Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 17 September 2015 at 10.00 am
County Hall

Membership

Chairman - Councillor Yvonne Constance OBE
Deputy Chairman - District Councillor Martin Barrett

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Monica Lovatt	Nigel Randall	
	Susanna Pressel	Vacancy	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *19 November 2015*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	Councillor Yvonne Constance OBE Email: yvonne.constance@oxfordshire.gov.uk
Policy & Performance Officer	-	*Claire Phillips Tel: (01865) 323967* *Email: claire.phillips@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

September 2015

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 14)

To approve the minutes of the meeting held on 2 July 2015 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Chairman's Report (Pages 15 - 16)

10:10

The Chairman's written report on meetings she has attended and matters dealt with since the last meeting is attached at **JHO5.**

6. Townlands Hospital, Henley - Proposals for future services (Pages 17 - 20)

10:20

To provide an update **(JHO6)** on progress on the proposals for future services for the new hospital.

David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group, will attend for this item.

7. Chipping Norton - Intermediate Care Beds (Pages 21 - 26)

10:45

A report on Intermediate Care to be considered by the County Council's Cabinet on 15 September is attached for information at **JHO7.** The outcome of discussions will be submitted by way of an Addenda to this meeting.

John Jackson, Oxfordshire County Council and Oxfordshire Clinical Commissioning Group, will attend for this item.

8. Update on the Horton Hospital, Banbury (Pages 27 - 34)

11:10

In February 2014, the Committee requested that an update report on services at the Horton Hospital, Banbury, be provided to the Committee in the following year.

The attached report **(JHO8):**

- Provides a general update on the Trust – wide developments as they have impacted on the Horton.
- Describes developments at the Horton General Hospital over the last 12 – 18 months.
- Summarises other issues considered by the Community Partnership Network.
- Identifies priorities for the Horton General Hospital.

A draft of the report was considered by the County Council's Locality meeting in July. The Group commented as follows:

'Members were pleased to have been informed and consulted and pleased that the issues had been set out so transparently. They expressed a wish that this level of communication should continue. They were generally supportive of the strategy, but recognised that there would be a continuing demand to keep a 24/7 accident and emergency and the CT scanner.'

Andrew Stevens, Oxford University Hospitals NHS Trust, will attend for this item.

9. Healthwatch Oxfordshire - Update (Pages 35 - 134)

11:20

Rachel Coney, Chief Executive of Healthwatch Oxfordshire (HWO) will give an update on recent projects **(JHO9).** Also attached at **JHO9** is HWO's report entitled 'Improving Discharges from Hospital in Oxfordshire.'

10. **Better Care Fund - Update** (Pages 135 - 138)

11:55

Attached is an update which has been produced by the Clinical Commissioning Group **(JHO10).**

11. **Forward Plan** (Pages 139 - 142)

12:15

This will be an opportunity for Committee members to review the key issues for the Committee for the coming year and to identify priorities for consideration at future meetings **(JHO11).**

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, 2 July 2015 commencing at 10.00 am and finishing at 2.40 pm

Present:

Voting Members:

Councillor Kevin Bulmer
Councillor Yvonne Constance OBE
Councillor Surinder Dhesi
Councillor Tim Hallchurch MBE
Councillor Laura Price
Councillor Alison Rooke
Councillor Les Sibley
District Councillor Martin Barrett
District Councillor Monica Lovatt

Co-opted Members: Moira Logie

Officers:

Whole of meeting Claire Phillips and Julie Dean; Director of Public Health

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

83/15 ELECTION OF CHAIRMAN 2015/16

(Agenda No. 1)

Councillor Yvonne Constance OBE was elected Chairman for the municipal year 2015/16 to the first meeting of the next municipal year 2016/17.

84/15 ELECTION OF DEPUTY CHAIRMAN 2015/16

(Agenda No. 2)

Councillor Martin Barrett (West Oxfordshire District Council) was elected Deputy Chairman for the municipal year 2015/16 to the first meeting of the next municipal year 2016/17.

85/15 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 3)

Apologies were received from Councillor Susanna Pressel, Dr Keith Ruddle and from Mrs Anne Wilkinson.

86/15 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 4)

Moira Logie declared an interest in Agenda Item 8 on account of her work as a regional fundraiser for the Sue Ryder charity and its activity at the Townlands Hospital.

87/15 MINUTES

(Agenda No. 5)

The Minutes of the meeting held on 23 April were approved and signed. There were no matters arising from the Minutes.

88/15 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 6)

The Committee noted that the Chairman had agreed to the following addresses, to be made at the items themselves:

Agenda Item 8 – Townlands Hospital consultation on changing the provision from the new building

- Town Cllr Ian Reissman, Chair, Townlands Hospital Steering Group
- County Cllr David Nimmo – Smith, local member for Henley - on –Thames

Agenda Item 9 – Provision of Intermediate Care Beds in Chipping Norton

- Clive Hill, Chipping Norton Hospital Steering Group
- Town Cllr Mike Tysoe, Mayor of Chipping Norton
- County Cllr Hilary Hibbert-Biles, local member for Chipping Norton

89/15 CHAIRMAN'S REPORT

(Agenda No. 7)

The Chairman gave a report on the meetings she had attended and the visits made since the last meeting. These included:

- Visits made to the Warneford Hospital and the John Radcliffe Hospital;
- Attendance at Healthwatch's Oxford 'Hearsay!' event;
- Conference on the NHS 5 year forward view and the transformation programme; and
- Attendance at the working group on Outcomes Based Contracting.

90/15 TOWNLANDS HOSPITAL CONSULTATION ON CHANGING THE PROVISION FROM THE NEW BUILDING

(Agenda No. 8)

Prior to the start of the discussion the Committee heard the following addresses:

Cllr Ian Reissman – Chair, Townlands Hospital Steering Group

Cllr Reissman urged the Committee to instruct the CCG to devote more time to informing the community of the detail in relation to the new model such as information on the care available at the hospital, numbers of patients it was envisaged coming through the hospital, and how this would be monitored. In his view there were significant risks to the new model given the insufficiency of evidence available. He added that GPs in Henley did not appear to be supporting the plans and CCG representatives in neighbouring Berkshire had not commented.

Councillor David Nimmo-Smith

Cllr Nimmo-Smith, speaking as local member for Henley, expressed concern about the alteration to the model, which, at the start of the consultation period included Emergency Medical Units (EMU) and at the end had introduced Rapid Access Care Units (RACU). He reported concern that the consultation process had left their questions unanswered and he asked for reassurance that their medical needs would be fully addressed in the new model.

He added that the Henley and District community felt that the consultation was therefore incomplete and flawed and that the rush to get the building up and running as soon as it had been completed was at the expense of a robust plan and appropriate consultation. He added that it appeared that neither of the senior partners of the two Henley GP practices had endorsed the model.

Notwithstanding the above, Cllr Nimmo-Smith felt that there was much that was good in the model and welcomed the facilities to be provided, such as more consultants and day care and an increasing outreach service from the Royal Berkshire Hospital in Reading. However, the community, who were the users of the facilities offered, had not bought into the new model. He urged the Committee therefore to ask why the CCG had structured the questions in a way that it made it easy to agree with all that they were proposing, why information had gradually trickled out which had changed the consultation; and why they had put to one side the comments made at the public meetings and in the Henley press.

David Smith, Chief Executive, OCCG gave a presentation on the model of care. He stressed that the hospital was due to be handed over to the NHS in November of this year and there had been an increase of £900k lease cost to bear thus making it very important that the best possible use of the facilities were made in the long term. He added that no decision had yet been made by the CCG and they planned to return to the 17 September meeting of this Committee in order to take any comments on board.

Andrew Burnett (OCCG) and Pete McGrane, Oxford Health, attended to explain the changes from the current model to the enhanced model. Andrew Burnett pointed out the expansion to outpatient unit which offered a rapid access clinical unit and Pete McGrane highlighted the growing body of clinical evidence which showed that patients often did not do well in hospital and the need therefore to use the rapidly expanding diagnostic technology in order to enable patients to be supported at home for a speedier recovery. Andrew Burnett added that there would still be a need for bed-based care and this would be provided by the Orders of St John at a home adjacent to the hospital. It had been identified that there was a need for 5 – 8 beds for the local population, some of which would be used for stepping up care, and some for stepping down care.

John Jackson stated that he had attended four public meetings in Henley to speak about the implications of the new model of care for social care. He added that a large amount of information had been provided by the County Council from March detailing the increasing provision of social care to be provided in the future to reflect the projected increase in the elderly population and the need to support patients to keep them out of acute care and looked after in the community.

In response to a question from a member about the issue of the number of beds to be offered at the hospital, David Smith commented that currently, a great number of this population had to go to Reading or elsewhere for their healthcare. This was a real opportunity, in a state of the art building, to provide real care for local people. He reiterated that bed care for those who needed it would still be provided in a building situated adjacent to, and on the same site. John Jackson also commented that the support of informal family carers was essential and the County Council was working very closely with the CCG to ensure the best possible support would be available to patients. This model would help to return patients to the best possible state so that they could live independently and not rely on additional support. He added that the new Care Act would be providing limited additional resources to pay for support to carers. It was thought that large numbers of family carers were not known and a strategy was underway to maximise the numbers of carers. Progress had been made in the last few years and targets had been included in the Health & Wellbeing Strategy to increase numbers.

A member asked if there would be a capability to spot - purchase beds from OSJ and did they have proof that services from the Integrated Locality Teams (ILT) would be available and at the right time. John Jackson responded that OSJ were, in principle, supportive, but detailed contractual conversations with OSJ had not started. Pete McGrane responded that information was available on the ambulatory care model and it was anticipated that there would be significant demand for these community based teams. The ILT's would see patients earlier thus reducing the potential for deterioration, as seen in a bedded setting, to be headed off. He added that the Trust was not seeing this in isolation from the significant changes in primary care services ie. in confederated care. The Locality Teams needed to be in situ to support patients and this had to be hand in hand with families and their carers'.

A member asked if the CCG was certain that it had received all responses to the consultation, particularly those made online. David Smith undertook to check this.

Some members commented on the rushed nature of the consultation and perceived failure of the CCG to take the public with them. David Smith responded that clearly there had been some opposition to the proposals and a petition had been submitted, the terms of which were purely focused on the beds. He added however that the support for the alternative model had got lost, that from a clinical point of view, it was believed this to be the right model of care for Oxfordshire. He stressed that the bed-based care would still be provided on the same site, but not within the hospital building, which was originally proposed. He also pointed out that the current building would have to be demolished at the point at which the building would be handed over. Should there be a delay there would be substantial problems.

A member asked if nursing staff would be conversant with the ambulatory care model. Pete McGrane explained that for the new model the Trust would want to use trained staff who would reach out into the community; and in the care home, there would be trained staff who would support patients back into the community. He added that colleagues in the Royal Berkshire Hospital were also very supportive of the aim to have in-reach geratology support to get patients back into the community.

A member asked if the staff would be NHS trained or would there be a different provider. John Jackson responded that the expectation would be that OSJ would employ the appropriately trained staff to meet patients' needs. He pointed out that this model was used for the 20 beds at the Isis Home in Oxford. He offered to arrange a visit for committee members.

David Smith was asked if the new model of care would put the CCG in a better position to accommodate the costs of running the building and would suitable transition arrangements be put in place to cope with winter pressures. He stated that members of staff were still working through the running costs but there was no doubt that costs would increase for the CCG. He confirmed that winter pressures plans were in place for when the building was taken over.

In response to reassurance sought from a member that facilities would be in place on patient discharge and that sufficient liaison would be made with Reading, Andrew Burnett stated that discharge plans were now much more refined. There was daily contact between clinicians and social services in place. However, there were still cross – border issues to be ironed out.

When asked why the change from the proposed Emergency Multidisciplinary Unit (EMU) to a Rapid Access Clinical Unit (RACU), Andrew Burnett explained that there was insufficient clinical throughput in the surrounding area to make running an EMU for 7 days per week worthwhile. The RACU could offer integrated staff presence, an x ray function and clinical availability for patients feeling unwell that day – with diagnostic facilities to enable people to remain in their own home if sufficiently stable to get through to the next day, rather than being taken into acute care.

A member asked if local GPs were signed up to the new model of care. Andrew Burnett responded that they were happy with the proposed model but were anxious that more work would fall on them if more patients were managed at home. John Jackson said that he and Pete McGrane had given some thought to this and had found that there had not been any more demand for GP care and community

services arising from the operation of the EMU in Abingdon. It was more likely that they were anxious about the possibility of losing the beds.

On conclusion of the discussion the Committee thanked Andrew Burnett, Pete McGrane and John Jackson for their presentation and agreed to note the report on the consultation; and **AGREED** (unanimously) to the Chairman's specific question that it was an 'adequate' consultation. The Committee noted the intention of the CCG to return to the Committee on 17 September to discuss the final decision of the CCG Board at the end of July.

91/15 PROVISION OF INTERMEDIATE CARE BEDS IN CHIPPING NORTON
(Agenda No. 9)

Prior to the start of the discussion the Committee heard the following addresses:

Clive Hill, Chipping Norton Hospital Steering Group

Clive Hill stated that last year the conclusion was, following the consultation which had begun in 2014, that the nurse provision was better provided by the NHS. The Chipping Norton community considered that the consultation process was binding and they were led to believe that the matter had been settled. He urged the Committee to conclude that the current decision to change NHS nurse provision to that of the Orders of St John Nursing provision was not viable on the basis that it had not been fully evaluated. He added that, given the rural setting of the town, there would be a need for fully trained, NHS nurses to ensure patient safety. Mr Hill urged the Committee to instruct OCC to extend the current arrangements to ensure that full evaluation of the consequences of employing Orders of St John nurses could be carried out, and if this was not done then to refer it to the Independent Reconfiguration Panel.

District Councillor Mike Tysoe, Mayor of Chipping Norton

Councillor Tysoe made the following factual observations which, in his view, would demonstrate that what was being planned was a significant change of service and not simply a change of management as currently claimed:

- That the average length of in-patient stay under NHS management is 27 days. Over a comparable period under OSJ management, average stay is 40 days. This 13 day difference would represent a significant cost as it would cause bed blocking in the acute sector and also cause 50 fewer patients per annum to have access to the unit. This had not been factored in;
- That under recent OSJ management, on average, active intervention and rehabilitation was delivered by physiotherapists for only 4 out of 14 patients at any given time. Currently, under the NHS management, an average of 10 out of 14 patients were receiving such care at a given time. This is a large difference and a completely different level of service.

- That if part of the cost-cutting would mean fewer than two qualified nurses on duty during any shift, then that is a level of service which is below that which the NHS considers to be safe;
- That currently, NHS management considers that a crash trolley on site should be essential for safety, it was Cllr Tysoe's view that this was not shared by the OSJ;
- That he had been told that the training given to OSJ nursing staff did not compare with the NHS nursing and auxiliary staff training. This was a different level of service with whatever associated risks to patients.

Cllr Tysoe concluded by stating that all the above needed to be investigated further before any further decisions were made concerning the Chipping Norton Intermediate Care ward.

Councillor Hilary Hibbert-Biles – Local Member

Cllr Hibbert-Biles urged the Committee to ensure that there was a full public consultation on the issue of the perceived downgrading of beds from sub-acute intermediate care to intermediate care for the elderly; believing that an officer review was not sufficient.

She told the Committee that she had been involved in various discussions over the years since 2002 on the issue of nursing provision at the Hospital. The outcome of the first round was a contract which provided a staff level and expertise to enable the unit to admit patients of all ages who needed a hospital environment. It did not state that after three years it would revert to a lower level of care and the care would be for the elderly only.

Last year she had been involved in discussions with the County Council (OCC) and Oxford Health (OH). It had been agreed that the clinical management would lie with Oxford Health, who had more experience in this field and there would also be a modern matron on site who would take shifts. There would also be a band 7 staff nurse, together with other NHS nurse providers. OSJ had overall management of the building which also included maternity (OUHT) and the first aid unit (SCAS). This arrangement, in her view, had worked well.

She added that, in a letter to David Cameron MP from the CCG in January 2014 it was stated that there would be no change to the current service arrangement being proposed and that the specification and contractual arrangements would not change. It would follow then that these beds should be sub-acute, as per the contract. It also states that these beds are for all ages and yet every briefing only talked about older people and the Older People Joint Budget.

She pointed out that the contract specified that community based bedded care services support faster recovery from illness, prevent unnecessary acute hospital admissions or avoidable use of long term care, timely discharge and maximise independent living. She added that that was what was needed.

It was Cllr Biles's view that Oxford Health still wished to take over the management of the nurses if a contract could be agreed. Furthermore, she believed that the beds could continue for a further four years, should the subsidy be given over to Oxford Health, who then could do the same as the OSJ had done. Cllr Biles also commented that until last year it had not generally been known that OCC had taken over the commissioning of the beds from the NHS and that she was concerned about this lack of transparency over the hospital.
She concluded by stating that these beds are the only intermediate care beds in the north of the county and a unit was needed that is expertly run by Oxford Health nurses to support the patient for a speedy return home – and also to stop bed blocking. This would also save money in the long run for both organisations.

David Cameron MP supports the nurses staying in the NHS and does not want the Unit to become more of a care home. To this end he was arranging a round table discussion with the appropriate parties. Until that meeting had taken place she believed that nothing could move forward unless there is a full consultation.

On the conclusion of the addresses, the Director of Adult Social Care, John Jackson, and Cllr Mrs Judith Heathcoat, Cabinet Member for Adult Social Care came up to the table. John Jackson read out the following statement:

'We recently announced our intention to appoint the Orders of St John Care Trust as the provider of intermediate health care in Chipping Norton, replacing Oxford Health NHS Foundation Trust.

Since 2011 the 14 bed intermediate care unit at the Henry Cornish Care Centre on the Chipping Norton War Memorial hospital site has been run, first by the Orders of St John Care Trust with nurses seconded from Oxford Health Foundation NHS Trust and since last year by Oxford Health Foundation NHS Trust in a partnership with the Orders of St. John Care Trust.

It has been decided to revert to the original proposal that the intermediate care beds are run by the Orders of St. John Care Trust as it has proved impossible to make the system work as it involves two sets of management arrangements.

In addition it is because intermediate care provided by NHS nurses cannot be provided within the available budgets.

This was intended as a straightforward reversion of provider with no anticipated change to the level or quality of service, so it was initially felt there was no need for public consultation.

However our proposals have clearly caused concern amongst some people in Chipping Norton to the extent that unjustified and unsubstantiated attacks have been made on the Orders of St John Care Trust and the services they provide.

The Orders of St John Care Trust have responded to this by saying they would only be prepared to continue to provide intermediate care if there is broad community support.

We therefore feel clear that there should be a public consultation about the choice facing the people of Chipping Norton: either they support intermediate care provided by the Orders of St John Care Trust or there will be no intermediate care in Chipping Norton.

If the local community do not wish the Orders of St John Care Trust to provide intermediate care, or in the face of lack of local support the Orders of St John Care Trust decide not to provide intermediate care, then none will be available in the town. If adult social services decide to commission other providers of intermediate care then this would almost certainly be much closer to Banbury to provide more equitable provision for the north of the county as a whole.'

John Jackson and Cllr Mrs Judith Heathcoat made themselves available to respond to questions from the Committee.

They were asked by the Committee what had triggered the statement. John Jackson responded that the starting point had been the managerial challenges. Both Oxford Health and the OSJ had worked very hard to make the original arrangement work. Originally, at the time of signing, possible risks had been mooted, and the issue had remained unresolved about who would be responsible in circumstances when there was a major failing. A further difficulty seen was that Oxford Health was providing a service which was effectively a care home. The collective view was that this arrangement would not work in light of the costs (set out in the note on the Addenda), and the fact that staffing costs of the current model were more expensive than the costs of providing intermediate care delivered by OSJ. He added also that no additional CCG resource could be made available and asked if it was appropriate to proceed with an expensive arrangement when an alternative care arrangement was available of equivalent quality. He stated that in his view there should be a public consultation based on what was realistic and based on what could be offered.

John Jackson also commented in response to critics that OSJ could provide good quality Intermediate care as demonstrated at the Isis in Oxford. He recommended that the Committee should visit Isis to view it at first hand. The Chairman accepted his offer.

A member of the Committee commented that the costs charged by OSJ appeared to be even higher than those of Oxford Health. John Jackson responded that the costs of the care home would be paid for by OSJ on the basis of a return to them on the costs of the building. He accepted that the figures had not been scrutinised in detail, but it did not alter the fact that the offer on the table would be significantly more than the budget available and significantly more than buying intermediate care beds elsewhere in Oxford.

A Committee member asked, as far as the patients were concerned, would the standards of care stay the same with 14 intermediate care beds. Cllr Mrs Heathcoat confirmed that the14 intermediate care beds would remain if the terms of the statement were agreed to.

John Jackson stated that Intermediate Care was not usually provided by the NHS nationally and confirmed that the OSJ were registered with the Care Quality Commission to deliver this service and met all training requirements.

John Jackson explained that his intention was to consult on the two options as soon as possible. This would be concluded in early September and the outcome would come back to this Committee in September. The staff consultation was to begin in the near future and they would be given the choice of whether to transfer to OSJ or to be redeployed in Oxford Health. He informed the Committee that the statement had been agreed beforehand with Oxford Health and the OSJ following a meeting with the 3 parties when it had become clear that the current situation was untenable.

The Committee thanked Cllr Mrs Heathcoat and John Jackson for their attendance and noted the report on Chipping Norton Hospital and expected further reports on the full consultation at its 17 September meeting.

92/15 HEALTH SERVICE RESPONSE TO THE FINDINGS OF THE SERIOUS CASE REVIEW OF CHILDREN A-F AND FURTHER ACTION BEING TAKEN IN RESPONSE TO CHILD SEXUAL EXPLOITATION IN OXFORDSHIRE
(Agenda No. 10)

The Committee were given a presentation on the Health response to the findings of the Serious Case Review of Children A-F and further action being taken in response to child sexual exploitation in Oxfordshire.

The attendees were as follows:

- Sula Wiltshire and Alison Chapman – Oxfordshire Clinical Commissioning Group
- Ros Alstead, Lucia Bell and Alison Chapman – Oxford Health NHS Foundation Trust
- Catherine Stoddart and Claire Roberts – Oxford University Hospitals NHS Trust
- Julie Kerry – NHS England
- Sarah Breton, Dr Jonathan McWilliam and Ruth Locke – Oxfordshire County Council

Members were appreciative of the form of the presentation which allowed for case studies to be given by those presenting to highlight the response of Health staff when dealing with children in their care. Questions were taken from the Committee about each case.

Questions asked by the Committee were in relation to the following issues:

A committee member asked about the approaches made by the Teams to build a relationship with any child thought to be in danger of exploitation, in order to support their health and social care needs. Sula Wiltshire and Dr McWilliam explained that there were a number of approaches. Each agency lead officer took responsibility for this area. Information sharing was a very challenging and complex area, but the multi-agency MASH teams had been established to meet this need. Key workers had been assigned and everybody was now aware of who to contact. Focus on the child safeguarding agenda was growing.

A member asked what provisions were in place for the Banbury area, particularly around the schools. Attendees responded that service provision covered all of Oxfordshire. Some active work was being undertaken in Banbury, but all market towns were being treated equally. Colleagues representing the Health and Social Care side were completely joined including support from paediatricians from the Horton Hospital.

A member of the Committee asked if patients' records were shared by all the agencies. Sula Wiltshire responded that information on aspects of care was shared if it needed to be shared to help inform a situation. An illustration of how well this could work was given in the form of a case study by Ruth Locke, a school nurse working in Oxfordshire. They stressed the importance of good practice and it being sustained and the need for an evidential basis. Furthermore, it was important to get the services right for a child, whether these be from CAMHS, Oxford Health, Public Health, OUHT, Social Services etc.

The Panel were asked about the safeguarding health needs of children with a learning disability in special schools. Ros Alstead responded that the aim was to provide an integrated service. Within Oxfordshire there was a general and a specialised service and children's care was coordinated and managed within the teams, often with CAMHS and with the clinicians closely linked in with the special schools. In all special schools there was a specialist nursing service for children with severe problems who were more at risk of sexual exploitation. The Safeguarding Board had produced a proactive training module for these very vulnerable children. Dr McWilliam explained that OCC produced 35 double school nurses who are trained to work in secondary schools and colleges and some primary schools. At the time of planning they were concerned to attain a general population coverage and it was felt that the balance was right.

A Committee member asked what was meant by horizon scanning. Sula Wiltshire explained that it was the responsibility of all agencies involved in safeguarding to feed into, and be aware of, the preventative agenda. She added that all agencies met regularly to take part in this.

Members of the Committee thanked all who attended and for the very informative presentation.

93/15 DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT

(Agenda No. 11)

The Committee had before them the draft Director of Public Health's Annual Report for 2014/15.

Following a full discussion it was **AGREED** to share the following comments with the Oxfordshire Health & Wellbeing Board on 16 July and to Cabinet on 21 July.

Members of the Committee felt that the report was very comprehensive, very readable and that it explained how services were to be delivered in each section, thus enabling scrutiny to be conducted effectively. Members expressed the hope that future reports would continue to be approached and written in a similar way. It was

satisfied that major areas such as Mental Health and Child Poverty continued to be given a high prominence. The Committee, in particular, endorsed the following factors:

Chapter 1 – The Demographic Challenge

The Committee was keen to flag up that more detailed information was required on the plans to commission a countywide dementia support service (page 10 of the report) to help patients and families throughout the disease and to help plan and navigate a path through services to make care less disjointed.

The Committee strongly endorsed recommendation 4 (page 13 of the report):

'OCCG, OCC, OUHT, OH and NHS England should develop, as a priority, their joint work to collaborate in transforming the local health system. This is in order to provide new models of care closer to home, care focused on prevention and early detection of disease, improved care for carers, prevention of hospital admission and speedy hospital discharge through improved community services, the modernisation of primary care and the funding of primary prevention services by the NHS.'

The transformation programme is of major interest to the Committee and will be the subject of scrutiny at its September meeting.

Chapter 2 – Health, Houses and Roads

The Committee also endorsed strongly recommendation 2 (page 21 of the report).

'The NHS should become a consultee for local planning decisions and the CCG should be offered membership on key planning groups. Planning and health infrastructure should be considered when developer contributions are considered.'

HOSC has already highlighted a disconnection between local authority planning and Health when planning large housing developments. Scrutiny of this issue forms part of the Committee's Forward Plan and it is hoped that there would be a full response to these issues from NHS England at the Committee's September meeting.

In addition it endorsed recommendation 4 (page 22 of the report):

'Cycling should be seriously encouraged in new road developments which are likely to attract high usage. Alternative cycle-only commuter routes using features such as rivers and canals should be considered.'

The Committee recognised the Government's increased input into the provision of cycle paths and provision being made in the forthcoming Local Plan 4. It was their view however that local authorities should also be consulting with CCGs with regard to the provision of cycling routes for the purpose of improving the health of the local community, and advocated a policy to be put in place to ensure input into S. 106 contributions.

94/15 OXFORDSHIRE HEALTH & WELLBEING DRAFT STRATEGY AND DRAFT INDICATORS

(Agenda No. 12)

The Committee had before them the Oxfordshire Health & Wellbeing draft Strategy and proposed performance indicators for comment **(JHO12).**

Dr Jonathan McWilliam (Oxfordshire County Council) (OCC)), Jackie Wilderspin (OCC), Ben Threadgold (OCC), Eddie Duller (Healthwatch Oxfordshire (HWO)) and Rachel Coney (HWO) came up to the table to respond to questions in relation to the content of the document itself and in relation to the HWO input on quality issues.

Following discussion it was **AGREED** to convey the following comments to the Health & Wellbeing Board on 16 July:

HOSC felt generally that the manner in which the Strategy had been laid out was good but there were instances where some accompanying statistics had been quoted, but others where they were not. Furthermore, reference to how organisations would respond to changing circumstances was not apparent. For example the impact on projected numbers of children taking up early education, given that there was going to be changes to the services offered by Children's Centres, and if any specific booster action had been identified in instances where progress was not being made. A further example of this would be to clarify what the plans were to improve the low numbers of carers receiving carers breaks (1,027) given that there are 16, 000 carers now identified in the county, Members were keen to understand the impact on the volume and the need for care from activity relating to the aim to 'Reduce the number of people delayed in hospital (DTOC) from an average of 147 per day in 2014/15' (page 18).

The Committee were pleased to see that the improvement of ambulance rural response times had been included in the list of issues which had been agreed for organisations to work on (page 8/9 of the report). This has been an ongoing major concern for HOSC and it asks the Health & Wellbeing Board to play its part in helping to achieve improved response times. It has found, for example, that the SN postcode is often read by SCAS as Wiltshire and not Oxfordshire, which has affected response times.

95/15 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 13)

Eddie Duller, Chair, Healthwatch Oxfordshire and Rachel Coney, Chief Executive, presented their report which gave an update on recent projects HWO were involved in (JHO13).

Eddie Duller reported that HWO were very concerned about areas that were adversely affected by financial constraint, such as those affecting Chipping Norton and Townley Community Hospitals, the result of which were new plans which appeared to have very little association with the original public consultations. They expressed concern that the form of consultation to be undertaken by John Jackson

with regard to Chipping Norton Hospital did not comply with the Government's code of practice in relation to consultation. The Chairman responded that the Committee would require an adequate consultation to be carried out only where there has been a substantial service change. As the managers intended no change in respect of the base services to be provided, then this did not constitute a substantial change.

The Committee agreed that the report was good and contained some very worthwhile projects. A member asked if there were any further 'Hearsay!' meetings planned. Rachel Coney responded that there would be a 'Hearsay!' event each year either in the form of locality meetings or as one central meeting. She added that the Chairman and the Director of Adult Social Care had been present at Oxford's Hearsay! event in June to listen to the concerns of users of social care.

With regard to section 7 of their report concerning the campaigns which HWO had been involved in, Rachel Coney agreed to circulate any pertinent correspondence around members of the Committee for information.

The Committee thanked Eddie Duller and Rachel Coney for the report and for their attendance.

..... in the Chair

Date of signing .....

Oxfordshire Health Overview & Scrutiny Committee - 17 September 2015

Chairman's report

Since the last HOSC meeting I have had a number of meetings and visits along with other committee members.

