risk in partnership with our patients, with their families, with their carers but the notion is to try and prevent the deterioration the de-compensation that can occur when people are unnecessarily admitted to hospital.

Q. Can you put the 15 beds in now and adjust them at a later date if they are not needed?

Q. Can you give reassurances that this (model) which will demand more resources will be funded properly bearing in mind the state of the NHS?

(David Smith) I'm going to ask Andrew to address the first gentleman's point because there is a lot of talk about Henley as an acute hospital doing everything, but it doesn't do that so I want Andrew to address that issue in terms of services that are provided and talk about services on the new site.

A. (Dr Andrew Burnett) What we are trying to achieve is a health care facility that serves the most people in Henley and the surrounding district including my patch in Sonning Common. We want to provide health care that is appropriate. To get the biggest bang for our buck is what we need to do is make sure we can provide the best services for the greatest number of people. Now, within the health service there will always be the need for inpatient care within hospital beds. Increasingly, the fact that health care is changing and technology is improving means we don't need to do a lot of these things with people sitting in beds means we can look at things in a different way. Now don't look upon this that by taking the current 14 beds and reducing them down to five; this is not what we are talking about. These are completely different beds; it is like comparing apples and pears. The beds that are currently in Townlands Hospital are not anything like the beds that we are going to be using.

Q. What are beds in Peppard (Ward) doing?

A. (Dr Andrew Burnett) The people that are on Peppard Ward come in the ward and stay on average for about 20 days. There is a turnover of people. It's not about a group of 14 people on the Peppard Ward being turned out onto the street because these people (patients) are turning over all the time. Some of these people come from local areas and some people don't come from anywhere near Henley. **(Somebody from the audience says: 'you can't get in')** And that is partly because the beds are full. So, it is not that straight forward. Don't just think we are going to get people and put them on the street because other beds will be available for them. Our responsibility is about beds in Oxfordshire. It is not just about beds for Henley. Remember, the hospital is being paid for by the taxpayers of the UK of which Oxfordshire is a part. So, we can't look upon Townlands as a fiefdom of Henley. So we do want to get the best bang for our money. So, you have to look at it as part of a wider picture within Oxfordshire. You cannot have a hospital within Henley that does everything. It would be lovely to have MRI scans and intensive care units but realistically that is not going to happen.

Q. Do you realise you are going to need many more ambulances, many more carers and many more doctors getting to patients in their own homes, very, very fast. Pain has to be dealt with immediately; you cannot have patients writhing in pain at home. Doctors need access quickly but the traffic in Henley is grinding to a halt - you cannot drive around in Henley. You cannot get a doctor or ambulance through because the roads are completely blocked. We have 500 to 700 houses coming into the town and you are generating an enormous amount of additional traffic. But not just ordinary traffic but emergency traffic but you have not thought about this enough.

A. (David Smith). It's about the services that are going to be provided. Henley is not going to be providing the full range of acute services. For the majority of people who need that type of emergency services, you don't come into Henley. It is either provided out of Reading or out of Oxford. The new Townlands hospital was never designed to provide this range of services. So, the beds have only ever been a replacement for the beds in Peppard Ward which is around step up and step down.

Q. We're talking here about people in their own homes. Of course, people in hospital will get very good pain management as they do at Sue Ryder but if you are going to provide terminal care, which you are going to do, as I understand, in our own homes how are you going to do it with fewer doctors and fewer carers and fewer ambulances?

A. (David Smith) What both Peter and John were describing is a model whereby we're committed to putting more of that resource into supporting people in their own homes through social care as well as health care rather than bringing people into hospital as they only way to provide care. That is the level of commitment the GPs are also looking for. And part of this was around what you were hearing very clearly from John Jackson of a commitment from the council that the resources are going to be put into doing that.

Q. I tried to get my mother in Townlands but she could not get in and the young nurse who was dealing with her had not even heard of Townlands. That was an extremely distressing thing to hear. My mother blocked a bed for two weeks and got weaker. It's taken long time to get her back to health. I rang Townlands and they asked if I had a private BUPA form for her. If she had a private plan she might have been accommodated on Peppard Ward. In addition, she contracted pneumonia and I asked how long it would take to put a package of care in her home and I was told an extra two weeks so there would have been four weeks of a bed wasted in the Royal Berkshire Hospital. Had she been able to get into Henley she would have recovered much quicker and freed up a bed. Why can't ambulatory care go in to Level 2 if Sue Ryder are not taking up this floor and Peppard Ward be retained on Level 1?

A. (David Smith) As we all know Sue Ryder was going to go into the top floor but they won't go in there we've had that confirmed.

A. (Pete McGrane) We do not provide any private services within Townlands and I'm not for a minute trying to discredit the point you made, but what I can't rationalise is why you have been asked that. There are no private patients within any of our community hospitals and no private arrangements between us and the GPs. Sue Ryder changed their model on provision; they are concentrating not on bedded hospice care but on outreach care and how they support patients in their own beds. Our aspiration is similar to that as we want to deliver care to patients in their own homes. The facilities within Townlands in the proposed new building, there are changes to the fabric to the way that building is being designed with regards to access to those floors for the patients we'll be admitting. Level 2 is not suitable to put patients. It's to do with fire access.

(David Smith) The question is do we put the Peppard Ward on the middle floor and put our other services on the top floor. Why is that not something we want to do?

A. (Pete McGrane) It is the easiest thing to do to admit someone to hospital, and it is the wrong thing to do for a significant group of our patients. Patients who are today in Townlands, and across other community hospitals in Oxfordshire, are there as a product that we weren't able to head off the deterioration in their conditions that has led them to be in those community hospitals. And, that is what our aspiration is to try and stop those things happening in the first place. We have evidence to suggest this, so when we get patients in their own homes their needs decrease much quicker than we anticipated. There will always be patients who we cannot treat in an ambulatory fashion.

Q. I worked on the Townlands Hospital on the ward and I want to know what you are proposing to put on the third floor and the impact on parking?

A. (David Smith) The honest answer is we don't know because we only have had it confirmed that Sue Ryder is not going to take up the accommodation but there are a range of options we are discussing with the services that could go in there.

Q. Can you share that with us as part of the consultation?

A. (Dr Andrew Burnett) We cannot share some of the discussions. What we want from this conversation is for you to tell us the services you want.

