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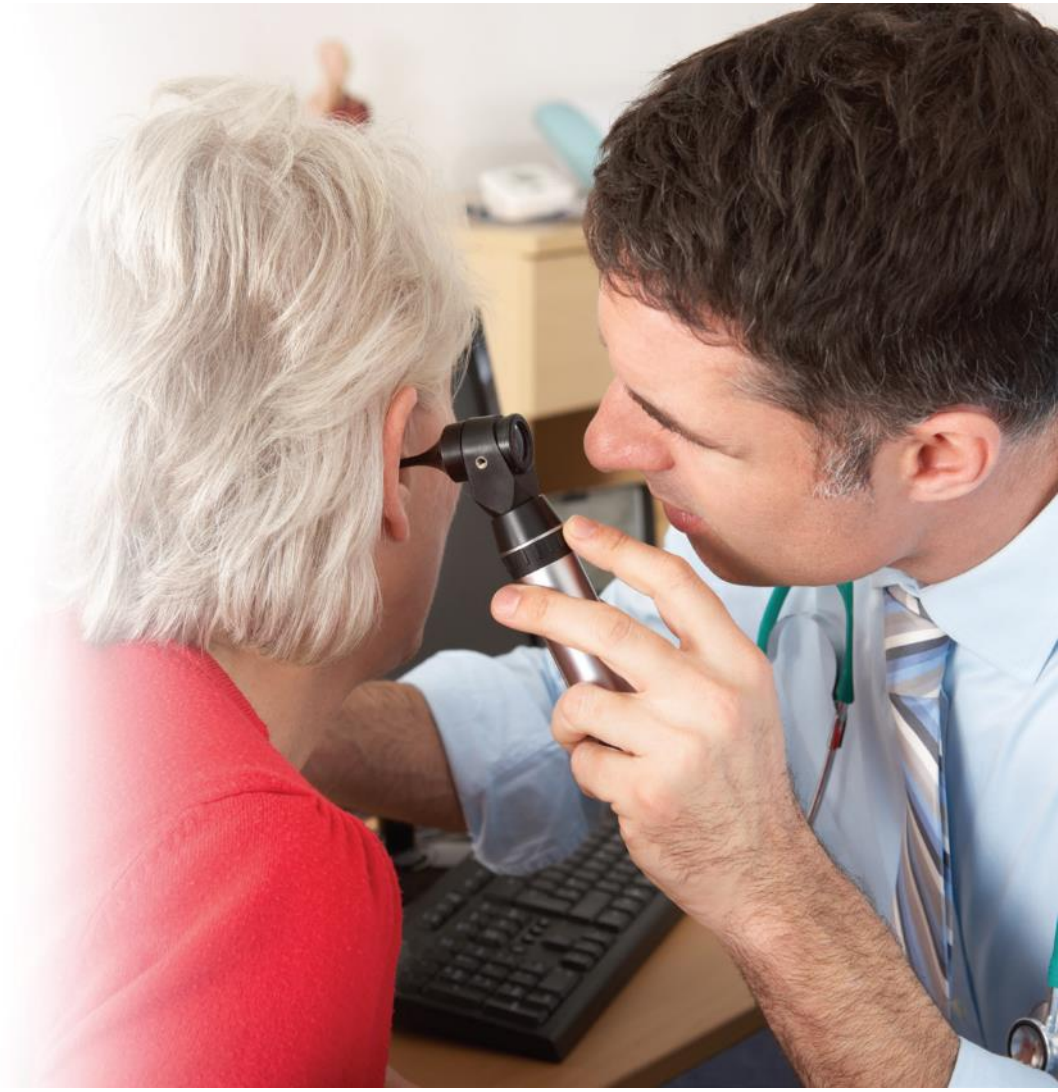
Healthcare Review



Stakeholder Forum

23 July 2014

Agenda for this evening's session

Agenda	Presenter
Welcome, introductions and the purpose of this evening	*Johnathan Bradley, Participate*
Stakeholder engagement	*Jane Meggitt* *Director of Communications & Engagement*
Case for change - a summary	*Dr Diane Bell* *Director of Strategy & System Redesign*
Presentation: Potential options for hospitals	*Dr Diane Bell* *Director of Strategy & System Redesign*
Round table activity - views on options	*Participate*
Break and refreshments	
Presentation: Care closer to home	*Dr Paul Hassan* *Chief Clinical Officer*
Round table activity - Care close to home	*Participate*
Next steps	*Jane Meggitt* *Director of Communications & Engagement*
Open questions and close	*Participate and all speakers*

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The purpose of today

Jonathan Bradley

Participate

Who are Participate?

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- Here to help
- Independent from the NHS
- Helping you to take part and get involved

participate
taking part and making a difference www.participate.uk.com

consultation INSTITUTE partners

What happens today?

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This is the fifth opportunity to have your say.

Presentations and table discussions relating to:

- Latest potential options for ***in hospital care***
- Further considerations for ***care closer to home***
- Your thoughts on public engagement

Your thoughts - captured and considered.

Time for questions, answers and listening.