1. **Witney Community Hospital – temporary closure of Winsric ward**

The chairman and other committee members met with Oxford Health on 22 July about the community hospital services in Witney.

Members were briefed on the proposal to temporarily (six months) close the Winsric ward at Witney Community Hospital. During this time capital works will take place to improve the facilities on Winsric ward. Members used the toolkit on substantial change and on consideration of the evidence advised Oxford Health that the proposal was a managerial issue and did not constitute substantial change so a public consultation would not be required.

Members were very clear to gain assurance from Oxford Health that the reduction in bed numbers

a. Did not affect their ability to deliver the full service required from the block contract with the CCG. [Oxford Health said that even with these levels of bed numbers they were overproviding the number of episodes of care specified in the block contract and the proposal would not alter this]
b. is only temporary

2. **Meeting about health service role in planning (25 August)**

The Chairman (HOSC) met Bev Hindle (OCC Strategy manager) and Libby Furness (CCG) to explore which organisation and what process ensured that the future demand for health care was considered in planning growth and major housing developments in Oxfordshire.

It was acknowledged that planning for future health provision is very difficult given the wide range of commissioners and providers as well as the role of the NHS Property Company. Examples of schemes to deliver new healthcare facilities in other areas were cited which had at the point of completion turned out not to meet the current needs. Also the potentially competing interests of primary care practices was noted as a real factor impacting the provision of new primary care facilities.

Libby Furness said that there will be a strand of work within the Oxfordshire Health and Social Care System Transformation Programme about planning and Bev Hindle referred to work starting on a Strategic Infrastructure Framework for Oxfordshire which will cover planning for health.

It was agreed that it would be useful for HOSC to return to this issue next year once some progress has been made and take it up with district councils.

3. Visit to SCAS operations centre, Bicester (1 September)

Five committee members visited SCAS Bicester to learn about their operation and see the service in action. We were briefed by Luci Stephens, Interim Director of Operations on the organisation of the SCAS service and move toward Clinical Co-ordination Centres for all services (111 and 999).

Members then visited the three service areas of the operations centre; 999, 111 non-emergency and patient transport service. Observing the management of calls was extremely informative and members gained a much clearer understanding of how the services work and link together.

The session concluded with a discussion with Luci Stephens and Sue Byrne (Chief Operating Officer).

4. Visit to Isis care home (7 September)

Five HOSC members visited the Order of St John (OSJ) Intermediate Care Centre in Oxford to learn about the service provided and establish the distinction between intermediate care and sub-acute care which has become important in the development of elderly care outside acute hospitals in Oxfordshire. We met Sara Livedeas, Strategy Director for OSJ nationally, and Patsy Just, Assistant Operations manager at ISIS, Oxford as well as nurses and staff from the centre and Natalya James, the OSJ manager from Chipping Norton Community Hospital who manages the OSJ service at Chipping Norton.

Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: Thursday, 2nd July, 2015

Title of Presentation: Proposals for Future Services at Townlands Hospital, Henley

Purpose: To provide the Oxfordshire Joint Health and Overview Committee an update on progress on the proposals for the future services at Townlands Hospital, Henley, following Oxfordshire CCG's Governing Body meeting 30th July 2015

Senior Responsible Officer: David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group

1.) Introduction

Following the completion of a public consultation exercise on the proposed services for the new Townlands health campus, a paper was presented to the CCG's Governing Body 30th July 2015 (http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/07/Paper-15.63-Townlands-Hospital-Henley.pdf). The paper set out the consultation process undertaken and the feedback received and presented three options for the Governing Body's consideration:

1) To proceed with the proposal as outlined within the paper, reflecting the amendments following consultation.

2) Reject the proposal the CCG has consulted on and implement the elements of the original 2012 business case within the gift of the CCG, for example 18 inpatient beds, but not the new services proposed and Rapid Access Care Unit (RACU) model within the new premises.

3) To endorse the clinical model proposed and to note the consultation responses but to recognise that further work is required to give the Governing Body full assurance on a number areas raised as part of the consultation; for example the transition plans, availability of qualified staff and clinical engagement, and to take the opportunity for further engagement with stakeholders in developing the responses to these issues, in order that the Governing Body can take a decision.

After a detailed discussion (http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/townlands-hospital-consultation/governance-and-hosc/), the Governing Body approved the recommendation and elected option 3.

2.) Activities undertaken since the Governing Body

In accordance with the Governing Body's decision, the CCG continues to work closely with the following local stakeholders to address the issues raised as part of the public consultation:

- John Howell, MP
- The Henley Townlands Steering Group
- Royal Berkshire NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Henley GPs
- South Central Ambulance Service
- Oxfordshire County Council
- Order of St John Care Trust

The CCG has met twice with John Howell MP and the Henley Townlands Steering Group to address the concerns raised, namely;

- the catchment area for the Townlands services,
- the nature of care to be provided by the Order of St John Care Trust,
- the capacity available in the community to support both the health and social care needs of patients seen at the Rapid Access Care Unit (RACU) and;
- transition from the old to the new premises and from the existing to new service model

The above items were discussed in detail in sub-group meetings held between the CCG, Oxford Health NHS Foundation Trust, Oxfordshire County Council and members of the Henley Townlands Steering Group.

In addition to the above, the CCG:

- continues to meet regularly with local provider organisations to inform robust transition plans which support safe and timely transfer of services from the old to the new premises.

- is progressing the proposed expansion of outpatient services with the Royal Berkshire NHS Foundation Trust.

- in partnership with Oxfordshire County Council, has instigated discussions with the Order of St John to discuss in more detail the intermediate care beds (step up and step down) to be secured from the Summer 2016 when the Order of St John premises are scheduled to be opened on the Townlands health campus.

- continues to work with clinical and managerial colleagues across local provider organisations to refine the RACU patient pathway and service specification.

- has reviewed delayed transfers of care (DTOCs) data with Royal Berkshire NHS Foundation Trust and the parties are agreed that the number of Oxfordshire patients defined as a DTOC at any one time is 2-3 with a ratio of 2:1 health to social care. This aligns with the bed modelling undertaken by Oxford Health NHS Foundation Trust which increases the number of beds required by 2 to reflect this need.

- has reviewed historic inpatient activity and the nature of care provided at the Townlands under the current model of care to assess and inform transition requirements and;

- continues to develop the financial and activity modelling for the RACU to ensure it is financially viable.

3.) Next steps

The outputs of the above activities will be used to inform the paper scheduled for the next Governing Body 24th September when the Governing Body will assess whether the additional work undertaken in response to the concerns aired, provide the assurances necessary to sign off the model and proceed to implementation.

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Division(s):

CABINET – 15 SEPTEMBER 2015

Consultation on the Future Provision of Intermediate Care in North Oxfordshire

Report by Director of Adult Social Services

Introduction

1. Intermediate Care services are designed to help people stay at home and prevent them from going into hospital if they become ill or are injured, and to support people to return home from hospital as soon as they can. These services, such as rehabilitation, therapy and reablement, improve people's ability to manage independently and live their lives as well as they can.
2. The County Council is the lead commissioner for Intermediate Care services in Oxfordshire and commissions a range of bed-based and home-based services across the county.
3. In North Oxfordshire bed-based services are currently sited in Chipping Norton at the Henry Cornish Care Centre, a building owned by the Orders of St John Care Trust. The accommodation, domestic and essential care are provided by the Orders of St John Care Trust, while Oxford Health NHS Foundation Trust provide nursing staff.
4. There is a growing body of evidence nationally that health and care services are better provided in people's own homes where possible, both in terms of clinical outcomes and people's experience of the care. Care at home can be flexible and tailored to the individual, and enables people to maintain their family lives and their independence.
5. Locally, the County Council and the Oxfordshire Clinical Commissioning Group are developing and evaluating new ways to support people in avoiding hospital admissions, to return home more quickly and to have the care they need at home. This includes building up Intermediate Care services available to people in their own homes, such as rehabilitation and reablement.
6. The current arrangements for running the bed-based Intermediate Care services at the Henry Cornish Care Centre in Chipping Norton came about through a complex history, the most recent part of which is summarised in this report. If the bed-based services are to continue, the way they are provided will need to change as they are not sustainable or affordable in their current form going forward.
7. The Orders of St John Care Trust has put forward a business case for a sustainable way of running the Intermediate Care Unit in Chipping Norton, about which some local people and politicians have expressed considerable concern.
8. In light of this concern, along with the move to consider more services being provided in people's own homes and the unsustainability of the status quo in Chipping Norton, the proposal is to carry out a public consultation into the provision of Intermediate Care services in North Oxfordshire. A fair and thorough consultation will allow future decisions to take into account people's

views on how Intermediate Care services in North Oxfordshire are developed and provided in future.

Background to Intermediate Care Unit, Henry Cornish Centre

9. Since 2011, following changes to NHS services provided in Chipping Norton, there has been a 14-bed Intermediate Care Unit providing bed-based Intermediate Care in Chipping Norton. The unit is part of the Henry Cornish Care Centre, a building owned by The Orders of St John Care Trust who also run a 36 bed care home from the same building. Chipping Norton residents account for approximately 30% of the people using the Unit. On the same site there is a maternity unit and an NHS outpatients department.
10. In light of the changes to NHS services in Chipping Norton, the arrangements for running and staffing the Intermediate Care Unit were established on a temporary basis and in a different way to other Intermediate Care services in Oxfordshire.
11. Oxford Health NHS Foundation Trust seconded nursing staff to the Orders of St John Care Trust to staff the Intermediate Care Unit. The Orders of St John Care Trust retained the contract to provide the unit, with associated responsibility for quality and outcomes, while Oxford Health held clinical responsibility as employer of the nursing staff. This secondment arrangement came to an end in February 2014,
12. New arrangements were put in place from March 2014 in which the nursing staff are managed directly by Oxford Health and the Orders of St John Care Trust provide the accommodation, property, essential care, domestic and 'hotel' services and is the registered provider.
13. Six key principles were agreed which would govern those arrangements, which were shared with the Chipping Norton Hospital Action Group. Both providers and commissioners would need to test out those arrangements against the principles to see if they could work. One of the principles related to the costs of the current arrangements.
14. Oxford Health NHS Foundation Trust and Orders of St John Care Trust put forward a business case to the council and the Oxfordshire Clinical Commissioning Group (the commissioners) in which it proposed continuing to run the unit through this joint arrangement in the longer term. The costs were more than the current costs of running the unit.
15. The model proposed in this business case was turned down by the commissioners on the basis that it did not represent good value for money when compared to other intermediate care provision in Oxfordshire and nationally.
16. As an alternative the Orders of St John Care Trust have developed a model to take over the provision of the Intermediate Care Unit, including the transfer of nursing staff from Oxford Health.
17. The council intended to implement this proposal as a simple change to the organisation providing what would be an unchanged service.
18. This was not seen as requiring public consultation, although Oxford Health planned to consult its staff on arrangements under this change. Staff were to be offered the opportunity to transfer to Orders of St John (with Transfer of Undertakings Protection of Employment - TUPE - rules in place) or to another Oxford Health service.

Key issues

19. The plans for Orders of St John Care Trust to run the whole Intermediate Care service were shared with stakeholders and the public in early June 2015. There was considerable concern expressed by the Chipping Norton Action Group, local people and some politicians.
20. The main expressed concern has been how nursing quality will be maintained if the employer is no longer an NHS organisation. There is good evidence that the Orders of St John Care Trust can provide high quality Intermediate Care beds, working to the social care focused model the council is commissioning across Oxfordshire.
21. After listening to these concerns the proposal is to carry out a thorough consultation on two possible models:

    A: The Intermediate Care Unit in Chipping Norton continues and the full 14 bed service is provided by the Order of St John Care Trust.

    B: Intermediate Care services based in people's own homes are further developed in North Oxfordshire, including Chipping Norton, and the Intermediate care Unit at the Henry Cornish Care Centre is closed. The space could be moved into use as part of the existing Care Home already on the site.

22. The consultation will also ask for any other options to be put forward, which will be considered as part of the final decision-making process where they are affordable and realistic.
23. In both models, Oxford Health NHS Foundation Trust would continue to provide skilled therapeutic input as part of any Intermediate Care service, which they provide through their contract with the Clinical Commissioning Group for community health services.
24. GPs would provide medical cover as needed. Under Model A this would continue to be paid for as additional service. In Model B, GP cover would be provided to existing patients in their own homes.
25. While Intermediate Care at home will continue to be developed across Oxfordshire, under model B services would be developed more intensively to provide a sustainable, appropriate alternative to bed-based care in the North Oxfordshire area.
26. There will be some people whose particular conditions and circumstances mean they need bed-based care. If the decision following consultation is to close the Intermediate Care Unit in Chipping Norton, those people would continue to be able to access bed-based Intermediate Care in other units in Oxfordshire.
27. The status quo is not sustainable within the present financial envelope or the long term financial situation facing the Council. The irregular joint management arrangements and the split responsibility for care quality and clinical responsibility between the two organisations were a pragmatic response to the circumstances and are not considered to be workable longer term.

28. The cost of continuing with a formalised joint arrangement has been estimated as costing £1,782 per bed per week, which is £782 more than Model A and £932 more than the estimated cost of home-based intermediate care in Model B.
29. Changing the provider organisation so that the Orders of St John Care Trust provide the Intermediate Care Beds at the Henry Cornish Care Centre would be considerably less costly in the longer term at approximately £1000 per bed per week.

Financial and Staff Implications

30. There will be some resources required to carry out the consultation. Staff time and resources will be provided through the Joint Commissioning and Central Communications teams.
31. The final decision about how Intermediate Care is provided will have implications for Oxford Health NHS Foundation Trust staff, which will be addressed primarily through the Trust.
32. The two proposed models have different costs, model B being estimated as less expensive than model A. Both are affordable within the finances available at the current time.
33. The current arrangement is more expensive than either model A or B, as outlined in the business case put forward by the Oxford Health NHS Foundation Trust and the Orders of St John Care Trust for the model going forward.
34. For information, the following table shows the costs for comparison:

Model of care	Cost per week	Cost per year (based on 14 people at one time)
Service as run currently by Orders of St John Care Trust and Oxford Health NHS Foundation Trust	£1,327 per bed (subsidised through a one-off sum from the former Primary Care Trust which will be used up by April 2016) £1,467 when subsidy ends	£966,482
Sustainable jointly run service, as put forward by Oxford Health and Orders of St John	£1,782 per bed	£1,298,000
Model A	£1000* per bed	£728,600
Model B	£850** average per person	£618,800

*This figure is the estimated cost of providing Intermediate Care beds through the Orders of St John, based on the cost in other parts of Oxfordshire (e.g. Isis Care Home Intermediate Care Beds cost £977/bed/week). Additional costs would be incurred initially as a proportion of nurses would be transferred with protection of pay and conditions (TUPE). These costs would reduce year on year through people moving on and TUPE arrangements ending. The National Audit of Intermediate Care provided in residential care homes (2014 Commissioners' Report) found the average cost to be £103 per 'bed day'.

**This figure is based on the average cost of providing home based Intermediate Care as reported by NHS Benchmarking in the National Audit of Intermediate Care Commissioners Report 2014, adjusted (increased) for Oxfordshire. Care costs here are known to be higher than the national average.

Equalities Implications

35. A Service and Community Impact Assessment (SCIA) for the proposed changes has been drafted, and will develop up to, during and after the consultation process. Currently there have been no negative implications identified for particular groups or those with protected characteristics under the Equality Act 2010.
36. A positive impact of implementing Model B may be to make Intermediate Care services more accessible to people in rural areas, as the services would come to them. Their families and friends might also find it easier to stay in touch. This flexibility of home-based services could also have a positive impact on individuals and families from Black and Ethnic Minority communities, where services tailored to individual cultural requirements could be of benefit.

Legal Implications and Risk management

37. The main risks associated with carrying out a public consultation relate to expectation and to robust legal process. The council has taken all reasonable steps to ensure the process is fair, thorough and transparent.
38. The consultation will include people most closely affected by any change to the way Intermediate Care is provided, such as those who have used the service and their families and friends.
39. The consultation documents and related communications will be clear about the decision-making process following consultation, and that responses are used to inform the decisions which will be taken by the council.
40. The information provided to people will be transparent in that new ideas and solutions likely to be raised through the consultation will be thoroughly considered. The consultation responses will be an important part of the information used by the council in making their decision about Intermediate Care provision in North Oxfordshire, along with other matters such as affordability and quality.
41. The final decision taken on Intermediate Care provision in North Oxfordshire will involve revised or new contractual arrangements, the details of which will be included in the report to Cabinet in January 2016 following the consultation.

Communications

42. There have been several meetings with the Chipping Norton Action Group and local politicians, including the Prime Minister as the local Member of Parliament. The council has engaged with the local media through regular briefings. The messages from this period of engagement have been listened to by commissioners, and as a result this wider public consultation is now proposed.

43. The public consultation will allow for wider engagement with the people of North Oxfordshire and others affected by Intermediate Care provision, to hear the range of ideas and views which they have about Intermediate Care.
44. The public, organisations and individuals with an interest in Intermediate Care provision will be engaged through meetings, questionnaires and focus groups. The ways people can get involved will be widely publicised including through the local media, newsletters and digital platforms such as Twitter.
45. The consultation will run from 5 October until 7 December 2015. A report of the findings from the consultation will be brought to Cabinet on 26 January 2016, along with recommendations about the course of action.

RECOMMENDATION

46. **The Cabinet is RECOMMENDED to agree that there is a public consultation on the way Intermediate Care is provided in North Oxfordshire in the future as set out in this report.**

John jackson
Director of Adult Social Services

Background papers: N/A

Contact Officer:
Ben Threadgold, Policy and Performance Service Manager, Joint Commissioning
01865 328219

September 2015

Oxford University Hospitals NHS
NHS Trust

HOSC Meeting

Title	**Horton General Hospital update**

Status	For information and comment
Purpose	This paper provides the Oxfordshire Joint Health Overview & Scrutiny Committee (HOSC) with an update on developments at the Horton General Hospital.

Author	Mr Andrew Stevens, Director of Planning & Information

Horton General Hospital update

1. Introduction

1.1. This paper provides an update to members on the Oxfordshire Joint Health Overview & Scrutiny Committee on developments at the Horton General Hospital.

1.2. The paper:

- Provides a general update on the Trust-wide developments as they have impacted on the Horton.
- Describes developments at the Horton General Hospital over the last 12-18 months.
- Summarises other issues considered by the Community Partnership Network.
- Identifies priorities for the Horton General Hospital.

2. Trust-Wide developments

Care Quality Commission

2.1. In February 2014 a team of 51 inspectors from the Care Quality Commission (CQC) visited the Trust's four hospital sites for two days on 25 and 26 February 2014. This was followed by unannounced spot checks on 2 and 3 March 2014. In advance of the inspection, the Trust provided thousands of pages of documentation to the CQC to help with their inspection. The CQC spoke to patients, visitors, carers and staff to form an overall impression of the services the Trust provide and to rate the organisation and its service in five areas (known as domains): safe, effective, caring, response to people's needs and well-led.

2.2. The CQC also held two public meetings, one in Banbury and one in Oxford. The CQC reported that the feedback from patients and members of the public at these two meetings was overwhelmingly supportive. During the two weeks of the visits, inspectors repeatedly tested out their initial findings.

2.3. Overall the CQC rated the Trust as good. The Trust was also rated as good overall against each of the five domains. Of 115 areas inspected at the Trust, 104 were judged as good and only 11 as requiring improvement. The Horton General Hospital as well as the Churchill Hospital and the Nuffield Orthopaedic Centre were all judged as good overall. The John Radcliffe Hospital because of some issues in the Emergency Department and Surgery was rated as requiring improvement.

2.4. The CQC identified many areas of good practice. The report also highlighted areas where the Trust was required to take action. These actions have formed part of an overall action plan which has been overseen by the Trust Board.

Foundation Trust application

2.5. The Trust has continued to pursue its Foundation Trust application. This has included an update to the Trust's Integrated Business Plan and Long Term Financial Model. The Trust is currently in the final Monitor assessment phase of the process.

2.6. The elections for the Council of Governors have taken place. The elected public governors from the catchment area served by the Horton General Hospital are:

- Cherwell
  - Anita Higham, OBE
  - Teresa Allen
- Northamptonshire and Warwickshire
  - Rosemary Herring
  - Steve Candler

2.7. Three of the four elected public governors are or have been members of the Community Partnership Network. This will help to ensure strong representation of issues relating to services in the North of the County on the Trust's Council of Governors, which will formally assume its new role once the Trust has achieved Foundation Trust status.

3. Service issues and developments

Emergency abdominal surgery

3.1 At its meeting in February 2014, the Health Overview & Scrutiny Committee agreed that it was it the best interest of patients for the suspension of emergency abdominal surgery at the Horton General Hospital to become permanent.

3.2 Since that time, further action has been taken to strengthen services within the surgical emergency unit at Oxford to ensure that all patients that are referred from anywhere in the county receive timely and effective care. Consultant staffing has been restructured to increase significantly the availability of consultant input onto the unit, which helps to ensure that patients receive an early assessment from a senior clinician. It also ensures that staff at the Horton can access a senior surgical opinion when required. In addition, consultant physician input into the unit has been introduced to enhance the level of care that patients receive including any associated non-surgical needs. Further strengthening actions are being taken, including the appointment of an additional consultant and two advanced surgical nurse practitioners.

3.3 The arrangements in place have been assessed as operating effectively by the Oxfordshire Clinical Commissioning Group and local GPs.

3.4 A comprehensive audit of the new arrangements was presented to the Community Partnership Network at its meeting in March 2015. This demonstrated that if one compares the ten month period between March and December 2013 and the same period in 2014, there had been a reduction of 14.6% in the number of patients who have needed to travel to Oxford. (Despite this overall reduction, during this period the number of people who did have to travel to Oxford and who were subsequently assessed and discharged without admission rose by 2%. Further action is being taken to reduce the number of patients in this category).

3.5 The table below compares the number of referrals for the last 3 months of 2013 and the equivalent period for 2014. This shows that on average there are ten fewer patients per month travelling to Oxford. This trend has continued.

Transfers of Emergency Abdominal Surgery Patients to Oxford

Month	2013 No. of patients	2014 No. of patients	2013 - 2014
October	**106**	**96**	**-10**
November	**97**	**90**	**-7**
December	**87**	**74**	**-13**
Total Q3	**290**	**260**	**-30**

3.6 As noted above the availability of consultant specialist opinion on a 24x7 basis at the Surgical Emergency Unit at the John Radcliffe together with other enhancements of the pathway have helped to achieve this reduction.

3.7 The Trust is also planning to introduce video “consultations” to further strengthen the patient pathway.

Cardiac rehabilitation services

3.8 A key theme of service developments at the Horton (and indeed across the Trust) has been to ensure that services are focused on providing care for those patients with the greatest needs that can be best addressed within an acute setting. To this end, cardiac rehabilitation services at the Horton have been refocused to offer a five day a week service for patients still under the care of the hospital. This now includes a Wednesday evening exercise and education class in the gym to allow patients who have returned to work, following their cardiac event the opportunity to attend the programme. This is an additional session that had not been previously available to patients from the Banbury area.

3.9 Once patients have completed this part of the programme they are still encouraged to continue exercising and maintain their health to prevent problems. Historically, in Banbury, this was done through an arrangement at the Horton gym. However, this was not in line with how the services are provided across the rest of the county where ex-patients are encouraged to continue exercising at their local gyms. Discussions were held with a local gym

in Banbury to provide an alternative service in the community. The local Spice Ball gym agreed to allow patients to attend at a concessional rate and this service model is line with national service provision and with local services at Witney and Abingdon, also within the OUH catchment area. The Trust will also seek to link with complementary services provided by Age UK across the county

Rowan Day Hospital

3.10 In a similar manner, the focus of the Rowan Day Hospital has moved away from providing social care to focussing on acute medical care and intensive rehabilitation. This development has been a joint objective of the Clinical Commissioning Group and the Trust. The Clinical Commissioning Group, supported by social care, has worked with GPs to signpost them to alternative providers of the more social care orientated services that had previously been provided in the Rowan Day Hospital.

3.11 Local GPs are referring patients with social and rehabilitation needs to the County's single point of access (SPA), which provides GPs and other healthcare professionals with a quick and easy way of referring patients to community health services, e.g. community therapy and community nursing. Oxford Health's community services include physiotherapy and assessments by occupational therapy to determine what aids or upgrades are needed to enable people to live safely at home. Social services include re-enablement, which offers short term social care, pendant alarms, day centres, volunteer centres and lunch clubs. They often refer to Age UK whose networkers can visit people in their own homes and talk to them about services that are available to them locally and encourage them to get involved. These patients are receiving the health and social care that they require in community settings or in their own home.

3.12 This development enables the Rowan Day Hospital to concentrate on both patients with the most acute needs and to provide a series of rapid response clinics. The Rowan Day Hospital is now providing services in the following areas:

- Day case blood transfusions
- Iron infusions
- Short synacthean tests
- Oxygen trials
- Magnesium infusions
- Infliximab
- Bloods
- Wound reviews
- IV antibiotics
- Balance and safety classes

3.13 In addition, the Rowan Day Hospital is also providing the Horton with a discharge lounge facility, mirroring the service available at the John Radcliffe

Hospital. The discharge lounge makes a significant contribution to the maintenance of patient flow through the day hospital.

3.14 This development at the Rowan Day Hospital was identified as an example of good practice by the CQC and is being progressed as part of the wider strengthening of acute general medical services on the Horton site. Additional developments include strengthening the medical input on the acute medical wards and enhancing the role of the supported hospital discharge service.

Psychological medicine services

3.15 The Trust has been innovative in its response to the significant and increasing proportion of patients on acute wards who are suffering from mental health problems alongside their physical needs. These will include patients with temporary mental health problems as well as those with more chronic conditions such as dementia.

3.16 The Trust has established its own psychological medicine service that works in a fully integrated way with other specialities. The Horton General Hospital has benefitted from this development.

3.17 On 24 November 2014, the Trust held a public meeting at the Mill Art Centre in Banbury as part of its wider public engagement strategy. Dr Sarah Pendlebury, an associate professor/honorary consultant, gave a presentation on “dementia and delirium; the impact of stroke and acute illness on thinking and memory”. The meeting was very well attended and there was a lively and challenging question and answer session.

Services for children

3.18 There have been a number of significant developments in services for children that are delivered at the Horton General Hospital. These have included:

- The development of a rapid access clinic for children
- The establishment of a range of services for children with cancer
- The expansion of paediatric surgical operating lists
- The establishment of a dedicated teenager/adolescent bay on the ward

3.19 In addition, the Trust has built and opened a purpose build children’s outpatient facility in the area previously housing management offices. This has greatly enhanced the facilities available for the care and treatment of children at the hospital.

3.20 All these developments are resulting in fewer children and their families having to travel to Oxford for their care and treatment.

Winter pressures

3.21 The north of the county, in common with the rest of Oxfordshire and the neighbouring communities witnessed a significant level of winter pressures over the winter. Overall patients served by the Horton have been impacted less by these pressures than those in Oxford. This is illustrated in the tables below.

3.22 The first table identifies the performance against the emergency 4 hour wait standard for the Emergency Department's at the Horton and the John Radcliffe for quarters 3 and 4 of 2014/15.

Emergency Department 4 hour performance – Quarter 3 and 4 of 2014/15

Month	Horton			JR		
	Attends	Breaches	% Perf.	Attends	Breaches	% Perf.
October	3,514	108	96.93	8,339	1,013	87.85
November	2,810	201	92.85	6,686	1,257	81.20
December	2,798	329	88.24	6,587	1,335	79.73
Total Q3	9,122	638	93.01	21,612	3,605	83.32
January	3,170	393	87.60	7,238	1,552	78.56
February	2,709	142	94.76	6,266	1,050	83.24
March	2,950	221	92.51	6,687	1,433	78.57
Total Q4	8,829	756	91.44	20,191	4,035	80.02

3.23 The next table provides data on cancellations as a result of bed shortages and compares the figures for 2013/14 with those for 2014/15.

Cancellations due to bed shortages

Site	2013/14	2014/15
Horton	8	11
JR	276	241

3.24 As the Health Overview & Scrutiny Committee will be aware, further action is being taken to seek to improve the systems resilience in the face of increases in demand pressures, particularly over the winter period.

Other service developments

Outpatients

3.25 The area of the general outpatients clinic freed up by the transfer of paediatric clinics to the new children's outpatients department has been used to increase the level and range of cancer clinics held at the Horton General Hospital.

Interventional ultrasound

3.26 The Ultrasound Department at the Horton General Hospital has been completely redeveloped in a £1m+ capital scheme. This has greatly enhanced the patient experience and the functioning of the department.

Pathology

3.27 The Trust is continuing to roll out core automation at the Horton General Hospital replacing existing equipment with new.

Ophthalmology services

3.28 A new ophthalmic microscope has been installed to replace the old piece of equipment. This £100,000 investment in new medical equipment will support the enhanced provision of ophthalmic services for the resident of Banbury and the surrounding communities.

Pharmacy services

3.29 The Trust took to the Community Partnership Network a series of options for potential efficiencies to the pharmacy service across the Trust. Taking into account the feedback from the Community Partnership Network and local stakeholders, the Trust only progressed those components that did not have an impact on the patient-facing pharmacy service. This involved the rationalisation of pharmacy stores.

4. Future priorities

4.1 Future priorities for the Trust in relation to services provided to patients in the North of the county include:

- Replacing the CT scanner at the Horton
- Redeveloping and enhancing endoscopy services at the Horton
- Developing outpatients and day surgery procedures at the Horton
- Centralisation at the Horton of Oxfordshire referrals for routine/minor urology procedures.

4.2 All the above measures are the subject of business cases that are in the process of being developed.

5. Conclusion

5.1 The above paper details the significant development of services that have taken place at the Horton General Hospital over the last 12 to 18 months.

Andrew Stevens
Director of Planning & Information
20 August 2015

healthwatch Oxfordshire

1. Introduction

1.1 This paper seeks HOSC's support on the main issues that the Healthwatch team have been working on since the last meeting in July 2015. It covers:

- Community Hospitals.
- The Big Plan.
- The findings of our report on Improving Discharge from Hospital in Oxfordshire.

1.2 Each section of the report sets out what Healthwatch believes needs to happen next, and we would welcome HOSC's formal support for each of these proposals.