Q. There will be no beds on the Townlands site from 1 Nov 2015?

A. (Dr Andrew Burnett) That's correct.

Q. And, in about six months to 12 months later when you have built the nursing home there will be five EMU beds and six to seven rehabilitation beds in the nursing home?

A. (Libby Furness, Oxfordshire CCG) When the new hospital opens those patients that are currently receiving care in Townlands will be re-located to the relevant community hospitals. For those people living in Henley it would be hoped it would be Wallingford because that is the nearest hospital. We also know that in Townlands Hospital there are people from Bicester and other parts of Oxfordshire, and we will try to ensure that these people go to a community hospital as near to where they live as possible. We know that the residential facilities that the Orders of St John (OSJ) is going to build for us will not be completed for at least six months after we anticipate the hospital opening. We have not got a contract (with the OSJ) as we are consulting, but we have had discussions with OSJ and in principle they are prepared to work with us.

(David Smith) We will be putting a contract in place with the OSJ; that is what we will do. It is appropriate that we go through a process of having this consultation and going back to the Joint Health Overview and Scrutiny Committee which will say what we can do. Once we have had that we will be sitting down and putting those contracts in place. We will not be opening these new facilities unless we can guarantee that, and that's where through (Oxfordshire) the County Council we will be putting the contract in place.

Q. I thought there was a glimmer of hope of five EMU beds in the care home plus and six to seven rehabilitation beds.

A. (David Smith) What we were talking about was a contract for around five beds. What we want is to have a more flexible use of the beds with the OSJ so if there is a need to have more we will do it that way. That needs to be negotiated with the provider of that service that is what we are committed to do.

Q. As of six months hence you are offering five EMU beds, and other people in Henley who want rehabilitation beds who have to go the Wallingford or other hospitals. Is that right?

A. (Pete McGrane) For those patients who require bedded care. The whole emphasis is a contract to head off deterioration....

Q. I realise that. I want to get to grips with Dr Unwin's point that we need some beds, and your points we need some beds. I am hearing that you are steering towards three core hospitals for beds, is that right?

A. (Dr Andrew Burnett) That has not been discussed at all.

Q. It looks like the 91,000 people of this town will not be entering Townlands Hospital but will be displaced to at least Wallingford, or Banbury or Abingdon. Is that for real, is that my understanding David?

A. (David Smith) No, it is not. Because, what you are describing is that we have a number of beds now and the only model is to have exactly replicated the same number of beds; but what is being described here is that there will less need for beds.

Q. Will the people of Henley in 2018, 2019 or 20120 have to trek up to Wallingford or Abingdon or Banbury? Is that the answer?

A. (David Smith) The honest answer is that piece of planning has not been done across Oxfordshire yet. Come November there is a hospital opening and the existing ward gets flattened because that is the deal that was done with the developer. That is the contract, so, part of the reason we are doing this now is because, if we don't do something, come the 1 November we are in danger of opening a hospital with nobody there at all.

(Anne Brierley, Service Director, Older People's Services at Oxford Health NHS Foundation Trust) The purpose of the model is about stopping using beds, where it is possible. But for people who do need beds but don't need an acute admission, they will still need to go to the Royal Berkshire Hospital. In terms of where we want to get to is, we have a number of beds in the care home providing both the step ups and the step downs. Based on our experience of the Abingdon EMU, if you offer a very local model including taking people home with the nursing and social care they need, you end up needing fewer beds. The contract we will ask Oxfordshire County Council to take up with the Orders of St John will be about flexibility.

We know we have more patients coming through all of our services from primary care to district nursing to emergency departments in winter. As part of the logistical discussion we want the commissioners to have is to have slightly more beds in the winter as the NHS has more patients coming through. The logistics of the site at Henley Townlands it is quite a small site. But we have to have (our plan) in place for the time between of closing Peppard ward to enable the site to be manoeuvred to build the nursing home – that's the difficult bit.

What we are proposing in that six month transition is for the patients we think will leave, we take them to Wallingford. What I want to be really clear about is that we recognise that there are a lot of people who find it difficult to visit a relative (at a hospital) that is further away. What we would do in this situation we would say if you need help with travel we will help with that because we are going to make a temporary move and we want to minimise the disruption until the care home is completed. We know one of the most important things for people in hospital is to stay in contact with their family and friends.

We started to put out a transition plan and one of the things we need to work through with you if we go ahead with this proposal is that we can tackle some of the important questions that people are asking. We have to be confident we have enough social care and we have to work with the fantastic nurses on the Peppard Ward and to support them in what they do - we don't want to lose them. As part of the challenge, is for our colleagues in primary care and our colleagues in social care to use the local population to feel confident to go ahead with this.

Q. Will there be more help for carers at the hospital and will there be a dementia specialist?

A. (David Smith) There will be an opportunity here to provide all of those services in Townlands in order that you don't have to travel. But we're not going to provide all those extra services with beds inside that building.

(Pete McGrane) We have to work with patients, their families and their carers on this. John described earlier the community integrated locality team, and central to them is we're bringing our community mental health professionals together with the physical health professionals that exist within our community nursing homes to work very much in partnership with the GPs in the localities so you are trying to be much more holistic and responsive to patients' needs. The reason we did this we'd be able to support patients particularly those with challenging dementia. Our whole focus has to be how we get community services in patients' homes to support people better.

Q. Is it alright to wait a month to see a consultant?

A. (David Smith) No, it's not alright. We need to have the resources to have more of these services locally.

Q. Where are you going to get the district nurses from to meet demand bearing in mind the number of district nurses has halved since 2003, and will there be respite beds for carers?

A. (Anne Brierley) If we don't have the right expertise and the right amount of staff resourcing in the community, we won't get the model to work. The work we've been doing is to recognise that when we have staff and services working in isolation from each other, we don't use the time or expertise of our staff very effectively. We see a lot of people each year - we have over a million patient contacts each year - and we found a number of different services were seeing the same patient on the same day. When we talked to patients about it they said they were 'fed up co-ordinating care that is your job to provide.' We recognise that is not the best use of expertise or staff. The integrated locality teams want to get away from the old culture. An OT (occupational therapist) may refer to a community therapist - the new model brings professionals together, teaching each other to do different tasks where safe. Some needs are physical, some are about confidence. Reablement allows 60 per cent of people to regain their confidence. The more we can work effectively, the more patients we can care for.

