SUSTAINABILITY AND TRANSFORMATION PLAN

SUMMARY OF INSIGHTS AND KEY THEMES EMERGING FROM ENGAGEMENT UNDERTAKEN IN THE WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP AREA JANUARY AND MARCH 2017

1. INTRODUCTION

1.1 This report summarises the insights and key themes emerging from analysis of the feedback from people who attended engagement events in the West Leicestershire Clinical Commissioning Group (CCG) area in January and March 2017.

1.2 The insights offer positive challenge to commissioners and providers in Leicester, Leicestershire and Rutland around specific aspects of the Sustainability and Transformation Plan (STP) and reflect views on:

- *How proposals could impact on people and their families in keeping well and supporting recovery*
- *What else we are encouraged to think about when developing our proposals for Leicester, Leicestershire and Rutland.*

1.3 The full set of insights which we have themed and analysed in order to produce this summary are contained in Appendix 1.

2. CONTEXT

2.1 The draft STP for Leicester, Leicestershire and Rutland was published in November 2016. In December we began the process of organising and promoting initially three events in conjunction with our health care partners, to allow people to find out more about the STP and the proposals for the future of health services in the area. The events also allowed people, including patients, carers, clinicians and other health and care professionals to get into indepth conversations about a number of health and social care topics, conducted in small working groups. Drawing on their own experiences they told us how the proposals may impact on them and what mattered most to them.

2.2 The first three events were held on:

- Tuesday 17 January - Hinckley Golf Club
- Thursday 19 January - Loughborough Town Hall
- Monday 23 January - Forest Hill Golf Club and Conference Centre, Botcheston

2.3 We then coordinated two further events in March on:

- Monday 27 March – Hinckley Golf Club
- Thursday 30 March, The Lyric Room, Ashby

271 members of the general public and 70 health and social care staff actively participated and contributed to the discussions.

2.4 The indepth conversations covered predominantly the following areas:

- The philosopy of the 'home first' principle
- Developing resilence in the community by supporting general practice
- Developing resilience in the community through integrated locality teams
- Developing resilience in the community through community services
- 24/7 access to urgent care that gets you the right care and treatment in a crisis

3. ANALYSIS: WORK UNDERTAKEN

3.1 The insights gained from each event were captured by trained facilitators on the evening and have been collated and themed. An analysis and evaluation of the qualitative data from 341 people has been undertaken and we have generated this summary report.

4. STRENGTHS AND LIMITATIONS OF INSIGHTS

4.1 The following are the strengths and limitations of the insights captured:

- Qualitative data, provides a high level of detailed insights from a robust sample size.
- Good mix of people on each table – staff, carers and patients.
- Events were widespread across West Leicestershire.
- Focus groups allowed everyone to have a voice.
- Audience was self-selecting group who already had a high level of interest in health services (highly activated).
- Limited demographic data particularly pertaining to older age group.
- Unknown spread of epidemiological data.
- Mix of staff and patients on tables allowed high level of informed conversations although some discussion may have been influenced by staff who had detailed knowledge
- Taking the learning from each event, minor modifications were undertaken to the agenda and topics introduced at each event, although the questions under discussion remained the same.
- Some topics may not have been covered in maximum depth.
- Although the events were designed to ensure everyone had a voice, it is possible that some people on each table may have dominated discussions and provided anecdotal views rather than views draw on their own experiences of health services. Other people may have been hesitant to express their thoughts based on their own experiences, especially when their thoughts opposed the views of others.

5. EMERGING THEMES

5.1 The emerging themes that mattered most to people cover five main topics of conversations which have been further sub-divided into areas that we believe mattered most to people, based on the extent of the discussion, recall of theme and the amount of people involved and contributing.

5.2 Philosopy of home first and developing resilience in the community by supporting general practice

- **Good idea in principle, but have reservations that it can be implemented practically**
  Many people felt that philosophy of 'home first' was good and that Federations as a way of making primary medical care more resilient as well as the provision of more services locally was a common sense approach. However, people needed to be convinced that there is evidence that it will work practically and required convincing that all the implications had been considered.
- **Money – costs, investment and funding**
  People wanted a greater understanding of the financial implications – the costs of new services and where savings would be drawn from.
- **Access (travel) and transport**
  People worry about being able to access services which may be geographically closer to where they live, but are not easy to get to particularly if they rely on public transport. They perceive that getting into an acute hospital is easier.
- **Accessing services**
  People have positive experiences of their GP practice and are concerned that Federations will reduce the access and time they have with their GP. People perceive that there is a problem in getting appointments at their GP practice and that the cause of this is patients not turning up for appointments they have made. Many solutions were suggested ranging from communications to remind patients they have an appointment scheduled to charging people for missing them.
- **Communication, awareness and education**
  People do not perceive health services as being proactive in communicating awareness of self-care, healthy living and prevention and lack the confidence that the culture change that they feel is required to change behaviour will be possible through the current proposals.
- **Staff, training and development**
  People felt that there would be a need for educating and training the workforce to adapt to the proposals. People also expressed concerns that the right staff are not being attracted into different careers and that health care jobs were not made attractive to candidates. People seemed positive about multi-disciplines working in general practice.
- **Integration and joining up services**
  People were largely positive about integration and saw the need for greater and closer working, particularly between health and social care to support patients being discharged home. They called for parity of esteem for mental health patients to provide more support. People also drew strong connections to voluntary and community services and felt there were untapped resources not being capitalised on. Community organisations that build social connection were valued by people as they were perceived to help them stay happy which in turn helps them keep well. Also the need was felt for stronger links between pharmacies and GPs. Some people called for wider integration across housing and involvement of schools to educate the next generation. People asked that cross-border issues been given greater consideration and an integrated approach adopted across STP areas.

- **Impact**
  People felt that the proposals would impact on families and they would be under greater pressure. There were concerns and fears that if families didn't live close by then this lack of support combined with changes in the delivery of health and social care services would impact on the health and wellbeing of patients.
  People perceive there is pressure in the system in relation to getting care packages in place. They are also worry about the care home sector and the quality of the care provided. There was a feeling that paid and family carers don't have a strong enough voice within the STP proposals and needs to be given greater consideration.
  Loneliness emerges as a significant issue with people concerned that plans will create greater social isolation. (We have seen this in other research, particularly for Frail and Older People).
  People were concerned about the ability to close community beds, when they perceive that there is a shortage of beds for people who are waiting to be discharged.
- **Data sharing, information (care plans) and IT**
  People want information shared, so they don't have to repeat their story. They want IT to support this and want patients as well as families involved. They want to be assured that there are safeguards in place around security and data protection, but don't want this to prevent the creation of one integrated patient information system that everyone can access becoming common place.
  People also wanted to be reassured that everyone who needed to be was involved in care plans and that they were shared.

5.3 Integrated teams

- **Good idea in principle but things to consider**
  People felt that the concept was good and liked the integrated approach, but remained to be convinced on how it will work in practice. They were worried about what they perceive as already stretched staff. Continuity and quality of care was important to people, as was assessment and planning prior to discharge. People also felt that prevention and self-management was important and needed to be given a stronger focus in the STP.
- **Money – costs, investment and funding**
  People were concerned about where funding and investment would come from to see the proposals come to fruition.
- **Access (travel) and transport**
  People wanted to feel assured that the transport infrastructure had been considered in the proposals.
  Concerns were also expressed in relation to cross border provision and links particularly for social care services and felt that it was important that this was considered in plans for integrated locality teams.
- **Accessing services**
  People felt the integrated teams should have access to beds in times of emergency including evenings and weekends.
- **Communication, awareness and education**
  People felt that there were cultural blockers to providing care locally in this way, as it was a different way of working that people would have to be supported to understand and this should start at an early stage in schools. They felt that integrated teams should include patients and families as a key part of the decision making process about care provided and they should be

integral to the care plan. People felt that we should expand our thinking around integrated teams to include the voluntary and community.
People also felt communications was important to support better coordination and information flow and that technology should support this. This was important for patients, carers and staff to build trust and stronger relationships. Having a common language across teams was felt important and this should translate to patients, remembering that 'one size doesn't fit all.'

- **Staffing, training and development**
  People also suggested what they saw as obvious links to leisure and well-being services.
  People were concerned about preserving a knowledge base for individual team members and felt that GPs were critical to the change.
- **Integration and joining up services**
  People came forward with a lot of suggestions about the additional disciplines that could join the integrated locality team as it goes forward including community psychiatric nurses, mental health teams, CAMHS, Local Area Coordinators, voluntary and community sector, private sector involvement and Macmillan Enhanced Support care.
- People were generally very positive about integrated working and joining up services with lots of suggestions for enhancing the work including having core navigators who have the skills and confidence needed to know when to escalate issues. People also felt that it could address the challenges with agency care and continuity with teams.
- **Impact**
  People felt that there would be a combination of positive and negative impact associated with the introduction of locality teams. They felt positive of the impact on care homes, and general provision of care in the community. They hoped that it would also have a positive impact on medication delays. There were concerns about the impact it would have on families and wanted to understand more about the impact on community hospitals and bed reductions.
- **Data sharing, information (care plans) and IT**
  People felt that it was fundamental that IT is joined up to assist communications. Shared records were essential across whole system including NHS 111. Perception was that technology needs to improve significantly in order that patients only need tell their story once.

5.4 Community and acute services

- **Good idea in principle but things to consider**
  People had mixed feelings about buildings. Many felt that we should concentrate on the provision of services and not be precious about buildings, however in later discussions the passion around investment in community hospitals was significant.
- **Money – costs, investment and funding**
  People were worried about funding at all levels including government allocations to a local level to facilitate change.
- **Access (travel) and transport**
  People were concerned about car parking, public transport and general access. They perceived these issues to be a greater problem at community hospitals and local practices than in an acute hospital. The voluntary and community sector could help solve this problem and good examples of this

were discussed. They also perceived that the urgent care centre in Loughborough could be better used by ambulance services.

- **Communication, awareness and education**
  People feel that there is a lot of work to do with the public to give them an understanding of proposals for change. They feel that people are only hearing certain aspects of the STP particularly around reducing buildings base and beds and they read this in media. Behavioural and mindset change is required and people felt that this would only come by providing considerably more information, education and awareness.
- **Staffing, training and development**
  People recognised that staff need to be supportive and on board with proposals for change to happen and be successful. They felt that training and development is key to create new ways of working and that roles need to be made more attractive for staff to encourage them to apply for jobs and be retained. Also reducing the stress levels of staff and the environments in which they work was felt to be important. People perceived that more staff would be required to provide services in the home, and this would need to be funded. Retraining of staff would be necessary and more equipment would be needed, as it would not be possible to share equipment in someone's home as you do in hospital currently.
- **Integration and joining up services**
  In this section as in previous ones people saw the importance of successful integration. The voluntary and community sector was highlighted as a sector that should be involved.
- **Reducing beds**
  People were generally concerned about the reduction of beds without having confidence that alternatives would work. They were particularly concerned about patients at end of life and what they still perceive as a struggle to stop patients being taken to A&E if they reach crisis point.

5.5 24/7 Urgent Care

- **Good idea in principle but things to consider**
  People were positive about the new services in principle. They felt that the needs of carers need to be taken into consideration and felt that we hadn't placed a focus on services for children.
- **Money – costs, investment and funding**
  People wanted to know where the funding and resources were coming from to make the new models of care work. There was also the perception that the new models were driven by the need for efficiency savings, but this shouldn't negate the need for additional funds.
- **Accessing services**
  Many people still felt there was a need for walk-in services locally and clear pathways for x-ray facilities and bloods. Many local people were also disappointed at what they perceived as limited access to the hub in Coalville. People also felt that Swadlincote Walk-in Centre did not encourage patients from outside of Derbyshire to attend.
- **Communication, awareness and education**
  Continuous communications was felt critical, particularly promoting NHS 111, to broadly educate the public on appropriate use of services using simple messages. There is a need to explain the new triage hub introduced and importantly get the message across that this is done by clinicians. The promotion of healthy lifestyles and prevention was also felt as important to this agenda.

- **Staffing, training and development**
  People were concerned about how appropriate clinicians were going to be found to support the clinical triage.
- **Integration and joined up services**
  People felt that mental health had not been given any emphasis within the new service and that we should consider pharmacy issues and alcohol and substance abuse services being involved in the navigation hub. Also crisis management at end of life should be integral.
  People were worried about the impact of people inappropriately using A&E and discussed solutions which varied from harder messages being delivered to some sort of penalty being introduced.
- **Data sharing, information (care plans) and IT**
  As with other services, people felt that data sharing, accessing records and good information systems were important to ensure the delivery of successful urgent care services.
- **NHS 111**
  People had a range of perceptions about NHS 111 services, many of which are very negative and don't align with service user feedback. This work shows that more awareness of what NHS 111 is and does is required to dispel what may be historical myths about the service.

5.6 Community services – Hinckley

Given the ongoing discussions in relation to the community services review in Hinckley this summary highlights specific themes in relation to Hinckley.

- **Good idea in principle but things to consider**
  People asked us to consider a range of things in connection with Hinckley Health Centre, and Hinckley and Bosworth Community Hospital. They asked that no services stop until new services are in place. They also wanted to see the introduction of walk-in facilities and for us to consider again the impact of an increasing population and number of homes.
- **Money – costs, investment and funding**
  People had a range of questions about funding and the allocation of any resources.
- **Access (travel) and transport**
  As in previous sections people asked us to take into consideration the difficulties of parking at the Health Centre in Hinckley and access to buildings using public transport.
- **Accessing services**
  People were keen to be assured that they would have access to community beds when they needed it. People felt there was a need for the provision of beds in a setting suitable for patients that have a clinical and social which need falls in between a community hospital bed setting and a home setting, to allow reablement.
- **Reducing beds**
  People in general remained unconvinced that there would be less need for community beds in the future. This view seemed to be borne out of the perception that we have a growing and ageing population and struggling to discharge patients from acute hospitals, and the media tell us there are insufficient beds.
- **Hinckley and District Hospital (Mount Road) and Hinckley and Bosworth Community Hospital (Sunnyside)**
  In general people felt positive about the proposals in Hinckley, but wanted

reassurance that we were considering; what would happen to the old community hospital building; back up if out-of-hours service moved from Sunnyside; consideration of children's physiotherapy/school nurses and learning disabilities services

- **Communication, awareness and education**
  People were keen to see consultation start, as they felt that there were Chinese whispers and rumours circulating and clear transparent messages were needed so that the public understood what the proposals were.
- **Integration and joining up services**
  People felt that there were opportunities for integration and joining up services and that the voluntary and community sector should be involved in plans for Hinckley.

6. NEXT STEPS

6.1 The research findings coming from the five events in the West Leicestershire CCG area should be examined along with similar research findings yielded from similar events in the rest of Leicester, Leicestershire and Rutland. The findings and learning should influence the refresh of the STP for the area taking into account what matters most to people.

6.2 Each discussion topic provides a range of insights which should be used to inform individual STP workstreams particularly Integrated Locality Teams, Urgent Care, Home First and Hinckley Community Services Review.

6.3 The findings present key insights that should support the development of communications, engagement and marketing plans both for the STP generally and for the individual workstreams and service areas.

6.4 The themed data also contains many questions from the public, which leading to and during the next phase of engagement and consultation process we should seek to answer through a range of methods.

