

My Care My Way – Home First

Public Engagement Report

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Contents

1.0	Introduction.....	2
2.0	Methodology and Sample	3
2.1	Methodology.....	3
2.2	Sample	3
3.0	Main Findings	6
3.1	Agreement/disagreement with statements regarding care provision	6
3.2	Ways the CCG can save money to pay for increased community care	9
3.3	Other steps the CCGs could take to keep patients safe and with good health outcomes.....	19
3.4	Alternatives to the CCGs proposals.....	29
3.5	Particular groups in the community proposals are unfair to	34
4.0	Summary and Conclusions.....	40
5.0	Appendix 1	45
5.1	Demographic profile of online survey participants.....	45

1.0 Introduction

My Care My Way is the 'Home First' model of care being proposed by Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups (CCGs). The aim of **My Care My Way** is to direct NHS money into supporting care for patients at home or as close to their home as possible. The CCGs are proposing these changes because they feel they can use the money provided by the government in a better way for patients by providing supported care at the place patients call home (this could be their private home or a residential care home) rather than in a hospital setting.

The current model of care is not clinically effective, cost effective or sustainable and not the best use of public money. Essentially there is not enough money to do everything and My Care My Way, the 'Home First' model of care is a proposal to make better use of limited resources.

The CCGs first consulted on a new model of care from December 2014 and throughout 2015. This was carried out through public meetings and events, an online survey and engagement with stakeholders including the local authorities, providers and patient groups. This consultation revealed that people preferred to be treated at home. People supported the proposed model of care in principle but wanted reassurance that there will be capacity for community based care.

In August 2016, a clinical audit was undertaken to identify whether the patients in the community hospital beds needed to be in hospital. This study, carried out across the Adult Intermediate and Rehabilitation Service (AIRS) beds open across the five community hospitals, showed that only 9% of patients across the AIRS beds on the day of the review met the criteria.

The rationale behind the proposed model of care '**My Care My Way – Home First**' is that:

- After hospital treatment, it is better for patients to become independent as quickly as possible. Patients who leave hospital quickly generally recover faster.
- Patients' personal wellbeing is better when they are at or near home where they are closer to family and friends. This helps them recover and get better faster.
- The CCGs believe that a 'Home First' model of care makes better use of NHS resources.

At present some of the beds situated in Community Hospitals across northern Staffordshire are temporarily closed to new admissions. The CCGs understand that this has caused concern amongst residents, patients and carers and many people have made their views known via the media, their MPs, on social media and directly to the CCGs.

The CCGs engaged with local people via an online survey and community events between the 1st November and 21st December 2016.

This report sets out the findings of the engagement process and has been prepared independently by Sarah Barnett.

2.0 Methodology and Sample

This section of the report details the methodologies used to complete the engagement process.

2.1 Methodology

The CCGs engaged with local people between the 1st November and 21st December 2016.

This report sets out the findings of community engagement around the 'My Care My Way – Home First' model of care and includes:-

- Results from the CCGs online survey (132 participants)
- Notes from public engagement events (detailed below)

The report also acknowledges and highlights responses made through the following:-

- Social media dialogue ('The Buzz')
- Copies of letters received by the CCG (including letters from MPs)
- Response from ASIST (Reach focus group report December 2016)
- A response from the Green Party
- Minutes of PPI Steering Group and Patient Congress meetings
- Petitions
- Health Watch report

2.2 Sample

2.2.1 Online Survey

A total of 132 participants took part in the online survey between 1st November and 21st December 2016.

Alongside questions about the My Care My Way Home First model of care, online survey participants were asked questions to help the Clinical Commissioning Groups understand more about the people who responded to the survey and to help ensure as many different people as possible were listened to through the engagement process.

A summary of the demographic breakdown of the sample taking part in the online survey is provided as Appendix 1 at the end of this report.

2.2.2 Community Engagement Events

Community engagement events were held in the following areas:-

- The Medical Institute, Hartshill, Stoke – 10th November 2016, 11.30am - 13.30pm
- Staffordshire Moorlands District Council, Leek – 15th November 2016 – 5.30-7.30pm
- The Manor House Hotel, Cheadle – 25th November 2016 – 2-4pm

- The Moat House Hotel, Festival Park, Stoke – 1st December 2016 – 2-4pm
- Bradwell Lodge Community Centre, Newcastle-under-Lyme – 15th December 2016 – 5.30-7.30pm

A presentation was given before participants were asked their views on a series of questions and/or given the opportunity to ask questions about the new proposed model of care. Additional comments were made and questions raised by participants at events and these are also acknowledged and included in the report.

2.2.3 Social media dialogue

Comments and articles in ‘The Buzz’ are included in this analysis. These include numerous comments from save our hospital campaigns. In summary, they claim to be campaigning until they are confident the infrastructure for the new model of care is in place.

“At present we are campaigning to keep community beds in our area open until the infrastructure in our community is safe and prepared sufficiently to allow people to go home and remain there.” The Buzz 12.12.16

2.2.4 Copies of letters received

A variety of letters have been received by the CCG from members of the public and MPs with regards to My Care My Way Home First – the proposed new model of care.

A template letter was also made available to campaigners entitled ‘Local Community Hospitals and NHS Cuts’ of which 829 copies were received by the CCG. In summary this letter expresses concerns about the closure of wards at Bradwell hospital and other local community hospitals and the way in which these are being carried out. The letter suggests they are not alone in these concerns and suggests the UHNM trust has objected to the ‘unrealistic timetable’ of these closures on the grounds of patient safety. Concern is also raised questioning whether alternative care of comparable quality (in nursing homes locally or for patients at home) is available or has been commissioned sufficiently by the CCGs or Social Services. The letter asks the CCG to rethink the proposals and not just reject these concerns. Concerns over the way in which changes are being carried out are also raised accusing the CCG of failing to be open and transparent, with decisions for the closure of three wards at Bradwell hospital in such a rush being taken behind closed doors at the CCGs’ joint boards meeting, under instruction from the Government’s NHS England not to discuss this in public.

Other letters also discuss concerns of secrecy with this seen to be unacceptable and to also increase mistrust among the public. The timing of the closures of beds and implementation of the new model of care are also raised as concerns in letters submitted, with the view that this should be delayed and done following the winter period.

2.2.5 Response from ASIST

Reach is a group advocacy project based in Stoke-on-Trent, supporting people with learning disabilities and is part of Asist, Advocacy Services in Staffordshire. Three Reach members took part in a focus group in November 2016 to talk about the My Care, My Way consultation and a report was prepared and submitted to the CCG.

2.2.6 Response from the Green Party

A formal response to the closure of beds at Bradwell, Cheadle, Longton Cottage and Haywood hospitals was received from the Green Party.

The Green Party believe the closure of these beds will have a significant and detrimental impact on the healthcare of the population of North Staffordshire and Stoke-on-Trent. They see this as a critical stage towards the complete closure of these hospitals after 2017 and part of a process of privatising the NHS in North Staffordshire. They also argue there is a conflict of interest here in that some of the beds at private healthcare facilities commissioned by the CCG following bed closures are at facilities privately owned by GP members of the CCG.

2.2.7 Minutes from Steering Group and Patient Congress meetings

Minutes from North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups Patient and Public Involvement (PPI) Steering Group meetings and Patients Congress meetings are also referred to in this report where the My Care My Way Home First model of care was on the agenda.

2.2.8 Petitions

A petition with 11,500 signatures from members of the public regarding Bradwell Community beds has been received by the CCGs stating:-

“We feel this closure of our community care beds is detrimental to the wellbeing and health of our aged population. Whilst we agree in theory to the strategy of My Care, My Way, Home First, we have grave doubts as to the feasibility to be able to achieve this safely with the currant [sic] lack of community and social care provisions available.”

A number of online petitions have also been submitted and received, with numbers on each as stated below (at 18th January 2017):-

- The saving of Bradwell Hospital community beds: 3336 signatures.
- Save Cheadle Community Hospital: 1583 signatures.
- Say no to the closure of Leek and Cheadle hospitals: 784 signatures.
- Save all the beds at Longton Cottage Hospital: 306 signatures.

2.2.9 Healthwatch Report

Healthwatch Stoke-on-Trent's role is to ensure voices are heard and members of the community have an opportunity to participate in the design of services when important decisions around health and care services are made.

Healthwatch Stoke-on-Trent has therefore been engaged in work concerning 'My Care My Way' for a period of time. This has included a survey asking members of the public and professionals to share their views and opinions about the proposals. A report on this survey has been prepared and submitted to the CCGs, with findings from this consultation also acknowledged and referred to in this report.

3.0 Main Findings

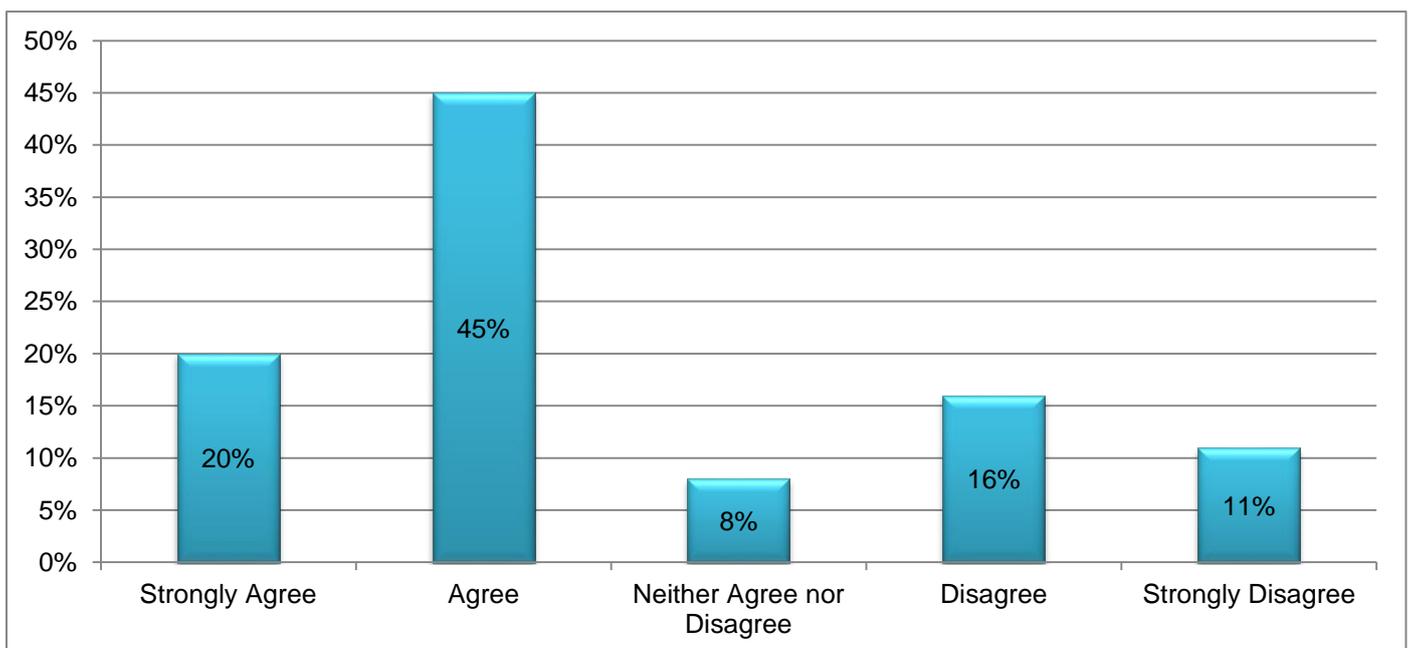
This section of the report details the findings of the engagement process. Responses to the online survey are reported with references made throughout to responses from the other engagement methods and communications received as appropriate.

3.1 Agreement/disagreement with statements regarding care provision

Participants were asked to what extent they agree or disagree with a series of statements regarding care provision and funding options. These statements are linked to the rationale for the new model of care – ‘My Care My Way Home First’.

Almost two thirds (65%) ‘agree’ (strongly agree and agree) that patients should be discharged from hospital as soon as possible and cared for at home with appropriate support.

Chart 3.1.1 – To what extent do you agree or disagree with the following statement:-‘As soon as is possible, patients should be discharged from hospital and cared for at home with appropriate support?’



