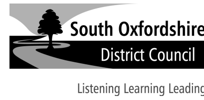
Notice of Meeting Public Document Pack



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 5 December 2013 at 10.00 am
County Hall

Membership

Chairman - Councillor Lawrie Stratford
Deputy Chairman - District Councillor Alison Thomson

Councillors:	Kevin Bulmer	Mark Lygo	Alison Rooke
	Pete Handley	Laura Price	Les Sibley
District Councillors:	Martin Barrett	Susanna Pressel	
	Christopher Hood	Rose Stratford	
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *27 February 2014*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Lawrie Stratford E.Mail: lawrie.stratford@oxfordshire.gov.uk
Policy & Performance Officer	-	*Claire Phillips Tel: (01865) 323967* *claire.phillips@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark

Peter G. Clark
County Solicitor

November 2013

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 4 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 8)

To approve the minutes of the meeting held on 5 September 2013 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Clinical Commissioning Group Strategic Update (Pages 9 - 14)

10:15

Dr Stephen Richards, Chief Executive Officer, Oxfordshire Clinical Commissioning Group (OCCG) will discuss matters of relevance and interest to the committee. Dr Richards will discuss the development of OCCG's 5 year strategy and plans for public engagement. He will also give a verbal update on services in the North of the County.

A briefing paper, produced by the OCCG, is attached at **JHO5.**

6. The Future of Community and Mental Health in Oxfordshire (Pages 15 - 34)

10:55

Eddie McLaughlin, Anne Brierley and Ros Alstead from Oxford Health will discuss their plans for remodelling community and mental health services and their approach to safety and security. Attached are the following briefing documents (all at **JHO6**):

- 'Service Remodelling of Oxfordshire Adult Mental Health Services.'
- 'Older People's Care, Long Term Conditions and Urgent Care – Service Remodelling and Current Delivery.'
- 'Oxford Health Safety and Security in Mental Health Wards in Oxfordshire.'

7. Performance Focus: Delayed Transfers of Care (Pages 35 - 46)

11:35

The following representatives from Oxfordshire County Council, the Oxfordshire Clinical Commissioning Group (OCCG), Oxfordshire University Hospitals NHS Trust and Oxford Health NHS Foundation Trust will present a report on the issue of delayed transfers of care in Oxfordshire including current performance and trends. They will also discuss plans in place to improve performance.

John Jackson, Oxfordshire County Council
Dr Stephen Richards, Oxfordshire Clinical Commissioning Group
Andrew Stevens, Oxford University Hospitals NHS Trust
Yvonne Taylor, Oxford Health NHS Foundation Trust

An update paper, produced by the OCCG, is attached at **JHO7.**

8. The Care Quality Commission's approach in Oxfordshire (Pages 47 - 68)

13:05

Teresa Anderson, Compliance Manager (Oxfordshire) and John Scott, Regional Communications Officer for the Care Quality Commission (CQC) will explain the role of the Commission, its work in Oxfordshire and the organisation's response to the Francis Report recommendations.

A briefing document entitled 'Update and Summary of Activity' is attached at **JHO8**.

9. Chairman's Report and Forward Plan (Pages 69 - 70)

13:25

The Chairman will give a verbal update on meetings attended since the last formal meeting of the Committee. There will also be an opportunity for members to discuss the Forward Plan. This is attached at **JHO9.**

recycled paper

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 5 September 2013 commencing at 10.00 am and finishing at 12.52 pm

Present:

Voting Members: Councillor Lawrie Stratford – in the Chair

District Councillor Alison Thomson (Deputy Chairman)
Councillor Kevin Bulmer
Councillor Pete Handley
Councillor Laura Price
Councillor Alison Rooke
Councillor Les Sibley
District Councillor Dr Christopher Hood
Councillor Susanna Pressel
District Councillor Rose Stratford

Co-opted Members: Dr Harry Dickinson and Mrs Anne Wilkinson

Officers:

Whole of meeting: Claire Phillips and Julie Dean (Chief Executive's Office); Director of Public Health

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

114/13 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Martin Barrett, Councillor Mark Lygo and Dr. Ruddle.

115/13 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

116/13 MINUTES

(Agenda No. 3)

The Minutes of the last meeting on 13 June 2013 were approved and signed as a correct record.

Issues raised under Matters Arising from the Minutes:

Minute 107/13 – 'Health & Wellbeing Strategy'

- The importance of receiving feedback from the Health & Wellbeing Board in response to matters of concern referred to them from this Committee and in respect of all aspects of its work;
- Concern about the numbers of ambulances operating in the West Oxfordshire area would be followed up with the South Central Ambulance Service NHS Foundation Trust.

Minute 110/13 – 'Alcohol Addiction: A review of issues, challenges, solutions and possible means for improvement'

- Feedback was given by the Senior Policy Officer regarding the actions decided by Committee:
- with regard to action (a) , the Senior Policy Officer undertook to circulate a copy of the letter received from Norman Lamb MP;
- with regard to action (b), a response from the Home Office was still awaited and this would be followed up;
- with regard to action (c), a letter had been received from Oxfordshire's Police Commissioner reassuring the Committee that he did not envisage any large cuts in funding in what he considered to be vital work; and
- with regard to (e), a list had been circulated to members of the Committee by the Senior Policy Officer on behalf of the Deputy Director of Public Health.

117/13 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There were no requests to speak to or petition the Committee.

118/13 HEALTHWATCH OXFORDSHIRE

(Agenda No. 5)

Sara Livadeas, Deputy Director, Joint Commissioning, OCC and Rosalind Pearce, Director of Healthwatch, updated the Committee on progress in relation to the establishment of the local Healthwatch. A written progress report was also before the Committee (JHO5).The Committee were informed that Healthwatch was almost fully staffed and, to date, nine members, out of a Board of 13 had been elected. Four co-opted members with experience were currently being sought in the Children & Young people, BME and diversity, carers and learning disability areas. The Board had begun working on their strategic plan.

Sara Livadeas reported a strong and independent Healthwatch was wanted for Oxfordshire comprising Board members with specific interests able to comment on services, devise community strategies and give feedback. She added that a traditional procurement exercise would begin shortly to find a provider for Healthwatch (the first being unsuccessful and the Oxfordshire Rural Community Council were awarded an interim contract to provide Healthwatch for 1 year). The County Council remained very open-minded in terms of what the organisation would

look like and to this end had slimmed down the service specification to make the process as straightforward as possible.

Biopic details of the newly elected Board members can be seen on the Healthwatch Oxfordshire website. Members requested details of the regional NHS Complaints Service.

Sara Livadeas and Rosalind Pearce were thanked for their attendance.

119/13 CLINICAL COMMISSIONING - UPDATE
(Agenda No. 6)

Dr Mary Keenan, Medical Director, Oxfordshire Clinical Commissioning Group (OCCG), presented the regular progress report from the OCCG (JHO6). She was accompanied by Julia Boyce, Assistant Chief Finance Officer, OCCG, and Ali Greene, Head of Communications & Engagement, OCCG.

Dr Keenan spoke to her report after giving the Committee a brief synopsis of the role and responsibilities of the OCCG. Outcome-based commissioning was discussed with Dr Keenan agreeing that it would be a challenge to identify outcomes but that mental health was a very circumscribed area which was supported by some very active user groups, who were very supportive of this approach. Apart from recovery, outcomes included whether patients were able to attain home, job and financial stability. Work on suitable outcomes continued to take place with users and clinicians. Dr Keenan added that outcome based commissioning was not a cost-cutting exercise, rather it was envisaged that it would improve outcomes for patients.

Dr McWilliam confirmed that the Health & Wellbeing Board was a partnership between local government and the NHS and that strong links were held between the two organisations. Dr Mary Keenan is Chairman of the Children & Young People Partnership Board and also a member of the Health & Wellbeing Board along with Dr Stephen Richards of the OCCG.

The on-going concern with regard to the situation around the Emergency Abdominal Surgery at the Horton Hospital was noted.

The Committee thanked Dr Keenan and her colleagues for attending.

120/13 FALLS IN OXFORDSHIRE
(Agenda No. 7)

Fenella Trevillion, Assistant Director of Older People Commissioning, OCCG; Sylvie Thorn, Senior Commissioning Manager, Older People, OCCG; Suzanne Jones, Head of Countywide Services, Oxford Health; and Chris Sylvester, Clinical Head of Falls Service, OCCG presented their report JHO7 that set out the strategy for falls prevention in Oxfordshire and explained current performance.

Fenella Trevillion pointed out that Oxfordshire's Falls Service was the largest in the country but this was not based on the amount invested or the numbers of staff working in the service. It was due to Oxfordshire's practice of training nursing staff as

practitioners, the outcome of which was that the system cost less in comparison to other areas. She added that Oxfordshire's system had been developed and used in other parts of the country.

During discussion and in response Members' questions, the following information was given:

Falls assessments were carried out at Health & Wellbeing Centres and in partnership with other services. Connections with community groups remained a very important area for falls prevention (central contact - Health & Wellbeing Advisers, (01865) 425140) and education sessions were delivered to day centre staff on a rolling programme. The Falls Clinics were run by Falls Prevention staff in day hospitals and clinics would continue to be run in a variety of settings to ensure everyone in Oxfordshire had good access to the service.

Fenella Trevillion agreed to provide further information, together with more statistical detail on the causes of falls and which were of the highest frequency.

The Committee thanked the Panel for their attendance.

121/13 HOW THE NHS IN OXFORDSHIRE IS RESPONDING TO THE FRANCIS REPORT AND SIR BRUCE KEOGH'S REVIEW

(Agenda No. 8)

The following representatives from the OCCG, Oxford University Hospitals NHS Trust (OUHT) and Oxford Health NHS Foundation Trust (Oxford Health) attended the meeting in order to present their responses (JHO8) to the Francis Report and to Sir Bruce Keogh's review:

Dr Richard Green, Director of Clinical Quality, OCCG
Ros Alstead, Director of Nursing & Clinical Standards, Oxford
Health;
Professor Edward Baker, Medical Director, OUHT;
Tina Ashmal, Manager of Quality & Safety, OUHT.

The first Francis Report on the Mid Staffordshire NHS Foundation Trust had been published in 2010. It had identified extremely poor care being delivered in a number of areas of the Trust. The second report, which went further and looked at the wider responsibility of the NHS was published in February 2013. Following the Francis Report , the Keogh Report was published and looked at 14 hospital trusts selected for investigation on the basis that they had been outliers for the last 2 consecutive years on either the Summary Hospital – Level Mortality Index or the Hospital Standardised Mortality Ratio. Background briefings on both these reports were attached at JHO8.

Following the presentations, Members asked questions and received responses in relation to the following areas:

Concerns were raised regarding the nutritional assessment of patients. The OUHT confirmed a patient's nutritional state was assessed on admission and was monitored

thereafter as it was a key part of their treatment. A plan was put in place were fed back to their GP. The wards ensured that patients are getting their meals at an appropriate time. Social Care Assistants (Enablement Team) were working to support people living at home to ensure that there was some evidence of them eating.

Members raised the need to assess patients with acute physical conditions also presenting with mental health problems. This had been recognised with the appointment of 3 physiotherapists who were assigned to people with acute medical problems. There had also been a focus to provide both physical and mental health services outside of the hospital, across the board for children and young people and adults with long term conditions and frail older people.

Members raised concerns about waiting times between the first and second hospital appointments. OUHT confirmed that each clinic was to be profiled as part of an 18 month rolling programme.

In response to recommendation 7 of the Berwick Report 'all data on quality and safety whether assembled by government organisations or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public' OCCG, OH and OUHT confirmed they would be sharing information via their Board papers. A significant amount of detailed data was already put in the public domain. There were elected members sitting on the Boards and much data was already under scrutiny as part of the Quality & Safety Committee.

Members of the Committee thanked the Panel for their attendance and for their very informative reports.

The Committee **AGREED** that there was a need to consider what data it wished to review in order to understand the key performance issues in the Trusts.

122/13 PUBLIC HEALTH - UPDATE
(Agenda No. 9)

The Director of Public Health for Oxfordshire, Dr Jonathan McWilliam reported that the Health & Wellbeing Board had held its inaugural meeting on 25 July 2013. It had approved some revisions and proposed measures to the current Health & Wellbeing Strategy 2013/14 for Oxfordshire notably raising the target from 60% of babies to be breastfed at 6 – 8 weeks of age to 62%. The Board had also requested the Health Improvement Partnership Board to investigate the possibility of raising the target for those invited for NHS Health Checks from 50% to 65% and to report back. This service was now being run by the County Council and the numbers undertaking checks was currently the best in the region. There was also a determination to keep teenage pregnancy rates low in Oxfordshire.

