Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 21 January 2010 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Richard Langridge

Councillors:	Tim Hallchurch MBE	Ray Jelf	Don Seale
	Jenny Hannaby	John Sanders	Lawrie Stratford
District Councillors:	Susanna Pressel	Jane Hanna	
	Christopher Hood	Rose Stratford	
Co-optees:	Ann Tomline	Dr Harry Dickinson	Mrs A. Wilkinson

Notes:

Date of next meeting: *11 March 2010*

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 Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk

Committee Officer - *Julie Dean, Tel: (01985) 815322*
julie.dean@oxfordshire.gov.uk

Tony Cloke
Assistant Head of Legal & Democratic Services

12 January 2010

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.

Health Scrutiny complements the work of the Patient and Public involvement Forums that exist for each of the NHS Trusts and Primary Care Trusts in Oxfordshire.

What does this Committee do?

The Committee meets up to 6 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

To approve the minutes of the meeting held on 19 November 2009 (**JHO3**) and to note for information any matters arising on them.

4. Speaking to or Petitioning the Committee

5. Oxfordshire LINk Group

10.10 am

Attached at **JHO5(a)** is a report which has been prepared by LINk Drug Recovery Project (DRP) group. One of the members of the group, Richard Lohman, together with Adrian Chant, will be available to answer any questions members may have.

A written update on the LINk's latest activities is also attached at **JHO5(b).**

6. Public Health

10.30 am

Report by the Director of Public Health on matters of relevance and interest.

7. Paediatric Training Accreditation at the Horton General Hospital

10.45

At the November Oxfordshire Joint Health Overview & Scrutiny Committee (OJHOSC) meeting, members agreed the following:

'The OJHOSC urges that discussions should continue with the Oxford Deanery aimed at achieving training accreditation for middle grade paediatric posts at the Horton General Hospital (HGH). The report from the Deanery visit to the HGH on 13 November should be made public as soon as possible.'

This referred to the Deanery visit, led by Mr Tony Jeferis, Acting Postgraduate Dean that evaluated the possibility of reinstating training accreditation for middle grade paediatricians.

The report has now been published and a copy is attached at **JHO7.** The outcome of the visit was that, due to insufficient workload, accreditation could not be given for training middle grade paediatricians. Mr Jeferis has agreed to attend the meeting in order to explain the reasons for that decision.

8. Stroke - Commissioned Care Pathway for Oxfordshire

11.30 am

The purpose of this item is to report on progress by Oxfordshire Primary Care Trust (PCT) and the Oxford Radcliffe Hospitals NHS Trust (ORH) in developing and improving stroke care and prevention in Oxfordshire. A paper by Suzanne Jones, Senior Commissioning Manager, PCT; Dr James Kennedy, lead consultant for Stroke at the ORH and joint regional clinical lead for Stroke; and the PCT's Development Manager for Stroke is attached at **JHO8**.

9. Centre for Public Scrutiny - Scrutiny Development Area bid - Access to primary physical health care for people with mental health problems living in rural areas

12:15 pm

The Centre for Public Scrutiny (CfPS) announced in November 2009 a two year programme aimed at raising the profile of overview & scrutiny as a tool to promote community well-being and help councils and their partners to address health inequalities within their local communities. As part of this the CfPS sought applications from scrutiny committees seeking to become what are to be called 'Scrutiny Development Areas (SDA's)'. SDA's would share learning with other scrutiny committees via 'action learning meetings' throughout 2010 and a national conference in 2011.

The chosen scrutiny committees would undertake a project during 2010 that would be used to form part of a national resource kit aimed at developing the role of overview and scrutiny in tackling health inequalities. They would be expected to use 'innovative approaches to undertaking scrutiny reviews' and to work in partnership with one or more district council scrutiny groups as well as other partners such as community groups and NHS colleagues. There would be only four of these across the country and each would receive a small amount of funding (up to £5,000) to help with the project.

The OJHOSC put in a bid to become an SDA, based around a project to review access to primary physical health care for people with mental health problems who find it more difficult to gain access to primary health services. This is compounded for people living in rural areas where access generally is more difficult. The project would seek to identify the evidence most relevant to developing future policy and action and

attempt to describe how the evidence could be used to develop practical improvements that would reduce these health inequalities. Unfortunately the bid was rejected by the CfPS and members need to consider how to go ahead with this piece of work.

10. Joint Oxfordshire, Hampshire and Buckinghamshire review of the performance of the South Central Ambulance Trust (SCAS) in rural areas

12.45

This joint review was instigated by this Committee following meetings with managers from SCAS. Members were concerned that the performance of the Trust was much worse in rural localities than in urban areas. This situation corresponded to that in other counties in the SCAS region and it was considered that it would be beneficial to undertake a joint project. Two select committee style sessions have taken place with a number of witnesses including members of the public, the Cabinet Member for Health from West Oxfordshire District Council, ambulance crew members, commissioners, first and co-responders, SCS managers and the Trust Board Chairman.

It is anticipated that a report will be available for public distribution shortly. When available, this will be circulated to members and added to the Committee's agenda papers on the County Council's website.

11. Joint OJHOSC/Children's Services Scrutiny Committee Teenage Pregnancy Working Group

13.00

The joint OJHOSC/Children's Services Scrutiny Committee Working Group was set up some months ago to examine progress on developing an improved strategy for reducing levels of teenage conception across Oxfordshire. The Working Group reviewed a joint County Council/PCT self assessment of progress and produced a number of recommendations for inclusion in the new strategy. These recommendations were all accepted, as can be seen in the attached letter (**JHO11)**.

The strategy will be presented to the Children's Trust Board in January. The Working Group plans to review progress nine months after the implementation of the strategy.

12. Chairman's Report

13.15

- Report on an informal meeting with the Chief Executive and other senior managers of the Oxfordshire & Buckinghamshire Mental Health Foundation Trust (OBMHFT).

- Report on a recent meeting with PCT representatives on proposed changes to commissioning mental health services.

13. Information Share

13.25

No items have been received to date.

Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Section DD of the Constitution for a fuller description.

The duty to declare …
You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

Whose interests are included …
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

When and what to declare …
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

Taking part if you have an interest …
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

"Prejudicial" interests …
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

What to do if your interest is prejudicial …
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

Exceptions …
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

Seeking Advice …
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held at Cherwell District Council offices on Thursday, 19 November 2009 commencing at 10.00 am and finishing at 12.35 pm.

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Tim Hallchurch MBE Councillor Jenny Hannaby Councillor Ray Jelf Councillor Don Seale Councillor Lawrie Stratford District Councillor Dr Christopher Hood District Councillor Jane Hanna District Councillor Rose Stratford District Councillor Hilary Fenton (In place of District Councillor Richard Langridge)
Co-opted Members:	Dr Harry Dickinson, Mrs Ann Tomline and Mrs A. Wilkinson
Officers:	
Whole of meeting	Julie Dean and Roger Edwards (Corporate Core)

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

58/09 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Hilary Fenton attended in place of Councillor Richard Langridge. Apologies were received from Councillor Susanna Pressel and Councillor John Sanders.

59/09 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

60/09 MINUTES

(Agenda No. 3)

The Minutes of the last meeting held on 17 September 2009 were approved and signed.

61/09 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

There were no speakers or petitioners.

62/09 BETTER HEALTHCARE FOR BANBURY AND THE SURROUNDING AREA
(Agenda No. 5)

In July 2007, this Committee had referred to the Secretary of State for Health proposals by the Oxford Radcliffe Hospitals NHS Trust (ORH) for changes to services at the Horton General Hospital (HGH). This had followed much local opposition from members of the public, local GPs and others.

In February 2008, following an investigation by the Independent Reconfiguration Panel (IRP), the Secretary of State had supported the view of the HOSC and rejected the ORH proposals.

The IRP had advised the Secretary of State to reject the Trust's proposals because they had failed to provide an accessible or improved service for local people. The IRP had recommended that the Oxfordshire Primary Care Trust (PCT), working with the ORH Trust, should carry out further work to set out the arrangements and investment necessary to retain and develop existing services. It was recognised that there would need to be changes because of major developments in the NHS around working hours (the European Working Time Directive) and training patterns. However, any plans for change should ensure that services at the HGH continue to be appropriate, safe, sustainable and accessible.

The full IRP recommendations were before the Committee (JHO5(a)). Also before the Committee was a 'Better Healthcare Programme Board (BHPB) – Programme Report which informed the PCT Board of their recommendations and on the next steps. The BHPB, at their meeting on 17 November, had agreed to:

1. Tell the PCT Board that, in the view of the BHPB, a consultant delivered paediatric and maternity service was the preferred model of service as it would preserve the 24/7 maternity and paediatric services at the Horton;
2. Support the proposal that the PCT Board should make its final decision on the **affordability and deliverability** of the model once the ORH clinicians had produced detailed operational specifications and those had been subject to the **clinical and financial challenge** process;
3. Tell the Better Healthcare Programme team and the ORH to present a plan to the Programme Board in January that would; **provide a timetable for the production of the specifications and how they would operate across the Horton and the John Radcliffe** and **a timetable for clinical and financial review;**
4. Approve the payment to the ORH for the time required to produce the specifications;
5. Invite the ORH Trust Board at its 14 January meeting to (a) support the creation of the specifications and (b) **approve the maintenance of the**

interim plan (the plan that has been keeping the service going with a hybrid rota of consultants, middle grades and locums);

6. Invite the Oxford deanery to continue working on identifying opportunities for accrediting middle grade paediatric training at the Horton.

In summary, the BHPB wanted the PCT and the ORH to agree on the development of consultant delivered maternity and paediatric services and to produce a timetable for when the information required to make the final decision on the service would be available.

Alan Webb, Director of Commissioning, and Ally Green, Programme Director for the Better Healthcare for Banbury Project, Oxfordshire PCT presented the PCT's proposals as contained in the report JHO5(a) explaining the role of the BHPB, its vision for the HGH , steps taken to date, the findings of the report and the road ahead. They also circulated a paper entitled 'Delivering the IRP recommendations' (a copy of which is attached to the signed minutes) which set out progress to date in achieving each IRP recommendation. They added that the ORH had confirmed their support to the steps taken so far via the BHPB and that they wished to continue to work with the Deanery, whatever the outcome.

Alan Webb briefly summarised the position to date as there having been:

- Significant progress;
- There was now an agreed model which had been partly signed up to; and
- There was now the challenge of making it work and the implementation of those challenges. All had agreed to work together to meet this.

Following this, there were a number of speakers who had been invited by the Committee to express their views with regard to the PCT's proposals and to request any assurances and/or caveats that they would wish to see attached to them. Their comments are briefly summarised below:

<u>Sumit Biswas, Chair, BHPB and Non Executive Director, Oxfordshire PCT</u>

- He offered the Committee his assurance with regard to the process and gave a flavour of the very full and robust discussions at the 17 November BHPB meeting;
- The report reflected a programme that was very complex in nature. The task of the Board (and from a non executive director's viewpoint) was whether a balanced and appropriate view had been taken;
- The IRP had charged the PCT to lead the programme, hence the need to invest significant time, effort and resourcing on the part of the PCT;
- The proposals straddled a number of constituencies from within and from outside the borders of Oxfordshire;
- A significant effort had been made to be as transparent as possible, all meetings had taken place in public for a well-informed debate and were very inclusive;
- The meeting on 17 November had been pivotal. From a Chair's perspective, there was much discussion about whether there was sufficient information to give a conclusion. Following the debate it was the view of the Board that there had been appropriate amount of information given, in the way the arguments had

been presented. In addition, the ORH had given a commitment to work through the process in an appropriate manner which would lead to a greater amount of detail within the public domain. Alan Webb had also reassured the Board that a better understanding of detail would be generated as the process and its implementation was worked through;
- Conversation had also focussed on ensuring that the outcomes and timescales were clear. A sub-group of the Programme Board had been charged with making clear what the next stage would be and to publish the details;
- The Board had also had an assurance from the ORH representatives present that there would be good, balanced and considered clinical leadership as part of the process;
- The finances had been looked at in aggregate. Part of the Terms of Reference for the next stage was to look at this in detail;
- Clarification and details were sought on consultant numbers, accreditation, market testing, and how it was envisaged that the Board would work with the ORH;
- This had been an important process with the IRP proposals, of an appropriate duration and detail. This understanding had now to go through to the next stage.

The Chairman thanked Sumit Biswas for his clarification of discussions at the BHPB.

Dr Peter Fisher, a former consultant working at the HGH

- A very detailed investigation and consultation with local people had taken place over the last eighteen months, with the aim of meeting the aims of the IRP recommendations, keeping vital services running and meeting the needs of the people living in the area;
- They agreed that it was very important to work out the detail and conduct explorations, with flexibility, common sense and less dogmatism, on matters such as how to reduce the time which the consultant paediatricians spent on the Out of Hours Service in order for them to be more present at the hospital, given the safety aspects of the national guidelines on more children being cared for at home;
- As the implementation evolves, the implications would be that the ward could be closed, this would require full consultation and it would have to be brought back to this Committee.

The Chairman reassured Dr. Fisher that this would be the case.

Councillor George Parish, Cherwell District and Banbury Town Councillor

- Cllr Parish gave a brief background on the position to date. He expressed pleasure in the support pledged by ORH;
- He commented that in 2003 there had been 1,500 births at the HGH and now there were 1,700, due to population growth within the Cherwell area. He added that what was proposed was a good solution if it was to go ahead in terms of population growth;
- It would also end eight years of staff uncertainty with regard to their employment position.

Tony Baldry MP

- Thanked this Committee for referring the matter to the Secretary of State because if they had not, then the IRP recommendations would not have come about;
- He believed that the PCT had responded appropriately to the IRP proposals and that all parties had worked very hard and constructively towards a satisfactory solution. All contributors had been open and transparent at meetings of the Community Partnership Forum(CPF) and the BHPB;
- Colleagues from Northamptonshire and Warwickshire had also attended the public meetings;
- Much detailed work had yet to be carried out to get a satisfactory answer as there is no 'plan B';
- In relation to the comments made by Dr. Fisher, he responded that Children's Services was an evolving service nationally and all involved would have to be very careful to ensure that the correct process was put in place at the appropriate time. In the meantime the HGH would continue to be a general hospital delivering a range of services as a general hospital should;
- David Cameron MP had visited the HGH twice recently as a large part of his constituency bordered Banbury;
- He stressed the importance of everybody having a clear understanding of the timescales, programme of work and of the procurement process, given the distractions of the general election next year;
- He hoped that whatever changes were made as part of the implementation process, a full consultation process would be in-built into the timetable;
- He added that much work could be done together to show the public that there was a parallel between deliverability and affordability, as there had been apprehensions about this for decades.

Andrew Stevens, Director of Planning & Information, ORH

- He reiterated that there was no need to wait for 14 January to confirm the complete commitment of the ORH to the proposals relating to the HGH;
- The ORH had learned a significant amount from the process with regard to public engagement;
- ORH continued to see the HGH as 'the jewel in the crown' for Banbury and the surrounding districts, giving continual general hospital services. This had led, for example, to a recently expanded Chemotherapy Unit and a Bowel Screening Centre established at the hospital;
- ORH saw, as their key task, to demonstrate safety and a quality of care which is in the best interests of children and families. The workshop uniformly agreed the interim plans, plans which might not continue to be not sustainable in the medium term;
- ORH were keen to demonstrate an openness and transparency to the challenges facing them;
- He listed the challenges facing the ORH Board:

1. There was no other site, except the Royal Free Hospital, London, who were running a combined rota across more than one site. Assistance would be required with innovative ideas to overcome the problems associated with this.

2. Whilst the ORH had been partially successful in recruiting to the posts in the interim, the figures presented to the Community Partnership Forum identified that there were only enough middle grade paediatricians in England to fill 75% of the posts. The solution must, therefore, be sustainable.
3. There must be robust planning to ensure that there is interdependence between the services and thought given as to what impact there would be on other services, and on specific services in the north of the county.
4. There were issues of affordability within the tariff. In 2010/14 the PCT would face £240m in cost pressures. Any additional monies would have to be found elsewhere within other services commissioned by the PCT. In the long term, collective thought was required in order to consider parallels to the detailed work being done, in order that flexibility could be built in for the future.

At this point a question and answer session was held. A number of questions were asked of the speakers so far, some of which are included below:

Q (to Alan Webb) How would the PCT address the problem of supplying consultants to deliver paediatric services when the long term aim was to remove the care of children from acute care to community services?

R Any changes to children's services would be made in the light of national change and development and of best practice. It would be right to give care in the community a long term consideration, as conditions such as asthma and diabetes could be managed with more sustainable care in the community. However, there are other conditions which could only be managed in an acute setting. Therefore, some services do need to change to accommodate delivery within the community and others need to be maintained within the hospital. The main challenge is how the consultants delivering services within the community will fill up their day. Any changes will be consulted upon.

Q Would it need to be consultant led if you have sufficient numbers who were training accredited?
R (Ally Green) It would partly depend upon the numbers of years in training. It would be likely that a consultant would be required to work beside those in years 1 and 2 of paediatric training. For those that have training amounting to 3 or 4 years and above, it would require a consultant to be on call rather than present on the ward. We are not sure at this stage, but it may be that if we had higher numbers of those with a higher level of accreditation it would probably reduce the numbers of consultants needed.

It may be possible for the rota to be hybrid. If we have a number of middle grade doctors submitting permanent applications, then these will be able to take a role in the rota as they will be able to work on, and run a ward. At the moment there is high reliance on using locum doctors and doctors with fixed term appointments which is not sustainable or ideal.

Q Are you giving training to middle tier doctors top priority?
R (Andrew Stevens) With regard to paediatrics, there has not, in the past, been sufficient numbers of patients to justify giving training recognition. In order to fill the

middle tiers we have had to rely on locums to fill the non training posts. With regard to Obstetrics, the Dean has said that the training could be retained.

(Dr Peter Fisher) There are two stages to overcoming this problem:

1. The Dean must be convinced that there is sufficient work to enable doctors to gain adequate experience here to justify accrediting the posts. This could involve paediatricians working more in the community and significant efforts have been made in primary care to this end.
2. To endeavour to make the posts more attractive. There is a shortage of trainees to fill the posts.

Q (To Alan Webb) What is the model you envisage ? What are the questions you have to decide on? And what happens if the answer is 'no' from the ORH?
R Alan Webb directed the Committee to the information given in the presentation entitled 'Best Alternate Model'. He added that the proposal is to consult on the delivery of a paediatric and maternity service as agreed on 13 October. There will be a mixture of training and non training posts. Maternity is more likely to be a hybrid model as it is easier to recruit into middle grade posts. The PCT Board on 26 November will be asked to sign off the plan and approve the next steps of the process, which will be to approve a service specification (ie. answering questions such as 'What will the model mean for the consultants'? 'What will be contained in their job descriptions'? etc). This will be looked at by the Board in January.

There is no 'Plan B'. This model is the only solution. We have to have a long term, sustainable solution and it has to be affordable. If there are issues, then these will be discussed within public debate. We are totally committed to making it work.

Q How much of a difficulty is the European Working Time Directive proving to you? What happens if the Government changes and the Working Time Directive is reviewed?
R (Andrew Stevens) The European Time Directive does make things worse, but it is not the core of the problem. The paediatric posts are not training recognised and the labour market for people to fill the non training posts is not there.

(Tony Baldry MP) Work will have to progress on the basis that there will be more changes to the European Time Directive and that it will continue to apply to hospital doctors.

Q The current community procurement process is in the form of a block contract. If there is a significant amount of service provision in Banbury, what would be the effect on paediatric services in the rest of the county?
R (Andrew Stevens) There is currently a cap on our contract which causes problems when we are looking to arrangements. Next year's will not be in the form of a block contract and risks will be shared.

Q Given the need to make budgetary savings next year. What guarantee do you have about funding this proposal?
R (Alan Webb) We have to make a £240m reduction over the next 5 years. Whilst there is no protection as such, the services are provided within areas of

significant deprivation, which is in line with the PCT's priorities. Any investment in Banbury will be taken in the light of the priorities of the PCT.

The Chairman thanked Sumit Biswas, Dr Peter Fisher, Councillor George Parish, Tony Baldry MP and Andrew Stevens for their views and for responding to questions from members of the Committee.

Julia Cartwright, Chair, Community Partnership Forum (CPF); Dr Richard Lehman, Banbury GP; Cllr Rosie Herring, South Northamptonshire District Council; and Cllr Gillian Roache, Stratford upon Avon Borough Council, were all called to the table in order to give their addresses. Alan Webb was invited to remain at the table.

Before inviting Julia Cartwright to speak, the Chairman paid tribute to all her hard work as Chair of the CPF.

