Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 18 September 2014 at 10.00 am
County Hall

Membership

Chairman – vacancy (please see Agenda Item 1)
Deputy Chairman - Councillor Susanna Pressel

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Les Sibley
	Yvonne Constance	Laura Price	
	Surinder Dhesi	Alison Rooke	
District Councillors:	Martin Barrett	Christopher Hood	Rose Stratford
	Alison Thomson		
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *20 November 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	-	vacancy E.Mail:
Policy & Performance Manager	-	*Ben Threadgold Tel: (01865) 328219* *ben.threadgold@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

September 2014

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. Election of Chairman for the remainder of the 2014/15 Council Year

To elect a Chairman for the remainder of the 2014/15 Council Year.

2. Apologies for Absence and Temporary Appointments

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

4. Minutes

To approve the minutes of the meeting held on 3 July 2014 (**JHO4**) and to receive information arising from them.

5. Speaking to or Petitioning the Committee

6. Oxford University Hospitals NHS Trust Action Plan - CQC Inspection

10:15

As requested by the Committee at the previous meeting, the final approved action plans developed by the Oxford University Hospitals (OUH) NHS Trust are attached at **JHO6**. These are in response to the Care Quality Commission (CQC) Chief Inspector of Hospitals Report which was published on 14 May 2014.

Andrew Stevens, Director of Planning & Information, OUH, will attend the meeting to discuss the detailed action plan and to give an update on progress since the inspection.

7. Emerging Findings of the Non - Emergency Patient Transport Services Consultation

10:45

David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group will provide an update on consultations and proposals regarding eligibility for patient transport services **(JHO7).**

Please find attached the following documents:

- Emerging findings of the non-emergency patient transport services consultation
- Non – emergency patient transport services – Public consultation report
- Appendix 1: Analysis of responses to consultation questions 1 – 7
- Appendix 2: Key findings from stakeholder meetings
- Appendix 3: Feedback from written responses
- Appendix 4: Glossary

8. Healthwatch Oxfordshire

11:05

Rachel Coney, Director of Healthwatch Oxfordshire will attend to present the attached report on recent projects **(JHO8).**

9. Oral Health of Children in Oxfordshire

11:25

Eunan O'Neill, Public Health Specialist, will present the attached report (**JHO9)** on the oral health of children in Oxfordshire (**JHO9**).

The Oxfordshire Joint Health Overview & Scrutiny Committee is RECOMMENDED to consider the above report containing information on the statutory dental public health functions of the Local Authority, the current oral health of five year old children in Oxfordshire and the actions being taken to provide dental public health services for the local community; and to make recommendations on future actions if needed.

10. Developing Musculoskeletal Services in Oxfordshire - a Briefing on Engagement Activity

11:45

Colin Sullivan, Oxfordshire Clinical Commissioning Group (OCCG) will update the Committee on the planned changes to the musculoskeletal services. A briefing on engagement activity is attached (**JHO10)**.

11. Outgoing Chairman's Report and Forward Plan

12:05

An oral update will be given on meetings which the outgoing Chairman had attended since the last meeting. The Committee's attention is also drawn to the Forward Plan which is attached at **JHO11.**

12. Dates of Future Meetings - for information

Please note that the Joint Committee will meet on the following dates during the remainder of the 2014/15 municipal year and the 2015/16 municipal year:

2014/15

20 November 2014
5 February 2015

2015/16

23 April 2015
2 July 2015
17 September 2015
19 November 2015
4 February 2016

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 Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 3 July 2014 commencing at 10.00 am and finishing at 1.35 pm

Present:

Voting Members:	Councillor Lawrie Stratford District Councillor Alison Thomson Councillor Kevin Bulmer Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke District Councillor Martin Barrett Councillor Susanna Pressel District Councillor Rose Stratford Councillor Mike Beal (In place of Councillor Surinder Dhesi) Councillor Steve Harrod (In place of Councillor Les Sibley)
Co-opted Members:	Moira Logie; Dr Keith Ruddle; Anne Wilkinson
Other Members in Attendance:	Councillor Nick Hards (for Agenda Item 6)
Officers:	
Whole of meeting	Ben Threadgold 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.

23/14 ELECTION OF CHAIRMAN FOR 2014/15

(Agenda No. 1)

Councillor Lawrie Stratford was elected Chairman for the municipal year 2014/15 – to the first meeting of the next municipal year 2015/16.

24/14 ELECTION OF DEPUTY CHAIRMAN 2014/15

(Agenda No. 2)

District Councillor Susanna Pressel was elected Deputy Chair for the municipal year – to the first meeting of the 2015/16 municipal year.

25/14 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Councillor Mike Beal attended for Councillor Surinder Dhesi, Councillor Steve Harrod for Councillor Les Sibley and an apology was received from District Councillor Dr. Christopher Hood.

26/14 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Councillor Alison Rooke declared a personal interest in Agenda Item 7 – 'Oxfordshire Health & Wellbeing Strategy 2014' – on account of her position as a Trustee of the Vale House, Oxford.

27/14 MINUTES
(Agenda No. 5)

The Minutes of the meeting held on 1 May 2014 were approved and signed as a correct record subject to the deletion of the word 'age' in the penultimate paragraph on page 5, and corrections to the final sentence in paragraph 2, page 7, so that the sentence reads:

'He added that the statistics for rural areas tended to be higher than those for urban areas.'

Matter Arising

With regard to paragraph 3, Minute 16/14, 'Oxfordshire Health & Wellbeing Strategy 2014 – 2015 (JHWBS) – 'It was felt that the current configuration of Health could be a real issue over the next 5 years and would require more integration of Health and Social Care to support it. It was also felt that the Committee should think about creating a tool kit to ascertain where the real issues were for scrutiny.' - Members asked that the previous toolkit used for Health Scrutiny when the Committee was first convened, be circulated in order to give focus to a consideration at the next meeting of what would be required.

With regard to the last sentence of paragraph, Minute 17/14, page 6, 'Oxfordshire Clinical Commissioning Group (OCCG) Strategy 2014 – 19 and Implementation Plan 2014/15, 2015/16' – 'He (Ian Wilson) agreed that issues remained concerning access to GPs which needed addressing in spite of efforts being made in the last two years.' Members asked whether the situation was improving in Oxfordshire.

28/14 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 6)

County Councillor Nick Hards addressed the meeting with reference to the closure of beds by the Oxford University Hospitals NHS Trust at the Didcot Community Hospital due to staffing problems and lack of support from GPs to look after patients. He added that he understood that the current and planned growth in Didcot had

increased the pressure on local GPs, which had had an effect on their capacity to support the community hospital. He commented that losing the beds was symptomatic of the problems faced by the town in that all types of health provision appeared to lag behind the demand resulting from an increasing population. He pointed out that beds in community hospitals such as Didcot helped to reduce delayed transfers of care at the John Radcliffe Hospital by moving patient treatment nearer to the home; and if this aim was to be met effectively, more resources were needed in the form of support for the GPs and more beds in community hospitals. Finally he called for more communication with patient and public involvement groups and more involvement at the consultation stage before decisions affecting resources were taken.

29/14 OXFORDSHIRE HEALTH & WELLBEING STRATEGY 2014 - 2015

(Agenda No. 7)

At the last meeting the Committee considered a report on the process which had been put in place to refresh the priorities in the current Joint Health & Wellbeing Strategy. The Committee were also asked to comment on the current priorities and the indicators being used to measure progress and demonstrate improvement (Appendix A to report HWB7).

Dr McWilliam, Director of Public Health now presented the draft Health & Wellbeing Strategy 2014/15 for comment. He was accompanied by Ben Threadgold, Policy & Performance Service Manager, to assist in responding to questions. The Strategy was due for submission to the Oxfordshire Health & Wellbeing Board on 17 July 2014 for approval.

It was **AGREED** that the following comments be conveyed to the Oxfordshire Health & Wellbeing Board for their meeting on 17 July 2014:

Children and Young People

Priority 1: All children have a healthy start in life and stay healthy into adulthood

- There should be a measure of access to Children's Mental Health services, such as availability of beds or waiting times

Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups

- There should be evaluation of how interventions resulting from the Pupil Premium are picked up across the county and their effectiveness.
- There should be measures relating to mental illness, drugs and alcohol use by children and young people

Priority 3: Keeping all children and young people safe

- There should be tracking of the impact of the proposed changes to housing related support on domestic abuse services / incidents

Priority 4: Raising achievement for all children and young people

- There should be a focus on young people achieving their potential as well as simply achieving national targets
- There should be a reference to the support of gifted and talented students

Adult Health and Social Care

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

- There should be an indicator to track changes to complex needs services and impact on patients / service users
- Include in 'possible new indicator on mental health delayed discharge' measures to track the homeless and previous hostel residents
- As well as delays in mental health discharge, there should also be measures of availability of mental health beds and waiting times

Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

- It should be made clearer that packages of care refer to social care rather than health

- Information should be broken down where possible to show where in the county people are being support to stay at home

Priority 7: Working together to improve quality and value for money in the Health and Social Care System

- It is important to ensure alignment between the Joint Health and Wellbeing Strategy and the Clinical Commissioning Group strategic plans
- That key NHS performance targets for key waiting times such as 4 hour, 18 week, cancer treatment and ambulance times should be included

Health Improvement

Priority 8: Preventing early death and improving quality of life in later years

- There should be a focus on smoking in school / amongst school age children

Priority 9: Preventing chronic disease through tackling obesity

- No comments

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

- No comments

Priority 11: Preventing infectious disease through immunisation

- No comments

30/14 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

(Agenda No. 8)

Having being asked by the Director of Public Health at the last meeting on 1 May for the Committee's views on the topics to be included in his forthcoming Annual Report; the Committee now considered the full Annual Report for 2013/14 prior to its submission to Cabinet on 15 July 2014.

A Member asked if the small, ring fenced grant received for Public Health made it sustainable in terms of their workload. Dr McWilliam responded that it was not known whether the grant would continue to the ring fenced, and currently his staff was working harder and more efficiently in order to maintain the basic sustainable level of what was required.

Dr McWilliam was asked if just one school nurse would be likely to make an impact on school sexual health services. He responded that the school health nursing service had been much improved by integrating nurses into the school team. It was envisaged that they would be working with staff to jointly produce a plan for that school. In terms of the community sexual health services, he added that the new contract would keep open every location in the county, as well as increasing the range of services available at the clinic. It also offered a one stop shop.

In response to a number of points raised by Members, Dr McWilliam assured the Committee of the intention to explore with GPs how the take-up number of Health Checks could be increased; and raise with GPs the need to be more diligent with their recording of data on ethnicity.

A member commented that a long term review of the Thriving Families programme did not appear to be included within the report. Dr McWilliam responded that the programme was very much a Government programme. However, his officers were involved in tracking these families along their life course in order to gain a long term view of its success or otherwise.

During the course of the discussion, the Committee **AGREED** to convey the following points to Cabinet on 15 July:

- The inclusion of an update/review on last year's performance against priorities would be useful to make the report more complete and helpful for scrutiny purposes;

- There is hardly any reference to Air Quality and Children's Centres, if at all; and

- Although it is acknowledged that the recording by GPs of statistics on ethnicity was improving, it was felt that more needed to be done in this area.

31/14 OXFORD UNIVERSITY HOSPITALS NHS TRUST (OUHT) - UPDATE
(Agenda No. 9)

Andrew Stevens, Director of Planning & Information, Oxford University Hospitals NHS Trust (OUHT) attended the meeting to give an update on various topics of interest to the Committee (JHO9). These related to:

- The Trust Strategy for 2014/15 to 2019/20
- The Trust Business Plan for 2014/15 to 2015/16
- The outcome of the recent CQC inspection
- Trust performance against key national standards
- Progress on the Trust's Foundation Trust application
- An update on the Cotswold Maternity Unit
- An update on the Horton General Hospital
- Other key developments

He introduced the report grouping topics under the headings of 'Strategy and Priorities for Patients; Quality and Performance; Local Services for Local Patients; and Working with Others. He corrected the second sentence in paragraph 9.2, page 73 refers to state (correction in italics):

'In order to help the local health and social care system manage the activity and financial pressures with which it is currently faced, the Trust has agreed contractual arrangements with OCCG that seek to manage risk across the system '*in a much more equitable way'*

A member of the Committee asked what action was being taken by the Trust with regard to meeting the admitted standard for orthopaedics and spinal surgery (5.11, page 68 refers). Mr Stevens responded that specialist orthopaedic surgery was a problem shared around the country due to sheer numbers coming through. The Trust was witnessing the centralisation of patients to specialist hospitals, of which the Trust was one, and it was therefore looking into the areas where patients were willing to consider other providers. Weekend operating was another option under consideration. With regard to spinal surgery, the Trust had taken action to restrict surgery to the catchment Oxfordshire and neighbouring counties. He commented on the need to conduct a national review of specialist commissioners with the aim of establishing referrals on a planned basis. A member asked why people would elect to go elsewhere for an orthopaedic operation when the resources offered at the Nuffield were of such high quality, Mr Stevens responded that it was a matter of giving patients a choice as they had a right to be treated within 18 weeks.

In response to a question concerning the problem in meeting the 31 day radiotherapy standard (5.14, page 68 refers), Mr Stevens assured the Committee of his confidence that the Trust would be again meeting the target very soon, adding their plans for a satellite service for local patients.

In response to questions, Mr Stevens reassured the Committee that the Trust were in the process of working up a business case on how equipment in theatres could be

refreshed; and that there was no restriction on grounds of age for operations in Oxfordshire.

With regard to the length of time it can take for the issue of medicines on discharge, Mr Stevens explained that improvements had been made. Winter pressures monies had been used to make pharmacy staff available during out of hours and at weekends. From September prescriptions would be checked and automatically dispensed by a robot.

A member asked how the Trust planned to achieve the level of cost savings and still meet the required targets. Mr Stevens explained that each department had been sent a particular improvement target and a variety of trust-wide transformation projects were underway to drive down costs and support doctors in a much smarter way, for example, the implementation of electronic patient records and sending out advice, as appropriate, via email rather than admitting patients to hospital.

A member asked how theTrust was putting into place the thoughts and ideas which had been gleaned from the listening events that were part of the CQC process. Mr Stevens responded that the Trust had already started work on some of the key issues raised, for example, an internal peer review process had been devised and an environmental issue within the Accident & Emergency had been tackled. He added that the principle issue was on embedding good practice across the whole organisation, such as staff training in dementia and engagement with the public.

In response to questions regarding what measures were to be taken to improve an effective discharge process into GP care in a timely way. Mr Stevens commented that the Trust were still involved with discussions on the use of monies for the Better Care Fund and it was also working very closely with Oxford Health, GPs and Social Care on Delayed Transfers of Care and the development of a single, integrated approach to community based support services. In addition, the Trust was looking at how an enhanced diagnostics, imaging and testing service could be provided outside of Accident & Emergency.

The Chairman thanked Mr Stevens for his report and for his attendance and also congratulated the Trust on behalf of the Committee on their ‘good’ CQC report.

32/14 AMBULANCE RESPONSE TIMES IN OXFORDSHIRE

(Agenda No. 10)

Steve West, Operations Director (Thames Valley) and Aubrey Bell, Area Manager (Oxfordshire), of South Central Ambulance Trust attended the meeting to discuss their report to the Committee on response standards and demand for the year 2013/14 and to respond to questions. Mr West introduced the report (JHO10) pointing out that within Oxfordshire demand had risen by 7% and category A red calls (potentially life threatening) had risen by 9%. Currently, within the organisation, the number of red calls had risen by 34%. The service had also seen a change in the pattern of 111 activity and the Trust was currently in the process of changing rotas to match this change in demand. This would pose a real challenge for the workforce and there would a consultation period on these plans was to follow later on in the year.

Within Oxfordshire performance statistics remained strong. However, as resources were becoming stretched, a number of initiatives, in essence different ways of working, had been put in place to address some of the challenges which the service was facing. For example, an interaction programme had been set up in the West Oxfordshire area to inform the public of the sites where defibrillators were; and the Trust were working with a private provider on the potentiality of a pilot for a satellite across the area. Talks with the military were currently in progress in the Thame area.

In order to give some context, the Committee was given a presentation on response times for red category patients and this was followed by a question and answer period.

A member asked if, in the future, average response times and variance around that average could be recorded, thus giving a clearer picture, adding that it appeared unfair that the Trust had missed the target by 4 seconds for Red 2 calls,

A member asked why the response times had worsened in parts of the county over the past few years. Mr West responded that hospitals had recorded an increase in acuity of patients presenting. Part of the increase was caused by the implementation of the 111 system. More calls were being classed as red calls, which had an effect on the percentage of patients SCAS were trying to respond to. Mr Bell responded also that it was difficult to put resource into areas where there were small numbers of calls per week. However, this was constantly under review and a variety of mitigating actions were being taken in these areas, such as the presence of co-responder teams.

In response to a question about why the 111 system was causing an increase in callout, Mr West explained that a joint audit had been carried out with consultants in the John Radcliffe hospital and it had found that 98% of patients calling were identified as appropriate care pathways, albeit with a different profile than it was historically.

A member asked whether the Trust was managing to maintain and recruit staff in sufficient numbers to meet the increased demand for extra resources required in different locations. Mr West replied that this had been a problem area and the Trust was looking at other resources, for example use of St John's private and voluntary ambulance support. The Trust was contracting with a number of private companies for paramedics, of which there was a shortage. However, despite the volatility in demand, its long term strategic objective was to use its own resource to staff its workforce.

A member commented that it would assist the Committee with any action it wished to take if it knew there was a health problem in a particular area caused by the increase in demand for resources. Mr West explained that the Government set the national standard (75% - 8 minute response) and the Trust was required to deliver it across the whole of the South Central area. Moreover it was committed to getting to patients as quickly as possible whether it be to an urban or rural area. He added that there was evidence that defibrillators improved patient survival - it was then important to get the patient to the right treatment centre. It was his view that it would be worth

reviewing how the Trust was performing clinically with outcomes for patients across its footprint. To this end, work was already taking place with stroke victims.

The Chairman reminded members that the OCCG were to be invited to the Committee's November meeting, alongside SCAS to consider the Trust/OCCG consultation strategy for future plans. He thanked Mr West and Mr Bell for their report and for their attendance.

33/14 HEALTHWATCH OXFORDSHIRE

(Agenda No. 11)

Dermot Roaf, Vice-Chair of Healthwatch Oxfordshire Board and Carol Ball, Co-ordinator, attended to present a report on recent projects (JHO11).

Mr Roaf reported that Larry Sanders, the founding Chairman of the Board had resigned and Jean Nunn-Price MBE had been elected Chair in his place. He also reported that the interim Director, David Roulston had now left and Rachel Coney would begin in her office as Chief Executive on 21 July. He added that it was hoped that more Board members would be recruited in the near future.

Mr Roaf then presented the update report (JHO11) which outlined the current project and research work being undertaken.

Members congratulated Healthwatch Oxfordshire on a good report and urged them to connect with and follow up the recommendations with the organisation concerned to ensure maximum impact.

34/14 MUSCULO-SKELETAL SERVICES

(Agenda No. 12)

Phillipa Mardon, Programme Manager for Planned Care, Oxfordshire Clinical Commissioning Group (OCCG), presented her report (JHO12) which informed members of a project being initiated by the OCCG to review and develop muculo-skeletal services, how it will be managed and how the OCCG would engage to inform the Committee of future developments.

Phillipa Mardon undertook, at the request of the Committee, to circulate via the officers, whether or not GPs were currently referring patients to osteopaths and chiropractors, together with a list of other project consultees.

In response to a number of questions raised by members of the Committee Phillipa Mardon gave her assurances that:

- A recourse analysis was in place to ascertain where the problems were, in for example, patient waiting times and how the service could operate more effectively;
- Whilst funding for the service was not being reduced, it was necessary to unbundle the costs to ensure that the money was being spent in the right place;

- Project workers were looking at how other CCGs in other areas had tackled similar projects and were inviting discussion;
- The Team were currently in discussion with a national adviser who was both experienced in looking at the appropriate tools to measure good outcomes and in sharing outcomes of work to ensure that patient engagement was as good as it could possibly be.