1.3 We hope that the main focus of debate at this HOSC meeting will be our report on Discharge from Hospital, but feel it is important that other key issues of concern that have arisen since the last HOSC meeting are also reflected.

2. Community Hospitals

2.1 Healthwatch Oxfordshire is concerned on a number of fronts about the developments that have taken place this summer in relation to the county's community hospitals. We understand the financial constraints under which commissioners and providers are operating, but the piecemeal approach to reconfiguration of services which appears to be taking place, and the nature and tone of the conversation on these developments is clearly worrying those members of the public who have contacted us about these developments.

Concerns raised are threefold:

a) Will supply meet need after the current changes?
b) Is there a proper strategy relating to provision of sub acute and intermediate care in our market towns, if so what is it and if not when will there be consultation on formulating one?
c) How can we have ensure that future conversations with the public build trust and understanding, and are not ever perceived as evasive or antagonistic?

2.2 Supply vs. need

Healthwatch will be asking OCC and OCCG formally for:

a) A summary of the data and information on which they have assessed the need for the number of episodes of intermediate and sub acute bed based care that

is required in the county now, and of their projections for future need, to be released to the public.

b) Evidence that this data and information has been used to inform decisions made this summer in relation to Witney, Henley and Chipping Norton community hospitals.
c) Evidence of how they are assured that supply will meet their projections of need after the changes proposed to these 3 hospitals takes effect.

We hope that HOSC will endorse our request.

2.3 Strategy

Some members of the public have asked us whether there is an overall strategy for current and future provision of community hospital and intermediate care beds, and whether this is being delivered in bite size chunks in order to implement the desired changes whilst avoiding the need for full consultation. We would like to be able to re-assure the public that this is not the case.

Healthwatch will be asking OCC and OCCG formally whether:

a) There is an overall strategy for current and future community hospital and intermediate care beds (formal or otherwise), and if there whether it can be shared?
b) If there is not, can we please have a statement regarding any plans to develop and implement a strategy for community bed based care.

We hope that HOSC will endorse our request.

2.4 The tone of the conversation

Healthwatch wants to work with HOSC to help the commissioners and providers we both exist to scrutinise to adopt as open, transparent and positive a tone in their dialogue with the public as possible, and to hold them to account appropriately when they are perceived by some members of the local community to have failed to do this.

It is the role of Healthwatch Oxfordshire to report the views we hear about proposed service changes, to pass on the feedback we receive about the quality of consultation processes and to go back to the public and report the responses we have received. As ever, we recognise that we often only hear from those members of the community who are unhappy about something and that the views we hear may not be representative of a whole community.

We also recognise the financial constraints that commissioners and providers are working under, and we recognise that OCC and OCCG have invested considerable time and resources in talking to concerned members of local communities across Oxfordshire.

That said, the debate about community hospitals this summer has generated strong feedback to Healthwatch about how the conversations could be undertaken better.

For example:

- The tone of OCC's announcement at the last meeting of HOSC about its proposed consultation in Chipping Norton generated feedback to Healthwatch that the local community felt threatened that if they did not agree with the proposed service change then they would lose their service completely. This has resulted in some members of the community telling us that they have lost trust in the validity of the proposed consultation, before it has even begun.

- The media release relating to the temporary closure of Wenrisc ward in Witney was perceived as being very opaque about how OHFT and its commissioners planned to resolve the underlying issue that OHFT cannot operate 30 of its beds because of financial and staffing constraints, once the refurbished ward in Witney re-opens. The admission of an underlying problem (the honesty of which was welcomed by those talking to us), combined with the lack of clarity about any long term solution has generated feedback to Healthwatch that some members of the public are concerned that the ward closure will not be temporary, or that other beds will have to close when Wenrisc re-opens.

Healthwatch was grateful that providers and commissioners delayed the start of the proposed consultation in Chipping Norton in order to consider how best to run this. We will be closely observing any further consultation activity (formal or otherwise) in relation to changes to service in community hospitals, in order to try and ensure it is as fair, open, transparent and constructive as possible.

Healthwatch believes that:

a) In both instances communication could have been done better.
b) Providers and commissioners could and should adopt a more transparent and constructive approach to public dialogue about changes to local services, even when full formal consultation is not required.

We hope that HOSC will endorse our assessment of how the consultation process could be improved.

2.5 The Big Plan

As reported to the July meeting of HOSC, a number of individuals and organisations have contacted us raising concerns about the planned changes to Learning Disability services. We know that OCC undertook a major consultation on the Big Plan, which many people took part in. However, worries are still being expressed to Healthwatch by some service users, voluntary organisations, staff and relatives and it is our responsibility to pass these on.

Healthwatch has written to the Director for Adult Social Care to raise these concerns and to request clarification on the steps that will be taken to address them. We are grateful that OCC has replied to these letters, and have shared the responses received with those who originally approached us to raise concerns. The main elements of the correspondence are attached as Appendix 2.

The concerns raised with us are that:

- The consultation document and process did not make it clear that the option of mainstreaming services meant that specialist teams would be disbanded.
- Disbanding specialist teams will remove a service that is vitally important to service users.
- The speed of the planned change means that new teams cannot possibly acquire the skills and experience required to replace the specialist community teams safely.
- The plan fails adequately to address the housing needs of the learning disabled population.
- The plan does not adequately address the issue of transition from children's to adult services.
- OHFT's most recent staff survey reports very high levels of bullying and harassment, and there is a concern that the Trust may not be able to manage the organisational change programme required to achieve a good transition at high speed – with subsequent risks to patients.
- The planning for this change of providers is not being informed by the lessons learned from the experience of transferring learning disability services from the Ridgeway Trust to SHFT.

Unfortunately the people and organisations who brought us their concerns have said to Healthwatch that they do not feel re-assured by the answers given - particularly in relation to the loss of specialist skills and the proposed speed of transfer of services from Southern Health Foundation Trust to a new provider. As far as we or the public know, these services are still due to transfer from Southern Health FT to Oxford Health FT in January 2016.

Healthwatch remains concerned, on their behalf, that transfer of services at this speed will create a risk to patient care. We will be asking commissioners and providers to re-assure the public that a proper transition plan is in place, to share the detail of this as soon as possible, and to demonstrate that this will be slow enough to allow for proper risk assessment and proper risk management.

We hope that HOSC will endorse our request.

3. Improving discharges from hospital in Oxfordshire

Healthwatch is today publishing its report into Improving Discharges from Hospital in Oxfordshire. This report presents the feedback we received from 212 patients, 14 care providers, 33 GPs and 44 pharmacists in the period March-April 2015.

In considering the report's recommendations we would like HOSC to note that the methodology, sample sizes and questionnaires were all developed and agreed with input from the relevant commissioners and providers, and that they voluntarily withdrew from the project steering group at the point we began to analyse findings and develop recommendations in order that the public could be assured that the report's recommendations are both objective and independent. Healthwatch would like to thank and congratulate OUHT, OHFT, OCCG and OCC for taking this approach, which exemplifies how local health and social care leaders should be working with their local Healthwatch.

The full report is attached as Appendix 1, but we would like to draw the committee's attention to its key recommendations:

1. Hospital trusts should take immediate action to increase the percentage of patients whose Estimated Date of Discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.

2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.

3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.

4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place.

5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just

6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed.

7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services.

8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically:

    - Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.

    - Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.

    - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary.

    - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.

9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.

10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.

11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.

12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.

13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.

14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.

Healthwatch would like to ask HOSC to consider asking OUHT, OHFT, OCC and OCCG to present a joint action plan setting out how they will respond to these recommendations at its meeting of November 19th 2015.

4. Feedback from OCCG locality forum Chairs

a) Healthwatch is developing much closer working relationships with the six locality based engagement forums set up and supported by the CCG. These groups liaise directly with patients and service users in their localities and provide feedback directly to the CCG on issues which it has the power to address.

b) Inevitably each of the forums receive feedback on services that is of interest to other bodies. Healthwatch has agreed with the chairs of these forums that it will therefore include a regular report from these locality groups in each submission it makes to HOSC and the Health and Wellbeing Board.

c) This month the South East and West Forums have asked us to report specific concerns, which we quote below:

South East has made two statements:

> "We are aware that the final plan for Townlands is to be taken to the OCCG Governing Body at their September meeting. We are pleased to note the increase in the availability of the RACU (from an original 3 days per week). Concern remains about the availability of beds and also the employment of Order of St John nurses rather than NHS nursing cover for the step up/down beds. The competence of the OSJ compared with NHS nurses is not understood and the current deduction is that because they are cheaper they might be less good at providing the care that is required. This is of course the same concern that currently surrounds the staffing of the intermediate care beds in Chipping Norton."
>
> "The lack of effective cross county boundary cooperation continues to cause concern. A recent example is where a local GP was unable to arrange wheel chair mobility support of a patient because the patient while registered with a practice in Oxon lived in Berks – this caused intense frustration as well as wasting a considerable amount of GP time."

West was:

> "Concerned about proposals to remove the District Nurse from Bampton surgery and to relocate the member of staff to a Witney based hub, but has subsequently received re-assurance from OHFT that whilst the District Nursing teams are being amalgamated, the team will still be located at the surgery".

Appendix One – Discharge report, see separate file.

Appendix Two – Healthwatch Oxfordshire's letters to OCC of June 23rd and July 3rd about the Big Plan and OCC's letter of August 6th which responds to these. All the correspondence relating to the Big Plan is available on request from Rachel.coney@healthwatchoxfordshire.co.uk

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John Jackson, Director Adult Social Care
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OX1 1ND

June 23rd 2015

Dear John,

The Big Plan

I am writing to you because a number of concerns have been shared with us about the Big Plan consultation process, the subsequent decisions made about service re-configuration and the plans to implement those changes. This letter draws together concerns that have been raised with us by 17 staff currently working in the learning disability service, all of whom have asked to remain anonymous, and/or individuals contacting Healthwatch and/or local voluntary organisations. Nobody who contacted us is seeking to maintain the status quo, but all those who have been in touch with us have serious reservations about the consultation process, the interpretation of responses and the current service change plans.

Clarity of the consultation document
People fully support the intention set out in the consultation document to ensure that locally commissioned mainstream services are accessible to people with Learning Disabilities, but contest that it was not at all clear to people answering the questions in the questionnaire that in agreeing to the statements as phrased, they were effectively agreeing to the abolition of the specialist support available from the current staff. Nor was sufficient detail given about the four new service tiers to enable people to make a fully informed response to the consultation. Staff, voluntary sector representatives and individuals have raised concerns with us that the consultation process and documentation were not sufficiently clear or accessible.
Please can you highlight the section in the consultation document that spells out clearly that in agreeing to the priorities, consultees would be agreeing to the abolition of specialist teams?

Interpretation of the responses
People who have contacted us are concerned that the commissioners have not paid sufficient heed to the very large percentage of respondents who either disagreed with the strategic intentions or were not sure if they agreed (q6) and who either disagreed with or were not sure if they agreed with the overall plan to reshape services (q7).

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52% of people with learning disabilities and 64% of others either disagreed with or were not sure about the strategic intentions, and 76% of people with learning disabilities and 73% of others either disagreed with or were not sure about the overall plan to reshape services in line with the proposed model. People who have contacted us feel very strongly that this should have signalled to commissioners that the consultation process had been inadequate and that the planned service redesign did not have the fully informed support of those responding to the consultation.
Given the answers to q 6& 7 in the consultation, please can you clarify the grounds on which the commissioners interpreted the consultation document as having secured agreement from consultees to the proposals to reshape services?

The Reasonable Adjustment Advisory Service (RAAS)
It appears that successful implementation of planned service changes relies very heavily on this team being able to build the skills of a very large cohort of staff currently employed in a wide range of mainstream services to meet the care needs of this specialist patient/service user group by January 2016. The community is concerned that this is unrealistic and that receiving services cannot possibly have identified and addressed all the adjustments they need to make in time to go live with safe and accessible services by January 2016 .
Please can you share the implementation plan for delivery of the proposed new model with us, and share with us details of the process by which commissioners will be assured that the new providers are ready and able to provide a safe and high quality service by January 2016?

Gaps in the future service model
Current implementation plans do not clearly set out how the vital advocacy, care co-ordination, social reablement and signposting services provided to individuals by the specialist health staff in the Learning Disability Community Teams will be replicated in the new model. The expectation in the community seems to be that GPs will take on this role in future, but given the strain on general practice there is real worry that this is not a sustainable solution. There is real concern therefore that even if the RAAS is able to support new providers to deliver services to this group of patients effectively, patients will struggle to access them. Patients and service users who do not have family members or informal carers able to take this care co-ordination role on will be particularly at risk, and those with carers may well see those carers put under further and potentially unsustainable extra pressure.
Please can you clarify how this care co-ordination/advocacy/reablement/signposting role will be fulfilled in the new model?

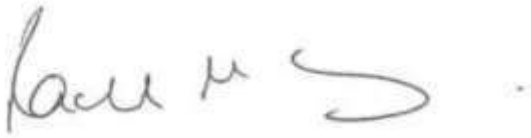
Quality of service provision
Whilst all concerned applaud the ambition of people with learning disabilities receiving their services from mainstream providers alongside everyone else, there is a very real concern that this will quickly lead to an assumption that this patient/user group do not require specialist support, and that nursing, therapy and other clinical and care staff who currently provide support to the general population will be expected to extend their support to this patient group - without the specialist training or experience required to meet their very particular needs. Even if current specialist staff are embedded into mainstream teams (eg specialist OTs joining the core OT team) , there seem to be no guarantees that their case load will be restricted to people needing their specialist skills, nor that anyone needing their specialist skills will be guaranteed a referral specifically to them. This raises concerns that the quality and appropriateness of services available to this particularly vulnerable patient group will deteriorate.
Please can you clarify what safeguards will be built into the new contracts which ensure that there will be no erosion of access to appropriate specialist skills for this patient cohort when services transfer to new mainstream providers?

Long term erosion of skills
Following on from concern that the new model will result in deterioration of access to specialist skills, there is a concern that we will not be able to develop a future specialist workforce in the County. The current service provider offers an important source of training opportunities for nursing, psychiatry, psychology and OT students wanting to specialise in providing services to people with Learning Disabilities. If Oxfordshire can no longer provide those training placements there is concern that in the future this growing patient cohort will be unable to access care from staff with appropriate specialist skills.

Please can you clarify what plans have been put in place with the relevant education bodies to ensure new providers can offer an attractive range of training opportunities so that future specialist workforce needs can be met in a sustainable way in Oxfordshire?

Given the very rapid timetable for implementation of the Big Plan I would be grateful if you could provide Healthwatch, on behalf of those who have been in touch with us, with a response to these specific questions within 14 days.

Yours sincerely



Rachel Coney
Chief Executive

Cc David Smith, Chief Executive OCCG, Cllr Yvonne Constance Chair of HOSC

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John Jackson, Director Adult Social Care
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July 3rd 2015

Dear John,

The Big Plan

Since I wrote to you on June 23rd, I have had further concerns raised with me, by individual Clinical Psychologists, and by a member of staff who wrote on behalf of the whole SHFT psychology team. These staff are at pains to state that their concerns are not motivated by fear for their own jobs, but by genuine concern for service users and their families.

The additional concerns brought to our attention by them in recent days are as follows:

The Big Plan and subsequent follow on documentation lack any detail on what implementation really looks like so staff do not understand how can risks be identified and managed and impact assessments be meaningfully completed. The lack of clarity and detail also faces staff with the ethical dilemma of how to handle communication with clients and their families as they are negotiating plans for therapy and interventions - particularly as it seems likely that the thresholds for access to psychology are likely to increase in the new service.
Please can you now publish the detailed service implementation plans against which risk and impact assessments have been carried out?
Please can you also clarify the providers' timetable for finalising detailed implementation plans and service specs and for communicating these to the staff currently providing care to this vulnerable patient group?

Staff report that many service users and families are still unaware of the Big Plan, and even those who are aware of it do not seem to realise that the services they currently access will no longer be provided in the same way.
Please can you set out how you will work with providers to ensure all those affected genuinely understand what is going to happen before services change?

Staff report that many GPs, and colleagues in mainstream services are as yet unaware of the Big Plan and its implications for them and their clients.

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Please can you set out how you will work with providers to ensure all these other professionals affected by these proposals genuinely understand what is going to happen?

I have already raised with you concerns about how staff in mainstream services can be adequately skilled up in 6 months to take over from specialist teams. SHFT staff now report that over very many years they have struggled to get mainstream MH services to see people with learning disabilities and are concerned that the cultural change required cannot be delivered in the time planned for implementation.
Please can you explain to how us you will be assured that appropriate organisational and cultural change programmes are in place to ensure a secure and safe transfer of services?

Staff currently support many people who do not feature in the Plan - for example they work with a considerable number of people who display difficult behaviour but who wouldn't meet the criteria for the intensive support team, with the aim of improving things before they escalate to a crisis.
Please can you explain to us how this group of users needs will be met in future?

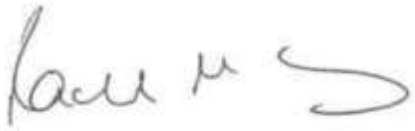
The psychology team currently undertakes a lot of work to support other teams who are working with people with complex mental health/.behavioural issues. Without this support many placements will be at risk of breakdown.
Who will be responsible for providing this support in future?

I have already raised concerns with you about how we keep a suitable skilled workforce in Oxfordshire for this community in the long term. However it is now apparent that extremely competent staff are already leaving Oxfordshire because of the uncertainty created by the Big Plan, and that this presents a real challenge for the safe provision of services while change is being implemented.
Please clarify the plans that are in place to ensure that adequate levels of suitable skilled staff can be retained through the period of transition.

On a slightly different note we have been asked what will happen to the Slade House site when services are transferred to OHFT and OUHT, whether this will be sold and whether the proceeds will be re-invested in healthcare estate in Oxfordshire?
Please can you tell us what the plans are for this site and, if it is to be sold, who will benefit from the proceeds of the sale and what if any restrictions/requiremetns will be put on them about use of the capital receipt?

Given the very rapid timetable for implementation of the Big Plan I would be grateful if you could provide Healthwatch, on behalf of those who have been in touch with us, with a response to these additional questions by the 13th July as part of your response to our original letter.

Yours sincerely



Rachel Coney
Chief Executive

Cc David Smith, Chief Executive OCCG, Cllr Yvonne Constance Chair of HOSC

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire County Council
New Road
Oxford
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John Jackson, Director of Adult Social Services

6th August 2015

Rachel Coney
Healthwatch Oxfordshire
Suite 2, Whichford House
1400 John Smith Drive
Oxford Business Park South
Oxford OX4 2JY

Dear Rachel,

The Big Plan

Thank you for your letter of 23rd July seeking further clarification in response to the questions you raised in your earlier letters of 23rd June and 3rd July.

In responding to the first part of your letter, and the specific question about the grounds on which the consultation outcomes were deemed to support the proposals, I would reiterate to th explanation in my previous letter; the purpose of consultation is not to secure agreement from consultees on proposals to changes services, or to provide a referendum that has a binding outcome. Rather, it is to ensure that people have the opportunity to comment and the potential to influence decisions by raising comments, issues and concerns, and that these are then considered as part of the decision-making process.

As set out previously, this opportunity was extended in a number of ways, including public and stakeholder meetings as well as online questionnaires, and the feedback from all these was captured in the summary report. It is also important to reiterate that the proposals were co-produced with people with learning disabilities, their families and professionals working with them across health, social care and the private and voluntary sectors.

The outcomes of the consultation process were reported to Cabinet, including a number of changes to proposals made as a result – these included the addition of an additional coordination function for medically complex patients and the move of the intensive support function into mainstream contracts. The Cabinet report stated that there was broad overall agreement with the vision and priorities, but also that there were a number of concerns raised about the ways it would be implemented. The Cabinet also received a Service and Community Impact Assessment setting out the risks of implementing the proposals in the Big Plan and mitigating actions where possible. In light of the financial challenges facing the Council, amendments to the proposals to reflect the outcomes of the consultation, and the mitigating actions identified the Cabinet took the decision to agree the proposed way forward.

Following the Cabinet decision, we are now in the process of developing detailed implementation plans. This is a very complex situation and there are a number of ongoing contract negotiations between the County Council, Clinical Commissioning Group and current and potential future providers of health services for people with learning disabilities in the County, so it would be inappropriate for me to go into detail at this time. However, I have responded to as many of your questions as possible below, and I am happy to commit to responding to the others in due course as the plans are developed and agreed further.

2. **Please can you highlight the section in the consultation document that spells out clearly that in agreeing to the priorities, consultees would be agreeing to the abolition of specialist teams?**

   The Big Plan sets out our strategic intentions clearly in the Strategic intentions section. In reference to specialist teams this says:

   "We will ensure health services make reasonable adjustments so that people with learning disabilities get the right level of care for their condition and advice on living well. This includes general practice, dentistry, acute health care, physiotherapy, and speech / language therapy.

   Rather than commission different health services for people with Learning Disabilities we will ensure mainstream health services make reasonable adjustments so that people with learning disabilities get the right level of care for their condition and advice on living well. This includes general practice, dentistry, acute health care, physiotherapy, and speech / language therapy.

   We will work with NHS England and local providers to ensure that nationally commissioned health services also make reasonable adjustments to support people in Oxfordshire living with Learning Disabilities. This includes primary care and dentistry and some hospital services

   We are proposing to change the way we commission and provide learning disability specific health and social care. As part of this work, we will establish a clear process for assessing eligible need for specific health and social care. We will provide services that maximise independence whilst continuing to meet assessed eligible needs." (p12)

   The strategy also sets out the proposed situation post-January 2016. It says

   "***Physical Health Support***
   Physical health support for adults with a learning disability will be provided by the NHS services that are available to the general population. We will explore how this can be achieved and what this means for non-specialist services.
   This is likely to be community health provision for speech and language therapy, neurology for epilepsy support, physiotherapy, dietetics, and occupation therapy in relation to mobility and other physical issues.

   Mental Health Support
   Mental health support for anybody with a mental health problem will be provided through mental health services. It is our ambition to bring the needs of people with learning disability and severe mental illness into scope of our developing approaches to outcomes

based contracting. People would have the same approach to their care, whether in the same or aligned services. This would include community and bed based care." (p13-14)

In reference to social work provision the strategy says *"Learning disability social care assessment and planning will be delivered in the same way as social care assessment and planning for everyone in Oxfordshire." (p14)*

3. **Please can you share with us details of the process by which commissioners will be assured that the new providers are ready and able to provide a safe and high quality service by January 2016?**

   As set out above, this is the subject of ongoing negotiations between the County Council, the Clinical Commissioning Group and the provider trusts. Appropriate assurance is built into the procurement, tendering and contract negotiating process, including gateway reviews and decision points. If at any point there are concerns about the ability to ensure a safe and high quality service, appropriate action and escalation will take place.

4. **Please can you clarify how this care co-ordination/advocacy/ reablement/signposting role will be fulfilled in the new model?**

   In terms of Care Coordination, for most people this will be provided in the same was as for other people across different client groups in line with the overall mainstreaming approach. However, there are also a number of proposals in recognition of specific needs, including the Autism and Intensive Behaviour Support service which will provide a 7 day a week early intervention and intensive support service for a small number (in the order of 250 in a year). The focus of the service will be on supporting the individual and the people they are living with (either family or support provider) to develop ways to effectively live together." (Big Plan, p15)

   In response to the consultation, the proposals agreed by Cabinet include the creation of a Medically Complex Case Management function to ensure that those people who need it have an integrated health service. This is in addition to the case management function for behaviourally complex clients.

   We will continue to commission advocacy in the same way as before. The Big plan proposes no change to this. This includes the commissioning of Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA) services, alongside the commissioning of peer and family advocacy groups. In line with our responsibilities under the Care Act, advocacy support will also be available to anyone who needs support engaging with any part of the assessment and support planning process.

   The Big Plan clearly sets out the reablement and signposting role as appropriately sitting in the community in a Learning Disability Wellbeing and Employment service.

   "*Our vision for the future is that the Learning Disability Wellbeing and Employment Service will have a broad responsibility to support people with learning disabilities across Oxfordshire to work, volunteer, and connect to their local community. Building on models with an evidence base of success this is likely to be a supported employment model alongside a community connector model.*

The Learning Disability Wellbeing and Employment service will be expected to work closely within the Mental Health pathway, and the Autism and Behaviour Support pathway, as well as receiving referrals from the Community Learning Disability Team. There may be scope for bringing a number of current people receiving day services into this service and this may increase the funding available for this service. This will be covered by the day services review." (Big Plan, p13)

We are in the process of specifying and procuring this service, which we are doing alongside people with learning disabilities, and anticipate it will be in place by early 2016

5. **Please can you clarify what safeguards will be built into the new contracts which ensure that there will be no erosion of access to appropriate specialist skills for this patient cohort when services transfer to new mainstream providers?**

   The new contract will specify the provision of appropriate access and support being available for all patients, as all current contracts do. Compliance with this requirement will be monitored as part of existing and ongoing contract management arrangements.

6. **Please can you clarify what plans have been put in place with the relevant education bodies to ensure new providers can offer an attractive range of training opportunities so that future specialist workforce needs can be met in a sustainable way in Oxfordshire?**

   The County Council has already agreed a workforce strategy for adult social care with a range of stakeholders including education bodies. Discussions are ongoing to develop a wider strategy for health and social care in the county, and links to education bodies will form an important part of addressing the needs of employers in the future. The contract with the new provider will also specify the requirement to ensure staff are appropriately trained, and compliance with this will be monitored as part of existing and ongoing contract management arrangements.

7. **Please can you clarify the timetable you expect providers to be working to for finalising detailed implementation plans and service specs and for communicating these to the staff currently providing care to this vulnerable patient group?**

   As set out above, this is the subject of ongoing negotiations and agreement. Outcomes of this process and details of implementation will be communicated to staff as soon as possible, and ongoing communication will be maintained throughout and beyond implementation.

8. **Please can you set out how you will work with providers to ensure all those affected genuinely understand what is going to happen before services change?**

   A detailed communications plan will be developed as part of the implementation plans.

9. **Please can you set out how you will work with providers to ensure all the other professionals affected by these proposals (and not employed by SHFT or OHFT) genuinely understand what is going to happen?**

   A detailed communications plan will be developed as part of the implementation plans.

10. **Please can you explain to how us you will be assured that appropriate organisational and cultural change programmes are in place to ensure a secure and safe transfer of services?**

    Transitional arrangements form part of the current negotiations. The success of the transition will be monitored closely as part of existing and ongoing contract management arrangements.

11. **Please can you explain to us how the needs of people who display difficult behaviour but who wouldn't meet the criteria for the intensive support team will be met in future?**

    Adult Social Care will continue to provide services on the basis of Care Act eligibility criteria. Where people have eligible health or social care needs, support for people with complex and challenging behaviour will be available from the intensive support team which will provide an accessible and home based service.

    Where people do not have eligible health or social care needs they will be signposted to information and advice, and other community based services. They will also be able to access the new Wellbeing and Employment Support Service, which will support social activity, physical activity, wellbeing, volunteering, and employment. The intensive support function for people with complex and challenging needs will also be open to referrals, and will respond where people's needs increase.

12. **Please explain who will be responsible for providing the support currently provided by the psychology team to other teams who are working with people with complex mental health/behavioural issues in the future?**

    The provision of necessary psychology support will be the responsibility of psychology services provided through mainstream contracts. Transitional arrangements form part of the current negotiations and the success of the transition will be monitored closely as part of existing and ongoing contract management arrangements.

13. **Please clarify the plans that are in place to ensure that adequate levels of suitable skilled staff can be retained through the period of transition.**

    Transitional arrangements form part of the current negotiations and the success of the transition will be monitored closely as part of existing and ongoing contract management arrangements.

14. **Please can you tell us what the plans are for this site and, if it is to be sold, who will benefit from the proceeds of the sale and what if any restrictions/requirements will be put on them about use of the capital receipt?**

    This is a matter for Southern Health Foundation Trust, working with NHS Englandand Monitor. We have not heard from Southern Health that they are intending to sell the site. The Council's position would be that, if sold, the proceeds from any sale should be used for the benefit of people in Oxfordshire, and that the site should continue to be used for health and social care purposes.

In conclusion, I am pleased that you will accept the invitation to meet with Benedict Leigh and Ian Bottomley to discuss this further. As I'm sure you can appreciate this is a complex and rapidly evolving situation and they will be able to discuss the emerging plans with you. They will also discuss the ongoing communications with Healthwatch Oxfordshire, and the role the organisation can play in providing assurance for patients and carers. They will be in contact to arrange this.

Yours sincerely,

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Director of Adult Social Services

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www.oxfordshire.gov.uk

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healthwatch Oxfordshire

Improving discharges from hospital in Oxfordshire

Healthwatch Oxfordshire

September 2015

Overall in-hospital care was excellent. After first night surgeon discussed with me the option of leaving that day or staying another night, leaving the decision to me and my carer (my wife, who is a nurse). Over course of the afternoon, with the support of the duty nurse, we decided that I was fit to be discharged and that was arranged promptly for late in the afternoon. The excellent aspect of this was that I and my wife were completely involved in the decision process, along with the very supportive duty nurse and the prior approval of the surgeon.

A resident with Parkinson's was going to be discharged and staff contacted hospital as they had not got the full history of client. By all working together a full package and with care and support was set up and also a move to alternative accommodation was authorised so client able to live independently with wife at home.

A Discharge Summary is precively that - a Summary, not the clinical narrative that lead to the test request e.g. obs, symptoms, signs etc… I currently am a clinician involved in a case where a patient was admitted and discharged three times in a row with no discharge correspondence at all - she died in the back of an ambulance on the way back to the hospital... This is an extreme example of where failure to provide discharge correspondence might have improved her assessment and prevented her death...

Not sure about how he will get home. Feel that he's been sitting on the discharge ward for 4 weeks. Could have been home earlier. Been a nightmare experience. He is weaker, lost hope, difficult for wife. Lots of false hope of discharge.

All quotes in this report are verbatim and unedited

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1 Executive Summary

Oxfordshire continues to have a seemingly intractable problem with discharging people from hospital in a timely and effective way. At July 9th 2015 the year to date average is still for 158 people to be experiencing a delay in their discharge from hospital in any given week – and there has been no sign of consistent improvement in these figures for many years.