Julia Cartwright

- Paid tribute to her team who had worked very hard without a set process;
- The Forum's independence had been a great help, together with equality of access to regulations. There had been collaboration at both a partnership and an organisational level;
- The Forum had a role of mediation and of education – and for these, and the above reasons needed to continue into the future;
- The Forum felt happy that the views of the community had been heard and respected. At the beginning there had been a significant amount of mistrust. She added that 'it would be a travesty if this was to be fractured in the future'.

Dr Richard Lehman

- Dr Lehman had practised as a GP in Banbury for 30 years and therefore was conversant with much of the history of the HGH. In 1992 there had been plans to reduce the numbers of paediatricians working in the HGH. In those days there was a 24 hour response and if the paediatric service had been removed, then it was realised that the Maternity and Accident & Emergency would have to follow. Despite the reassurances from the former Health Authority and the ORH, it was believed that Banbury and its surrounding areas would be left as a 'rump hospital' looking after long term conditions and the elderly;
- This history had entrenched within the community with the view that paediatrics had to be supplied in some form or other. This view was shared by most of the GPs;
- This consensus still applied – all were pleased with the process (all credit to the Forum) and with the ORH for opening up their previously entrenched position, despite opposition from their own clinicians;
- All shared anxieties with regard to the implementation and recognised the possible obstacles. They looked forward to better integration of primary and acute care to which the GPs were committed;
- The GPs were thankful that a process which used to be confrontational and self defeating had moved on in an incredible way since the last meeting of this Committee at the Cherwell DC Offices.

Councillor Rosie Herring

- Cllr Herring is a representative on Northamptonshire County Council's Health Scrutiny Committee, to which the proposals were to be presented and a formal response given;
- She believed that the position with regard to the paediatricians was key to this situation and recruitment middle grade paediatricians would prevent the 'domino' effect as described by Dr Lehman;
- She commented that the detail was of the most importance and urged the Committee and fellow councillors not to agree matters without full knowledge.

The Chairman and Alan Webb confirmed that the proposals did not require ambulatory services, as originally envisaged.

Councillor Gillian Roache

- Cllr Roache endorsed Cllr Herring's comment about the need to see the detailed PCT plans;
- She paid tribute to the 'inspirational leadership' of the CPF, saying that it was a privilege to be a member of a group which had facilitated so much engagement amongst people who had not engaged in the past;
- She expressed the hope that the Forum would continue until the services had been put in place to everybody's satisfaction;
- Cllr Roache stressed the importance of thought being given to transport links in what was a very rural area. She added that some areas were reliant on voluntary drivers.

Members of the Committee expressed the following views with regard to the proposals:

- Thought should be given to the areas being served by the HGH across the Oxfordshire borders. Julia Cartwright responded that one of the roles of the Forum was to go out and present to the various County/District councils bordering Banbury;
- There was a need for the ORH to talk to the Dean as soon as possible;
- Thought should also be given to where the Oxford Maternity Service would take their patients to, in the event that both the ORH and the HGH was full.

Members of the Committee all agreed that this had been a very useful session and thanked all who had taken part.

With regard to the proposals developed as part of the Better Healthcare Programme for Banbury and the surrounding area, the Committee **AGREED** to inform the Primary Care Trust Board at their meeting on 26 November of the following:

1. Whilst accepting that there still was a large amount of work to be done, the Health Overview & Scrutiny Committee (HOSC) is of the opinion that the work of the Primary Care Trust (PCT) and the Oxford Radcliffe Hospitals Trust (ORH) have undertaken to date complies with the recommendations of the Independent Reconfiguration Panel (IRP).The HOSC would wish to commend

both organisations for the positive attitude they have adopted to fulfilling the requirements set down by the IRP.

2. The HOSC recognises that a consultant delivered paediatric and maternity service is the best available option to those rejected by the HOSC in 2007 and subsequently by the IRP in 2008. Consequently the HOSC calls upon the PCT and the ORH to do everything within their capacity to develop and implement the consultant delivered service. Such a service development, provided that it does not constitute a change in the service being provided, would not require formal public consultation.

3. The HOSC recognises that there is a great deal of detailed work still to be done in forming and developing the consultant delivered model. Members would wish to see a timetable for the implementation of the service made public at the earliest opportunity and certainly no later than the end of January.

4. The HOSC is concerned about the sustainability and deliverability of what is being proposed and in particular the possible difficulties of recruiting to new consultant paediatrician posts. Members would urge that the PCT should encourage the ORH to seek imaginative solutions to filling these posts and that those solutions should be shared with the Programme Board and the Community Partnership Forum.

5. The HOSC urges that discussions should continue with the Oxford Deanery aimed at achieving training accreditation for middle grade paediatric posts at the Horton General Hospital (HGH). The report from the Deanery visit to the HGH of 13 November should be made public as soon as possible.

6. The HOSC would wish to see at an early stage plans for implementing a more community based paediatric service in Banbury and the surrounding area and the detailed implications for the HGH. It is expected that such developments would require formal public consultation.

7. The HOSC considers that the Community Partnership Forum must be retained as the main arena for Section 242 (formerly Section 11) informal public consultation.

8. The HOSC wishes to emphasise the importance of continuing formal and informal public consultation. As the paediatric service develops a more community based orientation the PCT should consult widely on the possible effects on services at the HGH.

9. The HOSC considers that it would be a very positive and welcome development for the PCT and the ORH Boards to issue a joint public statement committing themselves to the continuation of twenty four hour, every day maternity and paediatric services at the HGH for the foreseeable future. The statement should contain a commitment to consult the public on any future changes to the service whether driven by local or national priorities.

63/09 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 6)

Anita Higham, Oxfordshire LINk Steering Group member and Adrian Chant, Locality Manager, informed the members of the Committee of some recent activities which the Oxfordshire LINk had been involved in. They included:

- Representatives of the LINk had been involved in a number of public meetings and projects, for example, focussing on community projects with regard to interim care; access to rural services; the Banbury and City of Oxford Drugs and Alcohol service; and a training programme seeking to enable members of the public to enter and view proposals;
- The LINk had been represented as a patient group on the CPF. All meetings had been held in public and almost all had been attended by members of the LINk;
- The LINk were working in partnership with a group of Mental Health service users on the new contract;
- The LINk were monitoring a pilot scheme to give 250 people their own social care budget in the north Oxford area;
- There had been a 16% increase in LINk participants, amounting to an additional 515 people onto the database;
- A proposal was to be presented to the next meeting of the HOSC to request space for project groups to report on their work;
- She encouraged all present to understand what the LINk was aiming to achieve, and to look at the Oxfordshire LINK's website.

In reponse to a request for information about whether any visits had been carried out by the LINk , Anita Higham explained that they had authority to enter and view relevant and appropriate premises. It was hoped that they would be able to come back to the Committee with the results of their experiences to date.

The Committee thanked Adrian Chant and Anita Higham for their oral report and for responding to questions.

64/09 CHAIRMAN'S REPORT

(Agenda No. 7)

The Chairman gave a brief report on the following meetings he had attended since the last meeting:

- A meeting of the informal South Central Health Overview & Scrutiny Group had discussed the ORH application for Academic Health Sciences Centre status. He also informed the Committee that the first meeting of the joint review of the South Central Ambulance Service was due to take place shortly;
- A 'getting to know you' meeting with the new interim Chief Executive of the ORH;
- Meetings with the Chief Executives of Community Health Oxfordshire and the Oxfordshire & Buckinghamshire Mental Health Foundation Trust; and

- A discussion with representatives of the Xiamen Government officials of Health.

65/09 INFORMATION SHARE
(Agenda No. 8)

There were no information items reported.

..... in the Chair

Date of signing .....

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Oxfordshire

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Rt Hon Andrew Smith MP
House of Commons
London
SW1A 0AA

14 APR 2009

Your ref: EOT/LO4001/01091215

7 April 2009

Dear Andrew

Drug Recovery Project

Oxfordshire DAAT has commissioned a residential detoxification facility to replace what was the 'Drug Recovery Project' as the old premises were no longer available and the projects performance needed to be improved.

The opening of the new facility was delayed due to the search for appropriate premises and relevant permissions. New premises have now been sourced with formal arrangements currently being finalized, the expected opening of the new 'Howard House Project' is anticipated for September 2009. 'During the closure period no clients have been disadvantaged and additional funding has been made available for out of county placements while the new Oxfordshire facility was under development.'

This exciting new project will see 8 dedicated beds for Oxfordshire being available for entrenched drug and alcohol users to undertake detoxification with intensive aftercare support and move on accommodation now being in place to aid sustained recovery.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Catherine Mountford

Catherine Mountford
Director of Planning and System Reform
Signed on behalf of Andrea Young, Chief Executive

Your voice on local health and social care

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Drug Recovery Project

an Oxford City based health and housing solution providing detoxification and residential treatment for vulnerably housed and rough sleeping addicts

A report prepared by Oxfordshire Local Involvement Network (LINk) Drug Recovery Project Group

January 2010

Oxfordshire LINk is hosted by help&care

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Oxfordshire LINk Drug Recovery Project (DRP) Group report for the Oxfordshire Joint Health Overview and Scrutiny Committee meeting on 21st January 2010.

Introduction

Dear Overview and Scrutiny Committee Chair and Members,
Whilst Oxfordshire LINk acknowledges the good work undertaken by commissioners, partners and providers in the county's drug and alcohol area it is not the remit of this report to highlight this, rather to bring to attention areas of public concern. This report requests that the HOSC scrutinise the process of the DRP closure and clarify why replacement provision is still not in place. It is hoped, by the committee undertaking this piece of work, that publicly funded, well functioning drug and alcohol services within the county will in future not be closed without consultation or appropriate replacement provision being in place.

This report is informed by the November 2009 'Oxfordshire LINk DRP, Project Group Statement and Recommendation for the LINk Stewardship Group' which is included below and forms an integral part of the report.

Oxfordshire LINk DRP Project Group Statement and Recommendation for the LINk Stewardship Group meeting November 2009.

Abbreviations:
DRP – Drug Recovery Project: an Oxford City based health and housing solution providing detoxification and residential treatment for vulnerably housed and rough sleeping addicts.
NTA – the National Treatment Agency: a branch of the NHS set up ten years ago to implement, administer and regulate the government's Ten Year Drug and Alcohol Treatment Strategy.
DAAT – the Drug and Alcohol Action Team: the commissioner of county wide drug and alcohol treatments. A public funded arm's length organisation hosted by a public body, NHS Oxfordshire, formerly Oxfordshire Primary Care Trust.
SMART - Substance Misuse Arrest Referral Team: a local provider of drug treatment services who won the tender to run the replacement unit to the DRP
Ley Community – a local residential drug and alcohol treatment centre.
OBMH – Oxfordshire and Buckinghamshire Mental Health Care Trust, responsible for:
SCAS – Social and Community Addiction Service: the part of OBMH which assesses and funds people for detoxification and residential drug treatment programmes and also prescribes methadone, an opiate substitute. SCAS provided previous clinical cover for the DRP.
OUT – Oxfordshire User Team: a charity run by drug service users which runs workshops and also represents the service users voice to both commissioners and providers.
OJHOSC – Oxfordshire Joint Health Overview and Scrutiny Committee: has more powers than the LINk and both are expected to work closely together and complement each others' work.
LINks – Local Involvement Networks: the public's voice on health and social care services.
LINk SG – LINk Stewardship Group: a governance group of ten elected representatives.
ECHG – English Churches Housing Group: the provider of the Drug Recovery Project previously located at 170 Walton Street, Oxford from 2002 until the closure in 2007.

Brief history/background:

The DRP was a unique service for vulnerably housed addicts including rough sleepers and people experiencing homelessness. It was set up in Oxford because the City has the highest proportion of people experiencing homelessness per head of population outside of London and it had been acknowledged that the drugs service provision did not satisfy the needs of this vulnerable minority group. It was open from 2002 – 2007. Oxford still has the highest proportion of people experiencing homelessness per head of population outside of the capital.

DRP project group:

A project group was set up after the LINk organised meeting on 29th September 2009 which was well attended by a variety of different stakeholders within the homelessness sector as well as homeless and Drugs Services clients, the Rt. Hon Andrew Smith MP, Nicola Blackwood conservative Prospective Parliamentary Candidate, the chief executives of the Ley Community and SMART, the director of the DAAT, a representative from Oxfordshire User Team, the practice manager of Luther Street Medical Centre, a specialist community addiction nurse and other concerned citizens. An informed letter written to Oxfordshire LINKs for this meeting from Dr. Angela Jones is included at the beginning of '*Appendix 1*: *LINK notes from September 2009 meeting'* for information.

The DRP project group has met once per week since the meeting and has gathered signatures from the close neighbours of the former project who attest to not experiencing any problems during the five years that the project was in existence; *(copy available on request)*. This information was gathered to support the DAAT and SMART in their process of setting up a replacement unit – the main function of the Group. Darren Worthington, Chief Executive of SMART expressed his thanks for this valuable information. To gather background information, the Project Group also engaged with OUT, SCAS senior management, the City and County councils, former DRP employees and others including DAAT.

Over the course of these meeting and after thoroughly discussing and reviewing the information obtained, the Project Group **made a request to the LINk SG for a decision on whether the discrepancies and LINk non-compliance listed below warranted referring to OJHOSC in the form of a report.** This was agreed at the SG meeting of 25th November 2009

The Project Group came to this recommendation on account of the following:

1. The answers to a series of questions from the LINk to DAAT have often been answered evasively and on one occasion late.

2. The DRP closed in October 2007; the reason for the closure provided at the time was the Oxford City council owned property was no longer available and that performance needed to be improved. Freedom of Information requests to the City and County council have revealed that the closure of the project was not property related. This information is at variance with the reason given at the time of the closure by DAAT to Nicola Blackwood (Prospective Parliamentary Candidate) and to the response given to Andrew Smith MP in his request for information made to Oxfordshire Primary Care Trust earlier this year. Nicola and Andrew have been informed of the FOI request responses, as has the PCT. An independent 60 page report into the DRP in 2005 previously provided to the LINk Stewardship Group stated in the conclusions that 'Overall, the evaluators were impressed with the Drug Recovery Project, describing it in feedback to commissioners as "…a cracking little project". In terms of both qualitative outcomes for service users, and value for money, on a 'unit cost' basis, the evaluators were unable to identify any other initiatives able to challenge the DRP. However it is measured, the 'success rate' for the DRP is to be particularly applauded given the often entrenched and multiple needs of its target client group'; *Appendix 2.*

3. Evidence has been found by the Project Group that a consultation on the closure did not take place; *Appendix 3.*

4. The replacement unit cannot open without clinical cover. Darren Worthington, the chief executive of SMART explained in emails to the project group that responsibility for clinical cover for the new unit is with the DAAT and would be provided by a SCAS addictions nurse specialist, *Appendix 4.* In communications with the previous and present SCAS service managers, *Appendix 5*, it is noted that previous negotiations between SCAS and DAAT took place seven to eight months ago and finished without agreement due to governance and financial concerns raised by SCAS and that these remained. Previous negotiations in mid 2009 with the Ley Community to provide property for the 'Howard House Project' replacement unit also broke

down due to governance concerns they raised. This information conflicts with repeated statements that providing a replacement unit has remained a priority over the past 27 months.

In the light of these discrepancies and considering the remit of the LINk and what is in the present and future best interest of the public, the Project Group agreed to ask the LINk SG to take a decision on whether these issues are best served by being referred to OJHOSC so the Project Group can focus future work on supporting the process of setting up a replacement unit.

Oxfordshire LINk report to OJHOSC continued:

This report requests the OJHOSC scrutinise the process of the DRP closure and clarify why replacement provision is still not in place. It is hoped that by the committee undertaking this piece of work that publicly funded, well functioning drug and alcohol services within the county will in future not be closed without consultation or replacement provision being in place as commissioners will have been told by the committee that this is unacceptable.
We would also request that a clear message is given to commissioners that full co-operation with Oxfordshire LINk is required, specifically that requests for information are to be answered clearly, to the point and on time. We further request the committee to instruct commissioners to ensure that sufficient funding is provided for appropriate clinical cover for the required replacement unit as it strongly appears that this has been the cause on at least one previous occasion as to why no replacement unit is still in place after a 27 month gap.

Closure due to commissioning a replacement service is now illegal within the NHS (Lord Darzi's final report); closure is to occur when the newly commissioned unit is ready to take over. Commissioners are often far removed from the 'coal face' and, as in this case, a major service review and commissioning decision has been made without consultation, resulting in a highly vulnerable and minority group losing out on a unique and highly valued service for far too long.

Concern and shock was expressed around the time of the DRP closure to the DAAT director Jo Melling by the 2 main groups of organisations working within the homelessness sector, specifically the single homelessness group by its chair Leslie Dewhurst; *Appendix 6*, and the Network Meeting group by its representative Victoria Mort via Nicola Blackwood. Responses to both parties explained the closure was due to the property being no longer available. FOI requests, *Appendix 7*, to both city and county councils clarify the closure was due to a replacement unit being commissioned after a strategic review and was not property related. A later explanation to Oxford MP Andrew Smith from Oxfordshire PCT added that the project's performance needed to be improved, *Appendix 10.*

The Committee are aware that locally Oxfordshire PCT allowed the previous Oxford community hospital (OXCOMM) get to a stage whereby closure was inevitable and it was only with the committee's robust intervention that the interim provision was questioned and the replacement unit given the emphasis it required, so that Oxford now has an improved community hospital serving its growing number of vulnerable older citizens. Similarly it would appear in this instance that commissioners allowed tenders and leases, rather than bricks and mortar, to expire so their ending could be used to warrant closure.

It is the opinion of the LINk Stewardship Group that justification for the lack of a consultation on the closure of the DRP is repugnant; *Appendix 3,* (that it only served a small number of overall clients 'in treatment'). It is important to note the differences in treatment provision available within the county and that a high proportion of those 'in treatment' are not receiving detoxification and residential treatment such as the DRP provided, but rather maintenance and harm minimisation prescribing and other community-based treatments. Consultations are imperative because realities on the ground (in this instance that it will be very difficult to find a suitable replacement building) often come to light when they are carried out, thus informing commissioning decisions.

We request the Committee clarify with the City Council whether, if requested, they would have had a problem with the property continuing to be used until a replacement unit was up and

running and likewise with the previous provider ECHG. Over the past twenty seven months, whilst potential DRP clients have not had access to an often life-saving and life changing service, significantly higher financial savings have been made by both former DRP funding organisations (Oxfordshire DAAT and Supporting People) than those allocated (and unused) to 'fill the gap' (£40,000 DAAT), *Appendix 8*. Papers at the meeting of the Supporting People Commissioning Body held 11/12/09 confirm Supporting People reduction in spending last year being £83,000 due to there being no DRP service. It has been confirmed by SCAS senior management; *Appendix 5*, that previous negotiation for clinical cover at a new unit broke down due to governance concerns and because there was not enough money on the table to pay for what was needed. LINk request the Committee obtain assurance from commissioners to ensure that sufficient funding is provided for appropriate clinical cover for the required replacement unit.

We should also report that concerns were raised at the LINk organised meeting on 29th September that commissioners seemed to be favouring one provider, SMART, and that in the case of the DRP some considered it unwise that the tender had been given to them, a provider with no experience of providing housing and residential detoxification. These were part of wider concerns expressed regarding a monopoly of non NHS drug and alcohol service provision within the county. As the saying goes, 'one size/approach does not fit all', and this certainly applies within substance misuse treatment services whereby choice of different providers using different styles of approach is imperative to suit service users different needs. It is the LINk view that near monopoly of provision is not in clients' best interests. *Appendix 9* lists part of the series of questions LINk has asked the DAAT and the responses it has received. It is because of the nature of these responses that the following recommendations are put forward.

Recommendations to OJHOSC:

1. HOSC scrutinise the DRP closure and clarify why replacement provision is still not in place.

2. HOSC instructs commissioners: to ensure sufficient funding is provided for appropriate clinical cover for the required replacement unit; that it is not acceptable that well functioning drug and alcohol services are closed without consultation and replacement provision being in place: that any replacement unit continues to also serve entrenched Oxfordshire substance misusers who are vulnerably housed, homeless or rough sleeping; that full co-operation with Oxfordshire LINk is required, specifically that requests for information are to be answered clearly, to the point and on time.

3. HOSC clarifies with the City Council whether, if requested, they would have had any concerns with the property continuing to be used until another building had been found to locate the replacement unit and what the City Council have done with the property at 170 Walton Street, Jericho, Oxford since the closure.

4. HOSC notes the widespread concerns of which the LINk has been made aware around near monopoly of non-NHS service provision and informs commissioners of the probable detrimental impact this approach will have, as evidenced by the DRP case. It is generally accepted that monopoly often stifles competition which in turn stifles innovation. One size does not fit all.