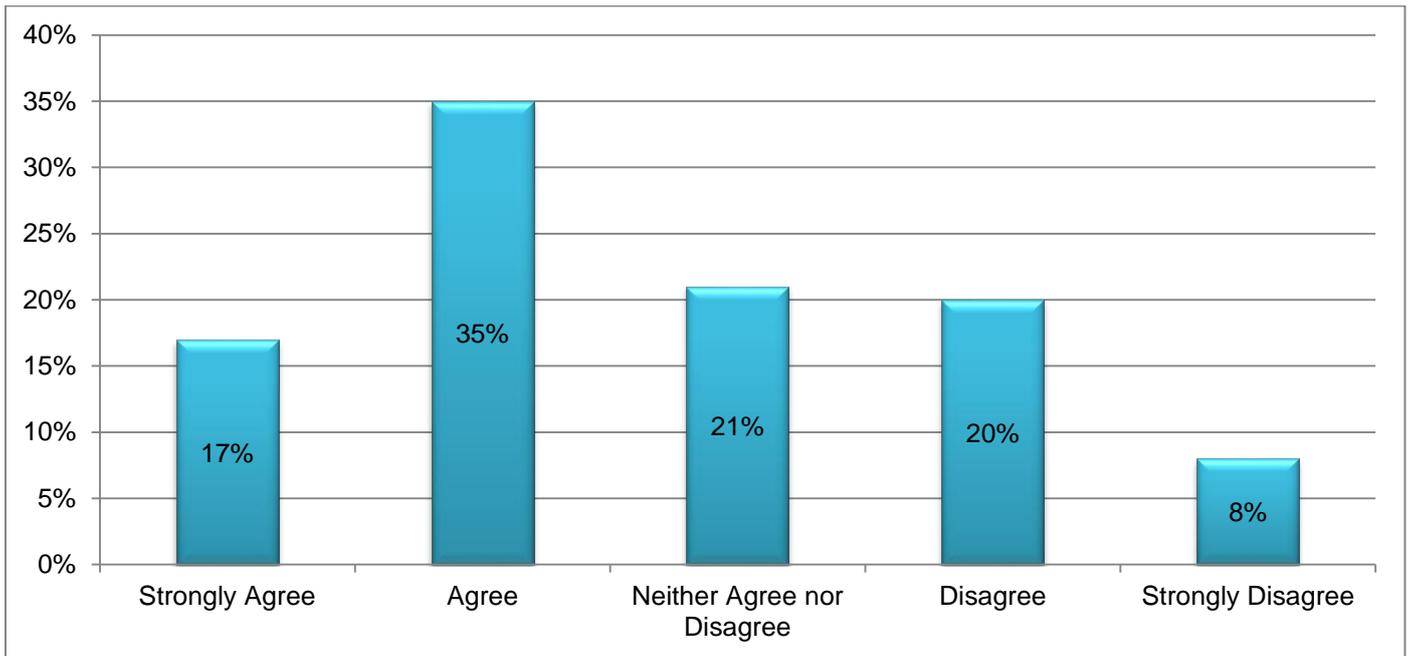
Base: all participants (132)

As shown in the chart above, 27% ‘disagree’ with this statement, with 8% neither agreeing nor disagreeing.

Part of the rationale for the My Care My Way Home First model of care is that it is argued that patients’ personal wellbeing is better when they are at or near home where they are closer to family and friends and that this helps them to recover and get better faster.

With regards to this, 52% of participants to the online survey ‘agree’ (strongly agree and agree) that caring for patients in the place they call home, with appropriate support helps patients to recover faster than being in a hospital bed.

Chart 3.1.2 – To what extent do you agree or disagree with the following statement:-‘Caring for patients in the place they call home, with appropriate support, helps patients to recover faster than being in a hospital bed?’

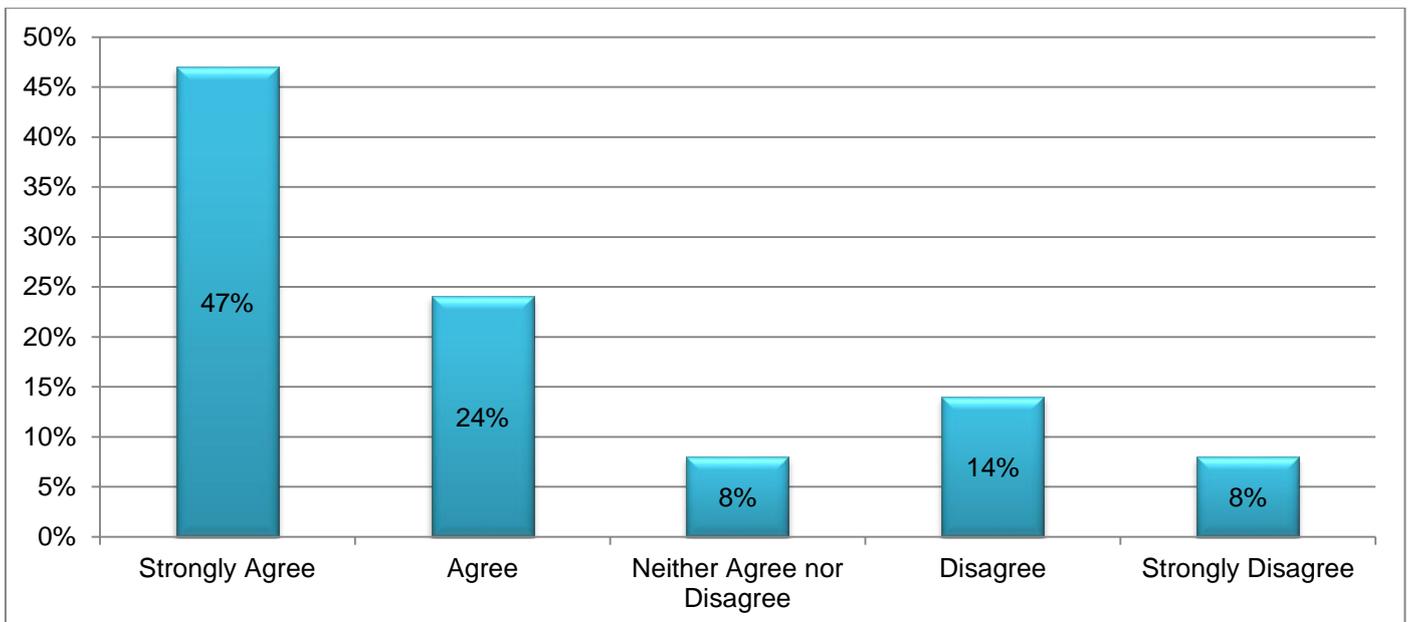


Base: all participants (132)

As shown, 28% 'disagree' with this statement with one in five (21%) neither agreeing nor disagreeing.

In considering funding, 71% of participants 'agree' that the CCGs should put more funds into supporting services which help patients to be cared for in the place they call home.

Chart 3.1.3 – To what extent do you agree or disagree with the following statement:- 'The CCGs should put more funds into supporting services which help patients to be cared for in the place they call home?'



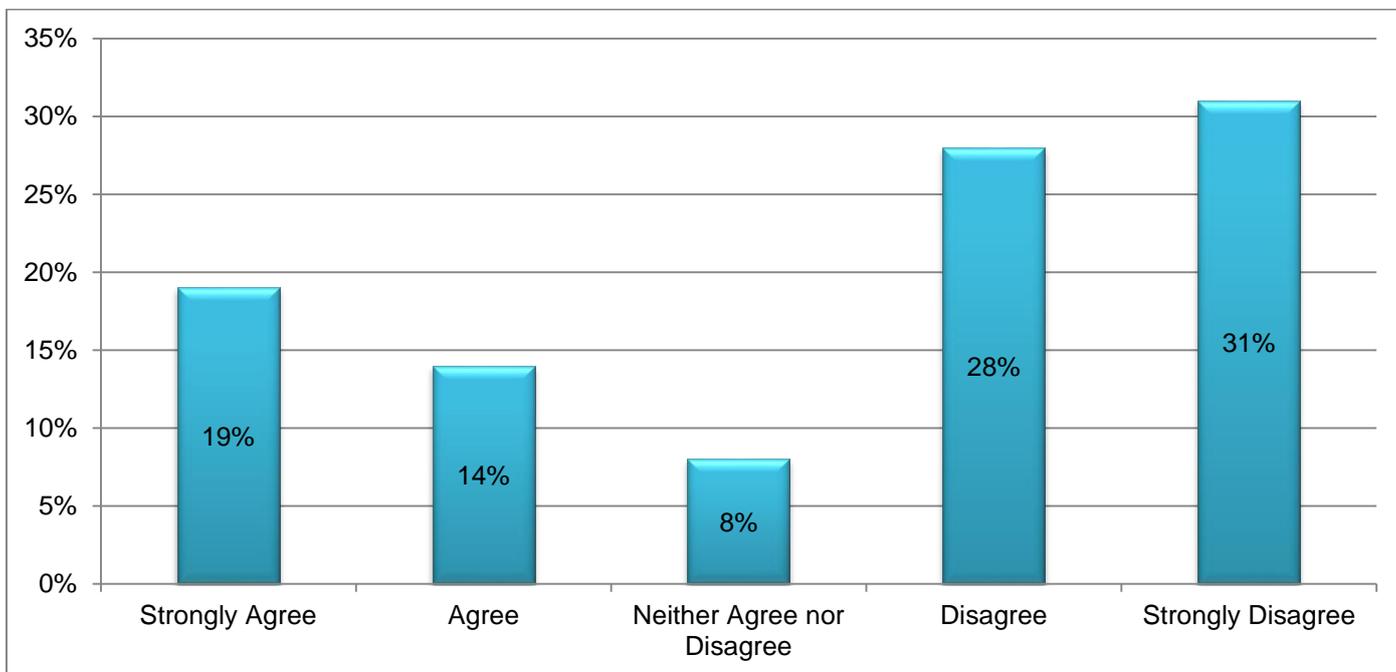
Base: all participants (132)

As shown in the chart above, 22% 'disagree' with this statement with a further 8% neither agreeing nor disagreeing.

Support for proposals for the new model of care 'My Care, My Way, Home First' reduces slightly when it comes to funding more care at or near the patients home meaning a re-direction of funds from community bed provision.

Only a third (33%) of participants 'agree' (strongly agree and agree) that the CCGs' proposals to re-direct NHS money from funding community hospital beds to funding more care at or near the patients home is the right thing to do.

Chart 3.1.4 – To what extent do you agree or disagree with the following statement:- 'The CCGs' proposals to re-direct NHS money from funding community hospital beds to funding more care at or near the patient's home is the right thing to do?'



Base: all participants (132)

As shown, some 59% 'disagree' with this statement with a further 8% neither agreeing nor disagreeing.

3.2 Ways the CCG can save money to pay for increased community care

Participants were asked if there were any other ways they believe the CCGs could make savings to pay for increased community based care.

The table below details the ideas raised and themes discussed by highest numbers of participants in the online survey.

Table 3.2.1 – Are there any other ways you believe the CCGs could make savings to pay for increased community based care?

	Number of participants	Total 132 %
Reduce management/admin and provide more hands on nurses	25	19%
Campaign to reduce cuts/lobby Government/more funding needed	10	8%
Improve communication/partnership working to improve flow/pathways	10	8%
Cut CCG committee member/board salaries	9	7%
Re-negotiate supplier costs/don't over spend on supplies/equipment	7	5%
Reduce spend on wasted medication/resources/re-use equipment	5	5%
Issue of re-admissions due to early/poor discharge processes	7	5%
Stop/reduce use of agency staff	6	5%
Fund preventative healthcare/educate healthy eating/prevent disease	4	3%
Not all rehab/limit to what rehab can take place at home – unrealistic expectations	4	3%
Ensure there are enough qualified staff in place to care for patients after discharge	3	2%
Support/safe care needs to be in place before beds go	3	2%
Night sitting service/overnight care needed	3	2%
Charge bed blockers/fine families who hold up discharge	3	2%
Keep some beds where needed but reduce some to fund homecare where it is better	3	2%
Lack of confidence in care at home currently	3	2%
None/not sure/no comment	13	10%
Don't know enough to comment	6	5%

Base: all participants (132)

As shown above, the majority of participants had comments/suggestions to make with 15% making no comment or suggesting they are not well enough informed to comment. Some participants at events, along with those in the survey sample, refer to being unable to comment or feel it is difficult for the public to answer questions concerning NHS finances as they do not have a full understanding of how and where existing budgets are spent.

Reducing management and administration costs and thus providing more hands on nursing staff is most frequently discussed as a way the CCG could make savings to pay for increased community based care, along with campaigning to reduce Government cuts, improving communication and working relationships between service providers and cutting CCG committee member/board members' salaries.

The themes above, along with others referred to by fewer respondents are discussed in detail in the sections below. Verbatim comments are also used throughout to highlight points raised. Thoughts and comments from attendees at engagement events along with other responses received to the proposed new model of care are also included in the relevant sections.

CAMPAIGN/LOBBY GOVERNMENT FOR MORE FUNDING

Participants in the online survey reiterate here a need for more funding, suggesting **campaigning to reduce cuts and lobbying the Government for increased funding**.

“Just invest more and actively campaign to reverse cuts.”

“Lobby Government for increased funding – people’s health should not be constrained by austerity cuts to local authority funding.”

An event participant asks...

“...what are you doing to fight the cuts and lobby against them?”

Concern is raised that the Government are supposedly pumping more funding in, yet cuts being made always focus on savings in connection to patient care.

Participants understand the need to save money and make cuts, but are keen to stress their view that this is a wider issue and that something needs to be done about the reduction in funding for the health and safety of communities.

“It is very obvious that there is inadequate funding and to imply that it is due to inefficiencies is disingenuous.”

MAJOR CHANGE NEEDS PLANNING AND CAREFUL IMPLEMENTATION

Participants discuss the **need for proper planning and careful implementation** in order for such a large change to be made to the structure of service provision.

“Changes to the current structure cannot be made until a full plan and strategy is in place.”

They feel the focus should be on providing quality care with the best outcomes for patients rather than about making savings. If resources have been cut to a level where it is felt quality care cannot be delivered, this should be made explicit to the Government.

“If the resources are not present then we can’t deliver safe care, we should not pretend that we are.”

CONSIDER RETAINING SOME OF THE BEDS – NOT A PRACTICAL SOLUTION FOR ALL PATIENTS

Concern is raised here about the safety of vulnerable patients who really need 24 hour care. Several participants are keen to see **at least some of the AIRS beds remain open**.

“Whilst recognising the need to make savings the closure of all local community hospitals appears a drastic approach and perhaps a balance of some community hospital beds combined with nursing home beds would be a more measured approach.”

This is suggested to be the case particularly where patients have no-one to care for them at home. Support is given here by some participants for a number of beds to be closed in order for funding to be released to provide home care under the principles of ‘My Care, My Way, Home First’, where it is agreed that this would be the best outcome for some patients.

“Keep some hospital places open for those who have no-one to care for them at home, but reduce hospital provision partially, to fund home care where it really is better.”