The main challenge for Public Health was how it could continue to improve Health and quality of care with tighter resourcing. Dr McWilliam concluded by pointing out that now the Health & Wellbeing Board was a formal legal entity, its agenda could be linked more closely with this Committee, as appropriate.

The Committee thanked Dr McWilliam for his report.

123/13 DIRECTOR OF PUBLIC HEALTH (DPH) ANNUAL REPORT AND TO CANVASS VIEWS IN ADVANCE OF THE NEXT DPH ANNUAL REPORT'

(Agenda No. 10)

The Director of Public Health, Dr Jonathan McWilliam, presented his sixth Annual Report for 2012/13. He reported that overall the review had been 'good', however there was no room for complacency. He had flagged three new areas for this year, loneliness and isolation, rural issues and ethnic minority groups across the County.

Members commented that they would like to see the recommendations for 'Breaking the Cycle of Deprivation' and 'Tackling Alcohol Addiction' strengthened next year. Members also expressed a wish for assistance with benchmarking data across all measures.

Members and Dr McWilliam discussed the report in more detail:

- Loneliness was understood to be a problem which was uniform across urban and rural areas but it was compounded by different issues affecting urban and rural areas differently;
- Data on black and ethnic minority populations was now being included within NHS Health Checks;
- A newly formed Public Health Protection Committee would be meeting in September to tackle the increasing problem of killer diseases; and
- There had been investment in the mental health service which had resulted in general improvement. However, Dr McWilliam agreed that it was a challenge to undertake outcome based measurement of performance.

Dr McWilliam reminded Members that Oxfordshire was the sportiest county in the country.

The Chairman thanked Dr McWilliam for his report adding that the Committee would wish to give their suggestions for topics at a much earlier stage when it was in draft form.

124/13 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 11)

The Chairman reported on his activities since the last meeting:

- He had met with the OCCG to discuss patient engagement in maternity services;
- He had met with OCC about intermediate care beds;
- He had had introductory meetings with OUHT and OCCG with upcoming meetings with Oxford Health.

Members of the Committee suggested the following issues for inclusion in the Committee's Forward Plan:

- Delayed Transfers of Care problems and issues and the steps being taken to improve the service;
- Outcomes based commissioning to include the measurement of Mental Health improvement;
- Pooled budget arrangements;
- Horton Hospital issues
- Health Inequalities – to include access to nutrition; obesity; homelessness; Black and Ethnic Minorities data;
- Recent breaches of security at Oxford Health FT facilities;Report on Ambulance Responders (March 2014 meeting).

125/13 CLOSE OF MEETING
(Agenda No. 12)

.... in the Chair

Date of signing ....

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NHS
Oxfordshire
Clinical Commissioning Group

Update paper for Oxfordshire Health Overview and Scrutiny Committee December 2013

Authorisation status

On 15 November OCCG submitted documentation relating to the three outstanding conditions of Authorisation. This will be submitted by the Thames Valley Area Team for consideration by NHS England. The formal opinion regarding the submission is likely to be reported in the public domain in January 2014. I am hopeful that the recent submission will enable NHS England to remove all three conditions. More information will be available following the second assurance checkpoint meeting with the Area Team on 2 December.

Proposal to Amend the OCCG Constitution

The 83 member GP practices within the six Localities are currently considering a proposal to strengthen the structure of the senior team of OCCG. At the time of forming the current structure more than eighteen months ago it was appreciated that changes might be required. The proposal, if supported, would lead to the appointment of three different posts; Clinical Chairman, managerial Chief Officer / Accountable Officer and Lay vice Chair. This would mean that Dr Stephen Richards would stand aside from his current position as Chief Clinical Officer / Accountable Officer and Ian Busby would stand aside from being Lay Chair. Both would offer themselves for consideration of appointment under the new structure.

This proposal recognises the need to strengthen the senior team to enable OCCG to address better both current and future challenges. The new model is similar to that found in 70% of the 211 CCGs in England.

The Financial Challenge

At 31 October 2013 (month 7), NHS Oxfordshire Clinical Commissioning Group (OCCG) reported an over spend of £7m against budget (2%) to NHS England. The forecast outturn for the year was £9.3m overspend against budget (1.5%). This includes commitment of all of the CCG’s contingency reserves of £7m.

The best case forecast outturn is for a deficit of £2.5m while the worst case forecast outturn is for a deficit of £13.8m.

The main driver of the deficit position is the year to date level of over-performance at the Oxford University Hospital Trust.

OCCG continues to face marked financial challenges. It was agreed that given the scale of the challenges OCCG should seek short term external support. A formal procurement process was followed and the preferred bidder, Deloitte started working with the OCCG team on 4 November. Deloitte will be helping us to deliver as much saving as possible in the current financial year and assisting OCCG deliver what will be a significant QIPP plan for 2014 – 2015.

A Call to Action

In recognition of the continued financial constraints facing the NHS in the next five years NHS England launched “A Call to Action”. Whilst the initiative was developed by NHS England the delivery and implementation of the programme is the responsibility of local health economies including both commissioners and providers. In this respect NHS England is working collaboratively with Monitor (the regulator for Oxford Health NHS Foundation Trust) and with the Trust Development Authority (the regulator for Oxford University Hospital NHS Trust)

Events are taking place in all six localities across the county. These events are intended to inform our population regarding the local financial pressures, the growing demands placed on services by the changing demography and the potential for innovation. The NHS will need to change if it is to meet these challenges. OCCG is seeking the public’s views on how we might address the challenge by making changes to the services that are commissioned. I would encourage as many people as possible to attend the scheduled meetings.

- Wantage 19 November 1.00 to 5.00pm
- Witney 20 November 6.30 to 9.30pm
- Oxford 21 November 9.00 to 12 noon
- Banbury 3 December 1.00 to 5.00pm
- Bicester 5 December 9.00 to 1.00pm
- Wallingford 19 December 9.00 to 1.00pm

An additional meeting has been scheduled to take place in Oxford Town Hall on 7 January 6.30pm – 9.00pm and is open to people from across the county who may not have been able to attend their local meeting.

Please note that for people who cannot attend this series of meetings they can contribute to the discussion online by registering with talking health or by twitter or accessing OCCG Facebook page.

All suggestions and comments from the public either in the meetings or via social media will assist OCCG in creating a 5 year Strategic Plan and delivering a 2 year Operational Plan that builds on the themes set out in “Improving the health of Oxfordshire”.

First drafts of the two plans will be submitted to NHS England on 14 February and a final version will be submitted to the Governing Body for the meeting in public on 27 March 2014.

The Integration and Transformation Fund (ITF)

The Department of Health has set out radical changes to funding that will place significant amounts of NHS funding under the joint control of health and social care commissioners. For Oxfordshire this translates to the movement of approximately 3% of OCCG's budget into the fund by 2015-2016.

Detailed discussions are taking place with the County Council and NHS providers to understand the implications of this change.

In principle the formation of the ITF is intended to ensure that a greater share of OCCG's financial allocation is allocated to more health and social care services in the community to support patients in their own home or closer to home.

Winter Pressures

Oxfordshire has been awarded £10.2m to increase capacity in health and social care services over winter. A range of initiatives have been planned including:

- Recruiting more clinical staff in A&E.
- The opening of 12 community hospital escalation beds for a period of five months.
- Increasing community nursing capacity - 27 nurses for end of life care, post-acute care at home, flu vaccinations for household patients.
- Purchasing additional equipment to be used in people's homes - bed rails, toilet seats, hoists, chairs, and walking frames, or could be minor adaptations to the home such as handrails.
- Increasing occupational therapy services – 12 additional occupational therapists.
- Public campaign to help the public use services appropriately.

OCCG is continuing to work very closely with Oxfordshire County Council and all providers of health and social care in the county to ensure that all urgent care services are safe and resilient through what is predicted to be a harsh winter. Mechanisms are in place to give assurance that the additional funding will be used to maximum effect.

Outcome Based Contracts

OCCG has been discussing the possible use of new forms of contract to deliver improved outcomes for patients and greater financial stability for the local health economy for more than a year. The Phase 1 feasibility report was published in January 2013. This is available on the OCCG web site. Following this, OCCG undertook a procurement process and appointed the Cobic Consortium to work with OCCG to progress work to deliver outline

business cases for three agreed areas of commissioned services; Mental Health, Maternity and Older People.

OCCG Governing Body will be assessing the outline business cases at their Governing Body meeting on 28 November 2013. This will include determining how OCCG will proceed towards delivery of this highly innovative model of contracting.

A new Priorities Forum for the CCGs in Thames Valley

Oxfordshire has benefitted for many years from the evidenced based recommendations made by a Priorities Forum. Principally the previous forum made recommendations regarding procedures that were deemed to be under the umbrella of Specialised Commissioning. The Health and Social Care Act 2012 passed responsibility for Specialised Commissioning to NHS England, and for Oxfordshire, are commissioned by the Wessex Area Team of NHS England.

The Thames Valley CCGs have agreed that a new Priorities Forum should be formed to address services commissioned by CCGs and a work programme has been agreed for the remainder of the year. Future recommendation made by the Thames Valley Priorities Forum will be brought to OCCG Governing Body starting in the early part of 2014.

Public Engagement

Each of the six OCCG localities have programmes for engaging their local communities and a report is provided to each Governing Body meeting. Below is a summary of the latest engagement activities that have been taking place across Oxfordshire:

A North Oxfordshire Locality Group (NOLG) public engagement event took place on in October. It was agreed to develop an Open Forum for better local public input into how to improve patient care in north Oxfordshire. Discussion included how services could be better joined-up, how patients could choose the best urgent care option, and how general practices could work together to improve local care.

In North East Oxfordshire Locality Group have been involving patients in their work including a Patient Participation Group education session, patients and carers actively participating in project groups,

Oxford City Patient Participation Group Forum was attended by patient representatives and other interested members of the public and stakeholders. The following priorities were discussed:

- Patient education and information.
- Development of primary care services – integration of health and social care. Care ‘closer to home’.
- Improved local access to diagnosis and consultant led clinics in the community.
- 111 – improving clinical expertise.
- Coordinated care for people with multiple health problems/ Long Term Conditions, coordinated through the GP practice.
- Improve services for people with addictions.

There was overall support for these priorities and the Forum made a number of suggestions for how they could be addressed (patient education and information in particular).

West Oxfordshire Locality Group (WOLG) held a public workshop on 20th November where they discussed OCCG's strategic direction as well as discussing next year's locality plan.

SELF (South East Locality Forum) continues to work well. In particular through its website which is established within Talking Health and is used to exchange ideas and communication between active Patient Participation Groups (PPGs) across the locality sharing newsletters, survey questions, 111 service, access/weekend opening etc. and sharing of PPG priorities, "shopping lists" of services that groups would like to see. This will help further inform the next locality planning meeting and priorities for next year.

The latest South West Oxfordshire Locality Patients Reference Group meeting was held at the Didcot Civic Hall on 22 October with around 11 Patient Groups represented. Key items of discussion were: the future provision of intermediate care beds, OCC financial challenge and the impact on plans around integrated health and social care, the launch of NHS England Call to Action.

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Oxford Health NHS
NHS Foundation Trust

Briefing to Oxfordshire HOSC
Service Remodelling of Oxfordshire Adult Mental Health Services

Ali Neary, Project Manager and Jackie Thomas, Head of Adult Community Services

1. Introduction and Overview

Recent changes in commissioning arrangements for local healthcare services and our desire to make our services the best we can for patients, carers and staff allowed the mental health division the opportunity to review our existing provision of adult mental health services across Oxfordshire and Buckinghamshire. This has allowed us to use these changes to help support the improvement of service quality and access for our patients and their carers across the two counties and review the patient pathway through all aspects of our service to ensure that this is meeting not just the patients' needs, but any other health or social care provider involved in their care and treatment. It is also hoped that the new model of care will bring about much greater collaboration with our colleagues from the third sector with the aim of providing better support for patient's employment, housing and wellbeing needs.

Formal staff consultation closed on 2nd November 2013 and as a result of the consultation and feedback received from staff, union colleagues and the Executive Team, we made several changes to the model. Using these to support our decision making process we are currently developing the operational policy and model of care for both the community and inpatient provision.

2. What did we want to achieve?

The remodelling project has been driven by the desire to improve patient pathways and support everyone involved in that pathway to achieve their own specific outcomes. Care Clustering and recent patient and staff surveys have all shown that there is a need to have:

- Clearly defined and transparent patient pathways which ensure patients and their carers have the information they need to make informed choices about their care and treatment.
- Fewer referrals between services and better transition arrangements within the division and into/out of services provided other clinical divisions of Oxford Health NHS Foundation Trust.
- Improved access to services to enable patients and their carers to get support and treatment as close to home as possible and by staff that are familiar with their care.
- Established partnership working with individual patients GPs, voluntary sector and the CCGs.