In this context Healthwatch Oxfordshire wanted to know what those affected by the discharge process thought about how it could be improved, and sought the views of patients, and of professionals who provide ongoing care after a patient has been discharged from hospital. We did not specifically focus on patients experiencing a delay in their discharge, as we recognise that they are a small subset of those being discharged from hospital.

This report presents the feedback Healthwatch Oxfordshire received about the discharge process from Oxfordshire hospitals from 212 patients, 14 care providers, 33 GPs and 44 pharmacists in the period March-April 2012, all of whom volunteered their views by choosing to participate.

We would like to thank and congratulate the staff and leadership teams in Oxfordshire Clinical Commissioning Group, Oxfordshire County Council, Oxford Health Foundation Trust and Oxford University Hospitals Trust for their co-operation with this project. They all enabled senior staff to join the project steering group. This meant that the project design, the questionnaires, the sample sizes and other key decisions about the project methodology were co-designed with them – so that we could ensure the findings would be useful to them. All four organisations then voluntarily withdrew from the steering group when we began the analysis of the data, so that the public can be assured that the recommendations this report makes have been derived independently of any influence from the affected commissioners and providers.

The 14 main recommendations arising from our study are that:

1. Hospital trusts should take immediate action to increase the percentage of patients whose Estimated Date of Discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway[1]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.

2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.

3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.

4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place.

5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them.

6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed.

7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to

[1] See Appendix 1 for the summary pathway

use any specialist provision, and whether there might be any costs to patients for these services.

8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically:
    - Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.
    - Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.
    - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary.
    - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.

9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.

10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.

11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.

12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.

13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.

14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.

2 Background

2.1 Reasons for the report

Healthwatch Oxfordshire is concerned that the voices of patients and carers have not been sufficiently heard, or responded to, in the ongoing debates between health and social care providers and commissioners about how to improve the discharge of patients from Oxfordshire's hospitals.

This report aims to bring the voices of those being discharged, and those caring for them, into the debate. We hope that commissioners will take its findings into account when setting quality standards – and that providers will respond to the recommendations. The quotes included have been carefully selected to reflect the balance of comments made by respondents.

2.2 Strategic drivers

Discharges from Oxfordshire's hospitals are an area of focus for Healthwatch for a number of reasons, including:

- Patient Voice, an experienced and active patient group, identified the need to carry out an initial study into Discharge arrangements and submitted a proposal to the Healthwatch Project Fund. As they were ineligible for funding, Healthwatch Oxfordshire decided to carry out an extensive and detailed study, incorporating the views of patients, carers, GP's and pharmacists.
- Oxfordshire is one of the worst performers in the country for Delayed Transfers of Care.
- Local GPs have raised the issue of the quality of the discharge process as an area of concern with Oxfordshire Clinical Commissioning Group.
- Healthwatch England has been sufficiently concerned about this issue to undertake a national special inquiry on the topic.

2.3 Healthwatch England's Special Inquiry: Safely Home

Concurrent with Healthwatch Oxfordshire's work to understand the discharge process from the patient perspective, Healthwatch England launched a special inquiry into hospital discharges. They heard from over 3000 people on their experiences of discharge and used available data to better understand the discharge process.

They highlight a June 2015, YouGov poll which outlines that:

- 18% did not feel they received all the social care support they required after leaving hospital.
- 1 in 4 (26%) felt their friend/relative did not receive the social care support they needed.
- 1 in 5 (21%) did not feel they were involved in decisions concerning hospital treatment and planning discharge, and the same proportion (22%) felt their friend/relative was not involved as an equal partner.
- 1in 8 (12%) did not feel they were able to cope in their own home after being discharged from hospital. 1 in 4 (24%) did not feel their friends/relatives were able to cope.
- 14% did not know who to contact for further help following treatment, 18% of people felt their friend/relative did not know who to contact.[2]

In their findings Healthwatch England list five reasons things that go wrong, including:

1. People are experiencing delays and a lack of coordination between different services;
2. People are feeling left without the services and support they need after discharge;
3. People feel stigmatised and discriminated against and that they are not treated with appropriate respect because of their conditions and circumstances;
4. People feel they are not involved in the decisions about their care or given the information that they need; and
5. People feel that their full range of needs is not considered. [3]

[2] Poll carried out by YouGov June 2015
[3] Healthwatch England, Safely Home: Special Inquiry. Published July 2015 available at http://www.healthwatch.co.uk/safely-home

Healthwatch Oxfordshire contributed evidence to the national special inquiry and some of the overall findings are echoed within our report. We hope that this report brings a greater depth of understanding to the local issues experienced in Oxfordshire.

2.4 Methodology

The project used a mixed qualitative and quantitative questionnaire methodology.

Questionnaires were made available online and shared through the media, the Healthwatch Oxfordshire website and through existing mailing lists.

The patient Before and After discharge questionnaires were completed either online or through interview with Enter and View volunteers.

The three 'professionals' questionnaires (Care Providers, GPs, and Pharmacies) were completed online and shared through the appropriate local professionals' organisations.

The project originally aimed to gather data that would allow recommendations to be made to each provider separately. However the project methodology relied on voluntary participation, and the cohort of those who chose to participate were overwhelmingly patients who had been discharged from an OUHT facility. Too few respondents were discharged from services run by other providers to make analysis by provider valid.

This report has been authored by Healthwatch Oxfordshire based on the findings of the questionnaires and Enter and View activity. The quotes that have been selected for inclusion represent the balance of comments made in free text sections of the questionnaires. The report has been reviewed for accuracy, before publication, by key stakeholders, including Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust and Oxfordshire County Council. Their comments and feedback have been taken into account in finalising the report for publication.

2.4.1 Aims and objectives

The project was designed to find out more about how we discharge people from hospital in Oxfordshire with a focus on the experiences of patients and of those supporting patients after discharge (care providers, pharmacists and General Practitioners).

The project originally aimed to discover and share information about:

i. People's experience of being discharged from Oxfordshire's acute and community hospitals.
ii. The impact that their discharge experience has had on their health and wellbeing, and the health and wellbeing of their families and/or carers.
iii. The impact of poor discharge processes on on-going care from the perspective of other care professionals.
iv. Examples of well managed discharge that the whole health and care community can learn from.
v. Examples of poorly managed discharge, and the key things local providers and commissioners need to work to improve.
vi. How the quality of the discharge process impacts on people's ability to live independently at home after a stay in hospital.
vii. The extent to which the discharge process is meeting the quality standards and/or processes agreed in contracts between commissioners and providers.

As the project was developed by the steering group the focus moved very much onto addressing the first five of these aims.

2.4.2 Questionnaire Development and Project Design

The patient questionnaires were authored by Healthwatch Oxfordshire and after significant review, amendment and addition by members of the project Steering Group, were approved for use. The project Steering group included representatives from Healthwatch, and representatives from Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, the Oxfordshire Association of Care Providers, the Local Pharmaceutical Council, the Local Medical Council and Oxfordshire County Council.

The Care Provider questionnaire was authored by Healthwatch Oxfordshire and the Oxfordshire Association of Care Providers (OACP), reviewed by the project Steering Group (as above) and approved by OACP.

The GP questionnaire was authored by Healthwatch Oxfordshire and the Local Medical Council (LMC), reviewed by the project Steering Group (as above) and approved by the LMC.

The Pharmacy questionnaire was authored by Healthwatch Oxfordshire and the Local Pharmacy Council (LPC), reviewed by the project Steering Group (as above) and approved by the LPC.

Decisions about methodologies, sample sizes, locations for Enter and View and strategies for encouraging participation were all agreed collectively by the steering group.

Supporting materials, including consent forms, information leaflets, posters, and staff briefing documents, were all reviewed and agreed by the project Steering Group before publication and use.

After the completion of fieldwork, the project steering group stopped meeting. Representatives from OUHT, OHFT, OCC and OCCG voluntarily withdrew from the steering group when we began the analysis of the data, so that the public can be assured that the recommendations this report makes have been derived independently of any influence from the affected commissioners and providers.

2.4.3 Enter and View

The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Local Healthwatch authorised representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. This activity is called Enter and View.

Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they will inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to CQC where they are protected by legislation if they raise a concern.

The Enter and View interviews with patients used the 'Before discharge' questionnaire as the basis of the interview. Interviews were carried out by pairs of trained Healthwatch Oxfordshire volunteers and/or staff – with one person conducting the interview and the second person acting as a 'scribe', noting the answers on a paper copy. These notes were later typed into the online questionnaire tool by Healthwatch Oxfordshire volunteers.

Enter and View visits took place on the following NHS hospital sites between 27 February 2015 and 31 March 2015:

- Abingdon Community Hospital (Oxford Health NHS Foundation Trust)
- Churchill Hospital (Oxford University Hospitals NHS Trust)
- John Radcliffe Hospital (Oxford University Hospitals NHS Trust)
- Horton General Hospital (Oxford University Hospitals NHS Trust)
- Nuffield Orthopaedic Centre (Oxford University Hospitals NHS Trust)
- Wallingford Hospital (Oxford Health NHS Foundation Trust).

2.4.4 Data Analysis

In order to stimulate responses, access to the questionnaires was made available through a public link online. Due to the public access to the questionnaires, up to a third of responses to some of the questionnaires have been excluded from the data analysed.

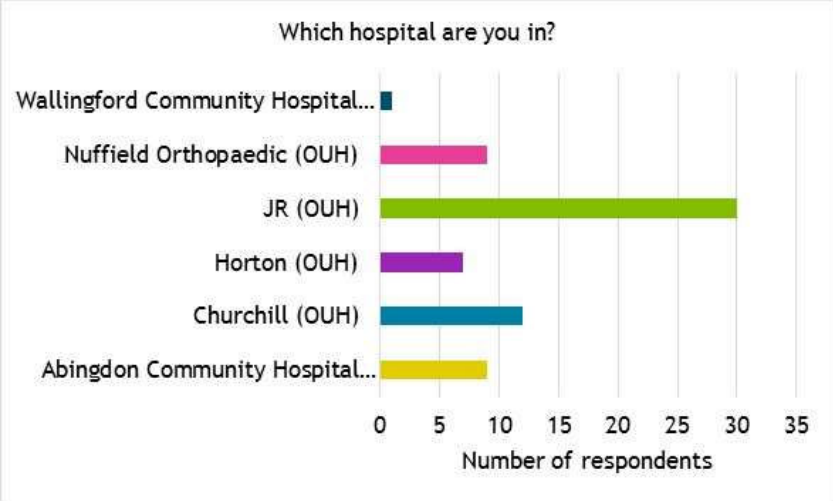
Criteria for exclusion included partial completions where there was too little data for analysis or where responses were clearly not valid patient responses (e.g. responses marked as ‘test’). All figures reported on in this report are from ‘cleaned’ data.

3 Discussion of Findings

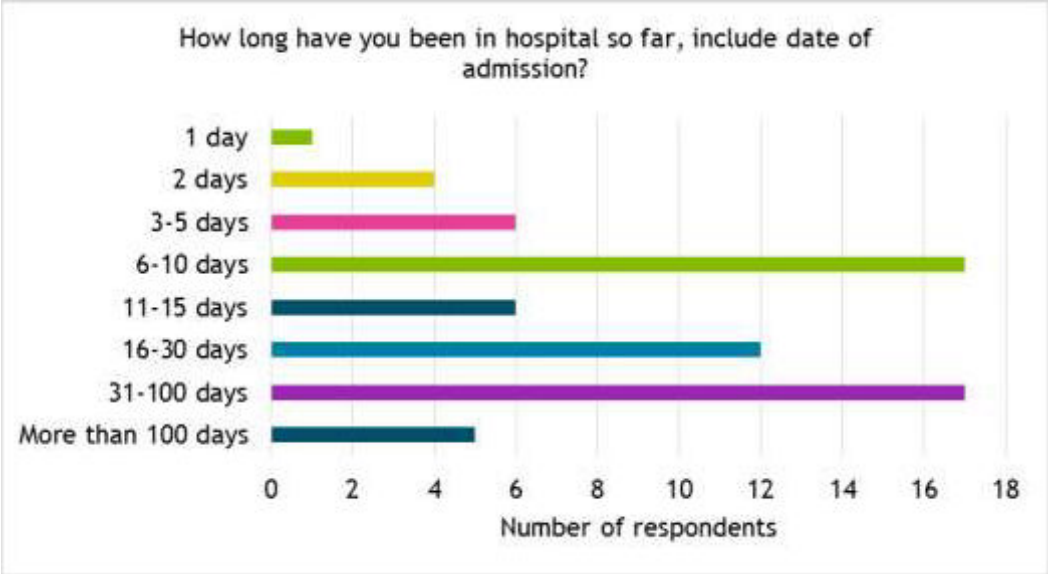
3.1 Patients: before discharge

3.1.1 About the respondents

68 patients completed our survey during a current hospital stay, and the focus for this group of patients was to explore their experience of the discharge pathway up to that point. Some described discharges from a previous admission and others described their current experience.



44% (30) respondents were in the John Radcliffe, 41% (28) were in other OUHT sites and 15% (10) in OHFT community hospitals. 28% of respondents (19) were in hospital following a planned admission, most had been admitted via A&E or their GP requiring urgent care.



16% (11) of respondents to this part of the study had a stay of under 5 days, 25% (11) had a stay of 5-10 days, 27% (18) were in hospital for between 11 and 30 days, 25% (17) had a stay of 30-100 days and 7% (5) were in hospital for more than 100 days at the point they completed the survey.

As the numbers are so heavily weighted towards those being discharged from OUHT facilities it was not possible to undertake a valid analysis by provider.

3.1.2 What worked?

This group had a high rate of overall satisfaction with their experience of discharge planning during their current stay.

- 80% (46) described their experience of planning their discharge as satisfactory or better.

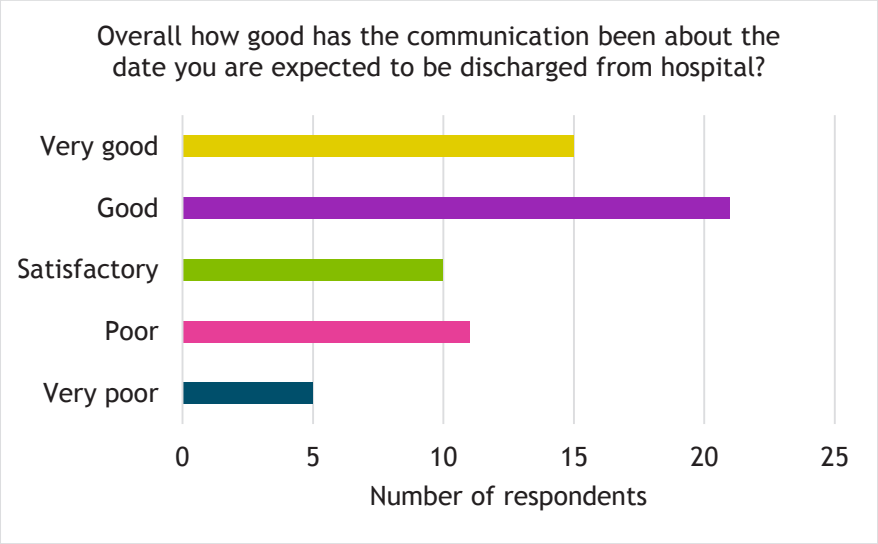
  Cannot speak well enough of them - kindness has been great

  No date yet agreed but happy with discussions and plans for discharge.

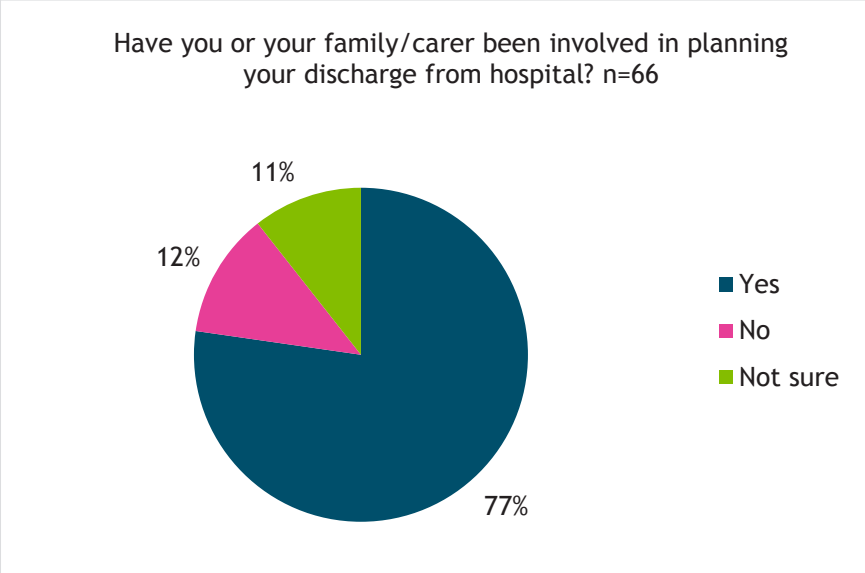
  Values were heeded. Voice was heard and my dignity was respected. I was made to feel like a human being.

  Preparation has been excellent - given lots of information - know what we are doing

  Can't think of anything. It has all been brilliant.



- 74% (50) rated communication about the date they expected to be discharged as satisfactory or better.
- 77% (51) said either they or their family or carer had been involved in planning their discharge.



Someone who described their overall experience as good commented that they had:

> *Had a big meeting with daughter, senior district nurse, OT, neighbour, physio and care agency and previous care agency*

It is this kind of approach that characterised a good discharge for this group.

3.1.3 What could be improved?

This group of patients also identified key areas for improvement. The comments made when they were asked more detailed questions and were given the chance to suggest ways to improve the process, suggest that the overall satisfaction ratings are masking some important areas for improvement:

> *I felt like a hamster on a wheel*

> *Need clear information, it's like being in a fog*

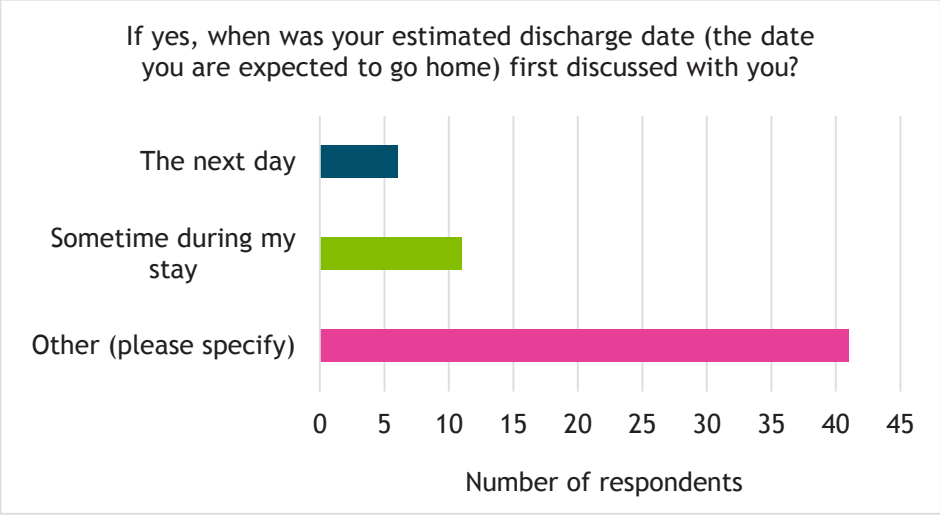
> *No-one has clearly sat down and said I want to talk to you about your wife's discharge*

Too many "busy bees" but no Queen Bee to organise things. The computer does not feel anything but the patient does!!

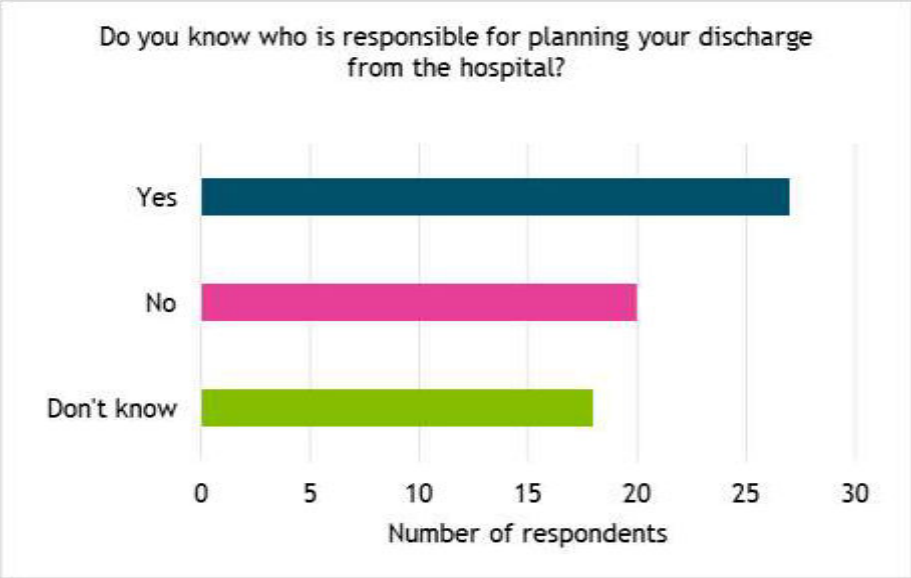
Not sure about how he will get home. Feel that he's been sitting on the discharge ward for 4 weeks. Could have been home earlier. Been a nightmare experience. He is weaker, lost hope, difficult for wife. Lots of false hope of discharge

3.1.3.1 Planning and communication with the patient

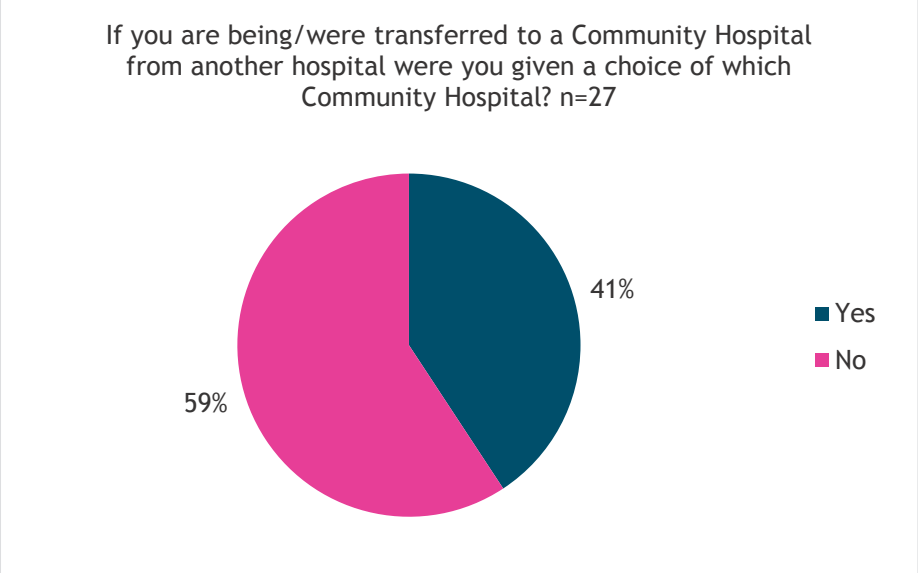
The key messages we heard from this cohort of patients about planning for their discharge and how well they were involved in this were:



- 9% (6) reported an estimated date of discharge (EDD) being given to them when they were admitted or the next day .The stated local target is for all patients to have their EDD within 36 hours of admission – see Appendix 1.
- 12% (8) reported that they were not involved in planning their own discharge.
- 11% (7) reported that they were not sure if they had been involved in the planning of their discharge.
- 20% (11) felt the experience of planning their discharge was poor or very poor.
- 42% (27) of these respondents knew who was responsible for planning their discharge, and 50% (30) of this group knew how to contact that person.



- Of those being discharged to a community hospital, 59% (16) said they had not been given any choice about which hospital they would be going to.



When we asked these patients how the discharge process could be improved the following were typical of the comments we received:

Someone should be in charge. Needs someone responsible. A co-ordinator monitoring.

Need a discharge planner, who sets out clearly the process and timings and responsible person named for each stage if not the

discharge planner - plan also needs to be kept up to date Medical side very good. Administrative side very poor

Provide more information so that patient can be more involved with discharge process and understand what is going on at every step

Better, earlier involvement in planning - need time to understand implications

I would like to have clearer information. Information confused. Mixed messages which I find very disturbing. Doctor says one thing, nurse says another

Communication - people need to be trained in communication as a 2 way process

If there was one person whose job it was to instigate and arrange for getting patient home it would be better. Nurses too busy and do not have all the information

Have not got any meaningful conversations with regard to any discharge plan

3.1.3.2 Communication between professionals

This cohort of patients also clearly felt that the discharge process, as they experienced it, could be significantly improved if communication between professionals about a patient were to be improved. When we asked them what would improve the discharge process we received comments like:

Need a link between hospital and GP

I would like to see them working together as a team. Mixed messages which I find very disturbing. Doctor says one thing, nurse says another

Consistency with answers - 4 different staff, 4 different answers

Better communication between departments improved preparation of discharge paper

GP surgery and Churchill MUST communicate much better. In fact they are making it more difficult

Keep other clinicians up to date with my care. Communication between departments is important.

Less departments (more communication).

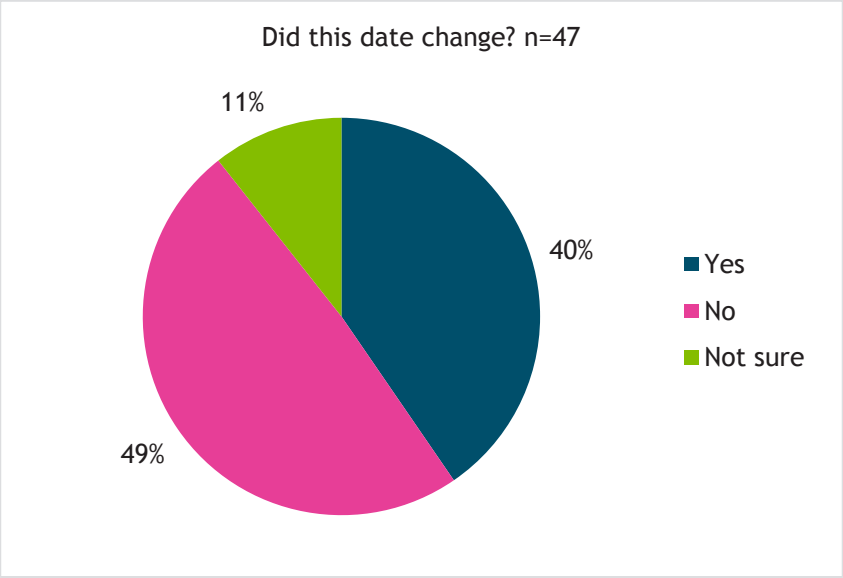
3.1.3.3 Changing plans

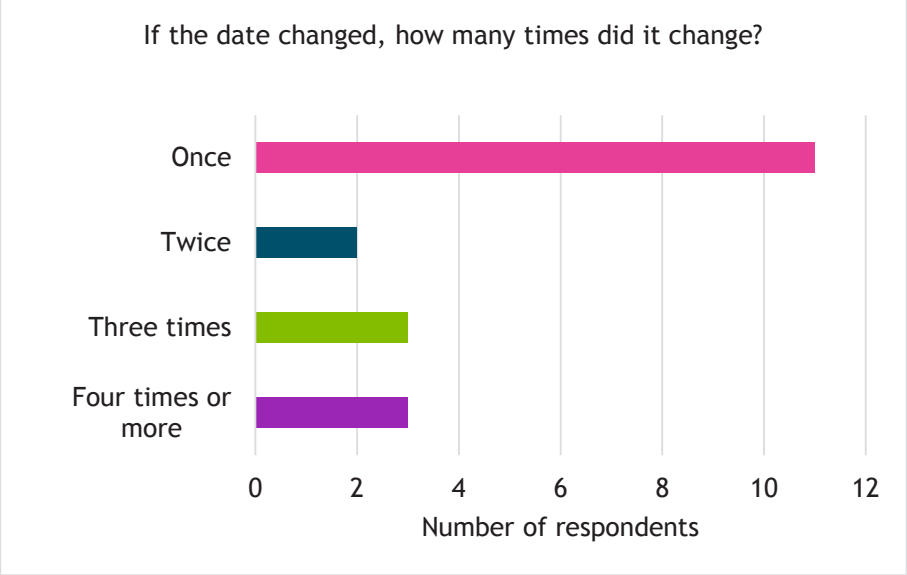
- 40% (19) of this cohort of patients said their Estimated Date of Discharge (EDD) changed during their stay.

- Half, 50% (11) of those answering this question had only 1 change, and 83% (19) of those whose EDD changed said they were told why the change was necessary.

- However, of those whose discharge was delayed beyond the point they were well enough to go home only 47% (15) had had the reason for the delay explained. 86% (12) patients whose discharge was delayed beyond the point they were well enough to go home experienced delays of more than 5 days.

- Only 8% (2) of respondents said they could have taken action to avoid being delayed themselves.





When we asked people whose discharge was delayed what they thought had caused their delay the answers we got included the following:

Not known

Nothing suitable to go too

Not explained - waiting for the care package to be put in. waiting 6 weeks. Told won't do shower until back home

Paperwork for the next stage of care package at home

Waiting for special hoist

Lack of availability of carers

Adaptations being done

Care plan was not in place - care providers have had to change

Hospital has been great - fit to leave a month ago - outside agencies dreadful

The problem was there weren't any carers available

Seems silly to offer home help if it cannot be pre-arranged to coincide with the date of discharge. Disjointed.

This suggests that planned changes to discharge relating to changing medical needs are being relatively well managed, but that completing the discharge for a person medically fit to go home is still being held up whilst plans for ongoing care are finalised – and in particular that access to care packages remains a problem.

3.1.3.4 Last minute hitches with pharmacy

Many patients in this cohort reported problems with the preparation of the medication they needed to take out of hospital with them, and indicated that this held up going home on the day of discharge.

