Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 24 June 2021 at 10.00 am
County Hall, New Road, Oxford OX1 1ND

Please note that Council meetings are currently taking place in-person (not virtually) with social distancing at the venue. Meetings will continue to be live-streamed and those who wish to view them are strongly encouraged to do so online to minimise the risk of Covid-19 infection.

If you wish to view proceedings, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Places at the meetings are very limited due to the requirements of social distancing. If you still wish to attend this meeting in person, you must contact the Committee Officer by 9am four working days before the meeting and they will advise if you can be accommodated at this meeting and of the detailed Covid-19 safety requirements for all attendees.

Please note that in line with current government guidance *all* attendees are strongly encouraged to take a lateral flow test in advance of the meeting.

Membership

Councillors:	Nigel Champken-Woods	Jane Hanna OBE	Freddie van Mierlo
	I.U. Edosomwan	Charlie Hicks	
	Arash Fatemian	Dr Nathan Ley	
District Councillors:	Paul Barrow	John Donaldson	David Turner
	Jill Bull	Amar Latif	
Co-optees:	Jean Bradlow	Dr Alan Cohen	Barbara Shaw

Notes: ***Date of next meeting:*** *23 September 2021*

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:		
Policy & Performance Officer	-	*Steven Fairhurst-Jones Tel: 07879 063934* *Email: steven.fairhurstjones@oxfordshire.gov.uk*
Committee Officer	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *Email: colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

June 2021

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Election of Chair for the Council Year 2021-22

2. Election of Deputy Chair for the Council Year 2021-22

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 22 April 2021 (**JHO3a**) and to receive information arising from them.

For ease of reference when considering the Matters Arising from the minutes, a list of actions is attached at the end of the minutes (**JHO3b**).

6. Speaking to or Petitioning the Committee

Currently council meetings are taking place in-person (not virtually) with social distancing operating in the venues. However, members of the public who wish to speak at this meeting can attend the meeting 'virtually' through an online connection. Places at the meeting are very limited due to the requirements of social distancing. While you can ask to attend the meeting in person, you are strongly encouraged to attend 'virtually' to minimise the risk of Covid-19 infection.

Please also note that in line with current government guidance all attendees are strongly encouraged to take a lateral flow test in advance of the meeting.

*Normally requests to speak at this public meeting are required by 9 am on the day preceding the published date of the meeting. However, during the current situation and to facilitate these new arrangements we are asking that requests to speak are submitted by no later than 9am four working days before the meeting i.e**. 9 am on Friday 18 June 2021**. Requests to speak should be sent to **colm.ocaomhanaigh@oxfordshire.gov.uk** . You will be contacted by the officer regarding the arrangements for speaking.*

If you ask to attend in person, the officer will also advise you regarding Covid-19 safety at the meeting. If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9 am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

7. Forward Plan (Pages 19 - 24)

10:20

The Committee's Forward Plan (**JHO7**) is attached for consideration.

8. System-wide update on Covid-19 (To Follow)

10:25

A presentation to update on the key issues for the Oxfordshire system on the COVID-19 pandemic.

9. Oxfordshire Clinical Commissioning Group Update (Pages 25 - 30)

11:40

The paper (**JHO9**) aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

1. Specialist in-patient palliative care and Henley RACU
2. ICS development and new ways of working
3. OCCG Annual Report
4. Thank you to volunteers
5. Botley Health Centre

Comfort Break

11:55

10. GP workloads (Pages 31 - 34)

12:00

The paper (**JHO10**) aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

1. General Practice workloads and appointment data
2. The delivery of services through the pandemic and vaccination programme

11. Future of Adult Palliative Care in Oxfordshire (Pages 35 - 42)

12:30

A presentation to update the Committee.

LUNCH
13:00

12. Community Services Strategy (Pages 43 - 64)

13:30

A presentation from Dr James Kent and Dr Nick Broughton.

13. Oxford University Hospitals Quality Report (Pages 65 - 80)

14:15

A presentation by Professor Meghana Pandit, Chief Medical Officer.

14. Oxford Health Quality report (Pages 81 - 136)

14:30

Annual Quality Account 2020-21 from Oxford Health NHS Foundation Trust.

15. Healthwatch Report (Pages 137 - 148)

14:45

Healthwatch Oxfordshire will report on the views gathered on health care in Oxfordshire.

16. Oxfordshire Adult Eating Disorder Service (Pages 149 - 160)

15:00

A briefing from Oxford Health NHS FT

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 22 April 2021 commencing at 10.00 am and finishing at 2.20 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	Councillor Kevin Bulmer Councillor Mark Cherry Councillor Mike Fox-Davies Councillor Susanna Pressel District Councillor Paul Barrow District Councillor Jill Bull District Councillor Phil Chapman District Councillor Jo Robb Councillor Jane Hanna OBE (In place of Councillor Alison Rooke)
Co-opted Members:	Jean Bradlow Dr Alan Cohen Barbara Shaw
Officers:	
Whole of meeting	Ansaf Azhar, Director for Public Health; Steven Fairhurst Jones, Senior Policy Officer; Colm Ó Caomhánaigh, Committee Officer

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

13/21 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Alison Rooke (Councillor Jane Hanna substituting) and City Councillor Nadine Bely-Summers.

14/21 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

The following declarations of interest were noted:
Dr Alan Cohen is a Trustee of Oxfordshire Mind

Jean Bradlow's husband is a consultant rheumatologist at the Royal Berkshire NHS Hospitals Trust.
Councillor Mark Cherry is registered with the Windrush Surgery.

15/21 MINUTES
(Agenda No. 3)

The minutes of the meetings on 4 February 2021 and 12 March 2021 were approved.

16/21 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

The Chairman had accepted the following requests to speak:

Item 8 Community Services Strategy
Julie Mabberley
Bill Falkenau
Cllr Jenny Hannaby

Item 9 OX12 Task and Finish Group Report
Julie Mabberley
Cllr Jenny Hannaby

It was agreed to take Item 9 before Item 8.

17/21 FORWARD PLAN
(Agenda No. 5)

The Forward Plan was agreed.

18/21 SYSTEM-WIDE UPDATE ON COVID-19
(Agenda No. 6)

The Committee received a presentation on the system-wide response to the COVID-19 pandemic. Ansaf Azhar, Director for Public Health, presented slides on the latest data which demonstrated a continuing drop in the number of new cases. This he attributed to a combination of the vaccination programme, widespread testing, lockdown, social distancing and COVID-secure regulations.

The numbers in hospital from COVID had come down dramatically but there was still pressure on hospitals due to the long waiting lists that had built up for non-COVID issues. The system was ready to respond if there should be another surge.

Ansaf Azhar responded to questions as follows:

- Workplaces were the most common sources of new cases but numbers were low. The return to school was well managed and there was only a small effect.
- There was currently no intervention available that was guaranteed to achieve zero-COVID and the costs to people's general wellbeing and the economy in trying to achieve that would be significant.

- There was no measurement to document how many people were suffering from Long-COVID. It was being studied closely but we were still learning about it. Maintaining a healthy lifestyle was still the best way of recovering from COVID.
- The number of new cases was back to where it was last summer but it never got down to zero then. There were new more transmissible variants around this time and it was important that people continued to following guidelines and carry out the regular testing being offered.
- The data was available on whether those who tested positive had been vaccinated but he couldn't comment on specific cases. The vaccine did not completely prevent infection but it would ensure that, if infected, the need for hospitalisation would be avoided.
- In terms of excess deaths – which was a useful way to compare different regions – Oxfordshire was comparable to the national average in the first wave and below average in the second.

It was agreed to provide statistics comparing Oxfordshire to other counties that Public Health England group with us as similar counties.

Testing

Ansaf Azhar presented data on testing showing that the numbers of PCR tests were dropping as fewer people were presenting with symptoms. There were now more sites open for LFD asymptomatic testing and kits could be collected from centres, including around 100 pharmacies. The number of positive tests was very small but it was still important to detect them to stop the spread.

Ansaf Azhar responded to questions on testing:

- The purpose of asymptomatic testing was to detect positive cases rather than give assurance from a negative result. The figures showed that LFD tests, although less reliable, had detected 70 cases in Oxfordshire in one week.
- Up to April 9 asymptomatic testing was focussed on the workplace but from that date the general public were encouraged to get tested twice a week. He noted the feedback that this message was not widely understood and would look at new ways of communicating it.
- Asked about people being reluctant to take the LFD test from a fear that they might lose their job by taking time off work to self-isolate – especially when this test was known to produce some false positives, he responded that those who tested positive could get a more reliable PCR test very quickly now. Support payments were available to people who had to self-isolate.
- The Pharmacy Collect system had only been put in place for a week or two and it was expected that the number of pharmacies participating would grow.
- Mask wearing will need to be continued in schools and in general. The advice was still to get a PCR if showing symptoms. Testing kits are available from all testing centres. He would take on board the comments about confusing signage at the Shippon test centre.

Vaccination

Jo Cogswell, Director of Transformation, Oxfordshire Clinical Commissioning Group, gave an update on the vaccination programme. This had progressed very well thanks to the strong partnership across the system. The top nine cohorts had been offered vaccination by April. The focus was now on second vaccinations but in the

last week over 45s had been offered first doses. Three pharmacies were now operating as vaccination centres with five more soon to come online. These have been targeted for market towns.

Tehmeena Ajmal, COVID Operations Director, Oxford Health NHS FT, described the work being undertaken to reach the 30,000 or so people in the nine cohorts who had not yet been vaccinated. Pop-up clinics were being held in churches and mosques for example and sprinter vans were being acquired to service more rural areas. Three different vaccines were available so that there were alternatives for those people, such as under 30s, who were not being offered the AstraZeneca vaccine. Work was continuing to ensure that those who might not be registered with a GP get a vaccine, including people who are homeless.