- An improved recognition of the carer and the role and influence that they have in supporting their friend or family member who is engaged with our services.

- Skilled and experienced leaders and managers who are able to lead the team to provide high quality and safe care.

- Staff who have the appropriate skills to provide specialist interventions based on NICE guidance and the ability to allow these staff to support their peers in other teams with patients who present with complex requirements.

These measures to improve the service have been mapped by the division, and we believe that locality based team model providing an extended service will be able to deliver not only excellent and safe care for patients, but also a service that ensures GPs continue to choose to commission our services, but also to recommend us to their patients as a their provider of choice.

3. The Consultation Process

Once we had developed our proposed model we wanted to ensure that we involved everyone who would be affected by the proposed changes, and over the course of the last 6 months we have held meetings with Oxford CCG Leads and Practice Managers (approximately 200 colleagues), Oxfordshire County Council (who have also been supporting the HR process for staff seconded to the Trust under our Section 75 agreements), as well as colleagues from the 3rd Sector and representatives from the Oxfordshire HOSC.

We have also held 7 patient and carer focus groups with over 50 representatives in attendance to share their views on the model and how this will impact on their care. Feedback from these has been, in the main, very positive, with the extended hours and integration of the crisis function being particularly welcomed. Patients did express some concerns about the possible changes to their care co-ordinators, and whilst we acknowledge that if individual staff choose to move teams/roles as a result of this remodelling then this might affect some patients. However, this should only be in a few cases as most staff will be slotted in to their existing locality so it is anticipated that the majority of patients will still maintain their current care co-ordinator.

Nevertheless, we took the concerns raised at these forums seriously and as a result we changed the process for staff being able to make open preferences. We discussed this with staff who were happy that, where possible, they would continue to work within their existing locality to ensure that patients could remain in contact with at least one of their existing care team, who was familiar with their needs and treatment plan. This will also ensure that this change is undertaken in a planned manner, and has the least impact possible on the delivery of safe and managed care for all of our patients.

4. Summary of Main Changes (Community Mental Health Services)

- Following the integration of our existing Community Mental Health Teams (CMHTs), Crisis Service and Assertive Outreach Teams the newly formed locality based Adult Mental Health Teams (AMHTs) will undertake both an assessment and treatment function. This will therefore reduce the need for patients to be moved from one team to another especially when they are experiencing a crisis and are consequently very unwell and will allow them to maintain therapeutic relationships during this period

- The AMHTs will be providing an extended hours service and the assessment function of the team will operate a 7 day/week service from 7am to 9pm.

- Overnight cover will be provided by up to 5 staff based in Oxford City who will work closely with staff on the inpatient wards, out of hours GPs and colleagues from the emergency services to support patients who are experiencing a crisis.

- The treatment function of the team will work from 9am – 5pm 7 days a week, with a minimum requirement, to run two late night clinics until 8pm each week, with the capacity to increase this if local demand requires it.

- The AMHT (both assessment and treatment function) will work collaboratively with colleagues from the 3rd Sector, so will be able to address patients housing, employment and wellbeing needs in a more robust and timely manner.

- The assessment function of the AMHT will become the Single Point of Access for all adult mental health services in their respective locality, so will also act as signposters to other services that we provide within Oxford Health NHS Foundation Trust if it is agreed that a referral is not appropriate for the AMHT.

- Oxfordshire will have 2 Day Hospitals which will become an integrated function within their respective locality based AMHT. These will be sited in Oxford City and Banbury and will operate from 10am – 6pm 7 days a week providing step down from inpatient care and will work within a partial hospitalisation model.

- The AMHTs will be based in Banbury, Oxford City and Wallingford with satellite clinics based throughout the counties in all existing market towns, as per our current provision.

- The provision of an integrated treatment and assessment team will ensure that if patients are discharged but subsequently become unwell again, there will be no requirement for them to be formally re-referred into the team, either by their GP, 3rd sector colleagues, or other services within the Trust. Patients known to the team will be reassessed by a member of staff who is familiar to them, and transferred to the treatment function if required, for appropriate support and intervention. This will minimise any delay in patients accessing any specialist care that they might need from our services.

4B. Summary of Main Changes (Inpatient Services)

- We wanted to use the implementation of this new model as an opportunity to improve the clinical seniority on the wards to ensure that the staff working with our most acutely unwell patients have the appropriate support and have clear clinical leadership. Each inpatient ward will have a dedicated consultant team and a Modern Matron and in addition their current establishment has been increased by two Band 6 posts. This will enable us to uplift the staffing that we currently have on each shift (5, 5, 4) to 6, 6, 4 (6 members of staff working the early and late shifts and 4 staff working overnight).

- Each ward will also have a 0.5 WTE Speciality Doctor, which is an enhanced provision from what we have currently.

- We are also working with the senior clinical team to develop a new clinical model and operational policy to support all staff working within an inpatient environment to deliver safe and excellent care. This will include new care pathways, guidance on practice in line with national standards (AIMS accreditation), privacy and dignity and quality and safety standards. The new operational policy will also include levels of competency that we will expect all qualified and unqualified staff to attain.

- As part of the new model of care we will have a clearly established and accessible pathway to improve the handover of care on admission and discharge between inpatient and community services.

4C. New/Additional Services

In addition to the formation of the new AMHTs the division have also been working on the development of new/additional services across the counties.

- The Emergency Department Psychiatric Service (EDPS) will be an Oxfordshire based service that provides support to the Oxford University Hospitals Emergency Departments based at the John Radcliffe and Horton Hospitals. They will be moving to working 7 days/week from 7am – 10pm. This will require an increase in staffing to provide the enhanced service and it is proposed that this is staffed with experienced Band 6 and 7's who have advanced assessment skills. This new service has been developed from our previous Psychiatric Liaison Service and will provide an enhanced provision to colleagues working in the acute sector.

- We have also recently secured funding from Thames Valley Police (TVP) to pilot a Street Triage Programme in Oxfordshire. Each night a Band 6 clinician will work alongside colleagues from TVP to assist police officers in their assessments of the general public who are potentially experiencing a psychiatric episode and may require admission into our services on a Section 136 of the MHA.

5. Implementation Plan

We are now working on the detailed planning for the implementation period, which will be a phased implementation from January to March 2014.

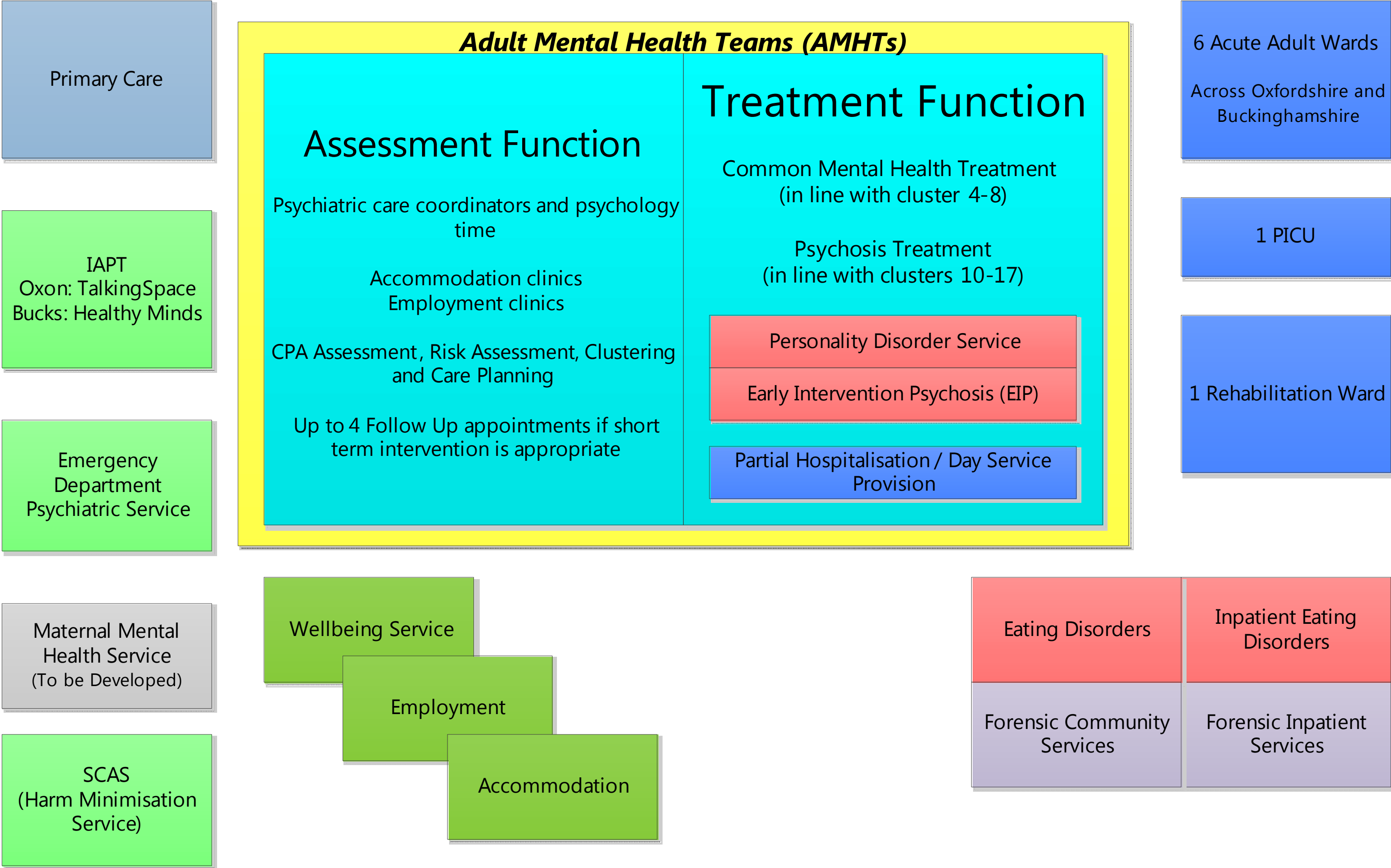
The mental health division are committed to developing a plan so that their new model of service is implemented in a phased and measured way in order to ensure that patient safety remains paramount throughout the changes. As noted already in this report the formation of the new locality teams might have an impact on some patients who could require a change of care coordinator as part of this process. However, we will ensure that the changes are made in a planned and coordinated way to provide assurance that all potential governance and safety issues have been raised and appropriate contingency plans are put into place.

The implementation plan also has a detailed communications plan to ensure that patients and their carers are appropriately involved and engaged throughout the implementation phase and that they receive timely and relevant information about the impact of any changes on the delivery of their care. One example of this is that we have drafted a factsheet for patients and carers explaining what the main changes to our services will be, why we have made these changes and who they can speak to if they have any further questions.

One of the initial tasks within the implementation plan is to formally appoint staff into the new Team Manager and Community Lead roles. Once we have staff in post for each new AMHT a bespoke package of leadership and development training will be established for each locality for them and the Consultant Psychiatrists in the team. This training will help the new management team to work collaboratively to embed new ways of working, improve quality of care and develop their locality team to ensure the new service meets all stakeholder expectations.

Oxford Health NHS
NHS Foundation Trust

Appendix A: Proposed Model of Care for Adult Mental Health Services



Briefing to Oxfordshire Health Overview & Scrutiny Committee
5 December 2013

Older People's Care, Long Term Conditions and Urgent Care

Service Remodelling and Current Delivery

1. Introduction

This paper sets out a briefing on the actions being undertaken by Oxford Health NHS Foundation Trust to develop and implement a model of care for older people, long term conditions and urgent care in a community setting that is right for the 21st century. This focuses on integration of physical health, mental health and social care for older people, and adults with complex and multiple needs. This is being undertaken in conjunction with partners from across the County (primary care, adult social care, acute services and the voluntary sector).

This paper also provides a summary briefing on progress to date in delivery of this, and how service remodelling and winter planning has been combined to drive the change needed and meet the significant increase in patient need and demand predicted for this winter.

2. Context

The step increase in demand in urgent care, especially for older people has been well documented both locally and nationally. This increase in demand reflects not only the increase in volume of care interventions required: it also reflects the increasing acuity and complexity of patients' needs. Community health and social care services (including GP practices) have a significant role to play in extending services closer to home to enable more patients with higher complexity of need to be treated closer to home wherever this is clinically appropriate. This approach aligns to health policy of the last ten years, and has significant benefits for patients (independence and well-being) as well as reducing avoidable spend in acute hospital settings and long term care (domiciliary and residential).