A number of participants feel that the CCGs have **unrealistic expectation**, in that it will not be possible or appropriate for everyone to be cared for effectively under the new model of care.

“Whilst reducing community beds is the right decision, decimating community beds is the wrong decision.”

There is concern that a ‘one size fits all’ approach is unrealistic and that, as one participant suggests...

“...having social care provision doesn’t remove the need for community beds.”

Concern is also raised that not **all rehabilitation can be undertaken with patients at home** due to a lack of equipment and space. As one participant concludes,

“I agree that for some patients support in the home is the best option, however where targeted rehabilitation is required to provide on-going support and help patients restore function and regain independence, there are limitations in what can be provided by therapy teams in a home environment.”

The ability for all rehabilitation to be provided at home is also questioned in the focus group report from ASIST, with one participant asking...

“...can they really get the same kind of rehabilitation doing it at home?”

Throughout the engagement process, members of the public stress the success and importance of the work carried out at community hospitals at present and concern as to whether this level of rehabilitation can continue under the new model of care.

“Patients do not lie on a bed all day when they are in a community hospital, intensive rehabilitation is a priority and how will this be provided when a patient is sent home to recover.”

LACK OF CONFIDENCE IN CARE AT HOME CURRENTLY/COMMUNITY NEED REASSURANCE

One issue apparent throughout the engagement is **a lack of confidence amongst the public in care at home** provision at the current time. Whilst numerous comments suggest agreement, at least in part, with the closure of beds and reinvestment of funding to provide care at home (where this is seen to be the better outcome for the patient), participants lack confidence in the current/planned provision and require reassurance that this model of care can and will be delivered.

“Where is the evidence that we will get ‘increased community-based care’? It is crazy to contemplate axing the vital community-based hospital beds we currently have whilst the care at home domiciliary services are currently so under-funded, in the hands of private companies, inadequate or just not there.”

Participants refer to ‘care at home’ constantly being in the news for its poor outcomes for patients leading one participant to suggest...

“...care at home is likely to be insufficient and leave patients alone and uncared for for long periods.”

There is therefore a need for the CCGs to persuade the general public that the new model of care is deliverable in order to reduce concern and scepticism among the community. As one participant suggests...

“...we need an end-to-end process map of how the ‘system’ works.”

Save our beds campaigners feel that without improvement to the existing care at home provision...

“...the current My Care My Way strategy is flawed and risky with a social care service at crisis point.”

The Green Party, in their response to the closure of beds at community hospitals, also express concern and display a lack of confidence in whether the new model of care is deliverable due to current provision of social care. They discuss how staff numbers for district nurses employed within Staffordshire and Stoke-on-Trent Partnership NHS Trust (obtained through a Freedom of Information request by the North Staffs Green Party) have fallen by 19% in 6 years (from 541 in 2010 to 438 at the present day). This leads to them questioning the success of this new approach to care.

RESTRUCTURE STAFFING/APPROACH TO STAFFING

In considering other ways the CCGs could make savings to pay for increased community based care, participants in the online survey refer to **reducing management and administration staff and providing more hands on nursing staff.**

“Reduce the number of managers and office based staff and replace them with front-line staff.”

Management being too heavily staffed is discussed as an issue for the CCGs and wider NHS services, with a need for this to be addressed in order for more ‘patient focussed’ staff to be provided.

“Look at higher management level where there is normally duplication, rather than cutting posts/funds at the patient end.”

Funding for more community based care is suggested to be possible by one participant by...

“...removing unnecessary layers of management for which no one seems to have accountability.”

Reducing the use of agency staff is also discussed by participants as an approach to making savings to pay for increased community based care.

“Ensure a supply of permanent staff so that there is less reliance on agency staff.”

Several participants suggest there to be a lot of agency staff working in the community hospitals. The amount it must cost for these agency staff, including paying their lodgings, is seen as a waste of money that could instead be used to keep the community beds open.

“There were too many agency staff in my local hospital and the agencies costs for these must be considerable.”

“Cease paying for agency staff working in hospitals - instead employ more nurses, so more funding is available for patients to receive excellent rehabilitation in community hospitals.”

The question of reliance upon agency staff is also raised at the Stoke-on-Trent Patient Congress meeting, with participants asking how much the new model of care will rely on agency and/or bank staff.

Participants also suggest **cutting the number of CCG committee members and/or reducing their salaries** to be another way CCGs can make savings to pay for increased community based care.

“Get rid of some of the CCG committee – cut their pay.”

There is a view that there is currently an imbalance between the money spent on management and commissioners salaries and money directed at services for patients.

“Cut the boards salaries for a start. You are taking away vital services for people, some of whom cannot go home to be cared for by relatives who work full-time.”

Participants in the online survey made specific references to **reducing from two to one CCG in the North** as an option to reduce costs and thus direct more funding to pay for increased community based care.

“The most effective and cost beneficial mechanism for reducing costs would be to reduce from 2 separate CCGs in the North to a single CCG.”

REDUCE OTHER COSTS (SUPPLIES/EQUIPMENT/OVERHEADS)

Participants in the online survey suggest there is a need for the CCG to **renegotiate supplier costs** in order to make savings to pay for increased community care. References are made to potential savings if supplies are bought in bulk and that some of the current suppliers are not viewed to be the best options available at the current time.

“From a personal perspective, as ex NHS staff ...there are massive potential savings in buying in bulk rather than on an individual ward basis.”

“Better purchasing – finding equipment at a better price.”

One participant cites an example of the expense of purchasing food through a current supplier in suggesting...

“If a patient is away from the ward and misses a meal, they can have a sandwich on their return – the cost of this is £13.00 including a ‘delivery charge’.”

This is seen to be excessive, with another participant suggesting...

“...the CCG should look to buy good stuff at the lowest price – they will find out there are a lot of private companies happy to do business with the NHS with good costs.”

Engagement event participants raise similar issues asking...

“...why are trusts allowed to purchase equipment and consumables? The NHS is a large body – why isn’t there a central purchasing system – that way it would be better value for money?”

Participants in the online survey also suggest opportunities to save money linked to **reducing spend on wasted medication and resources** and the need for some **equipment to be reused**.

Over prescription of medicines and prescriptions not being reviewed on a regular or ongoing basis are discussed with this leading to patients having an over-supply of medication that goes to waste.

“The amount of money wasted in medication that has to be discarded.”

An engagement event participant also cites an example of this...

“...you keep talking about money – something needs to be done about drugs. I had to get rid of bags of them when my parents died. My parents said they didn’t want them but they still kept being delivered. The amount of money for this must cost a fortune.”

Participants also suggest there should be an option for equipment such as walking sticks and mobility aids to be reused. Whilst it is understood that not all equipment can be reused, participants feel that there are occasions where this can be the case.

“Stop wastage by throwing away perfectly good equipment.”

One participant made the point that currently we are...

“...wasting money on new equipment when charities can sterilise it and reuse it – why can’t the NHS?”

Other practical suggestions for making savings to pay for increased community based care include the CCGs reducing their use of rented buildings and instead moving services to buildings within their ownership. A small number of references are also made to not wasting money on refurbishments to buildings where services are later to be withdrawn. One participant feels there is a need for more ‘joined up thinking’ discussing how...

“...money seems to be wasted on projects that end up not being used. Wards at community hospitals (certainly at Moorlands) were recently refurbished and now you are considering closing them.”

An event attendee also raises this point asking...

“...why was money spent upgrading community hospital wards prior to bed closures?”

Participants at engagement events also discuss this use of rental buildings with examples given of rented property being used when there are buildings like Cheadle hospital being closed.

SUPPORT/FOCUS ON PREVENTATIVE HEALTHCARE

Participants refer to a need for the CCG to support and **focus more on preventative healthcare**. Doing this, along with educating the community in healthy eating and encouraging lifestyle changes, is seen as a way to prevent disease and illness and thus in the longer term create savings to re-invest elsewhere.

“Education about being healthy and fit to prevent disease in the first place.”

“Encourage lifestyle changes where appropriate (e.g. for high cholesterol) to save on medication.”

PRIORITISE TREATMENT

Cutting back on non-essential treatment is discussed as a way to make savings to pay for increased community based care.

Ensuring people are entitled to free NHS treatment before they receive treatment is also referred to as a cost saving approach here, along with ensuring money for treating ‘health tourists’ is reclaimed.

“Ensure people who are not entitled to free NHS care pay for it before receiving treatment. This may sound harsh, but it is what other EU countries do.”

IMPROVE COMMUNICATION AND PARTNERSHIP WORKING BETWEEN AGENCIES

Participants in the online survey suggest **communication and partnership working between agencies needs to be improved**, with one of the results of this seen to be making savings to pay for increased community based care.

“There is too much waiting because multiple agencies don’t all work together to make the system flow, so you get bed blocking.”

“More efficient and effective communication and co-ordination is required between community and acute services.”

This improved communication between the acute and community care services is seen as key to reducing the ‘waiting’ time and resultant ‘bed blocking’, with more patients able to return home, with appropriate care in place, at an earlier stage.

“Savings could surely be made by improving partnership working with the hospital to create a more efficient pathway from acute to step-down only where necessary.”

Participants also refer to a need to **reduce duplication of paperwork and bureaucracy** in order to save money which can be used to pay for increased community based care.

“Reduce as much bureaucracy as possible and direct monies to care in the community nurses.”

IMPROVE COMMUNITY CARE/CARE AT HOME SERVICES

As discussed earlier in this section, there is a clear lack of confidence among the public in the community based care currently available and thus scepticism towards the delivery of this new model of care. A number of participants state the need for **support and safe community based care to be in place before community hospital beds are closed.**

“Support needs to be available and in place before beds go.”

Some participants understand the difficulties here, but as one who admits they are unable to suggest other ways they feel the CCG could make savings to pay for increased community care states...

“...but, the CCG needs to provide safe care before cancelling previous arrangements.”

Participants are concerned and nervous that appropriate care may not be in place and are keen to stress that it is vital **enough qualified staff are in place** to care for patients after discharge from hospital to home.

One participant in the online survey suggests the need for **opportunities to be identified whereby skilled employees currently working in community hospitals are redeployed into the new community based care services.**

“Identify opportunities for redeployment of skilled employees to community services.”

There is concern that skilled and trained members of the workforce will be lost and thus there will be additional cost implications for the CCG of new employees requiring training to ensure care is provided to the required standards. Ensuring an approach is taken to redeploy existing skilled staff could make further savings to pay for increased community based care.

Other costs saving suggestions are made with regards to changes to the existing model of community based care. Participants refer to the need for **logistics of care workers to be centralised.** Participants cite examples where they feel carers travel time could be much reduced.

“Centralise the logistics of the workers ensuring the full usage in one area of each worker – allocating one carer to a specific area to reduce travel time.”

A further participant shows support here for the new model of care, suggesting it to be essential to invest in community based care, including the **training of home care providers**, discussing how...

“...without this further investment in community services the health economy will never be able to step away from its dependence on bed based services.”

This participant discusses how until the capacity of community based services is invested in to a point where they have capacity and flexibility to support people in their own homes even during pressured winter months, the cycle of ‘reactive opening of additional beds’ will continue.

Whilst there is support for the new model of care and the need for more services in the community to help people recover in their own homes, concern is raised as to the need and requirement of some patients for 24 hour care. Overnight care is seen by a number of participants to be a challenge within the new model, with a number of participants keen to stress the requirement for some form of ‘night sitting’ or **24 hour care service** to be available where required.

“Some elderly need 24 hour care and that is not provided at home. Community care services are not sufficient to meet the 24 hour need.”

“I agree there should be more services in the community ... but this needs to include a night sitting service. A number of patients will be re-admitted to hospital if they are alone and vulnerable in the night.”

The Healthwatch report submitted to the CCGs also refers to the need for 24 hour care provision, with this pointed out to be a difference between community hospital care and care at home.

The availability of overnight care is seen by many to be essential for the success of the 'My Care, My Way, Home First' model of care with....

"...one thing you need to invest in, in order to get more patients 'home first' is overnight support as this is the biggest barrier to getting people back home."

IMPROVE DISCHARGE PROCESS

This **issue of re-admission to hospital** is also raised with regard to **poor discharge processes** and patients being discharged from hospital too soon. Online survey participants make reference to the need for improvements to be made to the discharge process as a way CCGs could make savings to pay for increased community based care.

"Short term savings by sending vulnerable people into unfit caring situations means they are likely to return to the acute hospital – this does not make savings long term."

One participant stresses the need for hospitals and care providers...

"...to make appropriately timed discharges so increased costs of poor support and lack of required treatments in the community do not lead to rehospitalisation."

Another discusses the importance of ensuring patients are not...

"...pushed out before they are properly treated, then they would not be bouncing balls going in and out of the acute sector."

Save our hospital campaigners (cited in 'the Buzz') support this view discussing how the...

"...discharge of elderly patients into less than adequate care regimes, and before they are therapeutically fit to leave intermediate care, means they are more likely to be re-admitted to acute care beds."

Engagement event participants also discuss readmission to acute hospitals following poor discharge processes. People are now seen to be having assessment for discharge in acute hospitals and it is suggested this will need to happen more without community hospital resources. One describes this process to be...

"...a mess! You are oversimplifying – it's going to get harder and harder – we need to do it properly or patients will come back in."

The discharge process is therefore seen to be a critical stage whereby savings can be made if the system works effectively (and thus there is a reduction in the number of patients returning to acute hospital within short periods of time). One participant feels the required improvements to the discharge process could be made by

"...having dedicated discharge coordinators who actually care about the individuals needs (some complex) who properly coordinate the discharge home. This includes ensuring an adequate care package is in place."