Indeed when we asked how the process could be improved, the area most frequently cited was the link with pharmacy at the end of the pathway, and typical comments included:

> *Pharmacy - pharmacy - pharmacy On ward is excellent. Doing their best. Change system/procedure - maybe start day before*
>
> *Biggest problem is pharmacy. Always 6 hours delay. Also happened in Reading - waited until 11.30pm. No one to ask who knows. Otherwise all done in 1-2 hours except meds*
>
> *Medication available and not delayed*
>
> *Get medication quicker*
>
> *If things could be sped up. Pharmacist provide medication. Junior Doctor to decide on medication.*
>
> *Delays at pharmacy*
>
> *Waiting for pharmacy and meds. Nowhere to wait if you vacate your bed.*
>
> *Delay in pharmacy providing medicines for discharge.*
>
> *Delay caused by late delivery of drugs.*
>
> *Prompt delivery of drugs - improve process for supply of drugs at discharge*
>
> *Having to wait for the Prescriptions was too long*

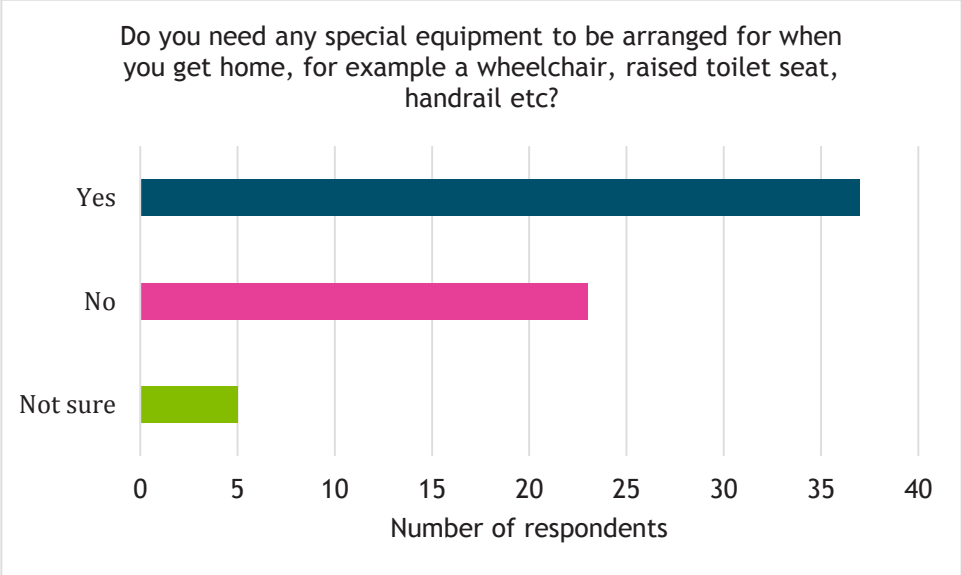
Medication could have been issued quickly or on the ward so as to avoid having to come into the discharge lounge at all

Previous discharge = bad - delayed pharmacy wrong meds

Medication for discharge delayed from pharmacy to ward

3.1.3.5 Access to equipment and support at home[4]

57% (37) of the patients in this cohort had been assessed as needing equipment at home when they were discharged. Most of these reported that their equipment needs had been assessed, and some said that the equipment they needed was already at home – with evidence of staff going the extra mile to make sure needs were met:



Things already sorted

Hoist - delivered 2-3 weeks ago - got other equipment

All geared up at home already. Hospital provided additional walking equipment, commode, raised seat

OT spending "own" time to find the most appropriate aids and equipment.

[4] Note responsibility for provision of equipment and support at home is not the responsibility of OUHT or OHFT.

However once again this is not a universally positive picture – either in terms of the equipment being available or the patient being confident about how to use it:

Has equipment which is not fit for purpose!

Partner made ramp otherwise discharge would have been delayed

OT has put a list in but waiting for the package to come through.

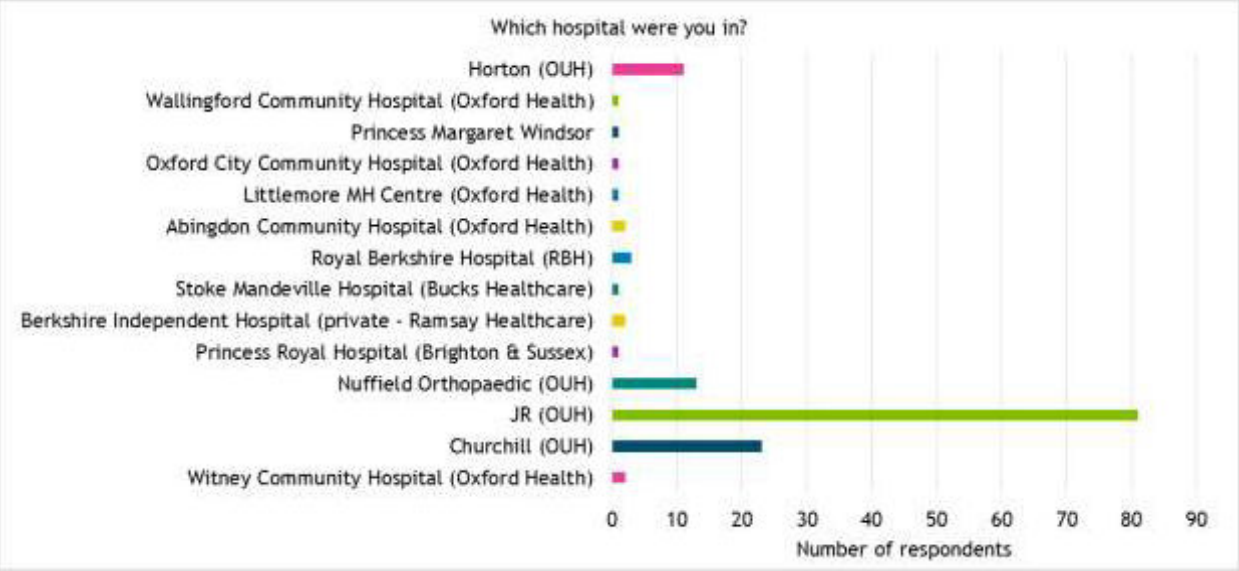
Discharge was agreed on Friday - on the Monday delivery truck arrived with all equipment including bed etc with no planning or communication. Didn't know what was coming and would have liked to see a list

I ONLY needed to be advised what to do and avoid when I got home with commode + zimmer after I had fallen and crushed my femur. But there was no advice

3.2 Patients: after discharge

3.2.1 About this cohort

144 patients completed our survey after their discharge had been completed.

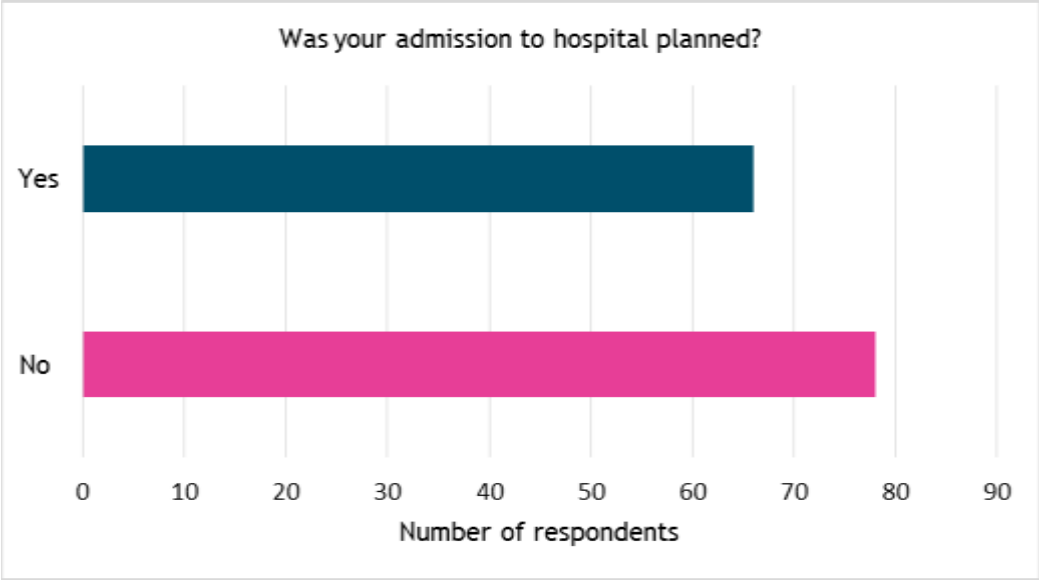


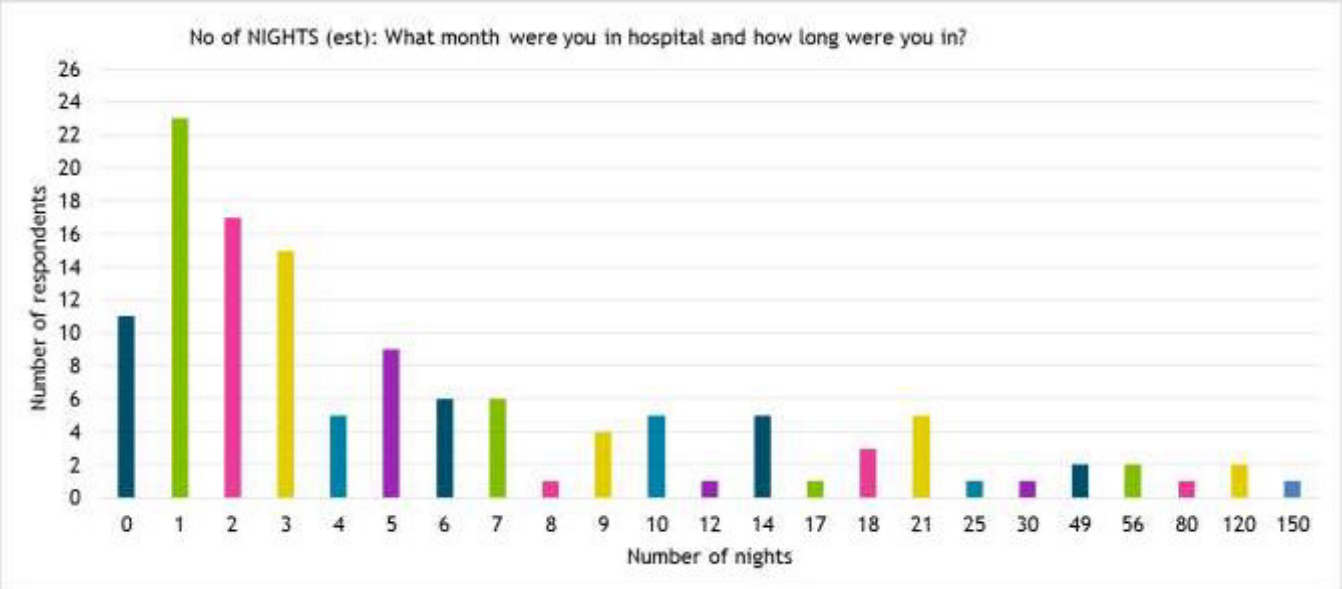
56% (81) had been discharged from the John Radcliffe, 33% (47) from other OUHT sites, 5% (7) from OHFT sites and 6% (9) reported discharge experiences from hospitals outside Oxfordshire. Again the small numbers of

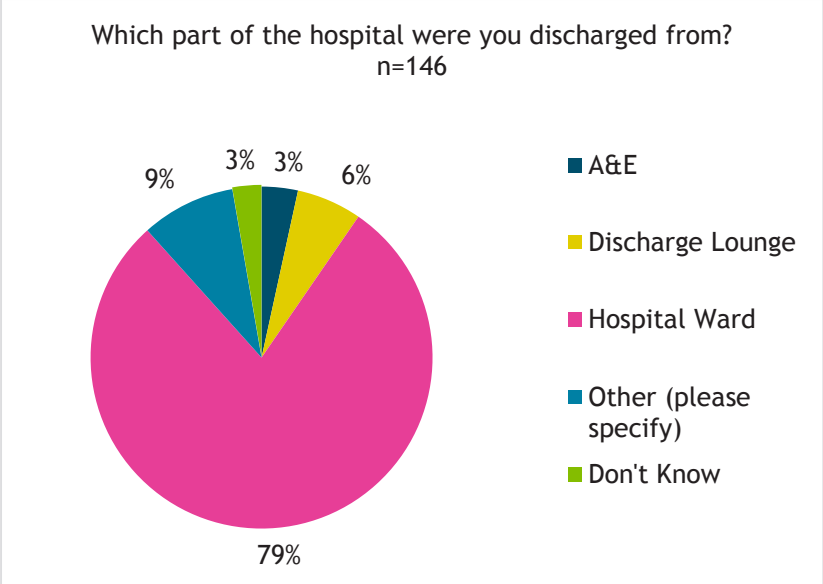
respondents who described a discharge from a provider other than OUHT made it invalid for us to undertake an analysis by provider.

For the patients in this cohort of the study:

- 54% (78) of them had an unplanned admission, and 45% (66) were on an elective pathway.
- 45% (66) had a stay of under 4 nights, 26% (36) of between 4 and 10 nights and 17% (25) more than 10.
- 79% (115) described a discharge direct from their hospital ward.
- 89% (131) were discharged home, 3% (5) were discharged to a community hospital and 3% (4) to a nursing or care home
- Of those respondents who reported a delay 17% (8) agreed that they could have done something to reduce their delay themselves





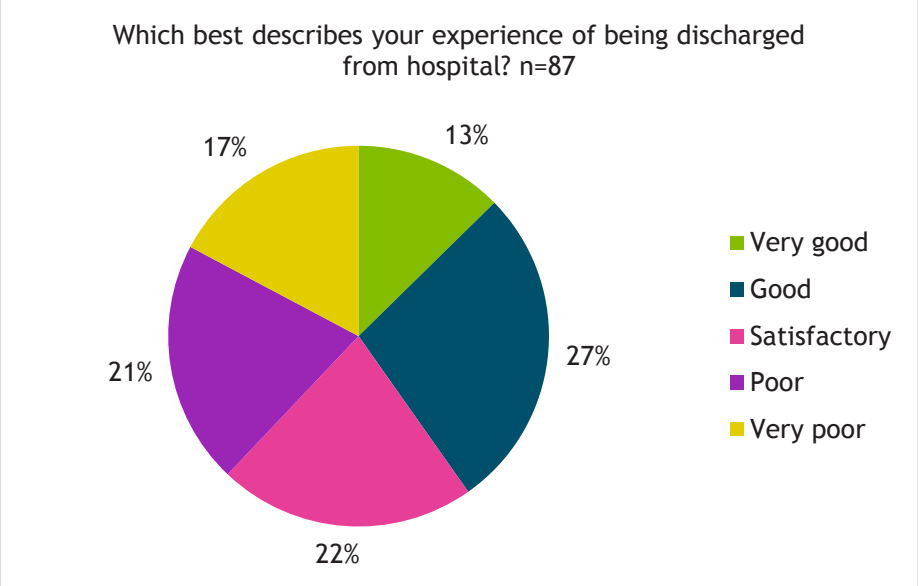


3.2.2 Overview

This group of patients, who had all completed the discharge pathway, described significantly lower levels of satisfaction than the group that were still in hospital when they completed the survey, but it was not all bad:

> *My experience of discharge from hospital was perfect. I was fully consulted and asked if I was ready to go home with the right amount of support.*

> *Overall in-hospital care was excellent. After first night surgeon discussed with me the option of leaving that day or staying another night, leaving the decision to me and my carer (my wife, who is a nurse). Over course of the afternoon, with the support of the duty nurse, we decided that I was fit to be discharged and that was arranged promptly for late in the afternoon. The excellent aspect of this was that I and my wife were completely involved in the decision process, along with the very supportive duty nurse and the prior approval of the surgeon.*



But it was also not all good – with 38% (33) of the respondents describing their experience of being discharged from hospital as poor or very poor.

When we asked patients what was good or very good about their discharge, respondents praised staff saying:

Everyone was very helpful, no problems at all, my husband took me home

Ward nursing staff tried very hard to make stay and discharge as easy an experience as possible.

The care and attention the nurses gave me.

Everyone was very helpful, but everything very rushed. I was unable to get around without help (but my husband did everything) and I did not realise how difficult everything would be for the first 3 weeks.

The nurse and student were kind but so stretched they had little time to actually see to me. I was given paper work and left when my friend arrived. I could not find anyone to tell I was leaving until down the corridor when I spotted a carer who I spoke to and thanked for her care of me.

However some had such a frustrating experience that in answer to this question which actively sought positive feedback, respondents said things like:

There was nothing good about it

Nothing, no one knew what was going on the bank staff did not know how to fill in the discharge form and we had to wait 3 hours for medicine. We finally got out at 9 p.m.

All appalling…. I'm disgusted at my treatment.

Never be admitted to the JR Die in the car park Find someone who can speak English

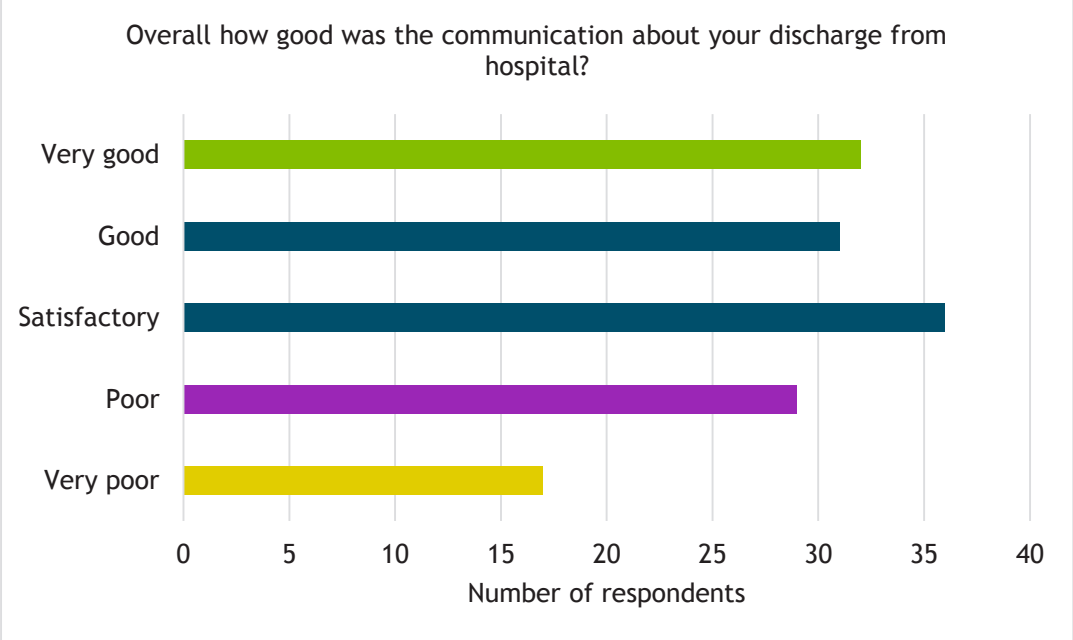
3.2.3 Communication

When we asked for suggestions on how the discharge experience could be improved, a common theme was the quality of communication. Trusts are getting it right sometimes:

I was consulted about every aspect of my discharge home from hospital after surgery.

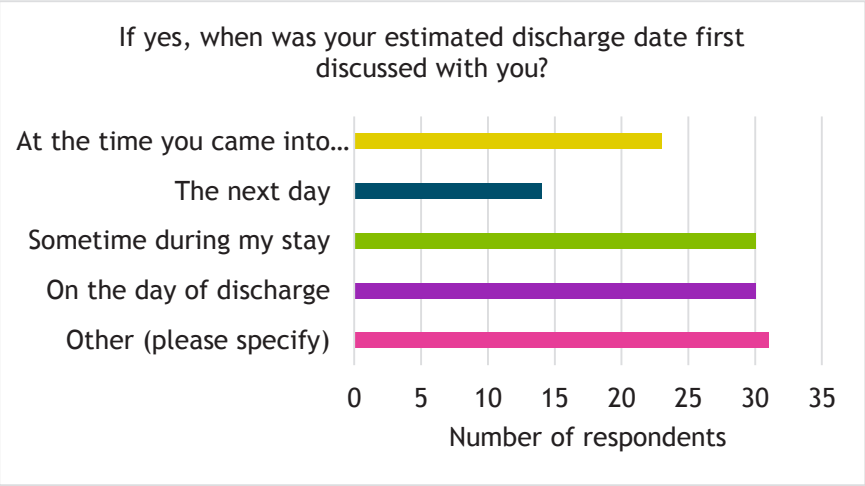
I was kept informed and was involved in every aspect of my discharge. I felt very comfortable with the whole process.

It was very thorough, apart from not being told to continue a certain medication. Otherwise cannot fault the discharge procedure.



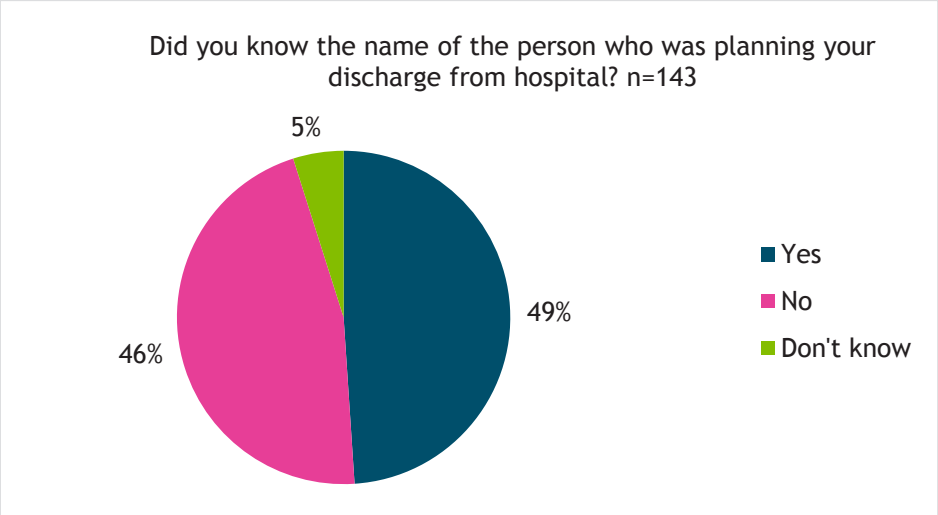
But a substantial minority - 32% (46) of respondents in this group said communication about their discharge was poor or very poor.

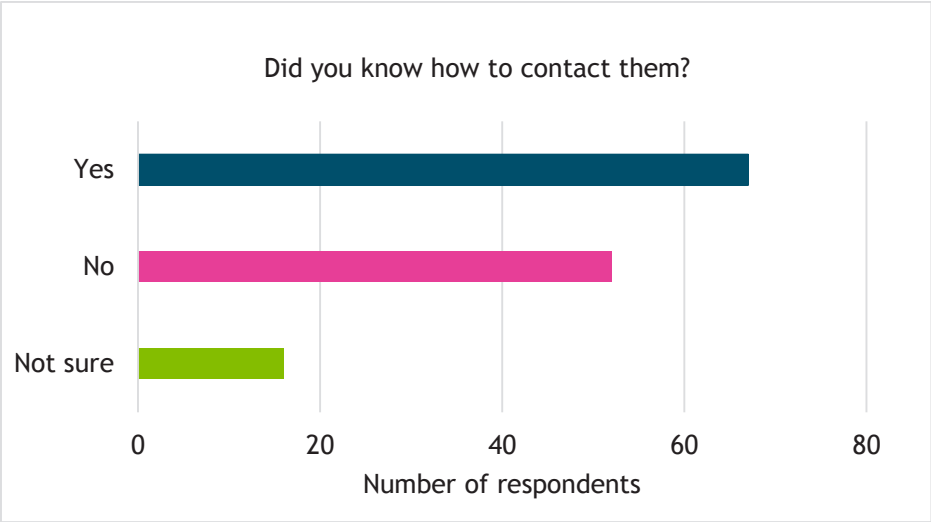
- Only 29% (37) reported having their EDD discussed with them for the first time on the day of admission or the next day, and the Trust's stated policy is to set EDD within 36 hours of admission (see Appendix 1).



- 23% (30) said the first time their discharge date was discussed with them was on the day they went home.
- 55% (77) patients said they had a say in the care and support they needed so they could be discharged from hospital.
- 62% (88) said they had the opportunity to ask questions about their discharge, but some reported finding this difficult:

Make sure there are enough staff on duty to do a proper discharge and have time to answer your questions. I felt guilty taking the nurse away from care of the other patients





- 49% (70) knew who was responsible for planning their discharge, but only 50% (67) of them knew how to contact that person.
- 63% (92) fully understood what would take place on the day they were ready to be discharged but 28% (42) did not.
- 68% (96) of people knew how to contact the ward they were discharged from when they got home, and 28% (40) needed to do that.

When asked to sum up what could be done to improve the discharge process, the need to make improvements to communication was a common theme:

Communicate with the patient and their GP or whoever is taking over their care…. We are people not bed numbers.

Someone to have the time to discuss in full how you would manage

Wish that someone listened to my concerns instead of rushing me out the door- I might not have had to go back in 3 days later if they had.

Consistency and better communication from orthopaedic team…seen by different orthopaedic teams on different days…found it difficult to keep up with the changing plans, one day he was told he might need to return to surgery and the next day he was told he would be able to return home. He found the idea of an extended stay distressing.

Talk with me please - COMMUNICATION!! At one point an SHO came over and told me he was taking blood, even though I already had a line in. He didn't gain consent, didn't look at me at all.

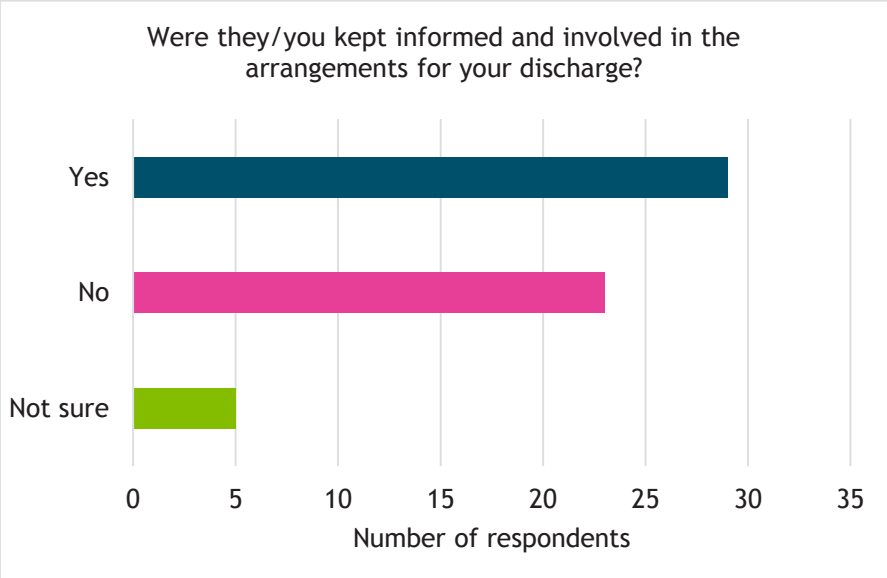
increase ability of staff to communicate effectively and to keep me and my husband appropriately informed. SHO lacked any form of bedside manner. I would go as far to say that he was socially inept

More training of staff in how to approach and manage patient care

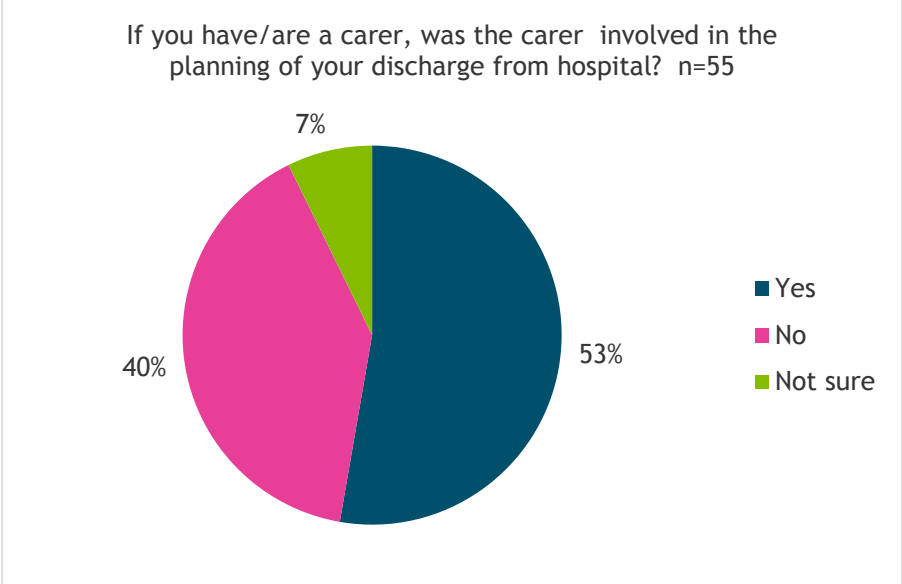
Improve communication and dialogue between each link in the process e.g. information provided over the phone prior to a person attending surgery, communication and dialogue on the day, both for the patient and the person accompanying them

3.2.4 Involving family or carers

Concerns about communication often extended to include concern about failure to include family members properly in care planning.



- 68% (98) of respondents in this cohort said someone had talked to them or their family or carer about the arrangements for their discharge.
- However when asked later in the survey if they or their family or carers were involved in planning their discharge, only 53% (79) said yes.
- And only 50% (29) said they or their carer was kept informed and involved in the arrangements for their discharge



Even when carers were reported as being involved, the involvement was often very late on in the process. 16% (11) were only involved in discharge arrangements a few days before discharge, and a worrying 28% (19) on the day the patient left hospital (19). Only 19% (13) of carers were involved on the day of admission or the next day.

The orthopaedic team visited him at different times, usually very early morning or after 8pm so family could not be present. On the day before discharge he had been told the orthopaedic team would review, hopefully to agree discharge, at 8am, so family got to ward by then, but although the named nurse tried to contact the orthopaedic team, no one came to see him until 1pm.

> *A long time passed from when the doctor said my son was to be discharged and when it actually occurred. We sat and waited for hours, expecting someone to come, and no one did. Finally, I went to find out what was going on, only to be told my nurse was on a break, and couldn't come now. More waiting ensued. Communication was very bad. Long wait was unnecessary.*

This set of responses suggests that family and carers are being *told* about plans far more frequently than they are being *involved* in discharge planning decisions throughout a hospital stay, and that their involvement is seldom from the outset of care.