Conclusion:

Whilst LINk has no doubt that commissioners, their host, funding and other partners wish to provide an improved version of the former DRP (an already highly acclaimed unit) and that this desire is to be applauded, we note with accompanying sadness of how vulnerable people suffer due to an apparent lack of foresight. Consultations are important, hence their status in law (regardless of how many people they serve). Lord Darzi's decision for the NHS in regard to commissioning new services closed loopholes that often left people without appropriate services for years. Where instructed by Oxfordshire citizens, as in this case, we will continue to advocate that Lord Darzi's decision be replicated across the county within well functioning health and social care services, thus helping to ensure continuity of appropriate provision.

Report ends

This content of this report was checked by the LINk DRP Project Group including the project leader and LINk steering group member Barrie Finch and the LINk locality manager Adrian Chant on 6th January 2010.

Appendices:

1: Letter to LINk and abbreviated notes from LINk meeting 29/09/09.

2: Extract from the 2005 independent report into the DRP commissioned by the DAAT.

3: Shortened response to letter from MP Andrew Smith 09/07.

4: SMART email response to LINk DRP project group.

5: SCAS service managers' emails to LINk DRP project group.

6: Letter to LINK/JHOSC from Leslie Dewhurst.

7: County and City council FOI responses.

8: DAAT email confirming 'unspent, fill the gap' funding allocation.

9: LINk questions to DAAT and responses.

10: Oxfordshire PCT response 07/04/09 to the Rt Hon Andrew Smith MP.

***Appendix 1**: Informed letter to LINk followed by edited notes from LINk meeting 29/09/09.*

Dear Oxfordshire LINKs,

My name is Dr Angela Jones and I am an NHS GP. I am writing to present my concerns regarding the closure of the Drug Recovery Project (DRP) to the meeting which I gather will be held on 29th September 2009. I am sorry that I cannot attend this meeting, but I will be away on a course which has been booked for several months. My own history and justification for having an opinion on this matter is as follows. I was a principal in general practice for 10 years in South Wales before returning to Oxford and joining Luther Street Medical Centre, the homelessness practice, where I was employed from 1999-2007 as, at various times, a salaried GP, joint Medical Director, clinical lead and shared care GP providing drug and alcohol services for people experiencing homelessness in Oxford. During that time, I set up a Postgraduate Course on the Provision of Health Care to People Experiencing Homelessness with the University of Oxford and ran 3 annual international conferences on Health and Homelessness which attracted over 100 delegates from all over the world.

For the last two years of my employment (and for a further year after leaving the employ of Oxfordshire PCT), I was seconded to the Office of the Deputy Prime Minister, later Communities and Local Government as their specialist adviser on Health and Homelessness and worked alongside Department of Health colleagues on a number of initiatives, culminating in the publication of the most recent rough sleeper strategy, "No One Left Out". I now work in Oxfordshire as a GP in the Didcot Resource Centre, a drug treatment centre for more hard to reach clients in South Oxfordshire, in the out of hours primary care service in Oxford City and as a GP for homeless people in Westminster. I am Chair of the Health Inequalities Standing Committee of the Royal College of General Practitioners and recently co-founded a small social enterprise, Inclusive Health, which aims to improve health care for socially excluded groups. I was part of the Management Team at Luther Street Medical Centre when the Drug Recovery

Project was set up and responsible for the clinical management of the clients and the supervision of the clinical staff working there. The model was that of a pre-rehab, in other words, it was a facility where rough sleepers, in particular, had the opportunity to exit the streets, to stabilise their drug use, to select a rehab facility and to gradually reduce their substitute medication in readiness for admission to their chosen rehabilitation facility.
During their three to four month stay at the DRP, they engaged in health promotion activity as well as participating in the life of the house, sharing in tasks etc and attending one to one and group sessions, all excellent preparation for rehabilitation, and designed to maximise the chances of successfully completing rehab. During this time, they were cared for by their usual GP who could monitor their mental and physical health and offer a unique level of continuity during this difficult phase.

The DRP was designed to enable rough sleepers with addiction problems and who wished to aim for abstinence to make a step change in their lives, one that was linked to addressing their substance misuse. It was felt to be necessary because the relentless pressures of the life of a rough sleeping drug user allow very little, if any, space for undertaking the necessary actions needed for change. Safe accommodation and structure are vital to foster change and although the direct access hostels within the city worked for some people, for many rough sleepers, there was not sufficient structure or support to provide for their needs. Many of the clients of the DRP had revolved in and out of the shelter / hostel accommodation, without making any ongoing progress and clearly needed different input: The DRP was one method of providing this more intensive structure and support and definitely filled a gap. (I would also have liked to see a similar model made available for those who for whatever reason did not feel able to aim for abstinence and wished to intensively address their issues in the context of maintenance.) I was no longer working at Luther Street when the DRP closed. My understanding is that some additional funding for residential detoxification was provided but it is clear from the above that a brief (5 to 7 days) admission in no way replaces the stabilisation and therapeutic value of the DRP. Thus, this very vulnerable group of clients have lost a vital element in their options for care and Oxfordshire lost a facility which had been recognised as best practice nationally.

The new Rough Sleeper Strategy stresses the link between complex trauma and rough sleeping. It is increasingly recognised that severe and enduring mental health and psychological problems related to childhood trauma frequently underpin many experiences of homelessness and this is the subject of ongoing work within CLG and several areas of the Department of Health. I strongly urge commissioners to ensure that a service, such as the DRP, providing a 'safe haven' for people who have become so marginalised as to find themselves sleeping on the streets, is once again developed and fostered, so that we can be seen to provide a humane and effective response to their situation and to enable them to leave the streets and find and maintain a home of their own.

I am grateful for this opportunity to share my thoughts on this issue.
Yours sincerely

Angela Jones

Dr A M Jones
MA BM BCh DCH DRCOG DFFP MRCGP

Meeting notes from 29/09/09: ***of particular note for report numbers 3, 4, 6 and on page 9 the 2nd paragraph highlighted in italics.***

1. Welcome & introductions
Anita Higham (AH) in the Chair, welcomed all to the meeting and introduced Jo Melling (JM), Director of Oxfordshire Drug & Alcohol Action Team (DAAT), Richard Lohman (RL) from the LINk Stewardship Group and Adrian Chant (AC), Locality Manager,

Oxfordshire LINk. AH provided a brief outline of the meeting's content, and informed people that LINk hopes to set up a small Project Group of 3 or 4 people following this meeting, to follow up any issues raised. A further meeting will then be organised for this group to report back to on progress.

2. What is the Oxfordshire LINk?
Adrian Chant gave a brief introduction to Oxfordshire LINk and explained what its statutory powers are, including the ability to request information about a service and receive a response within 20 days and visiting rights to view services as they are being provided. This is not an inspection, but a way of obtaining further information about a specific service. He encouraged people to register to receive future information and become involved.

3. Drug Recovery Project: update on the new service
AH asked Jo Melling to provide an update on the progress of a replacement service for the Drug Recovery Project (DRP): The DRP was set up as a housing-based project for Oxfordshire rough sleepers and homeless people requiring an in patient detox program. This project came to an end two years ago and the DAAT tendered for a new provider for an Oxfordshire based detox facility. SMART (a registered charity working with clients who have substance misuse issues) won the tender. They have had difficulty in finding suitable premises however report ongoing negotiations with housing providers. JM explained more about her role and the DAATs work in general:
JM is the Director of the DAAT for the whole of Oxfordshire. The DAAT is hosted by the PCT. The DAAT designs and tenders for services, it also performance manages, commissions and purchases services on behalf of its partners.

4. Questions to Jo Melling from the audience

Q – Wouldn't it have been better to keep the DRP open until somewhere new was found?
The City Council needed to sell the premises where it was located. There were a lot of things that we did not have a choice about when it came to closing the DRP. We did not think there would be a two year gap before the service was up and running again.

Q – There is a massive need for the service that the DRP used to provide. What is being done to re-provide this service?
The difficulty with the DRP is that is was a very unique service. We are continually trying to find new premises. We are going out to tender for a residential re-hab and looking at other options elsewhere. There is a lot of bureaucracy to wade through and a legal framework to adhere to. We hope to get a new DRP set up by the end of the year. There is a problem with people not wanting this facility on their doorstep and with this type of premises not obtaining planning permission. If a Project Group was set up, it could help lobby for the DRP.

General comments made
People need proper direction and help. Surely the Council could help find a place?
The people that are not visible need to be reached. People could come into the DRP for a short time and then go back to normal life. The DRP functioned very well.

Q – How can we move this issue forward for this group of vulnerable people?
We need a group of committed people to support the DAAT.

Q – Does the DRP have to be located in the City Centre?
No, it can be anywhere.

Q – Is this service just for people in Oxfordshire?
Yes. Homeless people come to Oxford for the service it offers, but can't use this service because they have to have a 'local connection'. There is a problem with services being inundated and they do not want to deny Oxfordshire residents the chance to use the service. The 'local connection' criteria is that you have to have an Oxford based GP.

JM observed that all the comments people made were very useful. She also said the following: The DAAT is committed to having a local DRP. Approx 140 people went through the DRP when it was running. They are not in a crisis situation, but they are taking this very seriously. The DAAT are sending people outside of Oxford to get the treatment they need. There are only a handful of other such facilities across the Country. We need to look to the future, not dwell on the past.

Further audience comments:
The tender for the new project was won within 6 months of the old one being closed. How could they have won the tender when they had no new building in place? The DRP was developed in Oxfordshire because there is a need for it. The DRP gave people the time they needed in a safe environment. It's difficult for some people to travel outside of the County. The DRP is really missed.

5. What are the countywide drug and alcohol support services?
JM gave an update on the services DAAT offers across the County. They have recently re-commissioned all their services and have separated out the Drug and Alcohol services. The provider of these is SMART. They are developing Family Support Services – setting up and developing family champions, 1:1 support and support groups. They are doing research into any unmet need there still is. They have a new Centre opening at the Banbury Health Centre. They are extending their premises in Witney. They have a new Mobile Treatment Centre that will be going out to rural villages. It will be a drop-in service, with treatment being facilitated from this

6. Questions

Q – All these services have been taken over by SMART. A lot of users aren't comfortable with them and don't want to access services provided by them. They won't be able to go anywhere else because they run everything. Where can they go? Can SMART answer some of our questions?

The representative from SMART had left, but it was suggested that some of these questions could be brought to the meeting in January.

7. How the LINk can help
People were asked if they would like to be part of the Project Group, looking at next steps and practical outcomes. This will be an informal group. Five people expressed interest.

8. Closing remarks and next steps
AH thanked everyone for coming, and extended her thanks to JM in particular.

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Anita Higham – Member of Oxfordshire LINk Steering Group, chair of meeting
Richard Lohman - Member of Oxfordshire LINk Steering Group, work programme group leader
Jo Melling – Director, Oxfordshire DAAT
Adrian Chant – Locality Manager, Oxfordshire LINk

The Project Group has met every Wednesday evening since 29/9/09. It consists of 2 service users, 2 LINk steering group members and a homelessness housing provider member of staff. Discussions with the chief executive of SMART during a break in the meeting of 29/9/09 revealed that the main impediments to the new unit had been public opinion and planning committees. In order to address these issues and support DAAT and SMART the project group agreed to try and gather signatures from neighbours of the former DRP attesting that they had experienced no problems whilst the unit was in place. If necessary this petition will be presented

at future planning committee meetings by the project group leader who would also give a brief 5 minute presentation. The project group has also agreed to formally approach the LINK for support in setting up a public meeting for the neighbours of the future unit should the neighbours express anxieties. This meeting would provide a forum for any questions to be answered, showcase the petition from previous neighbours of the DRP and allow the sharing of personal stories by ex-addicts who are now productive members of society.

A snapshot survey in mid October has revealed 22 people experiencing homelessness in the city fulfilling the criteria for the DRP and showing motivation for treatment provided by such a specialist unit. This figure consists of thirteen residents in Lucy Faithful House hostel, seven in O'Hanlon House (Oxford Night Shelter) and a few rough sleepers (Street Services Team). A countywide survey was not undertaken.

28/10/09 – All the close neighbours of the former DRP signed a statement saying that they experienced no problems whilst the unit was in place.

Appendix 2*: Extracts from the 60 page Independent 2005 report into the DRP.*

An evaluation of the
Drug Recovery Project

July 2005
Consultants
Andy and Lynn Horwood

Conclusions
'Overall, the evaluators were impressed with the Drug Recovery Project, describing it in feedback to commissioners as 'a cracking little project'. In terms of both qualitative outcomes for service users, and value for money, on a 'unit cost' basis, the evaluators were unable to identify any other initiatives able to challenge the DRP. However it is measured, the 'success rate' for the DRP is to be particularly applauded given the often entrenched and multiple needs of its target client group'.

Appendix 3*: Shortened copy of reply letter dated 09/07 to Andrew Smith MP (of particular note for this report – 3rd sentence and last paragraph)*

Dear Andrew,

Thanks for sending the reply from Ox PCT regarding the imminent closure of the Drugs Recovery Project. The DRP is specifically designed for rough sleepers as a needed stepping stone treatment prior to accessing residential rehabilitation; it is the only service of its kind. The reply from the DAAT via the PCT seems to say that as the DRP only treats 15-20 people a year and this is a minority of overall Oxon people in treatment there was no need for a consultation, this negates the status of rough sleepers as a minority group: it's like saying we wont bother consulting on black peoples views because they only make up a small percentage overall. The closure of the DRP has a significant impact on the rough sleeping population it was designed to serve and it will not be available for at least 5 months, therefore it surely required a wider consultation (wider than members of the commissioning group - I have spoken to OUT who informed me that they did not consult with users regarding this prior to the decision being taken).
The DAAT have informed me that they did not know that the lease of the property was ending! I find this hard to understand; surely as main purchaser of the service they would be aware.
The PCT/DAAT response states that during the tender process the council decided to take the property back (was there no contractual timeframe then?) I am aware that due to the lack of information regarding the closure being disclosed to DRP staff, that staff anxiety and staff

sickness levels rose. I would be grateful if you could raise the issue of why it would have been appropriate to have a consultation.

One last point, it seems that DAATs' across the country are not subject to the FOI Act despite being funded by public monies, could they be included within the current framework or would it need amending? My FOI request for details of any consultation was refused by the DAAT. Thanks for the swift response

Warm regards,

Richard Lohman.

Appendix 4: *SMART email to DRP project group (of particular note for the report is the 1st sentence).*

From: DWorthington@smartcjs.org.uk
To: richardntlohman@hotmail.com; adrian.chant@helpandcare.org.uk
Hello Richard,

Re: Details of the programme:

Clinical input/management is being provided by a dedicated SCAS nurse who will oversee all prescribing needs.

The therapeutic activities, programme design and auditing processes are aligned to NICE, Models of Care and Clinical Governance expectations respectively.

The programme is structured across 7 days and provides a range of support functions including; dedicated one-to-one sessions, support groups, education workshops and complementary therapies. All of this set against the backdrop of needing to support the longer-term housing needs of the majority of our service users, and developing the skills they need to live independently. When designing the programme we remained mindful that the unit is not intended as a 'residential rehabilitation centre'.

Re: Negotiations so far: As referenced in my previous mail, negotiations so far have broken down as a result of problems with actual and potential planning applications. Public opinion was the key obstacle during our application to Cherwell District Council whilst all other Councils, bar the West, have voiced concerns over a project of this type in their locale prior to going to planning.

Where partnership proposals have been in place with housing providers, the sourcing of suitable premises has been the main obstacle.

Thank you once again for the support.

Darren Worthington

CEO
SMART CJS

Appendix 5: *SCAS service managers' email response. Of particular note for the report the response on the bottom of page 11.*

From: Richard Lohman
To: steve.thwaites@obmh.nhs.uk
29/10/09
Dear Steve, please see attached as per our discussion this morning. I will contact Pauline Scully to see if things have moved on and note that when you were involved around 6 months ago that

nothing had been confirmed in regard to a dedicated scas nurse due to the concerns you had.

The LINks website is www.makesachange.org.uk and you will be able to access the local Oxfordshire LINks office tel nr and other details there

warm regards,

Richard Lohman.
Oxfordshire LINks steering group member.
LINks: your voice on local health and social care.

From: RICHARD LOHMAN
Sent: 29 October 2009 10:13
To: Scully Pauline (RNU) OBMH

Dear Pauline,

my name is Richard Lohman and I sit on the Oxfordshire LINks steering group. LINks replaced patient and public involvement forums however also covers social care. Oxfordshire LINks has been up and running with an elected steering group in place since March of this year, more details can be found at the website www.makesachange.org.uk including contact details of the Oxfordshire office in Witney.

The Steering Group is focussing on several areas raised by the public and one of these is the replacement of the former DRP which as you are probably aware was shut down 2 years ago. The unit provided residential detox and therapy for especially vulnerable substance misusers, particularly rough sleepers and people experiencing homelessness.

I was given your name by Steven Thwaites after we had a chat this morning and I am seeking clarification on whether it has now been confirmed by scas that a dedicated scas nurse would be overseeing all prescribing needs (see email below from Darren Worthington) in the new unit or whether this is still being looked at due to the concerns that Steven had raised circa 6 months ago.

I understand that you must be extremely busy and yet I would be grateful if you could respond as soon as you are able

With kind regards

Richard Lohman.
Oxfordshire LINk steering group member.
LINks: your voice on local health and social care.

From: Pauline.Scully@obmh.nhs.uk
To: richardntlohman@hotmail.com
29/10/09

Dear Richard,

Steve has informed me of your conversation this morning. *I can confirm that there has been no agreement at this point that SCAS will provide a dedicated nurse for this service. The concerns raised by Steve earlier stand, we have had no recent discussions with the DAAT about this.* We do remain open to discussing this with the DAAT in the future.

Best wishes
Pauline
Pauline Scully, Service Manager

Appendix 6: *Letter to LINK/OJHOSC from Leslie Dewhurst.*

January 2010

Drugs Recovery Project

I am writing in support of the LINKS Project Group's request to the County Council Health and Overview Scrutiny Committee to look into the closure of the DRP in Walton Street.

As chair of Single Homeless Group, I wrote to Supporting People and the DAAT back in early 2008, to express concern about the lengthy interim period between the closure of the DRP in Walton Street and the new contract being awarded in April 2008. It was with dismay that we then heard that the new service was not likely to be up and running until autumn 2008. It seemed unfortunate planning to close one service before the replacement service was ready to commence.

Of course, the expected opening of SMART's new service in autumn 2008 was then delayed and has still not opened. Though I appreciate the problems of securing appropriate premises and the relevant planning consents, this does seem to be an unacceptable length of time to go without a service which has been deemed both necessary and strategically relevant.

I do hope that you can do whatever is necessary to help bring this sorry situation to a speedy and satisfactory conclusion.

Yours faithfully,

Lesley Dewhurst
Chief Executive, Oxford Homeless Pathways
Chair, Single Homeless Group

Appendix 7 and 7a: *County and City council FOI responses (of note for this report the last 2 sentences in italics of appendix 7 and the 2nd paragraph in appendix 7a).*

Date: Mon, 16 Nov 2009
From: Grace.Mayo@Oxfordshire.gov.uk
To: richardntlohman@hotmail.com

Dear Mr Lohman

Thank you for your recent enquiry regarding the closure of the Drugs Recovery Project at 170 Walton Street, Jericho, Oxford.
I can confirm that yes, the Drug Recovery Project was provided at this address by English Churches Housing Group. From 1 April 2003 until the end of September 2007 the housing related support service provided to residents was funded by Oxfordshire County Council under the Supporting People programme.

This service was subject to a strategic review and was re-commissioned following a competitive process, to be provided by a difference provider and at different premises. Therefore the closure of the service at this address was not property related.

With Best Wishes
Grace Mayo
Quality & Performance Officer
Social & Community Services
Oxfordshire Supporting People Team

Appendix 7a
Subject: 1734 FOI - Drug Recovery Project
Date: Tue, 8 Dec 2009
From: James.Willoughby@Oxfordshire.gov.uk
To: richardntlohman@hotmail.com

Dear Mr Lohman

Thank you for your request of 30 November 2009 in which you asked for the following information: I would like to make a freedom of information request regarding the closure of the Drug Recovery Project at Walton Street, Oxford in 2007. The request is for the details of any consultation on the closure which took place, either with Oxford organisations working with the homeless and/or with service users.

Further to our telephone conversation of 4 December regarding your request, I have contacted the Supporting People Team as you suggested. However, after consulting this and several other teams within the County Council, I must inform you that no information regarding a consultation is held by the council.