It is acknowledged that many patients in community hospitals are waiting for community based care packages in order to be discharged. One participant in the online survey raises a further issue here with the result being a potential costs saving. They suggest the need for CCGs to police the way hospitals assess patients better. In their view,

"...the current approach means that if an assessment is carried out indicating a level of care needed but there is a wait in hospital, there seems to be no reassessment of the situation and so the person continues to wait for a level of care which they may no longer need."

Regular reassessment of patients needs upon discharge (whilst in hospital) is therefore seen as an approach to saving money and improving the flow of patients through the system.

TREATMENT AT ACUTE PHASE OF ILLNESS

Ensuring patients are treated properly at the acute phase of an illness is seen to be vital in the health service saving money overall. Providing early diagnosis of illness and ensuring patients are treated appropriately and in a timely manner are discussed as key deliverables.

Avoiding harm and hospitalisation from poor care is also seen as important in making better use of funds within the NHS overall. Ensuring community based care is of the required quality is seen as essential in order for the new model of care to work. Participants argue that where this is not the case...

“...the consequence is that poor community care costs more in the end as people are returned to hospital in worsened states and often have to stay for longer.”

The need for **independence to be promoted** at all times is also discussed as a way CCGs can make savings to pay for increased community based care. Several participants in the online survey raise concern that it is ‘too easy’ for patients to lose their independence during stays in hospital, which in effect increases the costs of their care requirement when they are discharged. One participant feels that patients in hospital should be encouraged to ‘self-aid’ where possible (in terms of administering their own medication such as eye drops/simple injections), with this reducing the requirement for such regular visits from community based care staff. They feel it is too easy for staff in acute hospitals to say ‘the district nurse will pop in to see you’.

Another participant highlights their agreement with the plans to move to the new model of care whilst also supporting the need for patients to keep their independence during their hospital stay in saying...

“...supporting people at home would be better for the patient’s wellbeing and gives them the encouragement to recover quicker. However, in hospital they can be washed and dressed when at home they would normally do it for themselves. Independence should be promoted at all times.”

FUNDING/CHARGES FOR COMMUNITY BED USE

Participants in the online survey make reference to the need for **charges to be applied for community beds where patients or their families are deliberately delaying their discharge**. This is seen to be one issue leading to funding problems and participants feel this needs addressing in order for the flow of patients to be improved.

“Start charging bed blockers or frequent bed huggers.”

“Fines need implementing when there is clearly delay tactics going on.”

“Families who deliberately hold up discharges should be fined.”

Other participants feel **community beds could be part funded by patients and/or their families**. Whilst this may not be a preferred approach, this highlights the strength of support and keenness to retain the current service these community beds are providing to the community.

Participants feel there may be scope for patients to be charged at least for food and provisions required during their stay, with one suggesting...

“...I cannot see why those individuals could not be charged something to stay there – at least to cover the cost of food.”

ISSUE WITH CAPACITY/QUALITY OF CARE HOMES

Many participants feel the closure of community beds will increase the demand and requirement for beds in nursing/care homes for patients who will not be able to be cared for in their own home. This raises concern for a number of participants with regard to availability of places and the standard of local nursing care home provision.

One participant is keen to see **investment in care homes to include a formal inspection process**.

Another refers to the lack of residential home places suggesting...

“...the residential home option is not a credible one as currently there are few places available and the number of homes willing to take on council paid places is reducing. So, although this is being used as an alternative one (cheaper) it is in reality a non starter – the population is getting older but residential care is not growing.”

VOLUNTARY SECTOR PROVISION

Two participants in the online survey made reference to making **more use of voluntary sector services** as a way they feel CCGs could make savings to pay for increased community based services.

“Put more money into the community initiatives and voluntary sector.”

“More use and commissioning of services from voluntary sector providers.”

Other references made by individual respondents include cutting general GP checks, reducing letters sent out to confirm appointments (using email instead), making sure administration staff are doing administration jobs – not the nurses, merging smaller GP practices into larger healthcare clinics, providing greater efficiency within hospitals and stopping district nurses going into nursing homes.

3.3 Other steps the CCGs could take to keep patients safe and with good health outcomes

Participants were asked if they think there are other steps the CCGs could take to keep patients safe and with good health outcomes.

The table below details the ideas raised and themes discussed by highest numbers of participants in the online survey.

Table 3.3.1 – Do you think there are other steps the CCGs could take to keep patients safe and with good health outcomes?

	Number of participants	Total 132 %
Employ more nurses for community care/home care staff	14	11%
Keep community beds open	13	10%
High quality training for home care nurses	12	9%
Better coordination of services	12	9%
Provide good quality home care	9	7%
Not lose all community beds – just some/strike a balance	7	5%
Ensure homecare is in place before closing beds	7	5%
Have care packages immediately available	7	5%
Concern/lack of confidence in change/the new model of care	6	5%
Concern over/expectation of re-admissions	6	5%
Proper pay/better pay for home care staff – make these roles proper careers/improve retention	6	5%
Use charities/voluntary sector more/develop voluntary sector services	6	5%
More funding from NHS/ask Government for support	5	4%
Improve health promotion	5	4%
Need a 'halfway house' between hospital and home	4	3%
Put money into local hospital beds/convalence homes – home visits cannot cover every need	4	3%
Look at modern technology to monitor home patients (CCTV/emergency buttons/motion sensors/audio equipment)	4	3%
Use community beds more efficiently/appropriately	3	2%
Listen to concerns of people on the front-line/go on the front-line to experience it	3	2%
Look at patients needs rather than costs	3	2%
More monitoring of care staff/check quality and frequency of visits	3	2%
In-house/centralised care at home service – cheaper/easier to manage than paying different private providers	3	2%
More monitoring of care homes/ensure they operate under same standards/principles as NHS	3	2%
More night sitters/implement night-time care	3	2%
Don't know/none	7	5%

Base: all participants (132)

As shown above, the majority of participants had comments/suggestions to make with only 5% making no comment. Most frequent responses suggest the need to employ more nurses for community care/home care staff, keeping community beds open, investing in high quality training of home care nurses, ensuring good quality home care is available and focusing on better communication between services.

The themes above, along with others referred to by fewer respondents are discussed in detail in the sections below. Verbatim comments are also used throughout to highlight points raised. Thoughts and comments from attendees at engagement events and other responses received to the new proposals are also included in the relevant sections.

KEEP BEDS OPEN/DO NOT CLOSE ALL COMMUNITY BEDS

In considering other steps the CCGs could take to keep patients safe and with good health outcomes, some respondents to the online survey feel there are no other steps and **restate the need for community beds to remain open**. These beds are seen as a crucial service of which the closure will have detrimental effects on patients and cause longer stays in acute hospitals.

“Keep the community hospitals open! I have personal experience of the benefits of these local hospitals. A member of my family was moved from the RUHS after a long period of treatment and stayed in Cheadle hospital for three weeks to recover sufficiently to return home. Had Cheadle Hospital not been there, it would have meant a longer stay in RUHS, blocking a bed.”

Concern is raised again here that early discharges and patients being discharged to home without appropriate care in place will lead to re-admissions to acute hospitals.

“We need intermediate care beds to allow for proper assessment and careful discharge.”

“I believe that community based hospital beds are desperately needed as early discharge home often leads to readmission to acute beds.”

Current provision and use of ‘community beds’ is seen to be supporting acute hospitals well in...

“...providing the step down required to free up beds, while still keeping the patient in a safe and supervised environment.”

Other participants clearly understanding the constraints around funding feel community beds should remain open but would like to see them **used more efficiently or appropriately**. Ensuring those in community beds fit the criteria for being there is seen to be a requirement along with ensuring alternative service provision is made available so that people are not using these beds as a ‘waiting room’ and are being discharged as appropriate.

“Use the hospital beds more efficiently and do not allow delayed discharge – put fines in place.”

A number of participants are keen to see a **balance maintained between community hospital beds and care packages in the community**. Both services are seen to be beneficial in different ways and for different patients needs. Whilst participants support the principles of the new model of care and agree that patients often have better outcomes from being treated at home as soon as possible, there are still cases whereby hospital beds are required.

“You need to strike a balance, community beds for those with no home support and additional care in the community for those ‘at home’.”

This view is supported by others who feel a **‘halfway house’ between acute hospitals and returning home** is essential.

“The care of people in their own homes is a fine idea where it can be staffed and funded, but community beds in local hospitals provide a vital service to many people and an invaluable ‘halfway’ house between the main hospital and home.”

A local MP supports this view suggesting in a letter to the CCG that...

“...proper provision must be made for my constituents who do require a stopover between hospital and home after having had surgery or after treatment for acute or chronic medical conditions.”

Providing a service that offers the care currently provided by community hospitals is critical with several participants suggesting the CCG could look to **fund convalescence homes or reinstate respite care provision**, with the underlying view that ...

“...home visits cannot cover every need of the recovering patient.”

“Put the money into local hospital beds/convalescence homes for the local community.”

“Bring back respite care for patients.”

LACK OF CONFIDENCE IN THE NEW MODEL OF CARE

In discussing other steps the CCGs could take to keep patients safe and with good health outcomes, online survey participants demonstrate or make reference to **a lack of confidence in whether the new model of care can and will be delivered**. There is a need for public confidence to be improved in order for support for the new model to increase. Whilst people agree that patients should be discharged from hospital and cared for at home and that being cared for at home can help patients to recover more quickly, there is less confidence in the model when it comes to a need for funding decisions meaning support for one service or the other.

This view is summarised by a participant discussing how...

“...it is all very well saying people are better off being cared for in their own homes but will they receive the same quality of care that they would receive in a hospital environment? I think you would need to show clear evidence that this is the case and that people could rely on the people providing this care on a consistent basis.”

Others who support the idea of ‘Home First’ and feel it is one to which everyone would ascribe, suggest there remains doubt as to whether it is realistic.

“In reality wanting to be at home and being able to be at home are two very different things.”

Findings from the Healthwatch report submitted to the CCGs also refer to this lack of confidence in the model, discussing how whilst participants recognise there is a case for change and do not disagree with plans to move care closer to home, they are concerned about the capacity of care in the community to deliver this.

This lack of confidence and questioning of the deliverability of the new model of care is also apparent with regard to **expected increases in readmissions to acute hospitals**.

“The policy is so short sighted in terms of cost savings as patients will just go round in circles and keep entering the acute hospital without the proper rehab and support in place in the community.”

A further participant supports this view discussing how...

“...a short stay in a community hospital where rehabilitation can be given to ensure full recovery before returning home reduces the need for people to be re-admitted to hospital.”

Participants who support the new model of care also feel it is **essential that home care is available and put in place before the community beds are closed**.

“Ensure that there is a robust support structure in place before closing Community Hospital beds.”

The concern and lack of confidence in ‘change’ is apparent here too with one participant suggesting that...

“...there are not enough community services currently for the speed at which the CCG are closing beds.”

In order for confidence to be increased, one participant suggests the need for...

“...a full and transparent review of the outcomes of patients accessing Nursing Home beds as an alternative to Community Hospital admission.”

MORE FUNDING NEEDED FROM THE NHS/GOVERNMENT

The requirement for **more funding from the NHS** is referred to again here with participants feeling this is essential in order for patients to be kept safe and to have good health outcomes. Participants refer to fears that the current situation is unsustainable with reduced funding leading to negative outcomes on patients.

“Closing departments and reducing beds is not providing the medical service required by an increasing and ageing population.”

Whilst participants accept the CCG have to make cost savings and are unable to fund everything, concern is expressed that services are reaching breaking point and that something needs to be done to secure more funding before cuts cause harm to patients.

“There is clearly a health crisis and insufficient funding or I’m guessing the CCG would not be resorting to such extraordinary measures to close so many beds with so little notice and apparent disregard for public and staff opinion.”

LISTEN TO PEOPLE ON THE FRONT-LINE/FIRST HAND EXPERIENCE

Participants feel that it is essential for commissioners to **listen to those on the front line**. Actually experiencing what goes on in the ‘real world’ may influence their decisions, with one participant suggesting they should...

“...get themselves out on the frontline to see what the problems are.”

This view is supported with a suggestion by the 38 degree’s group in ‘The Buzz’ that...

“...some people need to come out of their warm offices and open their eyes to see what is happening.”

Those submitting letters to the CCG with regard to the new model of care also feel getting firsthand experience and listening to the experiences of people on the frontline will be beneficial in decision making suggesting the commissioners should...

“...come out into the real world and see how it is.”

Participants are keen to see **patients’ needs, safety and their health outcomes to be of foremost concern**. Having the required steps in place to enable rehabilitation and patients to return home to recover as soon as possible is essential.

One participant summarises this suggesting the CCG need to...

“...look at the whole picture rather than the financial elements. Yes people recover better at home, if the correct overseeing is done but currently it is too fragmented. The care beds play a part in the recovery if only to get the patient in a position of being able to live with home care. By taking this element of recovery away the costs will ultimately increase overall as the bounce back to hospital will occur.”

Concerns that finances are being put in front of patients’ needs are also expressed in letters submitted to the CCG.

“This is a cynical exercise in accounting – cost cutting without any regard at all for the welfare of people who are ill, frail and vulnerable.”

Safety and good health outcomes for patients not being the priority is also discussed with regard to the wider situation, with one participant suggesting...

“...the NHS is no longer, and has not been for a long time, a clinically led service but it is financially led, the patients’ voice being totally irrelevant and thus ignored.”

IMPROVE/MONITOR QUALITY OF CARE AT HOME SERVICES

One of the biggest issues raised by participants in the online survey is with regard to the **quality and availability of care at home services**. Whilst the public lack confidence in the availability and quality of community care provision, support for moving towards the new model of care is limited.