(John Jackson) The amount of home care we provide in Henley is 50 per cent higher compared to 10 years ago. Oxfordshire County Council puts £2m extra into our budget each year for older population. We are targeting all of that on home care, with a budget roughly of £20m which allows 10 per cent growth in the amount of home care across Oxfordshire.

I am supporting the proposals because older people spend a long time in bed leading to deterioration in their ability to recover fully. The longer people stay in hospital, the more likelihood that they will need social care - and the likelihood is that they will need expensive social care such as going into a care home which is massively more expensive. We also know from talking to carers that

people want respite care, which can vary a lot – it could be an elderly person going off to a day centre a day a week could that could be really important.

Q. How many of the 14 beds at Townlands over the last six months have been occupied?

A. (Pete McGrane) There are occasions at Townlands we know when it will be difficult to admit patients but this is not very often.

(David Smith) We will put this data on our and the Henley Town Council websites.

Notes from facilitated table discussions at the public consultation event held by Oxfordshire CCG on 21 May 2015 at Phyllis Court, Henley on Thames.

The following notes are taken from the round table, facilitated discussions. The style of the notes varies according to the note taker and the discussions that were had.

Tables 1 & 2

- Are there any examples of case studies where this model has been developed and used? Are there any academic examples that we can have on the website?
- Are there any local case studies?
- Are there figures of what it costs for someone to have 4 visits a day with 2 people attending at each visit?
- Townlands has 15 beds with people in them most of the time, so no empty beds. There are normally 5 or 6 people from Henley in them, but there are people in other hospitals from Henley who cannot get into Townlands
- Where are the staff from the ward going to work, will they have a job and what if they cannot drive?
- We have gone from the war memorial hospital with minor surgery and maternity etc. and now you are saying we will have no hospital beds in Henley
- Is there sufficient money to support the transition period, as you normally require more to double run two services. What is the model to fund the interim period?

- Will the rapid access unit be 24/7, what will happen to people over night and at weekends?
- Do you have to pay for therapy at home?
- If you have a stroke what will happen to people who need rehabilitation afterwards, we feel there is the need for the continuation of the beds for rehabilitation
- We think we should be heard that 15 beds are needed for the population which is growing; Henley has lost so many services already
- Mental health and all the other services should be on the top floor leaving the middle floor clear for Peppard Ward
- Planning permission was agreed with beds in the hospital, so does the change of use affect the planning permission?
- Are the lifts big enough to take a hospital bed? We have heard that they are not
- If there is surplus space, will this be let / sold to private enterprise to make a profit?
- Is the Maurice Tate room going to be provisioned in the new design?
- What is the business case for the hole in the finances now Sue Ryder has pulled out?
- The proposed model will mean that people will be looking after their relatives 23 hours a day for free and propping up the NHS
- Everything reverts back to care at home, and where is this coming from, and will this cost more as staff will be travelling a lot
- We don't feel this is a consultation, there is no choice and the decision has already been made
- We don't think the consultation questionnaire is written well and we find the questions offensive and leading
- We think people should be able to voice what they really think in the consultation replies
- The people who attended tonight are not a full representation of the population, are there more events?
- It would be good to have different costed options from the business plan to have a more informed discussion and make decisions on

- 99% of people here want to keep the beds and that needs to be listened to
- There are not the people or the budget to deliver care at home
- Where is the private sector fitting into this? We are worried about the calibre of the staff delivering care at home
- Please can I have some national / international case studies of rapid access clinics and care at home

What other outpatient's services would you like that are not on the list

- Mental health and CPN's (Community Psychiatric Nurses)
- Memory clinics
- Diabetes support

Table 3

GP Dr Phillip Unwin: We need to be really clear about what's going to happen. As of November, patients will go to Wallingford, there will be no beds in Henley, beds will materialise 18months later at the Order of St John's if a contract is signed, it will be a variable number if it happens - there will be fewer because of the cost... at the very least we may have to agree to have a compromise – the solution is going to be a compromise. They will not want this development to happen without the town behind it. We should go ahead and deliver the compromise....

GP Dr Phillip Unwin: We need to see the back-up. It's a big promise to provide the social care back-up – so we have to go for what is achievable and sustainable in the long term. All these beds are not possible because they don't have the money.

GP Dr Phillip Unwin: Is the standard of care that St John's is offering as good as nursing home care? It is not the same quality of care you are going to get from St John's- you are probably not going to get that from St John's so we are looking at a compromise...our expectation was that we were thinking we would get the same beds – 18. As a compromise the Rapid Access Care Unit needs to have 6-10 beds for those patients who simply cannot go home...Now on the wards there are patients on the ward who have no social care back-up for months.

Member of the public: If there's got to be a compromise – I don't understand the implications of what they are proposing – people in the community who understand what's happening, we - local people need to lead this – they should have got the GPs and Townlands steering group to run this meeting. It should have been bottom up then the whole community would have been behind it. We are being told what is going to happen – they are handling us the patients badly – I actually think that what they are suggesting would work but it needs the social care back up to work. Our surgery

is going to have a meeting to discuss this if we can help everybody else understand a compromise could be acceptable – there is the War Memorial, there is the Maurice Tate. These are hugely important and cannot be brushed under a carpet – a compromise is needed...otherwise...

Member of the public: It sounds so illogical to change a system that's working before putting in a new system that isn't proven.

Member of the public: The basic design of the hospital is based on 3 years ago- they're going to knock down the old hospital before they've even tested this new system...You've got all the qualified staff in Peppard. What's going to happen to them?

GP Dr Phillip Unwin: I couldn't understand why we couldn't have our own Rapid Access Care Unit and a dozen beds...with lots of people like physios and OTs getting people out as quickly as we can...we had a discussion 6 months ago with David Smith on this. A team of people in the Rapid Access Care Unit driving this forward, and this other group and the first floor....There's a need for a half way solution compromise led by the GPs and other medical people in the town and the Townlands Steering Group.