We're here to deliberate

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- Open discussion
- Look at the issues
- Discuss the facts and dispel the rumours
- Understand different people's points of view
- Listen to other people without bias
- Give time for people to have their say

Comfort and access

- Natural break whenever you like
- Refreshments
- Ask if you need anything else
- Many ways to feedback
- This presentation is available in paper
- We will be circulating copies of more detailed slides as we work through the presentation

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Conversation clothes line - *hang out your thoughts*

Worry wall - *tell us what concerns you*

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Stakeholder engagement:
Taking the Review into the Community

Jane Meggitt
Director of Communications & Engagement

Activity that has so far supported the early stages of the Review (January - July 2014)

- Four **Stakeholder Forums**
- Four **Clinical Forums**
- Seven smaller '**locality meetings**'
- Social media activity
- Presence at identified events involving seldom heard groups such as:
  - Community groups
  - Pensioners forums
  - Colleges
  - Ethnic minority groups
  - Residents associations
  - Parish meetings
  - Carers groups
- The Bedfordshire Healthcare Review website (yourhealthinbedfordshire.co.uk)
- **203,847** local press reach
- **3,503** website visitors
- Face to face dialogue with over **2,000** people
- **51** community group meetings
- **600+** stakeholders receiving newsletter
- **52** news items in local media
- **12** press releases issued
- **1,349** Twitter followers

Continuing conversations…

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- More joint working between CCG & local providers, particularly with regard to communication with staff, members and patients
- More activity with key stakeholder groups
- Concentration upon reaching a wider demographic (including those deemed as ‘seldom heard’ stakeholders)
- Selecting venues with high public footfall - such as supermarkets, health centres and shopping centres
- More partnerships with key community groups who will enable access to their ‘sector networks’ of followers, members and associates

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Case for change - a summary

Dr Diane Bell

Director of Strategy & System Redesign

Bedfordshire CCG

Why the need for change?

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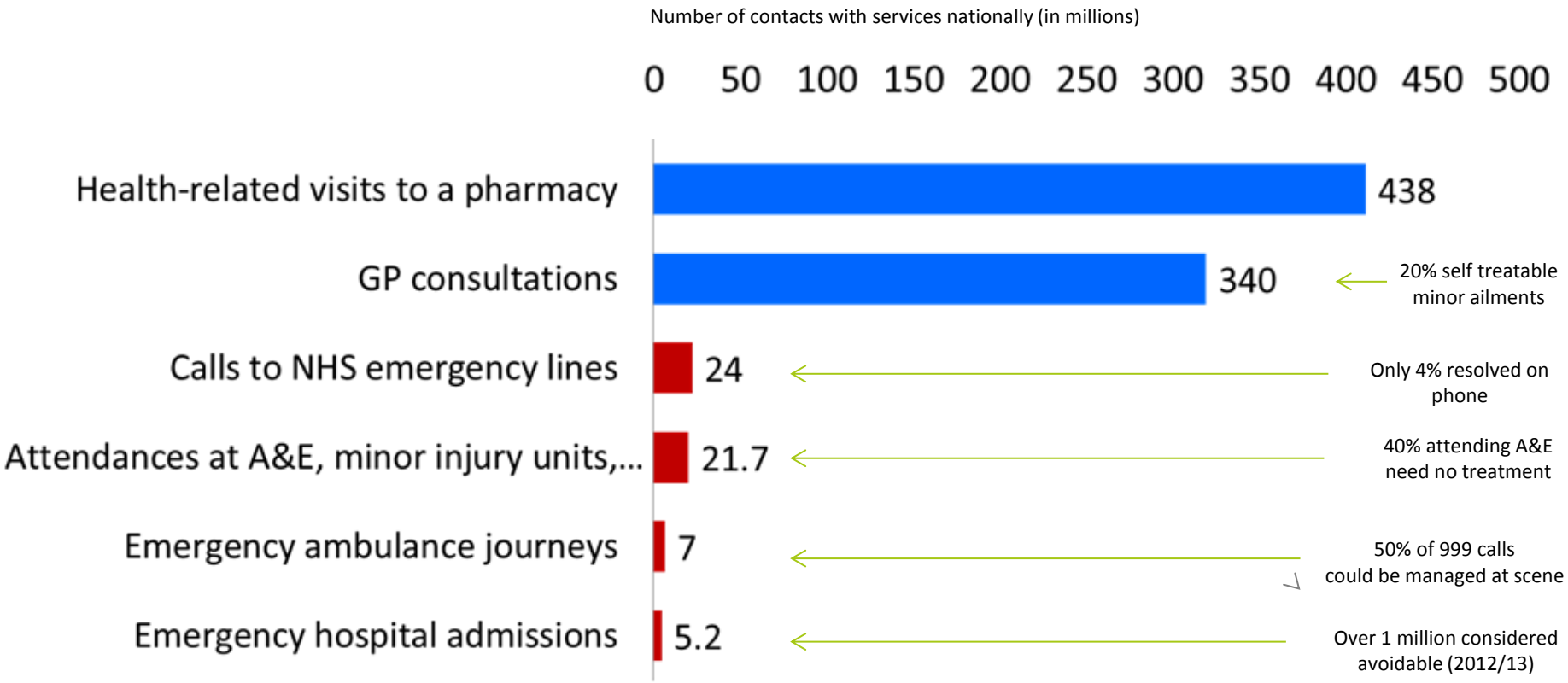
- Doing nothing doesn't mean nothing will happen
- If Bedfordshire CCG doesn't change the way we commission services we are forecast to make a loss of **£25m** by 2018/19
- Bedford Hospital is also forecasting a loss of an additional **£25m** by 2018/19 unless it improves the way it delivers services and improves efficiency
- A greater demand for healthcare and more long term conditions amongst an ageing population mean we need to:
  - Encourage more innovation and efficiency amongst service providers
  - Redesign a more integrated and efficient health system

Vast majority of healthcare delivered through primary and community care - we should be delivering this closer to home



Source: Transforming urgent and emergency care services in England, Urgent and Emergency Care Review End of Phase 1 report, NHS England

A new urgent and emergency care needs to shift more people from bottom to top, delivering as much care as close to home as possible

In this review we are working with certain assumptions

- Out of hospital care will be much better
- Hospitals will be networked
- Community services will be working much more closely with primary and acute services
- What we consult upon must be implementable
- Any models we propose must be clinically and financially sustainable

Any questions

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The potential options for hospitals

Dr Diane Bell

Director of Strategy & System Redesign

Bedfordshire CCG

The Urgent and Emergency Care review NHS England (June 2013)

The NHS review of **urgent and emergency care** services in England sets out to create high quality care for all.