“Care in the Community would be brilliant if it happened – but it does not.”

In order for the CCGs to keep patients safe and with good health outcomes, participants would like to see...

“...more agencies of good quality to provide home care.”

A letter submitted to the CCG regarding the new model of care cites an example of care in the community not being successful, with carer's visits lasting barely half an hour and carers being late. The letter goes on to explain how...

“...the care is lacklustre and we could not leave mother relying on their care alone. This is the second agency we have used, the first was always letting her down as they had few staff and no backups, which seems to be the issue with all agencies. The carer's hours are poor, the agencies pay very poorly, therefore the agencies are chronically understaffed.”

Putting more money into community based care and care packages is supported by participants, although for some this is limited by a need for this to be done in tandem with ensuring there is an **increase in the monitoring of staff and services to ensure the quality and frequency of visits is at an acceptable level**.

“Regularly check the quality and frequency of home care provision after discharge from hospital/care home.”

In order for this new model of care to work and to ensure the CCGs keep patients safe and with good health outcomes, it is seen to be vital that **care packages are available immediately**. Delays in accessing community care are seen as barriers to the new model of care, with participants suggesting links between agencies need to experience significant improvements if this proposal is to succeed.

“Improve links with social services to ensure care packages are organised much more quickly when looking to discharge patients from hospital.”

“Good patient assessments in hospital prior to discharge so that the care is in place ON DISCHARGE.”

Participants support the plans for more care in the community and agree in part that this is the better approach for some patients. However they feel...

“...waiting around for care packages to be put in place is damaging for peoples' health, especially when they are waiting for around 3 months or more for one to be put in place.”

A post in 'The Buzz' also refers to this issue discussing it currently...

“...taking nearly a month to arrange necessary support for patients waiting to be discharged.”

Other letters support the view that hospitals do not choose to hold on to patients and that the 'system' is responsible for 'bed blocking'. As one participant suggests...

“...patients do need to go 'home first' where at all possible, we all totally agree. Give us the infrastructure to do that and we will efficiently discharge patients.”

Three participants in the online survey refer to a need for an **in-house or at least centralised care at home service**.

“Improve care at home services by taking them back in-house, where qualified staff, employed by the City Council, or by the NHS can provide safe and skilled care to vulnerable people and ensure that they receive the best service.”

Whilst this is suggested to offer better outcomes through providing a quality service to vulnerable people, it is also suggested to be more financially efficient.

“A central in-house care provider would surely be cheaper than paying different private providers as you are paying for the back-of-house staff (finance officer, manager etc) for each organisation rather than having one (possibly already existing CCG FO etc) to pick up the work.”

One participant at an engagement event discusses their view on the current poor management of care at home, thus supporting the views above for the need for a more centralised service. They cite an example where two people in one household currently require care and have different carers coming in for each.

“Both my mother and father need carers and they have eleven people going into the house. Mum’s carer won’t even make Dad a cup of tea and they have two hours between their respective breakfasts.”

Whilst participants agree that patients should be cared for at home and that this helps patients to recover faster than being in hospital, there is an overwhelming caveat in that in order for this to work, community care services need to be in place and staffed sufficiently to deliver this new model of care.

“They need to ensure that community services are well staffed and can cope with the extra workload.”

Participants in the online survey also make reference to the need for **more nurses for community care or more home care staff**. Several participants feel district nurses are struggling currently with their existing workload, with one describing community staff to be...

“...on their knees with the amount of patients they are currently seeing.”

Improving the pay and conditions of staff in these roles is seen as a requirement in order to encourage people into the profession and to improve staff retention. Current pay is not seen to encourage this, with participants referring to staff ‘moving on’ regularly. In order for the new model of care to work, with a greater focus on care in the community, members of the public feel there is a need for a change in the way the ‘community care’ role is viewed to make it more of a career option, with pay reflecting this. As one participant summarises, there is a need to...

“...improve the payment of carers to attract individuals who want to do the work rather than those who cannot get employment elsewhere.”

An engagement event participant summarises this point in saying...

“...if you pay peanuts you get monkeys.”

Participants are also keen to ensure that any increase in pay needs to be...

“...better pay for the carers... not the agencies!”

Participants stress throughout the importance of the ‘people’ in making this new model of care deliverable.

“You desperately need more trained staff. My Care My Way is a very commendable idea but it cannot work without staff.”

Along with this need for more staff in the community to keep patients safe and with good health outcomes, is the need for **improvements to the training of home care nurses**. The need for adequately trained staff is also seen to be critical in the success of the proposed model of care.

“Qualified care – not NVQ1 or good intentions – qualified nursing care and plenty of it.”

“Invest in high quality training.”

Findings from the Healthwatch report submitted to the CCGs also refer to the quality of care at home staff raising concern that...

“...some workers may sometimes be young, ill-equipped and untrained.”

These points are summarised by one participant who suggests...

“Care staff are often poorly trained, poorly paid and do not have enough time to complete the necessary care in the allotted time.”

MONITORING OF CARE HOME STANDARDS

With the new model of care having a greater reliance on ‘nursing homes’, patients are keen to see...

“...more monitoring of care homes.”

Participants refer to a variety of standards across the sector, with homes not being monitored and standards in private care settings not necessarily replicating those adhered to by the NHS. There is concern that without CCGs putting more monitoring in place as part of the new model of care, we will be...

“...putting our most vulnerable into places where the quality of care is not guaranteed.”

A letter submitted to the CCG with regard to the new model of care also refers to this point, suggesting....

“...when I see CQC ratings for many of these it appals me that vulnerable patients are treated in this way.”

The Healthwatch report submitted to the CCGs acknowledges doubts over the quality of care in nursing homes in comparison with that currently provided by community hospitals.

“Respondents fear that the quality of that (care) delivered in nursing homes is not on a par with current provision.”

Ensuring standards are set and nursing homes are following the principals of the NHS is seen to be necessary in order for patients to be kept safe and with good health outcomes.

“You would need to invest in training the care home staff up to a more acceptable and safe level – to the standard of the NHS.”

PROVIDE CONTINUITY OF CARE

Providing **continuity of care** is also seen to be essential in ensuring health outcomes of patients at home are good. The concern over the high turnover of staff in community care and care being delivered by people coming into patients homes is highlighted by one participant discussing how...

“...older people like to see the same person, not a string of people.”

Seeing the same staff each day (as they do in hospital) allows patients to build a rapport and so build up trust in their care. Not seeing a new face every day with different carers needing to learn and understand their needs is essential. This is seen to be something that will become more of an issue with a move towards more care being delivered at home with one participant summarising that...

“...with more and more dementia and vulnerable people in their own homes, it is more paramount than ever to have continuity of care.”

This issue of continuity of care is seen to be of key importance for those with learning disabilities in the ASIST focus group report. One participant discusses the need for the same carers to work with individuals over time due to needing...

“...time to build trust between you and for them to know how to communicate with you.”

COMMUNICATION AND COORDINATION

In order for CCGs to keep patients safe and with good health outcomes, participants stress the need for **better coordination between services**. In order for the new model of care to succeed, there is a need to...

“...work in partnership with social care to sort out the current mess of social care provision.”

Stories seen in the media and peoples personal experiences generate an underlying concern (as discussed previously) in a greater emphasis being put onto care provided in the community. Delays in patients leaving community hospitals and being able to return home are often related to a lack of social care provision, care packages not being in place immediately and there being a lack of communication between different agencies. Participants are keen to see...

“...investment in better communications and a more linked up service.”

One participant supporting change and a move to the new model of care agrees that...

“...yes, people recover better at home, if the correct overseeing is done, but currently this is too fragmented.”

Another feels the most appropriate approach to ensuring this critical coordination is improved is to...

“...have a named person responsible for coordinating each person’s care.”

Another felt it may be beneficial for the CCG to consider the...

“... lessons of ‘care coordination’ (as delivered in mental health services) where patients with multiple needs have a single named professional who coordinates all elements of their care to ensure that communication and input is managed to reduce duplication and ensure the most cost effective care is offered.”

Participants also discuss a lack of communication between services in neighbouring areas.

“The problem will still be there – when someone is taken into hospital that is classed as out of area and it involves two health authorities they don’t talk to each other and it results in bed blocking.”

Along with this need for better coordination and communication between service providers is the need for **improvement to communication** and **clear communication** with patients and their families/carers. Participants discuss how patients can easily become confused and frustrated when they do not have a clear pathway, are unsure of their next move and are left unsure who to contact for their different needs.

“Many patients do not know who to call for each different aspect – medication, treatment, care etc.”

This point is supported by discussion at the Stoke-on-Trent Patient Congress meeting in April 2016, where the need for clear coordination between services to ensure patients and carers can be seen by one health professional/service and know key individuals who would be able to provide support when needed is referred to.

Across findings and comments from all engagement methods, participants summarise that...

“...communication is vital.”

MONITORING OF/SUPPORT FOR PATIENTS AT HOME

A further step the CCG could take to keep patients safe and with good health outcomes is suggested to be through improving the monitoring of and support for patients at home. Having **telephone support** or a 24 hour telephone support number would be beneficial.

Looking at **modern technology to monitor patients at home** is also suggested. Technology such as motion sensors and audio equipment are discussed, with one participant summarising that...

"...there should, with new technology be better ways of providing a safer outcome for patients in the home e.g. monitored CCTV coverage and warden schemes."

"Anyone at risk could be given free emergency buttons in case of problems."

These forms of support would give the public more confidence in the new model of care as they are seen to provide additional back-up and support to patients who may otherwise be isolated and 'at risk' when left alone in their own homes.

Despite support for the new model of care, one of the major concerns among participants to the online survey regarding this approach is the need for **night-time care** to be implemented, which it is felt services currently do not provide.

"Patients are at more risk at night when there is no care (or very little) available so implementing night time care is going to be a must if care at home is going to work."

Ensuring the place called '**home**' that patients are going to be cared for in **is appropriate and safe** is also seen to be important in order for patients to be safe and with good health outcomes. One participant raises this concern in discussing having been told of...

"...several patients locally who had gone home with no care package in place, no food and in some cases no heating."

This is also discussed in a letter submitted to the CCG where the importance of increased monitoring is referred to in order to ensure patients are safe and health outcomes are good with an increase in the number of patients recovering in their own homes.

"We need to assess if previous home situations are now safe and appropriate for these patients."

HEALTH PROMOTION/LOCAL HEALTH SERVICES/FACILITIES

Participants also feel the CCG could help to keep patients safe and with good health outcomes by focusing on **health promotion**, providing access to local facilities for rehabilitation and improving localised health provision.

Promoting healthy living, including healthy eating, reducing obesity and encouraging exercise programmes are seen to reduce the need for and demands on healthcare.

"Prevention rather than cure – if money is put into keeping people well then savings will be made across other areas of the health service before crisis is reached."

This is also addressed at engagement events where one participant gives their support for the new model of care, suggesting there is too much focus on the 'discharge process', when instead there should be more focus on preventative measures.

"Why don't we look at preventatives, even before get to hospital?"

Continuing to **encourage patients to engage with health checks and screening** is also important in reducing the demands on healthcare as time goes on.

Making better use of existing facilities is suggested as a way to ensure good health outcomes of patients. Local authority facilities such as swimming pools and gyms are seen as ideal places for rehabilitation to be offered.

Improving local health provision such as walk-in centres to ensure they provide the required services effectively will also help, with one participant suggesting the need to...

“...improve localised walk in services to prevent A & E crises.”

DEVELOP VOLUNTARY SECTOR SERVICES/SUPPORT LOCAL GROUPS

A number of participants feel CCGs should look to **develop voluntary sector services** and **provide more support to existing local groups** who can in return offer significant support to patients being looked after in their own homes.

Voluntary sector services, such as visiting and befriending, could provide a **critical service** to support this new model of care. Local organisations run by volunteers can offer a significant level of support to help to keep patients in their home environment.

One participant discusses the work of the charity 'Moorlands Home Link' who offer a range of services including a day care centre, befriending, bathing and meals on wheels, discussing how...

“...this organisation had been providing services for decades and everything is already in place – surely these kinds of group could be incorporated into My Care My Way.”

Encouraging friends and families to be involved in patient care and **supporting 'self-care development groups'** are also suggested as steps the CCGs can take to keep patients safe and with good health outcomes. One participant feels...

“...this should, if done effectively, reduce the appointments at the GP's surgeries and attendance at A and E.”

Other references made by individual respondents include reducing the use of the NHS for cosmetic surgery and lifestyle choices, improving the timetabling of district nurses to ensure their travel time is reduced and making sure patients who are discharged to home are able to leave their home at least once a week.

3.4 Alternatives to the CCGs proposals

Participants were asked if they thought there were any alternatives to the CCGs' proposals that have not been considered.

The table below details the ideas raised and themes discussed by highest numbers of participants in the online survey.

Table 3.4.1 – Are there any alternatives to our proposals that we have not considered?

	Number of participants	Total 132 %
No alternatives – just keep Community Hospitals open	10	8%
Gradual reduction in closing beds rather than closing a large number at one time – ensure capacity is available in the community first	8	6%
Rehabilitation in a Community Hospital/beds offering interim support before returning home	7	5%
Keep Community Hospitals open but use them more efficiently	5	4%
Fight for more investment/campaign against health cuts from Government	5	4%
Map resources currently available/better use of the voluntary sector	5	4%
Improve discharge processes/care packages so patients can move on more quickly	4	3%
Improve pay/conditions of staff in community care to encourage them to stay/allow job satisfaction	3	2%
Retain some provision for those in rural areas	2	2%
Review spending/reduce costs – look to cut management costs and procurement costs rather than patient care	2	2%
Brighton House model is good – social care with health support	2	2%
Reinstate respite care/support for families/carers	2	2%
Don't know/no comment/none	56	42%

Base: all participants (132)

As shown above, some 42% said there are no alternatives, or are unable to make suggestions. Most frequent suggestions, as shown, are to keeping the community hospitals open, having a gradual reduction in closing beds rather than closing a large number at one time and continuing to provide rehabilitation in community hospitals before returning home.