I think this can work, this is a facility that has to be justified financially and work, so getting emotionally upset and cross about this on both sides there needs to be give and take – but make the bloody thing work because OCCG won't be able to afford and the rest of Oxfordshire won't let us have this because of the cost because it's the money as well....So a Rapid Access unit...For Henley it's still quite a journey to get to Wallingford and Abingdon. There is a place for the Peppard type beds and in the middle/top floor they can put the other services and GPs... How is Wallingford going to cater for all of the people from Henley? This is part of a bigger plan being developed by OCCG. Interestingly if you talk to the Reading consultants they like to have Henley as a little outpost. It would take the pressure off the Royal Berkshire, but the Royal Berkshire is much more expensive than Henley...it's the Peppard ward that's the big sticking issue.

Member of the public: This all smacks of being a top down imposition. You have to bring the local community with you, the GPs and the local Townlands steering group because out of that can come a compromise.

Member of the public: Sitting round the table like this is much more appropriate and productive.

David Smith: The Steering Group want to have some more public meetings.

Member of the public: Can you reassure everyone as we had this expectation re: the number of beds – the new model of care is actually good – but we need some reassurance as the town would make this work if there is in reality the necessary social care support and resources.

GP Dr Phillip Unwin: A certain number of beds of the Peppard mode... and the Rapid Access Care Unit working together, if it's money I suggest you tell us it's money - if we cannot afford 18 beds tell us what we can afford, we really don't want patients going to Wallingford....David we've put this to Oxford Health and we may try to revisit this with them.

David Smith: If we get to a stand-off re: 18 beds we'll open a hospital and it will be empty that's a real danger.

GP Dr Phillip Unwin: Our patient panel is meeting about this so it is really important to us to give us a steer if we are going in the right direction – our surgery’s patients are having a meeting and I hope we can all come to a reasonable compromise.

David Smith: Let’s think how we might do that but I’m nervous about the steering group.

Member of the public: When the Townlands Steering Group meets we can’t have a repeat of this.

Lisa Gregory: Are any GPs part of the Townlands steering group?

Member of the public: it was a shock for us to hear it in this way (move from 18 beds and the new proposals).

GP Dr Phillip Unwin: This calls for compromise on both sides but the CCG needs to come half way....The stumbling block of 18 beds – because all the other facilities being offered is great. So if we had beds and a fantastic unit...

Member of the public: There’s been a recent shift in the local politics so the Townlands Steering Group is not so influential – it’s a Conservative Town Council now rather than a residents’ town council group.

GP Dr Phillip Unwin: At the Hart Practice session we may get a reasonable ground swell of numbers who will come up with the compromise solution quickly.

Member of the public: Yes, but for a patient group they need to understand what all this means including the logistics.

Member of the public: The CCG should be putting 18 beds in and then coming back with a complete plan.

GP Dr Phillip Unwin: For the Rapid Access Care Unit to work we need all the things to be happening at home – social care, social services, it all needs to be there and in place. How do we translate this commitment into real action?

Table 4

I’m quite sure that the authorities say this is with best intentions. How will it be funded? Where mistakes come from, confused about figures, are the beds in any figures?

It’s not 14, it’s 12 beds.

Talking about care provision, I look after three people in the community. I go in every day to clear out the horrendous mix. Exhaustion from travel.

Many of the elderly live alone – sometimes they need overnight care. There needs to be a change of strategy, travel, too slow. The package deal is not working.

Carers are not given enough money. Extremely expensive. They are on their own for the whole day.

It's a good idea but district nurses don't have the time to do what they have already.

Lady upstairs still has her leg dressed a year on.

Yes prolonged visits and care.

Re-think how we work with the family and carers – there are good examples, circles of support for example.

Age UK held up as national support.

Companionship.

We need to change the way we work – Bed numbers will be needed to increase and increase.

About all generalisations

Counsellor service

Mental Health – Older and Younger – Libby Furness (OCCG) referenced the drop in mental health and sexual clinics at sixth Forms.

Move away from GP referral system – open access.

Increasing demand as there is housing growth.

Increasing growth for community support

Henley is very good – neighbourly.

We need to change the culture of going to the doctor and popping pills.

Concern about the time to embed if the contract is 5 beds.

People feeling like they've lost the war memorial and funding for Maurice Tate room

The plan for hospital is great – Royal Berks staff consultant to care and visit.

What other services will be brought in?

What will be on 2nd floor?

You need to explain why the Drs weren't part of the panel.

Sometimes change isn't always a good thing. For example, nursing becoming a university degree. We have potentially lost good nurses as it has become academic.

Can you self-refer to the RACU?

How can we have more carers when it's so expensive to live here in Henley?

What checks are done on care staff?

There needs to be more driving checks – about quality of driving. They don't check on safe driving.

War memorial having (conversion) and bungalows is a wonderful place to live and we look after each other and have tea and biscuits on the lawn.

Table 5

I am interested in proposed models, this model makes sense but has taken people by surprise and they don't get it.

Peppard ward/step-up/step-down beds are completely different; assessment beds will people either go home or go to a care home. The concept of a brand new hospital without beds has been a shock. There will be 5 beds in rapid access unit.

A: David Smith – this is a different way of providing services. If you have a crisis tonight you will go to Reading and be seen by a junior doctor. With rapid assessment you could be home in 2 hours if a care package was available. Abingdon and Witney were these hospitals built for the new model?

A: David Smith – they were converted.

Some aspects of the model are attractive. In the snapshot of Henley – does it include the increasing population?

Step down from Royal Berks was not good, I spent 5 weeks at Reading, and needed 10 days in inpatient physio at Wallingford to enable me to get home. Luckily my wife was well enough to care for me. How would this model fit with person living alone or with frail partner?

A: David Smith – Social care is means tested

A: Val Wilson (Oxfordshire County Council) – People who have eligible needs for social care are assessed financially and most people will pay a contribution towards their care. But if someone is a carer and assessed as needing support that support will not be charged for.

A: David Smith – we have assurance from John Jackson that care will be there

Dr Chris Langley (Henley GP) – district nursing is not a popular job and there is a recruitment problem. Staffing wards is also difficult and it is expensive to provide 18 beds which are staffed for 24 hours, it is a dilemma.

Q: Townlands should take people waiting for a care package to save money.

A: David Smith – it doesn't save money and needs a change of model to prevent admissions. GPs need support in primary care.

Q: Health professionals travelling takes time, is this a good use of their time?

A: David Smith- we don't want to put people in beds that don't need to be there.