Appendix 1 - Themed Raw Data

Key themes:

- **Good idea in principle but things to consider**
- **Money – Costs, investment and funding**
- **Access (travel) and transport**
- **Accessing services**
- **Communication, awareness and education**
- **Staffing, training and development**
- **Integration and joining up services**
- **Impact**
- **Data sharing, information (care plans) and IT**

Session 1, Question 1

Resilient services in the community, including GPs

How could this impact on you and your family in keeping well and supporting recovery?

1. Good idea in principle but things to consider

1.a) Good idea in principle but some reservations

- Philosophy is good but practically is more difficult
- Good to know that people are on board. Attitudes have changed our generation
- Acute visiting service is good
- In principle this is a good idea
- It is an old idea
- Appropriate flexibility needed
- Federation sharing best practice is a good idea!
- Having a pharmacist link in with GP is good but better communication is needed
- Innovative way of accessing pharmacist
- Federation is good with specialism of GPs offering different services i.e. dermatology, COPD etc.
- Seems to be an obvious, good idea. Better services for patients and reduces demand on hospitals.
- Federations are common sense really
- Keen to see 'home first' model work. Also keen on federations
- Community nurse coming into home is a good idea to explain the services available
- Like idea of supporting people at home but suspicious that will cut services/save money/ abandon patients.

- Fine if money saved and spent on the right areas
- Local care better than travelling to Leicester
- Great in theory
- The way proposed is good i.e. virtual ward
- If it works this would help hugely, especially when having to take loved ones to various appointments
- The GP Federations should work well but need to keep a focus on the accessibility to services and that the services reflect the need of the population
- How do we know that each federation has the right skillset and resource to manage all health conditions?
- Do GPs have adequate facilities to deliver minor ops?
- There is a lack of confidence in the NHS being able to deliver
- How is it possible when we have wards closed?
- Sounds wonderful to have care closer to home
- Big gap
- Good if services can be kept close to home
- Benefits of patients being at home prevents the risk of infections but support still needs to be available regardless of where patients are cared for
- Principles good but changing mindsets is a long process

1.b) Need convincing it will work

- No resources/facilities available to have the services we are proposing
- Would not work as it is very complex. One system to help all patients. One system will not fit the needs of all.
- Surgeries are already so busy. How can they take on patients from other areas and still provide a good service?
- Need to know scale of problem to tackle it
- GPs have got expertise to provide generalised care – I think there are barriers – GP recruitment problems, financial limitations, premises issues
- Need new services in place before you can transition
- Reduce waiting times (at ops)
- Medics able to be medics
- Not enthused by what is being said. If we don't work together then it won't happen
- GP practices need to change the way they work a lot to be able to deliver the new model
- The Front of House in GP surgeries needs to work better as there are confidentiality and privacy issues
- Federations seem very good. Although I am worried that if some services are provided in another practice e.g. Bosworth and my practice is Burbage. It is a long way and difficult by public transport to get there. In this case I would prefer to go to hospital as it is easier to travel to.

1.c) Need to consider

- Look at referral patterns of referring patients
- Look at what is working well in practice and share
- Think pharmacist can be used as a resource to support GPs.
- Some things have to go to the acute
- I don't think that they should close community hospitals
- GP referrals/discharge not slick (needs fixing)
- Need to reduce admissions before changing ways
- Support networks

- Stretched/lack of resources already in primary care, how will this be addressed?
- Make things more local
- We seem to have a lot of contracts from out of area suppliers so the ideas are good but providers need to know the area
- Cosmetic surgery – need to look at this

1.d) Services V buildings

- Keep specialisms and services without getting caught up by the building
- Ensure sufficient services/not cutting
- Federated services e.g. minor injuries (does not need a new building)
- Venues are important – suitability, accessibility and centrality need to be considered as it has to be appropriate
- OOH GP 24/7 in Hinckley and local walk in centre in Hinckley
- Localised urgent care in Hinckley area
- Services within community hospitals need to divorce services from the building
- I would be concerned about OOH base being moved by Hinckley Community Hospital (member of stay), as the service supports the hospital.
- If care is moved to surgeries can they provide space, skills and capacity?
- GP hubs – impressed! Surgeries housing different types of treatments
- If and when possible, could GP surgeries care for patients rather than sending patients to a hospital?

1.e) Wellbeing services needed

- General well-being services are not available at present. Need joined up thinking to ensure that patients aren't abandoned

1.f) Process and can we deliver

- Is there a plan for patients?
- Worry about if we can deliver it
- All very good but what is the process and who is responsible?
- Same systems across practices

1.g) Mental Health

- Mental Health pathway issues were raised, particularly in times of crisis. Fragmented care. Feeling of going round in circles and getting no nearer to seeing specialist. Long waiting lists for specialist mental health care. Resources wasted on 'holding' appointments while waiting for specialist. Lack of communication between routine and crisis services. Appears to be an inability for referral between teams, always back to the GP for referral. Process falls down for patients with intermittent need; again have to go back to GP for referral, can't access services as needed, has to join waiting list again

1.h) Medicines and management

- As LPC I am worried that elderly and vulnerable patients currently have medicines delivered to their home and use a medicines dosage system. There is loads of over ordering.
- Pharmacist have in the past linked with Age UK in the City . Pharmacist had a mechanism of referring patients to Age UK if they needed support.
- We need to educate patients on medicines and repeat prescriptions, as many patients automatically tick everything as they think they still need them. Then half get wasted. A lot more medicines should come off prescription and a lot of money could be saved.

- Older people should be encouraged to only ask for the drugs they want, not all that have previously been supplied.
- More pharmacists in practice

2. Money – costs, investment and funding

2.a) Investment and cost

- Worry about the funding and how
- Less carers – no funding – why? Locality teams?
- What are the funding considerations and what is the impact?
- Free secondary care to do more specialist work
- Practices with overhead costs – don't get further funding – so they rent out to make money

3. Access (travel) and transport

3.a) Access and transport

- Easier, more local, easier transport
- It is OK to travel but I am young with transport. What if I was older or couldn't afford it?
- Access to public transport – need to look at it
- Federations are a good idea in principle but there is still a travel issue for older people and those without their own transport
- Good idea – with older people transport can be an issue. GP practices will be local which will make transport easier
- Reduce transport costs (patients and transport services)
- Access to transport services
- Need accessibility/ easy to travel to/ short travelling distances/ small radius
- Don't give a GP in rural area a specialism unless the GP is prepared to travel
- Community hospital – central and easy to get to
- Patient access
- Need to address the premises and parking issues if services are to be moved to a local destination as there is a big discrepancy in the GP premises at the moment
- Possibly having to travel further to federation GP
- Issue for transport from one practice to another. Harder than to hospital
- Long journey for patients at times between diagnosis and treatment
- If going to another practice to save a trip to the LRI this would be a great benefit but communication is key
- Patient mobility
- Making sure there is support and accessibility
- How as a patient/carer to access help
- Patients not getting access. Hospitals share letters and results
- Definition of local transport?
- Good to keep treatments local

4. Accessing services

4.a) Appointments and accessing my GP

- Is there enough GP resources?

- Concerns about GP being pulled out of workforce.
- What if other GPs are not able to take on services in their practice.
- We are struggling with getting appointments, will sharing services help with this.
- Concerns about some triage being by telephone and not getting to see my GP face-to-face.
- Do you follow up on appointments?
- Could be down to illness re why a patient can't get to their appointment
- Issue about appointments – not the same for all practices
- My appointments aren't always taken on time – I waste 1 and a half hours
- Access to GPs - phone on day, then have to wait 3 weeks. Phone at 8am and they are constantly busy. Haven't seen the sharing of services between GPs.
- In theory, sounds excellent. If you are at home needing care it's difficult to access GPs – need more community services
- Will there be an issue if a patient from a different practice gets straight into my GP for a procedure when I can't get an appointment with my GP? This could breed resentment.
- Happy to see PN, specialists
- GP practices working together – seems sensible but cynical of agenda – keeping people out of hospital
- Some GP practices have better facilities than common hospitals/LRI e.g. joint injections
- Why have patients been missing appointments?
- Are there enough GPs?
- Can't get appointments
- Doctors are great, we need more
- Struggle to access GP outside station view. Not enough appointments
- Centre Surgery – work on own e.g. yellow fever in the past – welcome
- Difficult to get GP appointments (3 weeks) e.g. GP gives 6 months prescription, nurse only 1 month
- How do we feel? If a person receives treatment then we are happy. If we are a patient at the practice then unhappy because the GP may not have time for his patients
- Need to have GPs available as we are still having to queue at 08.00 for an appointment
- There wouldn't be enough GPs for this to work; we need more GPs to cope with transfer of care to the community. We need capacity. Would we have enough surgeries? Building community services are already stretched e.g. district nurses. They will struggle to keep up with this new way of working – capacity, or lack of, will impact on my family.
- Need to address the non-attenders issue
- Need to ensure that the patients of the surgery do not miss out on appointment times when GPs are providing appointments for patients from other surgeries
- GPs should be stronger on DNAs – maybe penalties?
- Introduction of federations is a positive move to bring specialist services into the locality for patients to access
- I know my practice nurse and GP – I won't have this if I go across town
- Appointments are not taken up: DNA's, email patients they have an appointment the day before or text
- Penalty for missed appointments
- Of 399 appointments DNA, how many old patients?
- Missed appointments – have the appointments been sent to the patient's carer? Do they understand about the appointment they have forgotten?
- Continuity is important, seeing different doctors as part of the federation system – personalised continuity of care
- Ensure 'spare' GP appointments are available – if pharmacist can't do it etc.
- More use of practice nurses

- Give patients more choice e.g. x-rays are available at Melton/Loughborough but are only offered at Glenfield
- People value personal relationship with GP
- Lack of GP/extension of hours is not necessarily addressed with additional funding
- "There are many frustrations in the system such as not being able to get through on phones and it is important to get these sorted out as part of this process"
- Do not forget the importance of seeing a familiar face
- GP surgery is the right to be the first point of contact

4.b.) Waiting times

- Worried that discharge can takes weeks.
- Reduced waiting times
- 7 day waiting
- Hospital discharge problem if bed blocking

4.c) Opening times/OOH services

- Federations – out of hours? Weekends?
- In this plan will GP surgeries open for longer?

4.d) Cross border issues (access to out of county services)

- Cross border issues – CV postcodes are in Leicestershire
- Out of county impacts (one change can effect wider population)
- Will it be possible on the cross border when patients access services?
- Need to confirm STP Warwickshire e.g. is A&E at George Eliot closing?
- May be a negative impact in cross border areas if the systems in other areas are not the same and care coordinator roles and different and don't talk to each other in the same language

5. Communication, awareness and education

5.a) Awareness and education

- Education as need more advertising. Behaviour change for patients is required.
- Taking charge of your own health? More awareness. Where to get the information?
- Need to spend more time educating and preventing – not just treating
- Real need for patient education and management of expectations.
- Could extend GP answering message to include 111 – it's a great service
- Don't know where to go to get information. Need better signposting
- Dr x gave an overview of new clinical staffing models of care at WHC. Practice receives a number of queries from patients as to why receptionists ask for reason for appointment; mixed skill set in the practice creates a need to direct patients to the most appropriate clinician. Awareness needs to be raised as can cause real challenges in practices. "To help direct you to the right person" could be incorporated into the message by reception staff
- Referring to changes in clinical staffing models; patients need to get used to not always seeing a GP, real culture change. It was suggested that an explanation re changes may be better coming from the clinician during the consultation
- Increase the level of patient education about the practice clinical team, patients may then actively choose not to see the GP but the most appropriate clinician for their needs
- About personal nutrition
- Education of whole team

- Education (patients, GPs, schools, new mums)
- Signpost people to the right services
- Direct access to clinical professionals – needs to be communicated, need to know what is available
- Use of technology – Skype, mobile phone, texting
- Use of hospital/local services appropriately
- Getting information out to patients and for different health professionals to be called on as and when required
- Re Alan's comments and the two way deal between patients and the service there needs to be a sustained programme of patient education around using the new services and the importance of self-care and healthier living and again more instructional than advisory
- Re healthier lifestyles there are times when it is appropriate for GPs to be more "in your face" and instructive or directional rather than kindly advice
- Some things have to go to the acute
- I don't think that they should close community hospitals
- GP referrals/discharge not slick (needs fixing)
- Need to reduce admissions before changing ways
- Support networks
- Stretched/lack of resources already in primary care, how will this be addressed?
- Make things more local
- We seem to have a lot of contracts from out of area suppliers so the ideas are good but providers need to know the area
- Understanding how I get the help sign posting at GP
- Educating patients on what they can do or where to go
- Positive for patients but a lot of information to take in which is an issue of potential confusion for some about the treatment and care journey if there is no-one to accompany and explain at the time and afterwards

5.b) Working together and communications

- Working together
- Systems communicating
- Everyone knowing the changes and system
- GP's talking to each other
- Communication to family and between services
- Good communication is very important

6. Staffing, training and development

6.a) Training and development

- Need to skill up people in the homecare support market
- How do you feel about seeing another professional? Communication, skills/better skilled, trust surgery to know what is best
- Can doctors be stopped from retiring

6.b) Staffing and qualifications

- Systems needs to make sure that staff required are in place
- Staff need to be competent as on their own qualifications
- Worry about not having highly qualified carers

- GPs are p/t – need more GPs working f/t
- Clinicians used to run hospitals, what has happened?
- Consolidating staff across two/three workforce sites is very good
- Sometimes new doctors pick up on conditions when families doctor failed
- Patients feel like nurses are a second class service – generation shift
- If GPs are getting extra work, are they getting extra funding?
- High cost for switching, efficiency decreases if practice switch due to training needs
- Pharmacists are being cut back which will not help
- Manpower to cope with the changes?
- Will this model have staff implications?
- Should look at things like Push Doctor and web-based appointments
- Money, recruitment and retention.