The Chairman thanked Phillipa Mardon for the report and for her attendance and invited her to the September meeting to report on the consultation outcomes.

35/14 CHAIRMAN'S REPORT AND FORWARD PLAN

(Agenda No. 13)

The Chairman had nothing to report.

The Committee **AGREED** the proposed items for the Forward Plan (JHO13) and added the following:

18 September 2014

- Funding of access to psychological therapies (CCG)
- Consultation outcomes for review of Musculo-Skeletal service (CCG)

20 November 2014

- SCAS Strategy – more information required on numbers, hotspots, planning (SCAS)

Other topics to be included

- Immunisations and Sexually Transmitted Diseases – for scrutiny? (Director of Public Health)
- Outcomes – based contracting – should they be scrutinised by HOSC? (Director of Public Health)

36/14 DATES OF FUTURE MEETINGS 2014/15

(Agenda No. 14)

It was noted that the Joint Committee would meet on the following dates during the 2014/15 municipal year:

18 September 2014
20 November 2014
5 February 2015

NB: the County Council have set the following dates for the 2015/16 municipal year:

23 April 2015
2 July 2015
17 September 2015
19 November 2015
4 February 2016

.....

..... in the Chair

Date of signing

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Oxford University Hospitals NHS
NHS Trust

Oxfordshire Health Overview and Scrutiny Committee: Thursday 18 September 2014

Title	**CQC Action Plans**

Status	For information

Oxford University Hospitals

Executive Summary

1. This paper presents the final approved action plans developed by Oxford University Hospitals [OUH] NHS Trust in response to the Care Quality Commission Chief Inspector of Hospital's Reports, published by the CQC on 14th May 2014.
2. The action plan to address compliance actions ('Must Do actions') was submitted to the CQC as required on 12 June 2014. A copy is provided at **Appendix 1**.
3. The action plan to address the advisory actions ('should do' actions) was submitted to CQC as required on 31 July 2014. A copy is provided at **Appendix 2**.
4. The Care Quality Commission formally approved both Action Plans on 14 August 2014.
5. The Trust proposes that it should provide the Health Overview & Scrutiny Committee with an update on progress with the implementation of both action plans in December 2014

6. **Recommendation**

   HOSC is asked to:

   - Note the action plan developed to address the compliance actions ('Must Do actions'); and
   - Note the action plan developed to address the advisory actions ('should do' actions) and
   - Note that both action plans were formally approved by the CQC on 14 August 2014
   - Agree to the submission of an update on implementation of these action plans in December 2014.

1. Introduction

1.1. The Care Quality Commission (CQC) conducted an announced inspection of the Trust on the 25 and 26 February 2014.

1.2. Both prior and during the inspection, OUH Trust provided a large amount of documentation to the CQC. As part of the inspection, the CQC spoke to patients, visitors, carers and staff to gain a view of the eight service areas and to rate each of these in relation to five domains:

- Were services safe?
- Were services effective?
- Were services caring?
- Were services responsive to people's needs?
- Were services well-led?

1.3. OUH Trust received the final draft in advance of the Quality Summit arranged by the CQC on 12 May 2014. The Quality Summit was attended by invited members of the Trust Board and external stakeholders, including commissioners, NHS England and the Trust Development Authority.

2. Report findings

2.1. The CQC published its inspection reports for the Trust on Wednesday 14 May 2014. There was a report for the Trust overall and four further reports for each of the Trust's hospital sites.

2.2. The Trust as a whole has received a `good' rating overall and a rating of `good' for each of the five domains.

2.3. The CQC inspection was a comprehensive and thorough review of the way services are provided. The clear and overriding message from the report is that the inspectors observed caring and compassionate staff throughout the four hospitals and noted many examples of good team working. The detailed inspection reports offer a clear endorsement of the hard work put in on a daily basis to make sure compassionate and excellent care is provided to patients. The full reports are available through the following link: http://www.cqc.org.uk/directory/rth

2.4. The CQC assessed services on each site and rated them overall against the five domains, across eight core service areas, as defined by the CQC (where they are provided). All were rated 'good' except for A&E and Surgery at the John Radcliffe site, which were rated as 'requires improvement'.

2.5. The Trust-level report also specified the following areas where the Trust **must improve**:

- The Trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.
- The Trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The Trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.

- The Trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.
- The Trust needs to ensure that staff receive suitable induction to each area that they work within the Trust.
- The Trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

2.6. In each of the reports specific to each site, there were areas that the CQC had stated '**should improve'**. These are referred to as advisory actions which the Trust has reviewed in detail.

3. Action Plans

3.1. OUH Trust developed and submitted its action plan in relation to the 'Must Do' Compliance actions raised in the CQC reports on 12 June 2014. A copy of the final approved action plan is provided as Appendix 1.

3.2. The 'Should Do' Advisory Action Plan was submitted to the CQC on 31 July 2014. A copy of the final approved action plan is provided as Appendix 2.

3.3. The CQC formally approved both action plans on 14 August 2014.

3.4. Progress against both action plans is monitored and reported on regularly to the OUH Trust Management Executive Committee.

3.5. The Trust proposes that it should provide HOSC with an update on progress with implementation of these plans in December 2014.

4. Recommendations

HOSC is asked to:

- Note the action plan developed to address the compliance actions; and
- Note the action plan developed to address the 'should do' actions; and
- Note that both action plans were formally approved by the CQC on 14 August 2014.
- Agree to the submission of an update on implementation of these action plans in December 2014.

Eileen Walsh, Director of Assurance
September 2014
Prepared by: Clare Winch Deputy Director of Assurance

‘COMPLIANCE ACTIONS’ ACTION PLAN

Oxford University Hospitals NHS Trust received five reports setting out the findings from its recent inspection:

- An over-arching trust wide report containing a summary of all compliance actions from the individual hospital reports (the compliance 'must do' action plan attached covers all action included as part of this report)
- Four reports, one for each of the hospital sites; the Churchill Hospital, the Horton General Hospital, the John Radcliffe Hospital and the Nuffield Orthopaedic Centre. In addition to listing the compliance actions these reports included a number of 'should do' recommendations (this action plan is provided as Appendix 2).

Key

The following abbreviation relates to the trust’s internal monitoring system:

CA – Compliance Action

<u>Compliance Action 1:</u> The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury Surgical procedures. Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
CA 1.1	The **accident and emergency** department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.	The following outlines key actions already in place and additional actions developed as a result of the CQC inspection. These have been developed with involvement of key members of staff. **Actions relating to input from surgical specialties** • Following initial patient assessment in Emergency Department (ED), time critical diagnostics will continue to be ordered by ED. When investigations are assessed by ED to be less time critical, but they require a surgical opinion, patients will be immediately transferred to Surgical Emergency Unit and Specialist Surgery In-Patients ward. • Patients will be managed on an ambulatory basis wherever possible. • Where patients are assessed as not requiring ED medical input, they will be directly referred internally to the relevant specialty. • Patients requiring a surgical opinion in ED will be transferred to the ward for assessment if a request for assessment on ED is not responded to within 30 minutes, prior to a check on the capacity of staff to maintain the required frequency the required frequency of observations. The above actions will be supported by: • Diagnostic availability to SEU will be enhanced to that of ED and Emergency Assessment Unit (EAU)	**Executive Director accountability:** Director of Clinical Services Operational Lead: Divisional General Manager for Medicine Rehabilitation and Cardiac (MRC)	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014	ED Action Plan (Item 7) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
Page 19		**Improved Use of the Transfer Lounge** • Ensure that all specialties actively support the flow of patients by identifying patients to move to the Transfer Lounge before 10.30am. • Matrons to support ward staff to obtain early decisions on discharge from all hospital medical teams. • Operations Team will support ED and EAU Coordinator by working more closely with the wards to ensure beds are made available, when required. • Further support to be provided by the Directorate Operational Service Managers and Matrons with escalation to the Divisional General Managers and Divisional Nurses when constraints are not being actively managed.	Operational Lead: Divisional Nurse MRC Matrons Operations Team ED and EAU Coordinator Directorate Operational Service Managers	Actions in place by 4 June 2014 Performance improvements to be delivered by 31 August 2014 4 June 2014	ED Action Plan (Item 14) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.
		• Discharge by time of day to the Transfer Lounge will be reviewed weekly to monitor performance. • Breach analysis to be undertaken for any patients discharged directly from the ward (rather than via the Transfer lounge) to monitor performance	Operational Lead: Divisional Nurse MRC		Weekly monitoring reports	
		Expected referrals and transfers • From 4 June 2014, patients expected from GPs will be admitted directly to the appropriate ward and not held in ED • Transfers from the Horton ED for specialty opinion to be direct to the appropriate ward and not held in ED	Operational Lead: Divisional General Manager MRC	Actions in place by 4 June 2014 Performance improvements to be delivered by August 2014	ED Action Plan (Item 8) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained from 31 August 2014.
		• Paediatrics • Paediatric Clinical Decision Unit (CDU) to continue to pro-actively 'pull' patients who are ready to be transferred from ED at all times of the day and night. • Requests for Paediatric opinions at the Horton will be consistently responded to within 30 minutes by	Paediatric CDU staff	As above 4 June 2014	ED Action Plan (Item 10) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained as above.

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		consultants giving 24/7 resident presence.				
		• Monitor this by escalation to the Children's' & Women's Divisional Nurse and General Manager when this is not met.	Children's' & Women's Divisional Nurse and General Manager	With effect from 4 June 2014		
		Actions Internal to the Emergency Department – (To commence Monday, 2nd June 2014). **Plan at 2 hours for all patients in ED** • All patients to be assessed and have a defined clinical management plan within a maximum of 2 hours. • Internal monitoring to be undertaken in real-time by the Divisional and Directorate Management team accessing FirstNet. (FirstNet is the electronic system detailing the status of all patients in both EDs and is remotely accessible). Out of hours this will be done by the Operations Team with oversight from the Duty Manager. • Poor performance from the expected standard to be escalated to nominated shift floor consultant.	Director of Clinical Services Operational Lead: Divisional General Manager MRC	With effect from 2 June 2014	ED Action Plan (Item 6) Urgent Care Programme Group monitoring	ED waiting time target consistently maintained.
		Changes to Portering Activity • Review options to set up a dedicated portering team for ED and EAU to improve responsiveness. • Costed options to be presented to Director of Clinical Services • Implementation plan to be developed for immediate action. • Conduct an impact assessment of the changes to the service.	Divisional General Manager MRC	9 June 2014 30 June 2014 30 September 2014	ED Action Plan (Item 13) Urgent Care Programme Group monitoring Options Appraisal Implementation Plan Impact Assessment	
		Improving Transportation		For the month of	ED Action Plan	

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
		• Maintain a log of transportation issues particularly regarding access to 2 man/stretcher crews, to use in negotiation with providers. (defined timeframe) • Regularly review the log and relevant issues to be raised at Urgent Care Programme Group meetings.	All ED staff Director of Clinical Services	June 2014	(Item 15) Urgent Care Programme Group monitoring Transportation issues log	
		Areas for collaborative action with partners • Improved integration of care pathways across hospital, community, primary care and social care services to improve the ability to manage patients in the clinically appropriate setting. Build on current proposals being developed by the Trust and Oxford Health. The support of Oxford Clinical Commissioning Group (CCG) and Oxford City Council will be critical. • Managing demand across emergency care pathways to ensure that patients requiring emergency assessment and care are seen in clinical settings appropriate to their needs. • Collaborative approach to re-development of hospital sites and estate to address unsatisfactory accommodation. • Potential for developments such as patient hotels and family accommodation. • Improved access to hospital sites, additional parking facilities to meet the needs of increasing clinical activity and increased complexity and frailty of patients reflecting the change in clinical services.	**Executive Director accountability**: Director of Clinical Services Director of Planning and Information Director of Development and Estate	Timeframes linked to the Trust Business Plan.	Minutes of meetings between partners. Pathway documentation	Successful collaboration projects developed and delivered
CA 1.2	The **outpatient** department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide	Continue to implement the Outpatient re-profiling project: **Phase 1:** • To review all clinic templates to match demand and capacity run rate (detailed project plan monitored by monthly Outpatient Project Board (DCS Chair)	**Executive Director accountability:** Director of Clinical Services Operational Lead: Deputy Director of	Phase 1 to be completed by 30 June 2014	Project Plan Minutes of Outpatient Project Board – reported to (TME) Draft clinic	Outpatient re-profiling outcome: to provide net extra new outpatient capacity of 34500 slots and reduce follow up ratio from 1:1.88 to 1: 1.32 by

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
	suitable information.		Clinical Services		templates Follow up ratio monitoring	31 October 2014.
		Phase 2: To translate the new clinic templates into operational processes across all specialties	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 October 2014	Outcome of pilot reviewed and reported to TME Roll-out plan Progress report on plan reported to TME	As above: reduce follow up ratio from 1:1.88 to 1: 1.32 by 31 October 2014.
		Change outpatient's system from choose & book to directly bookable system (DBS). • DBS pilot in neurology and gynaecology to run from June - Aug 2014 • To agree an all speciality directly booking roll out plan with the CCG by 31 Aug 2014 • Commence implementation of the roll out plan beginning in Quarter 3.	Director of Clinical Services Operational Lead: Deputy Director of Clinical Service	31 Sept 2014 31 July 2015	Results of pilot roll out Implementation plan Reports on success rates to TME.	DBS outcome: GPs able to book new outpatient appointments in surgery with the aim of reducing failure rate to 10% by July 2015.
CA 1.3	In some **surgical specialties** waiting times for surgery were too long and operations were cancelled too often.	Implement existing plan. This includes utilising private sector providers to clear the high number of patients waiting over 18 weeks in these specialties. This has been initially rolled out in four specialties and will be extended across individual specialities in July. • Performance will continue to be monitored on a weekly basis via joint Trust and CCG 18 week meeting. • Outcomes will continue to be reported on a monthly basis via Integrated Performance Report to Trust Management Executive (TME), Finance and Performance Committee (FPC) and Trust Board.	**Executive Director accountability:** Director of Clinical Services Operational Lead: General Managers	30 June 2014 31 July 2014	Profile report produced for weekly meeting Detailed action plan for each of specialities performing below 90% IPR reports to TME, FPC and Trust Board	Trust level RTT 90% standard achieved Individual specialty RTT 90% standard achieved by 31 August 2014.
CA 1.4	There was not suitable attention paid to the identification, assessment and planning of care needs	**SURGERY** Cross reference to CA 4.1				
		EMERGENCY DEPARTMENT • Develop a Dementia pathway through the work of the	**Executive Director accountability:**	Pathway to be completed and	Reviews of Dementia	Vulnerable patients will be treated in

Ref	Issue identified	Action	Responsibility	Completion date	Evidence required	Outcome / success criteria
	for vulnerable people, particularly those with dementia in **surgery** and **A&E.**	Trust Dementia Steering Group • The pathway will identify those patients that need to be assessed and clinically managed in the Emergency Department (ED), and who require specialist input with guidance on their management with respect to their dementia and cognitive dysfunctional needs. • Continue to provide on-going specialist input and advice from existing staff including gerontologists who work in ED and the Trust psychiatric team, the Trust's dementia clinical lead and the Adult Safeguarding Lead. • Provide multidisciplinary teams with training to further develop knowledge and awareness of the dementia pathway and care of vulnerable patients and optimal communication with relatives. • Continue to implement training on care of patients with dementia to Clinical Support Workers through the CSW Academy at induction and for existing staff within local clinical areas. • Monitor the introduction of the new pathway and implement ongoing monitoring as part of assurance visits to ensure that it is followed appropriately.	Director of Clinical Services Operational Lead Divisional General Manager MRC Clinical Lead for Dementia Acting Chief Nurse (as Dementia Lead Nurse)	in progressive implementation by 31 October 2014 Initial training to be provided by 30 September 2014	Pathway documentation and care and treatment plans making reference to their specific cognitive needs. Records of attendance at training by MDT	the most appropriate setting to meet their needs. Monitoring of complaints shows less incidents relating to vulnerable patients. Initial pathway in place by 31st October 2014.

Compliance Action 2: The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury; Surgical procedures; Family planning; Maternity and midwifery services; Termination of pregnancies. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA2.1	There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the **maternity** department and on **surgical wards** and in **operating theatres.**	**MATERNITY** Recruit 14 WTE Band 5/6 midwives to fill remaining vacant posts (14 recruited to date). Those recruited will take up post between June and September 2014.	**Executive Director accountability:** Chief Nurse Operational Lead: Head of Midwifery	30 September 2014	Vacancy Control Form TRAC recruitment system	14 Band 5/6 in post by September 2014
		Recruit to the Delivery Suite Manager post	Head of Midwifery	Complete	Individual in post	Delivery Suite Manager in post
		Recruit to existing Band 7 in Maternity Assessment Unit.	Head of Midwifery	30 September 2014	Individual in post	Band 7 in post
		Review vacant Band 7 post within the community and recruit within 6 months.	Head of Midwifery	31 December 2014	Individual in post	Band 7 in post
		Utilise the reserve list of junior midwives if any vacancies arise, as required.	Head of Midwifery	31 October 2014	Database	Reserve list database in place and will be utilised where required
		Recruit 6.31 WTE Band 2 maternity support workers.	Head of Midwifery	31 October 2014	Vacancy Control Forms TRAC recruitment system	6.31 WTE Band 2 in post
		Implement the remaining aspects of the Maternity Staffing Business Plan agreed by TME in 2013. This includes recruitment of four WTE ward receptionist posts.	Head of Midwifery	31 July 2014	Business case Paper for Divisional Executive	4 WTE receptionists in post
		Continue to use Birth rate + on a 4 hourly basis to monitor activity and acuity to ensure staffing is sufficient to meet the needs of	Head of Midwifery / Clinical Midwifery Manager	Annual review	Annual review of staffing. Birth Rate	Sufficient midwives are in place to meet established staffing

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		women.			acuity tool	levels.
		Continue to support the fluctuating activity in maternity by using staff within the Hospital and community services.	Head of Midwifery	Ongoing	Review of staffing, Daily activity sheets	Sufficient midwives are in place to meet established staffing levels.
		SURGICAL WARDS • Continue to review staffing levels at least twice daily through a RAG (Red/Amber/ Green) rated pre-determined staffing levels tool. • Professional judgement to be utilised to determine if mitigating actions are required, to ensure adequate staff are in place to meet the needs of patients.	**Executive Director accountability:** Chief Nurse Operational Lead: Divisional Nurse Neurosciences, Trauma, Orthopaedics and Specialist Surgery (NOTSS)	Ongoing	Monthly reports on safe staffing levels	Safe staffing levels maintained
		Reduce nurse vacancy band 2-6 to 12% by September 2014 through the following actions:	Matrons for Trauma; Orthopaedics and Theatres; Specialist Surgery; and Neurosciences	30 September 2014	Division's performance reports which include staffing figures against establishment Vacancy Control Forms	Reduce nurse vacancy band 2-6 to 12% by September 2014
		• Continue rolling recruitment adverts for all nursing posts		Monthly review from June 2014		
		• Continue to engage with the Trust-wide overseas recruitment programme		Ongoing	Overseas recruitment programme	Effective use of the overseas recruitment programme, recruiting at least 10 WTE in the Division per year.
		• Weekly review meetings between Divisional Nurse, HR consultant and recruitment team to monitor effectiveness across the Division.	Divisional Nurse NOTSS	30 September 2014	Notes from weekly review meetings	Reduce nurse vacancy band 2-6 to 12% by September 2014
		• Recruit from foundation rotational programme for new graduates from	Divisional Nurse NOTSS	30 September	Staff recruited from graduate	

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Oxford Brookes University.		2014	programme	
		• Develop quarterly briefing papers to be presented to the Division by each Directorate, providing an update on local recruitment strategies and trajectory for reducing vacancies.	Divisional Nurse	Complete	Quarterly briefing papers	

		Support existing staff with retention strategies including:
		• Continue roll out of focus groups for nursing across Division, led by HR Consultants. Areas to be covered :
		  • Neurosciences
		  • Specialist Surgery
		  • Trauma
		  • Orthopaedics
		• Formulate and implement action plans as an outcome of focus groups.
			Divisional Nurse NOTSS and Senior Business Partner.	31 March 2015	Focus Group action plans	Nursing vacancy rate of 12% or less across the Division.