Q: When will you know if this model will work?

A: There is a degree of confidence.

Q: There is fear that there will be a repeat of 'Care in the Community' – the move from inpatient mental health care to the community, where services in the community were not in place when hospital beds closed.

Q: Why was there no national discussion to the move to this model? I agree that we can't continue with current model for health delivery.

Q: Is this a way of privatising health and social care.

Q: Chris Langley – we worry about the mover from secondary to primary care without any money to follow it.

There may be traffic issues with change of use bringing more traffic into town. Query park and ride. Reported that the traffic survey was now finished and report awaited.

Asked if there were any services that were not included – the following items were identified:

- Meeting room space to replace the Maurice Tate meeting room.
- A memory clinic
- Patients who need assessment for dementia currently need to go to Abingdon or Wallingford, it would be good to include mental health provision.
- Provision for carers including education and support for carers where they can meet and support each other with people to entertain the people they care for. It was acknowledged that this is already provided by Age Concern.
- Provision of counselling services was discussed, Chris said that this is mostly provided in GP surgeries

One person said that to redesign the building would cost as much again as it had to build the hospital.

Chris Langley was asked, what were the most common causes for people to be admitted to hospital? He said hip replacement, stroke and chest infection were the most common. Stroke patients should be seen in specialist units for the best outcomes. People recovering from hip replacements and chest infections may benefit for the step-up/step-down beds.

People want a clear explanation about why beds are not provided with data to back this up. Can't a different fire exit be designed to allow patients on upper floors to exit in a fire? One person said that we should start with some beds for overnight care. Another said they need beds, why not cut the numbers as need decreases. Another person said that we should start as we mean to go on – go for it. Chris Langley said that the current lack of beds were as a result of staffing issues. The final point was that the biggest worry was the dramatic cut in bed numbers – what about non car drivers and the huge amount of travelling time?

Table 6

Concerns that the CCG was presenting that the RACU would be open every day but it was rumoured that it would only be 3 days a week. Andrew Burnett confirmed this at our table, although qualified it with saying this would probably change as the service 'bedded in'.

The consensus around the table was that the RACU and move towards ambulatory care was acceptable in the long term but that in the short term needs needed to be accommodated with beds in the hospital until the new model was safe and sustainable for patients.

There were comments made about the model being theoretical and not enough evidence to show it would work / has worked elsewhere to warrant changing and losing the beds.

Concerns about car parking – is there room? If more outpatient clinics are being run, can the parking arrangements manage? Apparently a new bus service was due to run through the hospital grounds but this has now been retracted by the local bus company due to the hill.

Communication about plans and developments at the hospital needs to be much better and clearer and ensure the Henley Standard have the facts. The feeling on the table was that there was not much confidence in the process or CCG / providers as people felt they were not being given enough information.

Concerns raised about the community room – that the Maurice Tate room was not being recreated in some shape or form in the new hospital

Suggestions that the third floor could be used for the transition from bed based care to ambulatory model.

Feedback about the EMU in Abingdon working well when things were going well but when too many patients or difficulties staffing patients ended up being affected.

Concerns about the level of care received at OSJ care home beds / would they be hospital or care home beds?

Are the lifts in the new building suitable for a ward / inpatient environment?

What are the proposed service opening times for the RACU?

Will there be an equivalent Maurice Tate room?

Tables 7 & 8

Questionnaire

Q: There are leading questions. Who developed it? Did you get independent researchers in?

A: It was developed by NHS practitioners who are experienced in developing questionnaires and in patient engagement.

Model of Care

- All sounds brilliant if you are considering opening with beds and then reducing the number. It is better to start with what we have.
- What you're proposing is admirable and will bring care closer to home but we are not at that stage now so there needs to be a compromise.
- 6 to 8 beds – 8 would be preferable but you've not answered the problem about critically ill patients waiting to be discharged.
- The beds should be for Henley and its environs, not Eynsham, Bicester, Banbury.
- There aren't enough GPs already in general practice. Our surgery is losing two GPs and it is very unlikely there will be GPs to replace them.
- The terminology is very important - there is no contingency element in the plan. You shouldn't deal in absolutes.
- In ten years' time it could work. Look at obese children – if we could stop that happening it will be great but you can't change things like turning over the page of a book.
- I don't think it's been costed – what about pain management in people's homes?
- The theory looks great but, in practice, not so clever.
- Don't you have to pay for care in a care home? Would the beds at the Order of St John be free?
- What about the security of those beds at the Order of St John home? What if they say they can't do it?
- How do we know these beds won't be taken up by people who are not from Henley?
- We want to know the numbers of people who have tried and failed to get in to Townlands who are from Henley.
- If you close Peppard ward, people will have to go to Wallingford. Once the beds are gone, you can't get them back.
- The public transport to Wallingford is not good. People will find it very difficult to get there. There's only a one an hour, although there is a bus stop outside the hospital.
- X-rays are a bit hit and miss – the service needs to be more frequent, especially as your results have to go to Reading.
- The RACU – what time would it be available? Will it be 24/7?
- The build for the Order of St John home will take more than 6 months
- Stroke and TIAs – these are becoming more prevalent. People need help with walking and will presumably need a bed and the kind of help that you can't get at home. Intensive support is needed.
- You will need more community nurses as they will have to travel more to get to patients' homes
- I see Townlands as a half-way house with a more relaxed feeling
- Do we need more than five beds?
- We were told back in February that the heating would not be on in Peppard ward this winter.
- Is there separate access?
- Is the care home a separate building?

- The theory looks great - but, in practice, not so clever.
- Would we have to pay to use the beds at the OSJ home?
- What about the security of those beds? What if the Order of St John says it can't provide them? We have never seen contracts
- I would like to know the numbers of people who have tried and failed to get in to Peppard ward
- The Order of St John home will take longer than six months

Package of Care

- Will there be time to get packages of care together if people are only in step up beds for 24 to 48 hours? This is already the reason for bed blocking because you can't organise packages quickly enough.
- I can't believe that you're not expecting any more people needing domiciliary care.
- I am a carer to a blind husband and I've never had information about what I should be doing or where to get help.

Floor Plan/Sue Ryder

- I have looked at the floor plan and if you don't need all the space, why not divide it down the middle so that half can be for clinics and will make it more financially viable. I am presuming Sue Ryder would have paid £300k in rent - if the money isn't there, this is a risk.

