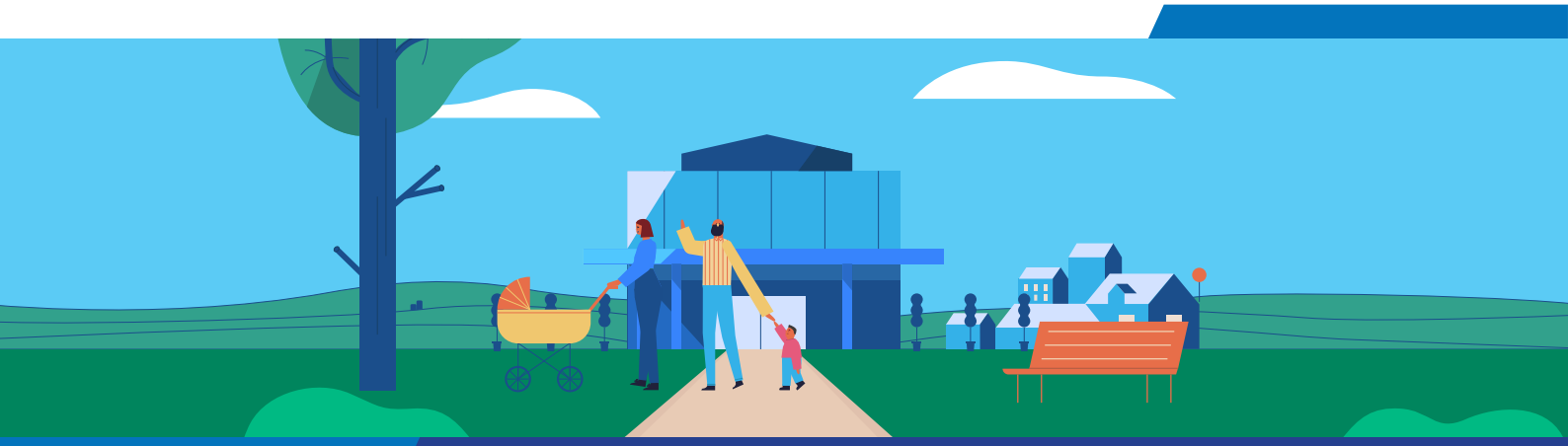
Community engagement summary report

This report provides a summary of the feedback received during the community consultative committee meetings for the period November - December 2020.



Fishermans Bend Community Hospital Community Consultative Committee meeting

Online via Microsoft Teams | Monday 16 November 2020

Engagement purpose

Community consultative committees provide a forum for members of the local community to participate in the planning and development of the Community Hospitals Program through open dialogue and consultation.

The meetings provide a mechanism through which views of the community are heard, emerging issues are monitored, and concerns and priorities of the community are voiced.

Session summary

At this meeting VHHSBA presented the committee with an update on the project including the development of an overarching service delivery model for Fishermans Bend Community Hospital, and Alfred Health shared their vision for the hospital with the group. Star Health and Alfred Health also shared their experiences in developing a local case management model implemented during the COVID-19 pandemic to ensure locals who tested positive were provided with wrap around support and tailored information.

The committee was invited to consider the examples provided and discuss what partnerships they would like to see at the Fishermans Bend Community Hospital to ensure the facility is an attractive option for patients needing care.

The meeting was held virtually using the Microsoft Teams video conferencing platform, and feedback was recorded using Mentimeter, an interactive presentation tool.

Who was there

Chair: Nina Taylor MP

Foundation members: Representatives from Star Health and Alfred Health

Community members: Ten community members from the Fishermans Bend area

Staff: Representatives from VHHSBA Planning and Development, DHHS System Design, VHHSBA Communications and Engagement.

You said

How information is managed and connected - the information about that persons' healthcare is just as critical as how we move them across between services.

I would like to be empowered and have the ability to know what I should be doing. When there are 3 weeks before my next appointment, how do I know if I am progressing well or not progressing well enough?

Every individual is going to have different healthcare needs. This hospital should be about how can we get you connected better to the services you need and back out into the community.

As a patient I would like a phone number I can ring to ask for help (to understand thing, or to check in if something has changed) maybe similar to nurse on call type service.

Culture is what makes the hospitals, not necessarily design. Building strong bridges with all related hospitals. How do you create the culture is something we need to bring into our work going forward.

Community feedback, concerns and sentiment

Support for **using technology to share information between patients and health services**, the My RMH app was highlighted as an example of this being done well.

Interest in how the **committee could help foster the desired culture** for the Fishermans Bend Community Hospital or assist in governance once it is operational.

Concern that the **proposed service delivery model could overburden GPs** who already have heavy loads. Suggestions on how to make systems work well for both patients and GPs / other health professionals.

Desire for **active patient follow up and easy access to medical information** once patients return home. Suggestions included a 'Nurse on Call' style hotline, a personalised care roadmap or use of an app to empower patients with the knowledge they need to continue their journey to good health at home.

Committee could foresee **many advantages to attending a community hospital** over a tertiary one including potentially shorter wait times, closer proximity to home or other commonly used services, opportunity for better continuity of care and a calmer / less overwhelming environment.

Questions around **what role pharmacists could play in the new model**, particularly given they can sometimes be higher touch services than a community hospital may be.