The Chairman thanked all those working in the system for their work in ensuring that all people, all ethnicities were able to access the vaccine. Officers responded to questions about the vaccination programme:

- Not all GP practices took up the offer to be part of the vaccination programme but where they did not, other practices in their Primary Care Network covered for them. Some practices will stop vaccinations after cohorts 1 to 9 and other centres will service cohorts 10 to 12. The BOB-ICS which organised the vaccination programme across Thames Valley was conscious of travel difficulties in certain areas and the roll-out of new centres in pharmacies will give much wider coverage across the county's towns.
- It was acknowledged that there was an issue in relation to GP centres with people getting short notice of their second dose. This was due to supply problems. The mass-centres had regular delivery dates but this was not the case with GP centres. Everyone should receive an invitation in the eleventh week after their first dose and should be offered the nearest available centre. While 12 weeks was the recommended interval, anything up to 16 weeks still gave the required protection.
- The vaccine supply was generally known about three or four weeks ahead and there was enough to meet the needs of the cohorts currently open.

Health and Social Care

Sara Randall, Chief Operating Officer, Oxford University Hospitals, described the longer waiting lists across out-patients, diagnostic and treatment phases, with just over 5,000 patients waiting more than 52 weeks.

Patients were reviewed by clinicians including a psycho-social assessment. One case of major harm had been identified and one of moderate harm. Cancer patients were reviewed when waiting over 104 days and prioritised on urgency. Some patients chose to delay – for COVID and other reasons – but they remained on the waiting list.

Diane Hedges, Deputy Chief Executive, OCCG, stated that three services were still closed to referral – Ear, Nose and Throat; Maxillofacial and Ophthalmology. GPs could escalate cases and patients were being given options to travel to other areas for treatment. A redesign of Ophthalmology was being examined to increase the staffing capacity.

It was agreed to come back to the next meeting with the plans for recovery based on the planning guidance that had just been published. It was also agreed to circulate to the Committee data on the numbers who contracted COVID in hospital in comparison to other counties.

Officers responded to further questions as follows:

- A staff wellbeing programme 'Growing Stronger' provided support to individuals and teams. Vacancy and turn-over rates had dropped in recent months. A lot of research funding which had been lost during the pandemic was coming back online.
- Deaths in the community within 30 days of testing positive were all being notified and it will be possible to give more detail on that at the next meeting.
- In ENT they were subcontracting in consultants, as well as referring out of county. A group had been formed to work on reducing waiting lists. Patients who did not turn up were been contacted. It was agreed to provide data on audiology referrals which were not included in the ENT waiting list figures.

The Chairman thanked all officers across the system for a very useful update.

19/21 OXFORDSHIRE CLINICAL COMMISSIONING GROUP UPDATE

(Agenda No. 7)

This had been a regular item on the Committee's agenda but had been suspended while focus was on the pandemic. The Committee had before it an update which included the transfer of services provided by Oxfed and the re-procurement of the MSK (Musculoskeletal) services. It was agreed to take the report as read and invite questions.

Jean Bradlow noted that while individual professionals in MSK services were doing very good work, communications between different aspects of the service were poor – especially across county boundaries. Since the commissioning of the new services was over a year away, she asked that this issue be addressed urgently.

Diane Hedges, Deputy Chief Executive, OCCG, accepted that there had previously been problems which had been discussed in the HOSC and had mainly been addressed but was not aware of any specific cross-boundary issues and asked for more information on that to be sent to her. She added that one of the aims of the re-procurement was to put in place a more integrated service. She accepted an offer from Dr Alan Cohen to go through the learnings of the prior Task and Finish Group and how these related to the new procurement.

20/21 OX12 TASK AND FINISH GROUP REPORT

(Agenda No. 9)

Before considering the report and the response from the Oxfordshire Clinical Commissioning Group, the Committee heard from the two following speakers.

Julie Mabberley, Chairman of the OX12 Stakeholder Reference Group, welcomed the final report but expressed disappointment that the Task and Finish Group had not

met with the Stakeholder Reference Group since May 2019 and made no comment on the detailed project evaluation submitted by the Group.

She endorsed the final conclusion of the report that the OX12 project failed because of the poor management of the project, together with a poor level of engagement and communication with the residents of the OX12 postcode.

She believed that Wantage Community Hospital used to provide very good rehabilitation for patients and that these facilities were still required. Furthermore, the former Day Care Centre could provide supplementary services for those patients able to return home.

Julie Mabberley called on the Committee to ensure that OX12's health and care needs were provided locally and effectively using all local health and care facilities including the Hospital, the Health Centre and the Day Care Centre going forward.

Councillor Jenny Hannaby supported the comments from the previous speaker and thanked the members of the Task and Finish Group and support officers for their work and thanked the Committee for its support over the years. Wantage Town Council's Health Committee had again called for the re-opening of the beds at the community hospital by whatever means it takes. They believed that the hospital was much valued by residents for the professional care it gave for rehabilitation, enablement and end-of-life care.

The Committee considered the final report of the OX12 Task and Finish Group and its recommendations. District Councillor Paul Barrow, Chair of the Group, summarised the report. He stated that it had been sent to OCCG in January with a request to respond by the end of March. They had instead sought to cover the OX12 issue under the broader Community Services Strategy but that paper was only circulated two days before this meeting.

The Task and Finish Group had thought that the needs assessment framework was essentially a good idea. However, they believed that the way in which it was carried out was wholly inadequate as outlined in the report. In their view such a framework should only be repeated once the criticisms of the Task and Finish Group have been taken on board.

Councillor Barrow asked the Committee to support the recommendations in the report and that the Committee's previous call to reopen beds in Wantage Community Hospital be acted upon now.

Diane Hedges, Deputy Chief Executive, OCCG, responded that everyone was agreed that they needed to work towards achieving the highest possible footfall for Wantage Hospital but that there was disagreement on the best range of services to achieve this. She was disappointed to hear the views of the Task and Finish Group that the framework had not worked.

Diane Hedges noted that the Joint Strategic Needs Assessment had identified that there was not enough reablement available to get people home from hospital. The evidence was clear that long stays in bed were harmful for patients in terms of

muscle wastage and there was a need for services to be reshaped to reduce the need for hospital beds and get people into their own home.

Diane Hedges concluded saying that they needed to focus on the Community Services Strategy where all of the partners were working closely together. She recognised the need to describe how it would be evaluated and resourced. They had also included a second paper on how the strategy would relate to the issues around OX12.

The Chairman expressed disappointment that OCCG had not responded to the OX12 report within the eight weeks they were given and that the response when it came was only two paragraphs. He was further unhappy that the Community Services Strategy paper was only made available two days before this meeting. He did not feel that this was in line with the “no surprises” approach that partners had agreed on. The Chairman asked if OCCG had any objections to the points outlined under recommendations 2 and 3.

Diane Hedges responded that she had brought many of the points relating to running an effective programme into the Community Services Strategy. Noting that Councillor Barrow had additionally asked that the beds be re-opened, she stated that they could not do that but that they would examine the issue of beds across the county.

The Chairman noted that the recommendations from the report had been proposed by Councillor Barrow. Councillor Mike Fox-Davies seconded the proposal.

The Chairman added that he wanted to take the beds issue under the next item. He thanked the councillors and officers who had worked on the committee over the course of its work.

RESOLVED:
In respect of the shortcomings of the Population Health Care Needs Assessment Framework and its implementation.

1. **The project plan:**
    a. **Evaluation should be an integral part of the project plan, and a project should not be signed off by the Health and Well-being Board (HWBB) without an evaluation plan in place.**
    b. **A clear project plan should be made available which describes the time required, the workforce needed, the skills and equipment needed, and the costs of such a project**
    c. **The project plan should set out the process for the programme of work, so that it is clear to all those involved**
2. **The Process led by CCG:**
    a. **Innovations Paper: Any review of the innovations and best practice must be detailed and comprehensive.**
    b. **Assets Evidence:**
        i. **A review of workforce issues, and how these might impact on service developments including re-opening in-patient beds, GP and community nursing staff, is needed.**

ii. A review of GP premises for an increasing population is needed.

iii. Greater clarity is required on how the detailed information provided by the population questionnaire will be used to formulate solutions

c. Health Needs Evidence:

i. The link between the JSNA and the local data sources including district planning and housing data should be strengthened.

ii. Information gathering and analysis methods should be reviewed including the use of more sophisticated software for data analysis and future projections.

d. Synthesis:

i. It is recommended that the local framework fits into wider county-wide and national policies on community health and social care (in-patient beds/domiciliary care, etc). This should also include Oxfordshire Health and Wellbeing Strategy, and other place-based documents.

ii. Greater clarity is required on how the three separate sections of the Framework are combined and used to formulate conclusions.

e. One of the major specific issues discussed within the project was the future of Wantage Hospital. We reiterate our earlier recommendation to HOSC that any decision made on the future of in-patient beds should be evidence-based and include the pros and cons of bed closures and of alternative provision and include consideration of Wantage Hospital within the proposed wider county strategy and not be based on the CCG report. We endorse the decision of the County Council (8th December item 15) that a comprehensive plan for OX12 by the system be completed which is acceptable to the local population and forms a significant part of, or acts as a pilot for, the county-wide review of community health service provision.

3. We recommend that HOSC requests that the operation of the scrutiny function be part of a County Council Constitutional Review. We recommend priority to the value of transparency and openness to ensure the public is aware of the challenges faced in scrutiny of the whole system.

21/21 COMMUNITY SERVICES STRATEGY

(Agenda No. 8)

Before receiving the presentation, the Committee heard from the following three speakers:

Julie Mabberley welcomed the document but noted that the timetable and actions looked very similar to those outlined at HOSC in September 2018. She asked if the governance was now in place and if resources had been made available. The Oxfordshire A&E Delivery Board urgent care work, due to be completed by the end of April, needed to be set alongside this to ensure completeness.

She noted that the timetable showed a period of 17 months and hoped that they would not have to wait that long for services to be brought to OX12. She described the role that the community hospital had played before closure in helping patients through the transition from acute hospital to home. In looking forward to the

community involvement in this strategy, she reported that members of the stakeholder group would be happy to be involved.