The themes above, along with others referred to by fewer respondents are discussed in detail in the sections below. Verbatim comments are also used throughout to highlight points raised. Thoughts and comments from attendees at engagement events and comments from other responses to the engagement process are also included in the relevant sections.

KEEP COMMUNITY HOSPITALS/USE BEDS MORE EFFICIENTLY

In considering if there are any alternatives to the CCGs proposals that participants feel have not been considered, a number reiterate the view that there are **no alternatives** and that **Community Hospitals need to be kept open**.

“There are no alternatives – just keep the community hospitals open.”

The need and demand for community hospitals is seen to be increasing rather than decreasing with an ever growing elderly population.

Others who feel community bed provision is still required suggest it could be used **more efficiently** and that there is a need for more monitoring to ensure the beds are occupied by people who do meet the criteria they are funded for.

“Keep the community beds open but implement much more stringent control over them making them more efficient.”

TAKE TIME TO IMPLEMENT – STAGED APPROACH

Participants refer to a need for a more **gradual reduction in the number of beds** and it being necessary to take time to implement the new model of care so as to not put patients and the community at risk.

“You should not close further community beds until the success or otherwise of alternative provision for those patients who would have gone to Bradwell or Cheadle has been properly evaluated.”

One participant at an engagement event criticises the speed at which the process is being implemented in suggesting...

“...you just plough on regardless too quickly – there will be a tragedy and vulnerable people in communities will pay.”

The concern expressed here is again often linked to that discussed in previous sections whereby the public lack confidence in the current care at home service provision. Whilst there is support for the new model of care and participants see benefits in this new approach, it is vital that **appropriate home care is in place before these community beds are closed.**

“Your proposals are good but the infrastructure in place to deal with them is insufficient.”

“Your proposals are unrealistic in the sense that you wish to remove one safety net before the other is in place. Care at home is the correct vision but it has to be in place before community hospital beds are removed.”

A safe alternative is therefore discussed to be providing community support and steadily winding down the number of beds, thus leaving some...

“...community bed status intact until there are sufficient staffing levels to allow any new systems a chance to work.”

Engagement event participants also support a more gradual approach in suggesting...

“...if you are going to do it properly you should get everything working and then close things – otherwise there will be one big mess.”

One participant also refers to there being **alternative providers** willing to take on the contracts for the beds and that more time needs to be given for such plans to be developed.

RETAIN SOME COMMUNITY BEDS SERVICE PROVISION

Retaining some community beds provision is seen as vital to offer **rehabilitation and interim support to patients before they return home** to avoid harm from patients being discharged before they are ready.

“Care at home as soon as possible is important but need to ensure that we are not discharging people that are not medically fit as this in turn results in higher cost and detrimental effects to the client.”

Several participants feel removing the ‘halfway’ care support will result in patients staying in acute hospital situations for longer and thus cause further ‘bed blocking’ issues in other areas.

Despite agreement in principle with the new model of care proposed, participants feel...

“...a blanket ruling which eradicates services leaves those who fall outside the norm at a disadvantage.”

This is seen as a particular issue for those living in remote or rural areas, where they could easily become very isolated if vital community hospital provision is removed. **Retaining some provision for those in rural areas** will be beneficial, otherwise these bed closures...

“...pose a serious mental health risk and also physical risks if people are struggling with mobility.”

IMPROVE DISCHARGE PROCESSES/SPEED OF COMMUNITY CARE PROVISION

It is suggested that **improving discharge processes and ensuring care packages** are in place to allow patients to move on more quickly will help to ensure community beds are only used for their original purpose. Fewer beds of this nature will then be required. This streamlined approach would be favoured by a number of participants as an alternative to the proposals set out.

“Community hospitals are obviously required or they would not be full all the time and if care packages were in place within a decent amount of time there would not be a problem.”

Another participant supports this view suggesting that they need to...

“...provide more community care quicker – the process takes too long.”

FIGHT FOR MORE INVESTMENT/CAMPAIGN AGAINST CUTS

Several participants again refer here to fighting for **more investment and campaigning against Government cuts** as an alternative proposal. They feel strongly that increased funding from central Government is required and that the only way to ensure the safety of patients and the community is to reverse cuts and increase funding.

“Start by demanding more funding and put health, rehabilitation and care above finance.”

REVIEW SPENDING/REDUCE COSTS IN OTHER AREAS

Participants in the online survey suggest an alternative to the CCGs proposals is to **review spending and reduce costs** in other areas. Reducing costs in hospitals in general, along with reviewing procurement processes and costs to ensure best prices are being secured are discussed. Looking at staffing costs is also referred to with one participant suggesting...

“...do not cut the menial staff – look to the staff ratio of management.”

Reducing these costs should be seen as a priority rather than cuts that result in negative impacts on patient care.

REPLICATE BEST PRACTICE MODELS/PROJECTS

Participants suggest the CCG should look to replicate **best practice models** or projects where good examples of care have been delivered. One model named by several participants as a good example is the Brighton House model (despite its closing). This option is seen to offer the kind of care required and to be cheaper than acute hospital care. Participants are keen to see more funding for this type of provision.

“The Brighton House model is good, as it is social care with health support.”

Brighton House is seen to be...

“...an ideal place for people to step down from a hospital setting. Funding should have been found for this to continue.”

A further participant refers to the need for further development of the award winning ‘Care Home Project’ in order for the CCG to avoid re-admissions from nursing homes to acute hospitals.

MORE FUNDING FOR CARE HOMES

In order for the new model of care to work, with a greater reliance on nursing homes to provide care in cases where patients are unable to return to living independently in their own homes, participants suggest a requirement for **more funding for care homes** to allow them to provide the required level of step-down care.

It is suggested that councils should not have closed so many care homes as these places will now be in even greater demand in order for patients to remain safe and cared for effectively.

Letters received by the CCG as part of this engagement process also question why nursing home beds are being decommissioned when the new model of care will have this greater reliance on these provisions.

“Could the NSCCG provide details regarding the reasoning for decommissioning nursing home beds, against a backdrop of decommissioning sub-acute beds at community hospitals, with the potential knock on requirement for increased demand for nursing home beds?”

The issue of a requirement for more rather than less nursing home beds in the future to meet the needs of the new model of care is also highlighted at engagement events whereby participants discuss the lack of availability of nursing home places where...

“...patients had assessments but needed to be there (in community hospital) because there was nowhere else to go.”

An event participant also raises this issue asking...

“...what is the back-up plan when nursing homes close due to underfunding?”

IMPROVE PAY AND CONDITIONS OF STAFF IN COMMUNITY CARE/LOOK AT STAFF RETENTION

Regardless of what model of care is implemented and alternative proposals available, participants are keen to reiterate the need for **improvements to the pay and conditions of staff in community care** if this type of care is to succeed.

“We will attract good community nurses if they are not under resourced, not undervalued. Patients will then experience better knowledgeable quality care and stay at home.”

Another supported this view in highlighting that, despite not being able to suggest an alternative proposal, it was important to note that...

“... the care situation needs addressing as many staff in my respite setting had previously done care in the home and left because the time allocated, travel time etc meant they got no job satisfaction as they couldn't adequately care for their people.”

Participants feel this should be taken into account and listened to if moving towards the new model of care is to be a success.

This issue was also discussed at engagement events with the concern here being about the quality of care provided. It is suggested care staff need to be paid more as the result otherwise is that you attract to these roles the people who are...

“...doing the job just to earn money.”

Staff retention is seen to be a long standing issue and one that may be challenging to change within the existing culture of Staffordshire and Stoke-on-Trent Partnership (SSOTP) NHS Trust.

MAP RESOURCES CURRENTLY AVAILABLE/BETTER USE OF VOLUNTARY SECTOR

A further alternative proposal or suggestion to support the implementation of the new model of care is to **map resources currently available** and to **make better use of the voluntary sector**.

Participants refer to the 'wealth of experience' in the voluntary sector that can easily be drawn upon. The CCG could look to support existing groups and set up new groups within the voluntary sector to provide services to support patients discharged to home with a package of care in the community. Better coordination and a wider understanding of the services already available will be beneficial to the community and those in need of further support.

Participants at engagement events cite examples such as age concern and unpaid first responders here as resources that may be better utilised.

REINSTATE RESPITE CARE/SUPPORT FOR FAMILIES AND CARERS

With a greater reliance on family members and carers to support patients returning home at an earlier stage following discharge from acute hospital services, participants feel there is a need for **more support for families/carers** and the need for **respite care to be reinstated**. One participant refers to the community beds previously offering this type of 'step-up' care, where the patient was admitted to a community bed to allow the carer time to recharge, thus...

"...allowing them to carry on looking after their loved one for longer at home."

Providing some form of respite care to allow this to continue is seen as important in ensuring the wellbeing of family members and carers if the patient is to remain in their home setting for a longer period of time.

Other references made by individual respondents as alternatives to the CCGs proposals include partial private funding of care, using new technology to monitor home patients and ensuring the existing staff are redeployed in the new care system.

3.5 Particular groups in the community proposals are unfair to

Participants were asked if they think that the CCG’s proposals were unfair to any particular group within their communities.

The table below details the ideas raised and themes discussed by highest numbers of participants in the online survey.

Table 3.5.1 – Do you think that our proposals are unfair to any particular group within our communities?

	Number of participants	Total 132 %
Elderly	58	44%
Family members/unpaid carers	21	16%
People with no local relatives/no family support	17	13%
Patients living alone	13	10%
Vulnerable	9	7%
Those in rural/remote areas	8	6%
Everyone/all	7	5%
Dementia patients	5	4%
Disabled people	4	3%
Patients who need 24 hour care	4	3%
Palliative patients	4	3%
Patients who genuinely need the beds	4	3%
Health care professionals/care staff	4	3%
Mentally ill	2	2%
Working families	2	2%
No	14	11%
Don't know/no comment	17	13%

Base: all participants (132)

As shown above, the majority of participants had comments/suggestions to make with regard to particular groups within communities to whom they felt proposals were unfair, with 11% suggesting they were not unfair to particular groups and a further 13% being unsure.

The elderly, family members and unpaid carers, people without local relatives or family support and living alone are most frequently referred to as the groups proposals are most unfair to.

The groups above, along with others referred to by fewer respondents are discussed in detail in the sections below. Verbatim comments are also used throughout to highlight points raised. Points raised in letters and other responses submitted to the CCG with regard to the implementation of the new model of care along with thoughts and comments from attendees at engagement events are also included in the relevant sections.

ELDERLY

Almost half of respondents to the online survey refer to the **elderly** as the group the new proposal for care is unfair to. Participants feel the elderly are at greater risk, need longer to recover and require additional support.

“The elderly are the ones that suffer.”

Older people are seen to be less able to fight for their needs and to be the group who deserve to be treated properly.

“These people have paid into the system from the age of 15 and deserve the best care possible.”

Letters submitted to the CCG also refer to the elderly being at greatest risk from the new model of care with them seen to be treated poorly as they are the least likely to complain.

“Cutting care for the elderly to the bone is the easiest way to make savings because, by and large, these are the people who will complain the least.”

Another participant suggests...

“...they are often weak and vulnerable and their plight does not make the front page of the Sentinel or local television and radio news. Their families are often stressed and anxious, unaware of their rights; on the whole they bravely accept their lot with little complaint. In my opinion they deserve better than that and require the support of those of us who are fortunate to have reasonable health, to ensure that they have some choice in their later years, something that I am sure you agree we all want and deserve towards the end of our lives.”

Continuity of care is also highlighted here as an issue specific to the elderly with one participant suggesting...

“...the proposals are unfair to older people, who are moved around from one place to another, no continuity of care, they just return back to A&E on the never ending carousel.”

The strength of feeling among participants that the model of care being unfair to the elderly is not acceptable is apparent with comments made including one participant asking...

“...what are you trying to do – carry out euthanasia on the old and vulnerable by neglect.”

MENTALLY ILL/DEMENTIA PATIENTS

Those with **mental illness** are also highlighted as a group to whom the proposals are seen to be unfair. The question is raised as to how the new model of care will be ‘useable’ by those with mental health issues.

Concern is also raised at the Stoke-on-Trent patient congress meeting on 18th October 2016 regarding...

“...the vulnerability and risks around mental health patients being discharged with no care package and no family to offer support.”

Patients with **dementia** are also referred to here as those to whom proposals are unfair, with this group...

“...needing expert diagnosis and carefully planned care prior to being sent home or to a nursing/residential home.”

Respondents feel specialist provision is needed for dementia patients and that it is vital services...

“...give these people chance to be rehabilitated and recover.”

One participant summarises the need for specialist care for **elderly and dementia** patients, with concern that the new model of care may not offer suitable provision for these groups.

“The elderly and those with dementia – we have seen the systematic closure of geriatric wards and hospitals over a number of years within the NHS. These patients then end up being treated in an acute hospital environment where ever growing pressure on staff is clearly evident. Elderly patients and those with dementia need specialist nursing staff.”

DISABLED PEOPLE

The proposal being unfair to the **disabled** is also discussed, with one participant suggesting this particularly to be the case for...

“...the newly disabled who may have become housebound after their discharge from hospital.”

PATIENTS LIVING ALONE

Patients living alone are also seen to be a group to whom the proposal is unfair, with...

“...people who live on their own needing extra support.”