The evidence base for how best to deliver integrated community-based provision to drive care closer to home is still emerging. However, there are two principles that are always present in effective care closer to home: rapidity of response by community services, and multi-disciplinary clinical co-ordination of care. The need for integrated care delivery is reiterated by national patient and carer feedback, in which multiple handovers and slowness or disjointed health / social care response are frequently cited as the primary source of stress and anxiety to patients and carers.

The need for a 21st century integrated model of care is clear: and this need is even more compelling given the fiscal constraints facing both health and social care. Increased demand and complexity of need is occurring at a time when funding resources are at best stagnant, or subject to significant cost efficiencies.

For Oxford Health NHS Foundation Trust this challenge is evidenced by the current average 20% over-activity against funding (via block contract) for community services. This reflects the additional care closer to home already being provided by community health services; and is a demand / capacity pressure particularly felt in community therapy and community nursing services.

Oxford Health NHS Foundation Trust is currently undertaking significant remodelling of its services to address these challenges so far as is possible within our resources. Broadly badged as "integration", these changes are based on core principles:

- A multi-disciplinary clinical model that comprises four elements: promoting independence and self-care, care at home, crisis management and recovery /reablement or end of life care.
- Integrated, multi-disciplinary team working for those patients with complex or escalating need, based on a local model of care
- Increased clinical skills to support a patient population with increasing complexity and instability of need in a community setting (home and bed-based care)
- Improved community response times for all aspects of urgent care need (0-2 hours where clinically needed)
- Service provision aligned to patient demand: core services provided 7 days a week, over extended hours (8am to 8pm)
- Model of care based on evidence-based research: and where this is not available, developing this in conjunction with provider partners and academic institutions
- Modernisation of service infrastructure; re-procurement of the electronic patient record (to enable mobile working, patient access to their own records etc.) and development of holistic and patient centred performance framework (replaces multiple performance indicators for individual service lines, as currently commissioned)

3. Service Remodelling

There are a number of work programmes in place to ensure consistent implementation of the above principles across the services provided by Oxford Health Foundation Trust. The breadth of these changes presents challenges in co-ordinating the delivery of these interventions, which will only deliver the intended benefits if achieved across the entire patient pathway (including partner providers).

Given that Oxford Health NHS Foundation Trust community health and older adult mental health services in Oxfordshire delivered around 920,000 face to face patient contacts last year, there is

an equivalent challenge to focus service remodelling on the patient cohort who will benefit from integrated care.

This has been defined as those who have:

- Complex co-morbidities (physical and mental health and social care)
- Escalating need or instability
- Multiple patient and / or carer needs

The summary overview of these is as below:

3.1 Emergency Multi-disciplinary Assessment Units (EMUs) and Interface Medicine

Building on the success of Abingdon EMU, implementation of an additional 3 EMU functions John Radcliffe, Horton and Witney Community Hospital). These will provide county-wide same day multi-disciplinary assessment and treatment for adults at immediate risk of acute medical admission.

These will be supported by the recruitment and development of a new genre of medical care (interface medicine), in which the clinical skills of acute geratology and medicine and enhanced primary care are integrated to enable increased community-based care of people with sub-acute and complex medical needs.
Delivery of this is progressing well, with the additional EMU functions planned to commence gradually at the remaining three sites from late November.

3.2 Integrated Localities

This centres on developing new ways of working together (community health, adult social care and older adult mental health) to provide improved co-ordination of care and a very rapid response for people with complex or escalating needs.

This has commenced with the development of a rapid multi-disciplinary assessment and treatment team response team in each locality, which began implementation in October. During the next five months this will develop as changes in specific services come together to provide the sustainable operational model for delivery by March 2014. This will function 7 days a week, 8am to 8pm.

3.3 Rehabilitation Pathway

This is focused on the development and implementation of an integrated pathway across community settings (community beds, adult social care and community health care at home). This includes extended hours provision for therapy services (specialist and rehabilitation) aligned to patient need, for example 7 day rehabilitation and increased access to specialist provision such as podiatry (for example, evenings and Saturday morning).

Within Oxford Health FT, some of these developments are currently being implemented and others trialled, with incremental changes taking place in line with the wider integration

plans. These changes will be a significant contribution to the implementation of integrated locality working.

3.4 Memory Clinic Pathway

Oxfordshire has set itself the challenge of increasing the prevalence of dementia diagnosis by 30% by 2017. This requires a significant reworking of the service model to deliver this increased volume within existing resources.

Work is underway to refine the diagnosis pathway within Oxford Health NHS FT to achieve all aspects of dementia diagnosis within a single clinic attendance for the majority of patients. This will reduce duration of the pathway for patients and enable more patients to be seen within the existing resources.

3.5 Older Adult Mental Health

As with physical health services, there is a challenge to move more care closer to home to improve outcomes for patients and reduce acute admissions where this is clinically appropriate.

Currently older adult mental health community teams work Monday-Friday, 9am-5pm, with dedicated crisis teams responding to urgent need during the out of hours period.

The new model of care for older adult mental health will increase the number of staff working in a community setting, as well as extending the hours of service delivery to seven days a week, and to 8pm weekdays.

This will provide greater capacity for community older adult mental health practitioners to respond proactively to escalating mental health need in older people (dementia and functional illness such as schizophrenia) and provide more treatment and support in the home. For people with dementia this will be augmented by better joint working across physical health, mental health care and social care (for example, Hospital@Home, community therapy, district nursing, reablement and crisis response) to assess, treat and stabilise both physical and mental health crises at home wherever clinically appropriate.

This additional resourcing will be achieved by improving MDT discharge planning on Older Adult Mental Health wards to reduce the average length of stay closer to the national average (currently Oxfordshire is an outlier, with an average length of stay of 100 days). Together with increasing the ratio of inpatient staff to patients, this will enable improved bed use allowing overall bed numbers to reduce (and the staffing resource to be deployed in community settings) without reducing capacity for number of inpatient episodes.

This is a significant development of the older adult model of care, which has been extensively clinically developed and reviewed. Formal consultation on these proposals is due to commence in Oxfordshire in January 2014, with the intention of implementing this model of care during 2014.

These changes will be a significant contribution to the implementation of integrated locality working.

3.6 Community Hospitals

Last year improved multi-disciplinary discharge planning in community hospitals significantly reduced average length of stay, and enabled an extra 700admissions to take place within the same bed resources. Locally-led clinical improvement actions also reduced falls byfor inpatients.

Community hospitals are continuing to build on this achievement, with a specific focus on:

- Clinical skills and processes to provide care for more sub-acute patients as part of the EMU pathway (removing need for acute admission)

- Improvement of the physical environment for people with dementia through the Dignity Plus Programme (refurbishment of day rooms, signage, crockery and cutlery and increased garden spaces)

The aim is to increase the proportion of "step-up" admissions to community hospitals (via the EMU pathway). This improves outcomes for older people (reduced length of stay and increased rehabilitation increases independence on discharge) especially for people with dementia, for whom the multiple changes in inpatient settings of the existing urgent care pathway increases confusion and distress.

3.7 Reablement

The Reablement Service (ORS) has made significant progress in the number of new episodes of care it is providing each month, despite an increase over recent months in the number of patients delayed at its back door (20-33 delays each week since June 2013). For example, in August 2012 started 170 new episodes of care; by August 2013 this had increased to 236.

Much work has been done within the service to improve scheduling and timely review and discharge of patients to achieve this; as well as significant work with acute and adult social care partners to smooth the referral pathway into the service.

Outcomes for the service have consistently improved with over 50% of patients discharged with no ongoing care needs, and 27% with reduced care needs. Feedback from clients is very good, with the service rated very highly for the quality of care provided, including kindness and understanding, respect and dignity and listening to what you had to say.

The service is working very hard to achieve the final 15% increase in patient episodes contracted, especially given the predicted demand over the winter period. This includes maximising use of flexible staffing contracts to increase capacity, continuing to refine scheduling processes (to make effective use of capacity, given the high throughput of the service and rapid change in patient dependency, the whole service needs to be rescheduled

around every two hours), and reducing time spent on travel through operational integration with crisis response staff.

The Reablement service will have a critical role to play in the implementation of the EMU functions at the John Radcliffe, Horton and Witney Community Hospital. This pathway will increase the number of people who have a same day comprehensive geratology multi-disciplinary assessment and are brought home same day with health and social care at home (avoiding the need for acute admission).

3.8 Community Nursing

Community nursing (District Nursing as well as specialist community nursing functions such as heart failure, respiratory, tissue viability) is a critical component to supporting people at home who have complex long term conditions, frailty or palliative care needs. This service has seen a significant increase in the demand (number of patients) as well as the level of need (complexity, acuity and instability of clinical presentations). This is now running at a monthly average of 19% over the contracted activity, which is funded under a block arrangement.

In context this is an increase from the contract levels of 19,500 home visits a month to as high as 24,663 (July 2013). This reflects the step change in patient need and demand seen across the urgent care pathway for the frail elderly (locally and nationally).

The Trust is working with OCCG to ensure that the service sustainably has the clinical capacity to meet local patient need as part of the drive to provide more care closer to home.

3.9 Personal Health Budgets

In Oxfordshire personal health budgets have been successfully implemented in Continuing Healthcare, and the Oxford Health leads are now supporting other health teams across south-east England in the national programme of implementation for April 2014. There has been a successful pilot of use of personal health budgets in Neuro Rehabilitation, which found that it had a positive impact on the participant's health and wellbeing.

The current work is focusing on 'integrated budgets' for those people who receive care from both health and social care, so the recipients, or their carer have just a single integrated personal budget. This supports the integrated delivery of hands on care by finical integration at an individual level. The team are also working with the older peoples mental health on the dementia care pathway, to see how personal health budgets could support people maintain their independence at home for longer.

4. Expected Benefits

The expected outcomes are:

For patients and carers

- More urgent care provided locally
- Improved proactive community response to escalating need
- Better access to services over 7 day period
- Improved co-ordination of care (fewer hand-offs and duplication of assessment)

For staff

- Pathways of care support integrated and holistic care for people with complex and escalating needs
- Reduced duplication of effort
- Greater proportion of time spent of clinical care
- Team working replaces multiple service approach to locality-based care

For Providers and Commissioners

- Better outcomes and experience of care for patients and carers
- More effective use of existing resources to help address increasing need and demand

5. Conclusions

This is an extensive programme of remodelling, which is centred on ensuring MDT rapid and local care for older people and those with complex needs in Oxfordshire. It aims to deliver a positive impact which is greater than the sum of its many parts through modernising all aspects of community health care, and improving integrated working across physical health, mental health and adult social care.

However, the change required extends beyond community services, with changes in the interface between primary and community services and acute / emergency services and community services necessary to enable integrated care closer to home.

These changes are expected to be completed within 18 months, with the significant level of change implemented by March 2014.

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Briefing for the Oxfordshire Health Overview & Scrutiny Committee

5 December 2013

Safety and Security in Mental Health Wards in Oxfordshire

1. Introduction

This paper sets out the range of inpatient facilities run by Oxford Health in Oxfordshire and outlines how they are run to maintain and improving the safety and security of patients, staff and the public. The majority of mental health conditions are treated effectively through a wide range of therapeutic and social interventions by multidisciplinary staff (Nurses ,Drs, Social Workers, OTs, psychologists and support staff) working in community based teams and day services which were put in place to facilitate the closure of the large mental hospitals. A small number of people need inpatient care when they have become acutely unwell or their mental disorder cannot be managed at home as it poses a risk to the individual or occasionally to other people. Inpatient admission for the majority is a brief episode on the journey to regaining better health and recovery

2. Inpatients wards in Oxfordshire

Oxford Health run 26 inpatient adult mental health wards including wards for children and young people (1 ward in Oxfordshire), wards for mentally unwell adults (5 wards in Oxfordshire), older adults (3 wards in Oxfordshire) and people needing more specialist services including people suffering from eating disorders (1 ward in Oxfordshire) and forensic wards for people who come from the courts for assessment or treatment of their mental disorder.

3. Forensic wards - secure mental health wards

There are nine 'forensic' wards, six of them in Oxfordshire. Patients have often committed serious offences, such as murder, arson or sexual offences as a result of their mental disorder and need hospital treatment rather than a custodial prison sentence. Patients may be referred from courts, prisons, high secure hospitals or the adult mental health services within the Thames Valley. Patients may be sent by the court for an assessment before they go to trial, to establish if they were mentally ill at the time they committed their offence and whether they require treatment. When they go to trial, if it is felt that they were unwell when they committed their offence, then they may get transferred to a forensic ward for treatment instead of receiving a prison sentence. Prisoners serving a sentence may also be referred if they become unwell whilst in prison and need a transfer to hospital for treatment. High secure hospitals (such as Broadmoor) also refer patients that have completed several years of treatment and are ready to move to a less secure unit where they can start using leave and becoming more independent. Occasionally mental health wards may refer a patient who

is very difficult to manage on acute wards due to their levels of aggression or challenging behaviour.