It also seems that when someone who is themselves a carer is admitted, the system does not communicate well or plan appropriately:

> *I am a carer for my husband and only finally managed to hear that his care was arranged the day before I went into hospital. I had to arrange everything. When I asked about care for me and my husband when I got home I was told this would be arranged at the hospital. I did mention this when I came for my assessment before op. But no help offered with, out staying in hospital longer but could not do this as my husband's care finished after the 9 days. I felt let down as I had explained the situation but no one seemed to be listening. Hence I have found it very difficult since I got home and become very depressed at times.*

> *I asked if I could get help when I got home as husbands care finished on the day I got home. He has memory problems I was told it could take up to 2 weeks so just had to go home and cope by myself*

In answer to the question asking respondents to sum up what could be improved about the discharge process, improving communication with family was a common theme. Typical of the comments and suggestions made were these:

> *Improve communication with immediate family. Involve immediate family in decision making.*

> *Discussion with family before discharge*

> *Communication with family*

Lack of explanation to carer of what care was going to be needed. No regular input from nursing service after discharge from hospital. More co-ordination of the discharge & more information to be given to patient & carer about discharge process.

3.2.5 Information

Problems with communication were also reflected in the comments people made about information.

- When information was given 88% (91) thought it was satisfactory or better and 88% (88) could understand it, but information appears not to being given as often as patients would like.
- 58% (85) received information about their expected recovery, but 32% (61) either did not or were not sure.
- 37% (53) of respondents did not fully understand or were unsure what would happen to them on the day they were ready to be discharged

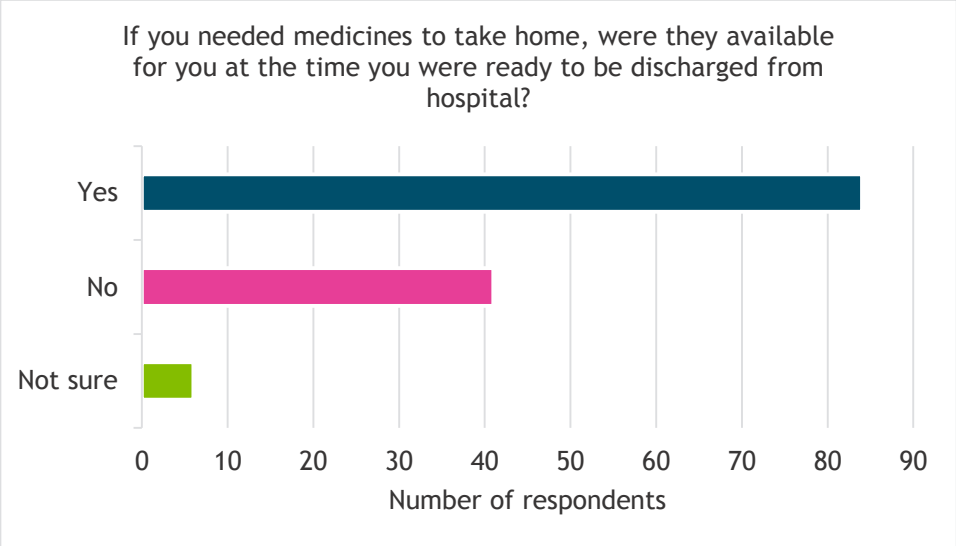
I would appreciate it if someone could tell me what was the outcome of my surgery (as, prior to surgery, the consultant was not sure which treatment option he would use to treat me until he was in surgery) and why I wanted the support of my husband by my side, because at that time, no one had told me what had happened to me and I was being prepared for discharge from the hospital without knowing

More information should have been given to me to tell me what to expect in the days after surgery. I needed to be told what I should feel like and what to do if this did not happen.

Need greater understanding about how patients might be feeling immediately after surgery, what might be distressing them, why this might be and how they can be supported.

3.2.6 Medication

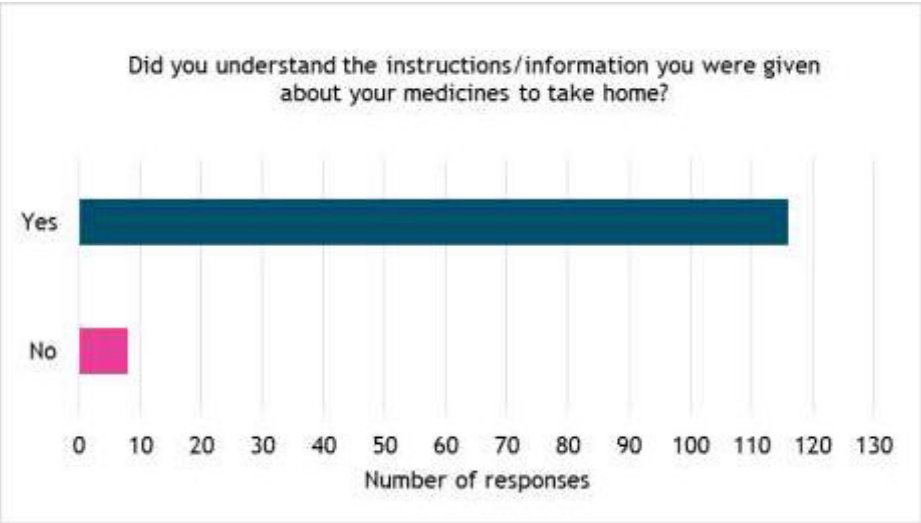
As with the patients surveyed before discharge, this group cited problems with the pharmacy part of the pathway more often than any other aspect of discharge.



- 94% (116) understood the instructions/information they were given about their medication to take home, but only 64% (84) patients said their medication was available for them at the time they were ready to be discharged.

We found one positive comment about the pharmacy part of the pathway:

> *The ward round to determine discharge was early and take home drugs decided on that round. The pharmacist came immediately afterwards and the drugs were available for me to go home in a timely manner so that I didn't have to go to the discharge lounge.*



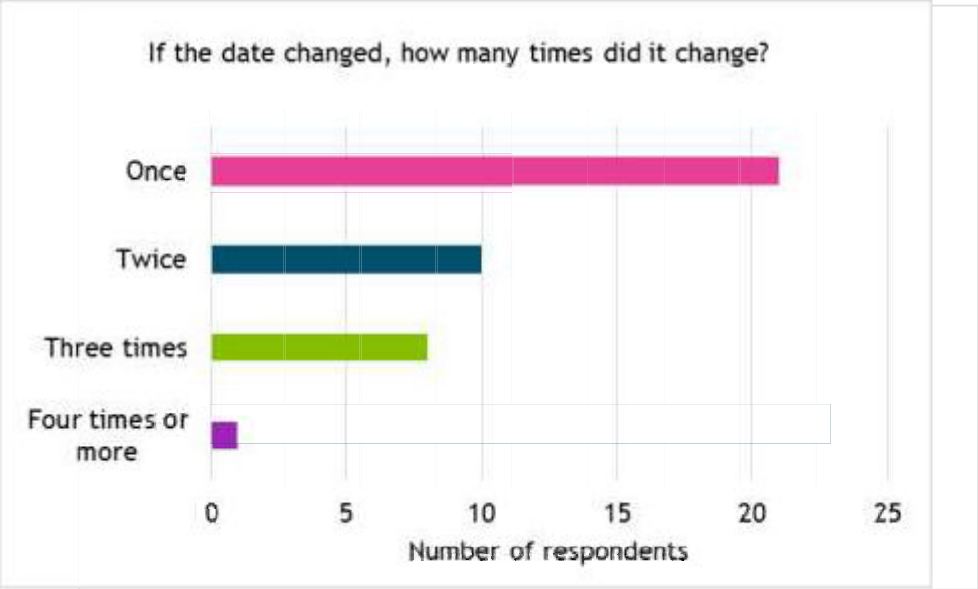
However this experience seems to be far from typical, and responses from respondents included:

> *Worst hospital experience ever! Shocking waiting time for a simple prescription.*
>
> *I had to wait for 1.5 days for my take home medicine. This was known weeks in advance so why order it from pharmacy at the 11th hour?*
>
> *Prescription waiting time was appalling!*
>
> *We never bother with hospital pharmacy as it takes so very long. On previous occasions it has necessitated a trip back to the JR the next day to collect medications.*
>
> *Waiting hours for medication to take home*
>
> *All the staff, doctors and nurses were outstanding in the way they looked after me. It is the system where take home medication is only ordered from pharmacy at the 11th hour that causes bed blocking, extra NHS costs, extra work for nurses and frustration for patients Ensuring the time waiting for medication is greatly reduced.*
>
> *My medication was still not available after 4 hours wait and had to be sent to me by courier - which is a waste of NHS funds.*

3.2.7 Changes of plan

A number of patients experienced changes to their Estimated Discharge Date:

- 31% (40) reported that their EDD changed
- 47% (19) experienced more than one change.



- Of those who experienced a delay, 40% (19) went home one day after their original EDD and 30% (14) stayed four or more days longer than they expected to.
- Of those who experienced a delay, only 57% (28) knew why they were delayed and 51% (21) said staff checked to see if they knew the reason for their delay.

3.2.8 Services after discharge[5]

Most of this cohort needed some sort of support post discharge, with only 35% (52) reporting that they did not need any support after leaving hospital. 19% (28) reported not being offered any support.

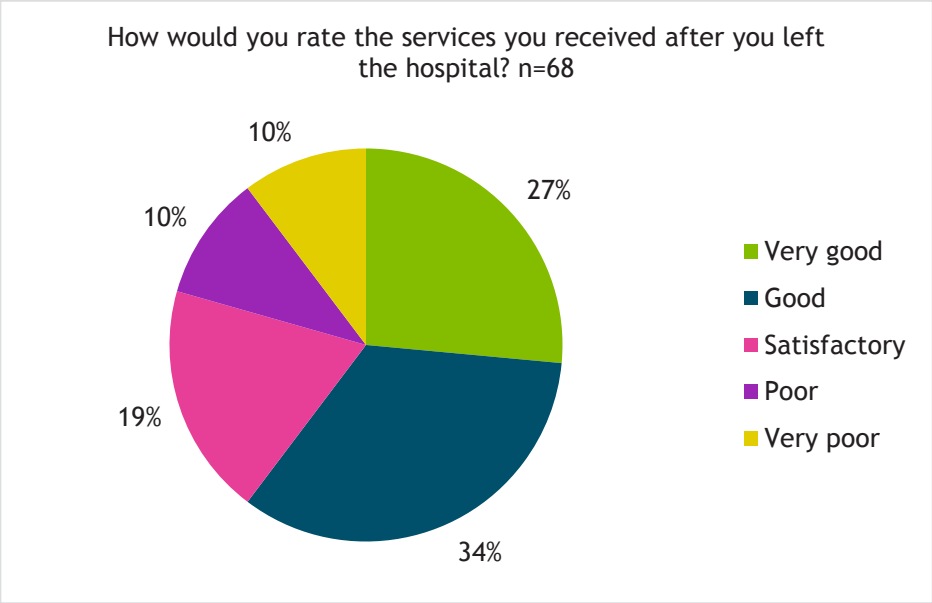
Of those who did get support the majority, 32% (47) said they got support from a source other than home care 3% (4), reablement 5% (7) or supported hospital discharge 6% (9).

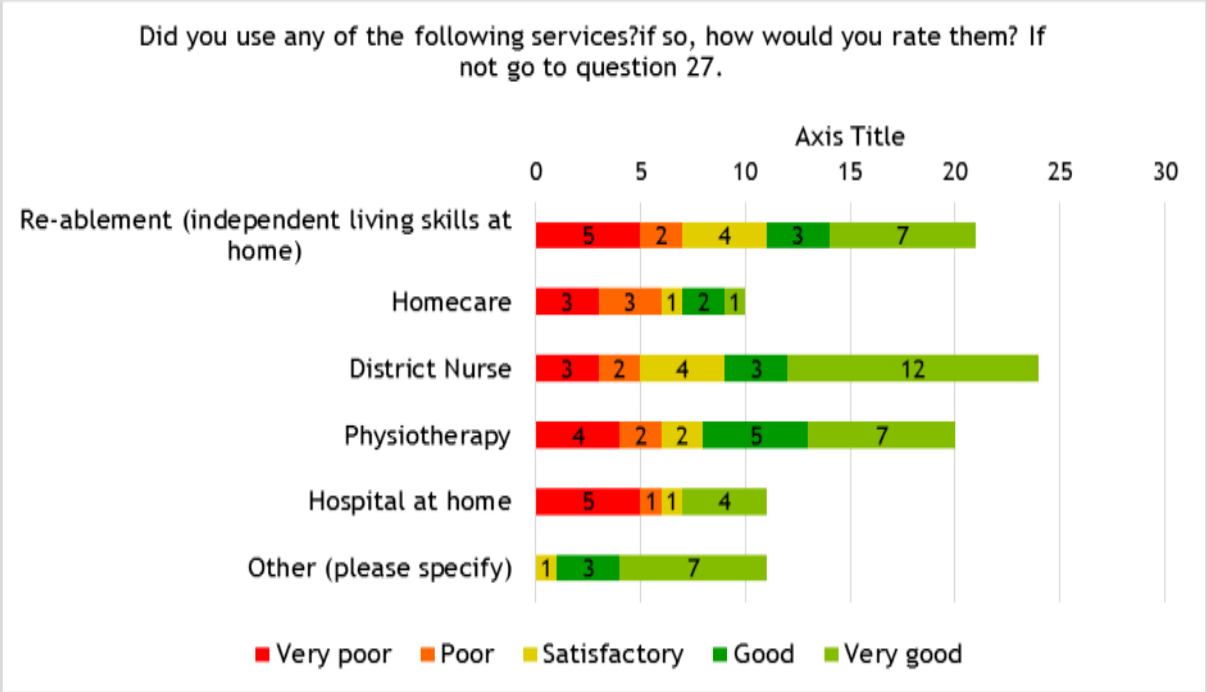
[5] Note that post discharge support services are not always the responsibility of OUHT

The other forms of support accessed included advice, physiotherapy, phone number for a nurse or consultant, support from the cardiac rehab team, equipment, district nursing, hospital at home or support from family and friends.

80% (54) reported the services they received after discharge as satisfactory or better, with 20% (14) rating them poor or very poor.

> *Discharged twice without support. Revolving door. Discharge not sustainable without assistance and support. Hospital acquired infection. Neglect of care elements including teeth, toenails and eventual UTI. Three additional A&E admissions by ambulance requested by neighbours who responded when condition deteriorated at home.*

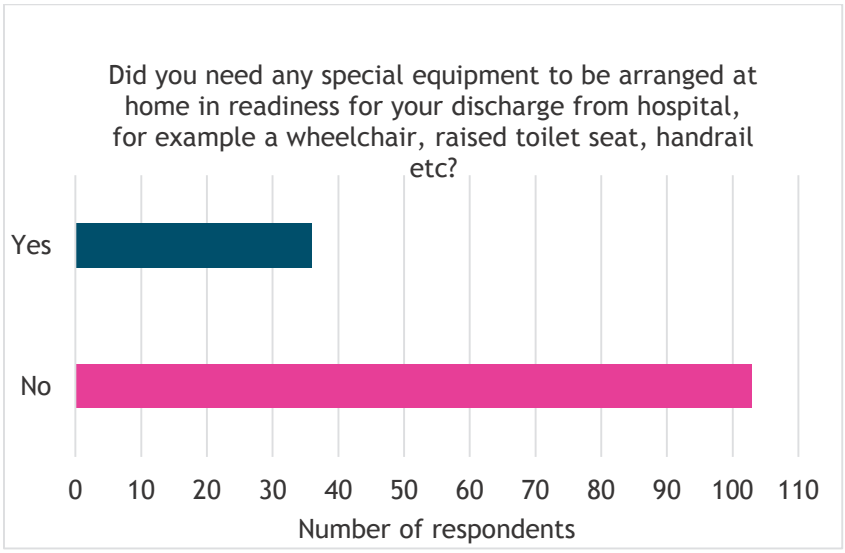




3.2.9 Equipment[6]

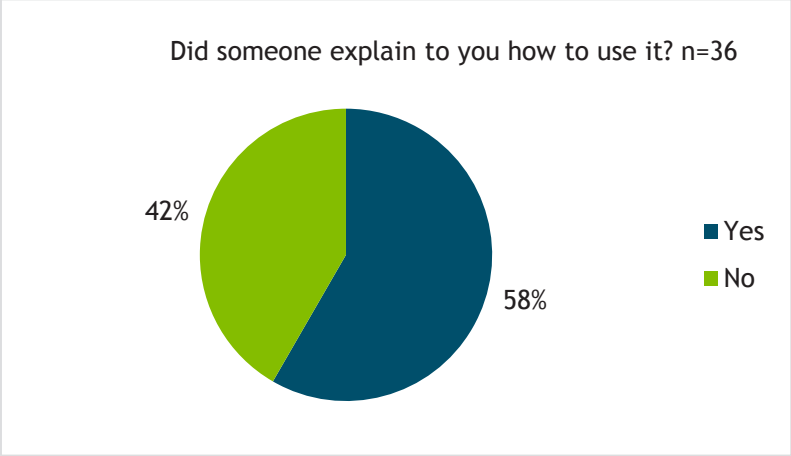
As reported by patients before discharge, 29% (36) of patients required some equipment to facilitate their return home.

- 25% (36) needed equipment to be arranged in readiness for their discharge.
- 58% (21) said someone explained how to use it
- 79% (31) said it was available when they needed it.



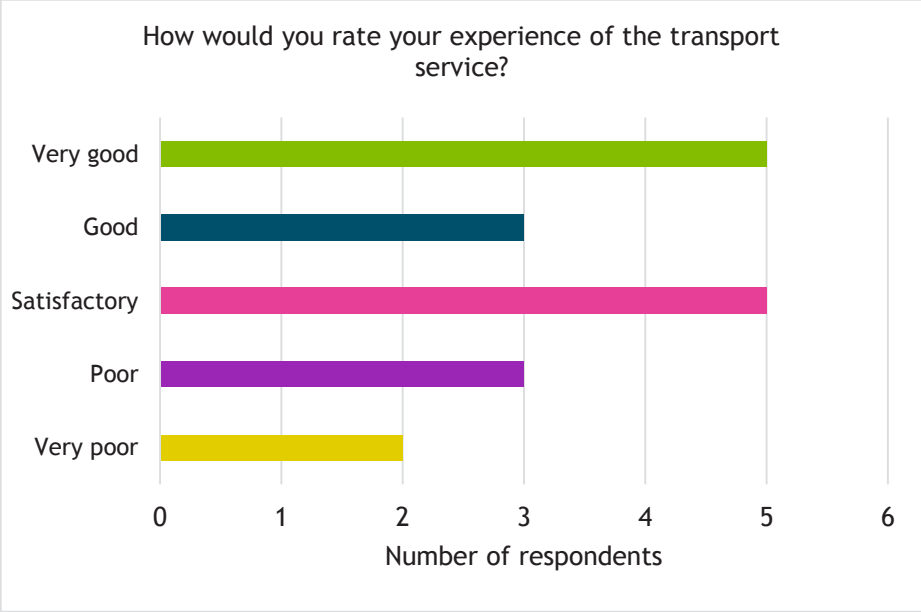
[6] Note that provision of equipment for use after discharge is not the responsibility of OUHT

However, with 42% (15) of patients unsure how to use their equipment when returning home, there remains room for improvement.



3.2.10 Transport

Of the patients who told us they were entitled to transport to help them get home, 55% (10) said the time it took to get home was reasonable, and 72% (13) rated their experience of the service as satisfactory or better. 52% (14) reached their destination at approximately the time they expected to – but 48% (13) either did not or were not sure.



my uncle was left waiting most of the day and then told it was too late, his nurse was too busy to chase the ambulance!

Having been discharged at 7:30pm we had to wait 5 hours for the patient transport service to arrive

Driver and companion very good and helpful.

It took a long time from leaving the hospital ward to arriving home. (approx 2 hrs 15 mins.)THis was because there were other people to be picked up/dropped off.. It felt a long time as the seat was not very comfortable.

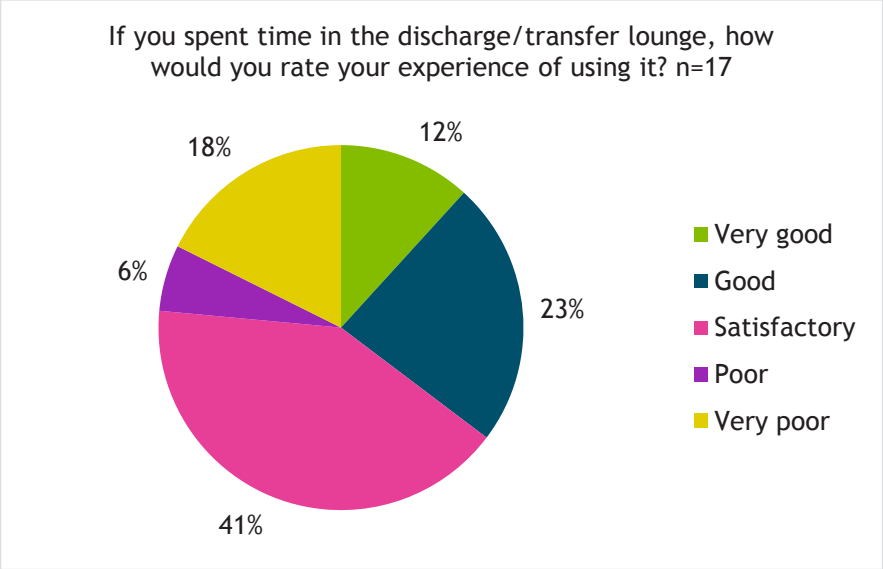
I have to award 5 to the service of the ambulance service. The staff are always so kind, considerate and sympathetic.*

OK. They left me earlier than expected in an empty house in a wheelchair with no food or drink accessible. Fortunately my daughter arrived half an hour later, then the carers

3.2.11 Discharge lounge

Experiences of the discharge lounge seemed varied, with the largest proportion of patients, 41% (7), rating their experience as 'satisfactory'.

- 16% (24) of this cohort had used the discharge lounge.
- 76 % (13) of them rated the experience as satisfactory or better but 24% (8) rated it as poor or very poor.



When individual comments about the discharge lounge are taken into account, a more negative perception of the discharge lounge surfaces:

It was awful. Understaffed and too many confused elderly people in there. One lady fell whilst I was there and had to be taken into A and E. I had surgery the day before was in a lot of pain and left sitting in a chair. I felt like I was rushed out with no info and little support.

Busy, lack of privacy. The discharge nurse was excellent

I understand that the bed was needed at 10am the day after my minor surgery but since I did not come up to the ward till 6.30pm I was still feeling effects of the anaesthetic and found sitting in the specialist surgery discharge lounge a little uncomfortable as I was sleepy. I had to wait for paperwork, medication and my sick note. I also had to ask for some ice cream because I was completely forgotton and because I was starved for over 18 hours the previous day was feeling a little weak. I got all my paperwork etc by about 3pm after vacating my bed at 10 am!

That was just dead time. Once you are out of the bed, then it seems not to matter when you leave, but I could have been out of the bed sooner, if discharge was effected more efficiently. You are always waiting for nobody in particular.

Do not "dump" people in the transfer lounge to wait for medication.

3.2.12 Patient Advice Liaison Service (PALS) & Complaints service

Though we didn't specifically ask any questions about the PALS or complaints service, a number of patients commented on this service anyway:

I complained to the PALS woman. e.g. Prior to that I complained to the Sister/nurse that the shower drain was blocked. Nothing was done about it. I eventually got the right man to fix it after 3 My experience of the complaints system is that that the hospital staff 'close ranks' and deny there is a problem…

There is no point in complaining the Horton will not do anything about it anyway

Poor experience of complaining to Oxford Health NHS Foundation Trust despite going through their own channels (i.e. PALS).

I complained to PALS but they did not reply

Overall, patients reported that they didn't feel listened to, or that they complained and never heard back from the PALS/complaints team at the hospital.

3.3 Recommendations arising from the patients who contributed to this study:

- **Take swift action to improve start of discharge planning.**
- **Provide a dedicated person for each patient to talk to about their discharge; make this person responsible for that patient's discharge; ensure the patient and his/her carers knows who this is and how to contact them.**
- **Require the responsible person to record each occasion when they involved the patient or family in planning the discharge and make the outcome of that discussion available to them, in writing, in language they can understand.**
- **Review the process for prescribing medicines at the point of discharge, starting the process earlier.**
- **Ensure patients know what equipment they are getting, when they are getting it and how to use it.**

3.4 Professionals: care providers

Healthwatch Oxfordshire liaised with the Oxford Association of Care Providers (OACP) to author the questionnaire for care providers on their experience of discharges from hospital in Oxfordshire, and to encourage OACP members to complete it.

3.4.1 About the respondents

29 questionnaires were started, of which 14 were sufficiently complete for analysis and inclusion in this report.

Of those who completed the questionnaires:

28% (4) were Care Home Managers
44% (6) were Domiciliary Care Managers
28% (4) were 'Other' (Sheltered Housing, Voluntary sector, Housing Association and Supported Housing for Learning Disabilities).

78% (11) of the questionnaires marked the views expressed as being those of "both themselves and of their colleagues". This would seem to indicate that the views expressed would be seen as largely 'consensual' by those completing them.

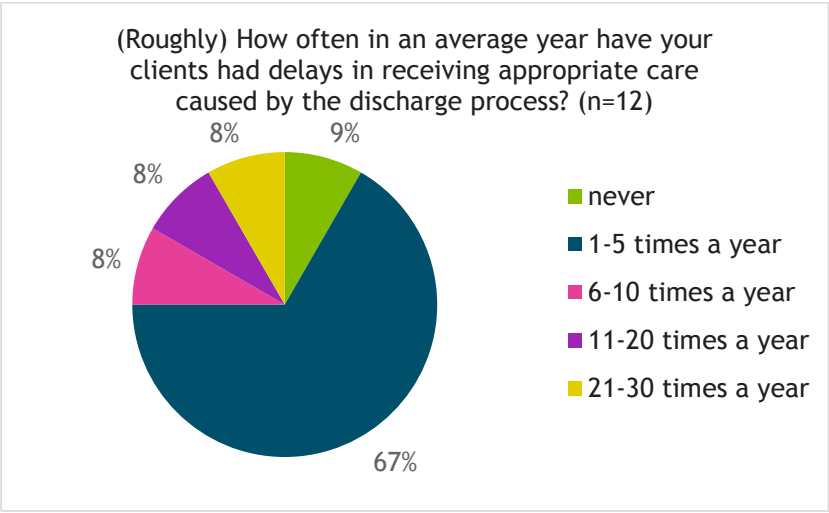
3.4.2 Quality of discharges

Responses indicated that 'good discharges' (ie there were no significant issues for the client) were not perceived as the norm:

- 25% (3) of respondents said that their clients experienced 'good discharges' more than 75% of the time
- 33% (4) of respondents said that their clients experienced 'good discharges' between 50% and 75% of the time
- 8% (1) of respondents said that their clients experienced 'good discharges' between 25% and 50% of the time
- 33% (4) of respondents said that their clients experienced 'good discharges' less than 25% of the time.

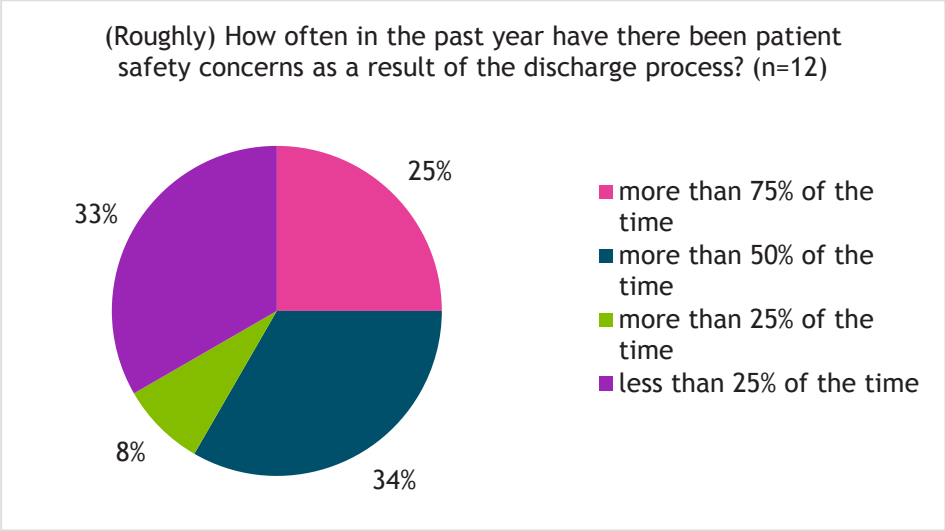
The overwhelming majority of respondents had seen their clients experiencing delays in receiving appropriate care caused by the discharge process:

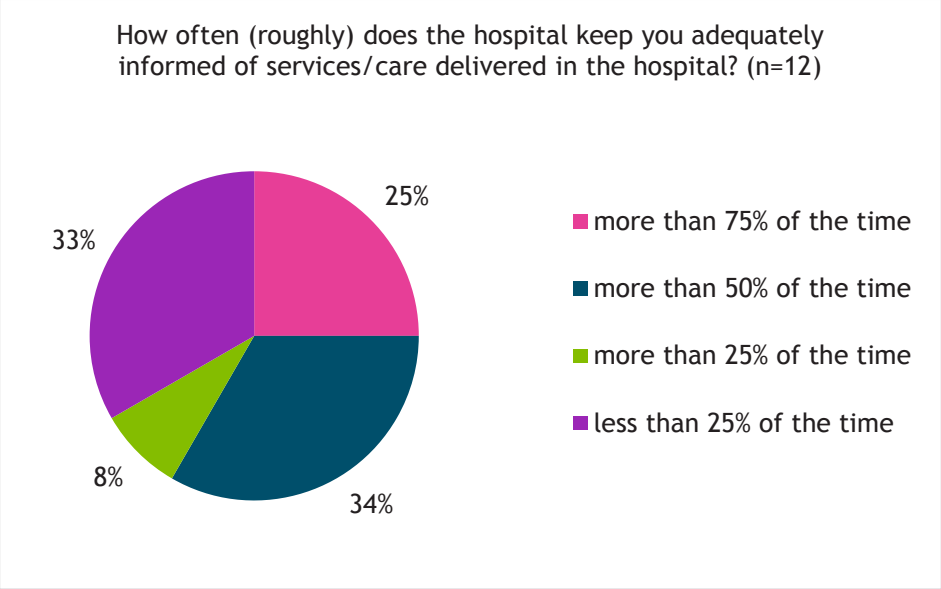
- Only one respondent said that their clients never experienced delays in receiving appropriate care
- all the other respondents said that their clients had experienced delays in receiving appropriate care
- 67% (n=8) of all respondents said that their clients had experienced delays between 1 and 5 times a year
- 24% (n=3) of respondents said that their clients had experienced delays between 6 and 30 times a year.