Bill Falkenau, Clerk of Wantage Town Council, reminded the Committee that he had previously spoken at the Committee meeting in February 2020 and had asked on behalf of Wantage Town and Grove Parish Councils that the OX12 Report be withdrawn and that the beds temporarily closed at Wantage Community Hospital be reopened. The concerns expressed at the time had been fully justified by the report of the Task and Finish Group that was considered under Agenda Item 9.

He believed that the Community Services Strategy paper had merit but appeared to have the effect of kicking the issue of the inpatient beds in Wantage further into the "long grass" for a prolonged period which was unacceptable. The Legionella risk had been dealt with since last September and he believed that there was now no legal justification for the beds to remain closed. He called for the reopening of the beds prior to work on the Community Services Strategy proceeding.

Councillor Jenny Hannaby referred to Page 5 of the presentation in Addenda 2: where it recognised that OX12 residents needed to have confidence in their access to effective rehabilitation whether in hospital or at home. She said that the question was "what hospital?" – Wantage or having to travel across the county?

Councillor Hannaby asked for the evidence that safe services can be provided long-term at home, free at the point of need. She noted that during the pandemic, patients who were not yet well enough to go home were put in a hotel with agency staff when they could have been looked after in Wantage Community Hospital.

Councillor Hannaby asked how much developer funding had been drawn down since OCCG took over primary care commissioning. She believed that there was £1.2m currently held by planners and suggested that some of that could be used to fund the proposed strategy.

Councillor Mike Fox-Davies noted that the strategy appeared to be very similar to one which was presented to a meeting in Didcot in late 2018. He drew attention to Page 6 of the presentation which was headed "Why different this time? Why will it deliver?" This was where he believed the focus needed to be.

Dr Ben Riley, Managing Director of Community Services, Oxford Health, introduced the presentation which outlined the proposed strategy. He acknowledged the length of time that had elapsed since the closure of the inpatient beds at Wantage hospital and reiterated the apology given by his Chief Executive, Dr Nick Broughton. They were committed to proceeding as fast as the pandemic would allow.

The strategy had been supported by the Health and Wellbeing Board at its meeting in March. It had the support of all the Oxfordshire councils as well as the CCG and the hospital trusts.

Stephen Chandler, Corporate Director for Adult and Housing Services, described the evidence available to show the benefits of reducing time spent in hospital beds in favour of more care being delivered in the home. The response to the pandemic had

shown how a strong partnership across the system could change the way health and social care were managed. He agreed with other speakers that the challenge was in delivering this change.

Dr Riley added that work was ongoing in developing an evidence pack which they should be able to share within a couple of weeks. Oxford Health had just published a more detailed Strategic Development Framework on its website. The presentation pack brought in points from the OX12 report – particularly on innovation and workforce planning. There was a dedicated email address available to start taking feedback as part of a wider engagement.

Dr Riley had met twice with the Wantage Town Council Health Committee and assured them that the needs of the population would be at the forefront. He gave an example of a pilot for urgent community nursing and therapy services in the Wantage area. Data from that will inform the strategy going forward.

Another pilot in mental health services was aimed to start in October and they were developing plans with Oxford University Hospitals to provide consultant outpatient clinics at Wantage Hospital. It was not a case of waiting 17 months before putting services into the hospital.

Diane Hedges, Deputy Chief Executive, Oxfordshire Clinical Commissioning Group, addressed the timetable for development and implementation. Extra capacity had already been created through stronger partnership working. The commitment was there to provide the resources. If at the end of the whole process it was decided that the inpatient beds at Wantage were not part of the plan that would be a consultation issue.

At the June Health and Wellbeing Board it will be outlined how the project deliverables will be arrived at and the way in which people can engage. The points made by the Task and Finish Group about evaluation will be taken on board and this can come back to the next HOSC meeting if that is desired.

The table on Page 8 listed programme actions but most of these could only be progressed when the country gets to COVID Level 2. Changes that require a consultation process will be identified but that will not stop progress in other areas. Diane Hedges concluded by agreeing with the Task and Finish Group that there was a need to have the difficult conversations about the options.

Councillor Jane Hanna stated that there had yet to be a proper discussion on Wantage Hospital. Other smaller towns had inpatient beds. COVID had changed the situation and there was a need to see the data around that. She also asked if the extension to the GP practice was going to be built this year.

Diane Hedges responded that the crux of the debate was around whether it was better to be local or to receive specialised services. She agreed to share the evaluation approach with members of the Committee before the next meeting.

Barbara Shaw expressed concern that services around sight and hearing loss were particularly affected by COVID and these had an impact on isolation especially for

older people. Diane Hedges responded that GPs can refer to audiology for hearing aids but, in regard to ear wax removal, people were being asked to self-care. She agreed the connection was an important one to make in regard to isolation.

Dr Alan Cohen welcomed the pilot projects but asked that their criteria for success be outlined so that they can be evaluated properly. He also noted that the next update on the strategy was going to the Health and Wellbeing Board for agreement before HOSC will see it so they would have no opportunity to scrutinise it.

Dr Riley responded that they were working with NHS benchmarking on this and that defining the criteria up front was part of the plan. Diane Hedges added that down the line detailed criteria will be needed on how to decide between options of the beds and these criteria would be developed in an engaged way as had been done for maternity.

The Chairman cited an example where the Committee previously agreed with a proposal to move stroke services from the Horton Hospital in Banbury to the JR in Oxford, accepting the argument in that case that it was more important to be safe than local.

The Chairman asked for a weekly update on developments and anything published on the strategy, as the Committee already receives from OUH and the Horton Hospital.

He read from the minutes of a Committee meeting held in Didcot in November 2018 at which very similar proposals were put to those presented today. He said that this process would have to be scrutinised closely to ensure that progress was made this time.

The Chairman asked that the next stage of the strategy be circulated to members of the Committee in good time for them to give feedback that will be presented to the Health and Wellbeing Board.

The Chairman also stated that the issue will be discussed offline as to whether it was best for the full Committee to monitor progress or have a Task and Finish Group in order to avoid the timing of Committee meetings causing any delays to the process, with a proposal to be brought to the June meeting.

The Chairman proposed the following:

- That Dr James Kent, Chief Executive, OCCG, come to the June Committee meeting to discuss if the timeline can be shortened to something more similar to that for Horton which took 12 months.
- That fail-safes be discussed to deal with any delays in the strategy – particularly any that affect Wantage.
- That Drs Broughton and Riley of Oxford Health address the issue that keeping the inpatient beds in Wantage Community Hospital closed for so long was essentially predetermining their future.

The proposals were seconded by District Councillor Paul Barrow and were agreed.

22/21 HEALTHWATCH REPORT

(Agenda No. 10)

The Committee had received its regular report from Healthwatch Oxfordshire on the views of the public on health and social care services. Rosalind Pearce added some comments on the issues that had arisen at this meeting:

- Agreed that the message on regular COVID testing had not been widely received and was happy to work with the Director for Public Health on that.
- Agreed that the plans to deal with treatment waiting lists need to be seen.
- While patients may be given the option to go out of county for treatment, there may barriers to that. It would be helpful if there was support with travel costs and if they could be assured that the next appointment will be local.
- They are still receiving some negative feedback on MSK services and will look for patient involvement in the commissioning of the new service.
- With regard to the 17 month timeframe for the Community Services Strategy, she noted that the move to one CCG over the BOB area (Bucks, Oxon, Berkshire West) was due in April 2022 and the Committee should seek assurances that decisions on the strategy will still be taken locally.
- A recent Healthwatch report identified that some GPs' websites were asking for proof of identity in order to register which was clearly not allowed under the NHS guidance.

Rosalind Pearce responded to members' questions as follows:

- She stated that she was happy to send all Healthwatch Oxfordshire reports to the Committee Secretary for circulation to members.
- They had not yet done work on experiences of self-isolating. She believed that the issue of digital exclusion would be important in that, given how health services are asking patients to go online more.
- She agreed to do some work to identify which GP practices have no Patient Participation Group (PPG) or an inactive PPG and then consider how to support these cases. Existing and active PPGs are supported with advice and webinars.
- Healthwatch England was participating in a working group on the government's coming White Paper on Integrated Care Systems. She believed that there was a commitment to local engagement in the BOB region but the challenge would be in the integration part of their work.

The Chairman and members of the Committee thanked Rosalind Pearce for the report.

23/21 CHAIRMAN'S REPORT

(Agenda No. 11)

The Committee considered the Chairman's Report on developments and communications since the last Committee meeting.

Barbara Shaw noted that the commissioning of the MSK service, which will operate across the BOB (Bucks, Oxon, Berkshire West) region, will be an in interesting test on how processes will work at that level and what input this Committee will have.

The Chairman thanked members for their work over the previous four years. In particular, he wished Councillor Mike Fox-Davies well, as he was the only elected member of the Committee not seeking re-election.

..... in the Chair

Date of signing .....