There are three types of forensic wards: medium secure, low secure and an open pre discharge unit. Medium secure units were established in the 1980s and were called medium secure as they were in between the security of high secure hospitals like Broadmoor and a local acute mental health ward. There are now clear specifications as to the physical environment (how high the fence must be how keys must be managed etc) procedures that they must operate (such as searching patients and what items are banned) and relational security (ensuring that staff know their patients well and there are ample therapeutic activities in which patients engage).

Most patients from prisons, courts and high secure hospital will initially be admitted to a medium secure unit. The Trust has two MSUs, the Oxford Clinic at Littlemore and Marlborough House in Milton Keynes. In these two locations there are two wards that can broadly be seen as an assessment ward and a rehabilitation ward. They only admit male patients.

Low secure wards do not have the same level of physical security as the MSUs but are still locked and many of the security procedures are the same. There are also now national specifications for how low secure units are built and run. The Trust's low secure wards are Wenric at Littlemore and Woodlands in Aylesbury. They usually admit patients who have been through the medium secure units and now need less physical security but do require ongoing care in a secure unit for some time. These patients may have treatment resistant schizophrenia. Some patients from adult mental health wards are also admitted to low security. Wenric only takes male patients but Woodlands takes men and women.

Thames House at Littlemore is an 'enhanced' low secure unit for women, with two wards that also can be thought of as an admission ward for patients who need high levels of support and a rehabilitation ward for women requiring less intensive support. It is called enhanced as it sits between medium and low secure services and is able to take both medium and low secure patients.

Lambourn House at Littlemore is an open pre-discharge unit that operates much like a hostel in the community. The unit is not locked, patients are self catering and encouraged to access services in the community rather than in hospital. This unit is an important part of the discharge pathway and is frequently the route for discharge from secure mental health care. Patients normally stay there for 6-12 months and then move into residential placements in local communities. It is analogous to an open prison setting to which prisoners might transfer towards the end of their sentence. The physical security of the building does not prevent them from leaving and they are expected to access the local community for work and leisure activities.

Patient pathway or journey through forensic services

A typical pathway for a male patient would be to be admitted to a medium secure assessment ward for six to 12 months, then transfer to the medium secure rehabilitation ward for a further one to two years. They might then go to low secure if they required further time (perhaps years) in secure care or to the pre discharge unit if they are working towards living in the community. Female patients might similarly move through Thames House to a low secure or pre discharge bed.

Forensic Wards are assessed by teams from the Royal College of Psychiatrists and peers from other units every year against the national medium and low secure standards. Our units are broadly compliant with some needs due to the age of Marlborough House, which needs a better reception area to meet the latest standards. The service has a Health and Safety / security lead, its own internal security procedures and all staff receive annual security awareness training. On every shift on every ward, there is a designated security nurse with clear security related tasks to oversee. The units are also part of the usual inspection regime of the CQC and of the assessment schedule of the Trusts Local Security Management Specialist (LSMS). The CQC include aspects of security in their standards – on a visit last year they raised that a bin store on the Littlemore site had been left unlocked.

4. **Adult mental health inpatients**

There are 8 adult mental health wards 5 in Oxfordshire. They are less secure than the forensic wards and entry and egress is controlled by the use of passes voluntary patients are free to come and go so long as this is an agreed part of their care plan. Most patients are admitted from the community when in Crisis and are admitted for around two weeks before returning to their homes.

There is one psychiatric intensive care ward called Ashurst on the Littlemore site. This ward has more security and controlled entry and egress with an air lock. Patients who need intensive nursing to manage acute distress are admitted for brief periods to this ward. The majority of patients are detailed under the Mental Health Act.

There are two male and two female admission wards divided between the Littlemore and Warneford sites. The mental health wards also have their security related procedures and a security nurse on every shift. There have been recent concerns over their physical security in that detained patients have been able to leave, by scaling the fence in the ward gardens or by forcing windows or doors. This weakness is in part due to an aging estate and in particular restrictive planning controls on the Warneford Hospital site. There has been a lot of remedial works to raise fence heights and fit more robust doors and windows and generally refurbish the wards, however given these planning restrictions the Warneford wards will not

have the same level of physical security as purpose built new mental health wards or the forensic wards.

Oxford Health NHSFT has built a new mental health inpatient facility in Buckinghamshire and in the medium term would wish to replace its aging estate in Oxfordshire.

5. Recent incidents

Two recent incidents have led to the press raising security concerns. A transferred prisoner went missing from Lambourn House (Littlemore), making his way to Poland where he subsequently died. Lambourn is not a locked secure ward so could not easily prevent this happening. The prisoner had been through the usual pathway through medium security to the pre discharge unit and was felt to be appropriately placed. The subsequent investigation which included the Medical Director of Broadmoor found three main causes for concern: the nursing observation on the night that he left were not done properly (staff did not detect that he had placed pillows in his bed and had left), a member of staff had some information about the patient that they should have shared with the team, and this man was still not well as well understood by the clinical team as he could have been. Action has been taken immediately to respond to the findings. NHS England and Oxfordshire CCG externally scrutinise the Investigation report to consider the need for a further independent Investigation.

The other incident recently covered by the press involved a female patient from Allen Ward (Warneford Hospital) who went missing. Although she was informal and could have left at any time, she climbed from her bedroom window. She was subsequently found to be living at her mother's address. Several days later she killed her mother; there had been no indication that this was a risk before the incident occurred. This case is subject to a Multi - agency Domestic Homicide Review.

6. Standardisation to improve quality and reduce error

All wards need to balance the need for physical security and safety with maintaining an environment that is therapeutic and as pleasant as possible in which for patients to stay. An approved list of furniture and fittings exists. The forensic wards fit as standard different doors and window compared to other wards. Windows for example do not open conventionality, they slide open to give some ventilation and have a secure internal mesh. Some acute wards are located in old buildings. At the Warneford Hospital, there are constraints on changing windows; they do have window restrictors in place however replacement to modern standards made more complex by planning controls.

The Trust meets every month in Oxon and Bucks with the police in 'Problems in Practice' meetings. A list of all joint issues that have occurred in that month is tabled and discussed to look at patterns or any issues in joint working with the police for example when patients have failed to return on time to wards . Data from the incident reporting system is reported

every quarter into the Integrated Governance Committee, including the number of patients who have not returned to wards on time or violent incidents and what wards are experiencing most incidents. All incidents of violence and aggression are also reviewed and reported externally.

The Trust is participating in a 'Safer Care' programme. This includes using improvement methods to reduce the harms. Its focus is to reduce the number of patients who do not return on time and reducing the level of violence and aggression and self harm. This is infancy, however initial results are positive. Acute wards are for example, issuing cards to patients going on leave to ensure they know how to contact the ward if they are running late. The focus is involving patients as active partners in their treatment and care plans to reduce the potential for harmful behaviour or incidents.

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Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 5 December 2013 10.00am

Delayed Transfers of Care

1. Introduction

Oxfordshire has a history of patients experiencing delays in the transfer of their care between hospitals and other care services. The Health Overview and Scrutiny Committee will meet with leaders of the local health and social care community on 5th December 2013 to discuss progress on this issue.

Represented at that meeting will be:

Oxfordshire Clinical Commissioning Group (OCCG) – from 1st April 2013 this has been the GP-led body that commissions hospital and community services in Oxfordshire and jointly commissions and purchases a range of services with the County Council

Oxfordshire County Council (OCC) – the Council has responsibility for carrying out assessments of people who may require social care services and for arranging on their behalf long term care services such as domiciliary care (care in peoples own homes) and residential care. It jointly commissions and purchases some services with the CCG.

Oxfordshire University Hospitals NHS Trust (OUH) – the provider of acute hospital services in Oxfordshire, OUH's performance is crucially affected by delayed transfers of care.

Oxford Health NHS Foundation Trust (OH) – the provider of NHS continuing healthcare assessments, community hospital services, the management of referrals and assessments for post-hospital services and also the delivery of some post-hospital services.

The design and delivery of safe and timely discharge in the County is a joint responsibility of all 4 organisations.

A number of other organisations make a valuable contribution to effective discharge, for example, SCAS (South Central Ambulance Service) and providers of long-term care services.

2. Delayed transfers of Care

2.1. A delayed transfer of care occurs when a patient remains in a hospital bed after

- A clinical decision has been made that patient is ready for transfer from that hospital bed **and**
- A multi-disciplinary team decision has been made that patient is ready for transfer from that hospital bed **and**
- The patient is safe to discharge/transfer from that hospital bed

2.2 Delays in transferring care are important because of their impact on the patient concerned, on other/potential patients and in terms of costs to the local health and social care economy. Across the country it is estimated that some 10-15% of hospital beds are used by people who could be discharged.

2.3 Patients who are in a hospital bed when they are medically fit for discharge prevent other people being able to be admitted to a hospital bed. At times of excess demand on the hospital system this rarely means that people will not be admitted in an emergency, however, waiting times may lengthen, people may be held in less than ideal facilities until a bed becomes available e.g. on trolleys and ambulance hand-over becomes very difficult as there is no capacity to receive incoming patients. A hospital system experiencing capacity issues may also have to cancel non-urgent operations in order to re-allocate available beds.

2.4 The impact of delayed transfer on patients affected is also of great concern. For all patients there is a quality of life issue associated with remaining in a hospital bed when ready to move into a lower intensity care setting. However, in addition, older people who spend excess time in hospital are more likely to lose their independence, becoming less likely to return to independent living in their own homes and more likely to require admission to a nursing or care home. In principle, there is also a risk of hospital-acquired infection, although a recent audit has shown that this is not evident in our local hospitals.

2.5 For healthcare commissioners, there is a fixed tariff they must pay hospitals for each type of condition with which a patient is admitted which is based on length-of-stay. When that patient stays for longer the healthcare commissioners must pay for these “excess bed days” thus increasing the cost-per patient. For hospitals which are paid on an anticipated length of stay basis, the day rate reduces for excess bed days. Thus, there is a negative impact on hospital finances.

2.6 For social care, the main impact of delays is in the numbers of people who require long-term residential care instead of being able to return to their own homes supported with a much lower cost domiciliary care package

3. Discharge performance in Oxfordshire

3.1 Work is underway to clarify the detail of the admissions from 1st October 2012 to 30th September 2013 to an acute hospital bed in Oxfordshire.

3.2 In the same period, 2339 people were admitted to a community hospital bed in the County. Of these, approximately 534 returned home with no further care need.

3.3 In the period 01/10/12 to 30/09/13, 2096 Oxfordshire residents were not able to return home on the day they were fit for discharge from hospital. However, what this means is that 90% of all patients admitted were not in fact delayed.

3.4 The average length of delay was 16 days with the majority of delays (64%) being under 15 days and a smaller proportion (13%) being significant delays of 31 days or more.

3.5 Reasons for delays are various. For example, in the local figures for a typical week, in this case, the local report of 17th November 2013 shows the following breakdown for a total of 129 delays:

- 22 (17%) people awaiting an assessment (17 NHS delays, 2 Social Care delays and 3 delays awaiting joint assessment)
- 20 (16%) people waiting for a community hospital bed
- 3 (2%) waiting for a community NHS package
- 1(1%) waiting for an intermediate care bed
- 17(13%) waiting for a reablement service
- 2(2%) of people waiting for equipment
- 23(18%) of people waiting for a care home placement
- 19(15%) of people waiting for a long-term care package
- 2(2%) of people delayed for housing-related issues
- 17(13%) waiting as a result of choice delays
- 3(2%) of people waiting for other reasons

The issue of choice is an interesting one. The figures above understate the impact of choice in the County. In addition to patients staying in hospital beds until they can move to the exact residential home of their choice, there is another cohort of patients who have refused to move to a community hospital bed unless it is in the location of choice. Oxfordshire does not have an exact geographical

match of community hospital beds to areas of demand, so patient choice is an ongoing challenge to the local health economy. Public awareness of this issue appears to be low.

A further issue not directly illustrated within the above report is that of people awaiting different types of housing. Many people can maintain independent living if appropriately housed e.g. in Extra Care Housing or in housing where major adaptations have been carried out, often using Disabled Facilities Grant (DFG) funding. An appropriate supply of appropriate housing and application of DFG funding is a District Council responsibility. There is partnership working on these issues that includes, for example, the County's Extra Care Housing Strategy.