		Recruit and appoint two further Professional Development Nurses, to ensure inpatient areas have access to this support.	Divisional Nurse NOTSS	Complete for one post and in progress for the other by 31 July 2014.	Vacancy Control Forms TRAC recruitment system	Staff supported by Professional Development Nurses as evidence by CGC papers and ward feedback/executive walkrounds.
	There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the **maternity** department and on **surgical wards** and in **operating theatres.**	**<u>OPERATING THEATRES</u>** Recruitment into substantive theatres and sterile services manager vacancy (Surgery & Oncology Division) and deputy theatre manager vacancy (Clinical Support Service Division)	**Executive Director accountability:** Director of Clinical Services Operational Lead: CCTA Manager / Theatre Manager	30 September 2014	Individuals in post	Appointments made & reduction in vacancies.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Ensure that staffing levels within theatres for scrub and anaesthetic and recovery nurses meet the Association of Perioperative Practitioners (AfPP) guidance	CCTA Manager / Theatre Manager	Ongoing	Divisional Performance reports	Relevant staffing levels as outlined by the AfPP are met.
		Use specialist journals in the recruitment of specialist theatre nurse / operating theatre practitioner. (Closing date of 2nd AfPP recruitment advertisement is 28 June 2014).	CCTA Manager / Theatre Manager	28 June 2014	Divisional Performance reports	Recruitment of experience scrub and anaesthetic practitioner to band 5 and band 6 roles to maintain levels of competent skill mix. Evidenced in divisional performance reports
		Continue to work closely with Human Resources towards a goal to optimise recruitment lead times to employment.	Recruitment Manager	28 August 2014	Reports on lead times	Improved advert to appointment time to an average of 8 weeks. Reported to Workforce Committee bimonthly and in the quarterly Organisational Development and Workforce Performance report.
		Attendance at a number of theatre, anaesthetic and recovery speciality specific national conferences as a spot interview opportunity to further optimise interested candidates at those venues	CCTA Theatre Manager	17 August 2014	Successful recruitment Divisional performance report.	Recruitment of experienced scrub and anaesthetic practitioners to balance skill mix and competence.
		Recruitment campaign at the British Anaesthetic and Recovery Nurse Association Conference –-6th June 2014 Greenwich, London	Theatres Band 7 charge nurses	Complete	Attendance record	Booking made and invoiced and staff identified to undertake interviewing on the day.
		Recruitment campaign will be carried out at the Association of Perioperative Practitioners	HR Recruitment lead CCTA Theatre	17 August 2014	Attendance record	Ongoing recruitment evidenced through the

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		Conference –-20th – 22nd June 2014, Brighton and 15th – 17th August 2014, York	Manager		Divisional Performance report	divisional performance report.
		Continue to implement a staged recruitment campaign targeting band 5 recruitment (followed by band 6's) using a co-ordinated approach with the other theatre suites across the Trust.	HR Recruitment lead Theatre Manager Charge Nurses	Ongoing		
		Reduce the use of agency staff through the work of the Agency Task and Finish Group.	Theatre Manager Charge Nurses	31 December 2014	Reduction in the use of agency staff. Task and Finish Group minutes	Ongoing reduction of agency staff (with a view to reducing to 0% within the next 12 months)

Compliance Action 3: The provider had failed at times to deliver care to patients that ensured their privacy, dignity and human rights were respected.
John Radcliffe and Trust Wide. Treatment of disease, disorder or injury. Regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA 3.1	The use of the **accident and emergency** triage room, the atrium area, and layout of the reception did not give patients privacy and dignity**.**	These issues were discussed by senior members of the ED Team and the Director of Clinical Services and the following actions were agreed:	**Executive Director accountability:** Director of Clinical Services	Complete	Meeting notes	Patient privacy and dignity maintained as evidenced by patient feedback, and internal assurance visits.
		Frost covering for the Triage Room windows to be ordered and the door lock to be removed.	Operational Lead: Divisional General Manager MRC	Complete	Frosting in place and door lock removed	
		Atrium issues to be addressed through actions taken to address patient flow (as set out in CA1.1).				
		Additional frosting to be ordered for Trust offices that overlook the Atrium to improve privacy issues.	Divisional General Manager MRC	20 June 2014	Visual check of completion	Patient privacy and dignity maintained as evidenced by patient feedback, and internal assurance visits.
		Display notices at the ED reception desks to explain the process for disclosing private information. This will include the opportunity for patients to write information, rather than verbalise it.	Divisional General Manager MRC	Complete	Notices in place	

Compliance Action 4: The provider had failed at times to take proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each patient, including appropriate information and documents in relation to that care and treatment.
NOC, Churchill, Trust wide. Treatment of disease, disorder or injury. Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with good practice standards.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA 4.1	There was no suitable information within care records to inform staff about the individual care patients needed. This was particularly in relation to the needs for vulnerable people, particularly those with dementia and patients requiring complex wound management.	**Oxford Centre for Enablement Ward (OCE)** To review and revise the risk assessments for post-acute patients requiring rehabilitation, with the input of relevant specialist advice to meet the needs of these patient groups. Benchmark and utilise existing approaches within the Trust where this is being well implemented.	**Executive Director accountability:** Medical Director Chief Nurse Divisional Director MRC Operational Lead: Divisional Nurse MRC Therapy Lead	31 July 2014	Patients risk assessments care plans	Risk assessment are in place and well completed
		Develop a system for individual patient care plans for in-patients on OCE ward.	Matron for OCE MRC	31 July 2014	Review of patient care plans	Care plans are in place and well completed
		Identify lead people with specialist expertise on dementia and wound management to train and support staff in these areas, including effective record keeping.	Matron for OCE MRC and Consultant Nurse, Tissue Viability	From July 2014 (and ongoing)	Training records	Staff have comprehensive knowledge of these areas and plans are well developed
		Review risk assessments and completion of patient records and care plans on a weekly basis.	Ward sisters with oversight from Matron for OCE MRC	From July 2014	Record of Weekly reviews	Risk assessments and care plans are well completed for the needs of the individual patient.
		Monitor compliance at directorate level during Directorate assurance visits.	Matron for OCE Directorate Operational Service Managers MRC	31 July 2014 and ongoing	Records of Assurance visit	As above.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		<u>Ward E, NOC</u> Review of current documentation in use across the directorate for identification and on-going management of patients.	Matron NOC NOTSS	31 July 2014	Meeting minutes Assurance audits	Risk assessments and care plans are reviewed and improved
		Establish a working group within orthopaedics facilitated by dementia lead nurse, with multi professional input. • Objectives and terms of reference to be determined at the first meeting. • Key objective to launch a training programme on dementia care that meets the needs of this patient group within an orthopaedic environment	Matron NOC Ward Sisters NOTSS Dementia Leader NOTSS Division	1 September 2014	Minutes of working group Training programme and records	Implementation of the dementia training and ongoing review every 6 months which demonstrates leadership within each ward in the provision of care plans that incorporate dementia patients.
		Divisional Dementia Leaders and Consultant Nurse, Tissues Viability to train and support staff in these areas, including effective record keeping.	Matron NOC with input from Divisional Dementia Leader and Consultant Nurse, Tissue Viability	31 July 2014	Training records	Ward sisters and senior ward staff have knowledge of the care of dementia patients and wound management
		Review ward sisters audit tool to ensure that it takes into account individual patient wound management needs.	Ward Sisters NOC NOTSS	30 June 2014	Snap shot audits by Ward Sisters and Matron	Effective wound management care is in place, (using the safety thermometer to monitor this).
		Review risk assessments and completion of patient records and care plans on a weekly basis.	Matron NOC and Consultant Nurse, Tissue Viability	From July 2014	Record of Weekly reviews	Risk assessments and care plans we well completed for the needs of the individual patient.
		Develop a cross divisional care plan that highlights the requirements for the use and management of VAC therapy for complex wound management.	Matron NOC NOTSS and Consultant Nurse, Tissue Viability	30 September 2014	Care Plan Divisional quality report	
CA 4.2	Records did not contain all the required information to ensure care was delivered safely to meet	**<u>John Warin and Geoffrey Harris Wards</u>** CQC findings to be discussed with all staff working on both wards	Divisional Nurse MRC	Complete	Meeting notes	Staff can demonstrate knowledge of relevant findings and plans

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
	the patient's needs. Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.	Review and standardise all assessment forms and handover sheets on both wards to ensure consistency.	Matron for Ambulatory Medicine MRC	30 June 2014	Risk assessment forms and handover sheets	Standardised documents in place that is completed and used to handover
		Matron to train and support staff in these areas, regarding effective record keeping.	Matron for Ambulatory Medicine MRC and Consultant Nurse, Tissue Viability	31 July and ongoing	Training records	Staff have comprehensive knowledge of these areas and plans are well developed
		Audit ten sets of notes every week (five sets of notes on John Warin Ward and five sets of notes on Geoffrey Harris ward) to assess the following; • Risk assessments are completed. • Completed care plans that relate appropriately to the risk assessments • The standard of information documented reflects all the information required to deliver care based on the patients' needs.	Matron for Ambulatory Medicine MRC	31 July 2014	Audit results	As above
		Monitor compliance at directorate level during Directorate assurance visits.	Matron for Ambulatory Medicine MRC Directorate team	30 June 2014 and ongoing	Records of Assurance visit	As above.

Compliance Action 5: The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision.
John Radcliffe. Treatment of disease, disorder or injury; Maternity and midwifery services. Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The trust needs to ensure that staff receive suitable induction to each area that they work within the trust.

The trust needs to ensure that newly qualified midwives are appropriately supported.

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
CA5.1	Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the **A&E department**.	Review and update local induction pack for new starters with consultant nurse in ED and cohort of new starters.	**Executive Director accountability:** Chief Nurse Operational Lead: Divisional Nurse MRC	31 July 2014	Minutes of meetings	Staff complete their induction and competencies are achieved as evidence by detailed monitoring of process in February 2015.
		Develop a new pack to be published, tested and implemented with overseas staff to ensure assessments and competencies meet their learning needs.	Divisional Nurse MRC	31 July 2014		
		Monthly sessions for the first 6 months from their start date, for new starters to feedback any concerns in the form of action learning sets.	Divisional Nurse MRC	With effect from 1 August 2014	Summary of action learning sets Competencies achieved	
CA5.2	Newly qualified **midwives** did not always receive adequate preceptorship.	Review and update the preceptorship package for all areas in the maternity service with liaison with ED (as outlined above) to ensure that shared learning is in place.	Head of Midwifery	31 July 2014	Completion of preceptorship package and attendance at the Trust preceptorship programme.	Staff are supported through effective preceptorship as evidence by a staged review of process in February 2015 and July 2015.
		Ensure midwives have the support required to induct them into the clinical areas. Each midwife to have:	Clinical Midwifery Managers	Ongoing	Positive feedback from new graduates.	

Ref	Issue identified	Action	Responsibility	Date completed	Evidence required	Outcome / success criteria
		• written plan • copy of the preceptorship package • nominated preceptor.				
		Newly qualified midwives to follow the established process of preceptorship for up to 12 months in order to achieve their competences. (There is a sign off process to ensure this is completed and before a Band 5 can move to a Band 6).	Practice Development Midwives	Complete	Preceptor package, competencies Individuals employed as Band 6's.	
		Continue to ensure that newly qualified midwives are aware of the support group for new graduates. This is currently well attended.	Supervisors of Midwives	Complete	Attendance records and evidence that staff are supported to attend	
CA5.3	Not all nurses qualified overseas working in **A&E** and newly qualified **midwives** were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.	For actions relating to supervision and support in A&E see CA5.1				
		Continue to support the four student Supervisor of Midwives (SOM's) to complete the programme, thereby ensuring from September the caseload ratio will be 1:18.	Local supervising midwifery officer (LSAMO)/Head of Midwifery (HOM)	30 September 2014	Successful completion of programme and demonstrate supervisory activity.	Supervisory caseload ratio 1:18
		To further address this, support will be given to six OUH midwives to attend the programme in 2014/15 to improve the ratio to 1:16 (dependent on leave / turnover).	LSAMO/HOM	30 September 2015	6 midwives supported to attend the programme.	Supervisory caseload ratio 1:16

'SHOULD DO' ACTION PLAN

Oxford University Hospitals NHS Trust received five reports setting out the findings from its recent inspection:

- An over-arching trust wide report containing a summary of all compliance actions from the individual hospital reports (a separate compliance 'must do' action plan has been developed and already submitted to the CQC)
- Four reports, one for each of the hospital sites; the Churchill Hospital, the Horton General Hospital, the John Radcliffe Hospital and the Nuffield Orthopaedic Centre. In addition to listing the compliance actions these reports included a number of 'should do' recommendations.

Of note, where a 'should do' recommendation has been reflected in the Trust compliance 'must do' action plan, the compliance action has been cross-referenced represented in a shaded box.

Key

The following abbreviations relate to the trust's internal monitoring system:

SD – Should Do Action

CA – Compliance Action

JR, NOC, HGH, CH – indicates specific hospital report the should do action was recorded in.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
ENVIRONMENT AND FACILITIES						
SD1	**Outpatient clinics – Health and Safety/Patient Welfare (CH)** Consideration should be given to the management of the outpatient clinics in the older parts of the hospital. Particular consideration should be given to the patient's welfare and their health and safety. This is because of the limited space in some areas and the general condition of some of the facilities.	Progress the business case initiation proposal for the relocation of Respiratory Services, including outpatients, to the John Radcliffe. (£100k allocated in 2014/15 Capital Programme)	**Executive Director Lead**: Director of Clinical Services <u>Operational Lead:</u> MRC Divisional Director	31 March 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to Finance and Performance Committee (FPC)	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
		Progress the business case initiation proposal for the relocation of the Clinical Genetics Department, comprising outpatient and office accommodation (£500k allocated in 2014/15 Capital Programme)		31 March 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
SD5	**Premises and facilities (CH)** Identified concerns relating to the facilities in the older part of the hospital were being addressed but the trust needs to ensure that suitable well maintained premises are available to patients and staff.	Progress the business case initiation proposal for the Churchill Day Surgery Unit (DSU) Redevelopment (£900k allocated in 2014/15 Capital Programme)	**Executive Director Lead**: Director of Clinical Services <u>Operational Lead:</u> S&O Divisional Director	31 January 2015	Business Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
		Progress Renal Development project for the Renal Ward (£3m allocation in 2016/17 Trust's Capital Programme)		31 March 2015	Business Case Monitoring of capital programme via Business Planning Group	Capital works completed. Positive feedback from patients, staff and

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
					and reporting to FPC	stakeholders via formal surveys.
SD 14	**Critical Care Security - HGH** The kitchen in the critical care unit should be better secured from the clinical area.	Obtain quotes and schedule for minor works to be completed	**Executive Director Lead**: Director of the Development and the Estate Operational Lead: Matron Adult Intensive Care & Critical Care Follow Up	31 October 2014	Quotes for work Physical check of works completed	Minor works completed.
SD 38	**Improved environment - Critical Care (JR)** The hospital should ensure a better environment within critical care.	Development of affordable Strategic Outline Case for investment (Adult Critical Care JR £9m allocated in 2016/17 Capital Programme).	**Executive Director Lead:** Director of Clinical Services Operational Lead: CSS Divisional Director	31 January 2015	Strategic Outline Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
SD 36	**Premises and equipment – Main JR theatres** The trust should ensure that issues relating to the safety and suitability of premises and equipment in the main theatres are promptly resolved.	Development of affordable Strategic Outline Case for investment (JR 2 Theatres £350k allocated in 2014/15 Capital Programme and further £24.5m in 2015/16 Capital Programme)		31 January 2015	Strategic Outline Case Monitoring of capital programme via Business Planning Group and reporting to FPC	Capital works completed. Positive feedback from patients, staff and stakeholders via formal surveys.
CARE OF FRAIL, ELDERLY PATIENTS (INCLUDING THOSE WITH DEMENTIA)						
SD 32	**Care of frail elderly (JR)** The trust should continue to ensure that positive	The OUH Dementia Strategy is to be developed via the Dementia Steering Group in alignment with the Oxfordshire	**Executive Director Lead:**	30 November 2014	Minutes and feedback from Dementia Steering	Positive outcomes delivered to frail,

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	outcomes are delivered for frail, elderly patients and those with dementia, especially when working with relatives/carers.	Dementia Development and Implementation Board (DDI) which oversees the regional implementation of the national strategy This includes: • A range of shared learning initiatives across the Trust as part of a cohesive approach to developing frail older person care including • Training programmes that address tiers 1, 2 and 3 training across the Trust • Further training of Dementia Leaders through the Worcester University 8 day programme to cover gaps across the Trust in combination with Oxford Health NHS FT • Wider implementation of the tier 1 training of staff via Dementia Leaders • The development of dementia friendly environments in Trauma, Emergency Departments and EAU as well as the Acute General Medical in patient areas • Reminiscence resources in Post-Acute Unit • Development of an approach to nutritional care included within the Dementia Strategy • Compassionate Care programme	Chief Nurse <u>Operational Lead:</u> Deputy Chief Nurse	31 December 2014	Group. Draft Dementia Strategy for wide consultation Physical inspection of Trauma Ward Reminiscence resources Compassionate Care Programme Attendance records and reporting quarterly to the Dementia Steering Group and nationally Positive feedback from staff, patients and carers Positive benchmarking with other acute Trusts	elderly patients Patient and relatives/carers feedback

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		Trust wide to enable a sensitive approach to communication. • Implementation of the 'Knowing Me' booklet to improve continuity of personalised care				
		Development of a Trust Pressure Ulcer Prevention Clinical Improvement Group (PUPCIG)	**Executive Director Lead:** Chief Nurse Operational Lead: Deputy Chief Nurse	31 July 2014	Implementation of PUPCIG group Terms of reference, agenda and minutes	Progression of the Trust PUP Action Plan
		Development of a Trust Pressure Ulcer (PUP) Action Plan (Valid from July 2014 to April 2016)	**Executive Director Lead:** Chief Nurse Operational Lead: Consultant Nurse, Tissue Viability	Action Plan to be ratified at Patient Safety and Clinical Risk Committee 31 July 2014	Bi monthly monitoring of progress at PUPCIG Quarterly action plan updates at Patient safety and Clinical risk Committee	Progression of action plan to agreed timescale or with agreed extension. Reduction in hospital acquired Pressure Ulcers
		Introduce and implement Fall safe care bundle across MRC Division	**Executive Director Lead:** Chief Nurse Operational Lead: Divisional Nurses	31 March 2015 (decision on implementation plan) with roll out to commence April 2014	Completion of Fall Safe Audits on all wards	Falls Safe Audits undertaken demonstrating 90% compliance with Fall Safe and a reduction in avoidable falls with harm
		Roll out Falls Safe across the NOTSS division in the following order 1 – Neuro, 2- Spec Surg, 3- Trauma, 4 – Orthopaedics	Operational lead: Divisional Falls Prevention Practitioner	On-going		
		Orthogeriatric team to continue to review	**Executive Director**	On-going	Monthly % on pre	Pre and post-op