However, this does not mean that a consultation did or did not take place, only that the council holds no information about it.
Please let me know if you have further enquiries. I would be grateful if you could use the reference number given at the top of this email.
Yours sincerely,
James Willoughby
Complaints and FOI Manager
Oxfordshire County Council

Appendix 8: *extract from 16/11/09 DAAT email confirming 'unspent, fill the gap' funding allocation.*

"… We increased the budget available to the residential rehabilitation placement team by £40K as an initial buffer after the project closed, this was not spent …"

Appendix 9: *LINk questions to DAAT and responses. The pertinent aspects are in italics.*

The following email was sent from Adrian Chant to Jo Melling on 4th September – both of the following questions were not answered as requested for or at the meeting 29/09/09.

1. How many rough sleepers accessed the DRP in the final two years of its operation?
2. Of the additional monies set aside after the closure to fill the gap in services how much has been spent on people who were rough sleeping?

The questions were not answered at the meeting or subsequently as needed within the 20 working day timeframe. A reminder email of the same was sent 12/10 repeating both questions. A reply was received on the same day which again did not answer the question or provide a reasonably helpful response, i.e. provide the numbers of No Fixed Abode clients for which figures are held.

04/09/09

Dear Jo,

We have received a request from the Steering Group if the following 2 questions could be prepared for discussion at the 29 September meeting (or supplied in advance as appropriate):

1. How many rough sleepers accessed the DRP in the final two years of its operation?
2. Of the additional monies set aside after the closure to fill the gap in services how much has been spent on people who were rough sleeping?

If it would help to discuss further I will be available in the office next week or on the mobile number below. Many thanks.

Kind regards,

Adrian

12/10

Dear Adrian

Regarding your questions below, The DAAT commission Drug and alcohol treatment we are not commissioners of housing, therefore the data we collect relates directly to an individual's treatment and treatment outcomes. *The national data requirements on the national database for treatment services (NDTMS) collects the following fields related to housing*

NFA (No Fixed Abode), Housing Problem, No Housing Problem

Therefore we did not collect data on rough sleepers. The project was not commissioned by us as a rough sleeper project as it would be inappropriate for us to commission a project on this basis as we are commissioners for treatment. So in brief I cannot give you the statistics you are asking for. Negotiations for new premises are well underway and we hope to make an announcement within the mouth.

Regards

Jo

The following letter was sent 22/10/09, a reminder email sent of the same was sent 5/11, a further request for response 12/11, a response was received 16/11.

Dear Jo,

The project group would like to be informed as to:

How much funding was set aside to fill the gap and was it ring fenced, and if so, how much of that funding was allocated and spent on what services?
If not ring fenced, again how much was allocated and spent, and on what services?

Your email of 12th October stated "Negotiations for new premises are well underway and we hope to make an announcement within the month". Please can you advise if this is still on target for announcement by the middle of November?

The LINK would like to be in a position to report back to Oxfordshire Joint Health Overview and Scrutiny Committee as part of the LINK update for their next meeting on 19th November and I would therefore be appreciative of a reply within the normal timescale of 20 working days under the LINKs legislation.

Thank you for your help.

Yours sincerely,

Adrian Chant,

12/11/09
Dear Jo,

I would be grateful to receive a response to my previous email. The LINk will be providing an update to the next meeting of Oxfordshire Joint Health Overview and Scrutiny Committee on 19th November and wish to be able to do this on current information received many thanks.

Kind regards,

Adrian

16/11/09

Adrian

My understanding was that the project group that LINKs set up was to work with providers in moving forward, does the group have terms of reference? Therefore I am not sure how productive it is to keep going over old information that is no longer relevant. I have sent over a large amount of information over that last few months on *a project which closed over two years ago and in its entire life span saw just over 100 people*, when the overall treatment system treats over Two Thousand Three Hundred Individuals per year. I appreciate that this is an emotive subject to some people, at the meeting and during all the correspondence we have stated that we continue to look for premises to develop a local residential detoxification facility. Something that others areas do not have, so Oxfordshire is not being denied a service that is everywhere else, quite the opposite. We have clearly indicated we are always happy to work with people to move forward and would welcome a more positive approach to this piece of work.

As far as funding is concerned what we do not and cannot do is have money sat unspent. *We increased the budget available to the residential rehabilitation placement team by £40K as an initial buffer after the project closed; this was not spent* and was used to offset the county councils decrease in the residential rehabilitation funding. Budgets in this form as not ‘ring fenced’ but allocated as described above. The money available for residential rehabilitation is part DAAT funding and part county council funding; the budget is management by the county council. Residential Rehabilitation placements are county council contracts.

We are progressing with the premises agenda and have meetings in place to discuss the move forward with a third party. We hope to have some information within the next 2

weeks; I cannot risk the process of negotiation by informing people of discussions when no agreement has yet been made. I am as keen as everyone to be able to make the announcement that we have premises and that a new project will soon be opening. In short I do hope that this will be forthcoming in November.

Kind regards,

Jo

The following email was sent 7/12/09 for which a response was received on 23/12/09.

Dear Jo,

I provide below information from the LINk project group:

As you are probably aware the DRP project group formed after the LINks initiated meeting has gathered signatures from the close neighbours of the former project attesting that they experienced no problems over the duration of the project and that this information has been passed onto Darren Worthington, where it is hoped it will be of use in the process of setting up the replacement unit. *If you have ideas on anything further the project group could do to support the process during this phase please do let us know.*

At the last meeting of the Oxfordshire LINk Stewardship Group, in order for the project group to focus solely on supporting the process of setting up the replacement unit, it was unanimously agreed that the information gathered by the project group in regard to the former DRP be forwarded to Oxfordshire Joint Health Overview and Scrutiny Committee for their attention. This is the normal referral process for LINk projects, the OJHOSC having requested reports of current activities from all LINk projects for their next meeting on 21st January 2010. Part of the report from the DRP project group will cover some discrepancies in information received in the course of the group's inquiries into the former DRP and its closure.

In order to complete our report I would be grateful if you can confirm whether any public consultation on the closure of the DRP took place at the time and if so, can we be provided with details of the type and scope of this?

Please do not hesitate to contact the group via the LINKs office with any work which the project group may be able to undertake in supporting the process of setting up the replacement unit to the DRP or should you require any further information/clarification.
Many thanks for your continued help.
Yours sincerely,

Adrian Chant,

23/12/09.

Dear Adrian, Thank you for your letter, it is great news this is going to the Oxfordshire Joint Health Overview and Scrutiny Committee, can I please have a copy of your report.

To confirm, there was no public consultation regarding the end of the contract that ECHG had for the DRP.

Regards
Jo

JHO5A

NHS
Oxfordshire

Oxfordshire Primary Care Trust
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford OX4 2LH

Telephone: 01865 336700
Fax: 01865 337094
Website: www.oxfordshirepct.nhs.uk
Email: andrea.young@oxfordshirepct.nhs.uk

Rt Hon Andrew Smith MP
House of Commons
London
SW1A 0AA

14 APR 2009

Your ref: EOT/LO4001/01091215

7 April 2009

Dear Andrew

Drug Recovery Project

Oxfordshire DAAT has commissioned a residential detoxification facility to replace what was the 'Drug Recovery Project' as the old premises were no longer available and the projects performance needed to be improved.

The opening of the new facility was delayed due to the search for appropriate premises and relevant permissions. New premises have now been sourced with formal arrangements currently being finalized, the expected opening of the new 'Howard House Project' is anticipated for September 2009. 'During the closure period no clients have been disadvantaged and additional funding has been made available for out of county placements while the new Oxfordshire facility was under development.'

This exciting new project will see 8 dedicated beds for Oxfordshire being available for entrenched drug and alcohol users to undertake detoxification with intensive aftercare support and move on accommodation now being in place to aid sustained recovery.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Catherine Mountford

Catherine Mountford
Director of Planning and System Reform
Signed on behalf of Andrea Young, Chief Executive

Your voice on local health and social care

Oxfordshire Local Involvement Network
Update for OJHOSC meeting 21st January 2010

(Extracted from LINk Newsletter published Dec 2009 with recent updates added)

Oxfordshire LINk has set up project groups across the County to take forward some of the key health and social care issues which have been raised by LINk participants:

Access to services in rural areas
Accessibility of Health and Social Care services in rural areas (for example transport to hospital appointments) has long been identified as an issue and there is a project group in place, currently looking at how accessible services are in Faringdon & SW Oxfordshire. The intention is to replicate this project in different parts of the county during 2010.

Self Directed Support (Personal Budgets)
The LINk recognises that this transformation is an enormous shift in the way care is delivered. The LINk will be carrying out research into the existing delivery and support of Personal Budgets, currently being piloted in North Oxfordshire, in order to assess the impact these changes are having on service users and carers. This large scale project will run throughout 2010

Intermediate Care
The LINk is proposing to carry out some work examining how patients are currently experiencing the 'Choose and Book' system for hospital or clinic appointments, which has been in operation for some while. The LINk is also seeking views on developments at Bicester and Townlands (Henley) Community Hospitals.

Drug Recovery Project
The LINk Project Group has been working with service users and local organisations, together with the Drug and Alcohol Action Team, to clarify reasons for the service's closure and to explore ways in which it can be reprovided for Oxfordshire users. The LINk DRP report is submitted with this update for consideration by the HOSC.

Other projects:
Alongside the above main work programme themes, the LINk has been approached by various groups and organisations in the county with a view to working in partnership with LINk participants to improve or develop services within the following areas:

Crisis House Project – to develop short term residential support for people experiencing mental health crises as an alternative to hospital admission or home-based treatment. The LINk will be working in partnership to provide support for research, help liaise with statutory bodies and publicise the work of the project.

Child Brain Injury Trust – to assist in research into the quality of information and consistency of service received by children, young people and their families who are admitted to A&E and/or a ward with any event that could also be associated with an acquired brain injury.

Mental Health Service Users Network – service priorities to be agreed

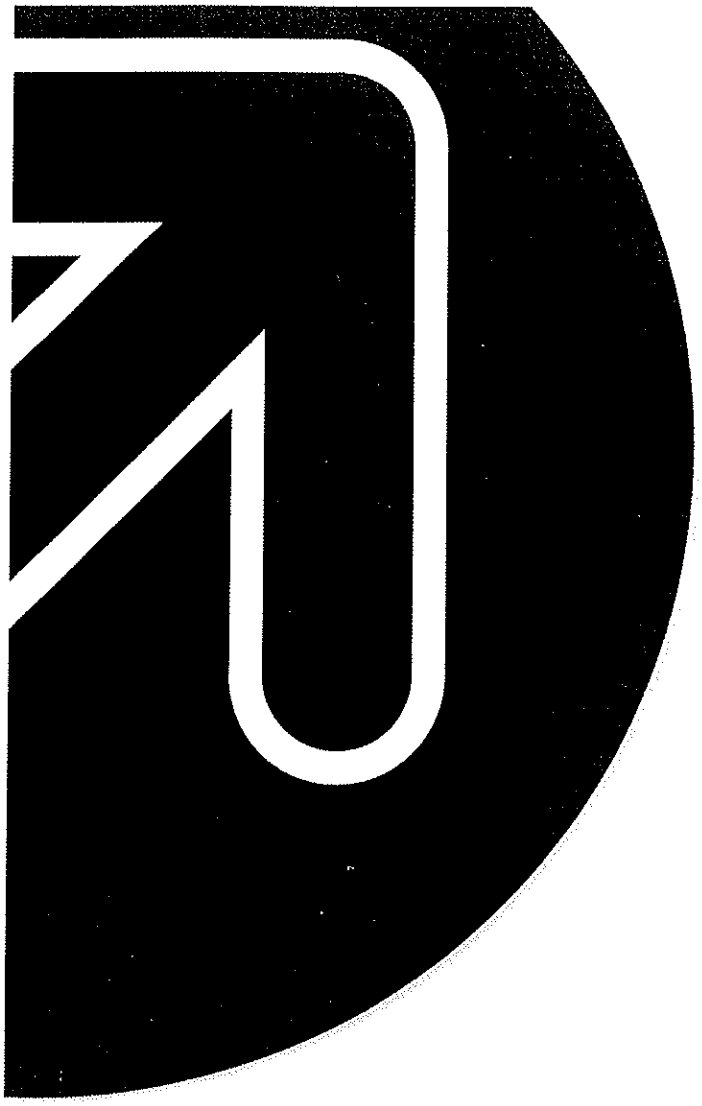
Mental Health services in West Oxon – service user and carer interviews on range and quality of mental health services in West Oxfordshire.

Neurological Alliance – promotion and assistance in establishment of this new group

Oxfordshire Unlimited – development of a physical disabilities 'User Led Organisation'

Social & Community Services – self-assessment process in collaborating with Care Quality Commission (LINk facilitation/hosting of a service user and carer event on 12th March 2010)

Adrian Chant (LINks Locality Manager)
01993 862855
Update 11/01/10



Oxford Deanery
Quality Management of Training

School of Paediatrics Visit

Authors: College Regional Advisor; Royal College Representative; and Acting Postgraduate Dean

Trust: Oxford Radcliffe Hospital – Horton General Hospital

Date of Visit: Friday 13 November 2009

Section 1

Type of Visit : **To assess training opportunities**
School: **Paediatrics**
Trust: ORH – **Horton General Hospital**
Date of Visit: **Friday 13 November 2009**

Preface
There are currently only GPVTS and FY2 posts in Paediatrics at the Horton General Hospital. There has never been training recognition for Registrar level doctors in Paediatrics. Prior to MMC there was a SHO post and a community SHO post. The remit of the visit on the 13 November was: 1. To determine current training opportunities for SpR/StRs in Paediatrics according to the curriculum laid down by the RCPCH and PMETB at the Paediatric Department at the Horton Hospital, Banbury 2. To advise on possible future training opportunities for Paediatric SpRs and StRs that might occur as a result of any possible future service reconfiguration.

Brief description of Trust Eg population served, size, locality, sub-specialties/teaching hospital
The Oxford Radcliffe Hospitals NHS Trust is one of the largest acute teaching trusts in the UK. The Trust provides high quality general hospital services for the local population in Oxfordshire and neighbouring counties, and more specialist services for patients from a wide geographic area. The Trust is split across three large sites: John Radcliffe Hospital; Churchill Hospital; and the Horton General Hospital. The Horton General Hospital in Banbury serves the population in the north of Oxfordshire and surrounding areas. It has over 220 inpatient beds and over 20 day-case beds, and is an acute general hospital providing a wide range of services. The visitors were made aware that there were considerable ongoing concerns about the configuration of the Horton Hospital services in general. The visiting team have not commented on these issues as their remit was to determine current training opportunities for SpRs and StRs. As the nature of the future configuration of services is still being explored, the visitors have not felt able to advise on future training opportunities.

Trust Representatives
Title
Deputy HR Director
Acting Clinical Tutor
Manager for Children's Services - ORH

Visiting Team
Title
College Regional Advisor
Royal College Representative
Head of School of Paediatrics, Wessex Deanery

Acting Postgraduate Dean
Lay Assessor
Trainee Representative
Deanery Quality Manager

Trust/School Staff to whom the final visit report is to be sent
Title
Acting Postgraduate Dean
Trust Medical Director
Trust Director of Medical Education
Paediatric College Tutor
ORH Paediatric Lead
Deanery Quality Lead
Head of School of Paediatrics
Deanery Business Manager
Associate Director of Workforce and Education
Director of Clinical Standards, South Central SHA

Information and reports received at the visit
Information details
Better Health Care Presentation and papers
File: information on the teaching programme and powerpoint slides relating to the various talks.

Section Two

Trainees interviewed		
Grade	Total	Specialties
F2	2	Paediatrics
GPVTS	1	Paediatrics

Middle grades interviewed		
Grade	Total	Specialties
Trust Doctor Rotating with JRH	1	Paediatrics
Speciality Doctor	1	Paediatrics
Long term locum	1	Paediatrics

Findings against PMETB/GMC Standards for Training
DOMAIN 1 - PATIENT SAFETY The duties, working hours and supervision of trainees must be consistent with the delivery of high quality, safe patient care. There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors.
GPVTS & FY2 Trainees 1. Trainees receive supervision from non-training middle grades and Consultants. 2. The non-training middle grades posts are often covered by locum. 3. There are strenuous efforts made by the Consultants to ensure patient safety and we are impressed by their ready availability to cover at any time. They are routinely in the hospital beyond 9pm. 4. The trainees felt well supported. 5. Handover arrangements appear strong. 6. Induction was felt to be good by the trainees. 7. The trainees are not being asked to undertake procedures unsupervised for which they are not trained. 8. Trainees are not regularly involved in clinical governance. For example, the critical incidents are reviewed at the management meetings which trainees do not attend.
Middle grades [non-training] 1. The 3, recently appointed, middle grades that we interviewed were very senior and exceptionally experienced, having 44 years Paediatric experience between them. 2. Their induction was ad hoc. 3. They have had no formal feedback or assessment of their performance.
DME, department clinical lead and educational supervisors 1. The visitors were told this is a quiet unit and serious illness is uncommon. This has caused staff, on occasions, to feel apprehensive and vulnerable in emergency situations. 2. In the original report, concerns were expressed about the current service being provided by very junior doctors and locums, and mechanisms for ensuring compliance of EWTD.

Findings against PMETB/GMC Standards for Training
DOMAIN 2- QUALITY ASSURANCE, REVIEW AND EVALUATION Postgraduate training must be quality managed locally by deaneries, working with others as appropriate but within an overall delivery system for postgraduate medical education for which Deans are responsible
PMETB survey results were reviewed and responses from trainees were reassuring in relation to areas which had been highlighted as concern, except for mid-point supervision [see domain 8].

Findings against PMETB/GMC Standards for Training
DOMAIN 3 - EQUALITY, DIVERSITY AND OPPORTUNITY Postgraduate training must be fair and based on principles of equality
Trainees [GPVTS & FY2] and middle grades [non-training] 1. There were no concerns raised. 2. There were no reports of bullying or pressure to maintain service delivery from either the trainees or the middle grades. 3. The trainees and middle grades were very positive about the working environment.
Findings against PMETB/GMC Standards for Training
DOMAIN 4 - RECRUITMENT, SELECTION AND APPOINTMENT OF TRAINEES Processes for the recruitment, selection and appointment of trainees must be open, fair and effective
n/a
Findings against PMETB/GMC Standards for Training
DOMAIN 5 - DELIVERY OF CURRICULUM INCLUDING ASSESSMENT The requirements set out in the curriculum must be delivered and assessed The approved curriculum must be fit for purpose
Levels of Activity There are 14 beds on the childrens ward. The average number of paediatric medical inpatients at midnight is 4.6. The visitors were told: 1. that these admissions include children with respite care needs. 2. in view of the ready availability of beds there is a low threshold for admission. 3. approximately 2 patients a month required emergency surgery. 4. potentially sick patients, who may deteriorate, are transferred to the John Radcliffe Hospital. There is a level 1 SCBU with 10 cots. 1. Singletons <32 weeks and twins <34 weeks are transferred in utero rather than delivered on site. 2. Babies are transferred if they require ongoing respiratory support, TPN etc. Out Patient attendances are about 2000 a year.
Trainees [GPVTS & FY2] 1. For foundation and GPVTS, there is sufficient clinical and practical experience in the placement to cover the relevant areas of the foundation curriculum and the GP curriculum. 2. They received regular bleep-free teaching, 4 hours a week, which has been designed specifically with their curriculum in mind.

3. They receive support in the completion and recording of assessments.
4. They reported that their ePortfolios were up to date.
5. We commend the practice that there is a special training clinic where trainees see new referrals and discuss these with the consultant.

Middle grades [non-training]

1. The visitors were concerned that there was no education programme for the middle grade staff.
2. None of them is attending outpatient clinics.
3. None of them is involved in clinical governance or audit.
4. They have received no formal or informal appraisal or feedback.
5. They are performing inappropriate tasks eg routine phlebotomy.
6. The visitors were concerned that the Middle Grades are performing 50% of the trainees' assessments without having any formal training in work place based assessments themselves.

Educational Supervisors

1. The programme has been appropriately designed for the GPVTS and FY2 trainees in the department.
2. The College Tutors report states that from January 2010 there will be 2 consultants working in the paediatric department at the Horton who are Paediatric School Board Members [College Tutor and Deputy College Tutor for Oxford].
3. 4 consultants have had recent training [within the last year] on educational supervision.
4. Although there is no local experience of delivering the curriculum and assessment of paediatric trainees, the consultants with joint appointments will have experience of training paediatric trainees at the John Radcliffe Hospital.
5. The number of practical procedures is adequate for GP and Foundation trainees.
6. The level of clinical activity within the department is adequate for trainees of this grade.

DME

No concerns were raised by the DME [Acting Clinical Tutor] apart from the effect on trainees of the inability to fill middle grade posts.

Findings against PMETB/GMC Standards for Training

DOMAIN 6 -SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY

Trainees must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload, personal support and time to learn

Support, training and effective supervision must be provided for foundation doctors

All doctors reported that this is a happy and supportive department.
There were no reported problems with bullying or undue pressure (for example to fill gaps in the rota).