7. Integration and joining up services

7.a) Integration

- No streamline between A&E – advice on social care/rest bite care to avoid people bed blocking
- Health and social care under integrated management

7.b) Working with and joining up services

- Local authorities stay well rather than stay ill (healthier lifestyles)
- Lots of passing of responsibility (GPs/A&E/CCG/local authority/NHSE)
- Foster volunteers to the elderly (Bedford CCG)
- The existing services are not joined up at the moment
- Pilot at the urgent care centre – GP triaging to avoid A&E attendances
- The Federation will help to reduce duplication of services

7.c) Voluntary and community

- Strengthen the links between GPs, care coordinators and the volcom sector which is still an area of untapped opportunities

8. Impact

8.a) Impact on families

- If family members are not available to take patients to appointments, who would take on this responsibility? How would the NHS cope with this added pressure?
- Positive impacts hinge on people having support – if you have a close family it will work, if not then it won't
- Assuming the family will be there – not everyone will have family there. If they do, the family will also lose income. This creates conflict between families.
- A need to rely on families more – what about people who don't have families?
- Impact on families – lots of elderly
- Working families – patient not cared for
- Communication to wider family members, central resource
- Need to look at hospitals that are right for patients and near their home for friends and family to visit
- Big impact on families, may be considered as 'passing the buck'

- Need to ensure that good services are available for those that do not have family supporting them

8.b) Social care support

- Dom care providers – shortage?
- Can't get people out of hospitals due to care packages not available.
- We need social care involved ASAP
- Social services funding is in a dire state, if there is not funding it won't work

8.c) Care Homes

- What happens if you are in a care home.
- I am concerned about people being neglected in a care home.
- Care homes need support themselves.
- Worried that we will be moving people after discharge to care homes out of our area and that some conditions won't be looked after.
- Need to invigorate the care home market to help with these cases – if more is invested in core nursing services less need for domiciliary care.
- Not enough home care support staff there at the moment. Reducing more as money not there
- Poor quality care at home can cause hospital visits

8.d) Carers

- Carers pulling out at last minute when awarded the tender
- I have a friend who has to have help at home, can't get out of bed and had to stop in bed all day as carers didn't turn up. They don't have a voice here
- Family carers – parent's children who are now adults – our cradle to our grave carers. Worn down, need care ourselves. Hear us or there will be two patients needing help.
- My son has learning difficulties, I am his carer and need to look after him but we are getting older
- Rest bite care is expensive but is needed for carers

8.e) Loneliness and Isolation

- Not dealing with loneliness and isolation
- Support for patients post diagnosis is lacking. "Patients feel alone". Look at additional support services that allow patients to discuss their condition; including with other patients going through the same. Raise awareness of existing support services
- Loneliness – older patients might need home help
- Concerned about 'granny' being left on her own.
- We have a vibrant voluntary and community sector that should be joined up and services wrapped around the individual. Loneliness is a killer.
- Home care is fine but when people are alone, depressed and isolated, homes not clean, environment issue – not always suitable for clinical care e.g. dressings
- Learning disabled – they need a voice. They need easy read, no jargon, easy to understand words. They have life-long disabilities and need to understand so then they can contribute to make choices
- Loneliness – not living as an existence
- Patients living alone
- Social isolation
- Too many people living alone – could people live together in a community building?

8.f) Home first

- Where is the evidence that Home First can be delivered as part of STP? Where is the financial evidence that it can save money? There was no financial appendices tonight
- Home first more inconvenient for families i.e. working families supporting older relatives
- Who is able to stay at home and who isn't? Needs to be 24/7 Home First
- Not convinced that home first is always best
- Home first – people see people being kicked out of hospital too quickly
- Experience of home first for an elderly patient working really well given the patient was kept at home until absolutely essential – excellent
- GPs need to identify LTC – GPs to have overview of care at home too
- Urgent care at home (treatment there and then)

8.g) Hospital/Bed closures

- Most difficult part of STP people alarmed by the closure of beds
- People don't want to go into hospital – we do need a way to keep them at home
- Plans for closures of hospitals are worrying – what are the knock on effects, Caroline explained a pathway to help with this, Understand of the impact is being looked at
- Don't close hospitals before there is a process in place. It builds resentment/distrust
- Services changing
-

8.h) General comments on resilience in communities

- What facilities will be available for people 1) who is going to ensure that the plan actually benefit people and services are easy to use irrelevant of being old, young, single condition, multiple conditions Concern of people in between visits (on their own) during middle hours – should be another safety net (personel ????) Is it part of the discharge notes to have an emergency button; Do you have to pay for it?
- Key safe
- Use of community hospital s beds needs to be better
- Concern of 24 hours care. What is the buffer in between the time before a care package is made after discharge
- Once patients are discharged the stress in the system is increased due to the lack of services eg closures of hospitals

8.i) Community services and support available

- Not enough support in the community, will lead to hospital admissions
- Need enough community services e.g. Macmillan nurses. Don't want to be abandoned if cutting services

9 Data Sharing, information (care plans) and IT

9.a) Shared information so people don't have to repeat their story and technology

- Telling their story over and over again is tiring for patients
- Need shared records. Been in a case where we have had 9 sets of notes
- Could patients carry their own notes? Little booklet to share
- I don't work for the NHS, I work in industry and shared notes are common sense. I don't understand why they are not. Patients need to support this and don't understand why they don't.
- All professionals should have access to records. I understand that there are concerns about data protection and security but sharing records is important

- Better sharing of information.
- Sharing records with out of hours pending can share elements
- Urgent care/emergency/social services – access to read medical information
- Families need to be included in discussions and issues around patient consent for data sharing and powers of attorney for families
- Professionals need to be using the same IT systems. It is hard to see how you are going to get that integrated communication which is needed for OTs, physios etc.
- Shared record might stop those problems
- Is health and social care able to share records without patient's permission?
- Important to have a continuous flow of records
- Procedural problem with booking appointments – not allowed to book in advance even if you are flexible about when you can go. When you know and see the same doctor the appointment time is wasted going over history
- Patient information shared on the system more. As information sharing is key, why has this still not been addressed? Shouldn't all practices be on the same system for better information sharing? Nationally there is no/little appetite for a specific IT system
- IT systems different (RIO/S1)

9.b) Care plans

- How are care plans going to work and actioned – hospitals talking to community and primary care
- The care package available stops the beds being freed up. So [pathway is blocked due to the end process,
- Personalised plans?
- Do GPs/health and social people know who their at-risk patients are? Need a proper assessment of when people need 24/7 care
- Yearly MOT (link to meds review) - Station View & Bowell – (though less well now)

Other comments

- Babies – not mentioned long-term care
- Standardisation and understanding everything
- Patient in control
- Recycling centre of medical equipment e.g. wheelchairs

Session 1, Question 2

Resilient services in the community, including GPs

What else would you encourage us to think about when developing our proposals for this area

- # Good idea in principle, but things to consider

1.a) Good idea but can it practically work?

- In theory it sounds great but will it work? It's going to cost money – services are already stretched
- If it works the way it is presented it will be brilliant but the weak link is social care

- Need to fund and staff properly. Not got the nursing staff.
- Need adequate provisions in place. Some families have carers who are trained so ok but home care services are on zero hour contracts. Only 15 minute calls
- District nurses are stretched already
- Philosophy is great but will it happen? No process in place
- Positive to have a joined up approach
- I want answers
- The secondary and primary links are not there at the moment
- "The principles are brilliant"
- Doesn't fill me with confidence. Info just going around and around the system
- It's another layer of complication
- "The idea is great but everyone needs to understand how it works, their role is and be able to explain it all to patients."
- People self-manage for as long as possible, they try and try and then are admitted in crisis.

1.b) Long Term Conditions

- There are a high level of respiratory needs/COPD in the area

• Money – cost, investment and funding

2.a) Investment and cost

- How much investment? How much is it going to cost?
- Shortfalls in funding but want to invest in a single system?
- First question is 'inappropriate' – spend less on healthcare than EU partners – irrelevant now
- 'Devil is in the detail' – the issue about finance is critical
- Hit people in the pocket if they fail to turn up for an appointment
- "We should consider a fine or charge for DNAs to GP appointments"
- Not all GPs work for NHS, they work for private facilities. Is that right?
- Increased screening – needs to be defined which ones
- Have we got GP resources to address the additional care e.g. bunions

• Access (travel) and transport

3.a) Access to services and transport

- Rare conditions need access to these services locally
- Choice – rely on professionals to determine
- Triage issue
- Appointments on the day – ring at 8.30am
- Services should be available at all times
- GPs just advise local services – may not be quickest/less parking/public transport
- Transferred out between practices
- With all the press reports with queues in A&E, why do people still want to go to A&E if they know they aren't going to be seen? This may be because they can't get an appointment at a GP Practice
- GPs don't have time to give patients time

• Communication, education and awareness

5.a) Education and communications

- Communication to families as no reassurance, impacts, social care e.g. district nurses etc.
- Hospitals not talking to each other

5.b) Culture and behaviour change

- Behaviour change rather than investment
- Culture fight – promote healthy lifestyle but marketing promotes other
- We are educated and we need to take responsibility
- Patient mentality has to change – biggest problem is how people think about the NHS. How do we get this across to patients?
- Have to change the mind-set of the public
- Is the community ready for this; are the community services ready for this?
- More positive press. Get the press onside. Locality – tell our positive stories more often
- Publicise alternatives to A&E better
- Difficult to change people's mind-sets
- Can you not put pressure on the government to change national policy on obesity?
- We could try to influence alcoholism and buying cheap booze – there are opportunities to influence local tax
- NHS has to enable patients to change
- Change mind-set of patients
- Clinicians need to change mind-set
- Monitor the journey of changing care
- Patients also need to have the means to do this differently in order to look after themselves
- We need to have solutions in place to help people change the way they live
- Will we still get to see our own GP or will practices merge?
- This links to patients missing appointments at practices. Why do they miss them? What is the follow up process? Why to people go to A&E if it's not urgent?
- Social issue – people don't have the community aspect as previously you would speak to your neighbour for advice
- Pressure on GP for 24/7 services – it is not raised in media that other services are in place to address this but patients require education to understand what is available and not rely on GP care 24/7

5.c) Healthy living

- This has been talked about for some time 'Healthy Living' but how will this be achieved?
- Concern re why there is a gap in healthcare needs for the young to the elderly. Is this due to quality of life?
- What is the way forward to make people live healthy lives?
- What is healthy? There are confusing messages in the media so what is a patient expected to do?

• Staffing, training and development

6.a) Recruitment

- Man power issue – recruitment of nurses, upskilling
- Seeing more part-time practitioners in practices as they don't want to work full time
- Can facilities keep pace, now and in the future? Is there enough staff?
- Should a federation have a dietician?

6.b) Training and development

- Staff training

- Staff to look at notes prior to appointment
- Education is critical in order to understand the process
- Press and media (national and local) focus on missed targets etc. A better use of communications would be to educate
- Education of the workforce too
- Practice nurses deal with more patients – they are undervalued
- GPs can pass on some of their duties to other health professionals to save money and time
- Why is there not more money for doctors and nursing training? It had been capped previously
- Make GP career more attractive. Lots of students want to work in hospitals and not primary care
- Using nurses instead of doctors but training places have been cut
- Communication between health professionals. The messages are not always getting through to all channels
- Consider have top tips for patients to follow
- Patients go to the wrong place for treatment. This needs to be looked at
- What staff do practices have? Nurses as well as GPs? The public have less trust in nurses and want to see a GP or go to A&E
- "When will district nurses come back under GP control?"

• Integration and joining up services

7.a) Voluntary and community services – connections

- Health services need to connect more with voluntary services
- Pastoral care can complement health care and increase patients well-being
- Sounds brilliant. The voluntary sector was brief – how can they be used to its fullest?
- Missed a trick – no reference to integrating nutrition services, friendship, book clubs etc.
- Lots of untapped resources – voluntary sector, PPG groups
- Potential resource is retired 'baby boomers'
- "There is surely a bigger role for support groups in this"

7.b) Getting home

- Care packages not organised
- Medications for discharge
- Not coming out of hospitals, social care
- Link between hospital and GP for getting you home
- Stuck in hospital as not beds in community setting and support
- There are difficulties in the system at the moment with the coordination of discharged patients between the different providers
- Can get people home quicker if the service works well

7.c)Federations and PPG support

- It is not going to change overnight but PPGs can help to explain where we can get healthcare
- PPG group did a survey of 128 people – 121 were happy with the new model, 7 would be happy if there was a reassurance about no reduction in available appointments
- The Federations can employ additional staff and split costs across the practices – this was considered a very positive thing

7.d) Adaptation of homes

- Length of time for adaptation to patients homes needs to be more timely

7.e) Integration

- Needs to be holistic – social care, housing, NHS working together. All practitioners need to play their part
- How does the prevent part of the pathway fit into GP practice?
- At one time within the GP surgeries all services were under one roof. This was better to access

7.f) Mental health

- Mental health is a concern, no other care is available
- Need more for mental health patients
- Long term conditions – what about if you have a mental health illness that you can't manage and are dependent on family?

7.g) Border issues

- Does social care cover right up to the borders? Had to go into hospital as no social cross
- Other agencies are already showing that the integrated teams approach works – same locality model

7.h) Pharmacy

- More information needed about pharmacists in practice
- Will this stop the current practice of pharmacist PPSG off NHS? Pharmaceutical companies and pharmacists making money
- "We need to make more use of local pharmacists – often they know you and can give you great advice, and even flu jabs"
- Pharmacists in the community to help

7.i) Involvement with schools

- GP service and schools – to start an early education about being responsible for their own health. Collaboration between local schools and GP (does it need to be GP?). No other health care professional could do it – long term preventative benefit
- Working with schools and supermarkets
- Need to educate next generation – schools, colleges
- Local health authority to go into schools and educate

8. Impact

8.a) Care in the community

- Care would be just as high in a community setting e.g. home first then in a 24 hour care setting – nursing home
- By co-ordination through integrated teams, duplication will be omitted and money released
- There is not the capacity for health and social care in the community –If you have an integrated team and one point of contact this could work well for the patient during daylight hours
- Cheaper to have people home than in hospital
- Good during daylight hours, what about out of hours?

8.b) Carers

- Carers might struggle with the new system

- Need to identify carers at a local level and how they navigate the system
- Where is the funding for carer support going to come from?
- Child carers – what help do they get?

8.c) Care homes

- Care homes: people there are forgotten, lack of communication, need to be included, care plan in a care home is very important, integrated teams need to work together, 1 GP to 1 care home, consistent approach of how we work will be more effective

9. Data Sharing, information (care plans) and IT

9.a) Use of technology and data sharing

- Lots of people are computer literate, could we have an app?
- Maximise use of technology – text and Skype
- Is there going to be a single system? System one is good e.g. Avail in A&E.
- Swedish/African system? Take own notes with you. Antenatal care
- The IT sharing, summary of records
- Repeated concerns about patient confusion re their care journey and pathway/s and the importance of patient consent for data sharing across multiple organisations
- Linking services – set of IT systems

Other comments

- What is the role of nursing in restoring people's health in this plan?
- Haven't we tried this before?
- In care plans, look for deteriorations – what if? Look at a wider picture – who else needs to know?
- Sick of blaming ageing population
- Google/online is right for some but not for all

Questions

- Where are the integrated teams in the H&B area? Explain?
- LLR plan – why are people taken from Hinckley to Nuneaton?
- How local is local?
- Where is the money coming from? Will resources be released from secondary care if moving care into the community?
- Will the teams manage demand?

Session 2, Question 1

Integrated Teams

How could this impact on you and your family in keeping well and supporting recovery?