What we heard

What would good care look like at a Community Hospital from your perspective?

- Transition to alternate service provides (and the return) for both the patients and their loved ones or carers.
- Clear referral pathways for people who present with something beyond the scope of the community hospital.
- Ensuring the hospital has access to my health records, and informs my GPs of my services/visits.
- Active follow-up to ensure the suggestions of what I should do are actually being done. ie am I still doing the exercises I was provided, or has something been hindering me? What extra assistance could support my transition to health?
- How information is managed and connected – the information about that persons' healthcare is just as critical as how we move them across between services. This is an area that the whole healthcare system is continuing to improve.
- I would like to be empowered and have the ability to know what I should be doing. When there are 3 weeks before my next appointment, how do I know if I am progressing well or not progressing well enough? This could be an app with feedback.
- If I tell the hospital that I have a regular GP, next time I go to the GP they should know what I went to the hospital for and be able to advise me on ongoing condition management.
- Will the hospital have an app similar to MyRCH which allows for results and appointments to be in hand, this is especially helpful when travelling interstate and overseas?
- I found MyRCH app very useful when daughter was undergoing treatment. When interstate we could take it with us when we checked into a hospital in Queensland and all her information and history was there. You take it round with you and schedule appointments straight on the app.
- I would know what my diagnosis is/was and what actions I should take and who I can contact to ask questions. I'd like a follow up phone call to ensure I understood it. Diagnosis can be life-changing and therefore potentially stop me understanding the rest of the meeting (due to trying to process the new diagnosis).
- A culture of high professionalism with staff characterised by diligence, attention and attention to detail delivered with a smile!
- Actively connecting to my GP, and 'pushing' the information to them rather than 'pulling it' when I make an appointment or visit the GP
- Documentation (digital or otherwise) given to the patient.
- Transition to tertiary hospitals is smooth and you are able to get there safely, and get back safely.
- Highly skilled health professionals to ensure the diagnosis and treatment are optimal.
- Public service providers all sharing same systems.

Are there any emerging areas of need that we haven't captured?

- Cultural care
- How will accessibility (space/sound) be addressed?
- I feel this is a lost opportunity not having overnight beds – compared to the UK version of Community Hospitals which do.
- Will the hospital be able to cater for Rare Diseases? Will they be able to liaise with the tertiary hospital on more complex cases?
- Every individual is going to have different healthcare needs. This hospital should be about how can we get you connected better to the services you need and back out into the community.

What would encourage you to attend a Community Hospital over a tertiary hospital?

- Shorter wait times
- Capacity for continuity of care
- Calmer environment
- If it has the services I need.
- Ease of physical access
- Less confronting /calmer and quieter facility.
- Good communication.
- Minimal wait times. Free parking. Welcoming environment. Excellent service providers.
- As soon as you say hospital, people have an expectation of overnight beds.
- If I was in the area already or familiar with the space from other events.
- Proximity to home or other services / facilities I use.

What are the important elements that the community would like to see in these types of partnerships?

- There needs to be acknowledgement the GP has 100's of individual patients. If we attempted to wrap around each of them, clinics will get overwhelmed and possibly start turning away patients.
- Communication / sharing of data, and diagnoses, and therapeutics between tertiary and primary health service providers. It really should be a universal app.
- So specialists will be coming out from tertiary or teaching hospitals to Fishermans Bend Community Hospital?
- Concerned with the amount of work that is being put on GPs – we have heard how bad tertiary hospitals are at communicating to GPs. Now GPs have to communicate with both tertiary hospitals and community hospitals.
- The follow up dates and predicted pathway forward for example: (1) things going well - keep doing what you're doing; (2) things not going well enough try A, B or C; or (3) things going better than expected try X, Y, Z. Almost a 'road map' type prediction of care would be great.
- What about funded prevention programs such as Bowel cancer screening, breast screening etc
- The long-standing poor communication from hospitals to GPs must be fixed. This really goes to culture change in tertiary hospitals.
- As a patient I would like a phone number I can ring to ask for help (to understand thing, or to check in if something has changed) maybe similar to nurse on call type service.
- Something which ensure carers are included (where relevant) such that for mental health someone else is able to cause an escalation if needed
- Is there a role for pharmacists in this new model - where they are often a higher touch healthcare provider than GPs for some people.
- Models of care and service design needs to be informed by deep diving into the everyday constraints impacting service providers (eg GPs RE: fee scales and burden of demand)
- Are their going to be services and community support groups meeting at the community hospital to learn from past patients (survivors)
- GPs are notoriously bad at communicating with their patients. They are already overburdened, and I don't see them being capable of performing this role in addition to their regular responsibilities.
- Is there a role for training students (Drs and allied health) in this model?
- Healthy collaborative culture within each health provider / service involved at the community hospital.
- Is there a place to community outreach and education? ie. should the outcomes (best practice or key points) of the daily huddles be shared more broadly with the community (healthcare or public)
- When we talk about all those different players – how can we really improve on some of the current practices where they are not talking to each other?
- Who will keep my doctor looped in?
- Culture is what makes the hospitals, not necessarily design. Building strong bridges with all related hospitals. How do you create the culture is something we need to bring into our work going forward.
- Consider how local community could have a role in governance once the hospital is open. How can we take this commitment to really listen and ensure it continues past the planning and construction phase?