Maurice Tate Room

- We must have the Maurice Tate room. It is well used by groups such as the Stroke Association, Blind Association and Headway.
- The Maurice Tate room has to be protected

Local History

- The trouble is that we don't trust you after our experiences with the War Memorial. The money was given to the NHS for it to stay in Henley and yet it disappeared to Northampton, which was totally unacceptable. My mother-in-law told me to not let that happen again and I would never forgive myself.

Parking and travel

- There would need to be more parking if there are more clinics. If there are 12 clinics with 20 minute appointments, there will be 108 cars per hour.

- If you close Peppard ward, people will have to go to Wallingford. Once the beds are gone, you can't get them back. The public transport is not good – getting to Wallingford is very difficult. There is a bus once an hour, although there is a bus stop outside the hospital.

Additional services

- NHS dentistry would be good –pretty much all private locally.
- Mental health – we need to focus on mental health provision for the elderly and young people. It is a part of the NHS that gets left behind. Recognition of depression and dementia.

Finance

- I don't think it's been costed - there is no mention of pain management at home

Table 9

Townlands benefits:

- Small, intimate and therapeutic

Anxieties:

- Continuity of care
- Staff burn out
- Gaps in care skills

Questions

- What would be the standard of care in OSJ?
- How is medicine managed?
- Extra transport is needed to deliver the RACU model?
- Transport and parking?
- Will there be a bus route directly onto the site?
- Balancing the two models of care in OSJ, consider – physical environment, health needs, staffing needed
- What is step up step down?
- How do we achieve rehab?
- Do people understand that this is just for a while?
- How do we manage equipment and diagnostics?
- What about rehabilitation and reablement?
- Graduated discharge

Children and young people

- Drop in for mental health clinics
- Sexual health clinics
- Support for new parents – currently linked into NOMAD

Additional services:

- More capacity for podiatry
- Bring back mental health for adults/memory clinics
- Young carers support
- Public health – addiction, smoking and obesity services
- Local chemotherapy
- Fracture clinic

Table 10

Ambulatory model

- Suggestions that there should be a robust discharge system in place to support hospital services, with district nurses and ambulatory care up and running to help patients leave hospital quickly otherwise the new model won't work.
- A nurse who works at Abingdon EMU said they were 'struggling' to get patients home from the EMU with delays mounting – 80% of patients don't go home, she claimed. This could happen at Townlands unless the right level of support/model is introduced
- Concern that there won't be sufficient time to train the nurses and care workers needed get the new model off the ground
- Current packages of care not sufficient i.e. 15 min visits (in reply they were told that Oxfordshire County Council will remove 15min home visits and improve the way they buy home care)
- Concern that OCCG is introducing the new model too soon – 'wait until you know what you need'
- Concern that local people have not got the full details on the ambulatory model
- Concern on the level of transport to get people in and out of hospital as part of the plan

Transition period

- Concern that Wallingford hospital won't have sufficient beds to cope with the increase in patients
- A participant said they had only found out about the planned closure of the Peppard Ward at the meeting (21 May)

Beds

- Concern that Townlands Hospital needs its beds; suggestion to have out-patients on the top floor, Peppard Ward to remain alongside the RACU
- Hybrid model idea to keep the Peppard Ward in the new hospital with 18 beds, and if the new model demonstrates it can work then reduce the number of beds
- Concern that after two years there might be a need to introduce a 'newer model' with more beds; this idea was reinforced with a suggestion we maintain flexibility so we can switch the model back to 18 beds if required
- Concern with a growing elderly population there will remain a need for 18 beds at Townlands Hospital
- As the Peppard ward provides 'great care' we could transfer the 18 beds to the new hospital and to maintain this level of care

Cost

- Question asking if there will be a cost if we replace the 18 bed model which is part of the current contract
- Concern that number of beds will be reduced to 5 whatever happens because it is more cost effective compared to having 18 (explained that for the 5 bed model to work need new services in place)

Consultation

- OCCG asked if the people of Henley said 'no' to our proposal will we continue with 18 beds (in reply there was an explanation of the consultation guidelines highlighting the role of HOCS who had the power to refer issue to the government)
- Suggestion the consultation document was 'biased' because there were no questions asking if people wanted the existing model (18 bed) to remain (in response they were told that there was the box to include any other suggestions)
- Concern not enough hard copies of the consultation had been distributed or some people were unable to access a computer to take part (in response told hard copies had been distributed and posted out)
- Suggestion for people to write to their MP to express their opposition to the plans

Cllr Ian Reissman (Henley Town Council)

We do think the principle behind the proposals have a lot of merit. But the plans seem incomplete regarding when the social services will be available and implemented. We are waiting to see more detail...We have a concern about step down beds, where will they go? And where will they go in the transition...where Oxfordshire wide will they be provided and where Henley fits in that?...Also the rush because the hospital is being built...The Townlands Steering Group will be holding meetings regarding the consultation.

Oxfordshire CCG Governing Body Meeting, Henley Town Hall 28 May 2015

The following are notes of the question and answer session held at the CCG's Governing Body meeting.

Bed occupancy/delay data

- Question asking if we were going to publish the Townlands bed occupancy data (in response told OCCG would talk to Oxford Health and get this info on the web site)
- Concern that patient delay data was unreliable (in response told this Delayed Transfers of Care data was signed off by partners and shared among them)
- Concern that all the beds at Townlands are required. Claim that six beds at Townlands out of 18 were closed and 16 patients at the Royal Berkshire Hospital waiting for beds in Townlands with priority given to patients from the John Radcliffe hospital (in response Andrew Burnett said patients at RBH were waiting for other packages of care)
- Concern that the five care beds (run by OSJ) won't be used for rehabilitation (in response told these patients will have access to rehabilitation services via rapid access unit and physiotherapy service)
- Concern that the step up/step down beds being planned for OSJ won't be ready for a year while care home being built – will these be provided in Wallingford in the meantime (John Jackson said working on bed options but plan to have the right bed provision in place by 1 Nov 2015)
- Suggestion to retain the 18 beds for a few years to determine if they are needed in case the ambulatory model doesn't work and the five beds are not sufficient (in response said that if all the beds put in no space for clinics and won't be able to have the new model of care)