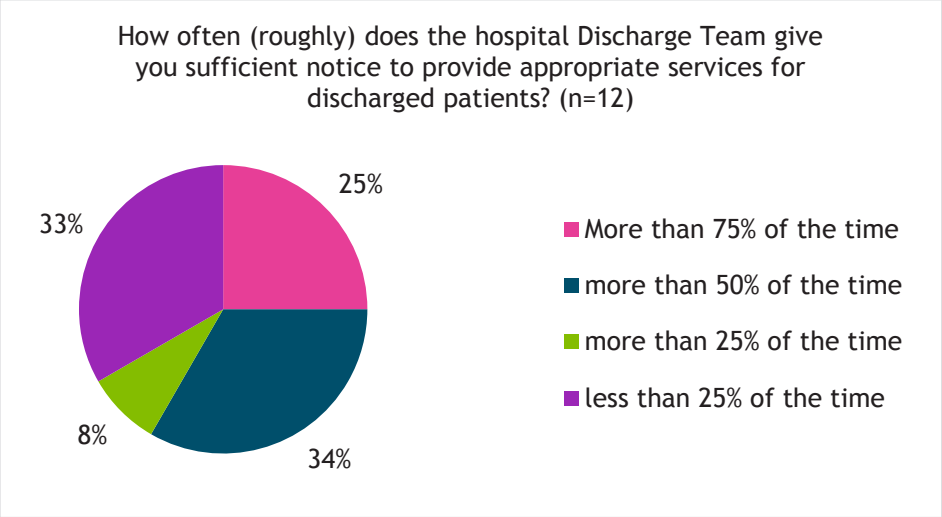


There was clear evidence of concerns on the quality of discharges over the previous months:

- 66% (8) of care providers said that there had been patient safety concerns more than 25% of the time in the previous year.
- 45% (3) of providers said that their clients had been upset or distressed by the discharge process more than 5 times in the previous year.
- 25% (3) of providers felt that they were kept adequately informed of services/care delivered in the hospital more than 75% of the time.
- 25% (3) of providers felt that they were given sufficient notice to provide appropriate services for their clients more than 75% of the time.







3.4.3 Key issues

When asked for the top three issues that they encountered with discharges, clear patterns emerged. More than 50% of the issues mentioned first were communication-related.

Typical comments relating to communication included:

Poor communication...[twice]

Person not knowing what is happening unable to make choices

Releasing patient without knowing that they are home

Lack of communication

Mixed messages

Transpacency of health professionals within the hospital

Lack of information

Paperwork not completed

A significant number of respondents mentioned patients being discharged too early and/or insufficient time to prepare for their discharge as being one of the top three issues

Comments/issues on the timing of patient discharges included:

pushed to take them back at short notice

no clear time for the client to be discharged

Cancelling at the last minute when rosters have been scheduled.

Person still very ill on discharge additional risk to health and wellbeing

inappropriate discharge

Readmission due to inappropriate discharge" "sent home before they are fully fit

33% (4) of respondents mentioned additional problems with medication. Medication-related issues included:

No medication sent

Medication not ready

No correct medication

Discharging with not enough medication and a perscription (sic) which is required asap.

Issues related to support in the community were also raised and these included:

Clients being sent home wiith little or no care/support

No support or care

Carer and cared for unable to cope independantly

Trying to get support back in when client has been discharged (sic)

3.4.4 Perceptions of good and poor practice

In terms of their impact on care provision, the following specific named items were ranked as having the greatest impact by the care providers (in relative order):

- patient discharged with no risk assessment in place
- patient discharged with no updated care package in place
- patient discharged with no discharge notes in place
- patient discharged with inadequate information about medication.

Perhaps unsurprisingly, these themes were also reflected in answers to the question "What characterises a 'good discharge' from *your clients'* perspective?"

Good communication Is discharged before 3pm Has all medication Has all documents.

"Communication from all parties involved in the care and support.

medications all present. all paperwork sent from the home is returned ie DNAR [do not attempt resuscitation forms]. Being discharged at a reasonable time of day. concise discharge

Timely communication prior to and in readiness for discharge so all appropriate care/support is in place upon discharge.

The same themes emerged in answer to the question, “what characterises a 'good discharge' from *your* perspective?"

Good communication between all parties, specsfic dates and times to enable provider to plan in advance instead of it being left to the last minute. To ensure that client is discharged with all correct medication/prescroptions.

correct discharge paperwork communication from hospital prior to discharge residents brought back before 17.00 at night all meds present all personal items returned all paperwork returned correct information from hospital

Good communication between hospital/GP/care and support services and family. Appropriate treatment medication and aftercare. TTO's [medication to take out] ready at time of discharge. GP receiving discharge notes in a timely fashion

and perhaps most succinctly, from one respondent:

Good communication

Poor discharges were seen as having a severe impact on care providers' clients.

Issues raised included confusion, frustration, anxiety, loss of confidence, stress, and reluctance to use health services again, lack of trust in the NHS, low mood and anger.

Poor discharges were cited by care providers as resulting in medication being stopped inappropriately, worsening of their medical condition, refusal to have treatment and in safety concerns.

A number of care providers cited readmission as being an outcome of poor discharges:

Re-admission to hospital.Worsening of physical and mental health Previous hospital treatment then serves no purpose Engenders lack of trust in NHS and has resulted in refusal for further essential treatment

One respondent succinctly identified the 'vicious circle' that arises:

they have to be sent back to hospital due to being sent out too early because of bed blocking

Poor discharges had a considerable impact on care providers' own workloads. Most cited additional work, additional time, and additional stress. In some cases the Safeguarding team had to be involved.

One answer summarised the wide-ranging nature of the impact of a poor discharge on their care provision:

> *Reassuring clients and getting the right care/support team in place as soon as possible. District nurse/hospital at home care /support agencies in place. Visiting clients more often where there are concerns. Trips to chemist to get emergency prescriptions/medication. This takes a lot of time up and thus impacts on daily workload.*

Care providers provided a number of examples of good practice on discharges. These included the following specific process:

> *When a client is admitted to hospital we add their name to our 'Hospital' board and ring the ward regularly for updates. From the start we tell the ward who we are and what care we provide and ask them to note our number. We explain that we plan our schedules one week in advance so ask them to bear this in mind. For the first week we cancel care on a day by day basis so that it can be restarted immediately if necessary. This generally works well.*

Other specific examples of good practice included:

- one respondent who cited the John Radcliffe Hospital as keeping both the care provider and the clients families well-informed
- Hospital at Home was cited by more than one respondent as giving good planned treatment and facilitating good communication
- good service from a Learning Disability liaison service
- after packages being put in for elderly patients needing rehabilitation
- having a dedicated discharge co-ordinator available.

One care provider cited the story of a particularly good discharge where services appeared to be well co-ordinated:

> *A resident with Parkinson's was going to be discharged and staff contacted hospital as they had not got the full history of client. By*

all working together a full package and with care and support was set up and also a move to alternative accommodation was authorised so client able to live independently with wife at home.

3.5 Recommendations arising from the care providers who contributed to this study:

- **Agree a protocol for communication with care providers where a patient has been admitted from a care home or with an existing package of care that starts from the point of admission.**
- **Overhaul the process for prescribing medicines at the point of discharge, starting the process earlier and ensure patients are discharged with the medication they need.**
- **Ensure patients are discharged with full discharge information including risk assessment, details of medication and details of medical and/or social care packages that have been set up.**

3.6 Professionals: GPs

Healthwatch Oxfordshire liaised with the Local Medical Council (LMC) to author the questionnaire for GPs on their experience of discharges from hospital in Oxfordshire - and to encourage Oxfordshire's GPs to complete it.

3.6.1 About the respondents

61 questionnaires were started, of which 33 were sufficiently complete for analysis and inclusion in this report.

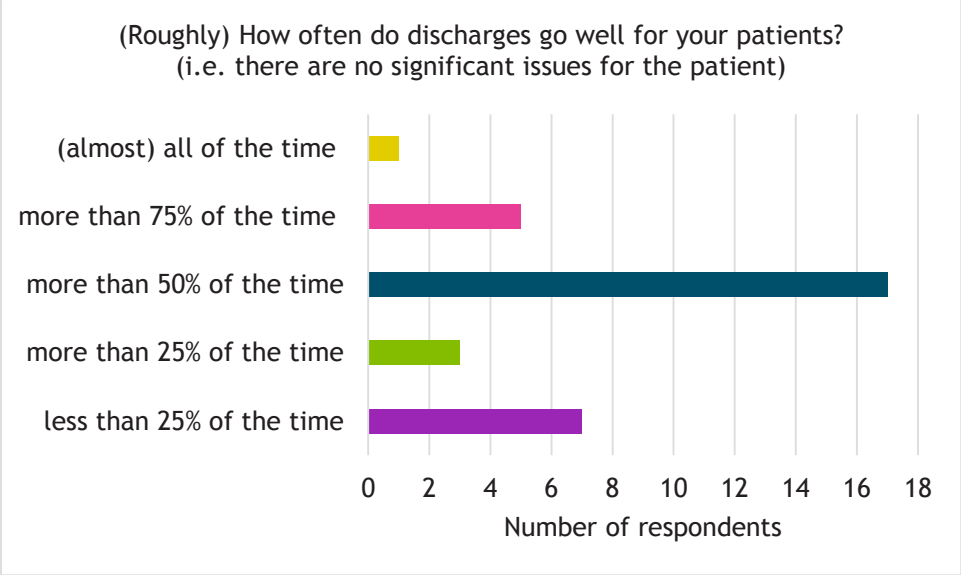
All those who completed the questionnaire stated their role as GP.

- 25% (8) of those who completed the questionnaire stated the views as being those of "both themselves and of their colleagues".
- 75% (24)of those who completed the questionnaires stated the views as being those of themselves.

3.6.2 Quality of discharges

Responses indicated that 'good discharges' (ie there were no significant issues for the client) were not perceived as 'the norm' by this group of Oxfordshire GPs:

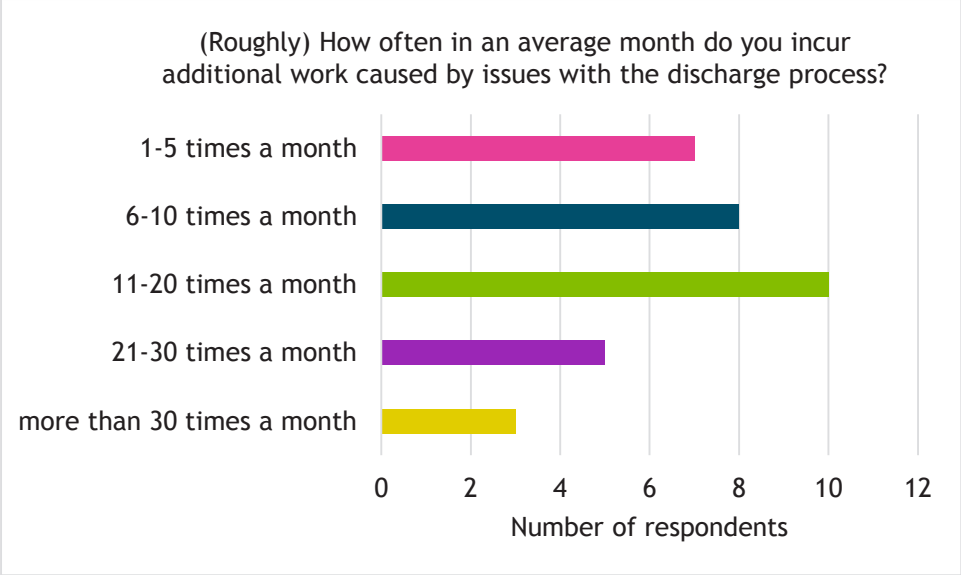
- Only 3% (1) of respondents said that patients experienced 'good discharges' almost all the time
- Only 15% (5) of respondents said that their clients experienced 'good discharges' more than 75% of the time
- 52% (17) of respondents said that their clients experienced 'good discharges' between 50% and 75% of the time
- 9% (3) of respondents said that their clients experienced 'good discharges' between 25% and 50% of the time
- 21% (7) of respondents said that their clients experienced 'good discharges' less than 25% of the time.



Almost all GP respondents had seen patient safety concerns in the previous 3 months caused by the discharge process. Comments on how frequently this had occurred varied from '25% of cases' and 'Several times a week' to 'I'm not sure, but we spend a lot of time trying to prevent problems'.

There was clear evidence of the impact of discharge issues on GP workloads. Estimates of the frequency of additional work caused by issues with the discharge process were as follows:

- 21% (5) of respondents said that they had additional work 1-5 times a month
- 24% (8) respondents said that they had additional work 6-10 times a month
- 30% (10) respondents said that they had additional work 11-20 times a month
- 15% (5) respondents said that they had additional work 21-30 times a month
- 9% (3) respondents said that they had additional work more than 30 times a month.



The majority 69% (22) of respondents estimated the additional working time caused by each issue to be between 11 and 31 mins:

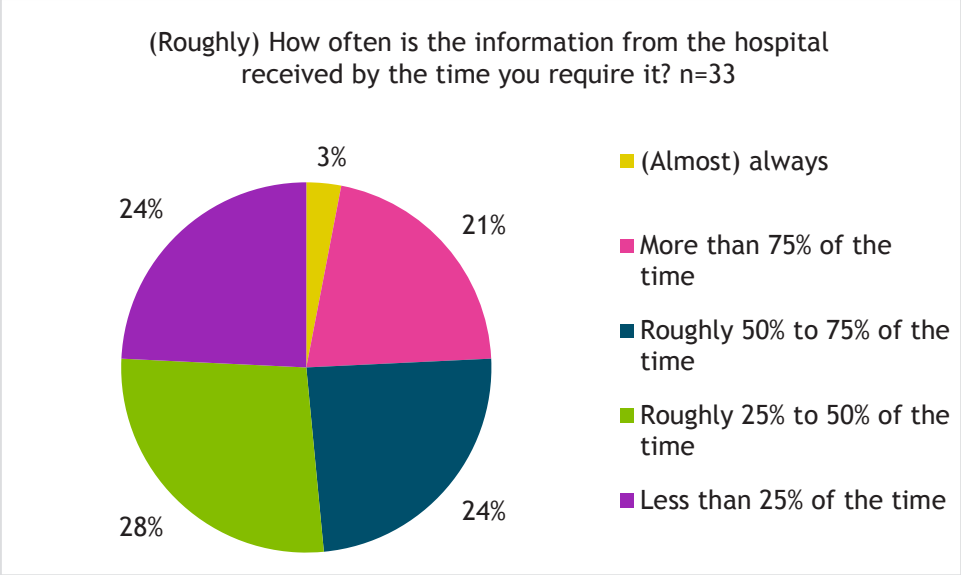
41% (13) of respondents estimated the extra working time per issue to be 11 and 20 mins

28% (9) of respondents estimated the extra working time per issue to be 21 and 31 mins

Using these figures, one might calculate that the additional work caused by discharge issues to the average GP responding to this survey would be in the region of four to six hours per month.

In terms of the timeliness of the information received, there were strong indicators that the respondent GPs felt that the information was often received too late, although there was considerable variance in their perceptions of how often this happened:

- 1 GP indicated that the information was almost always received by the time that they required it
- 21% (7) of GPs felt that they received the information by the time required more than 75% of the time
- 24% (8) of GPs felt that they received the information by the time required between 50% and 75% of the time
- 27% (9) of GPs felt that they received the information by the time required between 25% and 50% of the time
- 21% (7) of GPs felt that they received the information by the time required less than 25% of the time.



3.6.3 Key issues

When asked what were the top three issues that they encountered with discharges, clear patterns emerged:

- more than 50% of respondents cited discharge summaries/letters and/or other communication issues as their 'top issue'
- 33% of respondents mentioned medication-related issues second
- in total more than 50% of all issues listed could be seen to be communication or discharge summary related
- other frequently cited issues related to:
    - care co-ordination
    - care planning
- together, 75% of issues listed as GPs 'top three' could be seen to relate to these five areas (communications, discharge summaries, medication, care co-ordination and care planning).

Specific issues raised most often with discharge summaries were: timeliness; too much information/no clear synopsis (eg information appropriate to community nurses sent to GPs); lack of diagnoses; inaccurate medication information; lack of information about reasons for medication changes; handwritten discharge summaries; lack of clear information for GPs to act on/unclear follow-up plans; asking GP to chase on actions that hospital has initiated.

Wider communication-related issues included: lack of information provided to patients and/or their families; inappropriate assumptions about patient's home situation; patients being confused or unclear about future plans; lack of information about the Estimated Date of Discharge; not knowing that patient has been discharged.

More than one GP mentioned the value of a phone call directly to the practice prior to discharge, particularly for complex patients.

Issues related to medications included: wrong medications stated/medication errors (mentioned by 4 respondents); insufficient meds on discharge (e.g. after eye surgery); unclear why medication changes made; inappropriate medications used (e.g. Warfarin rather than more appropriate anticoagulants).

Issues related to care co-ordination included: hospital failing to follow-up on promised actions (e.g. contacting District Nurses – mentioned by a number of GPs); GP being asked to follow up investigations or arrange onward referrals; GP needing to chase outpatient appointments and arrange tests.

Test results was a frequently cited area of contention.

> *Dumping of test results follow up on us. This is endemic, particularly with CT scans.*

With regard to care planning, GPs mentioned the lack of information/clarity on follow up plans, the frequent changes to follow up plans, care not set up when required and lack of awareness of social needs of patients.

GPs were asked to rank a list of specific issues in terms of their impact on the GPs practice. This indicated the impact of issues around discharge summaries, readmissions and medications:

- 49% (16) of GPs listed 'patient discharged but no Discharge Summary/letter received' as having the greatest impact on their practice
- 67% (22) of GPs ranked 'patient discharged but Discharge Summary/letter arrives late' either first, second or third in terms of impact on their practice
- 55% (18) of GPs ranked 'patient readmitted within 48 hrs following inappropriate discharge' either first, second or third, in terms of impact on their practice
- 54% (18) of GPs ranked medication issues ('inadequate medication' or 'inadequate information') either first, second or third in terms of impact on their practice

3.6.4 Perceptions of good and poor practice

Perceptions of what characterises a good discharge from a patient perspective were clear and aligned closely to the quality-related topics above.

Key elements included:

- patient well enough to be discharged
- clear & concise communication, particularly to patient & family, GPs, community services and social services
- clear diagnosis & treatment summary
- clear information on medication changes (including meds stopped & started & why)
- sufficient medications for a number of weeks after discharge
- sufficient notice for all parties to prepare for discharge – plan & services in place
- well-structured, electronic discharge summary.

There was remarkable consistency in the answers from GPs. One answer summed up what was, by and large, consensus:

> *Clear plan for discharge agreed with the patient and their family/carers, with time for family/friends to prepare for this; appropriate agencies informed with enough time to start involvement with the patient as soon as they are discharged; clear concise communication with primary care so they know why the patient was admitted; what the diagnosis is; any plans for follow up; what drugs they have been discharged on and how long they should continue on them; also that the patient should go home with at least two weeks medicine to give the GP time to take over the prescription in an orderly way*

Perceptions of what constituted a good discharge from a GP perspective were, unsurprisingly, similar – if more succinct:

> *Good clear diagnosis correct meds info re investigations A GP plan A Hosp plan What I told the patient re plan*

Many GPs mentioned the importance of a concise, well-structured, accurate Discharge Summary, in addition to what a patient requires.

A number of GPs gave very specific advice on appropriate layout and/or format of Discharge Summaries, including the importance of having key

information at the top – and not burying important information in the middle of the text.

One respondent gave an example of quite how critical a Discharge Summary can be:

> *A Discharge Summary is precively that - a Summary, not the clinical narrative that lead to the test request e.g. obs, symptoms, signs etc I currently am a clinician involved in a case where a patient was admitted and discharged three times in a row with no discharge correspondence at all - she died in the back of an ambulance on the way back to the hospital... This is an extreme example of where failure to provide discharge correspondence might have improved her assessment and prevented her death...*

Specific examples of good practice on discharge included examples of junior doctors ringing the GP to explain the discharge plans (phone calls seemed to be particularly appreciated by a number of GPs), Emergency Multidisciplinary Unit (EMU) monitoring patients until they were seen as fit and stable, patients having a copy of their Discharge Summary, as well as their GP, and discharges from the Cardiology Department in Reading, who:

> *never slip up. Patients know who their consultants are. Letters are sent very swiftly. Plans are very obvious for the patients. Follow up is always organized.*

One GP had this comment on Discharge Letters:

> *A good discharge letter saves a lot of time. It avoids our staff having to bother hospital staff to get information that we should have been sent. It saves wasted appointments by patients coming to discuss the contents of a discharge letter.*

And one GP had this advice on good discharge practice:

> *Clarity Clarity Clarity What has been the thinking? What is the plan?*

GPs were very clear about the benefits of good discharge processes on their own practice and workload. Comments included:

> *Huge reduction in workload*

Streamlines care, prevents me having to recontact hospital, wasting their time and mine, to seek clarification

Helps enormously - not having to chase summaries or ring hosp doctors or to liaise with pharmacies. An enormously positive impact.

We asked GPs what single change/improvement they thought would make the greatest positive impact on discharges for patients.

The greatest number of answers focussed on the Discharge Summary, particularly on ensuring electronic delivery, its timeliness, quality and structure, reflecting the points mentioned above. Answers also mentioned the importance of ensuring that consultants take responsibility for the Discharge Summary, for the discharge itself and are named.
GPs also emphasised the importance of in person communication for complex cases.

Other answers included:

A unified patient record with relevant parts accessible by patients

Assume absolute responsibility for the actions you have taken in the hospital. After all they have a medicolegal responsibility for doing so.

More "step-down" services e.g intermediate care beds where patients can go from acute setting to rehab/community care rather than from hospital to home alone only to bounce back in again.

Patient being fully fit and able to cope, for the discharge setting.

Thinking about information you would like to receive if taking over care.

Finally, we asked GPs if they had any additional points about discharges in Oxfordshire. Their answers reflected the ‘case for action’:

They (discharge summaries) could and should be so much better. Once completed the clinician concerned should read through and ask themselves : 'can the person recieving this safely pick up the clinical management of this patient'

Please ask clinicians to take responsibility for what they are doing, think about the effect this has on the patient and do what they would wish a professional to do for their family member - communicate clearly with patient and primary care.

I would really value hospitals being utterly responsible for their actions. Dumping patients on the community is bad form and very bad for patients. Telling patients they will contact them with OP appts or with results and this never materialises is bad form and bad for patients. It is also not defensible. I have dealt with two cases of this this morning alone in my am surgery - so 2 x 10min appts.

They do need to improve Please use casenotes at the least please start to understand the impact on GPs if we have no information or incorrect information

There is a lot of room for improvement. Computer systems need standardising so that a standard discharge form is used.

Please can someone do some work on improving this.

3.7 Recommendations arising from the GPs who contributed to this study:

- **The electronic discharge summary should be redesigned with input from GPs.**
- **Standards for use of these electronic Discharge Summaries and Discharge Letters, including timeframes for delivery should be agreed across the system and enforced through training, education, audit and other appropriate mechanisms.**
- **Standards for supply of medications on discharge should be agreed across the system. These standards should include minimum periods for supply of ongoing medications, a requirement to explain reasons for medication changes, clear, printed, advice for patients on medications on discharge and processes to ensure alignment on use of medications across primary and secondary care.**
- **Wherever possible, discharging clinicians should phone and speak to the GP - particularly when discharging patients with complex care needs.**

- **Vulnerable patients requiring additional support should not be discharged at 5pm on a Friday.**
- **Hospital doctors should take responsibility for chasing results of tests they order and communicating the results to GPs and patients.**

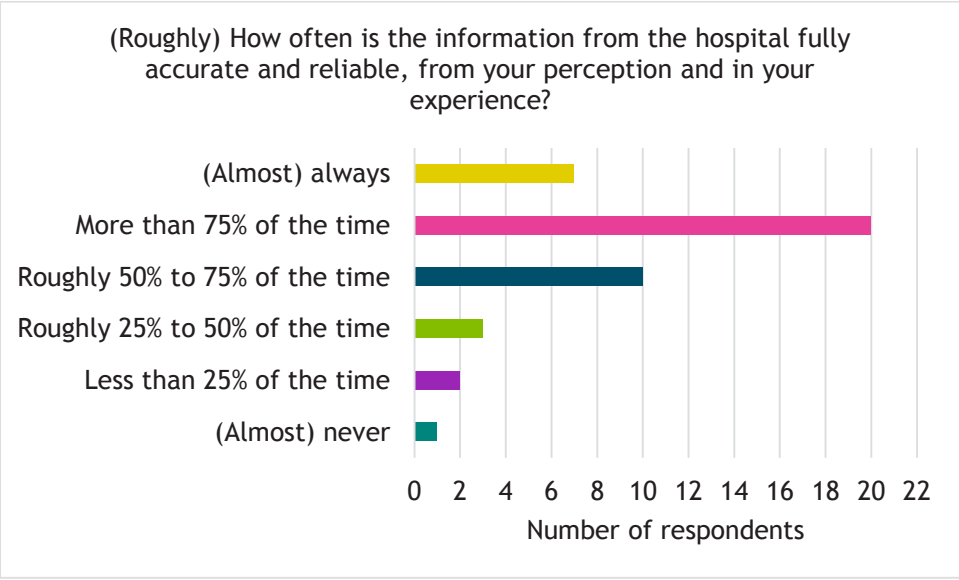
3.8 Professionals: pharmacies

The findings in this cohort are similar to those of the GPs. They focus significantly on communication, the benefits when communication is done well, and the stress to patients and additional workload for pharmacies when it isn't done well. Overall, the comments seem to suggest that when the information is received, it is usually accurate, with some suggestions for improvement. However, pharmacists are not routinely receiving information in a timely way.

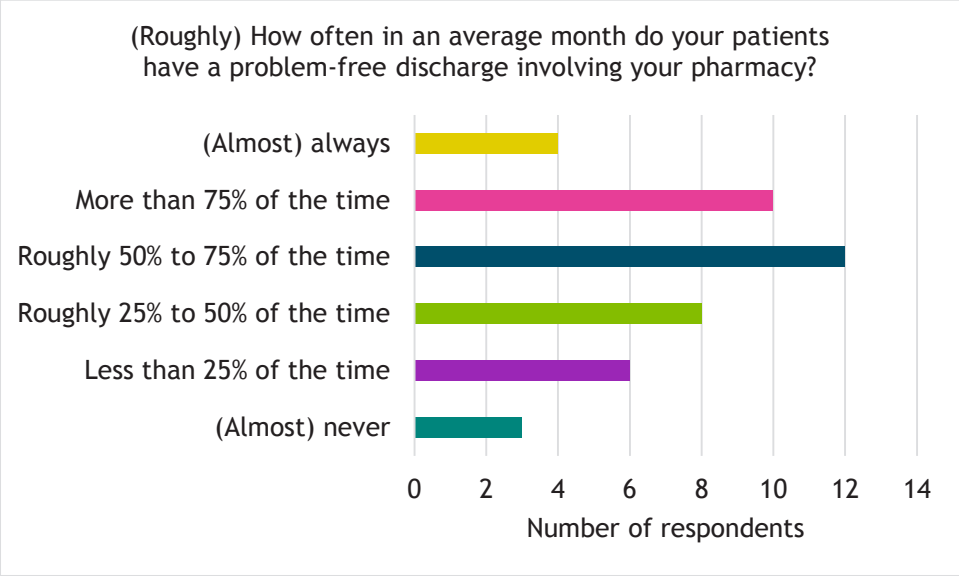
There were 44 respondents to the 'pharmacies' questionnaire, 20 of which categorised themselves as pharmacy manager, 20 as Pharmacist and 4 as 'other'.

3.8.1 Quality of discharges

- 62% (27) of participants report that information received from hospitals is fully accurate and reliable (almost) always or more than 75% of the time



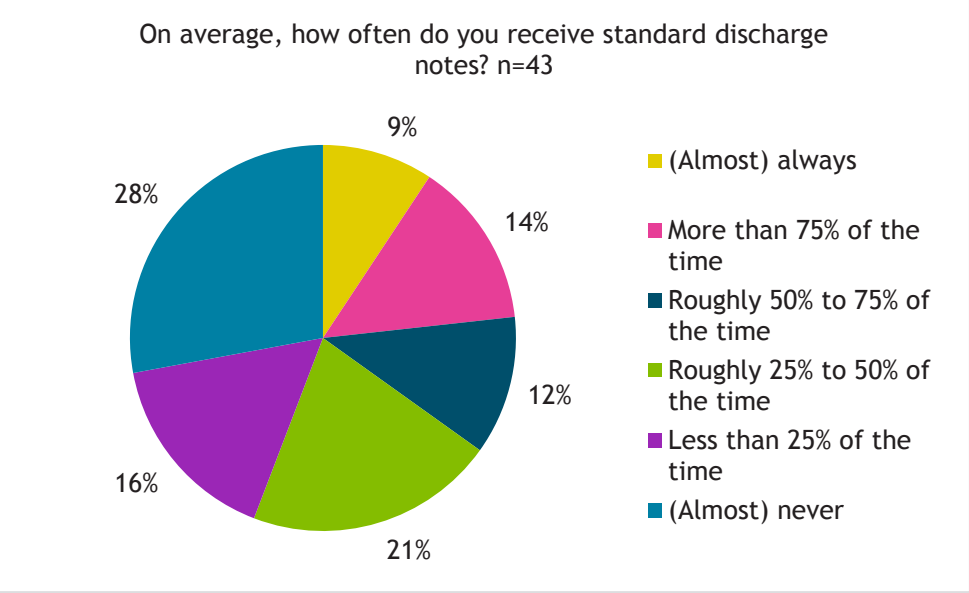
- 60% (26) of participants state that discharges are 'problem-free' 50% of the time or more.