The fear of isolation and these patients being vulnerable in the community is also discussed.

“Those who live in their own homes. They will be left on their own save for a few minutes a day a nurse or medical support person will check on them. These elderly patients will be very vulnerable.”

“Isolation in their home – which it is what it will end up being – will just become another way of ‘sending them home to die’.”

Whilst some patients have family members to visit and/or support them, several participants refer to the difficulty faced by relatives, where despite wanting to care for their relatives it is not possible to do so 24 hours a day.

“Families cannot be expected to look after frail relatives 24 hours a day – many have work commitments etc.”

PEOPLE WITH NO LOCAL RELATIVES/NO FAMILY SUPPORT

Following on from this, participants feel the proposal is also unfair to **people with no local relatives or family members** to support them. Those who have no family to assist them when they are discharged from hospital and need ongoing care are seen to be at risk and disadvantaged by the proposals.

“People who are estranged from their family or do not have a family. In the community beds there is always someone around to support a patient. At home some people have no one.”

“The people without children and grandchildren when older do not have a support system in the community and often their friends are frail and old too, or have died and any spouse/partner may also be deceased. They are totally alone.”

Concern is also raised that...

“...it needs someone, either the patient or their family, to chase things up at the moment, to make sure things get put in place. It is therefore disadvantaging those who cannot express themselves and have no family support.”

PATIENTS WHO NEED 24 HOUR CARE

Some patients are seen to require **24 hour care** and people feel the proposal is unfair to those with these needs. Patients need...

“...time to recover in a hospital setting where they can be cared for round the clock, provided with essential rehabilitation and regain confidence.”

A further participant summarises these views in saying...

“...there are patients whose after-care needs are 24 hour care. There is no way under the current proposals that these patients could receive the care they need.”

PATIENTS WITH LONG TERM ILLNESSES/PALLIATIVE PATIENTS

The proposal is also seen to be unfair to **patients with long term illnesses**. Sending people home is seen to be the right thing to do but...

“...only when they are well enough to return home. Many I know in the community and people I have personally helped have been alone and were sent home ill.”

There is a concern that **palliative care patients** will also be disadvantaged. Community hospitals are seen to currently offer support and access to palliative decision making.

Without community hospital provision for palliative care patients, there is concern that they will be sent home without the appropriate care and support in place, leading to a situation recalled by one participant where a family member was...

“...sent home with only family support, it was traumatic watching my mother die with no clinical support. The GP said he wouldn’t offer hospice support until nearer the end – when the end was near he told us we would have to manage by ourselves. This is not care in the community. It has affected our family ever since – we turned into carers with no experience except love.”

VULNERABLE MEMBERS OF SOCIETY

In considering if proposals are unfair to any particular group within society, references are made to **vulnerable** members of society.

“Unfair to the most vulnerable of society.”

There is thought to be a general lack of resource and people feel this will have the greatest impact on the vulnerable.

“The most vulnerable in our society are going to be at more risk and suffer due to lack of resources because no matter what there is simply not the care out there.”

One participant suggests that **patients with sensory impairments** will also be disadvantaged by new proposals, with the risk that...

“...people who are isolated by sensory impairment will not be served by infrequent visits.”

ALL MEMBERS OF THE COMMUNITY

Others feel that **all members of the community** will be affected by the new proposal with one participant suggesting...

“...they are unfair to the whole community and most unfair to those most in need.”

Participants feel no-one will be ‘better-off’ with the model of care and that...

“...there will be impacts on all due to additional pressures on existing services.”

“I think the proposals are unfair to everyone, other than those who have access to private health care.”

A further participant refers here to it being...

“...hard not to view these proposals as anything more than a ‘cost cutting exercise’ under the pretext that a better service will be provided.”

The general population being impacted upon is also referred to with regard to the proposals being unfair to **people needing A & E services**.

“Anyone in the Staffs region who needs A & E services. We’ve all seen the A & E corridors – it’s a terrifying prospect!! The more beds that close without adequate community support the worse the situation gets. At this rate there will be tents outside A & E – it’s becoming insane.”

FAMILY MEMBERS/UNPAID CARERS

The proposal for the new model of care is also specifically seen to be unfair to **family members and unpaid carers**.

Participants who feel the new model of care will lead to the need for more patients to go to residential homes suggest that if this is the case these need to be available and also convenient for patients and their families. Otherwise this is seen to...

“...disadvantage both patients and their relatives and friends who may not have the transport or finances to travel to non local localities.”

People not being able to visit family members due to them not remaining within their local community area is also seen to have an impact on their recovery.

It is also noted that in many cases, the unpaid carers or relatives are...

“...old people looking after old people.”

Where this is the case, there is a need for more support for carers. This is needed to ensure the health and wellbeing of the carer is not impacted upon and is seen to be something that has been required but not delivered for a period of time.

“Older people are caring for old people – they need more support which has been spoken about for years and is still not out there.”

“When one person over 65 falls ill, care by an older partner can put extra strain on their health and wellbeing.”

Participants feel that with the new proposals, there is a need for...

“...the impact on carers to be fully evaluated and if introduced additional support provided to carers to support their health, independence and wellbeing.”

This need for impacts on carers to be assessed is also discussed by engagement event participants, with questions raised as to whether...

“...CCGs can consider the impact on carers if rehab support is to go?”

If this isn't addressed, proposals are seen to be short sighted as...

“...family carers being put under pressure to do more and more will lead to higher costs long term.”

Participants in the focus group report from ASIST also express concern for carers here suggesting community beds are needed, not just for patients, but in order to provide respite for carers.

“Carers need support and respite as well.”

THOSE IN RURAL AND/OR REMOTE AREAS

Participants refer to the proposal for My Care My Way Home First to be unfair to **those in rural and/or remote areas**.

Trying to access such services in these types of areas is seen to be a challenge and something that will be a greater concern following the introduction of this new model of care. The lack of public confidence in 'care at home' is also highlighted here with this anticipated to become a greater issue in rural communities.

“At home caring is renowned to be awful these days, particularly those in rural areas, and it cannot be 24/7.”

There is also a concern that these proposals will lead to further isolation of people living in remote areas.

“I think these proposals are vastly detrimental to people living in rural areas. People have to travel to access services of any kind. If they have been ill/had an injury which limits their ability to travel or their mobility, their house transforms from a house to a prison.”

Concern is also raised regarding the logistics of carers accessing patients at home in rural and remote areas when weather conditions are bad. This is also discussed at engagement events with participants questioning...

“...will people in rural areas get the services they need in bad weather?”

Another participant summarises this issue in discussing...

“...the weather is so unpredictable. I know for a fact there has been elderly people living alone that have had care in the community, and the carers have not been able to reach them due to the snow and roads being blocked for several days. So if it wasn't for the good neighbours that have seen to them, these people would have died.”

This raises the question...

“...what safeguards have you got in place so people in rural areas can access these services without upset and worry.”

PATIENTS WHO GENUINELY NEED THE BEDS/NEED INTENSIVE REHABILITATION

As discussed in previous sections participants feel there is a need for some community bed provision to remain, with **patients who genuinely need these beds** seen to be adversely affected by the proposals.

“Those that really need hospital care before they go home.”

Participants suggest the proposals discriminate against those who cannot be cared for at home and those for whom equipment required for rehabilitation is simply not available in the home.

Where **patients require intensive rehabilitation** there is doubt that this can be sufficiently delivered in the home setting.

EMPLOYEES ACROSS THE HEALTH SECTOR

Proposals are also suggested to be unfair to **healthcare professionals and care staff** who participants feel will have even more demand placed upon them.

“They are unfair to healthcare professionals who are already stretched to the limit and generally work additional unpaid hours every day to ensure patients are safe and well looked after.”

With the new proposal, participants summarise that it will be unfair to...

“...the primary care staff and community staff who have to pick up the pieces.”

Participants also refer to the plans being unfair to **staff at community hospitals** who may be made redundant as part of the change in delivery of care.

This is also raised at the Stoke-on-Trent patient congress meeting with regard to what would happen to current staff within community hospitals and whether this is being taken into consideration.

OTHER GROUPS

Participants at the ASIST focus group discuss other groups who may be disadvantaged by the model of care to include the homeless, BME communities who speak different languages and the travelling community.

4.0 Summary and Conclusions

There is public support for the My Care My Way Home First model of care, but concern is raised regarding barriers to this model being deliverable and therefore doubts as to whether its implementation will be successful and have safe and good health outcomes for patients.

- Two thirds of participants agree that patients should be discharged from hospital as soon as possible and cared for at home with appropriate support.
- Just over half agree patients being cared for in the place they call home helps them to recover faster than being in a hospital bed.
- Some 70% agree that CCGs should put more funds into supporting services which help patients to be cared for in the place they call home.
- However, support for the My Care My Way Home First model of care reduces slightly when it comes to funding this type of care meaning a re-direction of funds from community bed provision. Only a third of participants agree that the CCGs proposals to re-direct NHS money from funding community hospital beds to funding more care at or near the patients home is the right thing to do.

Across all open questions in the online survey, discussions at engagement events, findings from the Healthwatch report and through other communications received by the CCG, there are a series of general concerns/themes raised regarding the implementation of the My Care My Way Home First model of care.

- Throughout the engagement process there is strong support for the service currently delivered by 'community beds', with participants holding strong views and showing support for this provision to continue. They describe the service as 'invaluable' in providing an essential service bridging the gap between the acute hospital and home and an essential part in patients' recovery.
- There is perhaps a misunderstanding among members of the public as to what the beds are 'funded' to provide and a lack of understanding or reluctance to accept the cost of this current service provision and budget limitations and thus the feasibility of this service continuing as is.
- Many participants feel it is essential that community hospital beds provision is continued and suggest further campaigning to reduce Government cuts is required. Others acknowledging constraints around funding suggest retaining at least some of the beds is required along with ensuring they are used more efficiently in the future (for the purpose for which they are funded).
- Having a balance between community hospital beds and care in the community packages and a 'halfway house' between acute hospital and home is seen to be essential, although the question is raised as to whether this needs to be in the form of the current community hospital beds, or a less clinical 'convalescence' home type facility.
- Several participants refer through the engagement process to the option for community beds to be part funded by patients and/or their families. Participants feel there may be scope for patients to be charged at least for food and provisions during their stay. It is felt charges should also be applied for community beds where patients and/or their families are seen to be deliberately delaying their discharge.
- Rightly or wrongly, it is understandable that the public have come to rely on the service provided and received in recent times from community hospital beds. This along with the fact they are acknowledged to be doing

such a good job means removing the provision is inevitably going to cause concern. The public need reassurance that the same level of quality care and treatment will be delivered under the new model of care.

- There is an issue here and throughout the engagement process, whereby people appear frightened of change, particularly where the result may be of harm to patients and the community.
- Participants are keen to raise concern that a 'one size fits all' approach suggests things to be too simple and that there will always be patients to whom this will not provide the required support and care. The expectation for everyone to be cared for effectively under the new model of care is seen to be unrealistic with it not deemed possible for all rehabilitation to be undertaken with patients at home.
- Concern is also apparent regarding the speed at which changes are planned/taking place. Participants suggest there is a need for proper planning and careful implementation if the new model of care is to be a success.
- A recurrent reason for not supporting the new model of care is the lack of confidence that it is deliverable, with participants concerned that the current infrastructure and care in place in the community is not sufficient to enable current levels of care received at community hospitals to be matched. Whilst the idea of My Care My Way Home First is seen to be 'admirable' and one which people ascribe to, it is also seen to be reliant on a satisfactory robust infrastructure to support it. Whilst it is discussed to be something people want, there is doubt as to whether it can realistically be achieved.
- This lack of confidence in current community care provision, along with the need to avoid harm and hospitalisation from poor care is also seen as important in making better use of funds within the NHS overall. Ensuring community based care is of the required quality and right standard is essential for the new model of care to work, with the consequence otherwise being patients returning to acute hospital.
- There is also a wider concern that the closure of beds at the current time is simply a step towards the closure of community hospitals in their entirety. Other clinics are discussed to be moving out of community hospitals with the anticipated result being that there will come a time when the economics of running the services remaining at these facilities will lead to closure.
- Closures of community beds and any additional closures or services/these establishments are seen to represent irreversible decline in NHS healthcare provision across the area and further steps towards privatisation of the NHS.

Participants suggest a variety of approaches they believe the CCGs can take to make savings to pay for increased community based care.

- Participants suggest reducing management and administration staff and providing more hands on nursing staff. Reducing the use of agency staff is also suggested along with reducing from two to one CCG in the North and cutting the number of CCG committee members and/or reducing their salaries.
- Renegotiating supplier costs and ensuring resources are bought in bulk is suggested along with reducing spend on wasted medication and resources and ensuring equipment is reused where appropriate.
- Having a greater focus on preventative healthcare through educating the community in healthy eating and encouraging lifestyle changes is suggested as a way to make savings to pay for increased community based care, along with cutting back on non-essential treatment and ensuring people are entitled to free NHS treatment before it is given.
- Communication and partnership working between agencies also needs to be improved along with reducing the duplication of paperwork and bureaucracy.

- CCGs may also make savings to help pay for increased community based care by ensuring that opportunities are identified whereby skilled employees currently working in community hospitals are redeployed into the new community based care services.
- Along with ensuring there are enough staff employed to provide the required level of care at home is the suggestion that logistics of care workers need to be centralised. Reducing travel time for carers and better organisation of services will allow staff to provide a greater amount and level of care.
- Improvements to discharge processes to reduce the number of readmissions to acute hospital could make savings to pay for increased community based care. Having 'discharge coordinators' to supervise this process is suggested along with the need for regular reassessments of patients needs upon discharge. These are seen to change rapidly and so money can be saved by ensuring the services they receive when they are actually discharged (particularly where there is a delay) are the required services, with this seen to also save resources.
- Ensuring patients are treated properly at the acute phase of an illness is seen to be vital, along with promoting independence during stays in hospital. Reducing the reliance on hospital staff to do things for them when they are in hospital and thus encouraging patients to do things for themselves where they can is seen to result in a lower requirement for support when they return home and receive care in the community.
- Making more use of voluntary sector services is also seen as a way the CCG could make savings to pay for increased community based care.