Trainees [GPVTS & FY2]
1. The GPVTS and FY2 doctors reported a good induction.
2. There was no recognised neonatal resuscitation training (NLS) but in house training was provided.
3. Trainees knew their supervisors and were undertaking WPBAs and had received feedback.
4. None had had a midpost review.
5. The provision of out patient clinic experience was highly valued.
6. All reported they were involved in audit.

Middle Grades [non-training]
1. The three middle grade doctors had undergone brief ad hoc inductions.
2. None of the Middle grade staff had received feedback or undergone an appraisal.
3. They had not received any study leave or any advice on professional development.
4. Middle grade staff spent a good deal of time teaching the very inexperienced junior trainees to do practical skills such as phlebotomy and often did these tasks themselves.
5. It was noted that there is not a phlebotomy service and this task does take up a good deal of junior doctor time for outpatient and non urgent samples.

Educational supervisors
1. The trainees receive 4 hours teaching per week.
2. This is related to their curriculum needs and attendance was good.
3. The trainees underwent mini PAT assessments and WPBAs with their consultant supervisors.
4. The middle grade staff also undertook the assessments and it was noted that they had not received training in undertaking these assessments.
5. 4 consultants have undergone training in Educational Supervision in the last year.

Areas for exploration with Training Programme Directors
The TPD was not interviewed for this visit.

Findings against PMETB/GMC Standards for Training

DOMAIN 7 - MANAGEMENT OF EDUCATION AND TRAINING

Education and training must be planned and maintained through transparent processes which show who is responsible at each stage

DME, trust management and department clinical lead.

1. The managerial team assured the visitors that the Trust as a whole existed as one although it was clear to the visitors that the Horton has a distinct identity.
2. The current trainees are the responsibility of the Foundation School and GP School , rather than the School of Paediatrics.
3. The Foundation School Director and the Head of the GP School both have good relations with the Horton Educational Supervisors.
4. The Trust has agreed to ensure that all its Educational Supervisors have been trained for their role. They have also undertaken to ensure that there is time in the Educational Supervisors workplan to ensure they have time to perform their Educational roles.
5. The major planned changes in the ORH Trust structure were shown to the Deanery the day before this visit.

Educational Supervisors

1. The Foundation Programme has just had its inspection and any recommendations will be carried out jointly by the Trust and the Foundation School Director on behalf of the Deanery.

Findings against PMETB/GMC Standards for Training
DOMAIN 8 - EDUCATIONAL RESOURCES AND CAPACITY The educational facilities, infrastructure and leadership must be adequate to deliver the curriculum
Trainees [GPVTS & FY2] 1. The PMETB survey shows that most GP VTS and Foundation Year doctors are satisfied with the paediatric training received. 2. The teaching programme is consultant led and specifically designed to meet the needs of trainees with emphasis on core paediatric topics. 3. A folder outlining the programme with printouts of the various powerpoint talks was reviewed. 4. Trainees commented favourably on the quality of the teaching programme. 5. The trainees felt confident managing straightforward paediatric problems and performing simple procedures like phlebotomy. 6. A concern however is the low levels of clinical activity and therefore fewer opportunities for hands on experience for trainees above the level of those currently at the Horton Hospital. 7. Middle grade doctors are currently locum staff who do not contribute or participate in the teaching programme but do considerable on the job teaching. 8. The trainees reported being well supported by nursing staff. Both trainees and middle grades commented on the friendly working atmosphere and approachability of consultant staff. 9. Library and internet facilities appear sufficient as outlined in the college tutor's report.
Educational supervisors 1. Four consultants have had recent training on educational supervision. 2. Consultants are allocated a study leave grant and time to attend educational sessions when possible. 3. Local training is available by both the Deanery and School of Paediatrics on various aspects of educational and clinical supervision. 4. The Terence Mortimer Postgraduate Centre at the Horton organises courses on teaching skills and leadership.
Findings against PMETB/GMC Standards for Training
DOMAIN 9 – OUTCOMES The impact of the standards must be tracked against trainee outcomes and clear linkages should be reflected in developing standards
n/a

Section 3

Areas of notable practice

- Please identify any areas of good or best practice.
- Please note as * any exceptional examples which have good potential for wider use or development elsewhere in the NHS.

1. Everyone remarked how friendly the Horton hospital is to work in.
2. The training programme, the consultant supervision, the maximising of training opportunities out of the clinical activity available is satisfactory for GPVTS and FY2.
3. The support from Consultants in other departments is also highly commended.
4. The training currently offered is highly valued by the F2 and GPVTS.

Areas for development

1. Career development of the present middle grade doctors
2. Ensure there is consistent, appropriately trained, safety net cover for junior trainees.
3. Ensure clinical and educational supervision of junior trainees is carried out by those who have been trained to do so.
4. Reconstruction of the night rota as existing arrangements are of little educational benefit to trainees.

General Observations

1. There are currently only GPVTS and FY2 posts in Paediatrics at the Horton General Hospital. There has never been training recognition for Registrar level doctors in Paediatrics. Prior to MMC there was a SHO post and a community SHO post.

2. Since the Trust was last visited in 2005 and the statement from the Postgraduate Dean in 2006, there have been no changes in clinical activity or service provision that would now make the department more suitable for specialist paediatric training at any level. Indeed it was reported by the managerial team that inpatient workload was decreasing.

3. New guidelines for training produced by the Royal College of Paediatrics and Child Health recommend that the level of clinical activity which would be required to enable a trainee to be able to realistically cover the curriculum would be for that trainee to see 400 new presentations per trainee per year. If on a compliant rota of 1 in 8, this would translate to approximately 3200 acute presentations per annum in a department. As Out Patient attendances are about 2000 a year, this would not be possible at the Horton . For neonatal training, a trainee would be expected to be present at 30 deliveries and be actively involved in the care of 20 infants receiving neonatal intensive care. This would not be possible at the Horton.

4. There is a national shortage of candidates of suitable quality for existing substantive training posts particularly above ST1 where posts are very difficult to fill. The ability to fill non- training grades at middle grade level nationally is almost impossible due to an absence of suitably trained doctors at this level. Therefore any rota, which relies upon non- training grades, must be considered fragile and not sustainable. It is essential for both patient safety and training that all rotas at all levels are suitably populated with appropriately substantive appointments

5. In addition, the Department of Health has called for a 5% reduction in ST1 entrants to specialty training in 2010 and this will impact upon higher training levels in subsequent years so that there will be a reduction in the need for training posts at all levels.

6. Uncertainty about the future of the department appears to have inhibited the exploration of sustainable ways of working or models of care in units of similar clinical activity.

Section 4

Recommendations [Mandatory requirements for approval]	Reference
The visitors recommend that this unit continues to develop its programme for Foundation and GPVTS trainees.	Domain 1,5, 6,8
The visitors cannot support the introduction of specialty paediatric training at the Horton. A department in which new training placements in paediatrics were to be developed would need to demonstrate: 1. that there was a requirement within the overall training programme for new placements 2. that the placements offered a unique opportunity that could not be delivered elsewhere is the programme 3. that the placement met the RCPCH guidance for clinical activity to enable trainees to cover the curriculum 4. that there was sustainable rotas at all levels 5. that the placements met all PMETB standards for training	Domain 1,5,8

Action Required
The night work undertaken by the present training doctors needs close evaluation for its educational value. The middle grade staff need career support including induction, teaching in assessment, appraisal and support for continuing professional development.

Signed by the Lead of the visiting team:
Dr Jo Philpot, College Regional Advisor

Date: 4 December 2009

Approved by Oxford Deanery Quality Management Group

Signed by **Dr Simon Plint**
Quality Lead
Oxford Deanery

Date: 4 December 2009

Signed by **Mr. Tony Jefferis**
Acting Postgraduate Dean
Oxford Deanery

Date: 4 December 2009

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NHS Oxfordshire

Integrated Stroke Pathway Oxfordshire

May 2009

Version 3.0

Content

- Background
- Health Impact
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    4. Hyper-acute assessment and treatment
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- Monitoring
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Purpose

This paper presents the initial work of the Project Team, and its working parties whose membership compositions covered all aspects of the stoke pathway delivery, to address the need to integrate the whole stroke pathway. In addition, it incorporates the initial consultation with the public, patients and carers to help guide service improvement.

Background

The performance of the Oxford Radcliffe Hospitals Trust in the recent National Stroke Sentinel Audit reflected the lack of routinely coordinated service provision across the county, from acute care provider to social care. While there are pockets of excellence and evidence of national leadership in stroke care, there is a need to ensure that there is equality of timely access for all patients to specialist service provision. In recognition of this, Oxfordshire PCT instigated a Project Team in late 2008 to develop its response to the National Stroke Strategy and the wide-ranging guidance that has emerged from the Department of Health in the last year.

The first phase: This recommends fundamental structural change to specialist stroke services in the setting of existing service provision, both in the response to non-disabling (TIA and minor stroke services), and disabling events (acute stroke intervention (thrombolysis) and stroke rehabilitation and recovery). There is recognition of the need to move away from a hospital centric model of care to one that places the patient at the heart of the pathway. This paper has been developed with the following in mind; access to specialist stroke services at the right time maximises the chances of a good outcome for the patient.

For example, specialist stroke rehabilitation has a strong evidence base showing a clear improvement in long-term outcomes (higher rates of survival and discharge home, lower rates of dependency and institutionalisation). This point is crucial when considering the long-term cost implications of a stroke service. Poorly provided rehabilitation services maximise the chances that stroke patients will not recover thereby requiring increased levels of care, both health and social, in the long-term. Financial savings achieved through high quality stroke care are realised downstream: collaboration with social care colleagues is vital. The implications of this have been demonstrated using predictive modelling facilitated by the Decision Support Team at the PCT, the first time it has been utilised to guide the commissioning of services.

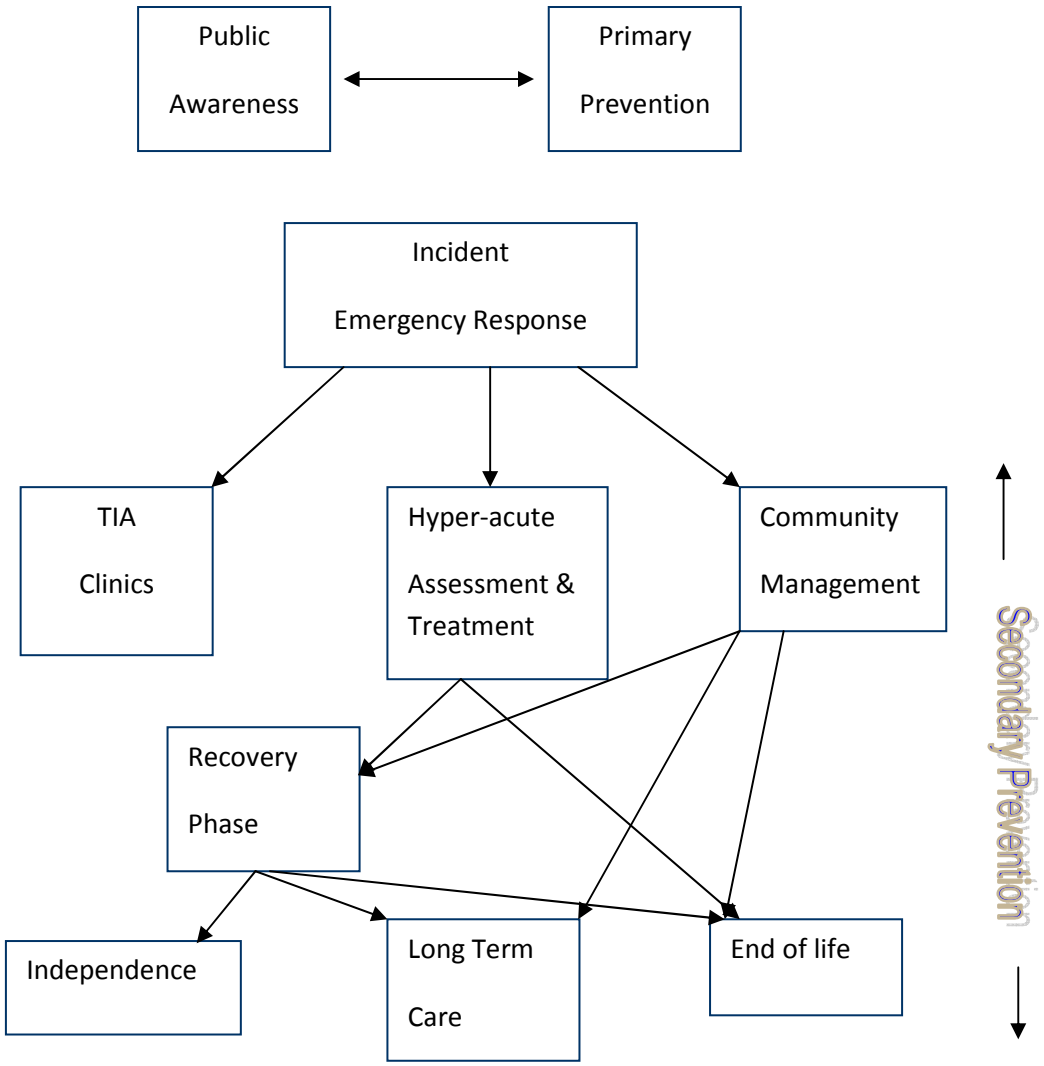
The first phase is now completed

The second phase: will involve the continued work to integrate stroke services across the county; all providers have committed to the establishment of Stroke Implementation and Development Group supported by project management from the PCT. This will be enhanced with further public-patient involvement to help to identify how the service can be improved. An education programme will be developed for the public and for all health professionals to clearly define what services are available where, and how to access them.

The Project Team recommends this report as providing the best opportunity to realise the following objectives:

1. To reduce the incidence of stroke in Oxfordshire
2. To reduce avoidable deaths following a stroke
3. To reduce the level of disability following a stroke

Stroke Integrated Pathway – Component parts



Supporting work streams

Information

Audit & Research

Workforce Development

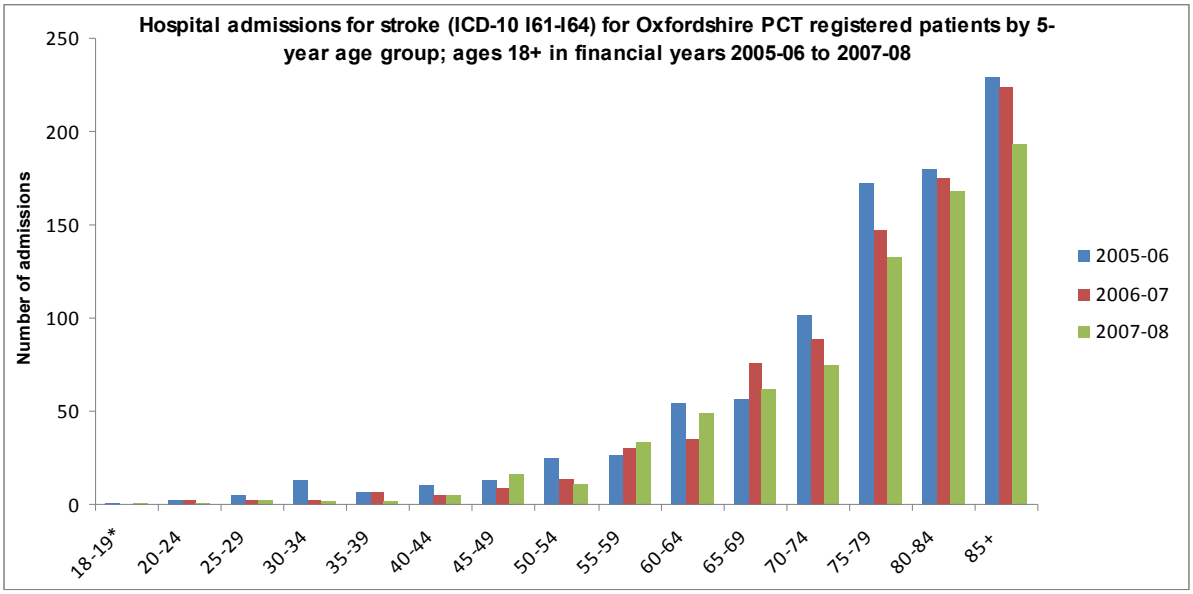
Market Development

Health Impact for Stroke in Oxfordshire

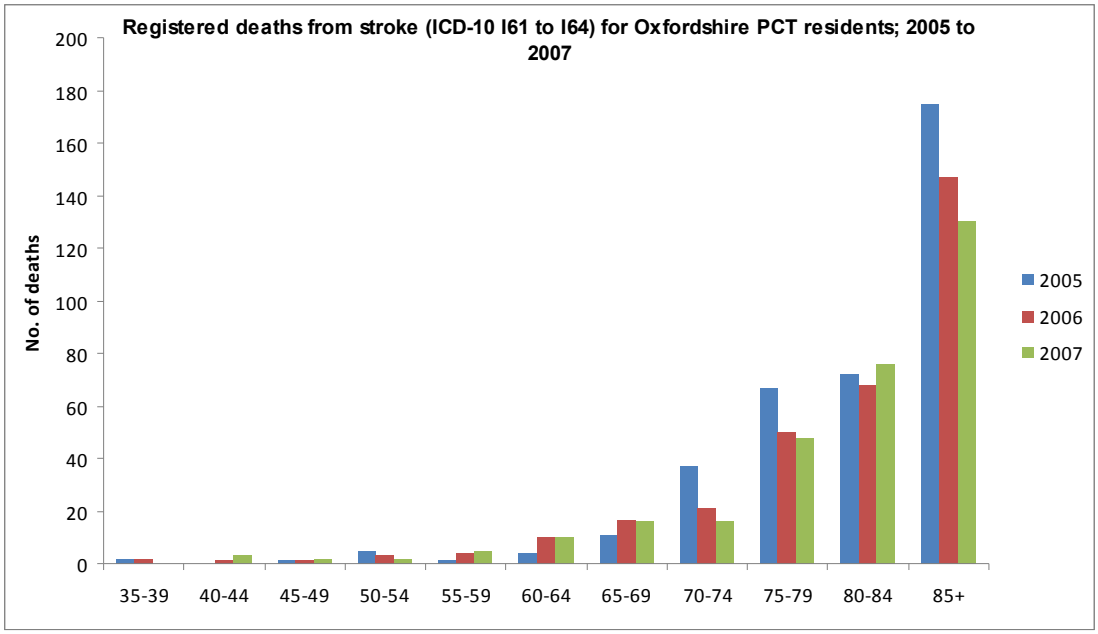
Through the 21st century the rate of registered deaths from stroke across England has been falling year on year, as it has across the developed world. This is due, in part, to improved health due to declining numbers of people smoking, better knowledge of dietary risk and improvements to treatment for conditions such as high blood pressure and cholesterol levels.

Oxfordshire has a healthier population than the English average, and this is reflected in the fact that the Oxfordshire average for both admission to acute care and death rate for stroke being lower both to the England and the South Central rates. However, the levels and rate of stroke in England and the rate of fall lags behind those of Western Europe.

It is estimated that 20-30% of people who suffer a stroke are likely to die within 4 weeks. Of those who survive, 40% require rehabilitation and of those 85% need ongoing support after hospital discharge. It is this last group that drive the cost burden to the NHS. On average, the calculated individual cost of a stroke to the NHS over 5 years is £15,000 and informal cost over the same period is £14,000.



Oxon PCT Admissions to Acute Hospitals with a diagnosis of Stroke	2005/06	2006/07	2007/08
ORH	771	643	605
RBFT	60	53	49
Swindon	6	5	4
Buckinghamshire	5	5	1
Others	9	12	10



Equal Access

Age

Although the majority of strokes occur in later life, a significant number happen to adults of working age, and all services need to offer appropriate care and support for all ages. In 2007/08 there were 124 (of 755 total) people in Oxfordshire PCT under 65 who were admitted to acute care with a stroke, this is 16.5% of total of people who suffer a stroke. The distribution of stroke incidence across the county has no major variation if population numbers and age variation are taken into account. In October 2007 there were 5.2% of the 65+ population living with the effects of a stroke in the county, and another 5.2% having experience a TIA (Transient Ischaemic Attack).

Gender

Strokes are more likely to occur in men than in women, but the latter are more likely to die from a stroke (National Stroke Strategy, 2007)

Deprivation and Social-economic groups

Area deprivation is associated with a higher incidence of stroke, a younger age at first stroke and an increased rate of reoccurrence, (Aslanyan et al, 2003). There is a higher reported incidence of morbidity and mortality from stroke in lower socio-economic groups, (Cox et al, 2006 and Wong et al, 2006). Within Oxfordshire there are two areas of significant deprivation, one within Oxford city and the other in Banbury, this should be remembered when planning for stroke services.