Staff recruitment

Question asking if nurses were being recruited ready for the closure of the Townlands Hospital in November 2015

Ambulatory Model

- Concern that community nurses will have to travel further visiting more patients in the community under this model some with complex conditions (in response told Oxford Health will provide this service)
- Concern the new model might require more district nurses otherwise burden will fall on GPs (in response told that is was not clear if this new model required more district nurses)
- Concern if there will be enough resources available to implement the new model, plus parking issues at both Townlands/Wallingford (in response told there was a need to look at car parking issues and discussing resources with Oxford Health/ we need to deliver a building that is sustainable for the future and 18 bed model is not sustainable/people going to RBH as they cannot get the services they need in Townlands)

- Concern changing use of site from 16 bed to day care might require change of condition of planning consent
- Request for home care to be explained in more detail (in response told that Oxford Health will provide this care with district nursing being supported through integrated teams)
- Concern around acute medical provision for patients at home (in response told that medical resources will be redirected for those who need extra help at home).

Top Floor at Townlands

- Concern over use of the top floor in the new hospital and a time frame around this (in response told OCCG working on a number of options being discussed for the top floor based on a 'health care need'/time frame was tight as any plan needs to be looked at by HOSC in July, in addition there was a contract in place for the use of top floor as part of the hand over in November 2015)
- Suggestion the consultation was a 'done deal' as OCCG are saying cannot have beds on the top for health and safety reasons which contradicts the previous idea for Sue Ryder to occupy this floor (in response they were told OCCG said they needed to finish discussions about the top floor)
- Question asking what the top floor going to be used for as the new model was similar to the Witney and Abingdon EMUs which had beds (in response David Smith said the building was been built to a design – through a contract - with space for beds and any change would be prohibitive on cost grounds. Any alterations needed these would be looked at when the new hospital was handed over)

Consultation

- Suggestion people were being 'duped' over reducing the number of beds and the process was 'underhand' as they were not informed about the meeting (in response David Smith said the Q&A session had been promoted via normal channels. Andrew Burnett said OCCG proposing an exciting plan based on 'rapid access' with a trade-off to not have long stay beds/community hospital beds are likely to be reduced in Oxfordshire/more people to be rehabilitated in their own homes)

Travel

- Concern that people might have to travel to Witney EMU (in response David Smith said there was never any suggestion people would travel to Witney EMU but this model of care is up and running in both Witney and Abingdon and it works)

Notes from the South East Locality Executive Meeting 2 June 2015

South East (SE) Locality Forum Views

John Reid (Chair SE Locality Forum) said while the SE Locality Forum had no agreed position there were concerns with the plans:

- number of beds
- bed blocking pressure following reduction in number of beds
- future use of the 2nd floor
- change of use of planning permission as ambulatory model will mean more people visiting the hospital
- lack of spaces at Wallingford Hospital
- no mention of how the new model will be funded
- consultation questions not very 'perceptive'
- concern about support for home care as part of the new ambulatory model

(in response Andrew Burnett said the new model will provide better care for local people, there will be more outpatient care not beds, better provision in the community, 18 beds won't be needed, further investment in social care, Gareth Kenworthy said funding plans for the new model will follow the consultation, and there will be a 'constraint' on the services available)

Patient delays

- Concern over the issue of delays in the local acute hospitals (in response told that patients were being counted twice, fewer acute beds in Oxfordshire compared to other areas, elderly population is growing, issue on recruiting home care staff)
- Home care
- Concern from a physiotherapist who works at the Townlands Hospital that there are delays in other parts of Oxfordshire for care packages citing an example from Oxford City where a patient waited 150 days for a care package

Beds

- Question from Dr Philip Unwin who asked if OCCG had money for the 18 bed model (in response Gareth Kenworthy said money was available for 18 bed provision but OCCG were consulting on another model)
- Concern if the ambulatory model doesn't work the beds won't come back to Townlands Hospital (in response Andrew Burnett said when patients are in a hospital bed their conditions deteriorate and they become 'deskilled' staying on a ward, and there will still be a need for in-patient beds in Oxfordshire in a bigger hospital setting to provide right level of support)

Peppard Parish Council 11 June 2015

Will the hospital just have 6 beds? Will these beds always be available? It sounds wonderful, if it works.

Who will staff it? Will it be doctors or other clinicians? It is important to have continuity of care for people with dementia and geriatric patients. They need recognisable faces. I've worked a 24 hour shift pattern; if I can do it so can doctors.

We need an intermediate stage of professional such as assistant doctors. A grade of professional is missing – just specialists at the moment. We need someone between a GP and a consultant - an assistant physician.

Getting a doctor to visit you is not easy thing to achieve. They don't do it so much. The call on GPs is making them harder and harder to come by.

If you are treating more people at home you'll be getting through four people a day instead of 14. Won't current staff be stretched further? Will you have enough staff?

Will the hospital open in December or will it be gradual?

Will there just be ambulances three days a week?

Will staff be able to re-train?

What about young people? People who come to the college from Reading who may want an appointment but don't want to take a day off from college and want to be able to drop in

What about live in care? I know of someone who has a live in carer and then has other carers at weekends. There's no continuity of care and it can be very upsetting. It takes a very special type of person to take on this role.

The hospital's already half built and there is space for 18 beds – what's happening to that space that won't be used? Why are we at this stage when the building is already half built?

Will it cost less money?

Why has it not been considered that you could slowly reduce the 18 beds to 17 then 16?

What is the disagreement with the Henley GPs? On Tuesday night the GPs welcomed an awful lot but are not convinced by the number of beds. Was that the first you heard on Tuesday night? Surely they are important?

I recently lost my mum. It's a lovely idea to return people to their homes but it took all the family caring around the clock to make it work. It is not unreasonable to think that 18 beds is adequate but how has this number been arrived at? If people don't have any support, isn't that the role of a community hospital?

How many people who are at home don't ask for help? I know someone who has a carer in at 8am and then 8.30pm but then sees no one else for the rest of the day. They need more personalised care.

It's positive to see health and social care working together. It is a great stress and strain on families - teams need to talk.

We also need to be aware of loneliness - carers rush in and rush out. Do you think it could work with voluntary organisations visiting?

What about care for young people – would a young person who needs a bed have to be cared for at the Order of St John home? Is a young disabled unit part of the scheme?