The objective of the national review is to create a system that:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week
- Is **simple** and guides good choices by patients and clinicians
- Provides the **right care** in the **right place**, by those with the **right skills,** the **first time**
- Is **efficient** in the delivery of care and services

The next slides show the different hospital models that have been developed in order to deliver this system

Based on the Keogh Review and working with local clinicians, six possible models for emergency care in hospitals have been described

5 Urgent care centre

Population of ~ 50-100k

- **Immediate urgent care**
- Integrated outpatient, primary, community and social care hub
- Same range of services as integrated care hub but with no beds

4 Integrated care hub with emergency care

Population of ~ 100-250k

- **Assessing and initiating treatment for large proportion of patients**
- Integrated outpatient, primary, community and social care hub
- GP and A&E consultant led urgent care incorporating out of hours GP services
- Step up/step down beds possibly with 48 hour assessment unit
- Outpatients and diagnostics

3 Emergency centre

Population of ~ 250-300k

- **Assessing and initiating treatment for majority of patients**
- Acute medical inpatient care with intensive care/HDU back up
- Consultant led A&E, Access to surgical opinion via network
- Possibly paediatric assessment unit and possibly obstetrics

2b Major emergency centre (b)

Population of ~ 500-700k

- **Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services**
- Moving towards 24x7 consultant delivered A&E, emergency surgery, acute medicine. Level 3 ICU. Inpatient paediatric
- Obstetrics with level 2 NICU

2a Major emergency centre (a)

Population of ~ 1-1.5m

- **p oviding a range o**

NHS England does not expect Bedford or Milton Keynes hospitals to provide hyper-acute specialist services required by Major Emergency Centres

1 Major trauma

Population of at least 2 -3million

-

Major trauma centres are nationally designated units with Addenbrookes and John Radcliffe as designated local providers

Urgent Care Centres ('5') provide limited A&E alongside a broad range of outpatient and diagnostic services

Basic model to which other services can be added

	Activities	% retained
	GP led **A&E**	60
	No **critical care** facility	0
	No **emergency surgical** patients	0
	No **elective surgical** day case patients	0
	No **inpatient medical** patients	0
	No **obstetrics**	0
	No **paediatric** assessment unit	0
	Broad range of **outpatient** services	90
	**Diagnostics** including blood tests, ultrasound, CT and X-ray	95

Infrastructure

- Consulting rooms for outpatient services
- Procedure rooms
- Rehabilitation and intermediate care
- No beds
- No theatres
- Diagnostic facilities, including pathology, chemistry, ultrasound, CT and X-ray

Patients and staff

- Open 12/7
- Serves a population of around **50-100k**
- 12/7 GP led workforce combined with nurse support and GP out of hours

Integrated Care Centres ('4') provide selected medical A&E and intermediate inpatient services but no critical care

Basic model to which other services can be added

Activities	% retained
Consultant led **A&E** with selected acute medical take	70
No **critical care** facility	0
No **emergency surgical** patients	0
Planned surgical day case patients & poss some low risk inpatients	0-90*
Some **emergency medical** patients	25
Most **planned medical** patients	80-90
No **obstetrics** OR lower risk unit for some deliveries, e.g., full term	0*
No **paediatric** assessment unit	0*
Most **outpatient** services requiring hospital infrastructure	90
Diagnostics including CT, MRI, plain film, ultrasound and haematology	95

*Services being analysed for addition to the basic model

Infrastructure

- Consulting rooms for outpatient services
- Procedure rooms
- Rehabilitation and intermediate care
- Acute admissions unit
- Inpatient beds
- Pathology hot lab
- Broad range of diagnostic facilities
- No HDU or ITU

Patients and staff

- Open 24/7
- Serves a population of around **100-250k**
- 12/7 consultant led workforce with network
- Focus on medical and low risk activities

Emergency Centres ('3') provide a wide range of A&E, medical and outpatient services but less non-elective care

Basic model to which other services can be added

Activities	% retained
Consultant led **A&E** seeing most conditions except emergency surgical cases	90
Critical care level 2	50
No **emergency surgical** patients	0
Planned surgical patients who do not need 24/7 onsite consultants	80-90*
Most **emergency medical** patients	90
All **planned medical** patients	100
Obstetric unit with co-located Midwife-led Unit (in some local hospitals) and level 1 Neonatal Intensive Care Unit	95
Paediatric assessment unit	100
All **outpatient** services requiring hospital infrastructure	100
All **Diagnostics** including CT, MRI, plain film x-ray, ultrasound and blood tests	100

*Services being analysed for addition to the basic model

Infrastructure

- Consulting rooms for outpatient services
- Procedure rooms
- Theatres
- HDU/ITU
- Rehabilitation and intermediate care
- Acute admissions unit
- Inpatient beds
- Pathology hot lab
- Broad range of diagnostic facilities

Patients and staff

- Open 24/7
- Serves a population of around **250-300k**
- Similar workforce to a district general site
- Emergency surgery would be transferred

Major emergency centres type b ('2b') provide a broad range of services, similar to those currently provided at both sites