4. Comparisons with other areas

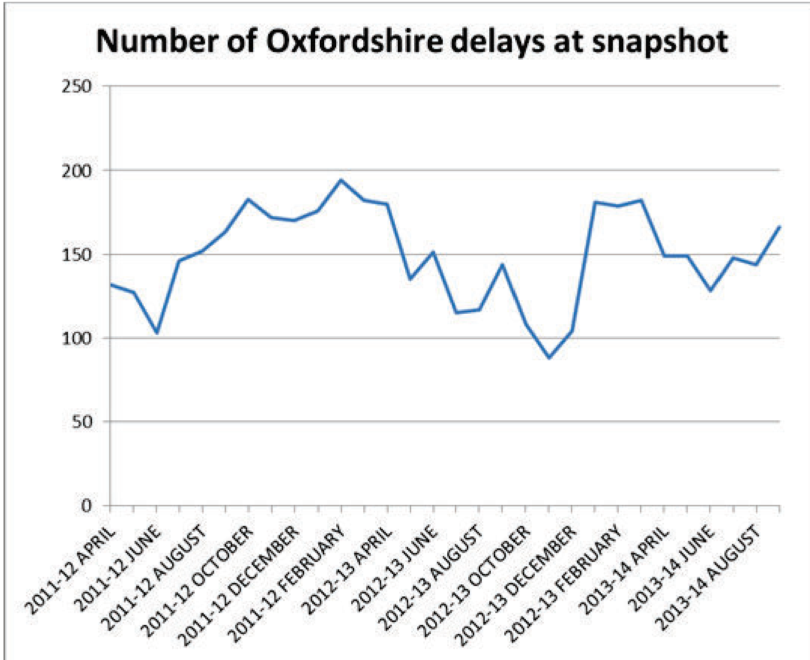
4.1 The Department of Health has published figures on delays since 2001. Originally these were weekly figures for acute hospitals only. During 2007/8 the figures were extended to include all hospital beds, including community hospital beds, beds in mental health hospitals, specialist hospitals for people with a learning disability and any sub-acute beds in an acute trust. From April 2011 reporting moved to monthly. Figures are published on a snapshot of the number of people delayed at the end of the month and the total number of days delayed in the month, for each hospital trust and local authority in the country. Guidance is given on the coding of reasons for delays so that this information should be consistent across the Country.

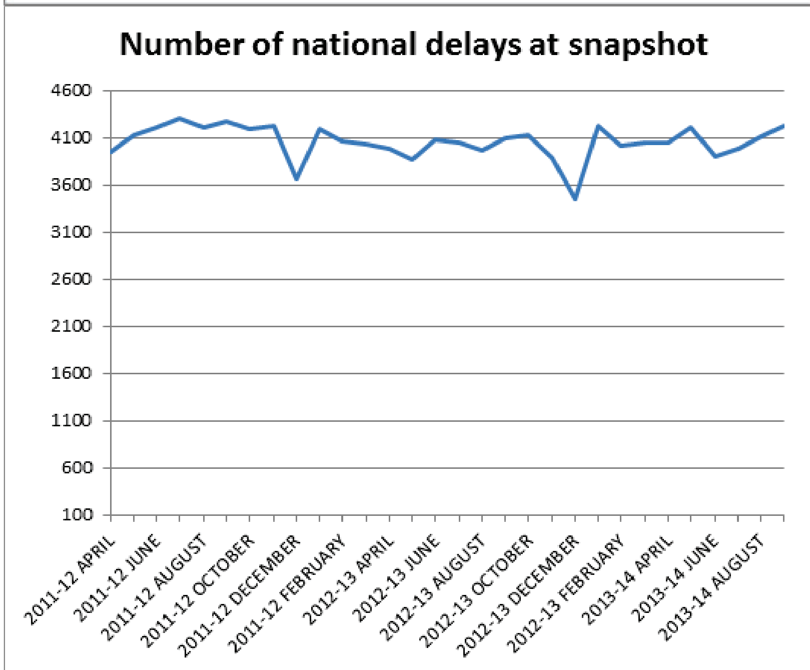
4.2 Partners within the health and social community in Oxfordshire have traditionally believed that some other areas of the Country do not code correctly and thus are shown in a more favourable light. This is a concern that has been raised elsewhere. In July 2013 the Health Select Committee said '*The national data available on delayed discharges contradicts the evidence of clinicians and managers across the acute sector. The Committee believes that the data is incredible and we recommend that Ministers swiftly investigate the method of data collection in order to understand whether the available figures genuinely reflect the situation on the ground*.'

4.3 However, there is one distinct difference between Oxfordshire and most of the advanced health and social economies that report DTOC data. In these locations, the intermediate care layer has been redefined in recent years and the vast majority of patients move swiftly into an intermediate care service when they are fit for discharge. Oxfordshire has not delineated bedded intermediate care services (that don't count within the DTOC figures) from other forms of sub-acute and community hospital beds (that do count within the DTOC figures). Therefore, even if the data from every other health economy was being reported strictly according to the guidelines, Oxfordshire would be still is at a disadvantage.

4.4 Other differences include the fact that Oxfordshire has 2.8 beds per head of population against an average of 2.4 nationally (more beds from which to discharge). In addition, in some health economies, acute and community provision is combined under one provider such that transfers between the two sectors do not lead to “double-DTOC” which is the case in Oxfordshire.

4.5 The graphs below show the number of delays taken from the monthly snapshot since April 2011 for Oxfordshire and nationally. Nationally, excluding the December snapshot (which reflects different practice of discharge over Christmas and New Year) delays have remained fairly constant varying only by 5% from the average. Although Oxfordshire's figures appear to have varied more, the main drop and subsequent increase in 2012-13 reflect more accurate reporting.





4.6 The latest published figures are for the end of September. Oxfordshire had the highest absolute number of delays in the country (166) and the highest per head of adult population.

5. Historical and cultural perspectives

5.1 For over 10 years, Oxfordshire has experienced high numbers of delayed transfers of care and has continued to have high levels of delays attributed to patient choice.

5.2 A succession of health and social care leaders have come under strong criticism for discharge performance from politicians, the public and the media.

5.3 There have been many programmes, projects and initiatives whose purpose was to reduce delays but which have not been successful in achieving that aim.

5.4 Historically, there have been times when organisations have not worked effectively together to achieve change and it has been difficult to achieve progress. However, the current phase, which started over two years ago, has been successful in respect of building consensus, achieving joint leadership from across the health and social care community and starting to work together on improvement planning and implementation.

5.5 The lasting legacy of past failures are, however, ever-present; a disincentive to local leaders in respect of taking risks, trying new approaches and committing to timescales for delivery of performance improvements.

6. Short-term improvement plans

6.1 The local health and social care community has been working in partnership to identify areas for improvement and to implement improvement plans in terms of patient flow through our hospitals and into ongoing services.

6.2 Activity to reduce unnecessary hospital admissions is subject to a separate plan and a comprehensive set of measures have been put in place to ensure that care is put in place in the community at the right time and thus people do not end up in crisis and in need of hospital admission. At present, emergency admissions in Oxfordshire are rising, but community providers are busy at present rolling-out Oxfordshire's EMU's (Emergency Multidisciplinary Units) programme. This roll-out will be carefully monitored to measure impact on reducing avoidable admissions and delayed transfers of care.

6.3 For patients who are admitted to hospital, the in-hospital discharge pathway has already been redesigned and the new pathway implemented earlier in 2013.

6.4 Within the new pathway, partner organisations are still working towards:

- incorporate Continuing Care criteria and End-of-Life care into the pathway
- achieving a 14 day turn-round for Continuing Healthcare assessments
- earlier notification by hospitals to Social Care of the requirement for assessment/ongoing services
- consistent presence of social care staff in hospitals 7 days a week

6.5 Considerable investment has been made in reablement services which are recognized nationally as an important after-hospital service. The number of people going through reablement continues to rise month-on-month and partners are continuing to work together to ensure that all patients who can benefit from reablement are referred to these services.

6.6 Partners have agreed to audit the performance of the new discharge pathway. The first audit was reported in September 2013. It contained useful insights but also indicated areas for improvement in terms of process. A second audit has just been carried out and will form the basis of refinements of the new pathway and an indication of progress in implementation and also of improvements that can still to be made. All partners that are represented at the HOSC meeting on 5th December share a high degree of confidence that they can bring the performance within the discharge pathway up to best-in-class standards.

6.7 The second aspect of improvement planning on which partners are currently working is preparing for Winter 13/14 and the anticipated surge in demand of patients over the Winter period as hospital admissions rise and pressure to achieve timely discharge increase. Oxfordshire was awarded over £10M in central funding to ease Winter pressures, much of which is focused on initiatives to achieve admissions-avoidance. However, there are many initiatives that are targeted at eliminating delayed transfers of care. Examples of investments being made with Winter pressures funding include:

- Additional hospital discharge coordinators and consultant cover in acute hospitals
- Pharmacists available on Saturdays and Sundays to facilitate weekend discharges
- Additional hospital transport available at weekends to facilitate supported discharge
- Additional social care staff to ensure care assessments are completed in a timely manner when people are discharged from hospital
- Additional funding for equipment and technology to enable safe discharge to home

6.8 From a patient perspective, there is a focus on ensuring that delays at the next stage of the pathway are minimised and that care delivers the best long-term outcomes for the patient rather than simply moves them on.

6.9 The challenge to the implementation of the new pathway using one-off Winter pressures funding will be how to make improvements in performance sustainable into 2014/15, especially given the deficit position of the CCG commissioner and the severe cuts in funding being anticipated by the County Council.

6.10 The combination of pathway changes and investments of Winter pressures monies are aimed at improvements within the discharge process itself. They will not address the major difficulty that Oxfordshire faces with discharge i.e. overcoming delays by ensuring smooth progression for patients into post-hospital services.

7. Strategic plans

7.1 A number of plans are being put in place that will have long-term impact on reducing delayed transfers of care. These are almost all managed through the Joint Management Group (JMG), ultimately reporting through the Health and Wellbeing Board.

7.2 The majority of plans will be delivered by joint commissioning of the CCG and County Council using pooled budget arrangements.

7.3 In respect of post-hospital *short-term* care services (intermediate care services lasting for up to 6 weeks), there is currently a plethora of services with different referral criteria and potentially some gaps and overlaps in service provision.

7.4 There have been a number of separate projects put in place to redesign the services that provide people with post-hospital recuperation, re-enablement and rehabilitation. More recently, it has started to be accepted that these projects are in fact inextricably linked. Work is now required not only on establishing the linkages between work-streams, but crucially the additional design elements required so that the Commissioning partners – Oxfordshire CCG and Oxfordshire County Council, can bring forward for public consultation, proposals to fundamentally re-shape intermediate care services in the County.

7.5 It has taken time to reach this level of agreement, but the commissioning partners are absolutely clear that getting this design-work right, and ensuring such services can be sustainably funded, is an absolute priority to ensuring that the County has the right intermediate care services, in the right places, with the right capacities, to ensure smooth flow out of hospital beds.

7.6 Proposals for the reshaping of post-hospital short-term care services (bedded and in people’s homes) are expected to be made in the first half of 2014.

7.7 The Intermediate Care services referred to above are underpinned by another set of services - the services to provide minor adaptations in people's homes, to provide them with equipment (walking frames, toilet raisers etc.) and to provide them with assistive technology (telecare). Best practice is to have these services in place on the day that someone returns home from hospital.

7.8 There are projects in place under the auspices of the Older Peoples Programme to reshape equipment provision and the use of assistive technology in the County, with proposals coming forward in early 2014.

7.9 Providing the designs adopted for intermediate care services and for adaptations, equipment and technology, are the absolutely correct designs, these changes will have a major impact on facilitating safe and timely discharge in the County.

7.10 The challenges with respect to *long-term* care services, domiciliary care in people's homes and residential care in care homes and nursing homes, are very different and the County faces substantial challenges in terms of meeting future demand.

7.11 Levels of social care provided in Oxfordshire are currently the same as in similar authorities. However, more people are coming forward needing care than in previous years and they are coming forward with higher levels of need. The number of older people coming forward for long term care rose by 4.8% in 2012/13 and has risen by a further 7.9% in the first 6 months of 2013/14. The average amount of care provided a week has risen by 9.2% and 1.7% in the same period.

7.12 In addition, more people in Oxfordshire go directly from hospital to care homes than elsewhere in the Country and they stay for longer in care homes. Long stays in care homes generally indicate that people are entering residential care more quickly than average and questions arise as to whether too many patients are being discharged straight to a hospital bed without the opportunity for rehabilitation in an intermediate care service and a subsequent return to their own home.