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HOSC Actions from 22 April 2021

Item	Action	Lead	Progress update
Forward Plan	a) The draft 24 June agenda published within the Forward Plan will form the basis of papers commissioned for that meeting	Steven Fairhurst Jones to commission 24 June papers as set out on the draft agenda	Complete
COVID-19	a) For excess death figures, Oxfordshire was comparable to the national average in the first COVID-19 wave and below average in the second. It was agreed to provide members with excess death statistics comparing Oxfordshire to other similar counties that Public Health England group us with.	a) Ansaf Azhar / Diane Hedges	In progress
	b) In the context of longer waiting lists than usual (across outpatients, diagnostic and treatment phases) and certain services remaining closed to referrals (Ear, Nose and Throat; Maxillofacial and Ophthalmology), it was agreed that the 24 June meeting's COVID-19 update would include plans for recovery based on the planning guidance that had just been published.	b) Diane Hedges	Plans to be included in the 24 June COVID-19 update for HOSC (due for publication on 14 June)
	c) It was also agreed to provide members with data on the numbers who contracted COVID in hospital in comparison to other counties.	c) Diane Hedges	In progress
	d) It was agreed to provide data on audiology referrals which were not included in the ENT waiting list figures presented on 22 April.	d) Diane Hedges	In progress

Item	Action	Lead	Progress update
CCG update	a) HOSC member Jean Bradlow noted the good work being done in MSK services but suggested communications between different aspects of the service were poor, especially across county boundaries. Diane Hedges (CCG) asked that any information on cross-boundary MSK communications issues be sent to her. b) Diane Hedges (CCG) accepted an offer from HOSC member Dr Alan Cohen to discuss the recommendations of the Task and Finish Group with regard to MSK services.	a) Jean Bradlow b) Steven Fairhurst Jones to put Diane and Alan in contact	Complete Complete
OX12 report	a) With regard to recommendation 3 of the paper, that the scrutiny function should be included in a constitutional review by OCC, OCC will consider the committee's resolution in setting the scope of its Constitutional Review.	a) OCC Monitoring Officer, Anita Bradley	In progress
Community Services Strategy	a) Councillor Hannaby asked how much developer funding had been drawn down since OCCG took over primary care commissioning. b) Cllr Hanna asked if the extension to the GP practice in Wantage was going to be built this year c) Diane Hedges noted the debate around whether it was better for patients to be treated locally or to receive specialised services wherever that might be. She agreed to share the evaluation data with members before the next meeting.	a) Diane Hedges b) Diane Hedges c) Diane Hedges	In progress In progress In progress

Item	Action	Lead	Progress update
	d) The Chairman asked for a weekly update on developments and anything CCG might publish on the strategy, such as the Committee already receives from OUH and the Horton Hospital.	d) Diane Hedges / Ben Riley	In progress
	e) The Chairman asked that the next stage of the strategy be circulated to members in good time for them to give feedback that will be presented to the Health and Wellbeing Board.	e) Diane Hedges / Ben Riley	In progress
	f) The Committee agreed that Dr James Kent, Chief Executive, OCCG, should come to the 24 June Committee meeting to discuss if the Community Services timeline can be shortened	f) OCC to invite Dr Kent	Complete
	g) That the 24 June meeting can discuss CCG's fail-safes which might deal with any delays in the strategy's progress, particularly any that affect Wantage	g) Diane Hedges / Ben Riley	In progress
	h) That Drs Broughton and Riley of Oxford Health address the issue that keeping the inpatient beds in Wantage Community Hospital closed for so long was essentially predetermining their future	h) Ben Riley	

Item	Action	Lead	Progress update
Heathwatch Oxfordshire report	a) Rosalind Pearce agreed to send all Healthwatch Oxfordshire reports to the Committee Secretary for circulation to members	a) Rosalind Pearce	In progress
	b) Rosalind Pearce agreed to try to identify which GP practices have no Patient Participation Group (PPG) or an inactive PPG and then consider how to support these cases.	b) Rosalind Pearce	In progress

HOSC Forward Plan – June 2021

The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The "PICK" methodology can help scrutiny committees consider which topics to select or reject. This is:

Public interest	➢ Is the topic of concern to the public? ➢ Is this a "high profile" topic for specific local communities? ➢ Is there or has there been a high level of user dissatisfaction with the service or bad press? ➢ Has the topic has been identified by members/officers as a key issue?
Impact	➢ Will scrutiny lead to improvements for the people of Oxfordshire? ➢ Will scrutiny lead to increased value for money? ➢ Could this make a big difference to the way services are delivered or resource used?
Council performance	➢ Does the topic support the achievement of corporate priorities? ➢ Are the Council and/or other organisations not performing well in this area? ➢ Do we understand why our performance is poor compared to others? ➢ Are we performing well, but spending too much resource on this?
Keep in context	➢ Has new government guidance or legislation been released that will require a significant change to services? ➢ Has the issue been raised by the external auditor/ regulator? ➢ Are any inspections planned in the near future?

The following items were agreed for the Forward Plan by HOSC members at Committee meetings up to and including 22 April. HOSC members wishing to raise additional items for consideration for the forward plan should notify the committee's Policy Officer in the first instance: steven.fairhurstjones@oxfordshire.gov.uk being clear about the scope of the subject and the intended purpose or outcome of HOSC's consideration of the matter.

All forward plan items and proposals will then be considered by the HOSC Chair and Vice-Chair in July with a view to prioritising items for September's agenda and producing a new Forward Plan for the Committee to formally agree at its meeting in September.

Last updated: 9 June 2021

Meeting Date	Item Title	Details and Purpose	Organisation
All meetings	Minutes, declarations of interest, speakers	Standing items	OCC
All meetings	COVID-19 update	Standing item for information and discussion	System partners
All meetings	OCCG update	Standing item for information and discussion	OCCG
All meetings	Healthwatch report	Standing item for information and discussion	Healthwatch Oxfordshire
September	BOB HOSC	Paper on preparations for the establishment and operation of the new Buckinghamshire, Oxfordshire and Berkshire West (BOB) HOSC	OCC
September	Director of Public Health Report	The annual report of OCC's Director of Public Health	OCC DPH
September	Health and Wellbeing Board Annual Report	An annual report to HOSC on the activity of the HWB, covering: • Activity of the Board over the financial year 2020-21 in pursuit of the Health and Wellbeing Strategy • Performance against aims and objectives during that period, including an overview of performance for all the sub-partnerships of the Board (e.g. HIB/Children's Trust & Integrated Systems Delivery Board). Plans for 2021/22.	HWBB
To be confirmed	"The First Thirty Days"	• Discussion of COVID-19 infection in care homes in Oxfordshire	Cllr Paul Barrow & OCC

Last updated: 9 June 2021

Meeting Date	Item Title	Details and Purpose	Organisation
To be confirmed	PET Scanning	• This item will provide follow-up information following the change of provider of PET scanning services for patients outside of Oxfordshire (but within the Thames Valley region). This item will report to the committee on the clinical pathways followed as a result of the change, the numbers of patients and patient flows. • It will also include any information on serious incidents which are reported.	
To be confirmed	Musculosketal services	• Oxfordshire CCG to prepare a paper to present an update on MSK services, how they have developed and where they are going, and how the recommendations of the HOSC Task & Finish Group on the subject have been followed.	Oxfordshire CCG
To be confirmed	Adult Social Care Green Paper	• The potential implications of the ASC Green paper on the local health and social care system	System-wide
To be confirmed	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns. • Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure
To be confirmed	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place since April 2017	NHS England

Last updated: 9 June 2021

Meeting Date	Item Title	Details and Purpose	Organisation
To be confirmed	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities	
To be confirmed	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell) • How District Councils and other partners link with and support social prescribing	
To be confirmed	Health support for children and young people with SEND	• How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care? • Linked to outcomes of SEND Local Area Inspection	OH, OUH
To be confirmed	Priorities in Health – Lavender Statements	• How the CCG manages competing priorities – Thames Valley Priorities Forum	CCG
To be confirmed	Commissioning intentions	• Committee scrutinises the CCG Commissioning Intentions	CCG
To be confirmed	Optometry	• Provision of optometry in Oxfordshire. • Trends and issues in the provision of optometry services. • How best practice and innovation from elsewhere are used within the services in the county. • To include a summary of the pathway and waiting times for NHS cataract surgery.	CCG

Meeting Date	Item Title	Details and Purpose	Organisation
To be confirmed – 2022-23	BOB HOSC review	To review the BOB HOSC 12 months after its establishment, as agreed at 12 March 2021 OJHOSC. Scope to include review of: • BOB HOSCs establishment and operation • The ToR • The toolkit • BOB HOSC's scrutiny activity to date	OCC

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 24 June 2021

Title of Paper: Oxfordshire Clinical Commissioning Group: Key & Current Issues

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

1. Specialist in-patient palliative care and Henley RACU
2. ICS development and new ways of working
3. OCCG Annual Report
4. Thank you to volunteers
5. Botley Health Centre

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. Specialist in-patient palliative care and Henley Rapid Access Care Unit

Following the closure, by Sue Ryder, of its palliative care inpatient unit in Nettlebed in March 2020, Oxfordshire Clinical Commissioning Group (OCCG) has been working closely with the charity to increase the number of South Oxfordshire residents being supported at home for their palliative care: currently there are approximately 20 people being supported by this service at any one time.

The Hospice at Home service is highly valued by patients and their families. However, in some exceptional cases, a very small number of people at end of life with complex care needs are better served by inpatient palliative care. Since March 2020 these South Oxfordshire patients have been admitted to the Sue Ryder Duchess of Kent Hospice in Reading or Michael Sobell House in Oxford.

Accessing beds in Duchess of Kent Reading will require significant further investment into the service provision in Berkshire, while the local community, councillors and GPs in South Oxfordshire feel travelling to Oxford city or Reading is not a suitable alternative in the long term. As such OCCG has been exploring options for providing inpatient palliative care beds closer to home. A south Oxfordshire based integrated solution with the Oxford Health NHS Foundation Trust (Oxford Health) and Sue Ryder is proposed.

OCCG is proposing to transfer funds that are tied up in beds that are not being used as they were commissioned as a back-up to the Rapid Access Care Unit capacity (RACU). Clinicians have consistently found they do not need them. We would use these funds to commission two supported palliative care beds at Wallingford Community Hospital from Oxford Health. These would be delivered in close collaboration with the Sue Ryder Hospice at Home service.

Four beds are currently commissioned in a care home adjacent to Townlands Hospital, Henley, to be available for Townlands RACU patients; the use of these beds has been very low since they were opened. Most people seen at the RACU have been ambulatory patients, with just 86 out of 2,900 commissioned beds days being used in 2018/19 and 2019/20.

Local GPs have confirmed that the decommissioning of these beds would have no adverse effects on patient care. In clinically appropriate circumstances, RACU

patients could be admitted to Didcot or Wallingford community hospitals if required; therefore, care home beds at the RACU are not needed as contingency.

Closing the RACU beds at Chilterns Court would save OCCG £293k per annum. There is a clear argument for a better use of public money and NHS resources in the south of the county to meet a known local need.

The changes in phase 1: two existing side room beds at Wallingford Community Hospital will be used as the palliative beds. In phase 2, adjustments to the building are recommended to convert an unused four-bed bay to create two palliative beds to improve the patient experience.