Activities	% retained
Consultant delivered **A&E** seeing conditions including trauma/emergency surgery	100
Critical care level 3	100
All **emergency surgical** patients	100
All **planned surgical** patients	100
All **emergency medical** patients	100
All **planned medical** patients	100
Higher risk **obstetric** unit with 24/7 consultant cover	100
Full range of **paediatric** care with 24/7 consultant cover	100
Full range of **outpatient** services requiring hospital infrastructure	100
Diagnostics including interventional radiology	100

Infrastructure

- Consulting rooms for outpatient services
- Procedure rooms
- Theatres
- HDU/ITU
- Rehabilitation and intermediate care
- Acute admissions unit
- Inpatient beds
- Pathology hot lab
- Full range of diagnostic facilities

Patients and staff

- Open 24/7
- Serves a population of around **500-700k**
- 24/7 consultant led workforce
- Networked for trauma and intermediate care

Long list of 36 potential scenarios has been reduced to 14

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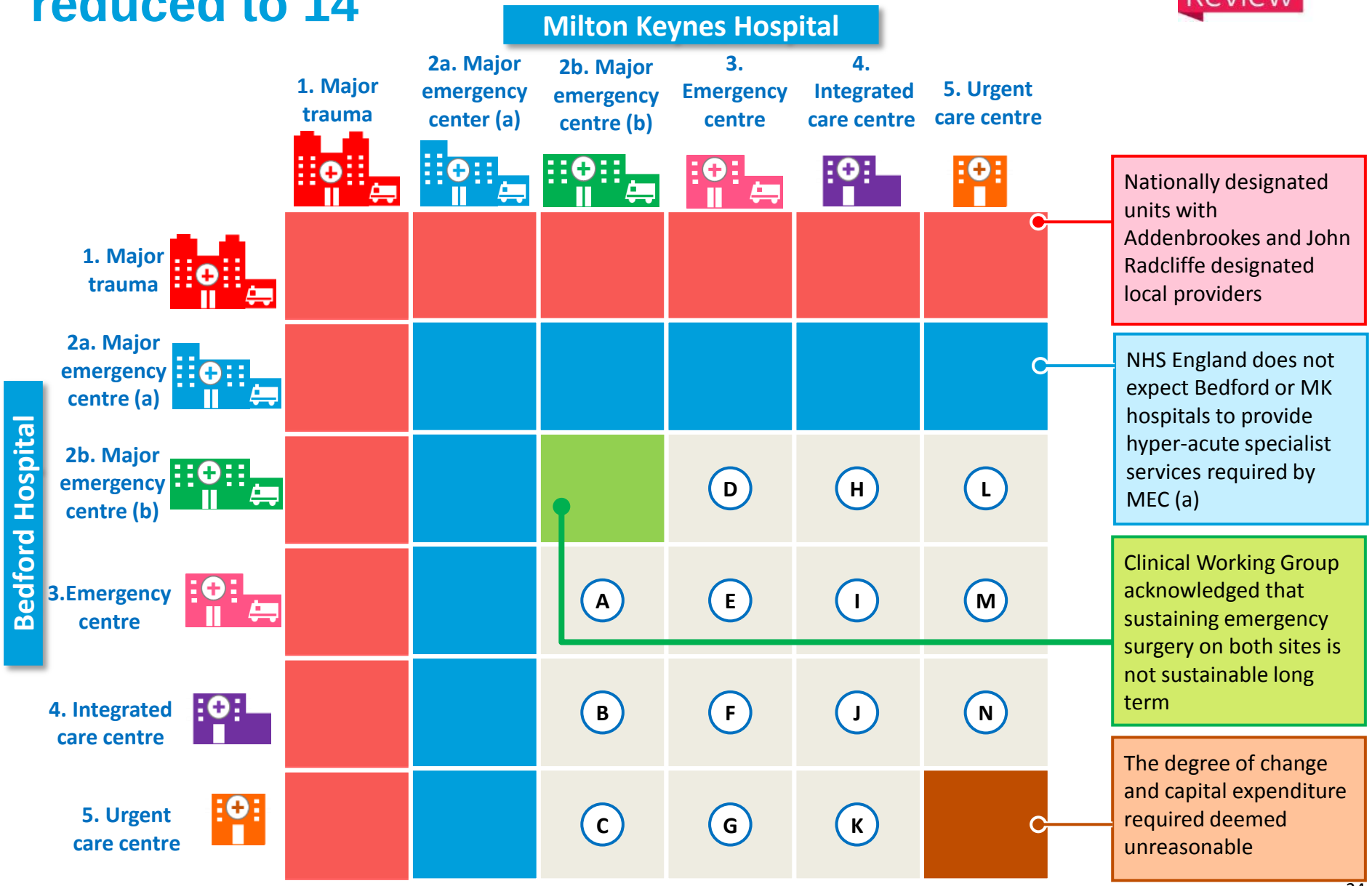