1. Good idea in principle, but things to consider

1.a) good idea but can it work practically

- Good in theory, not sure how it will work in practice – staffing not available locally

- Social care can't cope – funding and staffing. In the present climate this isn't possible
- Why is it going to work this time? What has changed? (Ownership and relationships)
- The principle is right but there is a long way to go. There are issues around services – communications is huge. Finance will also be an issue.
- Comfortable with being co-ordinated
- Trusted assessment – only once
- Not professional overload
- Need relationships and trust
- Only as good as the weakest link
- If the person leaves, who will take over the care?
- This is what we should be doing
- Better geographically
- Sub-locality – need to look at areas which is less than the numbers quotes e.g. Stoney Stanford
- Engagement is key
- We are almost presented with a finished product. What are the stops to get there? Blue sky is easy – pin pointing the steps to get us there
- So much of this is ideology and is not practical. Too many variables
- It's not an immediate solution
- There was a lot of opposition around the table to the thought of Integrated Teams. The general consensus was that it was another layer that wasn't needed and could cost a lot of money and lead to patients being lost in the system. It was also thought that this has been tried many times over the years and has never succeeded.
- Sounds great in theory – but wary of gaps
- Some ideas are wonderful – getting in early but is it feasible. Can you have continuity . Lack of continuity is a problem – different people,
- Sounds good - well presented. Services need to be co-ordinated, like to have continuity – important for older people; worried about supply of healthcare professionals
- Pleased to hear about integration
- Local services – how can it be <u>local</u> if local hospitals are going? Difficult to provide specialisms scattered over different localities
- We are sceptical – some of it works already. Example given of form filling saving going to Glenfield.
- There is the potential to reduce the variation in standards between local practices
- Who is going to provide care/carers in the integrated team?
- Good idea as long as it is funded and skilled with competent people
- When will they work out how many needs to be saved? Trying to implement before it has been fully rationalised
- Lots of benefits – encourage people to work together
- Think it will close the gaps very well
- These proposals are good but only if we have the money and professionals to care
- Patient's like to visit their own GPs as they know their medical record
- New services need to run at the same time as old services to ensure it meets patient needs
- Great idea! Good integration. This is required. Who is the key person in the team working with the patient and how does the patient relate to the team? Who co-ordinates their care?
- "The idea sounds good in practice but getting the coordination and integration right is critical"
- "The continuity and not having to repeat my story every time sounds so much better"
- "People can go one of two ways – some like to make their own choices and have their carers involved and other like to have decisions made for them"

2. Money – costs, investment and funding

2a) Investment and cost

- Finance - should have another line of financial graphs to show waste in NHS not just income and expenditure. £3.9M identified waste?
- Where are the resources coming from?
- Lack of clarity re financial circumstances – supportive but is backed up by budgets and workforce
- Is there funds available for model of care on the STP to run alongside the current system

3. Access (travel) and transport

3.a) Access, transport

- Transport will make it easier for people to get to localities. How are you addressing that issue
- Lack of care at weekend can't see GP at weekend
- Transport within the locality needs to improve – i.e. urgent care centre to home

3.b) GP practice

- Not enough practice staff in general, not just GPs i.e. practice nurses
- Issues in achieving the results resulting in patients experiencing difficulty in accessing appointments and seeing health professionals
- Can there be a cost saving where patients miss appointments

3.c) Border issues

- We are on edge of Leicestershire – mother admitted to care home Derbyshire then Staffordshire - it was really difficult to get her back to Ashby. She was a Derby resident we need to take down these artificial barriers. ICT needs to be cross borders
- Reassurance for people in Castle Donington of cross border hospitals ?? How would Leicestershire patients be assessed in hospital over the border?? How would this work.
- More consistency across CCG and practices all saying the same things i.e. lead GP for patients care who patients sees most of the time – lead care for the person its GP for health and social care co-ordinate what is needed
- Worried about closure of A&E in Burton, I would rather go to Derby or Burton

4. Accessing services

4.a) Coping with demand

- Are we going to cope with the demand of service required at home?
- Issue around immediate sustainability – how will we meet the current NHS crisis if we are losing 1500 front line staff?
- 24/7 advice line is 'a godsend' but 111 needs to restore its reputation
- Future housing will bring more demand – housing should be designed so they can use the space they are in
- SRN's, SEN's – do not need a university degree to help. Go back to the old system of nursing
- Can see the positive for people who need multiple appointments. Hope it will work
- The public need to understand what pharmacists can and cannot do – publicise

- This sounds like a good idea but there are a lot of Mrs. Taylors. How would the NHS cope with this given the current resource?
- Does this include district nurses? Yes. Is there a shortage of them? Yes!
- Locality teams will hopefully stop duplication
- Does this mean that GPs won't have time to patients if they are co-ordinating patient care?
- "This system should reduce the number of hospital visits"
- Internet doctors and patients who take themselves off to A&E
- Ageing population will apply more pressure to the system

4.b) Discharge

- We need a care package in place so that patients in hospital can be moved out quickly
- Patients having a choice of where they go
- The hospital discharge process needs massively improving, particularly re waiting hours for prescriptions before people can leave
- Burton hospital good site re hospital discharge

5. Communication, awareness and education

5.a) Awareness, Education, Self-Care

- Start educating mothers and fathers – help them believe there another way of thinking, women's and men's clubs; younger people,
- COPD events – good, Helped me to know how to use my breathing apparatus
- Practices nurses good – patients' needs to know
- Patients need to understand who is involved in the integrated teams
- Patients need to understand who is involved in the integrated teams
- Nothing said re health education – how will it happen – successful smoking – need that level education sugar
- Knowledge, signposting of – for conditions and prevention
- Prevention.
- Education
- Support for carers to care for person at home (involved in patient education progress)
- Education on understanding – single point access communication
- Training patient to do key treatments e.g. injections
- Patients drink, smoke and don't look after their health. Telehealth needs to be a permanent feature
- Patients to understand who cares for them when accessing other services i.e. when calling 111, who do they refer to and how is the care plan managed?
- What is level of awareness of GPs to services that are in their locality

5.b) Culture and behaviour change

- People see NHS as National Health Service. Average patient doesn't see budgets and borders etc, they don't take responsibility for themselves
- Turning dreams into reality for patients
- People more interested in illness rather than health

5.c)Communications and IT

- Using technology more effectively
- Sharing of information – need to be confident it is only on a 'need to know' basis especially social care. Don't want it to affect insurance
- PCO would need to know about vulnerable people

- Getting a common language
- Co-location? Can help communication
- Increase better coordination/information flow
- Summary care records
- Shared records/mobile technology to do real time updates
- Times, when coming out, whether was am/pm. Who – clearer communication of details of visitors
- Accessible information (in the right format for that person)
- Need to look at IT capabilities in Leicestershire as we are quite far behind other areas and this could be a risk to any plans
- Patient's care plan not the NHS, it should involve family and carers. Look at terminology, collaboration (partnership with patients) and develop local networks
- Got to be able to rely on the services and the information being provided correctly
- Take into consideration – benefiting vulnerable people. lines of communication for limited understanding; not one size fits
- Support people need to understand how to use and access services

5.d) Staff communications

- GPs speaking to specialists
- Nurse out to explain – very good but no follow up
- Better communication between services – patients sometimes have to call many different people/services/teams
- More communication between professionals and family (introduce a log book with the same care plan). Patient – team – family.
- Early intervention – how to identify crisis patients before a crisis occurs. Still a need for care homes
- This requires a lot of patient communication to build patient trust for other clinical professionals to take a lead in their care
- "Coordinating teams of professionals is incredibly difficult"

6. Staffing, training and development

6.a) Additional disciplines and considerations in team

- Staff training in decision making

6.b) Staffing

- Where does district nursing fit into this? DNs don't have enough time to treat patients properly
- Lots of surgeries short of GPs – opportunity to 'borrow staff' in the federations
- Where will integrated teams be placed?
- Additional administration and extra facilities
- If you want people four times a day – two people – it is a complicated package
- Concerns workforce – where are

6.c)Skills and responsibilities of staff

- Look at skills and responsibilities of different staff
- It seems like they are doing something (hospital) to only open something else (doctors)
- More staff where will you get them from. GP practices are struggling

- Nurses only give patents 10 minutes. Social care do 15 minutes visits and they have travelling time. Recruitment issues – may come from EU – Eastern Europeans.
- GPs to have extra services?
- Can see other specialists – doesn't have to be a consultant
- How do we capture all the expertise in the area ie com nurses, voluntary sector.

7. Integration and joining up services

7.a) Mental health

- Need to recognise significance of mental capacity
- Concerned about the impact of mental health
- Mental health – needs to be considered especially in an integrated team. Health and mental health – joint ????

7.b) Integration and closer working

- Have integrated systems with local council but not NHS
- NHS has integrated service with fire service but not passed onto police. It is a good idea for the NHS and local teams to share information. 'Angela's List' fire service called to lift people and also have power of entry. Particularly in rural areas 'lift' keys and fire keys identified as a fire risk.
- Working more productively with hospitals
- Mental health/dementia has to be central to this plan for integrated care
- Like to have heard about (HART) rehabilitation team – this is important link between acute card and community care

7.c) Direct comments about integrated locality teams

- Dedicated neighbourhood team – able to identify patients. PCOs able to spend longer than 15 minutes. Able to go and check giving care to the community
- Continuity of care
- Other non NHS/social care support teams
- Locality teams should be caring before and after illness
- Understanding the teams
- Core integrated team – need support
- Core navigators can be used and utilised – skill and confidence needed to know when to escalate
- Activity based community development – LPT. Trying to link in
- 24 hours service to include the right nursing team
- Sounds very good having the skill set delivered but if appointments are not available, how will this be improved?
- Need to address the challenges with agency care and continuity within the teams

8. Impact

8.a) Medication delays

- We need more transparency on prescribing and the VAT implications re GPs

8.b) Care homes

- Patients are falling between health and social care – care homes could be a step down from hospital? Use care homes as a case study?
- Need to work more with care and nursing homes, especially when discharged from hospital. A bit of extra support could help prevent hospital visits. Depends on staffing model/skills
- More people are actually scared of hospital/care homes

8.c) Impact on families

- Lots of reference in STP re "community" is this really relatives

8.d) Care in the community

- Like the idea of making consultants accessible in the community – really important for patients who can't get out of the house. This is lacking at the moment.
- Sounds great, integrated and a big improvement.
- Services provided in the middle of the community and in walking distance are really beneficial to patients, such as pop in support centres
- The home needs to be suitable to look after a patient. Is this possible?
- Social care is now covered often by therapists – expensive
- Use of voluntary organisations
- Patient's care plan not the NHS, it should involve family and carers. Look at terminology, collaboration (partnership with patients) and develop local networks
- "It feels as though self-management and healthier lifestyles is starting to work"
- People left on their own after diagnosis – needs to be a link between diagnosis and care
- Hospice Hope, work with NWL with patients with life limiting conditions support cafes, look at voluntary organisations who can give support. Patients don't feel alone.
- Who would be lead carer for the patients at the surgery, of they are not there it falls down

8.e) Social care

- Social care should be involved to have more influence and feedback
- Social care should be part of health care
- Poor social care is means tested. How to prevent integrated teams segregating patients from those that can and cannot pay?
- Are we talking about liaison between real time social care professionals – we will need social workers and carers to work together with health
- Concern about lack of money in both health and social care – very difficult to make this work

9. Data Sharing, information (care plans) and IT

9.a) Shared information so people don't have to repeat their story

- Data sharing – key – sounds

9.b)Use of technology

- System 2 has improved – rewards our one system. We go to Burton

9.c) Care plans or plans

- How do we get the service right? Needs to be a difference in care e.g. those who need a care plan and those that rarely use GP services.
- Risk stratification plan
- Have care plans in place for patients and health professionals to follow
- "My experience of care plans is that people don't read them"
- Can I initiate my own care plan and manage it

Other comments

- Are we considering moving to the next step rather than straight to moving the patient to home?
- This will be tested first before being rolled out
- Emergency pack
- Not being afraid to question
- Is the NHS trying to treat individual patients or the population?
- Have already seen some good examples
- 'Ethical care charter'
- Future worries for my children/grandchildren
- NHS should be responsible for all care
- When is this likely to happen?
- Good thing!
- About the patient not the organisation
- Put on SPAR it failed us, lots of changes
- Honesty from GP been impressed with this tonight

Questions

- If the model is right i.e. avoid acute money will shift to community?
- Is there enough staff for these integrated teams?
- Will it provide continuity of care?
- Who is funding it? Allocated budgets?
- What does frail mean? Dementia? LTC? Those frequently attending A&E?
- Where is all the extra community staff coming from?
- Can we share more information on how well the Vanguards have worked?
- If we are working on populations of 100k does that mean that H&B will get dedicated maternity services?
- How will cross boundary issues work?
- How are teams defined? Different areas could have very different needs
- Can we have more information about finance, eg, will there be a single budget across all partners?
- Already established federation of GPs – why can't we use what we have but improve it? Why another service and process?

Session 2, Question 2

Integrated Teams

What else would you encourage us to think about when developing our proposals for this area

1. Good idea in principle, but things to consider

1.a) Prevention and self-management

- Prevention and self-management is so important. Access to services to delay onset of LTC
- Feel that people are sat home in the middle of the night and end up going back in hospital. Recovery homes are suggested

- Patients need to be looked at due to many illnesses (pills cater to most illnesses)
- Carers being part of the care of the patient

1.b) Patient choice

- Choice of home birth may prove problems due to cost. Most may choose the best care which may be costly if home

1.c) Planning needed before implementation

- The assessment needed before going home to prevent patient deterioration
- Time consuming to incorporate the care plan which is long winded

2. Money – costs, investment and funding

2.a) More investment

- More investment will be required in community nurse services
- Staffing levels can only be achieved if there are finances to help in this area
- Lack of resources for GPs is a worry
- Will the reduction in staff workforce affect the STP plans?
- Staffing – ensure that roles are attractive and permanent

2b) Home adaptions

- Home adaptions are important – stairs/lifts are expensive for example. People don't want to move

3. Access (travel) and transport

3.a)Transport

- Transport bus routes
- Is transport infrastructure up to it? Easier to get to Leicester than to the next village

3.b) Cross border issues

- Services for Markfield fall under Hinckley and Bosworth. How will cross boarder provision work for social care?
- Look at boundaries between CCGs – different services in each area. (TS: STP plan is LLR – all 3 CCGs, the work described covers all areas and won't necessarily follow existing boundaries. Consistent services across all areas in LLR)
- Due to geography of NWL locality; consider patients living just over the boundary that may access services in LLR
- Not national in integrated locality teams is CPNs – they should be part of the team to give emotional support

4. Communication, awareness and education

4.a)Awareness and education

- We should be talking in schools about this as well, young adults need to understand this now
- Need to educate the team and the patient
- Need to know who we can call

4.b) Cultural change

- Cultural blockers to providing care locally – patients feel they want to be seen in the big centre with specialists providing care. Community hospitals generally have consultants providing services and a good service is provided; this is not made clear enough to patients
- More likely to be seen by a registrar than a consultant at LRI
- Early intervention
- "We need to expand our thinking to include more volcom involvement"

4.c) Information and understanding

- Need to share information
- Getting the patient to understand the plan and what a care plan means e.g. family to be informed but due to confidentiality this is difficult
- Patients need to understand fully
- Services need to know about 'me' and my wishes/needs
- Make it clear to everyone what this means
- Don't make decisions for patients without them
- Need an example guide of how health and social care are beginning to work together
- "Patients need to be informed about the changing process"
- Patients will think that this is a big bang

4.d)Awareness and education

- Highlight best practice for patients – a 'How To Guide'
- Get over to people that A&E is not a substitute for GP. Public awareness needs to be raised

5. Staffing, training and development

5.a) Additional disciplines and considerations in team

- No community psychiatric nurses in the team. We need to build on and include the resources that are currently available
- Needs to include mental health teams
- Need to consider adding in the Local Care Coordinator role to help signpost patients
- End of Life Care and links to Hospice Hope were discussed. (TS: EoLC is a key area through integrated locality teams)
- It was asked which services could be localised, specifically if there is a potential for cancer treatments to be delivered locally? (AG: Macmillan has an Enhanced Supportive Care Programme which they are interested in delivering in the community; there is potential for this to be offered at a locality level partly funded through Macmillan. Some chemotherapy
- Make links to leisure/well-bring opportunities
- Fancy names i.e. federations/localities, need Dr and nurse
- District nurse linked to GPs based in different areas
- De-skilling of staff is dangerous
- People in teams who know and have experience not just on paper. Hands on knowledge.
- LCT teams get people out of hospital more quickly – discharge isn't integrated. Too focused on medical points
- "Who will coordinate the different teams?"
- We need to look at services provided through the university and make the most of them
- "The council use a case conference approach to their service users and this is critical to coordination"

5.b) GP critical to change

- GPs will be critical in changing things. If GPs are aware of options then they can confidently talk to patients
- Knowledge needs to be preserved e.g. GPs reading the screen rather than knowing the patients personally
- GPs – new system
- Include GPs that provide support services
- How much specialists have to travel – spending time and money on the road
- GP's need protecting

6. Integration and joint working

6.a) Medication delays

- There are medication delays for people waiting to be discharged from hospital which is causing short-term bed blocking

6.b) Consider mental health

- What about Mental Health – no advocacy in the community
- Mental health problems, what are we doing?
- Mental health needs to be included
- Mental health soaring – costly

6.c) CAMHS

- CAMHS service is worse than adult mental health. Over stretched service with an over complicated referral process

6.d) Providers

- Alliance not mentioned in the STP – a lot of work mentioned to hand over to them

6**.e) Social care involvement**

- Frailty – because of the nature of the condition they will have a crisis every so often and will need to go to hospital. The issue is how to get them out again. We need to look at how social care is involved
- We need social care included in the planning
- As a patient this is very confusing – social care needs to be included
- More social care at home – involve social services. If frail then need every day help
- People to work as a team e.g. GPs, social services etc.