OCCG has met with Henley town councillors (one is chair of the Townlands Steering Group - TSG) to outline these proposals, which were broadly supported.

A further public meeting for the local community was agreed to gauge broader public support. This meeting will be virtual and will take place later in June (Wednesday 30 June). It is being hosted by the TSG and will be chaired by Healthwatch Oxfordshire. Presentations will be provided from OCCG and Oxford Health.

The HOSC toolkit is being completed in relation to this change and will be submitted to HOSC following the public meeting so the feedback from the community is appropriately captured.

It is notable this change is proposed while we are developing the Community Strategy; this countywide work will give us a steer for overall bed provision for Oxfordshire. The argument for advancing this change is to address a current service gap; the change could be reversed, and we will otherwise continue to waste public money. We are intending to garner local community support for this change. The changes could be revisited so, in particular, we will ensure the Community Strategy informs if the building work at Wallingford should start in year 2. This could be one of the pilots we wish to test as we develop the strategy.

It is recommended that we move to enact this model after a proportionate process of engagement, completing the HOSC Toolkit to demonstrate results of engagement and therein confirmation this does not constitute a substantial change.

2. Integrated Care System (ICS) development and new ways of working

Following publication of the White Paper, Oxfordshire CCG is working with Buckinghamshire CCG and Berkshire West CCG in developing the plans to manage the closedown of the CCGs and the safe handover of functions to the new ICS NHS Body. Further guidance is expected from NHS England soon.

Communications and engagement will be a key enabling workstream and an early priority is to develop an engagement plan for transition and ensure that we have opportunities for our partners, patients and the public to be involved as we move forward.

The membership of Oxfordshire CCG Governing Body Membership is also changing.

Dr Kiren Collison has been appointed to the post of Deputy Medical Director role at NHS England and she chaired her last Governing Body meeting as Clinical Chair for Oxfordshire CCG. The process for appointing a new Clinical Chair for the CCG is underway with any Oxfordshire GP eligible to apply for the role. Once the results of the ballot are known, the Oxfordshire Governing Body members will be asked to ratify the appointment.

As has been highlighted at previous meetings, both Buckinghamshire and Oxfordshire CCGs have a vacancy for the Lay Member lead for Patient and Public involvement (PPI). Given this year is one of transition the CCGs have agreed to have shared posts wherever this makes sense. Wendy Bower, Lay Member lead for PPI Berkshire West CCG, has agreed to cover this role for all three CCGs. Wendy will be appointed as a member of all three Governing Bodies.

In preparation for the new ICS for Buckinghamshire, Oxfordshire & Berkshire West, the three CCG Governing Body meetings will take place at the same time as a 'meeting in common'; the first of these took place on 10 June. This meeting is open to the public but until further notice, they will take place virtually with a link to attend being available on the OCCG website, along with all relevant papers.

3. OCCG Annual Report

The work to finalise the Annual Reports and Accounts for Oxfordshire CCG is well underway. The annual report including the statutory accounts will be submitted to NHS England by 15 June and then made available to the public on the website.

4. Thank you to volunteers

The successful delivery of the vaccination programme in Oxfordshire has relied on the support of volunteers. These volunteers have turned up to help at every vaccination site, looking after car parks, helping to coordinate queues, providing information and generally helping with tasks that mean the practice staff and others can focus on providing the vaccine and looking after people who are unwell.

There have been more than 1,000 volunteers across the local vaccination sites, many have been members of their GP practice Patient Participation Group, but others have come forward from the community wanting to help and to be part of the effort. People of all ages have volunteered, from young students through to people in their 80s. They have all received appropriate training and PPE as well as regular testing in more recent months.

On 8 June 2021, an event took place to recognise their efforts and to say thank you. The Oxfordshire LEP provided a small budget to support a modest gift and card to be given to each volunteer. These are still being distributed across all vaccine sites. A short film was made to record the voices of vaccine centre staff and some of the volunteers to illustrate the very real difference their efforts have made. This film is available on the OCCG website along with a recording of the event here.

5. Botley Medical Centre

Botley Medical Centre recently underwent a Care Quality Commission (CQC) inspection to check on progress after a previous inspection in October 2019 when the CQC rated the surgery as 'requires improvement'. Regrettably, the practice has not made as much progress as hoped and the CQC has now rated it as ‘inadequate’ and has drawn up a series of urgent required actions. As part of this the CQC have placed Botley Medical Practice in special measures which means the practice will need to provide updates about their progress and another inspection will happen within six months. The CQC report is available here.

Members of the CCG quality and primary care team have been working with the practice on a detailed plan to ensure patients can continue to have confidence in the care they are getting. We are supporting the practice to appoint a transformation partner to provide extra capacity and expertise to help the team address the issues. Progress will be carefully monitored and regular updates will be shared on the practice website.

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NHS
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Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 24 June 2021

Title of Paper: Oxfordshire Clinical Commissioning Group: GP Workload

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

1. General Practice workloads and appointment data
2. The delivery of services through the pandemic and vaccination programme

Report Author: Jo Cogswell, Director of Transformation jo.cogswell@nhs.net

NHS
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General Practice Workload

1. Context

This paper provides the Health Overview and Scrutiny Committee with an update on the delivery of services in general practice with specific reference to workload. Members will appreciate that the last year has seen unprecedented demands placed on the NHS because of the response to the COVID pandemic. Whilst those demands are not the focus of this report, they provide a key context to some aspects of workload.

2. Service Delivery during the pandemic

As a part of the level 4 incident declared by NHS England nationally general practice alongside other providers within the NHS was required to respond to key instructions and requirements. The CCG, working with other partners in the Oxfordshire system worked to support and enable general practice to enact those requirements seeking to maximise patient safety and patient services whilst minimising detriment to the practices.

A key feature and point of difference during the pandemic was accelerated delivery of remote and virtual services. As a clear step to reduce the spread of COVID practices were required to introduce a *total triage* approach. All practices introduced telephone triage which meant that patients were assessed by a GP over the telephone first, allowing many patients to be offered advice and potentially prescription or referral without the need for a face-to-face appointment.

This significantly reduced footfall at practices who were all supported to introduce robust infection prevention and control measures. Practices found ways to maintain services for patients whilst keeping them safe and reducing the risk of spreading infection. Most GP practices are used to busy waiting rooms and reception areas. Their consulting rooms can be unsuitable for organising furniture to allow 2m distance.

A dedicated additional service was commissioned to provide face to face appointments to the most infectious of patients – those who were COVID positive or suspected to be COVID positive.

General practice staff were supported to work from home where possible, again minimising the risk of the spread of infection and enabling some to continue working during periods of self isolation. IT kit and systems were provided to enable this.

3. Impact on service delivery from a patient perspective

Patients with appropriate IT at home have been able to use e-consult or video appointments in addition to the telephone consultations. There are always some patients who do need to be seen face-to-face and those patients were offered an

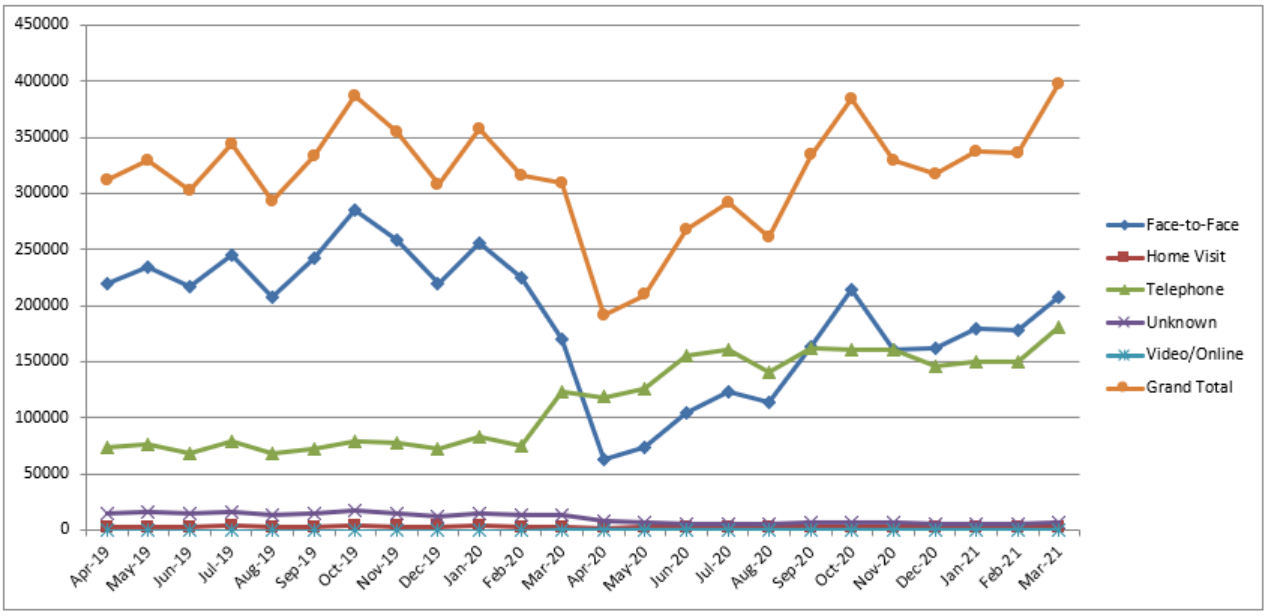
appointment in the practice with advice in advance about arrangements one arrival for keeping them, and staff, safe.

Feedback from patients has been mixed. Patients using e-consult have largely reported satisfaction with the service and for many this is something they would value continuing to be available. Others have also found telephone appointments to be convenient, an efficient use of time and have avoided the need for leaving home. Again, for many this is something they would want to continue to use in future.

There are two particular areas of concern coming from patients. The first relates to telephone systems in GP practices and the time taken to get to speak to someone. The second relates to a belief that face-to-face appointments have been unavailable to anyone.