Participants made numerous suggestions of steps the CCGs can take to keep patients safe and with good health outcomes through the engagement process.

- As discussed earlier in this section, lack of confidence in current community care provision being able to support the implementation of the new model of care, leads to the suggestion for care at home provision to require improvement in order for patients to be kept safe and to have good health outcomes.
- Having the workforce in the community to cope is a priority, with it seen to be vital that support and safe community based care is in place before community hospital beds are closed. This includes the need for there to be enough nurses, nurses to be appropriately trained and a need for an increase in the monitoring of staff and services to ensure quality and frequency of visits is at an acceptable level.
- Concern is also expressed here as it is argued that, whilst the concept is ideal, actual numbers of care in the community staff have reduced in recent years and so the view that district nursing and social care are not in a position to keep the pace. This is seen to act against the new proposals and it is suggested that it is vital this situation does not continue and is reversed in order for patients to be safe and with good health outcomes through the implementation of the new model of care.
- Participants also suggest there is a need for the pay and conditions of care at home staff to be improved in order to attract more people to the profession and improve staff retention. This is seen to be linked to the need for continuity of care, with participants discussing the importance of patients seeing the same staff each day as this allows them to build up a rapport and is important in patients' recovery.
- Many participants also refer to the view that closure of community beds will increase the demand and requirement for beds in nursing/care homes for patients who will not be able to be cared for in their own homes. This raises further concern in the engagement process with issues regarding the availability and quality of care places available. Investment in care homes is required if this approach is to succeed along with the need for a formal inspection process to be introduced.
- Listening to the people on the frontline and experiencing the 'real-life' situation is also suggested to be an important step the CCG could take in keeping patients safe and with good health outcomes.

- Participants are keen to see throughout the process that patients' needs, safety and their health outcomes are seen to be of foremost concern. There is concern that finances are being put in front of patient needs, with cost cutting being undertaken without regard for the welfare of patients
- A further step the CCG could take to keep patients safe and with good health outcomes is suggested to be through improving the monitoring and support for patients at home. Telephone support and looking at modern technology to monitor patients at home are suggested.
- Providing night-time care is also seen to be essential in order for patients to be kept safe and with good health outcomes, along with ensuring the place called 'home' patients are going to be cared for in is appropriate and safe.
- Health promotion and encouraging patients to engage with health checks and screening are also seen to be important in reducing the demands on healthcare as time goes on.
- Improving local health provision such as walk-in centres will also help the health outcomes of patients if they are to return home to be cared for in the community rather than admitted to a community hospital for rehabilitation.
- Developing voluntary sector services and providing more support to existing local groups who can in return offer significant support to patients being looked after in their own homes is seen as a step the CCGs could take to keep patients safe and with good health outcomes. This, along with encouraging friends and families to be involved in patient care and supporting 'self-care development groups' are also suggested.

In considering alternatives to the CCGs proposals, participants again focus on the need for community beds to remain open, to be used more efficiently, to be reduced in number more gradually and only when appropriate care at home is in place and for time to be given for alternative providers to take over the beds if possible. Participants also suggest a variety of other alternatives to the CCGs proposals.

- Participants questioned whether an alternative would be to keep at least some of the community beds open as these are seen to be vital for some patients to offer rehabilitation and interim support before they return home. Retaining some provision, at least in rural areas is seen to be a requirement.
- Participants suggest the CCG should look to replicate best practice models or projects where good examples of care have been delivered.
- Providing more funding for care homes is suggested as an alternative, thus allowing them to provide the vital step-down care and 'halfway house' convalescence provision strongly argued to be required.
- Mapping existing available resources and making better use of the voluntary sector is seen as an alternative proposal or suggestion to support the implementation of the new model of care, with participants referring to the 'wealth of experience' already available that can be drawn upon.
- Looking to reinstate respite care and provide more support for families and carers are also suggested as alternative proposals.

When asked whether they feel the CCGs proposals are unfair to any particular group within communities, participants refer to a wide range of groups.

- The majority refer to the elderly. Patients with mental illness and dementia are also seen to be groups to whom the proposals are particularly unfair along with the disabled.

- Patients living alone and those with no local relatives or family to support them are seen to be at risk and disadvantaged by the proposal, particularly those living in rural and remote areas.
- Other groups the proposals are seen to be unfair to include patients who need 24 hour care, those with long term illness, palliative care patients, vulnerable members of society, those with sensory impairments and those who genuinely need community hospital beds.
- All members of society are suggested to be disadvantaged by some participants with the new model of care expected to place additional pressure on health services, specifically including accident and emergency units.
- Proposals are also seen to be unfair to family members and carers and healthcare professionals and home care staff who will all have increased demand put upon them.

In summary, there is support for the new model of care, with the public agreeing that people should be discharged from hospital and cared for at home as soon as possible and that this helps patients to recover more quickly. However, there is a concern that this is only achievable if the right infrastructure to deliver the care is in place which is strongly doubted by the public at the current time. Public confidence in the My Care My Way Home First model needs to be increased significantly with many asking to see evidence of outcomes or impact assessments carried out before the model is rolled out, or a gradual shift in the provision of care rather than a rapid closure of community beds and immediate reliance on care in the community.

In many cases, what participants are fighting to keep is not the service community beds are 'funded for' but the service they have been 'providing' to the community in recent times. The public have got used to community hospital beds providing a crucial 'interim place to stay' between acute hospital and home, offering good levels of care and rehabilitation. Any proposals for change are therefore going to raise concern.

It is important that the infrastructure is in place for successful care at home to be provided and evidence to be displayed in order for public confidence in the new model of care to increase. Whilst many support the rationale for the change in care provision, there is a lack of confidence in the deliverability of the model and thus a fear of risk to the safety and health outcomes of patients.

5.0 Appendix 1

5.1 Demographic profile of online survey participants

This section of the report provides a breakdown of the demographic profile of participants in the online survey. A total of 132 participants completed the survey.

Highest proportions are from ST5, ST10, ST13 and ST3 postcode areas as shown in the table below.

Table 5.1.1 – Postcode

	Number of participants	Total 132 %
ST1	4	3%
ST2	4	3%
ST3	12	9%
ST4	9	7%
ST5	31	23%
ST6	2	2%
ST7	7	5%
ST8	1	1%
ST9	5	4%
ST10	20	15%
ST13	14	11%
ST15	1	1%
CW2	1	1%
CW3	2	2%
DE14	1	1%
LE2	1	1%
TF9	1	1%
WR1	1	1%
WV10	1	1%

Base: all participants (132)

Some 91% of participants are White, with 6% not responding or referring not to provide this information.

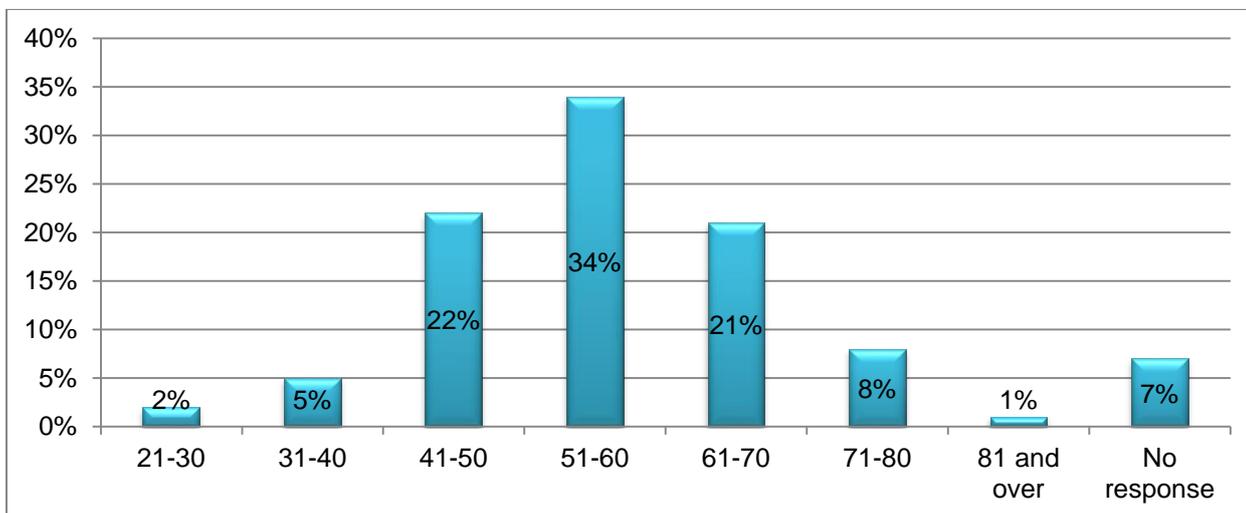
Table 5.1.2 – What is your race?

	Number of participants	Total 132 %
White – English, Welsh, Scottish, Northern Irish, British	120	91%
Any other White background	1	1%
Indian	1	1%
White & Black Caribbean	1	1%
Other ethnic background	1	1%
Prefer not to say/no response	8	6%

Base: all participants (132)

The highest proportions of participants are aged between 41 and 70 with one third being aged 51-60.

Chart 5.1.1 – What is your age category?



Base: all participants (132)

As shown, 7% chose not to provide this information.

Sixty-one percent of participants suggest their religious belief to be Christian, with 8% claiming to have no religion and 24% not providing this information.

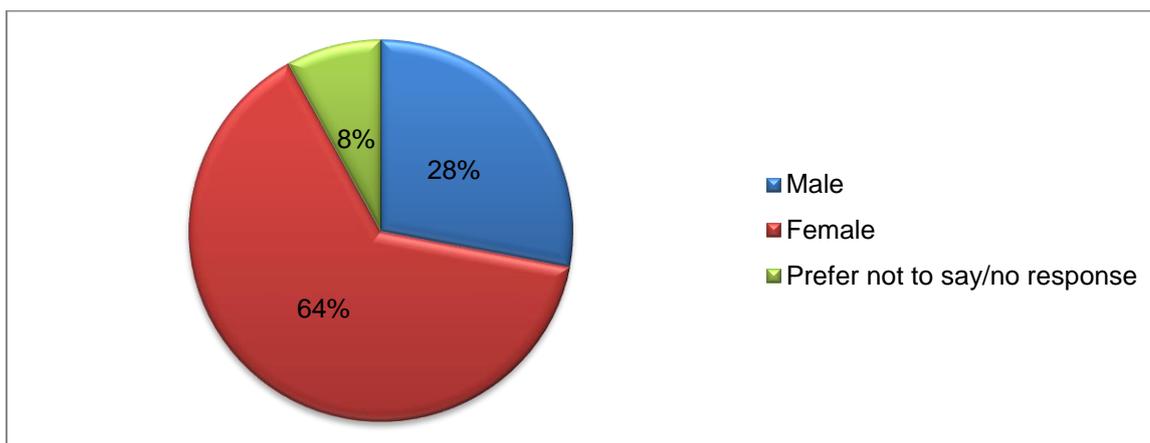
Table 5.1.3 – What is your religion or belief?

	Number of participants	Total 132 %
Christianity	80	61%
Hinduism	1	1%
Atheist	4	3%
Humanist	2	2%
Other	3	2%
No religion/none	10	8%
Prefer not to say/ no response	32	24%

Base: all participants (132)

Sixty-four percent of participants are female and 28% male.

Chart 5.1.2 – What is your gender?



Base: all participants (132)

None of the participants claimed to have gone through or be planning to go through any part of a process to bring their physical appearance and/or gender role more in line with their gender identity.

In considering their sexual orientation, the majority (83%) are heterosexual.

Table 5.1.4 – What is your sexual orientation?

	Number of participants	Total 132 %
Heterosexual (people of the opposite sex)	109	83%
Gay (both male)	2	2%
Lesbian (both female)	1	1%
Bisexual (people of either sex)	1	1%
No response	19	14%

Base: all participants (132)

Almost two out of three participants (65%) are married, with a further 8% living with a partner and 4% claiming to be single.

Table 5.1.5 – What is your relationship status?

	Number of participants	Total 132 %
Married	86	65%
Single	3	4%
Divorced	12	9%
Lives with Partner	11	8%
Separated	1	1%
Widowed	4	3%
Civil Partnership	1	1%
Other	10	8%
No response	11	8%

Base: all participants (132)

None of the online survey participants claim to be pregnant or to have given birth within the last 26 weeks.

Some 8% of participants claim to have a long term illness, with between 3% and 5% having other impairments or disabilities.

Table 5.1.6 – Do you consider yourself to have a disability?

	Number of participants	Total 132 %
Physical impairment	4	3%
Sensory impairment	6	5%
Mental health need	5	4%
Long term illness	10	8%
Learning disability or difficulty	0	0%

Base: all participants (132)

Only 49% of participants claimed not to have caring responsibilities for someone, with 28% caring for persons aged over 50 years of age.

Table 5.1.7 – Do you care for someone?

	Number of participants	Total 132 %
No	65	49%
Care for young person/s aged younger than 24 years of age	8	6%
Care for adult/s aged 25 to 49 years of age	3	2%
Care for older person/s aged over 50 years of age	37	28%
Prefer not to say	10	8%

Base: all participants (132)