	March 2012	March 2013	Sept 2013	% increase 11/12	% increase 12/13
At home via home care or direct payment	1,916	2,080	2,293	8.6%	10.2%
Average hours of care provided per week	10.9	11.9	12.1	9.2%	1.7%
In care homes	1,654	1,660	1,744	0.4%	5.1%

Total supported	3,570	3,740	4,037	4.8%	7.9%

7.13 It is currently taking longer to set up long term home care packages than we would wish. The council has put in places plans to develop the home care market to ensure packages can be set up more quickly. These plans include:

a. Setting up a new 24 hours fast response services specifically to provide support to people who are leaving hospital while their long term care needs are assessed
b. Developing small block contracts in areas where there have been difficulties placing people. This will ensure care is available in these areas and that care providers can respond more quickly to requests for service.
c. Set up arrangements to purchase care from new care providers in addition to those currently used
d. Working with neighbouring authorities to identify people who provide care just outside Oxfordshire to see if they would be capable and willing to also provide care in Oxfordshire

8. Future prospects

8.1 There are several Health and Wellbeing targets relevant to DTOC to which local partners are committed in the current year. These are:

- Reducing the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)
- Reducing the average number of days that a patient is delayed for discharge from hospital from the Oxford University Hospital (from 14.8 days)
- Reducing the average number of days that a patient is delayed for discharge from hospital from Community Hospitals (from 22 days)
- Developing a model for matching capacity to demand for health and social care, to support smooth discharge from hospital

8.2 Partners clearly believe that they have put in place short-term changes that will achieve these in-year targets.

8.3 With respect to the strategically driven improvements that can be expected to start impacting the system from mid - 2014 on, the questions which then arise are:

- How will the new pathway and the benefits derived from the implementation of that pathway be made financially sustainable beyond the current one-off Winter pressures funding, especially given the financial pressures on both CCG and County Council?
- To what extent, and at which date in the future, will there be a comprehensive portfolio of short-term post-hospital services for recuperation, reablement and rehabilitation, supported by adaptations, equipment and assistive technology, that have sufficient capacity to ensure smooth transfer from hospital services?
- To what extent, and at which date in the future, will there be adequate capacity of domiciliary and residential care services to ensure swift transfer of those needing to move into long-term care?

CareQuality Commission

Briefing for the Oxfordshire Health Overview & Scrutiny meeting Thursday 5 December 2013

Title	Care Quality Commission: Update and summary of activity.
Purpose	Information and discussion
Lead	Teresa Anderson - Compliance Manager Oxfordshire
	John Scott - Regional Communications Officer

Care Quality Commission

Executive summary

The paper was requested by Lawrie Stratford, Chair of Oxfordshire HOSC for a presentation to be given by CQC at the HOSC committee meeting on 5 December 2013. It sets out CQC's role and purpose and the intentions of joint working with HOSC. It presents an update on the changes that CQC are making to their inspection methodology following the Francis enquiry.

CQC are making significant changes to the way they inspect health and social care services. They have adopted a differentiated approach aligned to the three directorates of hospital, adult social care and primary care inspections. The three directorates are being led by three recently appointed chief inspectors. CQC are committed to keeping people, and their experience and voices, at the heart of inspections and regulation. CQC have acted upon the recommendations in the Francis Report.

Inspection methodology and intelligent monitoring is being tested during Wave 1 and 2 hospital inspections. The process is iterative and will be repeated for adult social care and primary care. The final timescale for the completion of this process, and of publication of ratings across all directorates is January 2015. Some services will have their ratings published much earlier than this.

The paper also provides an overview of inspection activity in the Oxfordshire area this year.

The CQC compliance team covering the Oxfordshire area is fully and adequately resourced. The team have covered 68% of their inspection programme with 32% of the inspection year left. The extent of non-compliance and issuing of warning notices is comparable to other areas in the south region.

The Care Quality Commission (CQC) welcomed the recommendations in the Francis Report. As a result of this report we have bought forward important changes including the appointments of three chief inspectors who are responsible for the three emerging directorates. These directorates will cover hospitals, adult social care and primary care services. The chief inspectors will lead distinct specialist teams.

The Francis report recommended that CQC was not abolished, but was allowed to evolve. The Government have supported this, and our strategic plan. CQC's funding has been increased and the workforce is increasing and changing to support the specialised and enhanced methodology.

CQC now have a strong board with extensive relevant experience. We have a clear strategic direction. We are developing a "just culture", encouraging an openness and commitment to learning. We are developing an Academy to support our workforce to become the best they can be.

We are confident the changes being put in place will result in an organisation which is not only clear about its role and purpose, but is able to carry out that role robustly.

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

We continue to protect the interests of people whose rights are restricted under the Mental Health Act.

CQC are committed to putting people at the heart of their work as recommended in the Francis report. We continue to develop ways of engaging with the public and hearing about their experiences. We are further developing the integration of people who use services into our work by setting up listening events, asking for feedback and including users of services in our inspections.

We are developing our relationships and information sharing with other regulators such as the GMC, NMC, GDC and Monitor. We are working alongside our colleagues locally to monitor and react to "smoke signals" through Quality Surveillance Groups and quality monitoring meetings. We are committed to working

with partner agencies to promote safe and effective services and to ensure that organisations and individuals are held to account, where appropriate.

The Francis report recommended that health and social care services are rated, and that ratings should include a standard below which services should not fall. CQC are introducing these ratings. These ratings are likely to be “inadequate”, “requires improvement”, “good” and “outstanding”. These ratings help to support the Francis report recommendation that CQC become part of the improvement agenda again.

The Francis report recommended that CQC specify the indicators by which it intends to monitor and measure services. We have done this. We continue to refine these indicators through our intelligence monitoring and by the iterative approach we are taking to our methodology and inspection pilots.

We have recently published the first wave of hospital inspection reports. These inspections have included broader and deeper intelligence monitoring, longer inspections of various clinical areas, the use of specialist advisors and clinicians, and the use of experts by experience. The inspections have been co-ordinated by experienced CQC compliance managers. The resulting reports show what was found and what information was used to come to the published judgements.

Our inspections are designed to answer five questions. Is this service well led, effective, responsive, caring and safe? Our hospital inspections have covered eight key areas – accident and emergency, medical care (including older people’s care), surgery, intensive/critical care, maternity and family planning, children’s care, end of life care, outpatients.

We are now doing our second tranche of hospital inspections. This will include the inspection of Oxford Universities NHS Trust. This will take place between January and March 2014. Listening events will be set up to hear from local people who use these services.

The process of testing of our methodology and piloting of inspections will be repeated in adult social care and in primary medical care.

CQC are committed to achieving their strategy within the following timescales:

October 2013

- First new inspections of NHS acute trusts
- Surveillance data published for all NHS acute trusts
- Our plans for adult social care published

January 2014

- First new inspections of mental health and community services
- First ratings published for NHS acute trusts

April 2014

- All regulation of NHS acute trusts now using new approach

- First new inspections of GP practices and adult social care
- Our plans for all providers now set out

July 2014
- First new inspections of ambulance services and dentists
- Surveillance data published for all adult social care, GP practices, community and mental health providers

October 2014
- All regulation of adult social care, mental health, community, and GP practices now using new approach
- Surveillance data now published for all health and care providers, and continues to be updated

January 2015
- All regulation of ambulances now using new approach
- Surveillance data for all health and care providers continues to be updated regularly

April 2015
- All regulation of health and care providers now using new model
- Surveillance data for all health and care providers continues to be updated regularly

Our enforcement powers remain unchanged. We will continue to take enforcement action where there are major concerns or where there is multiple and/or continued breaches of regulations.

The Francis report also recommended that CQC expand their work with scrutiny committees and further develop sounding board events. We are keen to establish these working arrangements in Oxfordshire.

CQC in Oxfordshire.

Adrian Hughes - Regional Director of Operations (South)

Deborah Ivanova – Head of Regional Compliance (South Central)

Teresa Anderson - Compliance Manager (Oxfordshire) leading a team of ten inspectors.

Since coming into post in April 2013 Teresa has established closer working relationships with Oxfordshire County Council and with Oxford Universities NHS Trust. She meets with these organisations quarterly. Teresa has been invited to a meeting with the local care home providers association and has spoken at a practice manager's conference. She is keen to further develop these relationships and to build relationships with HOSC and Healthwatch. Teresa and Sara Livedeas have agreed that it would be useful for Teresa to hear service user's experience through the groups she and her teams work with.

Although it cannot be guaranteed, Teresa is hopeful that she will continue to be the manager leading a team of CQC inspectors in the adult social care directorate. Teresa is a nurse by professional and has been a regulator for 12 years, and is passionate about adult social care. She is keen to take advantage of the current climate to work with other agencies and providers to further improve care provision.

In future, it is likely that there will be two other CQC managers in the Oxfordshire area, covering the specialisms of hospital and primary care regulation. Teresa is keen to share her knowledge and experience of the Oxfordshire health and social care services with them, and to work establish close working relationships to ensure a seamless service from CQC.

Teresa currently leads a team of ten inspectors who come from varied backgrounds including nursing, social care, practice management, healthcare management, police investigations and quality monitoring. Teresa's team is fully resourced and those resources are adequate to achieve CQC's purpose and role in the Oxfordshire area.

Table 1: South Central

There are 4952 locations providing services in the South Central region. The largest percentage of locations are residential homes (25%) followed by dentists (20%). Domiciliary care agencies make up the next largest category (15%). GPs represent 13% of the total locations regulated.

Type of Service	Number of locations providing service
Community social care	191
Dentists	1012
Domiciliary care agencies	736
GPs	644
Independent ambulance services	50
Independent community healthcare	115
Independent hospital	127
Independent mental health, learning disability and substance misuse services	17
NHS Hospital	87
NHS Mental health, learning disability and substance misuse services	52
NHS community healthcare	80
Nursing homes	446
Other	176
Residential homes	1219
Total	4952

Care Quality Commission

Table 2: South East

There are 5534 locations providing services in the South East region. The largest percentage of locations are residential homes (28%) followed by dentists (19%). Domiciliary agencies make up the next largest category (13%). GPs represent 12% of the total locations regulated.

Type of Service	Number of locations providing service
Community social care	199
Dentists	1053
Domiciliary care agencies	737
GPs	675
Independent ambulance services	33
Independent community healthcare	148
Independent hospital	155
Independent mental health, learning disability and substance misuse services	41
NHS Hospital	73
NHS Mental health, learning disability and substance misuse services	60
NHS community healthcare	67
Nursing homes	536
Other	177
Residential homes	1580
Total	5534

Table 3: South West

There are 5085 locations providing services in the South West region. The largest percentage of locations are residential homes (30%) followed by dentists (17%). Domiciliary agencies make up the next largest category (14%). GPs represent 12% of the total locations regulated.

Type of Service	Number of locations providing service
Community social care	180
Dentists	846
Domiciliary care agencies	708
GPs	624
Independent ambulance services	31
Independent community healthcare	109
Independent hospital	94
Independent mental health, learning disability and substance misuse services	25
NHS Hospital	133
NHS Mental health, learning disability and substance misuse services	57
NHS community healthcare	71
Nursing homes	491
Other	210
Residential homes	1506
Total	5085

Care Quality Commission

Table 4: South Central/South East/South West total number of locations combined

Across all three areas there are 15,570 services regulated by CQC. Residential homes are 28% of the total locations – the highest number overall followed by dentists (19%) and domiciliary care agencies (14%). GPs make up 12% of the total of locations. Nursing homes are 9% of the total across the regions.

NHS hospitals are 2% of the total of locations.

Type of Service	Number of locations providing service
Community social care	570
Dentists	2911
Domiciliary care agencies	2181
GPs	1943
Independent ambulance services	114
Independent community healthcare	372
Independent hospital	376
Independent mental health, learning disability and substance misuse services	83
NHS Hospital	293
NHS Mental health, learning disability and substance misuse services	169
NHS community healthcare	218

Nursing homes	1473
Other	563
Residential homes	4305
Total	15570

2. Compliance

Table 5: South Central Compliance

There are six outcome judgements which present major concerns in the region. These judgements were from inspections that took place in the East Berkshire, Windsor and Reading/Hampshire/Portsmouth/and Swindon and West Berkshire CQC team areas. There are 38 non-compliant major impact judgements overall, the highest incidences in the Buckinghamshire and Swindon and West Berkshire teams.

- There are two non-compliant major impact judgements in the Oxfordshire team area.