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		all patients with fractured neck of femur (FNOF) with specific interest in cognition and delirium. This includes evidence-based drug chart review, continence management and nutrition.	**Lead** Medical Director Operational Lead: Clinical Lead Geratology & Stroke		and post-op AMTS collected on all FNOF patients in >98% of cases	AMTS collected on all FNOF patients in >98% of cases
		Orthogeriatric team to continue to support the primary named nurse in discharge planning. This includes discussions with families about pre-existing memory problems, behaviours and concerns. On occasion this has led to diagnosis of dementia and/or formal best interests meetings with the rest of the MDT.				
		Continue to provide teaching sessions provided to the MDT on dementia and delirium			Training materials and attendance records	
		Continue to refer cases to the Psychological Medicine Team as required for their expertise and input.			Referral numbers	
SD 9 24, 32	**Staff training in dementia in ED – HGH and JR**	***(Compliance Action response for CA1.4)***				
LEARNING FROM INCIDENTS, COMPLAINTS AND PATIENT FEEDBACK						
SD 18	**Cross hospital and divisional learning from incidents (NOC)** The process for sharing learning following incidents was not effective. Staff were not	The results of the last Annual audit of the Incident Reporting and Investigation Policy to be reviewed to identify potential gaps in the system.	**Executive Director Lead:** Interim Medical Director Operational Lead:	31 October 2014	Audit Results	More staff report via staff survey results that they are aware of actions in relation to incidents.
		Survey staff to identify current approaches to feedback and learning from incidents.		30 September 2014	Survey results and results analysis	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	aware of the learning from incidents in other parts of the hospital or trust.	Undertake a wider review of local processes in relation to sharing learning and actions from incidents.	Head of Clinical Governance	30 September 2014	Staff survey results and action plans	Incident reporting rate grows and Trust benchmark in relation to NRLS reporting data improves from lower quartile upwards. Staff survey show improved results in relation to feedback from incident reporting
		Develop a method of measuring impact of any changes.		30 November 2014	Method of measuring impact of any changes.	
		Identify current trust wide groups (e.g. sub committees of CGC) / formal meetings in place and add a standing agenda item to cover cross divisional learning.		30 September 2014	Map of committees / formal groups in the Trust Agendas for each group	
		Learning from incidents will be disseminated to all sites using the 'At a Glance' process as described in the current Trust Policy.		30 September 2014	'At a Glance' notices issued Local assessment and use of notices	
		TME paper Quality Governance – Optimising the management and escalation of quality related issues will review the internal communication methodology.		30 September 2014	Communication review notes Procedure note on communication flows	
		Staff survey results for current year include aspects of feedback to staff following incidents. Local action plans in place to address issues. Link to • Pressure Ulcer Prevention Plan • Diabetes Business Case -Widening diabetes team		30 September 2014	Divisional staff survey action plans Progress on Pressure Ulcer Plan and Diabetes Business case monitored	
		Set up a working group to review and improve learning from the non-clinical incident reporting process.	**Executive Director Lead:**	30 September 2014	Terms of reference for Working Group	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
			Director of Development and the Estate Operational Lead: Deputy Director of Assurance		Minutes Procedure note.	
SD 25	**Complaints feedback ED (JR)** Staff in the A&E department should be made aware of complaints from patients to enable them to understand the need for changes and improve their practice.	Trust wide Complaints Review presented to TME 12 June 2014 – Action Plan to cover • Investigation Process • Training • Complaints Management System • Quality of complaints service and assurance • Reporting	**Executive Director Lead:** Chief Nurse Operational Lead: • Head of Clinical Governance/ • Safeguarding and Patient Services Manager	Evaluation of the full action plan to be completed by 30 November 2014	Quarterly Complaints Review Quarterly theme based Complaints Reports Quarterly Patient Experience Reports Update on progress reported to TME	Staff are aware of changes in practice that link to complaints. Reduction in number of complaints
		Local action within ED Complaints reviews already form part of regular Governance Meetings. Local complaints champions to be identified covering each staff forum to promote 'complaints conversations'	**Executive Director Lead:** Chief Nurse Operational Lead: • Safeguarding Adults and Patients Services Manager • Divisional Nurse MRC • Matron for ED & MAU	31 August 2014	Governance meetings Named champions in place	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
SD 35	**Learning from serious incidents (JR)** The trust should ensure that lessons learnt from serious incidents are promptly disseminated and embedded in practice.	As per SD 18 above linked to revised Incident and Investigation Policy. A paper on learning from serious incidents is to be presented to Quality Committee In August 2014 to address these issues.	**Executive Director Lead:**Interim Medical Director Operational Lead: Head of Clinical Governance	31 August 2014	Quality Committee paper	SIRI learning is further improved across the Trust and relevant actions are taken to enforce learning.
SD 28	**Improve Friends and Family response rate (JR – ED and Maternity)** The response to the Friends and Family test should be improved in A&E and Maternity.	Patient Experience Strategy Implementation Plan presented to TME 10 April 2014. Action Plan covers the recruitment of key staff, real time patient experience feedback and FFT. • ED – now 20% • Maternity – Head of Midwifery and Clinical Leads promoting FFT and accessing relevant lead.	**Executive Director Leads**: Chief Nurse and Director of Workforce and Organisational Development (OD) Operational Leads: • Safeguarding Adults and Patients Services Manager • Matron for ED & MAU • Head of Midwifery	Impact analysis from the full implementation plan to be reported to Quality Committee February 2015.	Divisional Quality Reports and Quarterly Performance Reports	By Q1 ED response rate to be over 15% By Q4 adult inpatient response rate to be 40%
		Monitoring of FFT response rates at TME and via performance review meetings.	**Executive Director Leads**: Chief Nurse and Director of Workforce and OD Operational Lead: Safeguarding Adults and Patients Services Manager	Completed		

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
STAFFING						
SD4	**Medical beds and staffing levels (CH)** The trust should continue with its recruitment efforts to ensure that sufficient medical beds are available to patients and safe staffing levels are maintained.	Recruit to current vacancy on John Warin Ward of 1.0 wte band 5 role (advert out) Await start dates for 2.0 wte Band 5 newly appointed candidates	**Executive Director Lead:** Chief Nurse Operational Lead: MRC Divisional Nurse	31 October 2014 30 September 2014	Monthly vacancy rates monitored against establishment figures	Maintenance of 33.14 wte establishment on John Warin Ward
SD 10	**Paediatric nurse on duty (HGH)** Although all A&E staff were trained in paediatric life support, guidance said the department should have trained paediatric nurses on duty at all times.	Actively attempt to recruit dual trained nurses (though it is recognised that this is a national shortage). To provide 24/7 cover 5.6wte nurses are required. Continue compliance with paediatric life support training for nurses band 5 and above	**Executive Director Lead:** Chief Nurse Operational Lead: Deputy Matron, Emergency Department	30 September 2014 31 October 2014	Skill mix review documentation Training documentation reports	Dual trained nurse employed 100% compliance within department for paediatric life support
SD 33	**Staffing - therapy staff (JR)** The trust should continue with their plans to ensure sufficient therapeutic staff, like speech and language and physiotherapists are available to meet patients' needs in a timely manner.	The Therapy Business Plan (Page 4 & 5; point 1.10 -1.12) addresses the therapy strategic workforce needs to 2019. Therapies are undertaking a partnership working approach with therapy staff and stakeholders to undertake full evaluation of workforce needs to include benchmarking, appraisal of evidence, data, and therapy team workshops. A gap analysis in the Critical Care Units against the Critical Care Standards and NICE CG83 Rehabilitation Guidelines has been completed. Business cases for	**Executive Director lead:** Director of Clinical Services Operational Lead: Head of Therapies	31 January 2015	Therapy Business Plan 2014-19 submitted to the MRC Division in February 2014. Business cases sent to Directorates for consideration	Evidence to demonstrate staffing levels are adequate to deliver a quality rehabilitation service

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		increased staffing levels against these standards are being presented to the Directorates /Divisions for the CTCCU and the NICU units.				
		Speech and language therapists are employed by Oxford Health. Review existing Service Level Agreement for the services they provide to OUH and as part of this process, review options for service provision.		31 January 2015	Formal review of the SLA. Options appraisal Implementation plan regarding SALT provision	Evidence to demonstrate that adequate SALT provision is in place
SD7	**Critical Care Medical Staffing (HGH)** The hospital should have cover at all times from medical staff trained in critical care.	Conduct a Trust-wide critical care review as a basis for the development of a Trust Strategy.	**Executive Director lead:** Director of Clinical Services Operational Lead: Division Director CSS Division	30 September 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
		Review and agreement of a Divisional Plan detailing the types of patient acuity cared for on the HGH Critical Care Unit		31 October 2014	As part of the strategic review the specific review of HGH CCU acuity and recommendations	Divisional Plan detailing the types of patient acuity cared for on the HGH CCU in place and implemented.
SD 20	**Staffing levels (OCE at the NOC)** The trust should continue with active recruitment, as despite recent improvements in staffing levels in OCE, staff felt they required more staff to provide the care some patients needed.	To continue with active recruitment - current vacancy is 3.3 WTE for Band 5	**Executive Director Lead:** Chief Nurse Operational Lead: Matron for OCE in MRC	30 November 2014	Report on vacancy rates	All vacancies filled. Sickness rates reduced to Trust accepted rates of 3%
		To use long line agency to support current staff		30 November 2014	Staffing rotas	
		To reduce current high levels of sickness absence.		30 November 2014	Sickness figures	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
RECORD KEEPING						
SD6 SD 17	**Standardised Codes – cardiac arrest (CH, HGH)** Codes used to inform staff of the medical procedures to be followed for specific patients in the event of a patient having a cardiopulmonary arrest should be standardised across the hospital.	Discuss findings and proposed actions at Trust's Resuscitation Committee on 23 June	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of meeting	Resuscitation Committee is engaged in the CQC action planning process
		Ensure relevant staff are aware of correct documentation in relation to DNACPR decisions and inform them of risks associated with use of codes.	**Executive Director Lead: Interim** Medical Director Operational Lead: Divisional directors via divisional nurses, clinical directors and matrons.	31 October 2014	Email / minutes or other documentation showing information cascaded to staff in divisions DNACPR audit records	Staff will articulate correct use of documentation in relation to DNACPR as demonstrated during periodic DNACPR audit.
		Agree acceptable & standardised terminology to be used when needed in communicating existence of decision between colleagues e.g. in ward handover. This format to be DNACPR	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of Resuscitation Committee Meeting	No evidence of alternate codes being used communication (eg on post take sheets, whiteboards etc) found during Matron's rounds, Executive walk rounds, spot checks by Resuscitation Department etc. /
		Circulate standardised codes and agreed terminology by email to all Divisional Directors and Divisional Nurses / equivalent for cascade to directorates / CSU's		31 October 2014	Email sent out	
		Modify DNACPR audit template to enable monitoring of awareness and implementation of standardised codes		31 October 2014	Audit templates revised and questions trialled	

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		and agreed terminology.				if alternate codes found in use action taken to alert staff to risks, and to modify practice to meet agreed standard.
SD 29	**Record keeping (JR)** The trust should ensure that patient records accurately reflect the care and treatment that had been planned and agreed for each patient in line with clinical guidelines and good practice standards, especially for those patients who cannot direct or inform staff of their needs.	Review current Trust guidance, good practice and existing measures in the Trust, then create an overarching action plan to address issues found. Some aspects to be addressed by EPR NHSLA standards to be used as the basis of good practice, results of documentation reviews to be shared and improved trust wide standard developed.	**Executive Director Leads:** Chief Nurse and Interim Medical Director <u>Operational Leads:</u> Divisional Nurses and Clinical Leads	31 August 2014 for standards to be re-issued	Revised standards	Trust can evidence improvements in documentation standards compliance via robust audit results.
		Provide support / education to all staff in regard to assessments / care planning and documentation standards across the Trust. Develop training programme (non-mandatory) on assessments / care planning and documentation standards across the Trust.		30 September 2014.	Training documentation.	
		Develop a records audit strategy with escalation process for poor performance and maintain rolling audit review to monitor compliance with records standards.		31 July 2014 for strategy and 30 November for rolling monitoring.	Audit documentation Audit Strategy & escalation plan	
SD 11	**Record keeping (HGH)** Clinical notes for patients in the medical wards	CQC findings to be discussed with all staff working on AGM wards. Matron and PDN to provide support /	**Executive Director Lead:** Chief Nurse	Completed	Meeting notes Band 5 foundation	Staff can demonstrate knowledge of

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	should include a records of all agreed care given to patients.	Education to all staff in regard to assessments / care planning and documentation standards. Include as part of Band 5 foundation programme.	Operational Lead: Matron / Ward sisters AGM		programme.	relevant findings and plans. All patients have a relevant, updated care plan that reflects the care they are receiving
		AGM JR / HGH are currently reviewing documentation to support care planning.		31 August 2014	Care plan template AGM documentation group minutes	
		Audit ten sets of notes monthly in AGM wards to ensure that:- • Risk assessments are completed. • Completed care plans that relate appropriately to the risk assessments • The standard of information documented reflects all the information required to deliver care based on the patients' needs.		To fit with timeframes from audit strategy 30 September 2014	Audit results	
		Monitor compliance at directorate level during Directorate assurance visits.		30 September 2014	Assurance visits feedback	
SD 34	**Record keeping – patient observation (JR)** The recording of patients observations could be improved to ensure the plan of care is followed and any changes in patients' conditions are quickly identified and actions taken.	***Observation of care to be included in action SD 29***				
SD	**Agency staff access to**	Longstanding Agency / Bank trained on	**Executive Director**	30 June 2014	Records of	No clinical

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
21	**EPR** The trust should ensure that in line with the electronic patient records policy, all agency staff have appropriate access to the electronic patient record system to avoid any potential risk to delivery of patient care.	EPR & issued with a smartcard Agency with a smartcard have it activated for the period of time they are contracted to work. All agency medical staff issued with time limited smart card Other nursing staff who do not have a smartcard, are buddied with a substantive member of staff in case they need to read EPR. ALL nursing documentation is paper based. Risk assessed that impossible to meet training needs of individual nursing staff doing one off shift and not needed as nursing documentation all paper based	**Lead:** Chief Nurse Operational Lead: • Matron Orthopaedic Directorate – Nursing • Clinical Director – Medical Staff		Smartcards issued and returned to / from Agency Staff	problems through lack documentation or documentation errors through lack of training on EPR
RESUSCITATION						
SD 17	**Review of DNAR decisions (HGH)** Decisions made by patients around resuscitation should be reviewed as required.	Discuss findings and proposed actions at Trust's Resuscitation Committee on 23rd June.	**Executive Director Lead:** Interim Medical Director Operational Lead: Senior Resuscitation Manager	23 June 2014	Minutes of meeting	Resuscitation Committee is engaged in the CQC action planning process
		Via Divisional Directors and Divisional Nurses all clinical staff are made aware and apply the Adult Unified DNACPR policy.		31 October 2014	Email to all Divisional directors and divisional nurses for cascade via directorates to CSUs.	Clinical staff will demonstrate awareness of policy in relation to review in response to modified question set during periodic DNACPR audit.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		Write to all OUH Consultants to advise them of the Adult Unified DNACPR policy and provide clarification in relation to reasons: (Committee to draft letter for approval and sign off by Medical Director)		30 September 2014	Copy of letter	Review section will be completed appropriately as demonstrated during periodic DNACPR audit.
		Modify DNACPR audit template to enable monitoring of awareness and implementation of the Adult Unified DNACPR policy		31 October 2014	Audit templates revised and questions trialled	Data from revised audit tool provides information about practice within organisation in relation to DNACPR review
		Participate in review of Unified DNACPR policy for adults V2 with representatives from regional organisations and review OUH implementation guidance in light of any recommendations or change from Resuscitation Council (UK) following on from recent 'Tracey' case.		To be determined when (expected) national guidance published.	Revision to policy and OUH local implementation guidance	Any revision to policy reflected in local implementation guide, awareness demonstrated during training and audit.
DIABETES CARE PATHWAY						
SD3 SD 19 SD 30	**Diabetes Care Pathway (CH, JR, NOC)** Identified shortcomings in the care and treatment pathway of inpatients with diabetes were being addressed but the trust needs to ensure that outcomes are delivered to	Diabetes Business Case Implementation Plan is in place and subject to active monitoring at the Trust Management Executive. The plan covers the following key developments There are several key areas for development work:	**Executive Director Lead:** Interim Medical Director Operational Lead: Divisional Director MRC	The Implementation Plan is due to complete 30 September 2015	TME monitoring, next scheduled review 10 July 2014. Internal performance reporting via Quality Committee	The Trust can demonstrate evidence based improvements in diabetes care and can show improved results in national clinical

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	these patients in line with good practice and clinical guidelines.	• Nurse recruitment and development • Podiatrist recruitment • Consultant appointment and reconfiguration of consultant support across Diabetes and Acute General Medicine • Establishment of the Diabetes Quality Group • Development of training packages for diabetes management across the organisation • Development of proformas for patients with diabetes admitted to the Trust • Development of automatic warning flags to ensure that all patients with an abnormal blood result are flagged to the diabetes specialist team • Early agreement of a suite of clinical indicators to measure performance and patient outcomes.			and to the Board.	audits.
BED MANAGEMENT						
SD8	**Bed capacity and A&E waiting times (HGH)** The hospital needs to ensure it has sufficient bed capacity for A&E to meet Government target waiting times.	***(Compliance Action response CA1.1)***				
SD 23	**Resuscitation beds ED (JR)**	Develop a specification and floor plan to increase resuscitation bays from 4 to 6/7	**Executive Director lead:**	Completed	Specification document and	Evaluation complete with

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	The trust should evaluate the provision of resuscitation beds in A&E so they are meeting the needs of patients at all times.	spaces.	Director of Clinical Services Operational Lead: ED Consultant		Floor Plan developed ED Action Plan (Item 19)	plan for increased provision
SD 26	**Management of bed meetings (JR)** The bed meetings should conclude with actions for staff and departments to take to proactively manage identified pressures.	Amend bed meeting report to include agreed actions and confirm that Trust system wide escalation policy is re-introduced	**Executive Director lead:** Director of Clinical Services Operational Lead: Deputy Director of Clinical Services	19th June 2014	Sample of revised report	Report includes agreed actions and the Trust can demonstrate
SD 39	**Improve number of high dependency beds (JR)** The trust should reduce the number of delayed transfers from ICU due to the limited high dependency beds within the hospital.	A Trust-wide critical care review has commenced which is leading to the development of a Trust Strategy, which will include examination of high dependency requirements across the whole of the Trust.	**Executive Director lead:** Director of Clinical Services Operational Lead: Divisional Director CSS	31 October 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
		The matron for adult critical care continues to work with the Lead Nurse of the Patient Pathway Co-ordinator Team to work through issues leading to patients being slow to transfer from critical care.	**Executive Director lead:** Director of Clinical Services Operational Leads: Matron Adult Intensive Care & Critical Care Follow Up	On-going	Updates at Monthly Trust Clinical Governance Committee	Reduction in the number of delayed transfers from Critical Care

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
RESPONSIVENESS – SERVICE PROVISION						
SD 15	**Critical care Outreach Service (HGH)** The provision of an outreach service for critically ill patients should be revisited.	A Trust-wide critical care review has commenced which is leading to the development of a Trust Strategy which will include examination of critical care outreach service requirements across the whole of the Trust.	**Executive Director lead:** Director of Clinical Services Operational Lead: Divisional Director CSS	31 October 2014	Strategy and Implementation Plan.	Agreed Strategy in place with supporting Implementation Plan
SD 12 **SD 33**	**Access to specialist medical services (HGH)** Patients should have access to specialist medical services when they are needed.	Map current provision of specialist medical services including on-call and cover arrangements (includes respiratory, cardiology, diabetes, endocrinology, neurology, oncology, dermatology, rheumatology) Risk assess gaps in access and related mitigating actions Clinical lead to continue to attend Risk Summit 24/7 meetings to ensure issues captured by Associate Director of Clinical Services	**Executive Director lead:** Director of Clinical Services Operational lead: • Clinical Lead Horton Medicine • Clinical Director Acute Medicine & Rehabilitation	31 October 2014 31 October 2014 On-going	Schedule of specialist medical services provided at Horton	No gaps in cover arrangements
DISCHARGE ARRANGEMENTS						
SD2 SD 31	**Discharge Arrangements (CH, JR)** The trust should continue making improvements to the internal and external discharge arrangements so that people who do not require a hospital environment are discharged to community services timely and	**Developing teams and services** • Discharge assurance & oversight group established. • Re-design and develop the Discharge Pathways Team, including the recruitment of more dedicated discharge coordinators. Systems resilience group established as part of the winter	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	Complete 31 August 2014	Minutes of the Discharge Assurance and Oversight Group Operational plan for the development of the SHDS.	Patients are discharged to appropriate care settings, receive the care they require and are not delayed in this process.