6.f) Voluntary sector involvement

- Voluntary sector needs to be linked into it
- Signposting to charities/voluntary sector that can assist
- Need advocate for patients to be their voice when they are not able to speak for themselves
- Third sector should be on the integrated locality teams
- Voluntary sector are involved
- Introduce voluntary sector – smaller roles, more recruitment? Not ask too much
- Volunteers to be included in the locality teams – lonely meeting lonely, volunteer meet Mrs Taylor

- Students to volunteer e.g. London its happening. Elderly teach the young

6.h)Private sector involvement

- Social care is largely private – when does it become social care rather than medical@?
- Care provided by private companies, how does it fit within the model?

7. Impact

7.a) Impact on community hospitals

- What effect will this have on services currently provided out of Community Hospitals? (e.g. Trying to use Community Hospitals to have the best effect. Some existing services may have to be moved out, potentially to GP practices / health centres, to enable bigger services to be moved out of the acute setting)
- Can be provided in community hospitals; which would be better for patients and can be provided cheaper than in the acute setting)

8. Data Sharing, information (care plans) and IT

8.a) Communications and IT

- How will the communication of patient record sharing with other services be implemented?
- We need to have the right IT system across health and social care
- If we are going to have integrated services then we need to have shared records
- IT issues within the different service providers (especially health to social) is preventing further developments
- Patients should have access to online medical record/care plan
- Technology would need to improve significantly in order for patients to tell their story once
- Communication/social media highlighting how to access / who to access at integrated locality teams
- Care plans need to be accessible electronically
- Urgent care centre staff can't see all the GP's notes at the moment – need different systems
- Use the same technology and processes
- Aligning services such as 111 so that patient experience is similar to a practice or other service they can access in the community
- Pharmacy is also being integrated – people need to understand the role of the integrated community pharmacist

Other comments

- Get it right on their side
- Raising expectations – things don't act as fast as they should do
- Leicestershire is not on the list. They lead on housing
- Somebody should take responsibility – head on block
- potential barrier
- Get back to the basics
- Health professionals – to deal with an assessor
- All care services have to be meaningful

Questions

- What is the break-up of the team?
- How can we get people out of hospital?

- This sounds better for the patient but are there the resources to deliver?
- There is a big gap in provision for mental health services/support. Will integrated locality teams reduce this gap?
- Can more context be put around NCS quoted missed GP appointments, how many appointments is this out of in total? 399 – how does that relate to what we spend now?
- Could the NHS have care homes/wards attached to hospitals? This would then act as a transition stage before going home
- Will the STP deliver and save the money needed?
- Are integrated locality teams a smoke/mirrors way of phasing overhaul of NHS services?
- Is triage permanent?
- Where does funding come from?
- No interface so far with volunteers, how are they involved?
- This has been said for a long time, how will it work?
- Will it make more work for GPs?
- What about integrating the voluntary sector more?
- Can pharmacists prescribe? If not then they should be able to prescribe
- Services are already stretched. GPs don't always know what to do and need expert help
- Would it be better or worse working in this way as opposed to patients going to hospital first?
- Needs to be well managed and kept under control. How would this be done?
- Will this not be expensive to run multiple services at the same time?
- How to we address loneliness? Try to avoid patients going to their GPs for a chat
- Introduce voluntary sector – smaller roles, more recruitment? Not ask too much
- Who leads/co-ordinates the services? This needs to be clarified
- Do we have stuff to cater for all the home dealing that we anticipate/promote?
- Acute services sector. How do you provide the engagement for locality teams? This may be a
- What is the role of nurses?

Session 3, Question 1

Community and acute services

- ***How could this impact on you and your family in keeping well and supporting recovery?***

1. Access (travel) and transport

1.a) Access and Transport

- Transport issues – people cannot get to the different places
- Car parking – need to be more information about what is available and how much it is going to cost and facilities to get change if needed
- Significant issues in transporting EoLC patients in times of respite need; both through NEPTS and EMAS, at what is a traumatic time for both patients and their family
- How many people in your area actually need beds in your area? Closures are not based on robust figures

2. Accessing services

2.a) Access to beds and services when needed

- Integrated teams should have access to beds in times of emergency where a bed is needed they should have access
- When we had PCTs and teams that worked across area, they had direct access to community beds
- Access and speed
- Services available at unsociable hours i.e. Sat/Sun
- Having occupational health/physio etc. available

3. Staffing, Training and development

3.a) Equipment and staffing

- Central return point for equipment
- Require right equipment and staff at the community hospital

4. Integration and joining up services

4.a) Other CCGs

- Where do city CCGs fit into this?
- Look at CCGs individually and need before you start shutting beds

5. Reducing Beds

5.a) Concerns about reducing beds

- We are reducing beds but consultants tell me that more is needed
- Don't think it will work – NHS moving too slowly
- Understand getting them out of the acute but they need beds in the community
- What is the motivation behind it all? Struggling to understand the reason we're cutting beds
- We have to be careful how ambitious we are with this
- Very concerned about the cuts in community beds
- People feel more reassured after being discharged if they have had a community bed first
- How will a reduction in beds help the current lack of bed situation? (TS: Home First will need to be in place and working well to enable this to happen. Big challenge. Social Care Services and the Local Authority are working closely with CCGs on this)
- How will a reduction in beds help the current lack of bed situation? (TS: Home First will need to be in place and working well to enable this to happen. Big challenge. Social Care Services and the Local Authority are working closely with CCGs on this)
- Why don't we increase the number of beds and staff rather than reduce the beds?
- Concern about community beds. If you reduce in times of emergency then you haven't got the beds

Questions

- Will there be a reduction in operations at acute hospitals?

Session 3, Question 2

Community and acute services

What else would you encourage us to think about when developing our proposals for this area?

1. Good idea in principle, but things to consider

1.a) Services v buildings

- Keep the services and not be precious about a building
- Holistic and individual service even when in a community hospital
- Narrative function on PRISM
- Acute hospitals – volunteers to direct you to where you need to go
- Private medication to find own premises
- Endoscopy – not a choose and book
- "On a separate note what is happening about the heart unit – at the moment it feels like the Sword of Damocles hanging over ECMO and children's hearts

1.b) Changes and improvements

- Overnight services need to be improved
- A big change in how services are organised is required
- Concerns around people being put in a care home and the expense around that
- If you were to ask patients where they want care they would say their home. But when you get into a crisis situation you need more care

2. Money – costs, investment and funding

2.a) Funding/costs/money

- The government overall is reducing the budget to the NHS
- There are huge salaries within management which should be addressed. This money needs to be put back into frontline staff to deliver better care
- The government overall is reducing the budget to the Blockages on funding – to move the service the funding needs to go with it. This is difficult as there are no monies for that transition period.
- Where does the money come from?
- More services available in the community saves money – whole welfare community – on travel
- Bardon Aggregates have funding available for community projects. This is the kind of thing we should be looking at for funding additional transport
- Social care is based on ability to pay – for all – there is a disconnect currently which may lead to an increased cost
- This has been highlighted before but nothing has happened. If it needs doing then do it.

3. Access (travel) and transport

3.a) Access and Transport

- Urgent care centre concerns: Loughborough UCC has good x-ray facilities – open 24 hours. No ambulances go there so use it properly. Send patients to LUCC.
- Rural community – same problem in Castle Donnington – use Derby! If there is a lack of transport then a facility is needed
- 7 day access to clinicians/diagnostic and support services needed
- What would a patient think about this? You have been discharged, maybe sent to a hospital miles away from your home. You are assuming family members can drive
- Public transport to community hospitals can be a real issue
- There was a good example of voluntary transport services at Measham and Markfield. Examples like this should be highlighted and rolled out
- "Car parking is an issue at Loughborough already so if we are planning more services from there we need to think about that" The mental health unit at Loughborough is a great example of a good patient environment which we could learn from"

4. Accessing services

4.a) Improved referrals

- Referral management becomes an access crisis
- Have better quality referrals
- Referral management has to be patient centred – right care, right place, right time
- Lack of rehab for stroke
- So few people in system e.g. physios in the community
- No mental health? Where would patients be referred to? This needs to be on the list

5. Communication, awareness and education

5.a) Behavioural change and communications

- Behavioural change with consultants with better communications
- Better communication across all primary/secondary care
- Mentality of 'if I go to A&E I will get a bed' – need to make sure that people go to the right place e.g. urgent care centre
- Please continue to inform and communicate as people will panic when they hear about beds closing. Need to do a lot of engagement with the public.
- "We must articulate what we are trying to do for the average person and not in techie language that people don't understand"
- How much do hospitals speak to GPs? Perhaps not enough
- Leicester General could be a discharge unit – give team time to get the package of care right
- Requires a massive cultural change
- Because it is a public service it is difficult to change mind-sets and persuade providers in their way of working – compared to private organisations patients will do the shouting on behalf of the NHS in order to make this change

5.b)Signposting and information

- Need to look at all the signposting and information channels out there already and utilise them

- Look at everything that is available e.g. MRI at Loughborough University and make the public aware
- "We must get the PR right in the totality of what we are trying to do. At the moment all we are hearing is three to two and fewer beds"
- Improved communication and technology

5.c) Education, awareness and Self-care

- Some patients, where possible, need to take responsibility for their own health
- Patients to act as co-ordinators to then decide and take responsibility. They should have all the information given to them on the offset.
- Patients need to know what is available and what this means for them
- Media pick up wrong messages – reducing hospital sites means cutting services. This is not the case
- Messaging around community consultant led clinics
- Currently patients wouldn't be aware of the various providers and this needs to be clearly reported. PPGs need to be provided with information/comms to share with patients
- Education of patients is key
- Culture change for patients

6. Staffing, training and development

6.a) Staff and training

- Having the right staff and the right training
- Training the new wave of clinicians to have forward thinking. LD working with junior doctors
- Education and training on new way of working with GP Practices and staff
- Stability in community nursing teams is crucial
- Integrated teams to link with hospital teams to manage smooth discharge and ongoing care packages
- Health and social care – same team just different positions in that team
- Recruitment is a national issue – make GPs/nurse roles more attractive
- Golden hellos' – tie people into contracts? Train and stay in area for X amount of years

6.b) Equipment and staffing

- Premise is care closer to home doesn't mean that
- We are facing that we are having to do more with less
- Not necessarily 3 sites to 2! It's about moving treatments and equipment
- Consultants can't be in two places at once
- Move the consultant and not the patient
- Stressful environment – change makes more stress. Targets adds stress. Take targets out!
- Can't do any of this without staff

7. Integration and joining up services

7.a) Other CCGs

- Loughborough only has one remaining ward so whilst the idea is good people are currently travelling across counties"

- Services commissioned to change – commission as an integrated service rather than in small chunks which is the current system

7.b) Involvement of voluntary and support services

- Involvement of voluntary organisations. They need to be working together with the NHS to help to achieve these goals
- Support services – should these be integrated in health services? Patients need to know what is out there, what they do and when

8. Data Sharing, information (care plans) and IT

8.a) Right care plan

- Getting right care plans for patients

9. Reducing beds

9.a) Concerns about reducing beds

- People need to have the correct skills in the community
- This won't work unless we can keep people at home
- Loughborough hospital pressures when closing Lutterworth and Oakham. Care is not consistent. Expand services in Loughborough and expand elsewhere. The where part needs to be clear
- Ashby hospital closed – no plans for Ashby
- Test model before closing
- Should be able to contact a health official 24/7 if something goes wrong
- There will be benefits of health professionals working together in one place
- Anything that promises a continuing healthcare would be an advantage to what is offered now
- Lack of local GPs to treat patients. This forces patients to go to other services i.e. urgent care/A&E
- Key word seems to be integration – make it happen, social side, district nurses, home first
- Epinal way site – reducing beds. We need to question if we need more beds and not less with home first – almost convalescent beds. Maybe rest bite is needed.

9.b)End of life

- Lack of palliative care beds in Community Hospitals creates a real challenge if pain management or respite is required. EoLC patients aren't as easy to manage at home; pain, fear etc. There does not appear to be any interest in the hospice movement; would be interested in exploring involvement in more detail. (TS: Hospice Hope contact details to be passed on to LLR BCT EoLC Team).
- Positive experiences of EoLC with community nursing teams were shared, as were less positive experiences in acute care setting
- It is a real struggle for families to stop 999 services taking EoLC patients to hospital; they have to be very strong in their message to enable the patients' wishes to be honoured.
- All aspects of EoLC need to be lined up to work well. If any element falls down the default position it to take the patient to A&E
- End if life care – crisis response

9.c) Access to beds and services when needed

- Need better relationships/services from social care

- If children have one problem e.g. heart, they might have many
- Social services need to be ready to deal with people who come out of hospital – good enough community services to support patients
- Bed cuts: there should be a bed when Mrs Taylor needs it
- Infrastructure is needed – all jigsaw, needed at the same time

Questions

- Not sure how NHS 111 fits into the picture
- How is it decided which care is given where? Consideration should be given to who can be treated at home and who cannot
- What about high technology and equipment – will this be available in the community? There will need to be balance to make it economically viable
- Is all this planning based on sound detailed research? (A lot of work going on)
- Why was LRI chosen as a preferred site? It has a bad reputation – dirty and not well managed
- What about care for the elderly unit run at low cost near the acute hospital
- Are there any opportunities to improve mental health services? This is a key service! There needs to plans in place to improve the existing mental health services
- How would this new model work with the government making changes and MPs coming in and wanting to make their mark?
- Where would the heart service go? Understand that services should be grouped together
- Seems like the community hospitals proposal is a backward idea
- Is there funding available to achieve these new plans?
- Why is the list not a complete list? Where would other services go that are not listed?
- Where would the community service be for Leicester City? Leicester General would move towards this
- Challenge is social care as they are commissioned/funded differently to the NHS. How do they fit into the integrated teams?
- Should the service be funded as a whole package?
- Is this service going to see a patient for all their needs in one place at one time? One stop approach
- Patients are not receiving care plans, when is this going to happen?
- Do practices have the resources to write care plans for the patients that have been identified for one through the integrated teams? This could be manageable when patients with similarities can be grouped together
- How does this work around patient choice of where they want to be treated? Will they use up the beds?
- Need to consider transportation, how will I get there?
- Win, win if you can be treated locally why wouldn't you want to do it? However, will there be a bed available if you take beds away? This is OK if you can really take demand away? What about if you fall short?
- Beds from LGH – where will they go?
- Community hospitals, where will they come from? They are closing them
- Not enough beds, struggling to cope at the moment. How many beds closed in 2 and half years? Evidence says that more beds are needed
- Example given of anxiety for families when patient is about to be discharged – where will my mother go? What support is available? Will there be a cost?
- This will mean more reliance on the family. Are there enough care homes to make this work?