Ethnicity

There is a greater risk of vascular disease in some sectors of the population, and these populations should be targeted with health promotion. Stroke occurs at a higher rate in Black people, and those with Pakistani, Bangladeshi and White Irish male backgrounds, (Health Survey England). By contrast Atrial Fibrillation is a greater risk factor for stroke amongst white people than any other group, (Hajat et al, 2006). Stroke services should also

be tailored to ethnic requirements, the issue within Oxfordshire is that the numbers of the BME population that suffer a stroke are very small.

Location of services

Research shows that specialist units for assessment and treatment have better outcomes in survival rates and levels of disability. Therefore acute care due to its nature needs to be located in large centres with access to appropriate diagnostics. The recovery phase also benefits from specialist care, and the location and access to these needs to be based on both the economic model and the population distribution.

References:

Aslanyan S, Weir CJ, Lees, KR et al. (2003) Effect of area-based deprivation on the severity, subtype and outcome of ischemic stroke. *Stroke 34: 2523-2629*

Cox AM, McKevitt C, Rudd AG, Wolfe CD (2006) Socio-economic status and stroke. *Lancet Neurology. 5: 181-188;*

Department of Health (2007) National stroke strategy

Hajat C, Tilling K, Stewart JA et al. (2004) ethnic differences in risk factors for ischemic stroke: A European case study. *Stroke 35: 1562-1567*

Health Survey for England 2004. Volume 1: Minority ethnic groups.

Wong KYK, Wong SYS, Fraser HW, et al. (2006) Effects of social deprivation on mortality and the duration of hospital stay after a stroke. *Cerebro-vascular Disease 22: 251-257*

Awareness and Engagement

National Stroke Strategy Quality Marker

- Members of the public and health and social care staff are able to recognise and identify the main symptoms of stroke and know it needs to be treated as an emergency.

- People who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services. People are regularly informed about how their views have influenced services.

Introduction

The purpose of this initial engagement work was to reach out to stroke patients and stroke carers across Oxfordshire to understand their experiences during both acute care and with longer term rehabilitation and support.

This engagement sought to find out views on a number of issues in order to inform the Oxfordshire Stroke Pathway of Care Project.

Engagement activity was undertaken with 39 patients and carers between February 25th 2009 and April 21st 2009. Meetings were held with the following groups:

- Family and Carers Support Unit
- Communication Support Services
- Stroke Clubs (Abingdon, Banbury, Henley, Wallingford, Witney)

A conscious decision was made to undertake more in depth and intensive interviews with fewer patients as opposed to seeking larger numbers. This was based on a concern that wider dissemination and less control would results in more superficial answers with less emphasis placed on anecdotal responses from stroke victims, many of whom have communications issues.

In addition, members of the Public and Patient Involvement team observed activities in each of the stroke clubs (with the exception of Wallingford, where postal surveys were issued due to a lack of convenient dates).

The activity undertaken should very much be seen as a 'snapshot of a rolling wave.' Further engagement will be required, and the links forged in this initial exercise will help fulfil this.

Awareness Raising

As the engagement project commenced a number of communication activities took place related to the national campaigns, this activity included:

- 15 minute BBC Radio Oxford interview on the Daytime show on the importance of early detection of stroke symptoms. This included a patient interview. This was organised by the communications team and undertaken Fenella Trevillion, Head of Joint Commissioning at the Oxfordshire Primary Care Trust (February 17th).

- A double-page feature for Oxford Mail and Oxford Times (February 23rd), covering the FAST campaign and interviews with patients.
- A FAST awareness poster campaign on buses across Oxfordshire (both internal posters and rear panels).

As the Pathway develops so will the linking in with external events and drivers

Initial Findings

Respondents at stroke meetings were given the opportunity to raise issues beyond the parameters of the questionnaire - where possible anecdotal evidence was recorded. The key messages are set out below:

Information

Approximately half of respondents felt that their care options were fully explained to them, mirroring the levels of dissatisfaction / satisfaction over whether care plans were meeting needs.

The majority of respondents felt that leaving hospital was similar to ***'stepping off a cliff'*** in terms of ongoing support.

There was a lack of awareness of the preventative actions that could have been taken to prevent stroke.

Treatments

Some respondents were unaware of the full implications of their conditions, for example, expressing surprise that there may be psychological implications, such as depression. As such they were unprepared to deal with this… ***'Is it normal for people to feel like this?'***

There was a perceived lack of information and coordination of planning for long term care … '***no anticipation of my needs'*** … '***no package of services to meet my needs'***

Psychological and speech & language therapies scored highest in terms of dissatisfaction. Occupational and physiotherapy scored highest in terms of satisfaction.

There was a perception that treatments (both acute and transitional) were more positive out of county, for example, in Gloucestershire and Warwickshire.

'I had support in Warwickshire but it's not been so good when we moved to Oxford'

Stroke Groups

Many patients and families only found out about stroke clubs by chance or not soon enough. … '***Would have been beneficial if there had been more publicity or some referral' … 'We would have liked to have known about it sooner'***

There is a lack of coordination between stroke clubs and the Communications Support Service, with patients with apparent communication needs aware of the former but not latter.

There was almost universal respect and value placed on clubs and the volunteers that run them, particularly as a socialising activity … '***Clubs treat patients as humans' … 'Stops me feeling sorry for myself'***

Carers were generally unaware of the carer's assessment

Observational notes

In undertaking the surveys, PCT staff also observed the stroke groups and recorded the following points:

The quality of activities varied greatly between the clubs, from being purely social (tea and biscuits) to activity-led group word games. There was a concern that although respondents enjoyed the clubs social activities, medical and rehabilitative measures were not so prevalent.

There is a need for many of the clubs to be 'energised', with new activities and new approaches. Stroke clubs are run by volunteers, who work very hard. However if they are aiming or to be identified as part of the process for meeting the rehabilitative needs of their client group there needs to be further professionalisation of this service. Currently only one or two effectively meet this need. Most are meeting social needs rather than health needs of individuals and are highly rated by the users for this work.

Demographics of stroke clubs and support groups were exclusively white and elderly. In conducting these surveys we observed a complete lack of younger stroke patients were and a complete lack of racial ethnicity.

Next Steps

The findings of the report will be used to inform the continuing work on developing a stroke pathway for Oxfordshire. PCT Commissioners and the Stroke Pathway of Care Project Group will take them into account in implementing the service specification, quality standards and the overall delivery of the Pathway.

As the Pathway develops it will be important to form a service users group in order build greater knowledge of service users experiences and to test assumptions and initiatives.

Where possible and appropriate further engagement work should be undertaken within acute care

As an immediate step it would seem necessary (ahead of the implementation of a new pathway) to review the information provided to patients so that they and their families are aware of the support networks in existence.

Economic and Predictive Modelling

None of the health or social care organisations in Oxfordshire has collected comprehensive data in the past that could fully inform the proposed service integration. This is for a variety of reasons, such as newly defined standards of care (e.g. TIA services based on risk stratification) or collection based on patient need rather than diagnosis. Linkage of existing data across organisations is also difficult.

The Department of Health's ASSET tool, which was developed to inform commissioners on how to develop stroke services, was felt to provide some useful information, but crucially, it did not take account of the existing patterns of delivery of health and social care in Oxfordshire.

Recognising this, the Project Team has worked with the Decision Support team at the PCT to utilise a new predictive modelling tool, scenario generator, for the first time to help target investment in service development.

At the Clinical Executive Workshop, the following will be presented showing the implications to patient outcomes and PCT costs:

- Base case scenario
- Creation of a comprehensive stroke unit at the Horton Hospital
- Opening of the Community Stroke Unit at Witney and creation of the Pilot Early Support Discharge Service in Oxford City
- Opening of a further Community Stroke Unit
- Coordination with Social Care
- TIA services

Known facts

Fast access to TIA diagnosis and treatment reduces the risk of going on to a full stroke

Levels of long term dependency are reduced by targeted specialist rehabilitation

Levels of death following a stroke are reduced by care on an acute stroke unit

Access to thromboylsis for appropriate individuals will reduce the long term effects of the stroke

Unknown facts

The effect of changing lifestyle e.g. smoking and obesity rates will have on the incidents and age of strokes

Long term capacity

Prediction on the capacity required for stroke care over the next ten years has found that the balance of decreasing incidents and the increase of the population over 65 of age, means that the incident number in true value will remain unchanged from the level in 2008/09. Therefore the capacity developed now should be future proofed for the next ten years, on the evidence available to us on trends.

Development of TIA Clinics

The development of daily high risk TIA clinics - the research indicates that assessment and treatment within 24 hours for individuals assessed at high risk TIA reduces the on-going incidents of full stroke. These clinics have a higher cost; however the modelling of costs indicates that this increased cost in Oxfordshire should be offset by the reduction of 3.7% annually of full strokes and the stopping of admission of patients to acute inpatient beds to access diagnosis and treatment.

Unbundling of Acute Stroke Tariff

HRG4 supports early discharge and transfer of patients into specialist community rehabilitation. There are three phases of care:

- Acute care – "early discharge" at seven days
- Early post acute care – the next five days for "rehabilitation" requiring 24 hour support
- Later post acute care – for all patients whose condition is such that they are not candidates for early discharge with / without rehabilitation

NHS Oxfordshire is investing £360k p.a. for the specialist community rehabilitation needed to support early discharge at seven days respectively during the early post acute care phase. Early discharge frees-up beds and other resources in Secondary Care. Unbundling the tariff releases spend on Secondary Care to provide specialist rehabilitation in Community Hospitals and at home.

Next steps

- Negotiation for both areas above is just starting with Oxford Radcliffe Hospital Trust
- Further development of the model is ongoing

Pathway Section 1

Stroke Prevention

National Stroke Strategy Quality Markers

- Those at risk of stroke and those who have had a stroke are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors.

- Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk.

Preventing ill health can be divided into three main categories,

1. Preventing ill health (primary prevention),
2. Preventing deterioration once illness is evident (secondary prevention)
3. Specialist prevention to ensure effective recovery (tertiary prevention).

When considering preventative care for those at risk of and who have suffered from strokes, all three aspects of prevention must be present to ensure an effective pathway.

Primary prevention is available to everyone and includes

- Smoking Cessation
- Weight Management
- Increasing physical activity
- Blood Pressure monitoring

Services which are currently under development include
- Vascular checks for those aged between 40 – 74

DOH (2009) Putting Prevention First

- Specialised weight management services for those with higher BMI's

- Brief intervention for alcohol abuse

Ideally, every contact with health care professionals should lend itself to brief advice and signposting to lifestyle intervention services.

Secondary prevention takes place once a person begins to show symptoms of either vascular disease or has suffered a mini stroke (TIA), so early signs of disease.

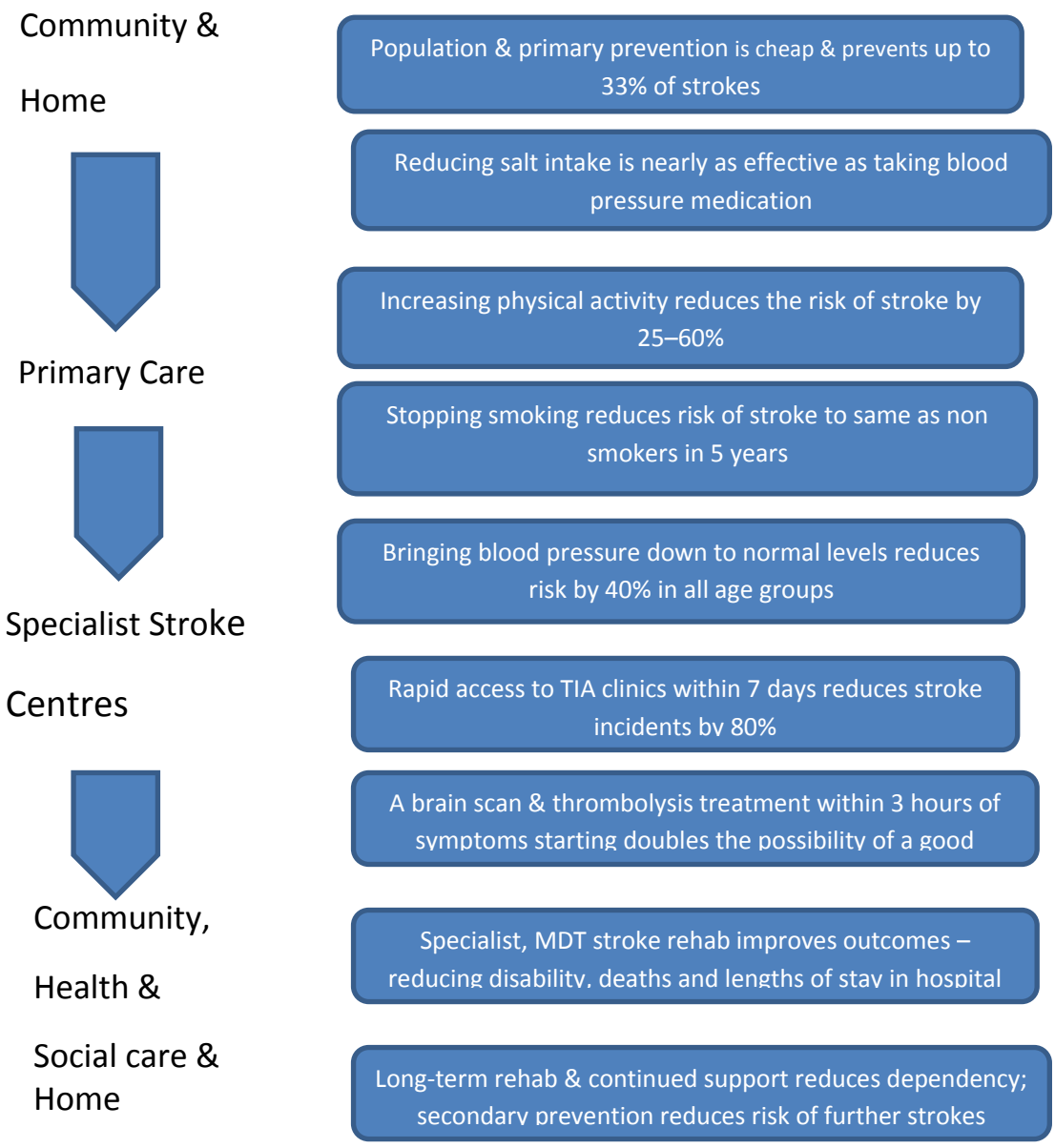
Early identification and education about the risk of stroke is of paramount importance. All the above services still continue to be relevant. TIA clinics will include signposting and brief intervention advice to lifestyle change services. Nurses specially trained in brief interventions will provide care for these patients ensuring they have the information they require to make adequate adaptations to improve their health. Primary care professionals will continue to provide health advice as part of the long term condition treatment management.

Specialist or Tertiary prevention is linked with treatment, ensuring effective rehabilitation to prevent deterioration and ensure functionality continues during early phases of care right

through to continuing care. Patients can contribute to better outcomes by ensuring weight is managed (making movement easier), smoking is reduced (better circulatory flows) and drug treatments are adhered too.

Prevention should be seen as part of the continuum of care which should be readily available along the whole stroke pathway.

The Benefits of Prevention (Source London Health Observatory)



Pathway Section 2

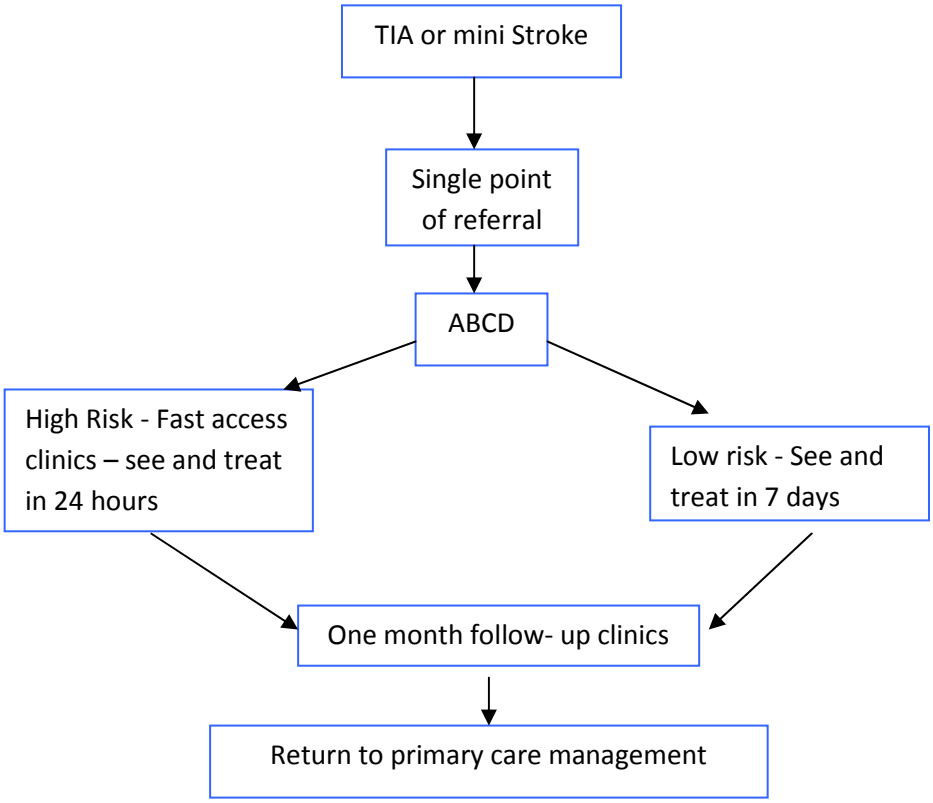
Transient Ischemic Attack (TIA) and Minor Strokes

National Stroke Strategy – Quality Markers

- Immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke.
- A system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days.
- Provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated.
- All patients with TIA or minor stroke are followed up one month after the event, either in primary or secondary care.

"Centralisation of services due to access to diagnosis"

Intended TIA pathway - Oxford Radcliffe Hospital Trust



TIA and minor strokes are common and are managed in consultant lead out-patient clinics. The risk of a stroke following a TIA is approximately 5% at one week and 10-15% at three months. Scoring known as ABCD has recently been developed to identify those at high risk, and research has shown that quick access to treatment can prevent potentially disabling

strokes by up to 80% at three months, (Rothwell et al, 2007 and Johnson et al, 2007). This means that high risk cases accessing swift treatment will decrease the annual number of individuals having a full stroke by 3.7%. In Oxfordshire this would equate to a reduction of 24 acute admissions.

Activity

It has been calculate from research and national data that there should be 1,500 referrals annually or 30 per week in Oxfordshire, of these 55% are high risk and 45% low risk.

Recent development

The Oxford Radcliffe Hospital Trust agreed in early 2009 to the organisations improvement plan to deliver a single point for referrals for suspected TIA and mini stokes and a re-organisation of out-patients clinics to give capacity to offer 365 day cover in the county.

The PCT has invested in the post of a nurse in the TIA follow up clinics to offer tailored health promotion and stroke prevention packages to all attendees

Change from current to future state

Current state	**Future state**
Scatter gun referral into Gerayology or Neurology clinics	Single referral point
No TIA specific activity data collection	All activity collected through single point of referral
No weekend or bank holiday rapid access arrangements	All high risk cases seen and treated in 24 hours
Admissions for TIA and mini-strokes	All TIA and mini-strokes can be seen and access diagnostics as out-patients
Paramedics taking TIA and mini-strokes to A&E	Paramedics having referral rights to rapid access TIA clinics
Secondary prevention information dependent on clinic	Tailored and targeted secondary prevention through nurse in follow up clinics

References:

Johnson C et al (2007) *Lancet 2007*:369:p283-292

Rothwell P.M. et al (2007) *Lancet 2007*:370: p1432-42

Pathway Section 3

Emergency Response

National Stroke Strategy Quality Marker

- All patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper-acute stroke services (where a stroke triage system, expert clinical assessment, timely imaging and the ability to deliver intravenous thrombolysis are available throughout the 24-hour period).

999 Responses

A stroke is coded as a Category B emergency response by the South Central Ambulance Service (SCAS) – to ensure that a patient emergency vehicle is dispatched to the call.

All paramedics are trained to use the FAST assessment tool.

All patients with suspected stroke could be triaged into three groups by paramedics:

- Those in whom acute stroke intervention (e.g. thrombolysis) may be indicated;
- Those for whom hospital admission is required;
- Those for whom hospital admission may not be appropriate and could be dealt with using alternative pathways e.g. TIA/ minor stroke pathway.

Discussions are ongoing with SCAS about how to respond in these three instances to ensure equality of service provision across Oxfordshire given that there are three different Acute Care Providers (John Radcliffe Hospital, Horton Hospital, and Royal Berkshire Hospital (+?Swindon Hospital).