Evaluation criteria for assessment of acute sites

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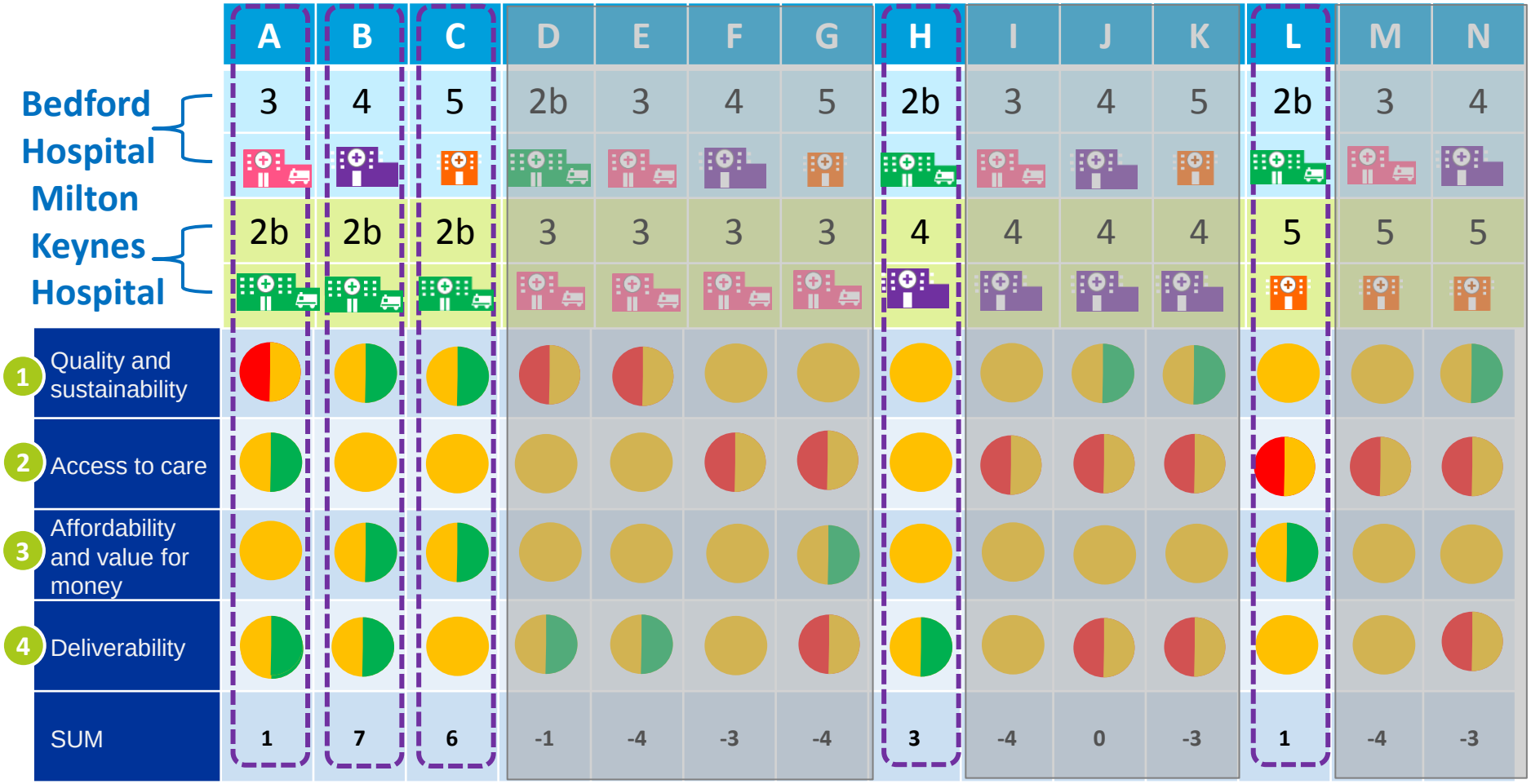
	Definition	Subcriteria
1 Quality and sustainability	• Ensure the populations of Bedfordshire and Milton Keynes receive high quality care that is clinically safe and sustainable	• To what extent does the option meet commissioning requirements for high quality care for the local populations? • To what extent would organisations be able to recruit, retain and develop sufficient high quality staff to support services at sites? • Does the option encourage greater integration of care?
2 Access to care	• Impact on access to high quality care	• What % of patients will continue to be treated on each site? • What is the impact of travel times (in ambulance, private car and public transport) to access high quality services? • What is the impact on patient choice?
3 Affordability and value for money	• Financial sustainability of option • One-off cost of proposed change	• Does the option represent good value for money? • How far does the option improve financial sustainability of sites? • What is the capital and transition cost implied by option?
4 Deliverability	• Challenge in delivering the option	• How significant is the change required to move to the new models? • Are the proposals aligned with national, regional, and local plans? • Are stakeholders supportive of the proposals?

Evaluation summary



2b. Major emergency centre (b)

3. Emergency centre

4. Integrated care centre

5. Urgent care centre

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So what does this mean for patients and the public

Meet the Jones family

They are a family living in Bedford Borough and Central Bedfordshire

Miss Phoebe Jones

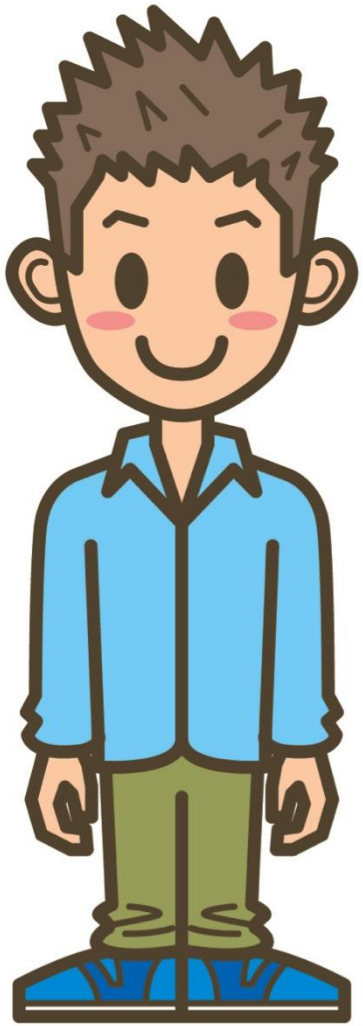
Phoebe is eight years old and has cerebral palsy. She uses a wheelchair and has seizures at least once a week.

Phoebe develops a fever, and Mum, worried by her condition goes to see their local GP – they know Phoebe, can see her history, and can do initial triage. The GPs thinks Phoebe has a chest infection and might need some time under specialist paediatric care.