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	effectively.	contingency planning • Further development of the Supported Hospital Discharge Service (SHDS) to include registered nurses and an extension of the time that they can take patients		30 November 2014		
		Policy • Update of the Corporate Bed Management Policy, including review of the repatriation policy. • Develop a non-medical led discharge procedure to cover the activity of nurses and therapists? In discharging patients. • Develop an Oxfordshire-wide Patient Choice Policy	**Executive Director lead:** Director of Clinical Services <u>Operational lead:</u> Deputy Director of Clinical Services	Complete December 2014 Complete	Updated Corporate Bed Management policy Non-medical led discharge procedure Patient Choice Policy	Policies are relevant, comprehensive and current.
		Documentation • Standardise discharge documentation across the Trust, including a process for auditing its implementation.		31 October 2014	Standard Discharge Form	
		Monitoring • Roll out 'real time bed state using the Electronic Patient Record. • Joint discharge analysis (OUH & Oxford Health) including the analysis of patient feedback regarding their discharge experience. • Linkage of the Real Time bed state		1 September 2014 31 July 2015 31 July 2014 and	Analysis and monitoring of bed management processes including transfers out of hours, multiple moves and delayed discharges.	Unnecessary moves within the hospital are avoided and patients are discharged to appropriate care settings, receive the care they require and are

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
		with the safe staffing analysis • Audit the implementation of the Corporate Bed Management Policy including transfers of patients at night and multiple moves (Quarterly basis)		ongoing		not delayed in this process.
		Transportation • CCG's hold the contract for provision of transportation of patients with the South Central Ambulance Service. The eligibility criteria is currently out for consultation. • Hold monthly operational meeting with the CCG to review issues • Increase the number of crews to an additional one between 5p.m. and 1a.m. (from July 2014) and a further crew from 5p.m. – 12p.m. for winter provision).	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	With effect from 30 June 2014	Reviewed contract and KPI's Minutes of monthly monitoring meetings Incident monitoring levels	Patients are provided receive the correct mode of transport in a timely way.
		Communication • Reviewed and updated patient discharge information • Development of 'Keep well, choose well, plan well' winter campaign and re-launch for Winter 2014	**Executive Director lead:** Director of Clinical Services Operational lead: Deputy Director of Clinical Services	31 December 2014 and ongoing	Patient information leaflets Materials relating to the Keep well, Choose Well campaign	Patients receive the information they require to make choices relating to their discharge and to fully understand the process.
STAFF ENGAGEMENT AND SUPPORT (WELL LED DOMAIN)						
SD	**Staff engagement and support (HGH)**	Regular visits to be scheduled by Divisional Director, Divisional General	**Executive Director lead:**	30 September 2014	Schedule of visits	Horton staff feedback that

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
13	The hospital trust should improve support to local staff so they feel more included and less isolated.	Manager and Executive Directors	Director of Organisational Development and Workforce Operational lead: • Divisional Director • Divisional General Manager			they feel more included and less isolated, monitored via staff 'pulse' survey results
		Introduce regular workforce and HR surgeries at the Horton, for staff to be able to access to discuss relevant issues	**Executive Director lead:** Director Workforce & OD Operational lead: HR Business Partner	30 September 2014	Schedule of surgeries and number of attendees, list of themes and issues raised from these surgeries	Positive staff feedback through surveys
		Schedule Listening into Action event, led by the workforce directorate	**Executive Director lead:** Director of Workforce & OD Operational lead: HR Business Partners	30 September 2014	Report from the Listening into Action meeting with recommendations and actions to take forward	Positive staff feedback through surveys
SD 22	**Staff engagement and support (NOC)** The trust should work to improve engagement with staff (particularly the consultant body) within the hospital in order that	The Trust is working on a range of initiatives to further improve staff engagement and support. This is a significant and long term undertaking involving focus group meetings and the development of specified proposed	**Executive Director lead:** Director of Workforce &OD	On going	Schedule of meeting dates Report on findings and proposed actions to address this issue	Improved engagement with staff so that staff feel consulted with and listened to

Ref	Issues identified	Action	Responsibility	Completion Date	Evidence required	Outcome / success criteria
	they are consulted about changes within the hospital and to ensure that they feel their views are listened to.	actions.				
SD 37	**Staff engagement and support – Surgery (JR)** The trust should take further steps to engage with staff and investigate reasons for disempowerment and low morale within the surgical domain.	Human resources business partners to undertake a deep dive to ascertain reasons and identify remedies	**Executive Director lead:** Director of Workforce & OD Operational leads: HR Business Partners	30 September 2014	Report on findings and proposed actions to address this issue	Improved moral and empowerment acknowledged through local staff survey
SD16	**Preceptorship for midwives (HGH)** Support for newly-qualified midwives (through their preceptorship programme) should be improved along with management of the maternity services.	***Compliance Action response CA5.2***				
SD 27	**Cross team working (JR)** Some specialist departments should work more co-operatively with the A&E team.	***Compliance Action response CA1.1***				

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Health Overview & Scrutiny Committee Update – Emerging Findings of the Non-Emergency Patient Transport Services Consultation

Purpose and Executive Summary (if paper longer than 3 pages):
To provide the Health Oversight Scrutiny Committee with an update on the Non-Emergency Patient Transport Service (NEPTS) consultation and an opportunity to review the emerging findings during this period of clinical and public engagement. These emerging findings are taken from the public survey, partner meetings and patient forums and further investigations by the NEPTS project team.

Background
Against the backdrop of rising demand and tightening resources, Oxfordshire Clinical Commissioning Group have been developed a five year strategy to make sure that services continue to be provided for the most vulnerable patients and at the same time make improvements to local service for those of greatest need that will advance patient experience and service quality.

As part of this programme of work, on 29th May 2014 the Non-Emergency Patient Transport Service (NEPTS) consultation was launched to review the eligibility criteria for those patients registered at an Oxfordshire General Practice.

In order to confirm the scope, stakeholder focus and the timetable for the consultation, a pre-consultation business case was presented at Oxfordshire's Health Overview and Scrutiny Committee on 1st May 2014. This was then subsequently approved by the Clinical Commissioning Group's Governing Body on 29th May 2014.

The aim of this consultation was to ensure that Non-emergency Patient Transport can continue to be provided for the most vulnerable patients in the future and make sure those patients who can travel by their own means, such as public transport, family or friend's car or taxis, do not inappropriately receive NHS-funded patient transport.

The public and those with an interest in or provide health and social care services were invited to feedback on two options that would restrict the eligibility criteria for this service and to highlight any other areas of eligibility criteria that could be considered. The proposals were:

Option A

- Patients capable of walking[1] and getting in and out of vehicles unaided and patients who can walk but require minimal assistance from a single ambulance crew[2] member to get in

[1] Walker journeys are those patients that can walk unaided and do not require any assistance in getting in or out of a vehicle.
[2] Single crew journeys are for those patients that require minimal assistance in getting in or out of a vehicle.

- and out of a vehicle will no longer be eligible for patient transport - these are people who can use the equivalent of a friend's or relative's car, taxi, public or voluntary transport
- Within the walker and single crew groups we would support continuing to provide patient transport to those receiving active care or treatment at the appointment by chemotherapy, radiotherapy, renal dialysis, eye surgery, deep vein thrombosis or vascular clinic treatment, patients who are up to six weeks post-transplant and those requiring care during transit, such as oxygen.

Option B

- The Clinical Commissioning Group sought to discuss with the public whether the CGC should make those who are receiving support in chemotherapy, radiotherapy, renal services and podiatry but not undergoing treatment at the appointment eligible in addition to the above.

Summary of Emerging Findings

- The majority of people agreed with Option A, to remove the majority of eligibility for walker and single crew journey, apart from the 8 treatment reasons cited.
- The public recognised the need for savings to be made and for the eligibility criteria to be robustly adhered to.
- The response levels to the consultation, in our experience, reflect that the proposals are not perceived as contentious
- The responses from partner agencies, patient partnership forums and the public expressed concerns related to:
    - The availability of public transport from rural areas and some towns in terms of both actual routes and operating times
    - Access to basic NEPTS, financial support and signposting information
    - The impact of the proposals on attendance rates for appointments
    - The availability of alternative local community and voluntary transport services
    - The need for integrated working to address wider transport issues across the county
    - Clearer eligibility criteria with respect to assessing mental capacity (especially important for those affected by long term confusion i.e. dementia) and specifically the frail and elderly
    - Accessibility to the main Acute hospitals and the need for additional hospital parking especially for volunteer drivers
- During the consultation an number of further areas were investigated:
    - The Clinical Commissioning Group met regularly with partner agencies to ensure the management of the project, importantly a number of areas of common interest are being pursued with the County Council with respect to the development of community transport plans.

- Data analysis has highlighted that 87 walker and single crew patients receiving podiatry treatment undertook 4400 journeys during 2013/14.
- There are examples of local high transport use that need to be reviewed with GPs and health care providers. For example 74% of all walker and single crew journeys in the county for Geriatric medicine take place in Banbury and the transport booking practices for care homes and intermediate care beds merit further investigation due to the high number of short 1-2 mile journeys taking place.
- That both rural and urban areas in Oxfordshire have very low volunteer scheme capacity for example Blackbird Leys, Chipping Norton, Faringdon, Kingston Bagpuize & Burford.

Further details on the consultation's recommendations and the action plan to mitigate the impact of the proposed changes to the NEPTS eligibility criteria are currently being finalised. This information will be published as part of the Clinical Commissioning Group's Governing Body report that will be issued in to the public domain on 16 September 2014.

The Clinical Commissioning Group wishes to thank all those that contributed to the consultation for their time completing the surveys, attending various meetings and for providing the CCG with their experiences and views which have shaped the outcome of this public consultation.

The Health Overview & Scrutiny Committee are asked to:

- Note the extent of the full public Non-Emergency Patient Transport Service consultation under section 244 of the National Health Service Act 2006 and the emerging findings
- Note that the full consultation report including recommendations and action plan will presented at the Clinical Commissioning Group Governing Body on 25th September 2014 and these papers will be published on the CCG's public website on 16th September 2014.

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Non-Emergency Patient Transport Services

Public Consultation Report

Contents

1. Introduction 3
2. Background 3
2.1. What are non-emergency patient transport services 3
2.2. Local – The picture in Oxfordshire 3
2.3. Who can use non-emergency patient services 3
3. Purpose of the public consultation 4
4. Process and Methodology 5
5. Key Findings 6
6. Next Steps 8

1. Introduction

Oxfordshire Clinical Commissioning Group (OCCG) funds and buys health services on behalf of everyone living in Oxfordshire. To do this successfully, OCCG needs to work with local people, Oxfordshire GPs, hospital clinicians, community healthcare and other partners including local government and the voluntary sector.

The following report reviews the public consultation on the proposed changes to the eligibility criteria for non-emergency patient transport services in Oxfordshire.

2. Background

2.1. What are non-emergency patient transport services?

Non-emergency patient transport services are provided to enable patients to get to NHS appointments in out-patient departments or for minor treatments or investigations. It is available for patients who are registered with a doctor's surgery in Oxfordshire.
Non-Emergency Patient Transport is provided free of charge to patients who meet the eligibility criteria; however, transportation is not an automatic entitlement and nor should Patient Transport Services be used for social needs, such as where a family member is unable to provide transport to an appointment. A number of volunteer or low cost transport services exist across Oxfordshire to support patients with a social need for transport who otherwise do not meet the NHS eligibility criteria. Some of these services apply their own eligibility criteria.

2.2. Local – The picture in Oxfordshire

This service is currently used by a wide range of patients, many of whom could travel by bus or car. The patient transport service costs the NHS in Oxfordshire over £3,700,000 a year and in the last financial year OCCG spent approximately £380,000 of this on patients who were able to use 'walk on' transport; that is patients who could travel by car and need no assistance in getting in and out of a vehicle. These patients are typically transported by the equivalent of a family car or minibus. Approximately £686,000 was spent on providing single crew transport for patients who required minimal assistance getting in and out of a vehicle. These patients also typically travel by family car or minibus, but a care assistant is available to help them get in and out. The remaining funding for patient transport was spent on patients with more complex needs, such as wheelchair bound patients requiring two people to assist them in and out of vehicles, patients requiring a stretcher during transit or those requiring care during their journey such as patients receiving oxygen.

2.3. Who can use non-emergency patient services?

The current eligibility criteria, also includes patients who:

• require continuous oxygen during transportation • require a stretcher

• cannot stand or walk by themselves more than a few steps and, • cannot travel by public transport or in a family or friend's car
• have a disability that prevents them from travelling by private or public transport
• have a medical condition that may deteriorate if they were to travel by private or public transport.

In 2011, Oxfordshire Primary Care Trust[1] consulted on the eligibility criteria for non-emergency patient transport services and it was agreed that patients who 'could travel by car and need minimal assistance in getting in and out of a vehicle' would no longer be eligible for non-emergency patient transport services.

3. Purpose of the public consultation

The purpose of the public consultation was to gather feedback on the proposed further changes to the eligibility criteria for non-emergency patient transport services in Oxfordshire. The public were invited to feed back on two options that would restrict the eligibility criteria for this service and to highlight any other areas of eligibility criteria that could be considered. The proposals were:

Option A

- Patients capable of walking and getting in and out of vehicles unaided and patients who can walk but require minimal assistance from a single ambulance crew member to get in and out of a vehicle will no longer be eligible for patient transport. These are people who can use the equivalent of a friend's or relative's car, taxi, public or voluntary transport.
- Within the walker and single crew groups, OCCG would support continuing to provide patient transport to those receiving active care or treatment at the appointment by chemotherapy, radiotherapy, renal dialysis, eye surgery, deep vein thrombosis or vascular clinic treatment, patients who are up to six weeks post-transplant and those requiring care during transit, such as oxygen.

Option B

- OCCG would further like to discuss with the public whether it should make those patients who are receiving support in chemotherapy, radiotherapy, renal services and podiatry but not undergoing active treatment at the appointment, eligible in addition to the above.

Under both options the consultation would enable the OCCG to explore and highlight any further areas of eligibility for consideration.

Some of those options could be:

- To assist in making voluntary sector support available to those patients no longer available for Non- Emergency Patient Transport Service (NEPTS).
- To offer more treatments closer to home so there is less need for patients to travel to central health care destinations. This is the direction of travel of OCCG's two and five year plan and strategy of joint funding and provision of services with partners such as Oxfordshire County Council (OCC).
- To work with the transport department in OCC and with partners within district councils to understand how public transport can better support patients and meet the needs of an aging population.

[1] Oxfordshire Primary Care Trust was the predecessor commissioning organisation to the CCG.

- To explore the reasons for inter-hospital transfers and determine how these could be supported in other ways or minimised.
- To explore the potential to support patients who do not meet eligibility criteria with fee paying options.

4. Process and methodology

The consultation was undertaken through the distribution of a paper survey to all patients using the Non-Emergency Patient Transport service during the three month consultation period, approximately 6000 copies of the survey were provided. The proposals were discussed at various stakeholder meetings as part of an on-going dialogue and an online and hard-copy survey were available on Talking Health. Individuals also had the opportunity for direct feedback via email, phone, or freepost. In total the survey was circulated to over 20,000 people.

The consultation was presented and discussed at various stakeholder meetings, as part of an on-going dialogue:

- Health and Wellbeing Board
- Health Overview and Scrutiny Committee
- Community Partnership Network
- Six Patient Locality Forums
- Six Clinical Locality meetings
- Practice Managers meeting
- Age UK Health and Social Care Panel
- Learning Disability Partnership Board
- Carers Oxfordshire Panel
- Autism Partnership Board
- Older People's Partnership Board
- West Oxfordshire District Council

In total 215 people responded to the survey, 74 of these were in hard copy format. Eleven written responses were also received.

The online/paper surveys were promoted in the following ways:

- Through all local media (TV, radio and print)
    - Publicity pre-consultation
    - Media interviews throughout the consultation.
- Community websites.
- Posters advertising the consultation were circulated to all 83 GP practices in Oxfordshire
- Voluntary sector organisations were notified of the consultation via Oxfordshire Community and Voluntary Action (OCVA), approx 620 organisations.
- A social media campaign was used to engage with over 4800 followers of OCCG's Twitter and Facebook pages.

- OCCG staff, and staff and Foundation Trust members (over 7000) at Oxford Universities Hospital's Trust and Oxford Health NHS Foundation Trust were notified via email and through the staff intranet.
- Age UK publicised the survey in their newsletter which is delivered to 10,000 households across Oxfordshire.
- Voluntary organisations such Autism Oxford, Carers Oxfordshire, Parent Voice, MIND, Restore and Age UK circulated the information to their service users/members and carers.
- Specific community/special interest groups were approached for their feedback, including My Life My Choice, Oxfordshire Unlimited, Patient Participation Groups (PPGs), parish councils and district councils, volunteer car driver schemes, good neighbour schemes, Oxford 50+ Network, Alzheimer UK and Patient Voice.
- Partner organisations including all the district councils, Oxfordshire County Council (OCC) and Oxford City Council were asked to promote the events to their staff and on their website.

Patient experience survey

As part of the consultation survey, we also provided people with the opportunity to tell us about their experiences of using the service in the last two years. Ninety three people completed the patient experience element of the survey, however, only 17 people stated that they had used the service in the last two years. It should be noted that 74 responses were received in hard copy format and as such people were able to leave some questions blank.

The data from the patient experience survey will be used to inform future developments to the current non-emergency patient transport service.

5. Key findings

Common themes emerged throughout the engagement both in the detail of the survey responses and from those who responded in writing and were spoken to at the stakeholder meetings. The key themes are outlined below.

- **Eligibility criteria**
  In general, people that responded to the survey agreed with the proposals and acknowledged the financial position of the CCG. People recognised the need for savings to be made and for the eligibility criteria to be robust and adhered to. This is clear from the survey responses where 93% of respondents agreed that NHS patient transport should be available for people who need it for a medical reason and that the reason why they need it should be checked.

  It should be noted however, that in the written responses from Oxfordshire County Council, and West Oxfordshire District Council, there was greater concern of the proposals disadvantaging those living in more rural areas, and that further work could be done in partnership to look at wider transport issues across the county.

  Option A
  Regarding the full proposals, it is clear that the majority of people agreed with Option A.

Option B
Of the responders ninety One people felt that patients attending an oncology clinic (for review without receiving chemotherapy or radiotherapy during the appointment) should continue to be eligible for patient transport

Slightly more people felt strongly about renal clinics, with 106 respondents feeling that patients should be eligible for non-emergency patient transport to attend a clinic for review without receiving treatment.

However, in comparison, 95 people agreed with the proposal that those attending a podiatry clinic for review without receiving treatment should no longer be eligible for patient transport service.

- **Rurality and equity of access**
  This was a strong theme throughout all types of responses to the consultation. Oxfordshire is a rural county and for elderly and frail patients, people felt strongly that travelling from remote parts of Oxfordshire to the main hospitals in Oxford would be challenging. Concern was raised that this could impact on attendance rates for appointments and that there would be a wider impact on services such as voluntary car driver schemes. People felt that there were opportunities for OCCG to mitigate the impact on these services through greater integration with other statutory providers and that alternative measures could be made to support patients who may not be eligible for patient transport should the proposed changes be implemented.

  Suggestions include:

  - Subsidised public transport
  - Encouraging more buses with wheelchair access
  - Bringing services closer to home
  - Changing appointment times to be in line with bus services

- **Mental health and vulnerable people**
  People felt strongly that the eligibility criteria needed to clearly reflect the impact of mental health conditions on people's ability to travel and that some measure for assessing mental capacity should be considered. This was especially important for those affected by dementia and Alzheimer, and specifically the frail and elderly.

  People were also concerned that for some patients, who do not have friends/family or support networks, the proposed changes may be detrimental and may impact on 'do not attend' rates across appointments.

- **Parking**
  Whilst respondents, in general, agreed with the proposals, the main concern raised around implementation was the impact any changes would have on parking at the existing hospital sites. It was felt that there were opportunities for OCCG to mitigate the impact of proposed

changes by negotiating additional parking at the hospital sites and making parking more accessible for volunteer car drivers.

- **Fee paying**
  People also felt that the NHS (CCG) should consider charging a nominal fee for the use of non-emergency patient transport services and felt that this could potentially be explored further.

Further detail of these themes can be seen in the appendices of this report.