4. General Practice appointment data

The graph below shows the number of general practice appointments each month for the last two years. Members will see that in April 2020, at the height of the pandemic response there was a significant drop in appointments. In line with the infection prevention and control measures we can see that telephone appointments as a proportion of all appointments has increased.



Oxfordshire General Practice Appointments by Mode April 2019 – March 2021[1]

In line with the recovery and restoration work in the Summer of 2020 appointment levels were restored to pre-pandemic levels by September 2020. These levels have been sustained since that time.

There have been reports of frustrations from patients about the ease with which they can contact their GP practice. Telephone systems in GP practices have come under significant pressure for many reasons. More patients have been trying to contact GP practices for advice and with general concerns, at the same time, more general

[1] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

business, including patient appointments have been taking place over the phone. Some practices have also been managing with higher levels of staff sickness and staff isolating which has reduced the number of people on duty at any one time to pick up the phone.

Face to face appointments have been available at every GP practice for the full duration of the pandemic and continue to be available. As previously reported, more than 50% of appointments are currently offered face-to-face. However, every face-to-face appointment starts with a telephone conversation with a GP to ensure the appointment is necessary and to identify what safeguards are needed beforehand. It is possible that the need for the telephone triage is influencing the public perception that face-to-face appointments are unavailable.

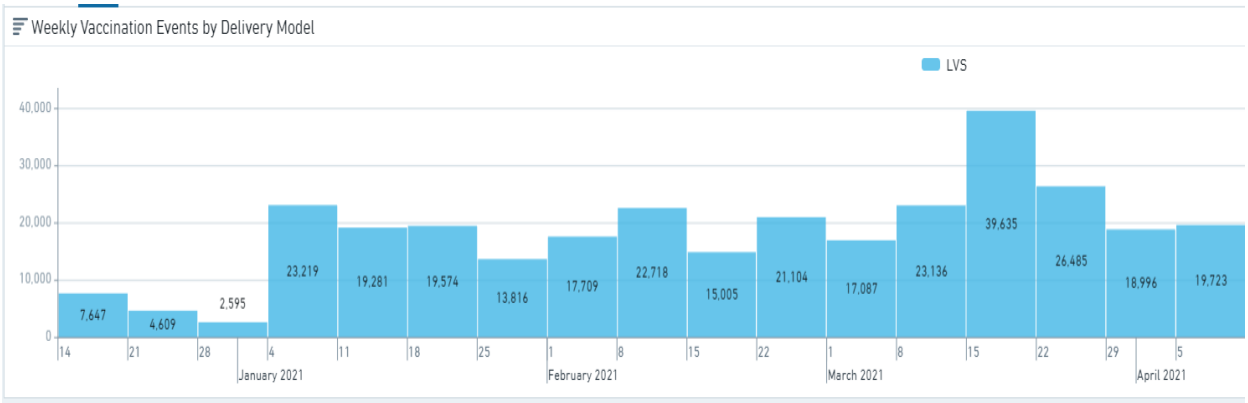
The table below shows the total number of appointments in the 2019/20 and 2020/21 years including the breakdown of telephone and face to face appointments. This data does not include appointments for COVID vaccinations.

19/20			20/21		
total	**telephone**	**f2f**	**total**	**telephone**	**f2f**
3,945,217	947,187	2,782,059	**3,656,640**	1,812,643	1,741,751

Oxfordshire General Practice Appointment information 19/20 and 20/21[2]

5. COVID 19 vaccination programme

General Practice in Oxfordshire, through the 21 Primary Care Network Local Vaccination Service sites has delivered more than 526,000 vaccinations in the period between December 2020 and June 2021.



Oxfordshire LVS vaccination events by week[3]

The graph above highlights the numbers of vaccinations delivered each week by general practice in Oxfordshire in addition to the core general practice appointments in the previous graph. General practice has made a significant contribution to the overall vaccination programme with a particular focus on the most vulnerable of patients in the JCVI priority cohorts. Some but not all sites continue to vaccinate those aged under 50.

[2] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice
[3] Source: NIMS data accessed through Foundry

Future of adult palliative care

Oxford University Hospitals, Katharine House Hospice and Sobell House, *working in partnership with others*

Professor Bee Wee CBE: Clinical Lead for Palliative Care OUH, National Clinical Director for Palliative and End of Life Care NHS England

Professor Chris Cunningham: Divisional Director for Surgery, Oncology and Women's Division OUH

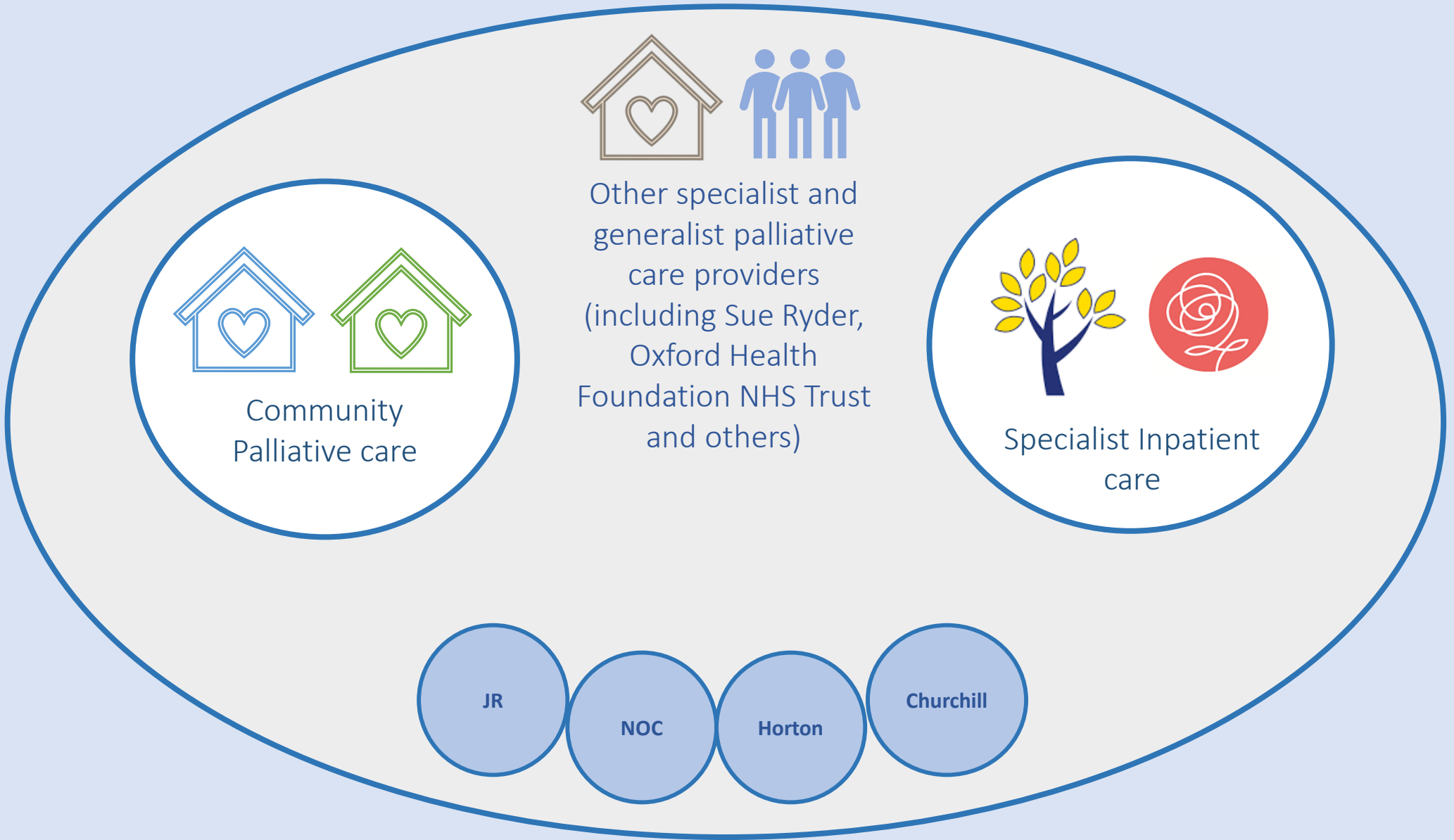
Lydia Brook MNurSci: Living Well and Supportive Care Lead for Palliative Care OUH

Robbie and Jan

KATHARINE HOUSE HOSPICE

SOBELL HOUSE

NHS
Oxford University Hospitals
NHS Foundation Trust



The National Picture

Six ambitions to bring that vision about

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

Challenges

Changing demographic and need

Health Inequalities

Workforce

Finance

Our Partnership: Moving Forward Together

Moving forward together, we are working to:

- Improve **quality**

- Improve **access**
  - **earlier** in the journey
  - for **under-served groups**

- Improve **sustainability** of services

KATHARINE HOUSE HOSPICE

SOBELL HOUSE

NHS
Oxford University Hospitals
NHS Foundation Trust

Thank you

We welcome questions and discussion

Oxfordshire Community Services Strategy Update for Joint Health Overview and Scrutiny Committee

Presenters: Dr James Kent and Dr Nick Broughton
June 2021

Actions from the April JHOSC meeting

1. Programme timeline and structure
   - Further details to deliver a whole system community services strategy and approach to evaluating success
2. Engagement process
   - Set out the extensive engagement planned in strategy development
3. Fail-safes/checkpoints
   - Checkpoint created to offer confidence in resolving Wantage Community Hospital inpatient future

Our response

We have:

- Reviewed project scope, timelines, resourcing and governance
- Developed an approach to be taken to evaluating success within the programme
- Developed an engagement proposal detailing start of the engagement process
  - Underpinning Strategy Principles to be developed by September
- Identified key fail-safes/checkpoints to ensure progress on agreeing long term future for Wantage Community Hospital

Context to be considered

- Plan to have 2 hour crisis response community response service in place by October 2021
  - 8am to 8pm, 7 days a week
  - 2 day reablement offer identified within the NHS Long term plan
- Currently re-procuring a ‘home first’ reablement model to support rapid discharge from acute hospital and at home
- Plan to recruit additional roles to primary care to support care closer to home agenda expecting 61 this year and a further 55 new roles over the following two years
- Improving digital capacity to run clinics closer to home

Key questions the strategy needs to answer

- How does Oxfordshire organise to enable our residents to enjoy optimal independence?
- What does Oxfordshire need to ensure to meet Population growth, demographics and need for services?
- What is the capacity of key services?
  - Enablement based
  - Bed based
- How should we maximise the use of our resources – estate, technology and workforce?
- How should we deliver care pathways and offer the integrated services to meet the needs of the population?
- What is the best way of delivering community bed based care?
  - Nature, number and location of Beds
  - Does this require Wantage in-patient beds to reopen?