Phoebe is taken to Bedford Hospital where it is identified that she needs paediatric care.

Option	Where could Phoebe go?	What could happen next?	Rehabilitation & follow-up
Now	Bedford Hospital	Phoebe spends 8 hours in Paeds Assessment Unit receiving treatment. Since she responds well, she can then go home.	Hospital writes to GP. Mum must make appointment to take Phoebe to GP for check up
A	Bedford Hospital	Phoebe spends 8 hours in Paeds Assessment Unit receiving treatment. Since she responds well, she can then go home.	Paeds Assessment Unit makes sure to alert community paeds nursing team to phone and check progress each of the next few days
B	Bedford Hospital	Phoebe spends 8 hours in Paeds Assessment Unit receiving treatment. Since she responds well, she can then go home.	Paeds Assessment Unit makes sure to alert community paeds nursing team to phone and check progress each of the next few days
C	Another hospital like L&D, Hinchingbrooke, Lister or Milton Keynes	Phoebe spends 12 hours in hospital Paeds unit before returning home	Other hospital writes to GP and may alert community paeds nursing team to phone and check progress each of the next few days
H	Bedford Hospital	Phoebe spends 8 hours in Paeds Unit receiving treatment. Since she responds well, she can then go home.	Paeds Unit makes sure to alert community paeds nursing team to phone and check progress each of the next few days
L	Bedford Hospital	Phoebe spends 8 hours in Paeds Unit receiving treatment. Since she responds well, she can then go home.	Paeds Unit makes sure to alert community paeds nursing team to phone and check progress each of the next few days

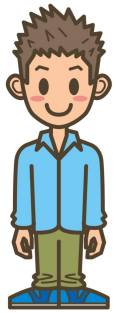
Mr Ben Jones



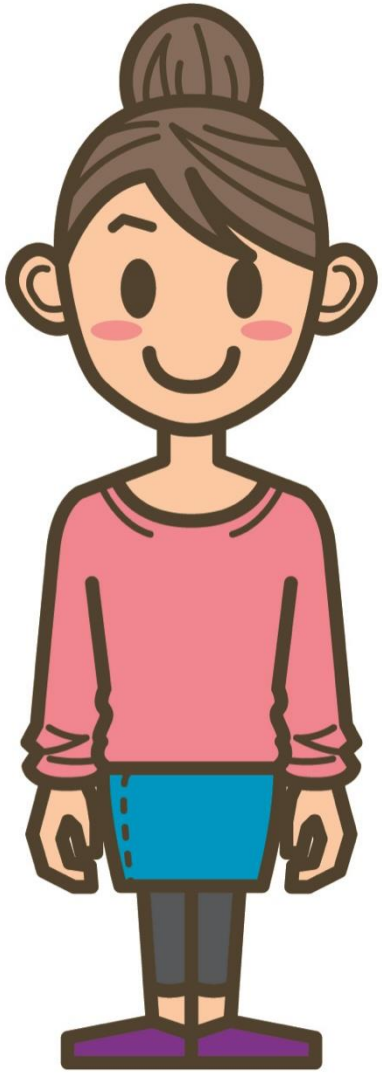
Ben is a 42 year old rugby fanatic who, despite tummy pain earlier that day, has gone to watch Bedford Blues in a pre-season friendly against Northampton Saints. By the end of the game, the pain has become excruciating, Ben feels sick and light-headed, and his friends take him by car to Bedford Hospital.

After tests, Ben is diagnosed with peritonitis and told he needs emergency surgery.

Option	Where could Ben go?	What could happen next?	Rehabilitation & follow-up
Now	Bedford Hospital	Ben is operated on in Bedford Hospital, spends 3 days in hospital before returning home	Hospital writes to GP. Follow-up at hospital outpatients.
A	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes	Ben is assessed at Bedford Hospital by A&E staff using telemedicine to liaise with the surgeon at the networked hospital. Ben is transferred to the network hospital (where the surgical team is waiting at the door for him) for surgery and spends 2 days in hospital	Network hospital writes to GP. Follow-up at Bedford Hospital outpatients by surgical team from network hospital.
B	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes	Ben is triaged at Bedford Hospital by A&E staff and almost immediately transferred to the network hospital for surgery. He spends 2 days in hospital	Network hospital writes to GP. Follow-up at Bedford Hospital outpatients by surgical team from network hospital.
C	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes	Ben is triaged at Bedford Hospital by A&E staff and almost immediately transferred to the network hospital for surgery. He spends 2 days in hospital	Network hospital writes to GP. Follow-up at Bedford Hospital outpatients by surgical team from network hospital.
H	Bedford Hospital	Ben is operated on in Bedford Hospital and spends 2 days in hospital before returning home	Hospital writes to GP. Follow-up by surgical team at Ben's local practice
L	Bedford Hospital	Ben is operated on in Bedford Hospital and spends 2 days in hospital before returning home	Hospital writes to GP. Follow-up by surgical team at Ben's local practice



Mrs Anastazja Jones (and in the end Baby Jones!)



Anastazja is a 36 year old mother of two who becomes pregnant again. She has Type 1 diabetes. After a difficult pregnancy with her second child, this time she received pre-conception advice and has regular input from her diabetes team during her antenatal care.

Anastazja's labour is induced early. During labour, there are complications as the baby is large and in a breech position, and Anastazja's diabetes is difficult to control.