Finally, it should be noted that the consultation was extensively publicised throughout Oxfordshire during the three month period. The response levels to the consultation, in our experience, reflect that the proposals are not perceived as contentious. Previous high profile consultations in Oxfordshire have attracted response levels closer to 1000.

Option A:

Patients capable of walking and getting in and out of vehicles unaided and patients who can walk but require minimal assistance from a single ambulance crew member to get in and out of a vehicle will no longer be eligible for patient transport - these are people who can use the equivalent of a friend's or relative's car, taxi, public or voluntary transport

Within the walker and single crew groups we would support continuing to provide patient transport to those receiving active care or treatment at the appointment by chemotherapy, radiotherapy, renal dialysis, eye surgery, deep vein thrombosis or vascular clinic treatment, patients who are up to six weeks post-transplant and those requiring care during transit, such as oxygen.

Option B:

We would further like to discuss with the public whether we should make those patients who are receiving support in chemotherapy, radiotherapy, renal services and podiatry but not undergoing active treatment at the appointment eligible, in addition to the above.

6. Next steps

The themes and feedback identified in this engagement report will be fully considered in further developing the eligibility criteria for non-emergency patient transport services in Oxfordshire.

This engagement report will be shared with those who participated in the engagement activity. The report will also be made available on OCCG's Talking Health website at: https://consult.oxfordshireccg.nhs.uk/consult.ti/5yrstrat/consultationHome To request a hard copy of this report, please email cscsu.talkinghealth@nhs.net or phone 01865 334638.

The next steps for the consultation are:

- 18th September - Summary feedback presented to the Health Oversight Scrutiny Committee
- 25th September – Consultation report and recommendations presented to the CCG's Governing Body.
- The Governing body will also consider the pace of implementation of the proposals. The original timeline proposed is as follows
    - 29th September – Consultation outcome letter sent to all respondents
    - 1st October – If agreed, any changes applied to new patient eligibility assessments
    - 1st November – If agreed, changes applied to new and existing patient eligibility assessments

Author(s): Julia Stackhouse, Communications and Engagement Coordinator on behalf of OCCG
Date: August 2014

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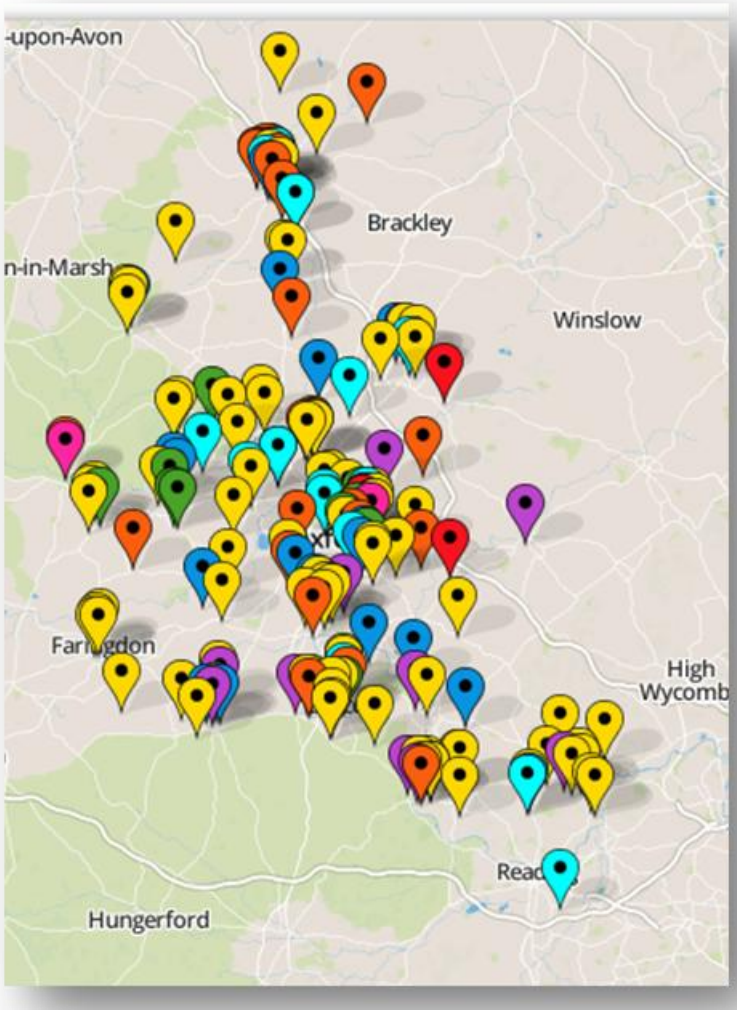
Appendix 1: Analysis of responses to consultation questions 1 – 7

In total 215 people responded to the survey, 95 of the respondents were people who had not previously used the non-emergency patient transport service but had a general interest in health matters. Sixty eight respondents were people who have used the current service or are a carer of someone who uses the service. The map below shows the spread of responses received across Oxfordshire.

Seventy four people responded in hard copy format and did not provide their postcode, so some of the responses shown below are not reflected on the map.



Question 1: Please tell us your interest in the NHS patient transport service?

44% of people responded to the consultation because they have a general interest in health matters. 18% of respondents had previously used the non-emergency patient transport service and 14% of respondents are carers of someone who has used the service.

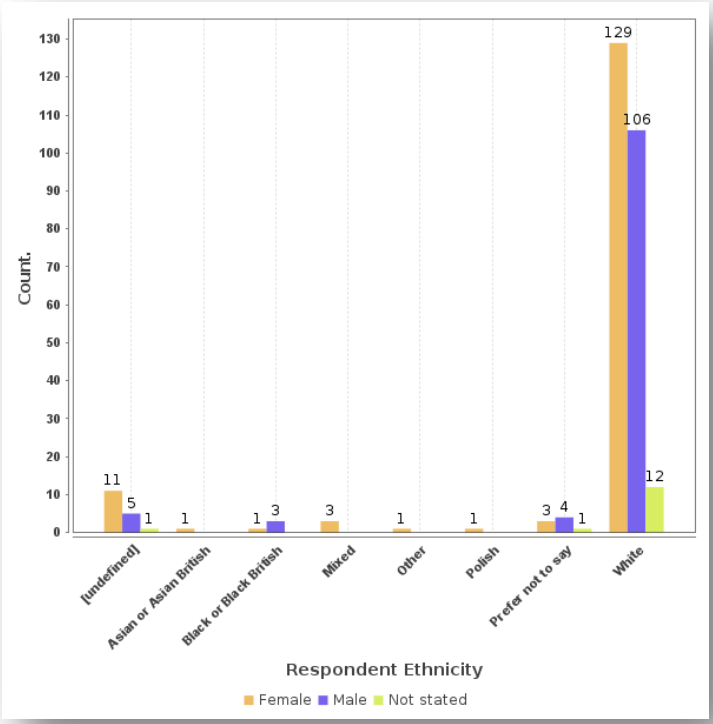
Appendix 1: Analysis of responses to consultation questions 1 – 7

Option	Results	
I am a patient that has previously used NHS patient transport		18% (39)
I am a carer for a patient that has used NHS patient transport		14% (29)
I am a patient or carer that has been denied NHS patient transport		0% (0)
I work within the Patient Transport service for SCAS		0% (0)
I am a volunteer driver / co-ordinator for a community transport service		7% (14)
I am a user of a community transport service		1% (2)
I am a member of NHS staff/work at a GP practice		6% (12)
I am an elected official, representing the views of my constituents		2% (5)
I support /work for an organisation which has an interest in patient transport		9% (19)
I have a general interest in health matters		44% (94)

The chart below shows the demographic split of responses to the survey by gender and ethnicity. In overall terms, the percentage of our respondents who defined themselves as Black/Black British was 1.4% compared with a 2011 census figure for Oxfordshire of 1.75%. However, 60% of our respondents were over 65 and among that age group the county percentage is 0.6%, indicating that our level of return is probably more representative for that group.

Our response form people defining themselves as Asian/Asian British was far more disappointing - 0.5% compared with an overall county figure of 4.85%. We used the health advocates who work with Asian communities to disseminate the surveys but are also mindful of the fact that there will be a concentration of this population in Oxford, where transport links are better.

Appendix 1: Analysis of responses to consultation questions 1 – 7



Question 2: Oxfordshire Clinical Commissioning Group (OCCG) has a finite amount of money to commission (purchase) health services and treatments for everyone in Oxfordshire. OCCG has to ensure that we improve the health and well-being of the population within the resources (both staff and money) available. This means that OCCG has to make difficult choices about the services it funds. With this in mind please could you tell us if you agree or disagree with the following statements?

Statement 1: NHS patient transport should be available for people who need it for a medical reason. The reason why they need it should be checked.

93% of respondents **agreed** that NHS patient transport should be available for people who need it for a medical reason and that the reason why they need it should be checked. In contrast 3% (six people) disagreed or strongly disagreed with this statement and nine people provided a neutral response.

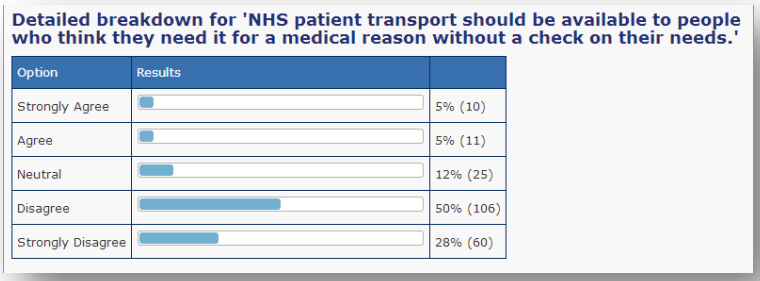
Detailed breakdown for 'NHS patient transport should be available for people who need it for a medical reason. The reason why they need it should be checked.'

Option	Results	
Strongly Agree		59% (129)
Agree		34% (74)
Neutral		4% (9)
Disagree		2% (4)
Strongly Disagree		1% (2)

Appendix 1: Analysis of responses to consultation questions 1 – 7

Statement 2: NHS patient transport should be available to people who think they need it for a medical reason without a check on their needs.

78% of respondents **disagreed** that NHS patient transport should be available to people who think they need it for medical reasons without a check on their needs. In contrast 10% of respondents agreed with this statement and 12% provided a neutral response.

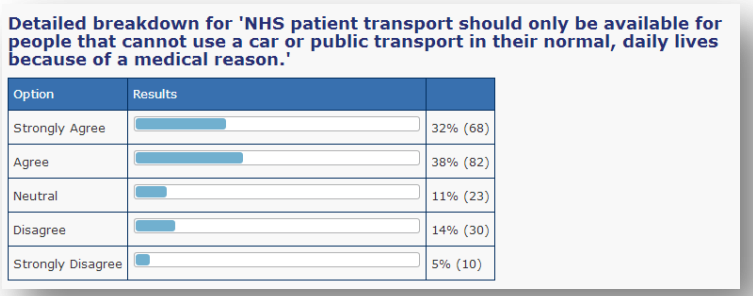


Detailed breakdown for 'NHS patient transport should be available to people who think they need it for a medical reason without a check on their needs.'

Option	Results	
Strongly Agree		5% (10)
Agree		5% (11)
Neutral		12% (25)
Disagree		50% (106)
Strongly Disagree		28% (60)

Statement 3: NHS patient transport should only be available for people that cannot use a car or public transport in their normal, daily lives because of a medical reason.

70% of respondents agreed that NHS patient transport should only be available for people who cannot use a car or public transport in their normal, daily lives because of a medical reason. In contrast 19% of respondents disagreed with this statement and 11% provided a neutral response.



Detailed breakdown for 'NHS patient transport should only be available for people that cannot use a car or public transport in their normal, daily lives because of a medical reason.'

Option	Results	
Strongly Agree		32% (68)
Agree		38% (82)
Neutral		11% (23)
Disagree		14% (30)
Strongly Disagree		5% (10)

Statement 4: Patient transport should only be available to people receiving direct treatment at the appointment (e.g. dialysis or eye surgery) or require care by a health professional during the journey and not for any other reason

The chart below shows that there was a narrow margin dividing views on this statement, with 42% of respondents **agreeing** that patient transport should only be available to people receiving direct treatment at the appointment or require care by a health professional during the journey and not for any reason, compared with 41% who **disagreed**. 18% of respondents provided a neutralresponse.

Appendix 1: Analysis of responses to consultation questions 1 – 7

Detailed breakdown for 'Patient transport should only be available to people receiving direct treatment at the appointment (e.g. dialysis or eye surgery) or require care by a health professional during the journey and not for any other reason'

Option	Results	
Strongly Agree		20% (42)
Agree		22% (47)
Neutral		18% (38)
Disagree		28% (60)
Strongly Disagree		13% (27)

Statement 5: Patient transport should not be provided by the NHS. People should make their own way to or from hospital or NHS services.

85% of respondents **disagreed** with the statement that patient transport should not be provided by NHS and that people should make their own way to or from hospital or NHS services. In contrast 7% of respondents agreed with this statement and 7% provided a neutral response.

Detailed breakdown for 'Patient transport should not be provided by the NHS. People should make their own way to or from hospital or NHS services.'

Option	Results	
Strongly Agree		3% (7)
Agree		4% (9)
Neutral		7% (15)
Disagree		35% (74)
Strongly Disagree		50% (105)

Statement 6: Patient transport should be available to everyone, whether their need is medical or social, but only if that person receives certain (e.g. disability) benefits

76% of respondents **disagreed** that patient transport should be available to everyone, whether their need is medical or social, but only if that person receives certain benefits. 10% of respondents agreed with this statement and 14% gave a neutral response.

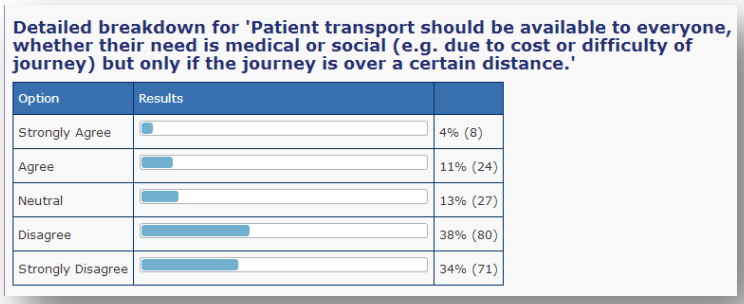
Detailed breakdown for 'Patient transport should be available to everyone, whether their need is medical or social, but only if that person receives certain (e.g. disability) benefits'

Option	Results	
Strongly Agree		3% (7)
Agree		7% (14)
Neutral		14% (30)
Disagree		34% (71)
Strongly Disagree		42% (89)

Appendix 1: Analysis of responses to consultation questions 1 – 7

Statement 7: Patient transport should be available to everyone, whether their need is medical or social (e.g. due to cost or difficulty of journey) but only if the journey is over a certain distance.

72% of respondents **disagreed** that patient transport should be available to everyone, whether their need is medical or social but only if the journey is over a certain distance. However fewer (15%) agreed with this statement and some (13%) provided a neutral response.

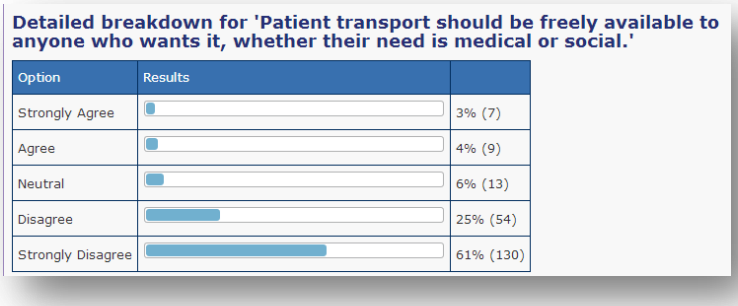


Detailed breakdown for 'Patient transport should be available to everyone, whether their need is medical or social (e.g. due to cost or difficulty of journey) but only if the journey is over a certain distance.'

Option	Results	
Strongly Agree		4% (8)
Agree		11% (24)
Neutral		13% (27)
Disagree		38% (80)
Strongly Disagree		34% (71)

Statement 8: Patient transport should be freely available to anyone who wants it, whether their need is medical or social.

86% of respondents **disagreed** that patient transport should be freely available to any who wants it, whether their need is medical or social. In contrast, 7% agreed that patient transport should be freely available.



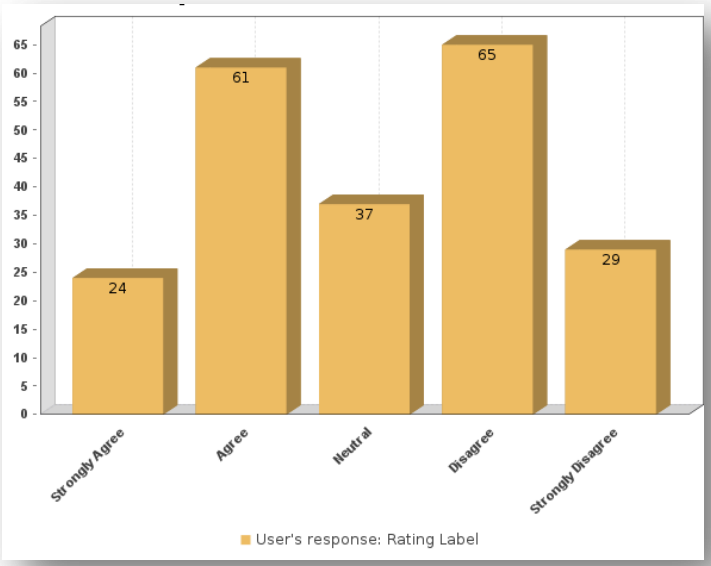
Detailed breakdown for 'Patient transport should be freely available to anyone who wants it, whether their need is medical or social.'

Option	Results	
Strongly Agree		3% (7)
Agree		4% (9)
Neutral		6% (13)
Disagree		25% (54)
Strongly Disagree		61% (130)

Question 3: Please could you tell us if you agree or disagree with the following changes to the eligibility criteria for non-emergency patient transport services:

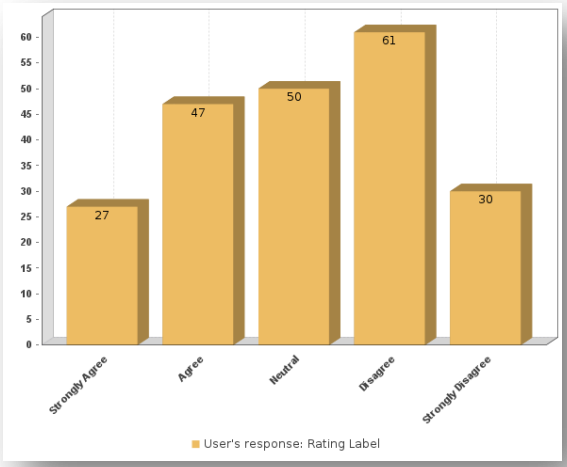
Statement 1: Patients that typically do not require management during transit, such as oxygen, who are currently accessing single crew ambulance cars, should no longer be eligible for non-emergency patient transport services under new criteria

Appendix 1: Analysis of responses to consultation questions 1 – 7



43% of respondents (94 responses) thought that patients who typically do not require management during transit, such as oxygen, who are currently accessing single crew ambulance cars, **should** continue to be eligible for non-emergency patient transport services, compared with 39% of respondents (85 responses) who thought that this category of patients should **no longer** be eligible under the new criteria.

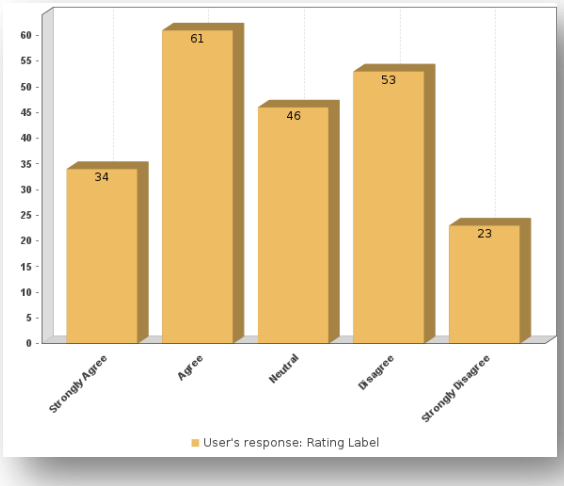
Statement 2: Patients that typically do not require management during transit, to attend an oncology clinic (for review without receiving chemotherapy or radiotherapy during the appointment), should no longer be eligible.