- Very fragmented – easy to say integration but how long will this take?
- Is resistance to this 'left shift' from the hospitals themselves? This new way of thinking is alien to some medical professionals and providers

Session 4, Question 1

24/7 Urgent Care

- ***How could this impact on you and your family in keeping well and supporting recovery?***

1. Good idea in principle, but things to consider

1.a) Sound good perhaps some convincing

- Proposal sounds great – improvement on what we've got
- If it keeps people away from A&E, it is the right thing to do
- If it works we would have a system that we think we should have
- General agreement that the proposals are good and no detractors from the principles
- What we have heard sounds great
- Feels like the good old days where GPs came out to see you
- Access by surgeries to paramedics – good idea

1.b) Improvement and positive

- Proposed changes should provide a big improvement, at the moment it is difficult to know who to contact
- This is one of the most positive things I've heard – shows we are going in the right direction
- Calling 111 is much better than having to go to urgent care
- This would help MS patients who get UTI's OOH's and need medication to save going to A&E
- I want the health managers to just get on with the job. We have enough confidence to know you are on our side
- If system works i.e. navigation hub. All bits of the jigsaw needs to work
- This is the start of a good system but people need to be educated
- Clinical hub must be seen as a facilitator and not as a barrier
- Cardiology at the urgent care centre is good
- Great in principle – concern about where the money is coming from. Also appears that you are investing and cutting at the same time – no spare pot
- Good idea that the clinical navigation hub can make appointments for patients, including with GPs
- It is good for patients to have a direct contact with their GP
- Agreement that service provision is good

2. Money – costs, investment and funding

2.a) Costs/funding

- Sounds like there are a lot of additional costs
- Strong concerns around no private funding and not being needed
- Average patients doesn't get who is paying from service,

3. Access (travel) and transport

3.a) Transport and location (including parking)

- What about parking at the urgent care centre?
- Concern about parking and access at the new health centre What communications have we had with other localities? High street is congested – people parking
- Wouldn't use Loughborough as more local services and would need to drive past Leicester. Not 'up the road'
- Loughborough is quite far to travel if you do not have your own transport
- Could care be transferred onto Melton Road?
- It would be better if we did not have to rely on 24 hour services outside Hinckley
- Told services would be closer to us – quoted hearing service – told we have to go to Burton
- High street audiology as an option? NHS slow to take offer up. A?? follow up to see how we move those services. Castle Medical Group?
- Assumes records will be available on System 1. 13 practices in northwest – why can't they rotate to have a t least one practice open at a weekend, is never there – if it takes a long time for patients to adjust to change in opening hours
- Ambulances coming from different countries

4. Accessing services

4.a) GP access

- Description given of mother taken to A&E and she clearly didn't need to be there. If she had been able to see her GP, she wouldn't have gone into hospital.
- Although we talk about patients not turning up for an appointment, I have had a consultant not turn up for me.
- Are these the best times, is this the key times?
- Why do doctors also teach? Does take time and take GP time away from patients
- Patients prefer their own GP than others
- Positive feedback re GPs – Castle, Meesham, can't fault it

4.b) Navigating the system

- "There is a lot of potential for patient confusion because people don't understand where they should go with different conditions"

4.c) Availability of services and Appointments

- "Much better than the old WIC in Hinckley which closed down through lack of use"
- EMAS told me that GLH was closing and that's why my husband couldn't go there
- Urgent care centres – bookable
- It is very difficult when late in the evening you are referred to an A&E that then cannot help the patient as they do not offer certain services
- Long waits for ambulance, not only 999 but also patient transport

5. Communication, awareness and education

5.a) Education and awareness

- Patients need to take responsibility for choosing the right option
- If you have a bad cut on your hand, you need to know what service to access.
- Concern that people are frightened of being sued if they don't got to A&E.

- Must publicise the at Coalville is NOT a walk-in – by appointment only
- Educate the community so they understand and know what to do when – maybe the elders more than the youngers?
- Reassurance needed re care homes. More clinicians at 111 will aid this
- Hard view of a patients using services inappropriately eg DNAs, drinks in A&E
- 2 areas of clinical activity – fractures or emergencies. Also has been a lot about critical incidents, Bridging gap between general care and intensive care. Haven't had to go into hospital. Chronic I can manage – care home is another level of care

5.b) Communications and messages

- Better info on website re appointments
- Example given of it taking 3 – 6 weeks for a letter to get from the acute hospital to a GP. Need to be more joined up in the NHS.
- Communication of results if patient referred onto urgent care at a different facility
- Communication with alliance needs to improve

6. Integration and joining up services

6.a) Mental Health

- What happens when mental health person rings 111? They will go through to mental health team
- Mental health nurse going out with paramedics? Is that true
- Is there a place to divert ambulances with mental health patients instead of A&E?

6.b) joint up services

- Much more joined up service

7. Impact

7.a) Loneliness and isolation

- If you are alone even with alarm you are on your own
- More and more people are living alone

8. Data Sharing, information (care plans) and IT

8.a) Care plans

- Group talked about the importance of end of life plans in an urgent care situation.
- Mrs Taylor shouldn't even have to call NHS 111 if she had a care plan in place.
- Care plans may help

8.b) Sharing data and IT

- Concerns about sharing records. Are systems secure.

9. Reducing Beds

9.a) Beds

- Concern about the potential lack of beds in the acute and proposal to close beds in the community

- 85% bed occupancy is how it works best
- How beds does Coalville have – what is the catchment areas
- Did they reduce beds in Coalville a few years ago. Yes agree they know their own kitchen. If they go home to be assessed and lose bed what can they do
- Has a cost analysis been done on reduction of beds v supporting people at home
- Acute/urgent requirement. If we are living longer more of us will need that urgent care ad you are reducing beds – If I need care for a week in hospital I can't have it if you reduce beds

10. NHS 111

10.a) NHS 111

- At what point do we advise patients to call 111 instead of 999?
- 111 patient waiting long time to answer and for someone to call back
- Demonstrating what NHS 111 is
- Poor perception of the current 111 service; more work needed to build trust
- Confidence in NHS 111 – what it will do and the changes
- NHS111 does not work now so how can this work?
- Public confidence in 111 service
- NHS 111 has a bad reputation. How is it going to be improved
- Growing mistrust of NHS 111 system
- Question – is 111 service going to be better? Does it need rebadging?
- Feel of changes – concerns on 111 – was useless – GPs said to ignore 111 due to the symptoms not being detected properly
- 111 does not have access to records so not effective (care plans will allow access)
- More confident going to A&E than NHS 111
- 111 handlers need training around how they listen and make decisions on where the patient goes/how they are triaged. It is hard to judge a patient's condition over the phone re how they are really feeling
- If a patient wants to speak to a clinician when ringing 111, can they?
- Between call to call handler you are asked questions. Referral – do you get a call back? Current service of call back causes more stress
- You hear scare stories of not being able to get through to the right people
- In the south part of Charnwood, NHS 111 direct you to LRI urgent care centre rather than Loughborough
- No mental health drop in centre – having to turn people away when they call
- I have had a good experience with 111 despite all the negative feedback you hear
- Call handler – triggers – doctor/nurse/pharmacist
- Mrs Taylor is home bound – how would she get medicine after being told to by 111?
- Not impressed with NHS 111
- Call handler has the pressure of trying to avoid A&E but then they direct patient there anyway which is not always needed
- Sometimes questions are hard to answer when unwell/dementia
- Questions need to be right when calling 111
- Confidence to make decisions
- Medical records can be found through NHS 111 and care navigation hubs
- 111 service – the person taking the call needs expert knowledge which is not what people have experienced. They need the training/clinical knowledge to direct the call more appropriately. What is the threshold before they direct to a clinician?
- People want to go through to a person

- Clarification on transfer times when talking to 111 (e.g. if non-urgent will it be 6 hours for a call back?)
- Referrals to a GP via 111 – is it practical to expect this given how busy GPs are?

11. Urgent Care

11.a) General comments regarding new models of urgent care

- What if you haven't got transport
- Why is OOO not open till 10pm like in Hinckley?
- How do they decide it is 111 or 999
- Difference between urgent/emergency?
- Felt disappointed that urgent care resource at Coalville on Saturday was a silly time to test it. What about Sunday for sports injuries,
- No GP service who work away all week. They need weekends. It is difficult when you work away.
- NEED TO KNOW WHY COALVILLE CANT BE A WALK IN SERVICE
- Why do patients going to Coalville hub have to make appointments and not if they go to Swad or Loughborough. Not an equal/fair service.
- It is wrong to push people to have assessment.
- How long will each patients be looked at before they go home
- Swadlincote surgery has said to Leicestershire patients your not Derbyshire patient – what are you doing here
- Support for hub at Coalville – need to make more patients aware + ?? to frail and elderly
- Coalville hospital from Ashby – 2 buses, car parking issue during the week
- Members of the group not clear re Swadlincote WIC – when open, can we use
- How do I make sure I speak to a GP
- There is a triage process – the ex
- Clinical navigaton team – hib telephone base will follow a process to determine an outcome that is best for the patient
- As it is based on the computer programmes may not be effective enough
- Out of hours – no self-referral only through 111 – is this satisfactory? Response: based on what is happening in county seems right path at this times
- Specialist services – out of hours – have access to a directory of services to recommend patients where to go
- End of life patients will have a back door to the services quicker
- Default position is go to A&E which might not be useful as it shows the safest option but my be alternatives not being used
- Coalville – how we will stop people just walking in

Other Comments

- Grown up service (AVS)
- Need to know timescales
- How dependent on hospital?
- District nurse/husband ex-GP – called – was told to go to A&E. he felt she was blocking up A&E?? Query – asking about 1 person as main point of contact.
- Good experience daughter –in-law pregnancy assessment referred to Kettering as they couldn't take her when she was due
- Hinterland – things not geling
- If there is all the wonderful care in home why are people in hospital

- Patients are not told about the official waste – they feel guilt asking for more care – but there is waste.
- View – A&E 4 hour target appropriate?
- p is lack of confidence = needs to look at
- Don't use that film (American style jingle) – it is for 5 year olds, annoying noise.
- Unsure why urgent care centres are called this when they do not all offer the same treatment
- There seem to be too many students using the UCC for sports injuries when they have their own medical centre which should be able to treat them and this takes up treatment time
- Currently testing – want to get it right
- Based on learning rather than thinking

Questions

- Is the clinical navigation hub staffed by clinicians?
- Will they be able to see patient records?
- UTI issue – is that what home visiting service is?
- Will the urgent care centre turn away patients who shouldn't be there? Some people come in with diarrhoea & vomiting or a cold which is irresponsible as they can deal with it themselves
- In Loughborough that is fine – what about Market Harborough or Melton Mowbray?
- Who is in A&E?
- Why NHS 111?
- What happens to drunk people?
- Do urgent care centres have capacity to treat properly e.g. enough doctors? Not sure capacity is there.
- Will doctors still do visiting out of hours?
- If it is the middle of the night and I am asked to go to a walk in centre, all family and neighbours are asleep. Do I call a taxi?
- Where are the 24 hour pharmacies?
- If transferred to pharmacist, how will you be able to over the counter medicine if out of hours?

Session 4, Question 2

24/7 Urgent Care

- ***What else would you encourage us to think about when developing our proposals for this area***

1. Good idea in principle, but things to consider

1.a) Carers

- Take carers into account

1.b) Childrens services

- No mention about childcare unit 3 years plus. Local service for children?

1.c) Pharmacy

- Pharmacy not mentioned

1.d) Ambulance

- No mention of ambulance service

2. Money – costs, investment and funding

2.a) Costs, Funding and resources

- Need resources to make this work
- Money into social care first
- Whatever efficiency savings can be made through these plans cannot cover up the need for proper funding
- Let's hope that there will be enough GPs
- CCG access to 106 monies
- What do you do if you have no funding for your social care? Need response
- Cuts don't need to be made if we have other choices
- National funding
- Are we looking at all sources of funding?
- We must get a system where people not living and working in the UK have to pay for treatment
- We are expecting 21st century medicine on 19th century funding. We all need to pay more into our NHS.
- Practice buildings are small, can we fund expansions?
- Health service being used by people who have not contributed
- Social care is underfunded. Personal budgets are not always spent wisely. Education needed around this
  Hospital funding should go back to the people

3. Access and Transport

3.a) Access and transport

- Parking at the health centre are a problem – there isn't enough
- Make sure that UCC can respond accordingly e.g. diagnostics. Make sure that we are sent to the right places who can respond in full
- How about access to other services beyond traditional UC?
- Don't want to be in Hinckley hospital, want to be at home but cross border issues mean we can't get there.

3.b) cross border issues

- Postcode issues (Derby postcode, Leics address)

4. Accessing services

4.a) Accessing services

- Still need something that people can access directly such as a Walk-in Centre
- Clear pathways for x-rays if fractures found etc

- Needs to be more clinical input – triage
- Clear pathway for bloods when taken and storing of bloods
- Making sure about backing staff not wasted when x-ray
- Make observation beds available
- Local hub solutions are West specific; 111 etc is LLR wide

4.b) Care in the community/ Home visiting services

- Acute visiting service – adviser goes before GP's acute intervention
- Move away from acute hospitals towards the community
- Visiting communication to visit patient
- Capacity HV – visiting at next morning
- Has any thought been put into this on the carers looking after family members? How will this impact them?
- Having visits planned and thought through but need to be relevant
- Are you bringing secondary care into the community?
- An explanation of the Urgent Primary Care Service at Coalville Community Hospital was provided; it was felt this was a good, innovative idea. Having a contact number provides reassurance and confidence for patients to remain in their own home over the weekend
- Home first. Need more investment in AHPs. Dietetics have a 10 week wait for dom patients and then a telephone call. Few patients have a visit

5. Communication, awareness and education

5.a) Communications and messages

- Getting message right re when to call 111 and when to call 999
- Communication about NHS 111 from CCG to GPs and patients
- Need to have a really good communication strategy – need to utilise all the existing communication channels
- Need to emphasise the new NHS 111 service and what it actually does
- Slow down the video, put it on GP surgery TVs
- Video on UCC TVs
- People will be very weary of this. They need to understand that they will be speaking to a clinician
- 'Crisis' – term not understood by public. Who is it?
- Diagrams don't make it clear
- Communication re 111/OOH through e.g. Parish council e.g. re access to UCC booked appointments
- Don't rely on PPGs as information cascade
- Flowchart of services and what might happen on websites/social media
- Political support? Local MPs
- George Eliot hospital is continuing emergency services for people in Hinckley. Nuneaton and Loughborough are walk in centres. How can we direct people to the right place?
- Good promotion of 111 (previous bad rep)
- Specialisms needed at care homes – education needed, publicised better, communicate (constant/accessible), supporting technology
- How does the consultation that the CCG is planning tie into urgent care?
- Getting the correct advice on the off-set
- When does the 24/7 service begin?