Option	Where could Anastazja and Baby go?	What could happen next?	Rehabilitation & follow-up
Now	Bedford Hospital, with Baby transferred to level 2 neonatal intensive care unit (NICU) at another hospital	Anastazja spends 2 days in Bedford hospital. Baby spends 3 days in NICU	Diabetes and obstetric follow-up at Bedford Hospital. Neonatal paediatric follow-up at Other Hospital.
A	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes	Anastazja spends 2 days in hospital. Baby spends 2 days in NICU and they are discharged together	Specialist follow-up for both Anastazja and Baby at Bedford Hospital and with her GP
B	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes		Specialist follow-up for both Anastazja and Baby at Bedford Hospital and with her GP
C	Another hospital like Lister, Addenbrooke's, L&D or Milton Keynes		Specialist follow-up for both Anastazja and Baby at Bedford Hospital and with her GP
H	Bedford Hospital		Specialist follow-up for both Anastazja and Baby at her local practice and with her GP
L	Bedford Hospital		Specialist follow-up for both Anastazja and Baby at her local practice and with her GP

Mr Maurice Jones

Maurice Jones is 73 years old. Whilst he watches the cricket on television, his wife Sylvia notices his face starting to droop on one side and he finds it difficult to reach out for his cup of tea. Aware of the FAST campaign about new-onset stroke, Maurice's wife dials 999 and an ambulance is there within 8 minutes.

The paramedic team agrees that Maurice is having a stroke.

Option	Where could Maurice go?	What could happen next?	Rehabilitation & follow-up
Now	Bedford Hospital between 9am-5pm or Luton & Dunstable, Northampton, or Lister 24/7	Maurice spends 7 days in hospital having acute care and rehabilitation	Hospital writes to GP. GP refers Maurice for community physio review, OT assessment and social care assessment
A	Another hospital like Northampton, Lister, or L&D	Maurice spends 2 days in hospital before returning home	At admission, hospital contacts Early Supported Discharge stroke team which gets Maurice into intensive community-based rehabilitation programme straight away
B			
C			
H			
L			

Miss Margaret Foster (older sister of Sylvia Jones)

Margaret Foster is a 76 year old lady who lives alone and has heart failure and diabetes.

Early one morning the postman discovers her at the bottom of the stairs after a fall. Unsure about the state of her health, the postman calls an ambulance.

Option	Where could Margaret go?	What could happen next?	Rehabilitation & follow-up
Now	Bedford Hospital	Margaret spends 16 days in Bedford Hospital before being discharged to a care home	Care home liaises with GP as necessary
A	Bedford Hospital	Margaret spends 3 days in Bedford Hospital before returning home with 4x daily visits from community multi-disciplinary team	Multi-disciplinary follow-up through primary care-based/geriatrician-supported multi-disciplinary team
B	Bedford Hospital	Margaret spends 3 days in Bedford Hospital before returning home with 4x daily visits from community multi-disciplinary team	
C	Another hospital like Hinchingbrooke, Lister, Addenbrooke's, L&D or Milton Keynes	Margaret spends **4** days in hospital before returning home with 4x daily visits from community multi-disciplinary team	
H	Bedford Hospital	Margaret spends 3 days in Bedford Hospital before returning home with 4x daily visits from community multi-disciplinary team	
L	Bedford Hospital	Margaret spends 3 days in Bedford Hospital before returning home with 4x daily visits from community multi-disciplinary team	

Any questions

40

[A1] Your thoughts on our ideas for hospital care?

- What do you think of the ideas?
- What do you like? And what do you dislike?
- What do you think this might mean for the way people are cared for in the future?

- Place your comments on the opinion board

- Refer back to the Jones Family

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Care closer to home

Dr Paul Hassan
Chief Clinical Officer
Bedfordshire CCG

Key emerging themes – patients want to see…

- Consistent access to GP with reduced waiting times
- Better discharge arrangements and partnership working with GP and community staff
- Better hospital aftercare, closer to home
- Better information and signposting for self-care; more focus on prevention
- More joined up care, with better communication and patient data transfer between providers
- Better use of IT for appointments, reminders, prescriptions
- More, better trained frontline staff
- More out of hours and community-based care

What our GPs have told us so far….

- We recognise that we need to work together…and want to
- We need to better use, and increase the skills of other clinicians e.g. Specialist nurses
- We need to be working on shared IT systems across the healthcare system
- We need to help our patients to understand where they can access the right help from the right places
- We need to focus much more on prevention
- We need to do this whilst maintaining consistency of care

As we explained to you at our last meeting, a variety of physical configurations for general practice could work

Model 1

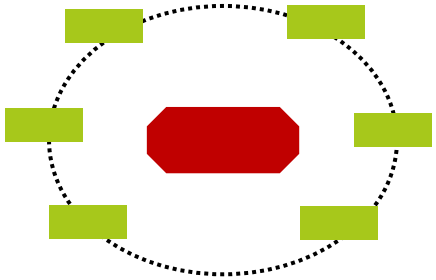
Single site

Community facility acts as central hub

GP services located within hub

Model 2

Hub and spoke

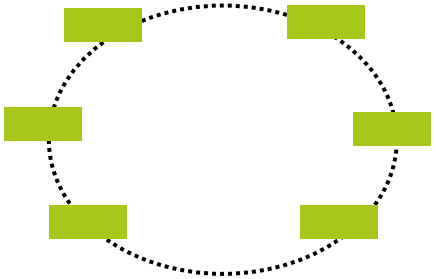


Community facility acts as central hub

Some GP practices may be located within the central hub, others around it

Model 3

Network



Network of practices providing extended hours urgent care

Different diagnostics and services distributed across practices

45

Primary care can be transformed through a hub and spoke model with general practices at the core

Health services	Which hubs
General practice services, coverage list size of 20,000+	Present in every hub
Community services	
Most outpatient appointments (including prenatal/ postnatal care)	
Minor procedures	
Proactive management of long-term conditions	
Urgent care	Hours and location depend on catchment population
Diagnostics – point of care pathology and radiology	
Out of hours	
Pharmacy	Depends on business case to setup or relocate
Other health professionals – e.g., mental health, optician, dentist	
Mental health services	