Programme plan checkpoints

To ensure that the system programme continues to deliver the necessary progress, it is proposed that checkpoints be included at: June 21, September 21, January 22 and June 22

	Months:			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Task	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**
CHECKPOINTS			x			x				x					x					
Develop programme structure and governance																				
Develop knowledge base & needs analysis including beds																				
Develop and engage on strategy principles and approach																				
Co-production of evaluation approach																				
Targeted engagement to support proposals																				
Develop plans to support implementation enablers																				
Develop options appraisal																				
Publish options appraisal and supporting information																				
Complete options analysis and pre-consultation business case																				
NHS assurance process																				
Formal public consultation																				
Consultation review and write up																				
Final business case to CCG/ICS Board for decision																				

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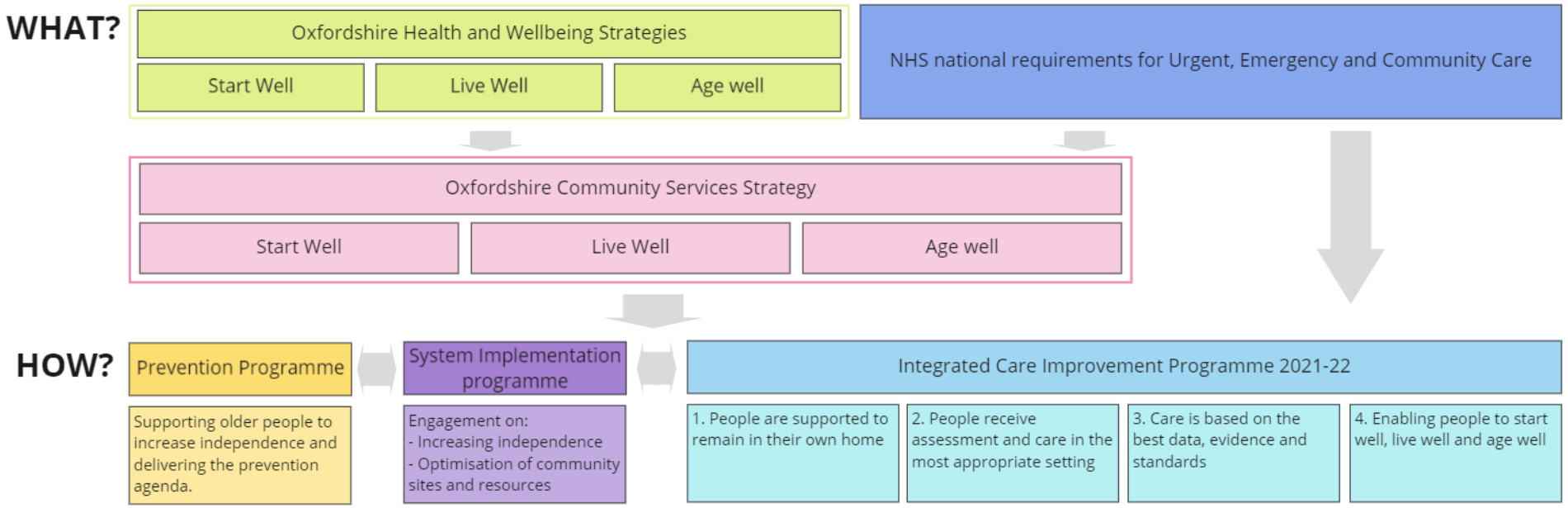
Further details of the timeline and programme phases can be found in the supporting paper

Fail-safes identified

- Regular reporting on checkpoints to every HWB & HOSC to provide assurance
- Sept 21: Early engagement on principles and aims of the strategy
  - Fail-safe: If unable to publish report on the early engagement work on the principles and aims of the strategy by this time, Chief Executives to report to HWB & HOSC to confirm actions to be taken to address delay
- Jan 22: Progress to countywide strategy options appraisal
  - Fail-safe: If unable to complete the work required to progress to the development of the options analysis and pre-consultation business case, then Chief Executives to report to HWB & HOSC to confirm actions to be taken to address delay and discuss alternative plan

Mainstreaming this work

A programme structure that will cover all partners for prevention, include primary care and community and through an Integrated care improvement programme deliver essential workstreams across both community and urgent care services

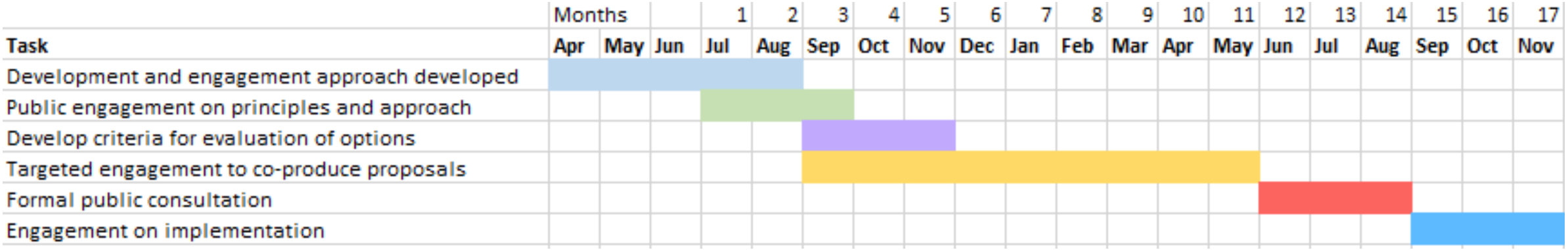


Resource plan

- Effective implementation of the strategy will require the following resource; Programme manager, Data lead, Engagement lead, Finance, Estates, Digital, HR/Organisational development

- Costs (prudent)
  - Additional staff costs 145k
  - Engagement and Consultation 150k

Engagement approach



Engagement is central to the delivery of the community services system strategy and will be broken down into a number of phases over the course of the strategy;

- Development and engagement approach developed; working with a range of stakeholders to develop the approach which will be taken to delivering the strategy
- Public engagement on principles and approach; developing the principles which will shape the strategy
- Development of the criteria for evaluation of options; co-production of the criteria to evaluate options
- Targeted engagement to co-produce proposals; working with members of the public, staff, carers and patients to shape the options
- Formal public consultation; Formal process to consult on and substantial service changes
- Engagement on implementation; Feedback of outcome of decision and implementation plan to deliver proposals

Additional information on the engagement process can be found in the supporting paper

Wantage community hospital approach

Wantage Community Hospital is central to the plans for community services in Wantage, Grove and the surrounding villages.

Services currently being delivered from the community hospital include: Speech and Language Therapy (children's and adults), Podiatry, School health nurses, Oxford University Hospital maternity services and birthing unit, Healthshare musculoskeletal services (MSK).

Since the beds were temporarily closed in 2016, significant expansion of new care pathways has enabled more care to be provided to older people directly in the home, which is generally their preferred option. This includes the accelerated roll-out of the 'Home First' and 'Ageing Well' pathways in the OX12 area, which has contributed to a further drop in the need for bed-based hospital care.

Over the past year we have seen a significant average reduction in length of stay and a reducing trend in bed occupancy levels, suggesting that there is no current need for greater numbers of general community beds.

In the short term, in order to test plans for more accessible services to a greater number of people in the community, we propose to run 'test and learn' pilots of outpatient services at the Hospital, starting by the end of quarter 2. These will focus on addressing identified local population needs – current plans include Audiology, Ophthalmology, Ear Nose and Throat as well as Mental Health services (all ages).

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Oxfordshire Community services strategy supporting information, June 2021

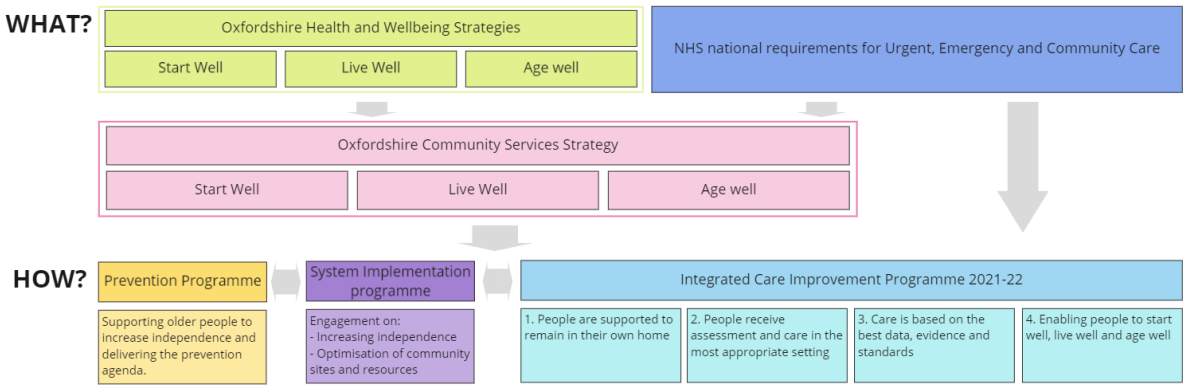
Building on the mandate agreeing the development of a whole system community services strategy, Oxford Health Foundation Trust, Oxfordshire CCG, Oxfordshire County Council, District, and City partners have been working to clarify the structure, governance and resources needed to deliver the strategy. Since this work was last shared, we have focused on developing three key areas:

- Programme structure and plan; Setting out the structure of the programme and the timeline for delivery
- Evaluation approach; Setting out how we will know if the programme is successful, this covers three key areas – test and learn pilots, evaluation criteria for the options proposed and the programme as a whole
- Engagement plan; Central to the success of this plan will be working with all stakeholders to develop change proposals to deliver community care across the county which will more consistently meet population health needs.