	Number of Outcome Judgements									**Number of Outcome Judgements Total**
Division (Location Relationship Owner)	Not Applicable	Non Compliant Moderate Impact	Non Compliant Minor Impact	Non Compliant Major Impact	Moderate Concern	Minor Concern	Major Concern	Compliant	Compliance	
Bournemouth and Poole	20	45	61	6	2	13		2180	406	**2733**
Buckinghamshire	24	48	35	7	5	40		2053	458	**2670**
East Berkshire, Windsor and Reading	23	42	63	5		31	1	1920	358	**2443**
Gloucestershire	34	36	44	2		3		2290	266	**2675**
Hampshire	16	27	34	3	9	10	3	1911	387	**2400**
Oxfordshire	7	43	54	2	2	14		1798	258	**2180**
Portsmouth	11	42	63		7	8	1	2272	542	**2946**
Southampton and Isle of Wight	9	41	57	4	1	18		2323	331	**2784**
Swindon and West Berkshire	17	44	23	7	4	24	1	2311	493	**2924**
Grand Total	**161**	**368**	**434**	**38**	**30**	**161**	**6**	**19058**	**3499**	**23755**

CareQuality Commission

Table 6: South East Compliance

There are two judgements in the region that present major concern, both in the East Sussex Coast CQC team area. There were 23 non- compliant major impact judgements, the vast majority (13) are from the Medway team area.

	Number of Outcome Judgements									Number of Outcome Judgements Total
Division (Location Relationship Owner)	Not Applicable	Non Compliant Moderate Impact	Non Compliant Minor Impact	Non Compliant Major Impact	Moderate Concern	Minor Concern	Major Concern	Compliant	Compliance	
Brighton and Hove	4	35	55	1	4	14		2386	570	**3069**
CQC Operations: South (East)		1						24	2	**27**
East Kent	9	13	41	5		23		2261	663	**3015**
East Surrey and Gravesend	15	89	137	1		20		2280	689	**3231**
East Sussex Coast	7	39	61		9	25	2	2640	339	**3122**
Medway	15	49	48	13	2	15		2479	614	**3235**
Mid Sussex and Worthing	8	32	77	1		12		1822	401	**2353**
North Surrey (Esher and Chertsey)	25	57	86		1	17		2503	561	**3250**
West Kent	6	46	55	2		82		2219	609	**3019**
West Surrey	45	27	46		6	12		1848	486	**2470**
West Sussex and Chichester	13	29	56			15		2055	341	**2509**
Grand Total	**147**	**417**	**662**	**23**	**22**	**235**	**2**	**22517**	**5275**	**29300**

Table 7: South West Compliance

There are two judgements of major concern, both in the Plymouth and East Cornwall CQC team area. There are a total of 30 non-compliant major impact judgements, the highest number being in the Cornwall team area.

	Number of Outcome Judgements									Number of Outcome Judgements Total
Division (Location Relationship Owner)	Not Applicable	Non Compliant Moderate Impact	Non Compliant Minor Impact	Non Compliant Major Impact	Moderate Concern	Minor Concern	Major Concern	Compliant	Compliance	
Bath and North East Somerset & Wiltshire	8	28	49	6	4	72		2282	706	**3155**
Bristol	10	48	68	1	2	30		2045	434	**2638**
Cornwall	7	72	107	9	6	34		2636	437	**3308**
Devon	12	25	70	4		41		2112	611	**2875**
Dorset	13	131	90	3	2	26		1636	416	**2317**
Plymouth and East Cornwall	16	75	94	3	13	23	2	2261	465	**2952**
Somerset and North Somerset	15	41	50		4	40		2449	872	**3471**
South Gloucestershire	38	41	41	1	4	42		2471	589	**3227**
Torbay	11	52	41	3	4	31		2372	396	**2910**
Grand Total	**130**	**513**	**610**	**30**	**39**	**339**	**2**	**20264**	**4926**	**26853**

3. Inspections

Table 8: Total inspections – South Central Region

There were a total of 5985 inspections in the period 01/01/2012 - 15/11/2013. Social care organisations were the majority of the total number of inspections in the period (77%) followed by primary dental care (14%). Independent healthcare organisations were 5% of the inspected total and NHS healthcare organisations represented 2% of the total figure.

Location Type	Inspection ID
Independent Ambulance	54
Independent Healthcare Org	309
NHS Healthcare Organisation	141
Primary Dental Care	859
Primary Medical Services	37
Social Care Org	4585
Grand Total	**5985**

Table 9: Total inspections - South East Region

There were a total of 6867 inspections in the period 01/01/2012 - 15/11/2013. Social Care organisations were the majority of the total number of inspections in the period (77%) followed by primary dental care (14%). Independent healthcare organisations were 6% of the inspected total and NHS healthcare organisations represented 2% of the total figure.

Location Type	Inspection ID
Independent Ambulance	40
Independent Healthcare Org	388
NHS Healthcare Organisation	146
Primary Dental Care	947
Primary Medical Services	36
Social Care Org	5310
Grand Total	**6867**

CareQuality Commission

Table 10: Total inspections - South East Region

There were a total of 6475 inspections in the period 01/01/2012 - 15/11/2013. Social Care organisations were the majority of the total number of inspections in the period (82%) followed by primary dental care (10%). Independent healthcare organisations were 4% of the inspected total and NHS healthcare organisations represented 2% of the total figure.

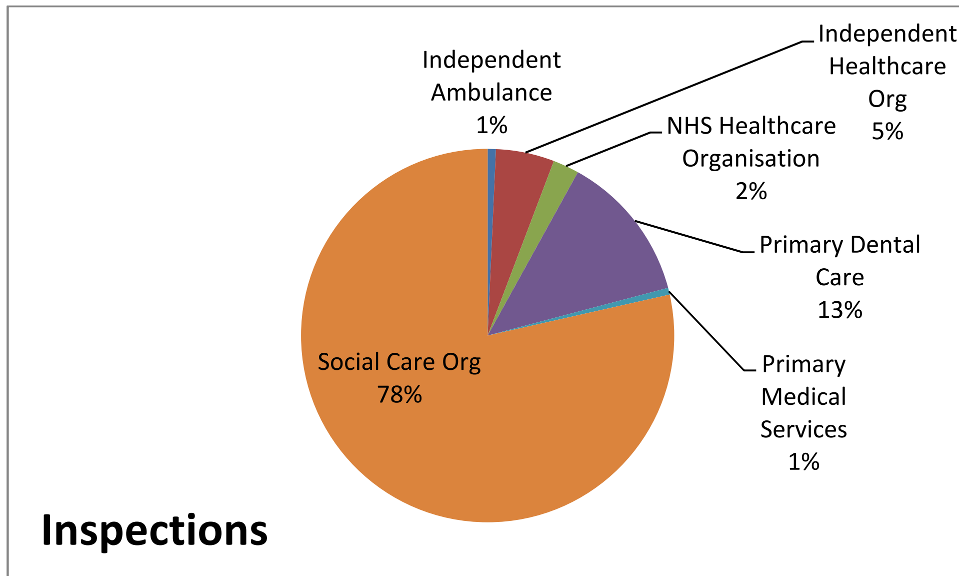
Location Type	Inspection ID
Independent Ambulance	42
Independent Healthcare Org	282
NHS Healthcare Organisation	153
Primary Dental Care	678
Primary Medical Services	38
Social Care Org	5282
Grand Total	**6475**

Table 11: Total inspections (South Central, South East and South West)

There were a total of 19,327 inspections in the period 01/01/2012 - 15/11/2013. Social Care organisations were the majority of the total number of inspections in the period (78%) followed by primary dental care (13%). Independent healthcare organisations were 5% of the inspected total and NHS healthcare organisations represented 2% of the total figure.

Location Type	Inspection ID
Independent Ambulance	136
Independent Healthcare Org	979
NHS Healthcare Organisation	440
Primary Dental Care	2484
Primary Medical Services	111
Social Care Org	15177
Grand Total	**19327**

Chart 1: Total inspections (South Central, South East and South West) 01/01/2012 - 15/11/2013



4. Oxfordshire CQC Compliance Team Area

Table 12: Total locations by type/sector

In the Oxfordshire CQC compliance team area the largest location type/sector is social care (46%). Primary dental care is the second largest sector (27%). Primary medical services make up 19% of services, independent healthcare organisations 5%, NHS organisations 2%. Independent ambulance is 1% of the total locations.

Location Type/Sector	Location ID
Independent Ambulance	5
Independent Healthcare Org	26
NHS Healthcare Organisation	8
Primary Dental Care	125
Primary Medical Services	89
Social Care Org	212
Grand Total	**465**

Table 13: Type of Service

Of the 508 locations the largest type of service in the area is dentists (25%). Domiciliary care agencies are the second largest type (19%) and GPs third (17%). Nursing homes represent 12% of service type.

Type of Service	Number of locations providing service
Community social care	18
Dentists	125
Domiciliary care agencies	96
GPs	89
Independent ambulance services	5
Independent community healthcare	11
Independent hospital	15
Independent mental health, learning disability and substance misuse services	1
NHS Hospital	8
NHS community healthcare	4
Nursing homes	62
Other	19
Residential homes	55
Total	**508**

Table 14/15: Compliance in Oxfordshire team area

There are currently four non-compliant major impact judgements. These are in outcomes 4, 7, 16 and 17

The non-compliant major impact judgements are for two services:

- **St Katharine's House** Ormond Road, Wantage, Oxfordshire (Care home with nursing)
- **Slade House (**Southern Health NHS Foundation Trust) Headington, Oxford. Assessment or medical treatment for persons detained under the Mental Health Act 1983

	Number of Outcome Judgements								Number of Outcome Judgements Total
Division (Location Relationship Owner)	Not Applicable	Non Compliant Moderate Impact	Non Compliant Minor Impact	Non Compliant Major Impact	Moderate Concern	Minor Concern	Compliant	Compliance	
Oxfordshire	7	43	54	4	2	14	1798	258	**2180**
Grand Total	**7**	**43**	**54**	**4**	**2**	**14**	**1798**	**258**	**2180**

	Number of Outcome Judgements								Number of Outcome Judgements Total
Outcome Number	Not Applicable	Non Compliant Moderate Impact	Non Compliant Minor Impact	Non Compliant Major Impact	Moderate Concern	Minor Concern	Compliant	Compliance	
01		1	3			2	260	33	**299**
02			1				66	4	**71**
03	1								**1**
04		10	4	1	1	1	298	17	**332**
05		1	2				26	12	**41**
06							6	4	**10**
07		2	3	1		2	176	37	**221**
08		6	6				121	42	**175**
09		3	3				49	5	**60**
10		1				1	32	16	**50**
11		1	1			1	7	4	**14**
12		1	1		1		88	11	**102**
13		3				1	92	25	**121**
14		6	8			3	218	18	**253**
16		6	6	1		3	214	18	**248**
17			1	1			73	5	**80**
18	1								**1**
19	1								**1**
20	4								**4**
21		2	15				72	7	**96**
Grand Total	**7**	**43**	**54**	**4**	**2**	**14**	**1798**	**258**	**2180**

Table 17: Total number of inspections in the Oxfordshire team area

The largest number of inspections are scheduled inspections (526) followed by responsive follow up inspections.

Inspection Type	Number of Inspections
Desk Based Follow Up Review	5
Responsive - Concerning Info	55
Responsive - Follow Up	62
Scheduled	526
Themed	11
Grand Total	**659**

MORE INFORMATION, FEEDBACK, EBULLETINS.

- The CQC strategy can be found on our website Care Quality Commission www.cqc.org.uk
- Email enquiries@cqc.org.uk to send us information from your scrutiny reviews and other work from your programme
- Please email involvement.edhr@cqc.org.uk if you want to get involved in national CQC developments. This will take you directly to the involvement team
- Scrutiny committees should receive local press releases and updates on our national reports. Working with CQC guides for OSCs and councillors.
- From June a new two monthly e bulletin for all OSCs from CQC – setting out our latest news and ways you can get involved in our work
- A new report on how CQC and district councillors can work together (due June/July 2013)
- An updated briefing for OSCs about working with CQC (due July 2013)
- A briefing for councillors about our role in monitoring the Mental Health Act (summer 2013)

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Draft HOSC Forward Plan – Proposed Items

27 February 2014

- CCG Operational and Strategic Plans (CCG)
- A&E services (CCG, OUHT, OH, SCAS)
    - Demand and performance
    - National plans
    - Community Responder Service
- JSNA (PH)

Items to be scheduled

- Drug addiction expert review panel (PH, CCG and providers)
- NHS England commissioning update:
    - Primary care
    - Specialist services
- Public Heath obesity strategy (PH)
- District Nursing and Health Visitors (OH)
- Draft Director of Public Health Annual Report (PH)
- Health advocacy service (CCG)
- Pooled budget arrangements (CCG, OCC)
- Outcomes based Commissioning (CCG, OH)

Annual progress and priorities reports

- South Central Ambulance Service
- Oxford University Hospitals Trust
- Oxford Health Foundation Trust

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