Appendix 1: Analysis of responses to consultation questions 1 – 7

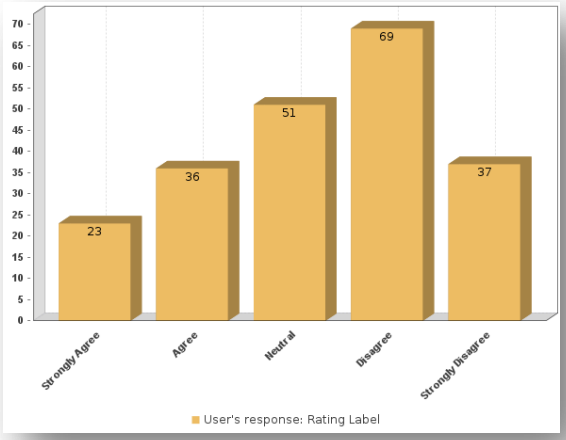
49% of respondents (91 responses) felt that patients who typically do not require management during transit, **should continue** to be eligible for transport. 28% of respondents (74 responses) agreed that these patients should **no longer** be eligible.

Statement 3: Patients that typically do not require management during transit, to attend an podiatry clinic (for review without receiving treatment), should no longer be eligible.



44% of respondents (95 responses) **agreed** that patients who typically do not require management during transit to attend a podiatry clinic should no longer be eligible to transport, compared with 35% (76 responses)who **disagreed** with this statement.

Statement 4: Patients that typically do not require management during transit, to attend a renal clinic (for review without receiving treatment), should no longer be eligible.



Appendix 1: Analysis of responses to consultation questions 1 – 7

42% of respondents (106 responses) **disagreed** that patients typically not requiring treatment, attending a renal clinic should not be eligible for transport compared to 35% (59 responses) who **agreed** with this statement.

Question 4: Do you have any other suggestions on how the eligibility criteria could be changed?

Sixty six people answered this question. Fourty six comments were made suggesting that each case should be made on merit, case by case and by a trained health professional, preferably a GP who knew the individual's health conditions.

There was concern that some people may not appear to meet the medical criteria, due to having co-morbidities or other health conditions that when considered together could impact on their ability to use alternative forms of transport to get to appointments. Comments were received about the importance of 'mobility' in the eligibility criteria. Many people may be mobile and physically capable of using alternative transport but have conditions that prevent them from doing so, such as mental health conditions, dementia, alzheimers, autism or they may be frail and have other conditions such as continence issues.

'Please consider the patients with mental health difficulties, such as dementia, who may be well able to stand and walk, however are going to easily get lost and become vulnerable. The same applies to other patients with different mental health conditions and with learning disability'.

'Your proposals are far too inflexible and take no account of the very elderly with multiple problems and in particular cognitive impairments. My 90+ parents could not use public transport - they would get get lost/confused/disorientated'.

There was general agreement that the eligibility criteria should be medically defined, as opposed to socially, however, it was felt that the criteria needed to be more explicit and clear, but at the same time robust and applied consistently.

'The person who makes the decision about whether the patient's medical condition should entitle them to receive transport should be a healthcare professional who understand that patient's medical condition: e.g. patients Parkinson's disease with fluctuating and unpredictable mobility could be eligible if, during their 'off medication' periods, they are unable to walk even if they can walk independently when in their 'on medication' state. Such patients would find it impossible to use public transport but I have known them to be refused NHS transport because they are known to be mobile some of the time'.

'Eligibility should be based on physical, mental and health needs only'

Appendix 1: Analysis of responses to consultation questions 1 – 7

It should be noted that over 10 responses came from individuals who would appear to still be eligible for patient transport even under the proposals.

Question 5: The current eligibility criteria states that patients who 'cannot stand or walk by themselves more than a few steps and, cannot travel by public transport or in a family or friend's car' are eligible for non-emergency patient transport services.

Oxfordshire CCG would like to change the criterion to the statement below. Please could you tell us if you agree or disagree with this change of wording:

Statement: Patients who: 'are unable to stand unaided by another person and cannot manage any journey in private or public transport for the purposes of daily living or have a disability and are genuinely unable to travel by private or public transport to and from their appointments or for the purposes of daily living by virtue of their disability' are eligible for non-emergency patient transport services.

75% of respondents **agreed** with the proposed change in wording to the current eligibility criteria in contrast 18% **disagreed with** the change.

Option	Results	
Strongly Agree		42% (92)
Agree		33% (71)
Neutral		7% (15)
Disagree		10% (21)
Strongly Disagree		8% (18)

Appendix 1: Analysis of responses to consultation questions 1 – 7

Question 6: Are there any additional areas that we should be considering in addition to the options detailed already?

53 people answered this question, the key themes raised were:

Rurality and equality of access

21 comments were received raising concerns that access to Oxford hospitals from all parts of Oxfordshire is not equal and that patients attending appointments should be considered eligible for patient transport if they are unable to access their appointment due to lack of available public transport or volunteer driver car schemes. People were also concerned about the disparity between someone being able to travel locally on public transport and someone being able to navigate longer distances in unfamiliar environments, noting that some routes to Oxford may require multiple bus changes and therefore may be perceived as too complex for some elderly and frail individuals who may be mobile and therefore considered not eligible.

'Trying to frame an across the County set of criteria will mean equality of access is not achieved. Eligibility Criteria for those living within the Oxford City/Abingdon bus services area should be more restrictive than those where there are no bus services. Location, public transport services must be considered'.

'You need criteria that include the frailty/disability level of the patient and/or those travelling from places from which public transport is either non-existent or involves a long and complex journey'

Suggestions to overcome this include:

- prioritise availability of patient transport by bus routes
- change appointment times so that people can use their bus passes to travel on public transport
- maximise alternative travel options, eg: subsidised taxis, more buses with wheelchair spaces
- encourage the public to offer lifts
- bring services closer to home
- encourage bus companies to service towns better

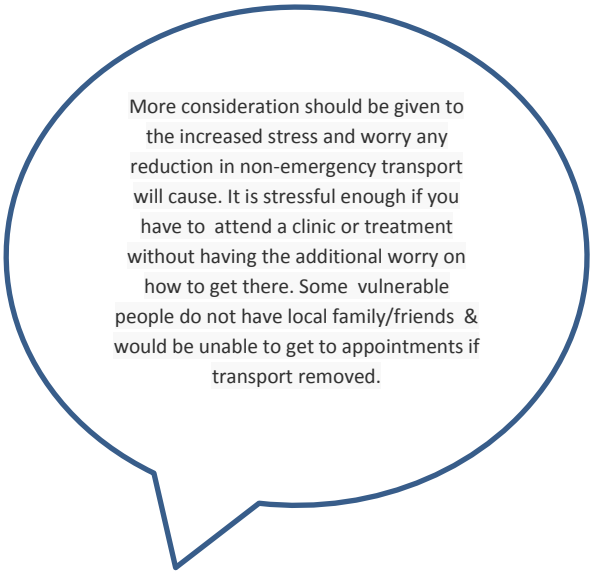
Will there be any increase in the number of wheelchair spaces on Oxford's buses? With only one space per bus (currently) the move of patients onto other means of transport could overload the available services.

Some cosideration has to be given to patients that live in an area with little or no public transport and where no voluntary transport facilitiess are available. A patients circumstances always needs to be considered.

Appendix 1: Analysis of responses to consultation questions 1 – 7

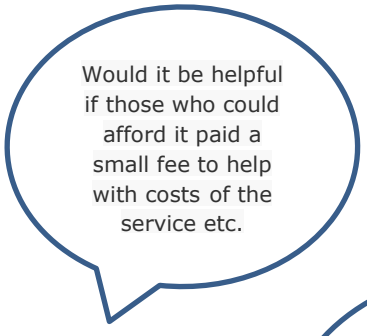
Mental Health

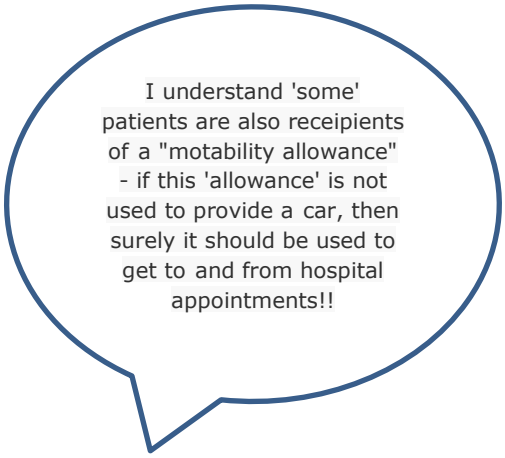
There was a trend throughout the responses that the medical criteria do not take into account any mental health conditions that may prevent an elderly or frail person being able to access alternative forms of transport. 22 comments were received specifically relating to concerns around mental health and cognitive impairment. People also felt strongly that there needs to be some 'safety net' provision for people who do not have friends or family to rely on. The main concern for these patients is that if they are not asked about their personal circumstances as part of the eligibility criteria they may not attend their appointments. This in turn could potential lead to an increase in missed appointments and wider use of the 999 service.



Fee paying

11 comments were received relating to charging people for using patient transport services. In some cases this was suggested as an alternative offer for patients who are not eligible. People also felt that there needed to be further work done to maximise alternatives for people, either through means-testing or funding for volunteer car driver schemes to develop further.





Appendix 1: Analysis of responses to consultation questions 1 – 7

Question 7: If you have any other comments you would like to make about this consultation or the future of NHS patient transport, please indicate below.

Seventy nine people answered this question, raising themes that have already been covered in Question 6 and Question 4. The main themes were:

Parking

Ten comments were made about parking issues and how this impacts on the proposals to the change in eligibility criteria. Specifically people felt that parking at the hospitals was expensive and that for some individuals attending multiple appointments this would not be financially viable. In addition to this, availability of parking can determine how viable it is to access appointments by car.

If you made car parking free this would be more encouraging for use of private transport.

Where-ever in the policy the patient is required to fend for him/herself then facilities must be adequate access at the destination. I am thinking for example of parking at cost with easy access to the place of appointment.

The consultation should consider the impact the changein transport eligibility will have on car parking/access to the hospitals. For example, 50 dialysis patients arrive at the Churchill around 8am (i.e. before the clinics properly start). At the moment they most arrive on transport, perhaps 10 minibuses/vehicles (I guess). If less patients were eligible then the number of vehicles needing access will increase. Space on that (and all hospital sites) is minimal and even a small increase would impact significantly. The issue would be compounded at lunch and supper-time - when one NEPTS minibus can drop off 5 people and pick 5 people us (one minibus for 10 journeys rather than 10 vehicles for 10 individual journeys).

Volunteers car driver schemes

Incorporated within the responses there were a variety of mentions of volunteer driver schemes and concerns were specifically raised about the availability of such schemes to cope with increased demand, and whether the availability of such schemes is equitable across the county. Respondents felt that having dedicated porter services and parking for volunteers drivers would be beneficial.

Improved parking facilities would be a great help. Some volunteer drivers decline going to addresses where it can be a 'nightmare'.

It would help people who are disabled but can drive if contact could be arranged at the car park so that a porter/volunteer could assist them on the sometimes long journey to a department/ward

Within this consultation there must be consideration of how volunteer driving schemes can be supported and funded to meet the proposed increased demand.

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Appendix 2: Key findings from stakeholder meetings

The three month public consultation solicited views from a broad spectrum of the community and local transport providers. Ten public meetings and patient focus groups were held to present the Non-Emergency Patient Transport Services proposals. These were led by a member of the Clinical Commissioning Group's NEPTS project team, NHS Communications team or the Assistant Director for Urgent Care.

The meetings were as follows:

- Older People's Partnership Board – 3 June 2014
- Community Partnership Network – 4 June 2014
- South East Oxfordshire Locality Forum – 12 June 2014
- North Oxfordshire Locality Forum – 18 June 2014
- Carers' Voice Panel – 19 June 2014
- Older People's Health and Social Care Panel (Age Uk) – 26 June 2014
- South West Locality Forum – 15 July 2014
- Learning Disability Partnership Board – 21 July 2014
- West Oxfordshire District Council

At these forums a presentation was given and then an open question and answer session took place where the attendees were invited to raise questions and comments.

Common themes emerged throughout the engagement and in the detail of the survey responses, these are outlined below.

Key themes from the stakeholder events

The following explores the key themes and suggestions that emerged from the questions and suggestions made at each event that took place during the consultation.

As the consultation period progressed, it became clear that many members of the public understand and accept that NHS resources are constrained and those patients that are currently eligible for the transport categories of 'walker' or 'single crew assistants' would need to seek alternative ways of attending their appointments under the terms of the proposal.

Strategic planning and joint integration

The stakeholder forums' voiced a strong desire to see further co-operation between transport providers and commissioners in Oxfordshire so that any changes are not undertaken in isolation.

> 'An opportunity is presented by the current OCC review of transport and the review of PTS to integrate transport for the most vulnerable much more effectively than at present.'
>
> (Age UK).

In particular it was noted that such planning discussions should involve the commercial transport providers since the majority of the local transport provision is provided by them. A number of potential integration ideas were mooted including exploring joint NHS and Local Authority transport resources, the market development of commercial bus routes to be re-routed to hospital sites and sustainable funding options.

Participants highlighted that the short timescales for the implementation of any changes to the criteria would not permit for longer term and sustainable multi agency engagement and sought assurances that the plans for such work be developed as soon as possible. In their response to the consultation Oxfordshire County Council has highlighted that they are;

> "already in dialogue with OCCG regarding the possibility of the channelling resources to provide a coordinated and enhanced offer of support to the CT sector in light of the proposed changes to NEPTS."

Patient impact

The Health & Social Care Panel made the point that to enable people to maintain their independence and wellbeing in the community the ease of access to health care is essential.

The main patient groups identified as being most at risk by the respondents were those patients with long term confusion (dementia), those who can walk but were too immobile to access public transport and people living in rural areas where there is poor access to public transport.

The provision of rural public transport links to health care treatment centres was raised, in particular the need to develop rural bus routes direct to health care sites and to maintain those rural bus routes subsidised by the County Council (the latter being outside of the scope of this consultation).

A number of other patients groups were cited during the consultation, such as those who use wheelchairs or other specialist equipment or who require emergency transport. However, it is worth noting that such groups would still be eligible under the new proposals and that the consultation was specifically for the non-emergency patient transport service.

It was the view of two groups that the patient's ability to attend a hospital appointment would possibly result in an increase in the 'Did Not Attend' levels.

Treatment closer to home

The development of local health services was strongly supported at a number of forums; the benefits cited included improved general access to care to the local population, reduced distances and number of journeys that both patients and transport providers would have to make.

The ability to flexibly plan and then cluster outpatient appointments around geographical areas was also presented at two of the meetings, the benefit being to reduce the number and distance of the journeys required. These might include the 'consultative' and 'non-active treatment' based appointments and could be conducted in a health centre or similar.

Booking, information, provision and signposting

Consistent challenges from a range of community volunteer groups and patient forums were the needs for high quality, easy to access information and personable advice to patients and carers on the assessment process, eligibility criteria, alternative transport services and if appropriate details of

the Health & Travel Cost Scheme. In relation to financial support, Age UK cited that the NHS Health & Travel Cost Scheme was a closely guarded secret.

> "It has been found that many people do not know about the current criteria for PTS travel or that certain benefits can enable them to apply."
>
> West Oxon District Council, Social & Economy Scrutiny Committee, NEPTS Briefing Paper, July 10th 2014

A number of points were identified in relation to the booking criteria. These centered on the need to consistently apply the criteria, making the criteria as simplistic as possible and being clear that the criteria were based on medical not social needs and that the former centred on the patient's disability, mobility, medical condition or the likelihood of suffering from any side effects from the treatment received at the appointment.

It was felt that the timing of appointments needs to be reviewed to see whether efficiencies could be made and whether appointments could be booked to account for difficulties that the patient might have in relation to their transport needs (for instance booking later in the day to account for bus timetables).

Age UK highlighted the role that the Oxfordshire Travel Advice & Information Line (OxTAIL) has had in assisting the public to navigate through the system and saw an opportunity in this service being the central integrated source of transport information in the county. More should be done in the promotion of this service particularly through GP practices and the Community Information Partnership.

Further to this, the County Council have sought to clarify the how ineligible patients are informed of the reasons for refusal and the alternative options so as to reduce the patient frustration that is observed by the Oxfordshire Travel Advice Line.

Alternative options

The capacity of the volunteer car schemes as an alternative for patients who are no longer eligible to receive non-emergency patient transport was raised by the Community Partnership Network. The implication being that there might be insufficient capacity to absorb the increased demand. Age UK cited that the mitigation of this might be found in the development of an integrated transport plan as discussed above.

Practical transport issues

The availability of adequate parking for family, friends and volunteer drivers has been questioned as the demand for volunteer driver spaces and general parking will increase due to the proposed changes in eligibility criteria. Age UK suggested that "Entrances to car parks often show full but the parking for disabled is empty" more could be done in this regard.

Further to the implications of changes in eligibility is the potential that more people will require assistance getting in and out of conventional cars used by family and friends rather than the vehicles used by the single crew ambulances.

Cross county board transport

This was an area not covered under the consultation since proposed changes to eligibility criteria will only apply to patients registered to an Oxfordshire GP. Further communication on this will be provided.

Appendix 3: Feedback from written responses

In addition to the stakeholder events and public survey, we also received 11 written responses; these included responses from the Community Partnership Network (CPN) in Banbury, West Oxfordshire District Council, Age UK, Carers Voice and the Oxfordshire County Council's Supported Transport programme. The corporate responses will be displayed in the OCCG public website.

Corporate response concerns were most strongly reflected from the **C**ommunity Partnership Network, West Oxfordshire District Council and West Oxfordshire District Council

- West Oxfordshire District Council determined that neither of the proposed options as shown in the report can be supported;
- CPN raises a number of concerns and amongst many requests call for the CCG to approach this exercise from patient need and have flexible guidelines based on this
- OCC Supported Transport Programme response requests that any likely pressure on these services and related services, such Oxtail service are understood and supported.
- Age UK have echoed concerns of others on Integration of transport solution, importance of information provision and important practicalities such as parking and drop off

There was recognition of OCCG's need to save money and in general respondents agreed with the proposals. However, it was felt by five of respondents that this needs to be in partnership with other statutory services and that transport as whole needs to holistic.

'The PTS is part of a much wider countywide transport 'whole system', a system that is not without flaws, all of which impact on other parts of the system. One part of the system cannot make changes without impacting on the rest of the system and impairing still further the ability of people – particularly the more frail, whose independence is already seriously compromised – to get around'.

The main areas addressed in the written responses were:

- Funding for community transport
- Elderly and Frail, impact of people who have co-morbidities
- Rurality and equality of access across the county, including cross boundary issues

'I would agree that cuts need to be made and that non-essential transport need to be considered'

Some specific suggestions were made for OCCG to explore in mitigating the impact of any changes following these proposals, which included:

- Exploring bus subsidies for people who are not eligible
- Exploring additional funding for volunteer driver schemes
- Investigating a nominal fee charge for the use of non-emergency patient transport
- Delivering more care closer to home, so people don't have to travel
- Ensuring that there is greater wheelchair provision at the hospital sites
- Improving parking facilities at the hospital sites
- Providing greater information to patients about the eligibility criteria and the options available to patients who are not eligible.

'Consideration should also be given to how difficult it is to actually get a parking space at the John Radcliffe and Nuffield Orthopaedic hospitals at the moment and would need to increase car parking facilities'

'Sadly the public availability of wheelchairs for patients at most hospitals in Oxford is unreliable, if it exists at all'

It should be noted however, that some of the respondents asked for a longer implementation period to ensure that any changes were rigorous and communicated appropriately to people in Oxfordshire.