Minor Injury Units, GP practices and Out of Hours

All staff that may be the first point of contact for a patient with a suspected stroke working within minor injury units and GP surgeries should be fully trained in the use of the FAST assessment tool.

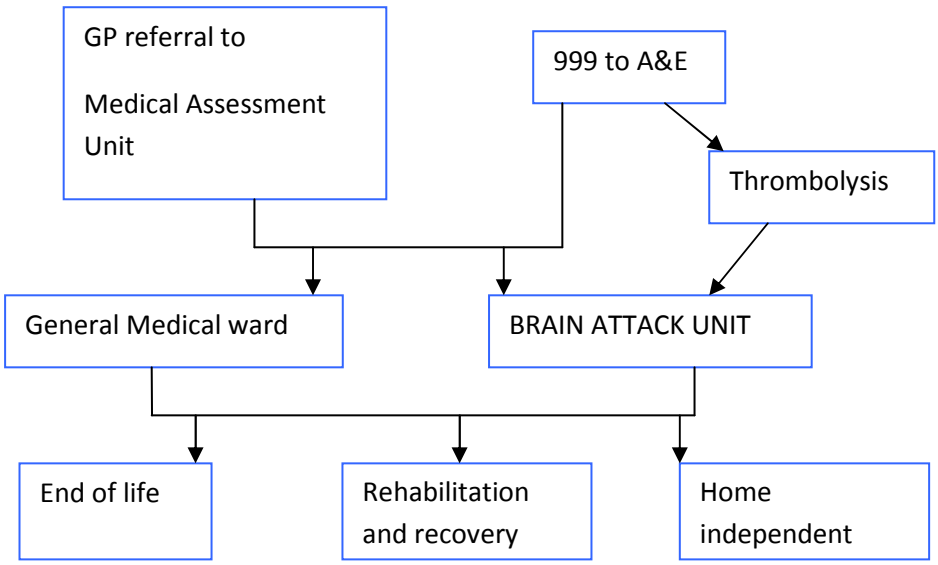
999 services should be accessed as indicated above.

Pathway Section 4

Hyper-acute Stroke Assessment and Treatment

National Stroke Strategy Quality Markers

- Patients with suspected acute stroke receive an immediate structured clinical assessment from the right people
- Patients requiring urgent brain imaging are scanned in the next scan slot within usual working hours, and within 60 minutes of request out-of-hours with skilled radiological and clinical interpretation being available 24 hours a day.
- Patients diagnosed with stroke receive early multidisciplinary assessment – to include swallow screening (within 24 hours) and identification of cognitive and perceptive problems.
- All stroke patients have prompt access to an acute stroke unit and spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care.
- Hyper-acute stroke services provide, as a minimum, 24-hour access to brain imaging, expert interpretation and the opinion of a consultant stroke specialist, and thrombolysis is given to those who can benefit.
- Specialist neuro-intensivist care including interventional neuroradiology/neurosurgery expertise is rapidly available.
- Specialist nursing is available for monitoring of patients.
- Appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues.



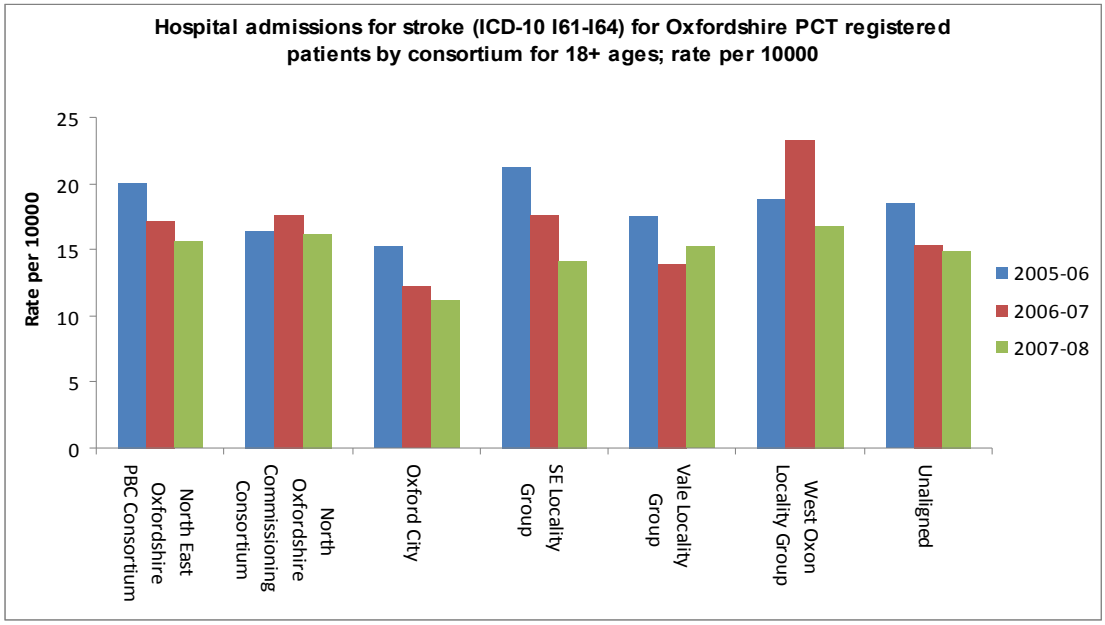
Activity

Hospital admissions for stroke 2005-06 to 2007-08

Oxfordshire PCT registered patients by consortium; all ages including community Hospitals & OCE

Consortium	Financial Year			Grand Total
	2005-06	2006-07	2007-08	
North East Oxfordshire PBC Consortium	117	101	92	**310**
North Oxfordshire Commissioning Consortium	127	137	147	**411**
Oxford City	224	177	167	**568**
SE Locality Group	111	92	74	**277**
Vale Locality Group	125	100	110	**335**
West Oxon Locality Group	105	132	98	**335**
Unaligned	91	75	60	**226**
n/a	1	6	8	**15**
Grand Total	**901**	**820**	**756**	**2477**

Source: SUS (U_DS 07/01/09)



Key Principles

All clinical staff in the Emergency Department should be competent in the assessment for stroke

There will be 24 hour, 365 day access for all patients in Oxfordshire to specialist stroke clinical services to provide assessment for suitability for acute stroke intervention including thrombolysis, where indicated.

All patients diagnosed with suspected stroke will undergo a brain scan within 24 hours of admission, unless they are being considered for acute stroke intervention in which case they should be scanned in the next available slot.

Standards of care on the acute stroke units will follow the Royal College of Physician Guidelines, 2008, and will offer:

- High dependency care
- Physiological and neurological monitoring
- Early rehabilitation
- Palliative care
- Will meet the needs of all ethnic groups and all adult age groups

The capacity of the Brain Attack units will allow 90% of patients with a stroke accommodated on this unit.

All patients diagnosed with a stroke will undergo swallowing assessment within 24 hours of admission.

All patients will undergo assessment by the MDT according to the standards set out in the National Stroke Sentinel Audit. The standards are currently: Physio assessment within 72 hrs; Assessment of communication problems by S&L therapist within 7 days of admission; OT assessment within 4 working days; and, Social work assessment within 7 days of referral.

Rehabilitation of patients will commence as soon as an MDT assessment and care plan has been complied, it will offer high quality, flexible and patient centred rehabilitation

A patient when they do not need medical supervision or intervention overnight (regular unplanned medical review)to be transferred from acute care for on-going rehabilitation, support and care in the community.

All patients who require palliative care will be cared for within the Oxfordshire End of Life pathway of care

If a patient is being transferred home then their GP should be informed of this prior to them leaving hospital

There should be strong relationships between the Brain Attack unit and social and community services to allow for seamless transfer of care across organisation and locations

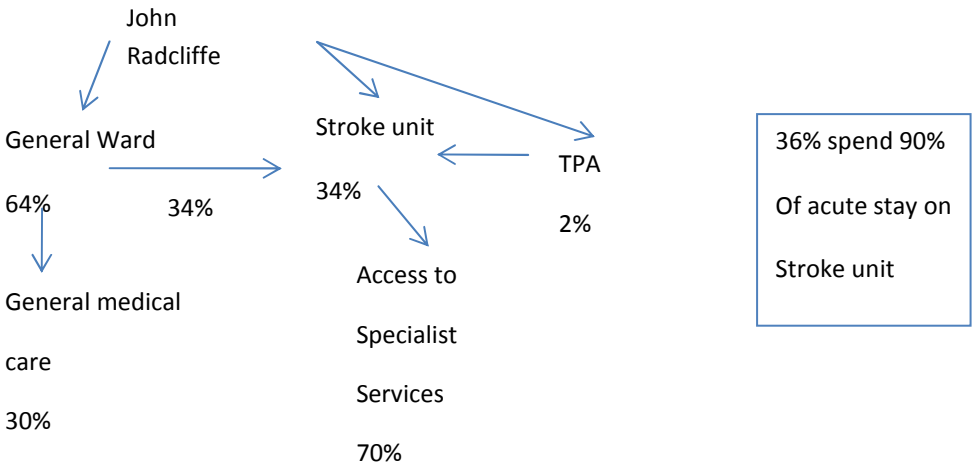
Oxford Radcliffe Hospital Trust

Two Brain Attack Units

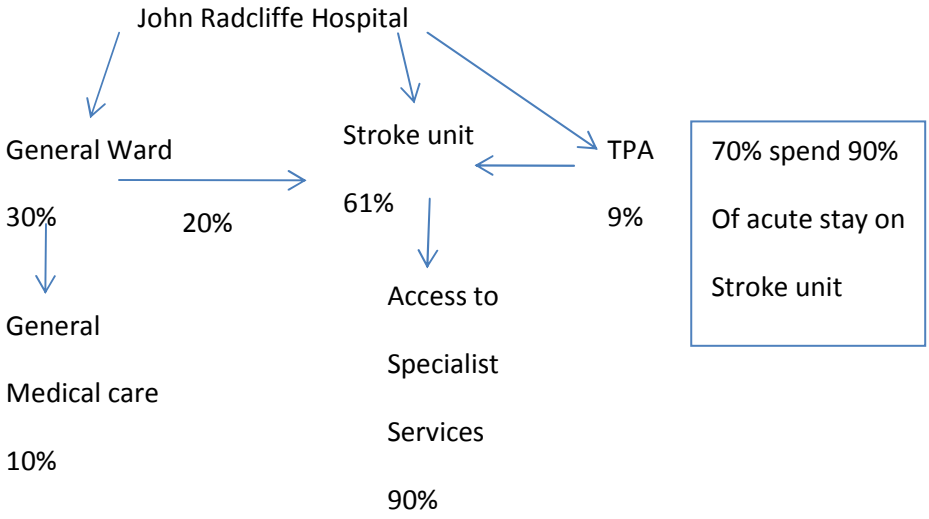
1. John Radcliffe Hospital – Acute Brain Attack Unit of 18+1 bed
2. Horton Hospital – Acute Brain Attack and early Rehabilitation Unit 8 beds

Current state

2009



Future state



Recent Developments

Oxford Radcliffe Hospital Trust Board agreed to developments and funding in Acute Stroke Assessment and treatment:

- Agreed need for additional full time Consultant to ensure sustainability of thrombolysis rota
- Development of a comprehensive stroke data set
- Additional therapy posts at Horton Hospital Stroke unit

Change from current to future state for ORHT

Current	Future
Long & inappropriate length of stay (LOS) in acute care	Normal maximum LOS = 12 days
36% spend 90% of stay on Brain Attack unit	70% spend 90% of stay on Brain Attack Unit
2% of strokes Thromboylysed	9% of strokes Thomboylysed
ORHT in bottom quartile of sentinel audit of improving quality of care	ORHT in top quartile of sentinel audit
Several medical teams managing stroke care	Few defined teams managing stroke care giving consistency of care
No clear pathway of care in acute services	Clear pathway and consistency on transfer between services internally and externally

Pathway Section 5

Recovery Phase

National Stroke Strategy Quality Marker

- People who have had strokes access high-quality rehabilitation and, with their carer, receive support from stroke-skilled services as soon as possible after they have a stroke, available in hospital, immediately after transfer from hospital and for as long as they need it.

- A workable, clear discharge plan that has fully involved the individual (and their family where appropriate) and responded to the individual's particular circumstances and aspirations is developed by health and social care services, together with other service such as transport and housing.

Rehabilitation

This is the period when individuals undertake a comprehensive programme to reduce or overcome the deficits following the stroke. It is to assist the individual to gain the optimal mental and physical ability which the damage of the stroke to the brain allows.

Rehabilitation is carried out in a number of settings (see criteria below) and is defined by the individuals medical and social requirements, rehabilitation starts as soon after the stroke the individual can tolerate it.

Specialist stroke rehabilitation has a strong evidence base and has been shown to improve long term outcomes. This releases financial savings downstream, and cost shifting and collaborative pathway development are vital.

Activity

Currently there is poor data on the numbers of patients with a stroke in rehabilitation services due to poor coding – or services working on needs basis not diagnostic basis. It will be important for at least two years to monitor the activity through the recovery services to allow accurate long term commissioning. Therefore activity data below is taken from limited known data and extrapolation of national data.

It has been estimated that nationally 40% of individuals require rehabilitation and of those 85% are discharged with some level of dependency that requires long term care. Therefore in Oxfordshire this means that:

268 in 2007/08 Required rehabilitation

227 in 2007/08 required some form of long term care annually

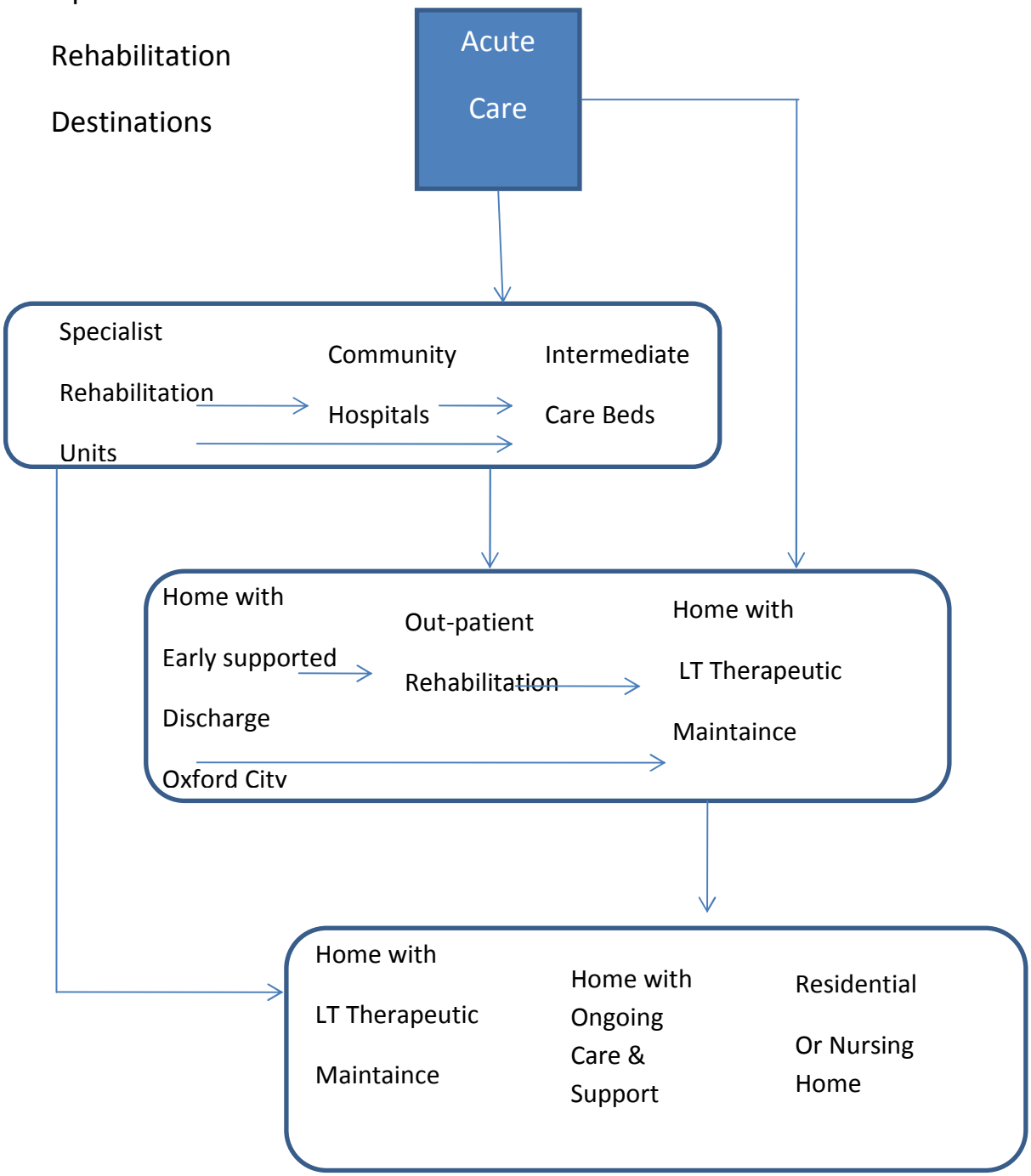
End of Life Care

For this area of care refer to the Oxfordshire End of Life Strategy

Carers Support

For this area of work refer to the Oxfordshire Carers Strategy

Options for Rehabilitation Destinations



New services in the pathway for 2009/10

Specialist rehabilitation unit at Witney Hospital

- No increase in capacity – improvement in care and outcomes

This is the up-grading of 10 existing consultant led beds in Witney Hospital to have the medical input and staffing levels to deliver specialist stroke rehabilitation, allowing discharge from the Acute Units at John Radcliffe and Horton Hospital from day seven following a stroke

Additional investment in therapy and nursing - £220k

Early supported Discharge team in Oxford City

- Increased capacity of 48-55 additional individuals treated in the community

A new pilot service for the registered patients within Oxford City and Kidlington GP practices to trial the concept of Early Supported Discharge for Oxfordshire as laid out in the National Strategy. The trial will start in July 2009 and run for 2 years with full evaluation taking place for October 2010, to meet the commissioning cycle of the operational investments if it proves to be a successful way of delivering rehabilitation.

Total investment over 2 years - £276,400 –split of ORH £80k, PCT £80k, SHA grant £116,400

Outline Criteria for Each Rehabilitation Step

Brain Attack Unit: 24/7 specialist medical input required

Community Specialist in-patient: 9-5, 5 days a week consultant led medical input, with 5-6 day specialist MDT input

Early Supported Discharge: Therapy led input with MDT link / supervision to acute unit, 5 days a week therapy input, care input 7 days no night cover, with medical input of general medical services

Community Hospital: 24/7 nursing cover, MDT generic therapy input 5 days per week, GP medical cover. Offering continence, cognitive, communication rehabilitation, plus behaviour support and place of safety

Intermediate care beds: limited registered nursing cover, MDT generic therapy input up to x5 per week, GP medical cover, and safe environment with night time toileting.

Intermediate care at home: care input 7 days, no night time cover, MDT generic therapy input up to 2-3 times per week, GP medical cover

Out-patients: single professional or MDT, short targeted rehabilitation session – from x3 per week to x1 per month.

Key Principles

Rehabilitation programmes are built around the individual needs with patient agreed goals, and are everyone's responsibility to carry out through a 24 hour cycle.

Rehabilitation is both physical and physiological to assist in the adaptation to a changed situation and is based on building a positive perception of 'myself' in their new situation.

The need for tailored rehabilitation should be balanced between patient and family choice of venue close to home and the provision of specialist units.

Rehabilitation units should be supported by appropriate qualified clinicians with competencies to deal with complex issues and available to address respiratory, swallowing, dietary, continence, skin health and communication issues,

Have high levels of co-ordination between health and social care that allows continuity of support and care,

Recovery can continue for many years after an individual has had a stroke, and is multi-factored e.g. functional, emotional or return to social/work life. Targeted rehabilitation is time limited and goes from highly intensive specialist input to patient and family delivered.

Discharge from care planning should start early within the pathway, involve the individual, their family with health and social care working in partnership with other agencies such as housing, so avoiding delays in discharge.

GPs will be informed of an individuals discharge home prior to this occurring with a full on-going plan and a copy of their final assessment.