What about end of life care? Our experience in Wales is that it is totally underfunded and there is no continuity of care. I'm very cautious as I've seen it myself – young carers 17 years old coming in giving my mum and quick wash and then off. As a family we needed more support

How much does the decision affect the building proposal?

As someone who works with young people, I feel I need to advocate for their needs. We need to make sure that they are catered for and that there are services for younger people as well. Are the current facilities just for older people?

Q & As from the Peppard Parish Council event on 11 June

Q. What is the difference between the EMU and RACU models?

Response: (Pete McGrane) There is a difference in the opening hours and access to services.

Q. Will the RACU be open 7 days a week?

Response (Pete McGrane) Some of the components of the 7 day service will be used but we'll need more work to confirm which ones. Nurses and therapists will work over seven days but there won't be a need for consultants to be present throughout the week.

Q. How many beds are there in the Abingdon EMU?

Response (Pete McGrane) 60 beds in Abingdon.

Q. How many GPs will be involved in this new model?

Response: (Maria Melbourne) We'll work closely with local GPs to keep patients safe and well at home.

Q. Why cannot we have both the RACU and the 18 beds as we have the money?

Q. Why is the plan to have fewer beds when 450 new homes are being built in Henley and more people are living longer?

Q. What will be provided on all the three floors – seems we could a ‘white’ elephant on our hands?

Response (Pete McGrane) Things have changes at the hospital – Sue Ryder won’t be using the hospital as their service model has changed. Our focus is on delivering health care on the second floor.

Q. Why not use the second floor for patients who are being bed blocked in the Royal Berkshire Hospital?

Response (Pete McGrane) Official figures show there are only two delays per week at the Royal Berkshire Hospital.

Q. Have you allowed some slack in your plans if your calculations don’t work out?

Response (Pete McGrane) We would revisit the model in that case. That would be a decision for commissioners.

Q. That would be a waste of money then? (re. new model failing)

Response (Pete McGrane) No, it would not be a waste of money.

Q. Are you questioning the professionalism of clinicians if you don’t want to admit people to hospital?

Response (Pete McGrane) We’re not saying that. If you have a stroke you go to hospital. There will always be patients who need hospital care but with other patients we can intervene quickly to avoid admission.

Q. Will you be able to recruit the extra staff to run the services you are proposing - better to have all staff based in the hospital ward?

Response (Maria Melbourne) There will be full clinician care with support networks in place to help people.

Q. How will you provide more than five beds if your calculations are wrong?

Response (Pete McGrane) We’ll purchase more beds from the care home.

Q. The care home could be full?

Response (Maria Melbourne) More people are living at home.

Q. Why not use money from the sale of land at the hospital to pay for both the 18 beds and ambulatory beds?

Q. What are we consulting on?

Response (Pete McGrane) We are trying to explain our proposals but this is not a done deal. You can share your views with us.

Q. Will there be diabetic services at the hospital?

Response (Pete McGrane) Yes.

Q. How are you going to recruit and train staff you'll need?

Response (Maria Melbourne) We'll use agencies and the 'direct payment' method and link up with voluntary organisations.

Q. How will poorer people in Henley get home care from?

Q. We'll need beds for respite care?

Response (Maria Melbourne) The nurse at home service will provide this service or a clinician in a care home.

Q. Will you provide geriatricians in Henley?

Response (Pete McGrane) This is an example of the modus way of working.

The Bell Surgery Patient Participation Group Meeting 15 June 2015

- There are a lot of positives to be welcomed.
- As a GP I have concerns about the capacity of the multidisciplinary team and, in particular of District Nurses and social care.
- I would also like to know how flexibly the step up/step down beds would be and how this would work with the beds being used within the care home. For example, what if more beds were needed but the home was up to capacity?
- I am also concerned about the opening hours and think that it should be at least a five day a week service.
- With regards to the beds, we are concerned that these will close too soon to have safe and effective care in place. Abingdon does have a ward next to it. Without a ward to support the Rapid Access Care Unit there will be an impact on district nursing which is why we are keen to support the Townlands Steering Group proposal for beds in the new hospital.
- Will nurses be caring for people in the Order of St John beds? I am concerned about the qualifications of the staff there.
- There are lots of advantages to the RACU and I would like to see both provided. Re-provide the beds in Peppard and the RACU to give the system the ability to flex accordingly so that if it was decided.
- I am not convinced about the care that can be provided at the care home. My experience with my 94 year old father is not something I would look forward to. My neighbour has a sophisticated care package of both BUPA and NHS and yet BUPA has said to them that it's not been able to send someone out.
- If the hospital had not been built, would we be having this discussion? It feels like we're dropping off a cliff edge and are being presented with a fait accompli. We are being asked to trust you. Can't you work with the Townlands Steering Group and work together over time?

Why was the decision made in 2012 without future proofing? Why have things changed so massively?

- We're not really seeing the Integrated Locality Team working on the ground so I am not convinced we are ready for it.
- Why are you not considering something like an EMU? My mother was in west London in a hospital bed and was bed blocking. A care home wouldn't take her because she required nursing care. If we had some beds it would help bed blocking. Those people who are not from Henley who are using the beds, where will they go?
- Peppard ward provides intermediate care and rehabilitation. Lots of rehab depends on social care. I am worried that social care has been historically underfunded so can it cope? You talk about increases in funding but it just doesn't seem enough when people already can't leave Peppard ward because packages of care aren't in place.
- There's no transition plan and no dates. All this needs to be in place – we'll never get Peppard ward back once it's gone.
- I'm very concerned at the suddenness of this and the big bang approach. It all seems very plausible, but I am concerned about the gap between the theory and practice. Perhaps a gentler approach is called for?
- As GP we go to Peppard ward every day plus carry out home visits. Will we have an increased workload? Will it become unmanageable and will it leave patients at risk of readmission?
- How will the RACU be staffed and is it flexible enough?
- How do people get referred to the RACU?
- Is the growth in the population being taken into account? 450 new homes are being built and the population will increase by ten per cent.
- What about the gap of eight months when Peppard closes? Can you expand the capacity at Wallingford – travel and transport there is not very easy or practical for the elderly.
- What will happen to the current staff at Townlands?
- I have written to the local MP and raised it as an issue for referral to the Secretary of State.