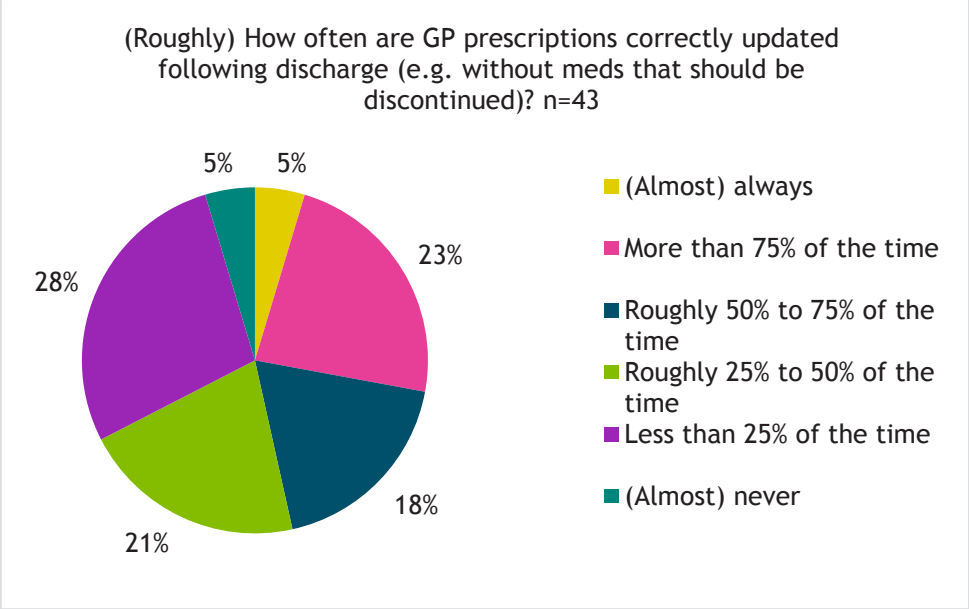
- 60% (26) of participants report their workload is impacted by issues of the discharge only 1-5 times per month
- 53% (21) report that dosette boxes are being recommended appropriately by hospital more than 75% of the time or (almost) always

3.8.2 What could be improved?

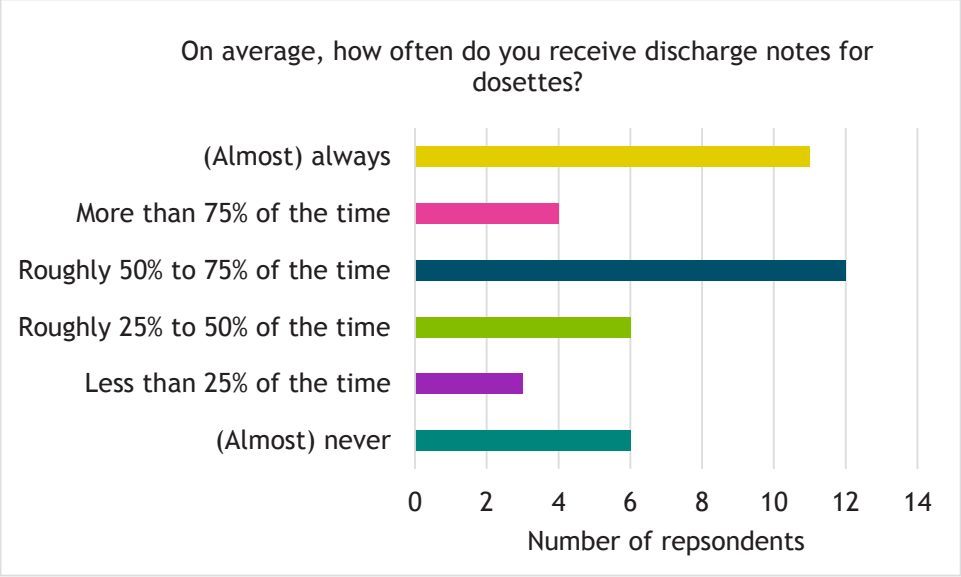
- 65% (28) of respondents are receiving standard discharge notes 50% of the time or less.



- Only 38% (16) of respondents said they are (almost always) or more than 75% of the time receiving the information they need on time.
- 53% (23) of respondents report that GP prescriptions are updated correctly less than 50% of the time.



- 16% (7) reported an uninterrupted continuation of medication prescribed in secondary care as occurring (almost) always
- 44% (15) of respondents report receiving information on dosette boxes before patients run out of medication 50% of the time or less



The respondents to the pharmacies questionnaire were very clear about both the impact of poor communication on patients and their workload, and on what could be improved.

Typical comments on the impact, include:

> *V stressful [for patients]*
>
> *The patient doesn't get their medication on time*
>
> *Delays in meds, distress & loss of confidence in service*
>
> *We try to minimize impact, but they will be anxious about receiving their meds*
>
> *Sometimes we don't get discharges and we have to ring round trying to get someone to copy us into the discharge*
>
> *GPs may not always do prescriptions for changes until they get the discharge note - which is sometimes quite delayed. Patients not always told of changes as they query it with me and it takes time to chase up*

There was a particular concern on the impact of delays on safety:

> *Sudden demand of urgent DDS boxes which do not hav resource to dispense and check safely*

Pharmacies had a few concrete recommendations on how discharge summaries, and communications on discharge, in general, could be improved:

> *Discharge summaries on time, GP record updated on time*
>
> *Two weeks worth of discharge meds from hospital and all notes given to us and GP at the same time, i.e. day of discharge. This give plenty of times for all concerned to organise meds.*
>
> *Patients leave hospital with a clear idea / written plan of their new medication/treatment. The GP and pharmacy are notified (either by hospital or patient) and are able to organise continuing supply in plenty of time. Good communication is key.*
>
> *Nominated Pharmacy to be emailed when patients admitted and discharged. This will avoid dossette boxes being prepared when*

pharmacy unaware of admissions and allow warning of when they may be resumed.

Communication that the patient meds have changed, if they are on a dossett box and when they will need their new set of dossett boxes.

Recently received report from a patient that clearly listed stopped medication/continuing medication/new medication and a temporary medication which was useful

It seemed that two weeks' worth of medication upon being discharged from hospital was the ideal window for pharmacist and GPs to have received all of the relevant information required to ensure continuity in medications after discharge. A number of comments specifically mentioned how helpful it was to include the medications that had stopped during a hospital admission as being as important as those that had started in the same period.

3.9 Recommendations arising from the pharmacists who contributed to this study:

- **Ensure patients leave hospital with two weeks worth of medications.**
- **Ensure pharmacists are notified when patients are admitted and that they receive copies of discharge summaries on the day of discharge.**
- **Ensure discharge summaries include information on all changes to prescriptions (what has been started, stopped, changed – and why).**

4 The gap between information given to patients and their experience.

According to its website, OUHT produces several leaflets for patients to help inform their discharge from hospital, and has a ward poster called Planning for Discharge. [7] The Planning for Discharge poster helpfully summarises for patients, in a flow chart format, 15 steps in the discharge process. Using the data reported in Chapter 3 Healthwatch Oxfordshire has identified 10 points in the process, as described to patients in this poster, where experiences of discharge do not appear to be matching the information given to patients about what to expect.

[7] See Appendix 1 Planwell, Planning for Discharge; Planning to Leave.

The Planning for Discharge Poster says:

1. *Planning for your discharge will start on or before admission where possible. We will discuss your estimated date of discharge and together agree a plan.*

   Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.

2. *We will discuss your needs and agree the help you need at home with the involvement of your family and/or carer.*
3. *We will expect you to be fully involved in planning your own discharge, together with a relative, carer or friend as appropriate.*

   Only 54% (79) of the patients who completed the survey on line said they or their family or carers were involved in planning their discharge.

   Only 50% (29) said they or their carer were kept informed and involved in the arrangements for their discharge.

   Even when carers were reported as being involved, the involvement was reported as often being very late on in the process. 44% (30) of carers were only involved in discharge arrangements a few days before discharge (11), or on the day the patient left hospital (19). 19% (13) of carers were involved on the day of admission or the next day.

4. *If you have started new medication, you will be given a supply to take home. Your GP will then prescribe more if required.*
5. *We will explain your medication. There are also written instructions on the packaging and an information sheet will be provided.*

   Whilst 94 % (116) of the patients who completed the survey after discharge understood the instructions/information they were given about their medication to take home, only 64% (84) patients said their medication was available for them at the time they were ready to be discharged and issues with medication were cited more frequently than any other issue.

6. *We will aim to get you 'Home for Lunch' on your day of discharge wherever possible. We may ask you to move to a transfer area/lounge or day room; here you can wait in comfort for your relative/carer/transport and medication. This will enable us to start treating another patient.*

   We did not ask a specific question about what time people got home, but anecdotal evidence gathered by volunteers in the course of undertaking interviews with patients for this project suggests that "home for lunch" is not always achieved. 24% (8) of those who used it, rated their experience of the lounge as poor or very poor.

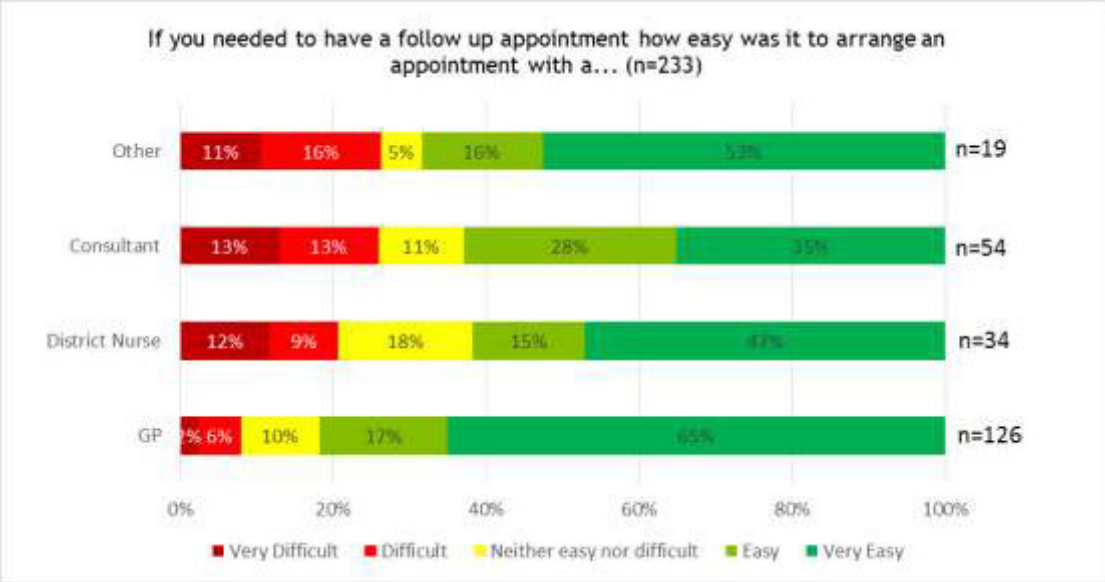
7. *You will be given, and we will send, a letter to your GP explaining the reason for your hospital stay and giving details of your medication.*
8. *If you and your team agree you need help at home, a discharge letter detailing support services will be sent to your GP.*

   GP's clearly told us that there are a number of problems with discharge summaries. The most frequently cited issues were timeliness; too much information/no clear synopsis (e.g. information appropriate to community nurses sent to GPs); lack of diagnoses; inaccurate medication information; lack of information about reasons for medication changes; handwritten discharge summaries; lack of clear information for GPs to act on/unclear follow-up plans. Lack of information provided to patients and/or their families and patients being confused or unclear about future plans were also cited by GPs as a problem.

9. *If you need a follow-up appointment or further investigations, we will arrange this before you leave.*

   We asked patients how easy they found it to make the follow up appointments that they needed. Most people found it was very easy or easy to arrange follow up appointments, particularly with GPs. However, 26% (14) found it difficult or very difficult to arrange a follow up with a consultant, 27% (5) with 'other' and 21% (7) with a district nurse.

One of the top problems raised by GPs was the frequency with which they are asked to follow up investigations, arrange onward referrals, chase outpatient appointments and chase test results.



10. *If you need equipment at home, we will agree arrangements with you. We will show you and your carer how to use any equipment provided before you leave hospital.*

    79% (31) of the patients who needed equipment said it was available when they needed it, but 42% were unsure how to use it when they got home.

4.1 Recommendations relating to the gap between patient information and patient experience.

- **OUHT, OHFT and OCC should pay particular attention to improving performance in the 10 areas where the process as laid out in the "Planning for Discharge" poster is not being delivered.**

- **The poster should be redesigned as a leaflet that is given to all patients and discussed with them, and their carers/family members by the person responsible for planning their discharge. The Trust should routinely monitor that this is happening to ensure it becomes standard practice.**

- **That leaflet should include a space in which the name and contact details of the patient's discharge co-ordinator can be written and it should include information on who the patient should contact if they are unhappy about their discharge plan.**

5 Recommendations

Across all cohorts of participants to this study there were remarkably similar, and in many cases, simple recommendations. We would recommend that commissioners, providers, patients and professional bodies work together to enact the following recommendations:

The 14 main recommendations arising from our study are that:

1. Hospital trusts should take immediate action to increase the percentage of patients whose Estimated Date of Discharge (EDD) is set within 36 hours of admission, which is step 1 of the local pathway[8]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day.

2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.

3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan.

4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place.

5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them.

[8] See Appendix 1 for the summary pathway

6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed.

7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services.

8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically:
    - Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.
    - Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.
    - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary.
    - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself.

9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.

10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.

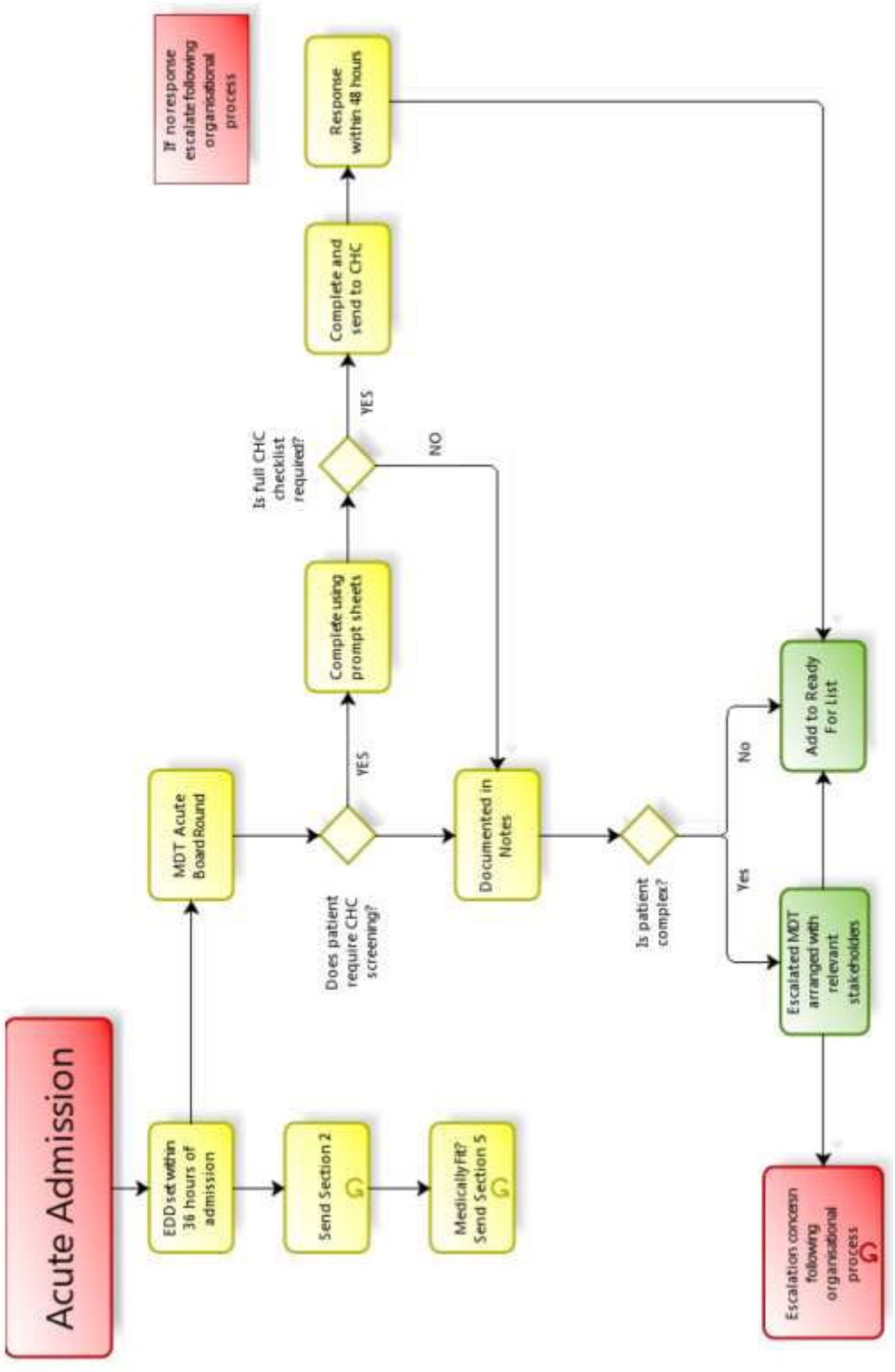
11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.

12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge.

13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.

14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.

Appendix 1: Discharge pathway flowcharts




Your hospital stay – planning for discharge
What we will do
Planning for your discharge will start on or before admission where possible. We will discuss your estimated date of discharge and together agree a plan.
We will discuss your needs and agree the help you need at home with the involvement of your family and/or carer.
If you need to be transferred to a community hospital, we will send you to the first available bed. This may not be the one closest to where you live. The priority is to start your rehabilitation as soon as possible.
What we expect from you
We will expect you to be fully involved in planning your own discharge, together with a relative, carer or friend as appropriate.
We expect you to arrange your own transport home. Hospital transport is for people who meet strict medical criteria only.
You need to arrange outdoor clothes, your house keys, ensure heating is on and that you have enough food at home.
Please let us know if you require a medical (sick) certificate.
Medication
Medication which you brought into hospital, and still need, will be returned to you.
If you have started new medication, you will be given a supply to take home. Your GP will then prescribe more if required.
We will explain your medication. There are also written instructions on the packaging and an information sheet will be provided.
Day of discharge and follow-up
We will aim to get you 'Home for Lunch' on your day of discharge wherever possible. We may ask you to move to a transfer area/lounge or day room; here you can wait in comfort for your relative/carer/transport and medication. This will enable us to start treating another patient.
You will be given, and we will send, a letter to your GP explaining the reason for your hospital stay and giving details of your medication.
If you need a follow-up appointment or further investigations, we will arrange this before you leave.
Help at home and equipment
If you and your team agree you need help at home, a discharge letter detailing support services will be sent to your GP. The support services will be arranged before your discharge.
If you need equipment at home, we will agree arrangements with you. We will show you and your carer how to use any equipment provided before you leave hospital.
For more information, visit: www.ouh.nhs.uk/leavinghospital
Oxford University Hospitals NHS
NHS Trust

Appendix 2 & 3: Data tables & Questionnaires

Due to their length, the 5 questionnaires used in this study and the data tables are available in separate appendices. Appendix 2 & 3 will be available at www.healthwatchoxfordshire.co.uk or you can contact the office on 01865 520520 or on hello@healthwatchoxfordshire.co.uk to request a copy.

About Healthwatch Oxfordshire

Healthwatch Oxfordshire is an independent organisation that listens to your views and experiences of health and social care in Oxfordshire. We work to help you get the best out of these services, whether it is improving them today or helping to shape them for tomorrow. We have the ability to hold health and social care providers to account.

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Acknowledgements

Healthwatch Oxfordshire would like to thank all of the patients and service users that contributed to this project through interviews and online. We would like to thank Patient Voice for identifying and alerting us to the need for this study. We would also like to thank our local providers including Oxford University Hospitals Trust, Oxford Health NHS Foundation Trust, the Local Medical Committee, the Local Pharmaceutical Committee and the Oxfordshire Association of Care Providers who co-operated with us in this project. In particular, we would like to thank our project steering group and patient reference group for their help in designing the questionnaires, and our Enter and View volunteers who interviewed over 60 patients and service users for this project.

Disclaimer

This report relates to findings from online questionnaires as well as interviews conducted with Enter and View volunteers which took place in the Spring of 2015. The sample sizes from some respondent groups are small and need to be interpreted with caution. Participants were encouraged to give their personal perspective on the discharge process. Recommendations are based on the overall feedback received.

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Oxfordshire
Clinical Commissioning Group

Health Overview and Scrutiny Meeting:
Better care Fund Update
17 September 2015

1.0 Introduction

The BCF Plan was approved by the Oxfordshire Health and Well-being Board (HWB) on 09 January 2015 following a lengthy stakeholder engagement process. It is an ambitious program, made up of 12 individual projects that aim to support the local health and social care economy embedded in principles of integration and joint service delivery.

In an effort to ensure successful implementation and delivery of overall BCF Programme, Oxfordshire has put in place strong local governance arrangements. These arrangements aim to provide system wide leadership to the constituent parts of the programme as well as adequate scrutiny to allow the achievement of the 2% reduction in NELs based on the 2013-14 activity level, as per our original submissions.

The ultimate responsibility for the successful delivery of the programme lies with the Health and Wellbeing Board (HWB) and the System Resilience Group (SRG). There is a well-established BCF Programme Board, which meets every 6 weeks with a membership representing all stakeholders, including NHS England. The Board is chaired by the Director of Delivery and Localities.

2.0 Overall Progress

The Oxfordshire system has continued to implement and embed the original principles that the BCF was founded upon. There have been many successes over the last quarter with regards to the implementation of some of component projects with some preliminary data coming across. The system has collectively been working towards dealing with the challenges within the system through aligning the requirements of the BCF with other strategic priorities, most notably the Older Peoples Outcomes Based Contract (OBC).
We have continued to see progress in terms of a system change to deliver an integrated, coordinated and preventative health and social care system especially for patients with complex and changing needs.

The Digital Proactive Care Plan (dPCP), that was under development as part of the Oxfordshire Care Summary, is now operational and includes all of the mandatory care elements from the range of care planning forms available in Oxfordshire (including Oxfordshire Urgent Care Service Handover form, Special Patient Notes, Advanced Care Planning, Anticipatory Care Discussion form for Patients without capacity, Anticipatory Care Plan for Hospitalisation form and Unplanned Admissions Enhanced Service Care Plan). As of

the 31 July 2015 50% of care plans produced by GPs in primary care for patients within 2% of their population who are thought to be at high risk of admission were established in the digital format (dPCP). As of 31st July 2015 the new view of Oxfordshire Care Summary presents digital care summary information to view on systems for A&E, OOH, 111/SCAS.

We continue to increase the number of care homes that receive Proactive Medical Support, and have identified and are supporting the top 2% of the population most at risk of an emergency admission.

Integrated Locality Teams continue to be developed and embedded into the local health and care pathways; They also:

- Continue to test different models of co-location which will be evaluated 3 months after go live to understand where the added value is to the change in practice and outcomes for staff and patient
- In the south-east locality the health and social care leads have started to work with 2 practices to test out how a single care plan 'for the most vulnerable and at risk of admission patients' can be developed and delivered together – the first practice outputs will be evaluated in October and the second in November before rolling out an agreed tested model in the new year.
- Personal care planning training – the integrated teams are part of the Thames Valley Year of Care Training plan, with Oxfordshire having 5 qualified trainers by the end of the year. Training of the personal care planning approach is starting in the two south localities in November with unregistered and newly qualified staff.
- Circle of support – this national pilot delivered by Age UK and part of the six locality teams has a local extension of funding until April 2016, with the national evaluation is due in December

In line with the BCF Programme, the Oxfordshire system continues to work with providers to develop Ambulatory Care Pathways, including Emergency Multidisciplinary Units(EMUs). The system has joined the Ambulatory Emergency Care Network to develop this area of important work further. This is in line with national and local agenda to treat patients in an ambulatory way where possible and appropriate. There are generic pathways for patients with ambulatory conditions and their progress through the system is subject to a current review, as is the progress and impact of the EMUs on the patient journey.

Care Act reforms implemented from April 2015 are now bedding in, and we are meeting all statutory requirements. The new assessment and support planning process for carers is working well, with around 70% completing online self-assessments. The process is being

reviewed on an ongoing basis, and some minor changes were made to ensure that needs were being accurately captured and reflected in resource allocation.

Help to Live at Home continues to be on track to deliver a new model of home care, with tender documentation due to be issued 1st September. The Information and Advice Strategy is currently out to consultation, proposing a new model of provision that moves away from individual funding streams and towards a more coordinated, countywide offering.

The Workforce Strategy for Adult Social Care is being picked up regionally as a model of good practice, and focus is now on establishing appropriate governance arrangements to oversee implementation. Discussions are ongoing about how to develop an overall strategy for workforce across health and social care in the County.

1. Primary Care supported through the Prime Minister Challenge Fund has continued successfully with the implementation of services, and some of the updates include:
    - **Oxfed (Oxford City GP Federation):** Operations Manager has successfully been recruited who will be supporting the lead GPs in the project mobilisation work. Practice Care Navigators - OxFed are working closely with Age UK and the Care Navigators have now been recruited and currently inducting.
    - Practice Visiting Nurses - The lead advanced nurse practitioner and the visiting team posts are now out to advert. OxFed have received advice and support from Oxford Health who provide the local Community Nursing Service. Secondment opportunities are being offered to Oxford Health community nursing staff, ensuring strong collaborative working, a joint strategic approach and an opportunity to share learning.
    - Shared records for out of hours (OOH)-: the providers of the Out of hours service have been receptive to plans and their IT department is working with OxFed and EMIS to ensure the technical solution can be implemented as soon as possible.
    - **PML:** The Early Visiting Team pilots for North and North East Oxfordshire have been successfully rolled out, with two more teams to follow. From 1st June to 10 July the teams undertook 138 visits. Feedback from practices has been very positive.
    - **Abingdon:** E-consultations was up and running at the end of last month. There have been some technical issues in the first couple of weeks (not unexpected). EMIS Anywhere terminals and EMIS mobile software is to be deployed so that GPs can deal with patients remotely including doing EPS prescriptions.
    - **Online health resource:** an online health resource, County of Oxfordshire Advice on Care and Health (COACH), is being created by the Abingdon Federation for

eventual use by all Oxfordshire Federations. This design work is well underway with strong patient and stakeholder engagement.

3.0 Conclusion

The BCF plan is an ambitious set of projects which have the potential to provide more appropriate care for Oxfordshire residents and in doing so address enduring problems such as reducing delayed transfers of care and contribute to consistently achieving the reduction by 2% in the number of non-elective admissions target the system has set for itself.

The plan also aims to address the increasing demand for urgent and emergency care posed by demographic change in over 65s, which is growing at an annual rate of 1% per year. The impact of this growth is an average 4.3% growth a year in demand for non-elective admissions. Reaching a 2% reduction overall therefore compensates for growth and a further reduction to reach the 2% target.

Oxfordshire Health Overview and Scrutiny Committee

Forward Plan

September 2015

It is suggested that the committee considers it's prioritisation of topics for consideration and inclusion on the forward plan using the following categories

- Scrutiny of Health Strategy (Commissioner and Provider)
- Scrutiny of Major Service Change (Commissioner and Provider)
- Scrutiny of Quality/Performance (Major reports only)
- Scrutiny by Topic (As per member interest)
- Input from the 'patient voice'

Meeting Date	Item name	Date of addition and reason for adding to FP	Lead organisation
19th November 2015			
Scrutiny of Major Service Change (Commissioner and Provider)	Oxfordshire NHS Transformation Programme	Aug 15 - moved from Sept as early stages of development and needs discussion with boards.	Major joint item OHT, OUHT, CCG
Scrutiny of Major Service Change (Commissioner and Provider)	Update Adult Mental Health – Outcomes Based Commissioning	Discussed Feb 2015 – delay to contract being agreed	CCG, OUHT
Scrutiny of Health Strategy/Quality/Performance	Oxford Health Foundation Trust - Strategy - CQC Inspection outcome(Sept) - ***May have to move to Feb***		OHT
	OUHT New Chief Executive introduction		OUHT
Scrutiny of Quality/Performance	Health Inequalities Commission & health of BME women	Proposals for the commission went to HWB in March. Results after 6 mths due to go back to HWB	CCG
Scrutiny of Major Service Change	Community Hospital review		CCG

(Commissioner and Provider)			
Input from the 'patient voice'	Healthwatch update		HW
4th February 2016			
Scrutiny of Health Strategy (Commissioner and Provider)	Outcomes Based Commissioning - report on progress		CCG
Scrutiny of Major Service Change (Commissioner and Provider)	Commissioning of Public Health services for children and young people – update inc school health nursing	Raised at previous meeting CSE item (Jul 15)	PH
Scrutiny of Quality/Performance (Major reports only)	Overview of CQC activity locally		CQC
Input from the 'patient voice'	Healthwatch update		HW
21 April 2016			
30 June 2016			
15 September 2016			
Items to be scheduled	**Item name**	**Date of addition and reason for adding to FP**	**Lead organisation**
Scrutiny of Major Service Change (Commissioner and Provider)	OUHT - Update on implementation of action plan (post inspection), plus achievement against targets (delays in operations)	To include updates on vacancies, recruitment, retention and agency staff	
Scrutiny by Topic (As per member interest)	Planning and consulting NHS in advance of housing development	Initially discussed by HOSC in Feb 2015. Discussions with CCG/OCC suggest waiting until transformation programme and infrastructure framework developed.	Districts, NHS England

		Review in early 2016	
Scrutiny of Quality/Performance (Major reports only)	NHS recruitment and retention strategy		CCG
Need to identify:			
Past recommendations	July 2015- HWB Board **AGREED** to **RECOMMEND** that the Oxfordshire Joint Health Overview & Scrutiny Committee scrutinise the role of prevention of obesity, focusing on the collective roles of the district councils, the clinicians and on public health.		
Annual/regular reports	NHS providers quality reports - SCAS - OUHT - Oxford Health	April each year	
Annual/regular reports	Better Care Fund		
Annual/regular reports	Discharges and management of winter pressures	April	CCG/OCC/OUHT/OHT
Annual/regular reports	Director of Public Health's Annual Report	July	PH
Annual/regular reports	Health and Well-being strategy refresh/annual report	July	HWBB

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