Appendix 4: Glossary

- **Non-Emergency Patient Transport services (NEPTS)** are provided to enable patients to get to NHS appointments in out-patient departments or for minor treatments or investigations. It is available for patients that are registered with a doctor's surgery in Oxfordshire.

- **Walker** – requires no assistance - can manage steps, mobility needs will normally be met by a car with a Voluntary Car Driver (VCD) but may be a minibus or ambulance.

- **Single Crew Vehicle** – requires minimal assistance, no attendant in back with them during journey – may require use of wheelchair to or from vehicle and the patient will need to easily transfer with one person out of the wheelchair and onto a seat in the ambulance for the journey.

- **Carer -** Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment.

- **Commissioning** - The process of specifying, securing and monitoring services to meet people's needs at a strategic level.

- **District and City Councils** - These cover a smaller area than county councils. They are responsible for services like: Rubbish collection; Recycling; Council tax collections; Housing.

- **Facebook** - Social networking website where people can share views, information, comments and pictures.

- **Healthwatch Oxfordshire** - An independent organisation that listens to people's views and experiences of health and social care in Oxfordshire. From April 2013 this organisation replaced the Local Involvement Network (LINK).

- **HOSC** – Health Overview and Scrutiny Committee.

- **Oxfordshire Travel Advice Line (OXTAIL**) **-** offers free impartial advice on a range of transport options for older people or those with a high level of support needs. Please call us to see where we can help in planning your journey

- **Stakeholders -** A person or group with a direct interest, involvement, or investment in something. Stakeholders are individuals or organisations that have a direct interest in a service being provided.

- **Twitter -** Twitter is a social networking tool aimed at enabling its users to exchange up-to-the-minute news and opinions on specific topics in just a few words.

- **Talking Health –** Oxfordshire CCG's consultation and engagement area on our public website (see https://consult.oxfordshireccg.nhs.uk).

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Healthwatch Oxfordshire

Update for the Health Overview and Scrutiny Committee – 28th August 2014

1 Introduction

1.1 On July 3rd HOSC received a comprehensive report from Healthwatch Oxfordshire on the activities the organisation has undertaken to date. The new CEO, Rachel Coney, took up post on July 21st and this short report is to update HOSC on key actions and decisions taken by Healthwatch during her first month in post.

2 Governance

2.1 Healthwatch is grateful to Jean Nunn Price and Dermot Roaf for stepping into the Chair and Vice Chair roles on an interim basis in June of this year. The organisation is now actively seeking a new Chair and new Directors to bring its board up to full complement.

2.2 Plans are also being progressed to set up a wider reference group to strengthen the organisation's listening capability.

3 Project Fund

3.1 One of the mechanisms Healthwatch uses to enable the voices of the particular patient and service user groups to be heard is through its project fund. Small sums of money and expert advice are provided to groups to enable them to research and relay the experience of their members.

3.2 During the autumn, reports researched and written by the Asian Women's network and Oxford University Students will be published by Healthwatch. These will make recommendations to a variety of commissioners and providers, who are currently being given the opportunity to review drafts ahead of publication.

3.3 Grants have recently been awarded to Restore to undertake research into best practice in service user participation in mental health services and to the Oxfordshire Neurological Alliance to identify gaps and weaknesses in patient experience of neurological services.

3.4 Local health and social care organisations have responded well to these reports, and Healthwatch is now developing its internal mechanisms for tracking the commitments made by others to deliver change as a result of our project fund work, in order that those organisations can be held appropriately to account .

4 Healthwatch initiated research

4.1 Healthwatch initiated a research project into patients' experience of accessing GP services in the County. The pre-publication draft of this report will be with the relevant parties for review by early September, and it will be published approximately 4 weeks later.

4.2 At its August meeting, the Board agreed that the following areas should form the focus of Healthwatch initiated research over the next six months:

4.2.1 Patient and carer experiences of the quality of the discharge process from acute and community hospitals in Oxfordshire.

4.2.2 The degree to which patients and services users experience dignity in the care they receive in the County.

4.2.3 The impact of the recent changes in prison healthcare commissioning and provision on prisoners' access to healthcare in Oxfordshire.

4.3 Where possible, this work should be conducted by volunteers trained under Healthwatch Enter and View powers to do qualitative research in care settings.

4.4 The next step is to scope and develop full project proposals for each of these areas and to agree with the relevant agencies and potential partners, exactly how and when this research will be conducted.

5 Raising awareness of Healthwatch Oxfordshire

5.1 Healthwatch needs local people to share their stories of health and social care with us. Over the autumn we will be seeking to increase the amount of information the public bring to us, and will be developing our internal systems tracking and analysing this information.

5.2 We will have a particular focus on rising awareness of what we do with children and young people, in order to ensure we hear their stories, as well as those of the adults in our communities.

6 Events coming up

6.1 Healthwatch is working with OCVA to stage a conference for voluntary organisations from across Oxfordshire. The event will take place on October 1st and it will:

6.1.1 Showcase work already undertaken by Healthwatch in partnership with the voluntary sector.

6.1.2 Be a practical demonstration of how we can work together, as we will be actively seeking information from voluntary organisations to inform the CQC's planned inspection of Oxfordshire GP practices.

6.1.3 Seek the views of voluntary organisations on our future priorities.

6.2 On September 10th Healthwatch and the University of Oxford Health Experiences Institute are co-hosting a debate about the national proposals to opt patients into the care.data system, which will extract data from GP practice systems. This NHS England project, originally scheduled to launch earlier this year, has been officially paused while NHS England undertake a national listening exercise. Our debate will be chaired by Dame Fiona Caldicott and will give local people the chance to explore their concerns with two members of the national care.data advisory panel and a member of the Healthwatch England national committee. A film of the debate will be submitted to NHS England to inform their future decision making on this subject.

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Division(s):N/A

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE – 18 SEPTEMBER 2014

Oral Health of Children in Oxfordshire

Introduction

1. This paper will discuss the oral health of children in Oxfordshire and outline the statutory responsibilities of the Oxfordshire County Council in relation to oral health services.

Exempt Information

2. There is no exempt information contained within this report.

National and local context

3. Oral health is an integral part of overall health. A significant proportion of the population in England experience very good levels of oral health. Successive oral surveys have shown that child and adult oral health has been improving over the past 30 years. However, the vulnerable, disadvantaged and socially excluded groups are at greater risk of oral diseases affecting their teeth, gums, supporting bone, and soft tissues of their mouth, tongue and lips.

On 1st April 2013 the statutory responsibility for the commissioning of dental public health functions transferred from the NHS to local government.

The dental public health functions of LAs are described in regulations and include a statutory requirement to provide or secure provision of oral surveys. The statutory instrument states that:

A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area—
Oral health surveys to facilitate—

i. *the assessment and monitoring of oral health needs,*
ii. *the planning and evaluation of oral health promotion programmes,*
iii. *the planning and evaluation of the arrangements for provision of dental services as part of the health service, and*
iv. *where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.*
v. *The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.) so far as that survey is conducted within the authority's area.*

Domain 4 (Healthcare public health and preventing premature mortality) of the Public Health Outcomes Framework includes and indicator relating to “tooth decay in children aged 5.” Continued local dental epidemiology survey provision will be required for the monitoring of this indicator.

Oral Health of Children in Oxfordshire

The oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (formerly known as the national dental epidemiology programme). Surveys are conducted annually, usually over academic years. They are carried out on randomised stratified samples although the commissioning bodies can opt to commission wider surveys e.g. census surveys. The surveys are co-ordinated and supported by a team from Public Health England (previously the Dental Observatory which was part of the North West Health Observatory). This team develops the survey protocols, delivers examiner training and collates and disseminates the data.

In the 2007/08 and 2011/12 surveys of 5 year old children the primary sampling unit was the district authority. The latest survey of 5-year-old children, for which full results are available, was carried out in 2011/12.

Tooth decay (dental caries) is the most important oral disease in children. Dental caries is commonly measured using the dmft index, which is a record of the number of decayed (d), missing (m) and filled (f) teeth (t). Data are usually expressed as $d_3$mft where a tooth is considered as decayed when there is obvious decay into the dentine of the tooth.

The Oxfordshire data for mean $d_3$mft for the 2011/12 and 2007/08 surveys are shown in figure 1. It can be seen that the average number of decayed, missing and filled teeth ($d_3$mft) for 5yr old children in Oxfordshire is 0.98, which overall is statistically similar than national levels ($d_3$mft = 0.94).

- The mean number of 5yr olds with decayed, missing or filled teeth in Oxfordshire has increased slightly in 2011/12, however is this based on a smaller sample size (approximately 26% of all 5yr olds).
- Cherwell and Oxford City continue to have higher than the national average in terms of numbers of decayed, missing and filled teeth for 5yr olds.
- The rate of decay in 5yr old children in West Oxfordshire increased since the last survey. It is thought that this increase is likely due to a statistical anomaly created by the sampling methods used for surveying the children.
- The mean for South Oxfordshire and the Vale of the White Horse is lower than England.

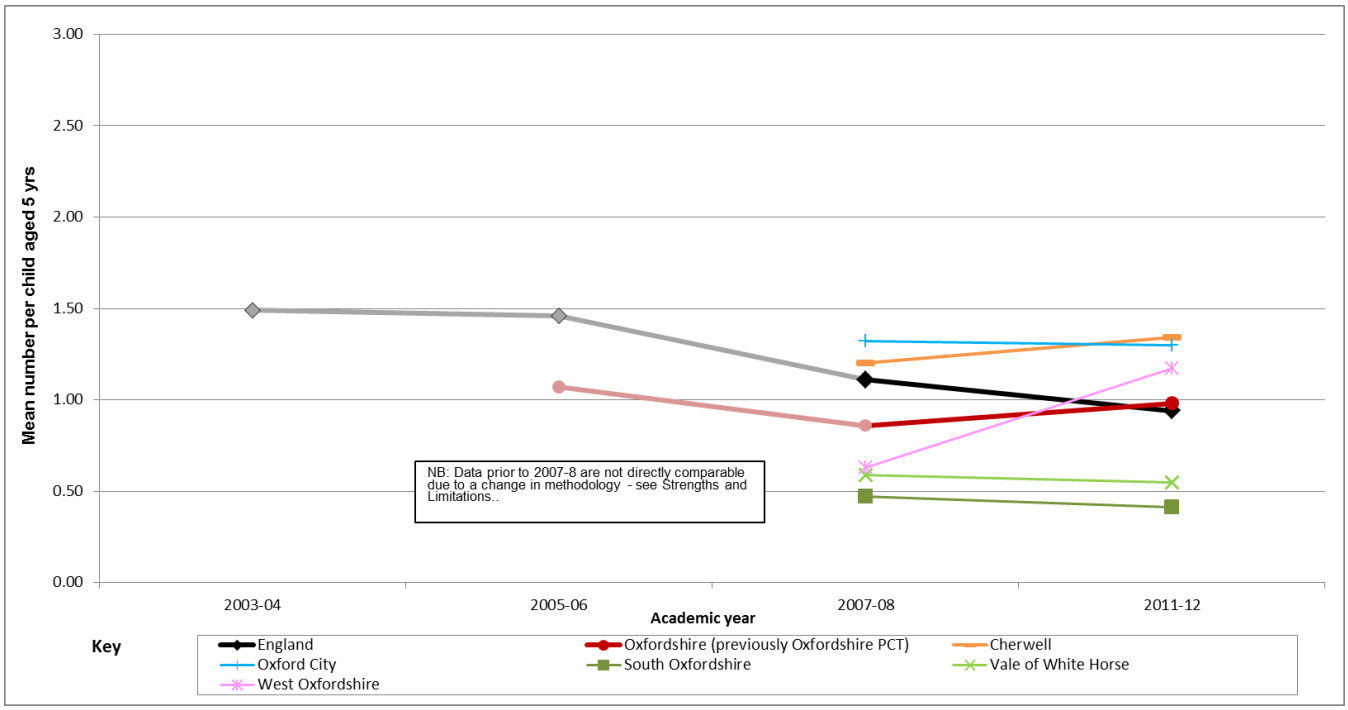

Figure 1 Mean $d_3$mft in 5 year old children in Oxfordshire 2011/12, 2007/08

4. *Actions being taken to address oral health issues in children in Oxfordshire*

- Access to services is an important factor in reducing oral health inequalities. OCC considers access from an early age an important issue and in April ran a campaign in pharmacies promoting the attendance of young children at the dentist to establish a relationship with a family dentist from an early age.

- The public health directorate are consulting with our current provider to deliver a work programme to meet the local need to improve oral health behaviours for the current financial year. Actions being taken include;

    - Provision of training for health and non-health professionals working with children
    - Accreditation of settings for early years and primary school settings
    - Wider oral health promotion including signposting to services, social marketing, resource development and partnership working

The service is prioritising areas of need based on latest survey work and sociological indicators agreed with the commissioners.

- The contractual arrangement for the current services expires 31 March 2015. The services of dental epidemiology and oral health promotion from 1 April 2015 is currently out to tender. The service being tendered will aim to:

1. Provide local oral health data in line with national protocols
2. Improved knowledge of how to access NHS dental services in the wider public
3. Contribute to the reduction in health inequalities relating to dental care, with a priority focus on children, older people and vulnerable groups;
4. Achieve best value and make best use of the dental public health budgets
5. Develop oral health promotion services to meet best practices and population needs

Equalities Implications

5. The public health directorate will continue to work in partnership with NHS England as commissioners of dental services and advocate the provision of services which reduce access barriers to the local community and in turn contribute to the reduction oral health inequalities.

RECOMMENDATION

6. **The Oxfordshire Joint Health Overview & Scrutiny Committee is RECOMMENDED to note the statutory dental public health functions of the Local Authority, the current oral health of five year old children in Oxfordshire and the actions being taken to provide dental public health services for the local community.**

Jonathan McWilliam
Director of Public Health

Background papers:

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September 2014

Developing Musculoskeletal Services in Oxfordshire – a briefing on engagement activity

Introduction

This brief contains an outline of engagement activity undertaken to date to support Oxfordshire Clinical Commissioning Group's Musculoskeletal Services project and planned engagement activity for the next phase of the project.

Background

Musculoskeletal (MSK) services in Oxfordshire are commissioned by Oxfordshire Clinical Commissioning Group (OCCG). One of the largest contracts in MSK services in the county for the Musculoskeletal Triage and Tier 2 Treatment Service is held by Oxford University Hospital NHS Trust (OUHT) and is due to expire in 18 months. OCCG is required to develop a commissioning strategy within the next 12 months for an MSK service that is future fit, meets patient need, is efficient and provides a quality service for Oxfordshire patients. To do this we need input from patients, the public and clinicians. The project is being managed in two phases:

1. Phase one: Strategic Outline Business Case (Current state analysis and 'what constitutes a good service'). To be presented to the OCCG Clinical Executives on 23rd September 2014.
2. Phase two: Full business case (future state analysis with recommendations for change). To be presented to the OCCG Clinical Executive on 25th November and OCCG Governing Body on 27th November 2014.

As part of the current state analysis OCCG has explored feedback from both patients who have used the service, GPs and hospital clinicians. The CCG has also conducted data analysis to understand the current demand for the service and patient and clinician experience.
As part of this work OCCG has identified an increasing number of referrals and rising expenditure with the service. The financial impact of this rising demand cannot continue to be met within the current service model.

Patient Advisory Group (PAG)

An invitation was circulated to patients with experience of MSK services in Oxfordshire within the last two years to join the MSK PAG; via Talking Health (OCCG's online public consultation tool which has a membership of more than 2,500 Oxfordshire residents), via our locality Patient Participation Groups; via our Equality and Access Commissioners and our stakeholder networks.

The PAG consists of 14 Oxfordshire residents. Among these members, 13 are MSK patients and one is a carer of an MSK patient. The PAG have nominated a representative who also sits on the CAG and MSK Project Steering Group.

Clinical Advisory Group (CAG)

The membership of the MSK CAG include Clinicians from across OCCG's localities, those with an MSK specialism and MSK clinicians from provider organisations in Oxfordshire.

Both PAG and CAG groups met weekly for four weeks to discuss the MSK pathway, to explore and understand what works well highlight delays, issues and inefficiencies that occur and exist between services and providers as well as discuss what constituents a good service.

Communications and Engagement Aims
The aims of the communication and engagement strategy are;

- To provide clear, timely information about the need to make changes to Musculoskeletal services in Oxfordshire, to improve patient experience and meet the financial challenges the NHS is collectively facing
- To provide communications on involvement opportunities to maximise engagement in the project
- To ensure that feedback from patients, key stakeholders and the public on the current service is captured and opportunities are offered to help shape the future service.

Phase One – Engagement Activity To Date
OCCG have just completed the first phase of engagement to help inform an outline strategic business case proposal for the future of MSK services in Oxfordshire.
A Patient Advisory Group (PAG) and a Clinical Advisory Group (CAG) was established to explore MSK services in Oxfordshire. These groups fed into an overarching MSK project steering group.

The OCCG MSK project team have identified the following opportunities;

- Review of MSK services to ensure value for money
- Improve referral quality to reduce the number of patients who are treated in secondary care
- Make sure care pathways are integrated and efficient
- Maximise opportunities to deliver care in the most appropriate settings

Phase One – Key Findings
Some of the key themes that emerged during the Patient Advisory Group and Clinical Advisory Group meetings were:

- Good quality treatment once seen by the appropriate clinician
- Issues with accessing services in a timely manner
- System is confusing for clinicians and patients
- Delays between referral and appointment booking
- Delays between assessment and treatment
- Some patients are not being seen in the right place first time
- Inefficiencies in communication and exchange of clinical information between clinicians and providers – not integrated
- Need for patient information about care, treatment and care pathway at the outset
- Need for facility for patients to track their referrals and appointments throughout the pathway

Phase two – Engagement Activity Planned

The next phase of engagement will inform the full business case. Activity will engage patients, stakeholders and the public on key findings and test the plans. Two engagement activities will take place during this phase, a public survey on MSK services and a second series of PAG meetings.

PAG and CAG meetings

We are working to both increase and broaden the membership of the PAG. We will be holding four PAG meetings and four CAG meetings. These will once again inform the project Steering Group during the next three months of the project. The fourth and final PAG and CAG meeting will be held together to agree the solutions proposed in the business case.

Public Survey

We will be running a public survey on Talking Health (OCCG's online consultation platform) and via our Equality and Access Commissioners taking the survey out to community groups and networks to get a broad range of views on the survey. The survey will be publicised throughout Oxfordshire.

The survey will test some of the key findings identified in phase one which include access issues, communication and information issues amongst a wider audience. The results of the survey will provide additional data and evidence to support the PAG, CAG and Steering Group and help inform decisions.

Experience Based Co-design

The CCG are also making tentative arrangements for using filmed experience based co-design (involving patients and clinicians) within the design methodology.

Evaluation

A report will be produced to present the findings and views of the patients and wider public during the engagement period. Results will include quantitative and qualitative feedback, media and social media coverage, web hits on Talking Health and numbers engaged.

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Draft HOSC Forward Plan – Proposed Items

Below is a list of forward plan items that have been suggested by HOSC members during previous meetings and discussions held to identify priorities for the year ahead.

20th November

- Delayed Transfers of Care (annual performance from OCCG, OUH, OCC, OH, SCAS)
- Outcomes based contracting (CCG)
- Transforming Primary Care (CCG)
- Emergency Services in Oxfordshire (SCAS annual report, emergency responders, rapid nurse assessment) (SCAS, CCG)
- Community Hospitals (CCG)
- Adult Drugs & Alcohol Treatment (PH)
- Health Weight Strategy (PH)
- Healthwatch

5th February

- Health Strategy (OCC Pooled Budgets & Better Care Fund)
- Health & Well Being Board / Health Improvement Board
- Healthwatch
- Public Health (PH contracts, STIs, Sexual Advice Centres)

23rd April

- NHS England Commissioning
- GPs
- Healthwatch
- Immunisations (NHS England)

2nd July

- Adult Mental Health
- Child Mental Health
- Oxford Health Foundation Trust Strategy
- Urgent Care Pathway
- Healthwatch
- Annual Reports

Items to be scheduled:

- Complex Health Needs
- CQC Inspections
- Southern Health
- Health of Ethnic minorities
- Hospital discharges to the homeless

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