Monitoring

<u>Patient outcome tool</u>

Oxfordshire has adopted FIM – Function Independence Measure

The FIM is undertaken early in a patients recovery phase and re-taken regularly through the recovery phase

Change in FIM scores will be reported on discharge from each service quarterly

Change from current state to future state

Current state	**Future state**
No specialist community stroke rehabilitation	Sufficient commissioned capacity for levels of rehabilitation to allow 12 day LOS in acute units
No agreed pathway and criteria for different levels of rehabilitation	Agreed criteria for different levels of rehabilitation

Insufficient levels of specific rehabilitation therapies available in the community	Sufficient commissioned capacity of different therapeutic input
No out-patient neuro-rehabilitation	Switch from day hospital model to focused neuro-rehabilitation out-patients
Limited therapy outside of intermediate care service and Occupational Therapy long-term care	Define requirements and develop community rehabilitation accordingly
Lack of key specialist therapeutic services	Clinical lead and specialist services accessible in the community
No clinical Psychologists	Clinical psychology to support recovery services though out the pathway

Pathway Section 6

Long Term Care, Review, Return to Work and Community Life

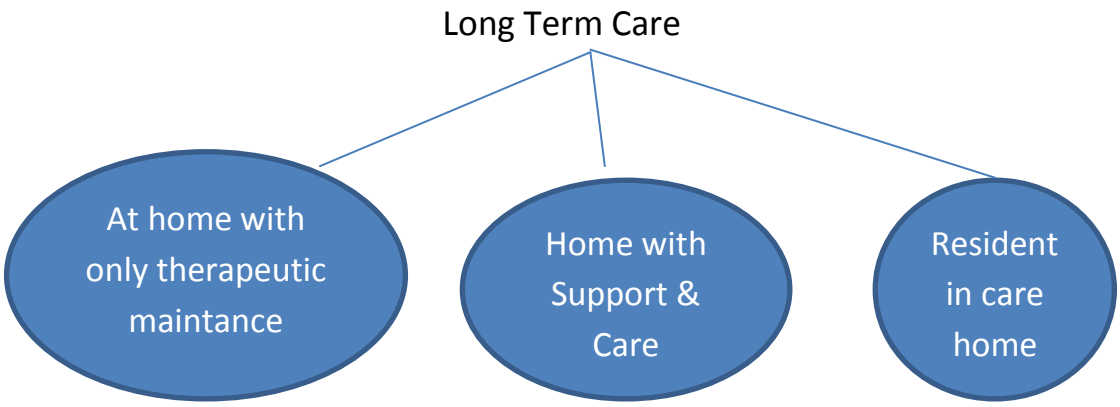
National Stroke Strategy Quality Marker

- A range of services are in place and easily accessible to support the individual long-term needs of individuals and their carers.
- People who have had strokes and their carers, either living at home or in care homes, are offered a review from primary care services of their health and social care status and secondary prevention needs, typically within six weeks of discharge home or to care home and again before six months after leaving hospital.
- This is followed by an annual health and social care check, which facilitates a clear pathway back to further specialist review, advice, information, support and rehabilitation where required.
- People, who have had a stroke, and their carers, are enabled to live a full life in the community.
- People who have had a stroke and their carers are enabled to participate in paid, supported and voluntary employment.

Stroke long term care

Defined as

Support and care on-going to maintain daily living for someone who has permanent and substantial levels of disability from a stroke



- 45% of people who suffer a stroke will recover sufficiently to be living at home independent – 301 in 2007/08 in Oxfordshire
- 27% are left with a disability that requires on going care and support - 20% will be in a care home and 80% receiving care and support at home – 45 entering care homes

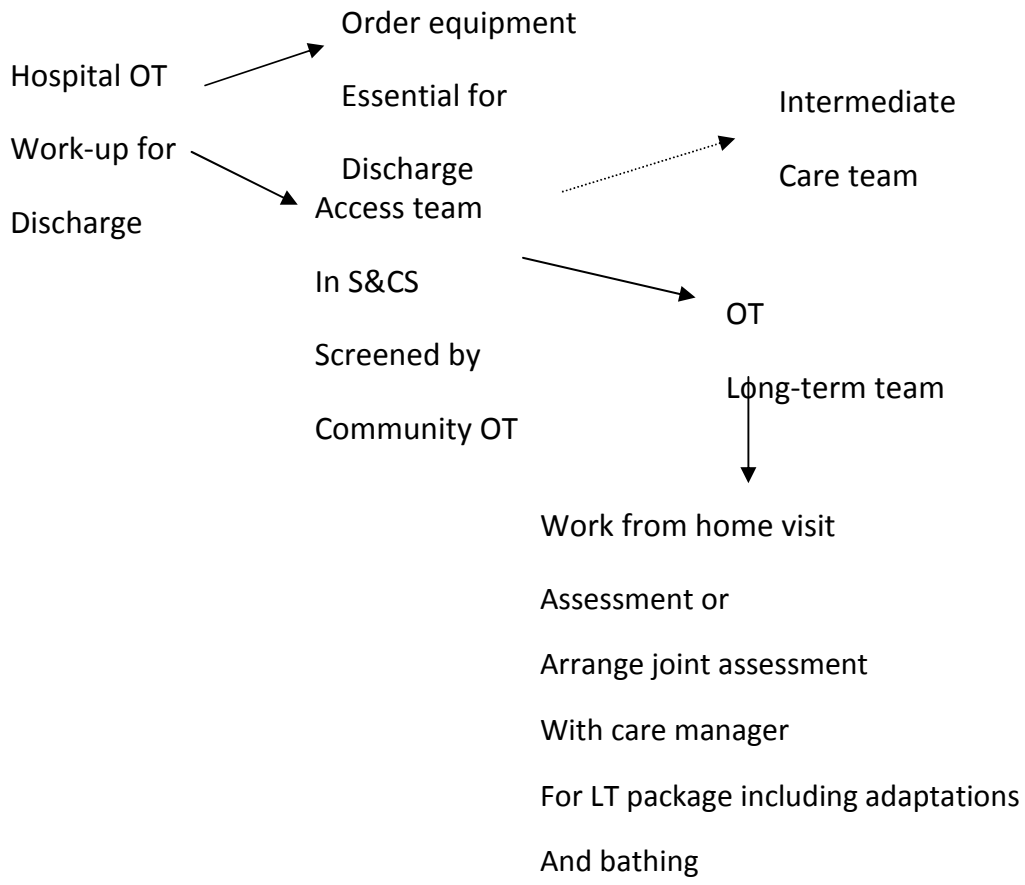
and 181 receiving support and care at home, paid or unpaid in 2007/08 in Oxfordshire

- It is nationally calculated that 25% of all Nursing Home residents have had a stroke

Areas of long term care

- On going therapy – e.g. Speech and Language Therapy
- Outpatients consultant appointments
- Stroke networks for survivors' and their carers
- Equipment to maintain maximum independence
- Adaptations to homes to remain living in them
- Return to work services
- Reviews by primary care practitioners
- Communication Support groups
- Socialising support to integrate back into their community

Long-term Occupational Therapy Pathway



Social and Community Services three year grant

This is grant money from the Department of Health to all Social Services Departments from 2008-2011, to support the development of long term care for stroke survivors and their families, in Oxfordshire the total is £333k.

Developments

- Stroke co-ordinator in post for 2 years from March 2009
- Training programme to improve the skills and competencies for carers both paid and unpaid in care homes and home settings (£150k)
- Development with the Stroke Association of a return to work service
- Grant to the Stroke Association to improve the support to the carers of stroke survivors

Additional developments

- Information campaign – awareness raising amongst staff of strokes and the 'FAST' campaign through the County Council intranet and the staff magazine

To start

- Financial and benefit advice

Oxfordshire County council web-page

"How do I stay in my own home?"

Self assessment web page www.oxfordshire.gov.uk

Community Management

On-going Assessment and Review

Individuals and their carers should have a review from a primary care service for their health and social care status and secondary prevention needs:

- 6 weeks after discharge home or entry into care home
- 6 months after discharge
- Annually after this for a health and social care check

This is a new development to have a formalised process and will require a specification and planning into a primary / community care service

Change from current state to future state

Current state	**Future state**
Lack of consistency in patients experience	Consistent standards and experience for patients

Services not joined up	Transfer of care across organisational boundaries joined up
No formalised review tool or mechanism	All stroke survivors have access to regular review of their on-going needs
Poor return to work and adults of working age services	Develop return to work and services tailored for adults of working age
Patchy on-going support and self care	Expert patient / self care support network
No care home quality markers	Quality standards within care homes

Next Steps

This is the area that has been identified as to where the most work is still required; the work has started with the appointment of a stroke co-ordinator in early 2009 in Social and Community Services. The next step is a workshop on long term care for stroke survivors at the end of May, and working on the development needs for this area and rehabilitation in tandem due to the phasing of rehabilitation into long term care in a patients recovery.

Monitoring

Vital signs to Health Care Commission

1. Patients who spend at least 90% of their time on a stroke unit
2. Transient Ischemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours

Local indicator within Operational Framework 2009/10

1. Number people over 65 who have a stroke -

Based on a 5% reduction in strokes 2009/10 amongst the over 65s to predicted levels taking account of demographic growth

Functional Independence Measurements – individual patient outcome measure

Stroke Sentinel Audit

CQUIN data - started April 2009 with ORHT

Stroke	% of patients with high risk Transient Ischaemic Attack (TIA) and acute stroke who have had brain imaging (MRI) are scanned in the next scan slot within 60 minutes of request out-of-hours with skilled radiological and clinical interpretation within 24 hours	80% - broken down by hospital site	Provider report as per returns to National Sentinel Stroke Audit	Quarterly
Stroke	Stroke patients in whom a haemorrhagic stroke, or other contraindication, has been excluded have aspirin treatment within 48 hours of admission	100% - broken down by hospital site	Provider report as per returns to National Sentinel Stroke Audit	Quarterly
Stroke	Stroke patients have a initial swallow screen test performed within 24 hrs of admission, unless there is a documented contraindication	100% - broken down by hospital site	Provider report as per returns to National Sentinel Stroke Audit	Quarterly
Stroke	Patients presenting with Transient Ischaemic Attack (TIA) are risk assessed and high risk patients treated within 24 hours, low risk within 7 days	Achieving 50% by quarter 4, average of 42% over the year	Provider report as per returns to the National Sentinel Stroke audit split between sites	Quarterly
Stroke	Patients who spend at least 90% of their time on a stroke unit	Achieving 70% by quarter 4, average of 68% over the year	Provider report as per returns to the National Sentinel Stroke audit split between sites	Quarterly
Stroke	% of patients admitted directly to specialist stroke unit from A&E	Threshold to be developed in year	Provider report as per returns to the National Sentinel Stroke audit split between sites	Quarterly

Key Data on activity and quality will support individual Service Specifications, and will utilise data sets that are already required and not burden clinicians with additional collection.

Development Plan

The National Strategy for Stroke is a ten year development plan (2007-2017) to improve the quality of care for those who experience TIA's or full strokes. In December 2008 a project team was established in Oxfordshire to scope current services and capacity etc. and to outline the Oxfordshire Integrated Stroke Pathway to be the vehicle to implement the National Stroke Strategy Locally.

To establish a high quality and cost effective integrated pathway, there are a series of developments areas to address by the PCT and Social and Community Services commissioners, working with current providers or developing new providers through tendering services.

Listed below are the areas identified for development, to oversee this work and to ensure the governance arrangements it is proposed that there is:

- A Stroke Development and Implementation Group established in Oxfordshire, consisting of commissioners, clinical leads, users, voluntary Groups and main contracted providers from the PCT and Social and Community Services to take the work of the project team forward. This group would be accountable to the Joint Older Peoples Commissioning Board.
- A Stroke Development Manager 0.5wte on a two year fixed term contract to project manage the developments.
- When the PCT Medical Director is appointed they will have responsibility for the stroke pathway work in their portfolio.
- Oxfordshire is part of the South Central Stroke Network and a member of the Steering Group, the Oxfordshire Stroke Group and development manager would work closely with the network, especially in pan South Central developments.

Development Areas

Awareness

Rolling programme on FAST training across all front line health and social care practitioners and with care agencies

Patent and Carers Involvement

Establish a patient and carers group to input into all the developments of stroke care in the county

Emergency response

To have an agreed protocol with South Central Ambulance Service

TIA assessment and treatment

To ensure the implementation of the new pathway and clinic arrangements

To establish referral rights of paramedics to TIA clinics

To agree tariff arrangements and service specification

Hyper-acute assessment and treatment

To ensure the implementation of the new pathway

To complete negotiations of unbundling the stroke tariffs

Increase level of patient involvement in the development of services

Develop neuro-psychology input

To agree service specification

Increase Speech and Language Therapy communication input

Criteria and consistency in neuro-surgery referral agreed

Recovery

Consultant Therapist to clinically lead & co-ordinate community services

Speech and Language Therapist in intermediate care teams

Access for all individuals who require it to video fluoroscopy

Speech clubs across the county

Full Specialist stroke team in the community

Clinical Psychologist – 2.0wte

Therapy after 6 weeks intermediate care – apart from limited capacity in physical disability team

Outpatient neuro-rehabilitation

Return to work rehabilitation

Services targeted on younger adults

Specialist disability counselling

Long Term Care

Psychological support

Analysis of numbers in the community

Review current standards of care

Develop quality markers for care homes and domiciliary care

Ongoing assessment and review

Return to work support & services

Long term social inclusion and expert patients / self care

Information

National Stroke Strategy Quality Marker

- People who have had a stroke, and their relatives and carers, have access to practical advice, emotional support, advocacy and information throughout the care pathway and lifelong.

Audit

To agree audit and monitoring of the pathway with all providers

National Stroke Strategy Quality Marker

- All trusts participate in quality research and audit, and make evidence for practice available

Market development

The PCT and Social and Community Services, to work together to stimulate and develop the market in recovery and long term care, identifying new providers of support and care.

Workforce development and education

A consultation education strategy for health and social care staff involved in stroke care was published by the department of Health in April 2009

National Strategy Quality Marker

- All people with stroke, and at risk of stroke, receive care from staff with the skills, competence and experience appropriate to meet their needs

Contributors

Project Team		
Name	**Role**	**Organisation**
Suzanne Jones	Project Manager	OPCT
Angela Baker	Public Health Lead	OPCT
Judy McCulloch and Simon Wardt	Communication & PPI Lead	OPCT
Bob Bister	Finance Lead	OPCT
James Kennedy & Martin Westwood	Clinical Lead – emergency and acute treatment	ORH
John Walton	Primary Care Lead	OPCT
Varsha Raja	Social Care Lead	OCC
Jonathan Coombes	Community Lead	OPCT
Gaby Price and Chris Morris	Decision Support	OPCT
Carol Gough	Rehabilitation Lead	CHO
Esme Mutter	Assistant Regional Manager	Stroke Association
Hannah Baker	Contacts Lead	PCT

Working Groups		
Name	**Role**	**Organisation**
John Raburn	Operational manager	SCAS
Chris Higdon	Operational manager	ORH
Sue Bright	Speech and Language Therapist	CHO
Bev Reetham	Physiotherapist	ORH
Martin Westwood	Clinical Lead Nurse	ORH
Carol Gough	Nurse	CHO
Liz Gaunetlett	Occupational Therapist	Intermediate Care
Nikki Proffit	Physiotherapist	OCE
Varsha Raja	Commissioner	S&CS
Mary Barrett	Service Development & Policy Manager	S&CS

	Occupational Therapist	S&CS
	Occupational Therapist	S&CS
Attendees of Stroke Rehabilitation Workshop		
Name	**Clinical Area**	**Organisation**
Sue Bright	Speech and Language Therapist	CHO
Bev Reetham	Physiotherapist	ORH
Jane Williams	Co-Clinical Lead South Part SHA	SHA
Jonathan Coombes	Manager	CHO
James Price	Consultant	ORH
Martin Westwood	Nurse	ORH
Sudhir Singh	Consultant	ORH
Carol Gough	Nurse	CHO
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Leslie Sloan	Physiotherapist	Intermediate Care
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Delis Wells	Family & Carers Support co-ordinator	Stroke Association
Mr Denis	Stroke Survivor	
Mrs Denis	Carer	
Mr Skilton	Stroke Survivor	
Mrs Skilton	Carer	
Varsha Raja	Commissioner	S&CS
Mary Barrett	Service Development & Policy Manager	S&CS
Tony McDonald	Manager	ORH
Ian Reckless	Stroke Physician	ORH
Nikki Proffitt	Physiotherapist	OCE

Abbreviations

CHO	Community Health Oxfordshire
DOH	Department Of Health
ESD	Early Supportive Discharge
FIM	Functional Independence Measure
MDT	Multi-Disciplinary Team
OCE	Oxford Centre of Enablement
ORH	Oxford Radcliffe Hospital
PBC	Practice Based Consortium
RBFT	Royal Berkshire Hospital Trust
SALT	Speech And Language Therapy
SHA	Strategic Health Authority
TIA	Transient Ischemic Attack
TPI	Thromboylsis

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OXFORD, OX1 1ND

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20th November 2009

Dear Councillors,

Thank you for you letter of recommendations regarding the service provision for reducing teenage conceptions in the county. We welcome the Oxfordshire Joint Health Overview and Scrutiny Committee and Children's Services Scrutiny Committee's focus on teenage pregnancy as it is a priority for the Children's Trust.

Staff in both OCC and the PCT have recently conducted a thorough data based self assessment of our progress on teenage pregnancy. It highlights a number of strengths in Oxfordshire which we know we can build on. These include commitment at a strategic level; strong investment in sex and relationships education and school health nurses; high quality contraception and sexual health services, including an outreach nurse; publications; websites and information from Integrated Youth Services and a growing number of Safety card (condom distribution) outlets.

The teenage pregnancy data self assessment also highlights a number of gaps and areas requiring action. We have taken these gaps as the basis of a new teenage pregnancy strategy which is being formulated at present. We welcome the recommendations from the scrutiny joint working group. Below are our responses to the recommendations:

- **Support should be targeted towards the most vulnerable young people, in particular those who are in poor attendance or excluded from school. Support should also be directed towards both rural and urban areas.**

Agree. We will continue to target areas where we know teenage pregnancy rates are at their highest and therefore where young people are at their most vulnerable. We intend to continue to strike a balance between targeted services and high quality universal services for all young people in the county. We will continue to invest in school health nurses and offer a new phone advice line to some of the most vulnerable. The Bodyzones (health, youth work and advice drop-ins) in rural areas will continue as they are thriving and clearly what young people want in rural areas. We currently have a sexual health contract for services to young people which includes targeting those who are excluded from school. We intend to expand this work where possible in the new strategy. Furthermore we also plan to commission new nursing services in FE colleges.

- **Health Centres play a key role and should be consistent in providing contraception and sexual health services for young people.**

Agree. All GPs have a role to provide contraception for all women and this is part of our commissioning strategy. Providing young people with high quality, appropriate advice on sexual health and contraception remains a vital part of the teenage pregnancy strategy. We intend to introduce the You're Welcome standard to Oxfordshire. This standard measures how welcoming and accessible a service is for young people. It is judged by both professionals and young people.

- **The delivery of good quality sex and relationship education should be consistent throughout Oxfordshire schools.**

Agree. We have invested in improved sex and relationships education (SRE) across the county in three ways and we intend to continue this investment. We have created an SRE specialist teacher post who delivers lessons, teaches small groups of vulnerable young people and advises schools in the areas with the highest teenage pregnancy rates. We have invested in a theatre based education programme across the county which addresses alcohol abuse and sexual health and is extremely popular with pupils. Finally we are also delivering the Personal, Health, Social and Economic (PSHE) education teachers' Continuing Professional Development (CPD) training course. In the new teenage pregnancy strategy we aim to continue to roll this out across the county and to secure training for staff in Pupil Referral Units and teenage pregnancy target schools.

- **Leadership should be embedded at the area level through securing Senior Teenage Pregnancy Champions on the area trust boards and the item of Teenage Conception should be a recurring agenda item on partnership agendas.**

Agree. In the new teenage pregnancy strategy we intend to form a task and finish group that achieves specific outcomes, this will include appointing teenage pregnancy Champions on each Area Trust Board. We would welcome the Scrutiny Joint Working Group's influence and drive to achieve this aim.

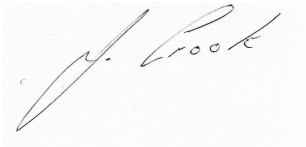
- **Information sharing between districts and the county should be better joined up, especially for data on young people and young parents who are homeless or in supported housing.**

Agree. The Local Strategic Partnership is currently working on a data sharing agreement and we have appointed a senior lead for teenage pregnancy data as part of our self assessment. We will make high quality data collection and performance monitoring a priority for the new teenage pregnancy strategy.

- **The strategy should include an information provision for young people on contraception sex health services (including hours and services available), emergency hormonal contraception, and other sources of information such as** www.spired.com**.**

Agree. Currently information is available on spired.com, the Young People's Survival Guide, via support professionals and in occasional campaigns. The new strategy will establish a teenage pregnancy communications plan and make sure young people get clear messages about their health and where to get help.

Yours sincerely,



Jonathan McWilliam — Director for Public Health

Jim Crook — Interim Director for Children Young People and Families

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