- There was a rumour that Hollycroft MC was closing down. This was quelled on the night as we had the business manager from Hollycroft on our table but this may be something that needs to be communicated – Hollycroft is not closing, it is in fact extending
- GP practices need to tell patients about other services
- There needs to be much more patient education about services, eg, what is difference between a WIC, an MIU, a UCC and A&E
- Social media education – what to use what
- Use of social media
- How do we improve the option of 'to be on the safe side, go to A&E?'
- How does the STP plan propose to educate people to self-care? Informing the public is a massive marketing job for the CCG to do
- Need a constant communications campaign – use of apps to inform people of choices available
- UC Vanguard site (LLR is). Urgent care definition is different to everyone. What is urgent care? Get the message across. There needs to be a punchy message and it needs repeating. What is A&E for?
- Deliver message – who? Not just NHS. Advertise on buses/train/media if funding is available. Use other agencies to get message across. Get message to youngsters (at school, 6th form) – media is quick and easy.
- Re-educate by advertising 999 – fire/police/ambulance, put your health first and ring 111
- Need broad education to direct people appropriately – target young people to use GPs
- Education and communication to patients/public – change individuals mentality and provide patient with confidence and assurance that the 111 service will listen and help them
- Use patient experiences to communicate out good experiences
- What about the deaf and blind?
- Retelling triage and A&E. Urgent care same info e.g. blood tests
- Use children to teach parents the best use of the health service. Things for them to take home. Simple – education with all the info.
- Use the 'Charlie said' concept for social media
- Education in schools
- Get info into the Loughborough Echo
- CCG documents printed and available in surgeries
- Real ease for publicising

5.b) Education, awareness and managing expectations

- More awareness
- GPs to promote alternative options such as urgent care and 111 on their answerphones/websites
- Information needs to be in GP surgery
- Publicity needed to promote NHS 111 if improved. Navigation is LLR (local). Best way to do is every way possible
- Better signposting needed
- Can the urgent care video be dubbed to meet other minority ethnic groups to help them understand the service otherwise you can't target them to change their mind-set
- Can't rely on the video, stories from patients with good experiences from the service
- Confidence building, patients/public having a clear understanding of what is available
- Patient leaders need to reflect the local population with language skills
- People don't understand
- Language barriers – translate
- Manage public expectation, need to work better here

- What are the expectations of what the NHS can provide?
- Behaviour change of health professionals dealing with patients
- Media can also be blamed by our approach to healthy lifestyle
- Ambulances need/have intelligence for decision making
- If education is on the forefront then we may not need any of the suggestions
- We need to think about pressure on our ambulance service, a facility in Hinckley may relieve such pressure
- How many patients know about it – they need to
- Need the public to buy into it
- Whatever you do, you will have to give people confidence

5.c) Healthy lifestyles/ prevention

- Kids are eating unhealthy at school
- Food industry works with government and education
- Screening for prostate and stool screening has to be looked at. Screening has implications as can avoid surgery
- Really key diagnostics e.g. radiology, could be extended beyond 5pm. Applicable to all urgent care centres. Soft tissue injuries

6. Staffing, training and development

6.a) GPs and other staff and training

- GP OOH services – need an observation area. Couple of GP 'out of hour' beds to avoid admission
- Lot more resources needed – particularly staff
- When are you going to find district nurses?
- Enough GP/healthcare professionals and keeping them
- London practices employ nurses/pharmacists etc rather than lots of GPs
- Safety of clinical staff during those hours. Right person 'security'
- Clinical trained staff – passed through to right person
- All 111 call handlers should be clinically trained so they have a greater understanding of health conditions as opposed to reading off a script
- Other issues may need to be address to understand why more GPs are needed
- How will the NHS fund additional GPs to take the calls from 111? They also have their own lives etc.
- Consider the hours that GPs are prepared to work. Have an alternative to the GP & A&E
- Some GPs still close half days. Need 08.00-18.30 service

6.b) Staffing and resources

- In hospitals, all specialists look at the patient
- More nurses needed – patient safety is needed first
- Problems: increase of mobility in hospital and safety of the patient in the community. In the process of change there needs to be an overlap. Solution offered – need more nurses and money
- No process would change fully until it solves the situation. Need more social care
- Elderly care. Do we have capacity for patients with dementia and suitability of travel staff?
- Non healthcare – healthcare professional
- Clear pathway for bloods when taken and storing of bloods
- Primary care is too GP heavy

- Out of hours – who would run it?
- Consider opportunities for AHPs to take on new roles in federations – not all doctors and nurses
- Need to show capacity for model to work. Need responsive, accessible, sustainable services in primary care for model to work
- Speedy discharge i.e. 6-00am decided OK but cannot happen until specialist comes – 6pm
- Restore school nurses and health visitors
- Heath centre building fit for purpose
- Please consider including Allied health professionals as part of the clinical navigation hub e.g. could assess patients' needs

7. Integration and joining up services

7.a) Mental health

- Have mental health crisis services been linked in? Use of quieter areas to assess mental health patients. Mental health patients will then be able to walk home. Local support available
- No acute mental health care mentioned

7.b) Inappropriate use of A&E

- People who attend inappropriately need to be given direct and hard messages for next time
- Should we penalise people who attend A&E because of something they have done to themselves, e.g., drunks
- Understand from the news that A&E is crumbling
- A&E is the default position – then they send you to urgent care and GPs
- Safety net from the care service
- 4 hours (A&E) service is the wrong target. It sends the wrong message to the patient.
- What is the difference between urgent care and walk in? It is confusing (labelling of different urgent care centres)
- Frequent attendees need flagging up
- Need x-ray service in Loughborough 24 hours a day. This will prevent people having to go to the urgent care centre in the evening and then the LRI the next day

7.c) Pharmacy issues

- GP prescriptions are just given (over-prescribing)
- GPs can let patients down e.g. over use of prescriptions as they don't say no to patients
- Dehydrated, antibiotics

7.d) Joining up of services/working with other services

- How can paramedics be part of GP services? Will you take these from ambulance services or recruit your own? Need to consider work pool
- Who will host services? Pressure on 'estates' to offer clinics existing now
- Is the clinical advice hub 24/7 service care navigation to a waiting list? Will lead to triage system
- Alcohol services and substance/drug services need to be included
- Need to work with the LA around new housing developments and any community funding that is available

8. Data Sharing, information (care plans) and IT

8.a) IT and Access to patient records

- GP navigators need access to full patient records. They only have access to patient notes at the moment
- Ensure medical records are easily accessible
- IT issues! Too many processes and not enough doing
- Information systems are key – can Nuneaton, Coventry & Warwick see imaging?
- Have Dr surgeries notes from Swedish system

9. Reducing beds

9.a)reducing beds

- Population is growing, can we get rid of beds

9.b) End of life

- Crisis management in EoLC should be included. As should mental health crisis teams, with links to adult social care crisis teams
- Ageing population problem. Evidence is needed

10. NHS 111

10.a) NHS 111

- Systems – GP – urgent care centres – 111 – social care. Issues with hacking will need to be addressed
- NHS 111 received bad press – they are not a medical person. Ensure questions asked are relevant and go to the rightly trained people
- The timescales for NHS 111 ringing back need to be part of the structure
- Have 111 live information on where a pharmacy is open
- Call handlers need to be knowledgeable in each area – will the general public be in on the interviews, just the right tone of voice – callers are stressed
- Good communication between 111 and GP and good training for 111 call handler
- 111 is not a good service. NHS Direct was very good. 111 could be replaced by an online survey as this is what a call handler does in effect
- There is a problem with people using 111 to try and jump the queue. This needs to be looked at
- Urgent appointments need to be offered case by case and not by who calls first
- Knowing when to call 111 needs communicating
- Are they area specific? How does 111 work with mobiles?
- 111 name has been tarnished in the media – do we need to rename the service?
- Call handlers have confidence and knowledge to deal with those difficult patients/ address language barriers/mental health patients
- “Lots of work to do on NHS 111 reputation due to bad press”
- “Can NHS 111 handle things such as panic attacks without someone being sent to A&E?”
- “We need to be firmer at the frontline when people come with the wrong thing”
- Need to ensure the smooth transfer of patients so that they do not get caught in the NHS111 system when what they need is an urgent care appointment
- Keep it simple – straight into a good 111 service

Other comments

- Go back to old ways – turn up and wait – will test how ill you are
- Speakers need to talk into the microphone
- Reduce duplication
- Hinckley UCC please
- Transition period will need to be managed
- Should take questions from the floor from the public

Questions

- Will people who are equally sick have to look after each other?
- Mental health crisis – how will it work?
- Will there always be a GP at the urgent care centre?
- Who will do the home visits?
- Can the well qualified, highly skilled nurse practitioners also be part of the urgent care?
- Why is the Loughborough urgent care centre is more successful than other care centres?
- Introduce 'Deliveroo' for out of hours medication?
- Regularly updated care navigation hubs – how many staff members would you need?
- Will plans be equality impact assessed?
- How about being able to contact a GP online for non-life threatening problems?
- What will the impact of potential closure of cardiac services at Glenfield have?
- Proportions of people using A&E, where do they come from?
- Is there a time frame?
- What are the quick wins? Act on these first and then celebrate
- Who leads a diabetes federation? We would be keen to run diet and diabetes groups locally. Please contact Alison.Scott@lnds.nhs.uk
- Integrated team – 24/7?
- Do we know how many patients currently in Sunnyside could be safely treated at home?
- Is there a plan to recruit and train more staff to care for people at home?
- Lots seem to be moving – HHC – is there enough room?
- What's happening? Where to now? More next session

Community services

- ***How could this impact on you and your family in keeping well and supporting recovery?***

1. Good idea in principle, but things to consider

1.a) Increase in population

- Population growth (housing and employment) – 9000 to 2036
- Better for the environment
- Outside area services – some people go outside area for services
- New housing increasing population

2. Money – costs, investment and funding

2.a) Funding

- NHSE recognise Leicestershire has been underfunded. If capital bid is not successful, then looking at other funds. Looking to LA. What they can help to invest in. Lower rent from private provider. Centralised hub
- What happens if NHS England says we can't have the funds?
- If the CCG doesn't get the funding approved, what is plan B?
- The planned closure takes time. Have to have a 3 month public consultation. Need to secure funds first
- Are we sure money from closure of beds go into the community
- More people seen at home – to save money? What is the evidence. What do we do when it is not safe to have care in the home?
- What do we do when there's not the staffing, less money, less people – dementia is growing
- Has anything been done to challenge it is not enough money?
- Scissors of doom how will this help to close the gap
- How will it work – NHS is national funding. Council is all about local

3. Access (travel) and transport

3.a)Access and Transport

- Sunnyside is at the end of town – transport
- Need a bus that goes to Sunnyside car park – especially unsafe crossing road to go back into town (hospital hopper?)
- How do you feel? Depends on circumstances e.g. transport issues. It seems that the move is not far and will mean that people don't have to go to Leicester which is better.
- Patients that are being looked at are very unlikely to be getting public transport

4. Accessing services

4.a) Access to beds and services when needed

- There are a lot of people living on their own. There aren't quite capable of going to their own home from hospital, but don't need a community hospital. There should be something between a community hospital and someone's own home.
- Why cutting beds – are you cutting the right number?
- 92 year old mother – GP or nurse currently speak to – who will I speak to in the new world?
- Long waits already – how do others get to see a specialist
- Will some of the teams going out to the private sector
- My daughter is deaf - the audiology is run by a private sector organisation

5. Communication, awareness and education

5.a) Education

- Need more education
- Education for consultants in A&E to admit elderly patients

6. Staffing, training and development

6.a)Equipment and staffing

- Concern – need to fund services for people to stay at home. Need more staff
- Very big ask, getting teams together
- Concern knowing staffing levels – not enough GPs – cant recruit enough – where are these staff coming from
- Long waits already – how do others get to see a specialist

6.b)GPs

- GP must know that patient has been in hospital – currently wait on discharge letters
- Not enough GPs for ordinary appointments. How are GPs going to offer specialist services?
- Can GPs really be kept local?

7. Impact

7.a) Carer support

- Lack of carer support
- We have a care plan for my Mum - if mum has a water infection then the plans tells the paramedic who her doctor is. It works well

7.b) Family and community support

- Concerned about patient representation – our PPG is full and cant join – not representative
- Putting all effort into the most frail – what about everyone else
- More burden on community
- Not everyone has got a family members to support them. How would that person be supported?
- Elderly person who can't use the phone – they don't perhaps know that they are going down hill
- I am a diabetic on my own and I feel I am
- At home you need someone to see you that you know.

8. Reducing beds

8.a) Concerns about reducing beds

- Concerned about the reduction if we can't get patients out of acute. What will cure the issue at LRI?
- We have got to look at this from the outside in. The media are saying we are short of beds.
- How safe is it to reduce community hospital beds?
- No available beds making it worse to access beds
- Concern about reduced beds
- Positive phased approach is important to test the model at home first before release beds
- What about patients who are not sick enough for the acute bed but too ill to go home and there is a reduction in community beds?
- Also community hospitals do have discharge difficulties.
- Not convinced that there will be less need for community beds
- Is there any evidence that we do not need as many beds in Hinckley?

- Need to ensure that the number of community and hospital beds are enough for the expanding population

9. Mount Road and Sunnyside comments

9.a) Mount Road and Sunnyside comments

- Concerns around what will happen to the building (Mount Road).
- Nurses on table explained how the hospital works and concerned that she wouldn't have the back-up of the OOH doctor at the hospital and would be in a position where the paramedic would have to be called to the hospital.
- Who would get the money from Mount Road if it is sold?
- Mount Road – can't do bowel screening as doesn't meet spec
- No point spending on old buildings if not sustainable
- Moving services to Sunnyside is good!
- Have you considered putting planning forward for the extra wing? It was a 3 winged hospital originally
- Expansion of OOH needed – more than 1 GP
- Will still keep things local
- Make sure not everything is in the centre of Hinckley
- Excellent idea – very exciting!
- Why does Mount Road still exist? Public health?
- Purpose build hospitals would be better for people of Hinckley even if built onto the side of sunny side
- Don't need endoscopy suite in H&B as new one at George Eliot – alliance offer to patients other sites. Patients prefer to wait to be seen in H&B
- Access to Sunnyside ambulance – rarely go to
- Local services near to home
- End of life care beds being available – supportive of the refurb and increase of rooms
- Need an interface between community hospital and home. This would be based on level of risk.
- Not pleasant experience for people to go to hospital – no dignity
- Use of other ward for day case will allow terrific turnover
- Need more staff in community to support new model
- Get local MPs involved in the plans on Mount Road? Not clean or fit for purpose
- The space worries me as it is very small. Hinckley needs a place for children's physiotherapy/ school nurses/ learning disabilities
- Staff – have clinics. Need to get in and out. Access for staff is very important as it impacts on appointments
- Consider other premises to deliver health services from
- "The plans for the refurb and better use of the health centre are brilliant"
- "I went in to Mount Road for a procedure the other week and we have to accept that it is very antiquated"
- If community hospitals are closing, what happens to staff if they do not want to work in the community?
- It is important that the new community services are available before the old facility is closed
- Timing key for facilities working together (OOH & x-ray) available at the same time
- Close doesn't mean 'stop' – just move

Other comments

- OOH GP/EMAs pick up frail elderly without clinical assessment
- Service in the meantime is impacted and get less and less. Services get worse
- Crisis in health recruitment
- More bureaucracy
- Will the systems deliver what is required ie linking different locations
- Health cynicism,
- Concept is fantastic
- When does the five years kick in
- How does it all start
- No representatives for children social care
- Map that shows location of specialist services
- Need consistency of services

Questions

- Is mental health staying at Glenfield?
- George Eliot brand new endoscopy – why duplicate in Hinckley
- Thurnby Lodge half way house – one size does not fit all
- Children mental health services threshold and out of are placements
- Community hospital proposed services – need to talk to the staff who work in the Hinckley facilities – bottom up works well – staff working in the departments should be asked what they think
- How will the 11 service (clinical navigation hub) deal with patients with special conditions/ medical history to access care promptly?
- Will social support be provided overnight in the community home forts model? Patients seem to end up in A&E due to lack of social support overnight
- How are you going to get all the services in the Health Centre at HDH?