Successful Care Closer to Home should be delivered through Multi-Disciplinary Teams (MDTs)

MDT

Primary Health Care Team

Practice

GP

Practice Nurse

District Nurse

Community Matron

Social Care Representative

Community Mental Health Representative

Social Care Specialist

Mental Health Specialist

Acute Specialist

Improved efficiency in primary and community care

	Lever	Example initiatives	Delivering impact
Skill mix 	• **GP focus on complex cases;** GPs will continue to play the generalist role and also begin to spend more time overseeing delivery of care by multi-disciplinary teams • **Increased used of nurse practitioners**;	• Common information & assessment protocols • Systematic implementation of best practice across all community health, supported by better technology and processes • Career progression, training and education support for all primary care nurse	• Shift 30% of GP time to nurses
Increase patient facing time 	• Better use of **technology** (e.g. e-consults) • Reduction in admin time (e.g. automation) • Reduced **coordination** time (e.g. GPs spend liaising with other services)	• Enhance skills of the administrative staff for basic clinical tasks and more general advice and support for patients • Use mobile IT • Development of new roles (care coordinator, case management team, rapid response teams) • Reduce travel time for community staff through better workflow planning	• Increase patient facing time from 50% to 66%
Demand manage ment 	• Promote better **self-care** • Ensure **appropriate care setting**	• Encourage GP practices to make records accessible to patients • Address individuals' health and social care needs through supported self-care and goal-setting • Establish single point of access for all community services • Multi-skilled, multi-professional teams at the right scale direct patients to 111, pharmacists, etc. as appropriate	• Manage 20% of core primary care visits through 5 minute e-consults

Introducing Mrs Holmes

Mrs Holmes is a 76 year old lady widow who lives alone. Her health is generally good but has become increasingly socially isolated.

Lack of integration of services in health and social care leads to worse outcomes for patients …

Mrs H cries for postman to call ambulance after spending a night on the floor following a fall	Mrs H admitted to assessment unit bed following medical assessment	Son tries to convince Mrs H to move to care home. Social support initiated after weekend, taking a week to carry out assessments/make suitable arrangements	Mrs H passes away after 18m of deteriorating health in a nursing home she felt she was coerced into
Ambulance called but have to wait for police to gain access through locked front door	Son calls ward to discover situation. Decision made for Mrs H to remain in hospital without her involvement	Disjointed approach returns dead-ends for suitable accommodation during which patient acquires an infection	Mrs H has reduced quality of life, becoming depressed and lonely in her final days

In future, integrated care with better communication will lead to smoother delivery of care to those who need it …

Mrs H cries for postman to call ambulance after spending a night on the floor following a fall	Mrs H admitted to assessment unit bed following medical assessment	MDT meets during weekend with son to establish rehabilitation and unified approach to care step down. Home assessments now complete	Two months later Mrs H moves to a housing scheme where she is joined by her friends till she passes away ten years later supported by a dedicated End of Life team
Shared EHR alerts ambulance to collect key from neighbour, ensuring timely assessment. Urgent Falls Service alerted to initiate home assessment	Son and GP alerted to situation and estimated discharge date set	Mrs H transferred to rehab, preventing prolonged stay and infections. Home adapted during this time to ensure timely return as per her wish	Mrs H is supported in semi-independent living of her choice where she receives due care and support

Examples of how integration can work
Complex Care Team (CCT)

- A multi-disciplinary team set up to enhance the quality of care delivered to care home residents, reducing acute costs and unnecessary treatments
- Holistic nursing reviews, dementia reviews, medication reviews

Outcomes

- £130K savings in medications (first 12 months)
- 25% reduction in A&E attendances (first 2 months)
- 38% reduction in hospital admissions (first 2 months)
- 53% reduction in OOH use (first 5 months)

- Now providing ongoing support for care homes, collaborative working with partner organisations and reactive minor illness service

Residents get a far better level of treatment, are taking fewer drugs, having fewer hospital admissions and fewer GP visits

The team provides excellent ongoing support in caring for our residents using their own knowledge and liaising with other services

Using CCT has cut down greatly on the need to call GPs out

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[A2] Your thoughts on our ideas for care closer to home?

- What needs to be available out of hospital to:
- Prevent people going to hospital when they don't need to
- Ensure patients can go home earlier
- Ensure patient care is better after discharge
- Make people aware of out of hospital services and help them to have the confidence to use them

- What more can be done?

- Refer back to the pretend family and people

- Place your comments on the opinion board

Any questions

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BEDFORDSHIRE & MILTON KEYNES

Healthcare Review

Next steps

Jane Meggitt

Director of Communications & Engagement

Bedfordshire CCG

Next steps


Report published & shared with key stakeholders
Report presented to Governing Body
Final report considered and decision to go to consultation
Formal consultation phase
Considerat-ion phase
Decision announced

Any questions

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[A3] Your thoughts on ongoing engagement and

- How well are we doing?

- Using your pretend character, tell us
  - How do we make them aware?
  - How do we encourage them to participate?
  - What are the best methods to involve them in the consultation?

- How can you and/or your organisation help?

- Place your comments on the opinion board

‘Q&A&L’ Final Session

- Questions
- Answers
- Listening

Thank you for your time and feedback

If you have any further thoughts you can get contact the review team by

Email: communications@bedfordshireccg.nhs.uk

Web: www.yourhealthinbedfordshire.co.uk

Feedback forms on your table

BEDFORDSHIRE & MILTON KEYNES Healthcare Review

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