Session 3, Question 2

1. ***What else would you encourage us to think about when developing our proposals for this area***

1. Good idea in principle, but things to consider

1.a) Additional things to consider including at hospital/health centre

- Expand OOH capabilities
- Health and safety of patients and staff need to be considered
- Children's therapy – what are the plans? Need a floor space which is large for physiotherapy. Can we see a floor plan?
- Low priority tests e.g. heart scan
- Proper treatment in rehab ward so patients are not bouncing back to emergency care
- Need to ensure that services are not stopped until all services are moved and fully running at the new site to ensure that service is still available
- The transition will be difficult, how will this be managed?
- Is there an option for the two wards to stay and for an extension to the existing building?

- Has the health centre been evaluated fully to understand how much space they have that can be better used?
- How will existing services that are managed at the Hinckley HC deliver the same care to patients if moved?
- What happens to the donations made when the hospital was first set up?
- The more facilities available in Hinckley, the better for the patients
- Need to ensure that services are not stopped until all services are moved and fully running at the new site to ensure that service is still available
- Where are people going to park at Hinckley Health Centre? The parking is bad at the moment so moving more services there will make it even worse
- The community hospital plan needs to take into account the increasing population in H&B
- There was a concern that the plans would lead to a single sex ward at H&B hospital. Need to be more clear about the message and the facilities
- Would have been happier with the further development of Sunnyside rather than continuing to try and provide services from the centre of Hinckley
- Would like to have a Walk-in Centre
- Are you considering x-ray and Ultrasound out of hours? This would help divert people from A&E
- As our population is growing so rapidly what are the timescales for introducing all these changes and what is the resilience plan"
- How can you measure enough capacity in community services to choose beds in hospitals (right disciplines)

1.b) Services V Building

- Better if urgent care was delivered in a walk in centre
- Move GP OOH to Sunnyside
- If it was sold this could bring more money into NHS
- Mount hospital unsafe option
- If Mount Road is decommissioned, can a community use the building instead? E.g. could the old building be used / re-commissioned for an alternative community use? Could it be used for an urgent care support for mental health?
- "Will the two end of life suites stay at Sunnyside?"
- What will happen to the site/building if it is no longer used?
- History of the building – need to look at safety. It is not fit for purpose.

2. Money – costs, investment and funding

2.a) Funding

- How will the £7.7 million be broken down between sites?
- Will it really only cost 7 million?
- How does the overall budget affect wider West Leicestershire?
- How much money will be needed for the preferred options discussed? When will the public have sight of this?
- Make sure that the section 106 monies are secured before they run out in June"
- Limited money will be spent wisely

Hospital funding will we get the money

- Does the funding for Hinckley rely on the STP

3. Access (travel) and transport

3.a) Parking

- Where are people going to park at Hinckley Health Centre? The parking is bad at the moment so moving more services there will make it even worse
- "Both the health centre and Sunnyside will need more car parking so we need to think about that"
- Can we use the old hospital space into a car parking site? What is happening to the old building?

3.b) Public transport

- Need to take public transport into consideration when looking at H&B hospital. This has been a problem in the past and could adversely affect people with mobility issues

4. Accessing services

4.a) Availability of services

- Direct access to pharmacy on site
- Phlebotomy access instance results (quick wins)
- Could minor injuries be included?

5. Communication, awareness and education

5.a) Communications

- Need to go out to consultation as public only hearing services will go – radiology/endoscopy/theatres. Need to clearly see what is being given
- More transparency with the public – potentially attract more funding from local businesses / local people
- What is staying/what is going
- Only get a couple of paragraphs in newspapers e.g. Hinckley Times – Chinese whispers
- Rumours George Eliot A&E is closing down
- Want clear messages
- Advertise engagement events in local newspapers, supermarkets, Sainsbury's, coffee shop in Atkins building, Wykin Community Centre and club, heart of the community
- Communication when services change so people know how to access services e.g. OOH
- When is the consultation?
- Understanding the practicals around to refurb
- Clearer understanding of what rehab beds are for at Sunnyside
- Moving services not closing them
- What about day care? Need to know what's included
- Please answer the questions we are asking
- Nursing staff are concerned about capacity and need reassurance. They need their questions answered

6. Staffing, training and development

6.a) Staffing

- GP recruitment? What is attractive about it now?
- Will there be consistency of staff to build relationships with patients in the community. Patients with mental health seeing the same people
- Right support service (e.g. admin)
- Specialism in the community is an opportunity for professional development – will need access to training
- Personnel and staffing – concern
- Please look at staff retention

7. Integration and joining up services

7.a) Mental Health

- Mental health services – are there any plans to develop more for the people of Hinckley?
- Mental health services at Hinckley Lodge on Tudor Road, do we assume this will stay as it has not been mentioned? It could be a useful resource

7.b)Voluntary and community sector

- What is the role of the voluntary sector in this?
- Voluntary organisations to support e.g. transport

7.c) Joining up of services and access

- EMAS are involved in care line talks
- Is Leicester City involved in this?
- What is the role of a private NHS provider – is this a possibility?
- Nuneaton new endoscopy unit – what is the capacity? Endoscopy/day care needs to be co-located
- How will we get specialist support from UHL into integrated teams?
- If people can access care in the community e.g. see their consultant – this will be the amount of people at UHL we have now
- Social care needs to integrate with NHS - responsible?
- one size fits all' – doesn't work (rural/urban) different needs
- Disparity in Hinckley - social demographic/education/poverty/mental health/housing – treating people at home is not possible there

8. Data Sharing, information (care plans) and IT

8.a)Communications and IT

- Right technology and sharable
- Better links between GP and pharmacy when advice given
- Electronic transfer for pharmacy to GP
- Better communication – talk to each other
- Understanding important of sharing – look at cost; staff; training – not being afraid, benefit of patients
- IT systems/access to plans – problem

- Getting people to that system

Other comments

- Focus on using all facilities
- Right balance between home first/beds available
- Need to take in to consideration EoL at home and the pressures this puts on carers at home
- " "We are hearing mixed messages about Centre Surgery – is it closing or not….?
- Should be a longer term plan rather than just a 5 year solution
- Patient confidence over next five years
- Support to live healthier – how this happen

Actions

- Have council to speak at event
- Who are they responsible to
- Target date and implementation – things are already happening
- Risk stratification tool – identify population who are not at work
- Recruitment? How - workforce on plans - other health staff input
- Acute hospital – GPs need care system Time? Mental health equality

Questions asked on night in Q&A at Ashby event

- 1) info on costs?
- 2) staff resources
- 3) wealth of evidence if the system works
- 4) what provision are you going to provide the system and consequences 3.99 million
- How can this plan work if the government doesn't come up with the money
- 6) what % of beds are disappearing will we need community hospitals as convalescent hospitals
- LPT to provide systems across boards – explain proposal?
- 7) Time delay – waiting list of elective care
- Are there plans to replace the carers health and wellbeing service provided by VASL carers are central part of the NHS Plan - Alan Plumpton
- Who is actually going to deliver these plans – sounds good on paper
- Who is doing it at GP level?
- It is not going to be easy
- It is about educating people as well- knowing who can see then, could be a nurse
- Perception is difficult, people have received care in one way for 40 years – hard to change minds
- You see numerous different people for different things – no –one looks at the whole picture
- Clinicians don't always read notes or can't always access then
- Not always about transferring notes – about different systems
- It is about patient education and knowing what to do
- Wasn't aware if the extent of 111 service; Still dial 999 for emergencies; should be on all GP screens; Posters in pharmacies; PPGs supporting; Fixed strapline of prescriptions for 111
- Primary care hub sounds interesting
- Outreach to families
- Transport is difficult
- Can only manage people at home up to a certain point – falls are a nightmare
- Are people coming out of hospital who can't cope?

- Difficult to get place in nursing home – it's not easy
- Sometimes you need to deliver care – support for carers is vital
- Cost of care is enormous wherever you are
- Support for carers needs to be discussed
- Paperwork is very difficult
- Carers are not young themselves
- Where do carers fit into the STP and what support is available
- Lack of ring fencing monies for STP is paying off old debt and not being used for STP
- STP for LLR needs £320 capital monies – if not forthcoming what is plan B?
- No detail about finance and workforces and capacity planning – befre we go to consultation needs detail regarding current baseline and future plans
- What about 111 service to improve initial triage before clinical navigaton hub?
- Concerns regarding creeping privatisation in primary care – can they meet the public sector requirements
- Why don't you tell politicians that we want to see changes driven by evidence not wishful thinking
- We would like to see the whole plan through consultation rather than statutory parts of the plan

Ashby Civic Society

We support the NHS and Your Aims

Question

Will you process with your STP proposals including the removal of hospital infrastructure without the certainty of being given the funds necessary to make it work, including double running to provide it is providing as good or better care than at present? Also will you provide us with a response to the concerns raised by the national Audit Office, the British Medical Association and De Montford University?

Educate patients – so many good schemes out there – exercise on referral – we don't know about them

Don't blame old people – it is put across very simplistically

Diabetes is going to be a major issue, there is a lot you can do to reduce your sugar

We are not all the same

Questions

Will you come back in 12 months' time to update us

How are we going to recruit community teams when recruitment is so difficult

How important are the federations/ GPs working together

How are you going to implement this – wonderful ideas- who is going to do things – where is the money coming from

Pay people a decent wage

Free at the point of delivery – we have doubts about this – watch assurances can be given this will ?? locally - audiology

Community hospital

- Tried to access rehabilitation bed at Coalville ended up at market Harborough – ended up in Kettering ???? NHS paid for taxis to take to Harborough
- How decide 'clinically safe'
- Concern care for people at home – but what is the right level of support
- Concern over end of life care – not hospital – but ate there sufficient hospices

- Is STP linked to workforce plans, eg physio cut – but they may need more physio to deliver
- Provision of midwifery services – STP encourages more people to have babies at home – do we have enough midwives?
- Does the plan (delivery services ta home) need more skilled staff
- Ideas to save money - rationalisation prescribing = eg patients large no of medication; missed appointments

What haven't you said?
How are you going to plan to ensure that appropriate level of education re self-care and prevention takes place?

What have we not covered
Where all the staff are coming from? And how will staff be trained – taken resources
Reports says little about nursing – quality of nursing crucial. National training v local requirements
Question – how is this going to save money
Will Coalville be big enough to cope with the exchange
Education re self-care – really important – need ???? drive – seems underrepresented in plan.

To cases were discussed but theory may seem right but in reality there are problems
The sharing of records are evolving, the digital pathway (secure line) is also moving forward-
Cross border interface issues are being looked at to ensure services are used fairly - Question 2
Looking at the care home sector is o e the priorities - Question 2
What will be done for the council to pay a realistic rate
Worried about the transition period - Question 2
There needs to be extra resources and help may not work . respite test is required before going fully into new system - Question 2
There were priorities before and things have not happened due to the resource not being available
GPs being a consultant on other practices – how will that work? Question 1 – response: other professionals with be part of the process
GPs will chose what role they will take to ensure this new process to work - Question 1
Worry about non-professional advice eg 111
Social work manager seems positive – there should be additional funding on adult social care.

Hospital services in the community
Missing point – needs to be an intermediate place to take up these simple things eg intro venus fluids
GPs have confidence on community hospital beds
50% increase on patient that need more resources – need to look at the increase of needs
Message to MPs need to close the gap – maybe more from looking at the reality (debts are being paid – money is used ineffectively)
How do we manage the deficit – ring fence money of solutions of services
Leics hosp had little support on hospital development – looking towards PFIs.

Other questions
When will NHS recognise voluntary sector
Problem of recruiting good quality carers desperately short
Is there enough frontline staff to deliver the plan?
Reduce the burden on NHS, have more people less reliant on NHS. Wellbeing outcomes are patients really listening – get a measure on wellbeing
Prevention is important- how do we measure the outcome

Looking forward – community services
Disturbed to hear might close hospital beds
Have an emotional response to losing beds
Care would be in a different place but would it be the same care as in hospital. Its getting the balance
Make sure alternatives are in the community
More and more locums in the community
EOL – friends/carers/family can get frightened – not able to manage care
Being able to die in your own home.
24/7 access to urgent care
If I go to Swadlincote will they have my records
Complaints about 111 due to not being clinical staff directing to A&E
People not using drugs effectively
Who has medical records – NHS 111 don't
Card that contains records
Lots of good intentions who is in charge of this to see it through

Questions asked on night in Q&A at Hinckley event

I ward for inpatient and 1 planned – will there be enough beds in Hinckley?
Concerned about reducing beds
Co-ordinated discharge – how will we get that right
Mental health – what will happen in a mental crisis?
Where is the home care coming from
What happens is a carer runs in to crisis – what is the support for carers?

PPG self-appointed
Social services cuts for quite a long time NHS overspends have to paid with interests. Money going to city of London not local
BCT was meant to reduce need for beds, we still haven't and we need more – why?
If 50% people still seen by 111 but how is A&E attendance still happening and going up
Difference between care plans now and with integrated teams.

Capacity - how can we be sure that we are right about the bed numbers – demand is going up. Right member of staff with right disciplines
Deal with patients with specific needs, mental health etc. how can we make sure they are getting the care they needs. What about unusual conditions which present rarely?
Beds
Mental health and how is it supported
Do you know what happened to palliative care
What will be the impact of consultants time? Travel?
Concern of monk road hospital – could part of the buildings be used
Car parking/leisure centre always full. Useful to have more car park. Can this be done?
Monk road – what can happen to that site
GEH expanding plans. can this be factored in as a positive
How does It systems work across border Hinckley/GEH
What is happening to the volumetric unit and physio/OT building in HBCH
What would impact on you and your family to keep well and support recovery?
How will it work – integrated care, can it provide this service? Is it fit for purpose? Is the workforce available? What about cross communication across services

The need to all work on one system
There is a need to look at other support services eg slimming world; community interest groups that are funded by NHS England; LEAP run by dieticians. A potential to work with the private sector.
The need for good signposting to support services
Patents that know how to access services helping this patients that do it
Very important that the resources are in play so that the plans can be implement effectively – sometimes you need to invest to achieve efficiencies
As treatments improve and more are given, eg knee replacements didn't exist years ago, the costs will go up, there will never be enough funding for everything
Treatment that totally lack evidence should be stopped (clinical evidence
Right treatments at the right time, backed by clinical evidence