Programme structure and plan

Working across the county system partners, we have broken down the strategy into an overarching strategy framework (the 'what') and three implementation programmes (the 'how'). The implementation programmes are:

- Prevention programme; supporting older people to increase independence and delivering the prevention agenda
- System implementation programme; engagement on increasing independence and optimising community sites and resources
- Integrated care improvement programme; delivering workstreams across both community and urgent care services



The Prevention Programme will require involvement of a wide range of partners in particular. The means to deliver this most effectively are being explored with Local Authority Colleagues including potential to report into the Health Improvement Board. The system implementation programme is focused on delivering the work which will enable us to identify any areas which would require substantial change and therefore may need higher engagement and then public consultation.

The programme has been broken down into the following workstreams with checkpoints to assess progress in June 21, September 21, January 22 and June 22.

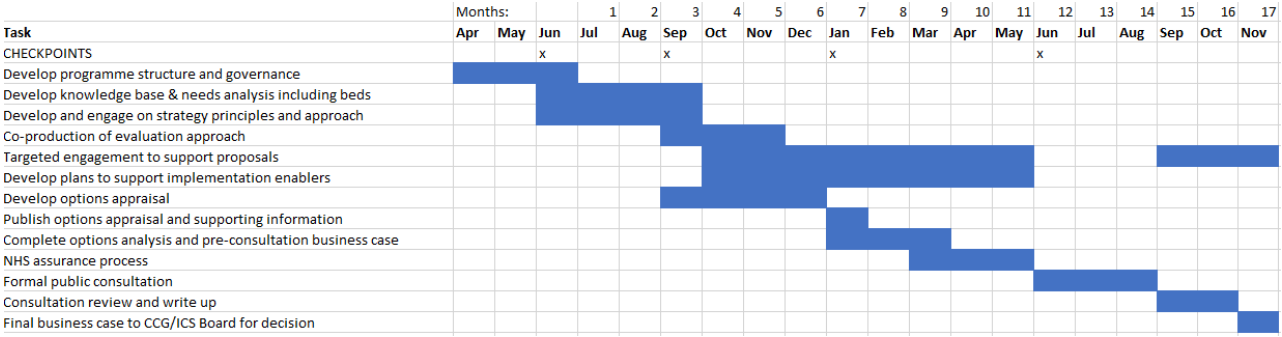
A number of fail-safes have also been built in to ensure that the strategy work delivers the required outcomes. Specifically, these include;

- Regular reporting on checkpoints to every HWB & HOSC to provide assurance
- Sept 21: Early engagement on principles and aims of the strategy

Fail-safe: If unable to publish report on the early engagement work on the principles and aims of the strategy by this time, Chief Executives to report to HWB & HOSC to confirm actions to be taken to address delay

- Jan 22: Progress to countywide strategy options appraisal

Fail-safe: If unable to complete the work required to progress to the development of the options analysis and pre-consultation business case, then Chief Executives to report to HWB & HOSC to confirm actions to be taken to address delay and discuss alternative plan



The timeline for the engagement process within the community services strategy has been developed based on best practice including the process which was followed to make a decision on the Horton Obstetrics unit. It is important to note that the Horton consultation was a much more specific/defined question about maintaining obstetrics at the Horton or not. The options were therefore all about possible medical staffing models.

Even with a more clearly defined question the work from the first Horton HOSC meeting to decision took a year; this was still tight as the Oxfordshire CCG and OUH were working across NHS and local authorities boundaries (for getting information and partner involvement) and to ensure that there was enough engagement and stakeholder input. In addition, some background work had already been completed from receipt of the Secretary of State letter in March 2018 before the first Horton HOSC meeting in September.

This work on community beds is more complex as the nature of the question is much more open to interpretations; it is county wide and there will be potentially multiple different options which will need to be worked up and engaged upon including costing and appraisal. As a result, we feel that it is not realistic to further shorten the timeline if we are to deliver a process which engages effectively with all stakeholders.

With HWB & JHOSC support for the approach described herein we will rapidly work up the principles which will inform; the strategy, the support we need for residents and underpin the evaluation of success of the work. These principles will be developed with all Strategy partners to reach a document for engagement with the public before September.

Evaluation approach

We have been asked to layout our approaches to evaluation of this work. There will be different levels that need evaluation:

1. Overall **System Programme**
2. **Test and Learn Pilots** – will determined by specifics of each scheme
3. **Specific options on beds and any other areas of significant change** – in scoping the options for bedded care this will be part of the programme informed by public engagement, criteria will not be clear until this time

System programme review

As mentioned above, a central part of the next steps will be to develop and engage on the Principles for the strategy by September. This will inform how we will evaluate this work. Initially, the following measures have been identified to help identify the impact of the community services strategy in terms of our population:

- Outcomes that help a person best gain or regain levels of independence so that they can manage their own needs review, informed by the HWBB Older person strategy ambitions. This may include patient or service-user reported measures.
- Monitoring activity and outcomes throughout our system
    - In the community/voluntary sector how many people helped, with what impact, what did they do (increased physical activity, decreased loneliness)
    - At NHS, social care and partner "front doors"
    - Attendances and length of stay in hospital
    - People gaining greater assistance to remain in their own homes
    - Through short term help to people numbers in, length of stay, outcome in terms of long-term care needs
    - Through helping people better manage their long- term conditions
    - Through ensuring the right interventions/help is available to people with complex needs
    - Through practitioner experience, demands, ease of referral etc

Assessment of the programme as a whole will also reflect how this work has contributed to the delivery of the outcomes set out within the joint health and wellbeing board strategy.

Test and learn pilots

As part of the implementation of the community services strategy we will identify opportunities to test proposals to provide evidence of the opportunities to deliver services differently. We have already shown that we can do much more through the pandemic and we need to take this learning and evidence its impact further.

As we test new ways of delivering services the criteria will be developed to evidence impact. Throughout we will need to evaluate system cost/benefit. We also need to consider overall capacity requirements for services; what might be done remotely, in people's own homes and what can only

be delivered through additional physical locations. A key area for test and learn is our HomeFirst work which has extensive weekly reviews of key data as set out by national NHS requirements.

Wantage Community Hospital clinics

An early pilot we will put in place is to test out-patient clinics within Wantage community hospital to provide additional services to the population of Wantage which will not require them to travel to Oxford. The first clinics are due to start by the end of quarter 2 and will then be reviewed after 6 months to assess their impact. This will be a temporary arrangement whilst we determine the future of the beds.

As with the wider strategy, we will base the evaluation of each pilot on whether or not it meets the principles agreed for the wider strategy. We will also put in place specific metrics to measure impact and outcomes which will be weighted. Examples of the metrics which could be used to evaluate the proposal include:

Quality and safety of care

Is the service providing best practice and evidence-based care?

Is the service meeting identified population needs?

Is the service delivered in a way that ensures a high level of quality with respect to staff training, skill-mix and use of equipment and resources?

Patient contacts

- Is there sufficient demand to justify this service within the local area at the proposed scale of delivery?
    - Number of referrals
- How many people are benefitting from this service?
    - Number and characteristics of patient contacts
    - How efficient is the Clinic at delivering intended interventions and outcomes?
    - Numbers of DNA/cancelled appointments
- How has digital technology been used and is this safe, effective and equitable? Is this benefitting the community?
    - Patient location data
- Has the pilot improved access to services?
    - Waiting times
    - Reduced travel times/distances (considering environmental impacts of both patient and staff travel)

Patient feedback

- Are people positive about their experience of the service?
    - Patient feedback surveys

Staffing implications

- Is it possible to staff this effectively?
    - Staff vacancy rate
    - Cost of staffing
    - Number of staff required to run the service

System benefits

- Is this a cost-effective and affordable service?
    - Capital and revenue cost implications

    - System cost implications
    - Benchmarking against other similar services
- Is there an opportunity to deliver services differently?
    - Review opportunities to run clinics digitally
- Demand within the wider system
    - Waiting lists across the wider system for these types of services

Whilst understanding system cost/benefit we will work through the overall capacity requirements for the service; what might be done digitally and what are physical capacity requirements. This will then assist in establishing if these clinics are beneficial to Oxfordshire as a model of care.

Options appraisal framework - Specific options on beds and other areas of significant change

The following approach will be taken to developing specific evaluation to create case for options on beds other areas of significant change:

Developing and weighting the criteria;

- This will be undertaken following input from stakeholders including workshops described in the engagement process (see below communications and engagement plan)

Option appraisal;

- The output from other work streams will be used to provide the information required to assess each of the shortlisted options against the agreed and weighted criteria.
- An appraisal panel who will be set up to undertake the scoring and full option appraisal. It is proposed this will include NHS clinical and managerial; key partners; community groups and patient/public members.
- The output from the appraisal panel will be presented for discussion at stakeholder event(s) and presented to HOSC prior to any formal consultation.

Communications & engagement plan

Our vision is to improve the health, wellbeing, independence and care experiences of individual residents, while strengthening the interdependence of people, families and communities across all of Oxfordshire. To achieve this, we have identified four areas of focus;

- Quality; achieve the best health outcomes and experiences
- People; be the best possible place to work in community care
- Sustainability & Partnership; enable people and communities to stay healthy and resilient
- Research & Training; continuously improve health in our communities

We can only achieve this vision by engaging effectively across our local community and stakeholder groups. This engagement strategy shows how we will do this by:

- Engaging and listening to our stakeholders and acting on what they tell us to share our proposals for change
- Engaging with and energising our staff as our most important asset

Background

Significant engagement has been carried out across community services within Oxfordshire over the past few years. There has been countywide work and in-depth work in specific geographies or needs areas. The engagement exercise carried out as part of the OX12 project delivered by the CCG to explore options for Wantage Community hospital will also inform the thinking. This plan builds on

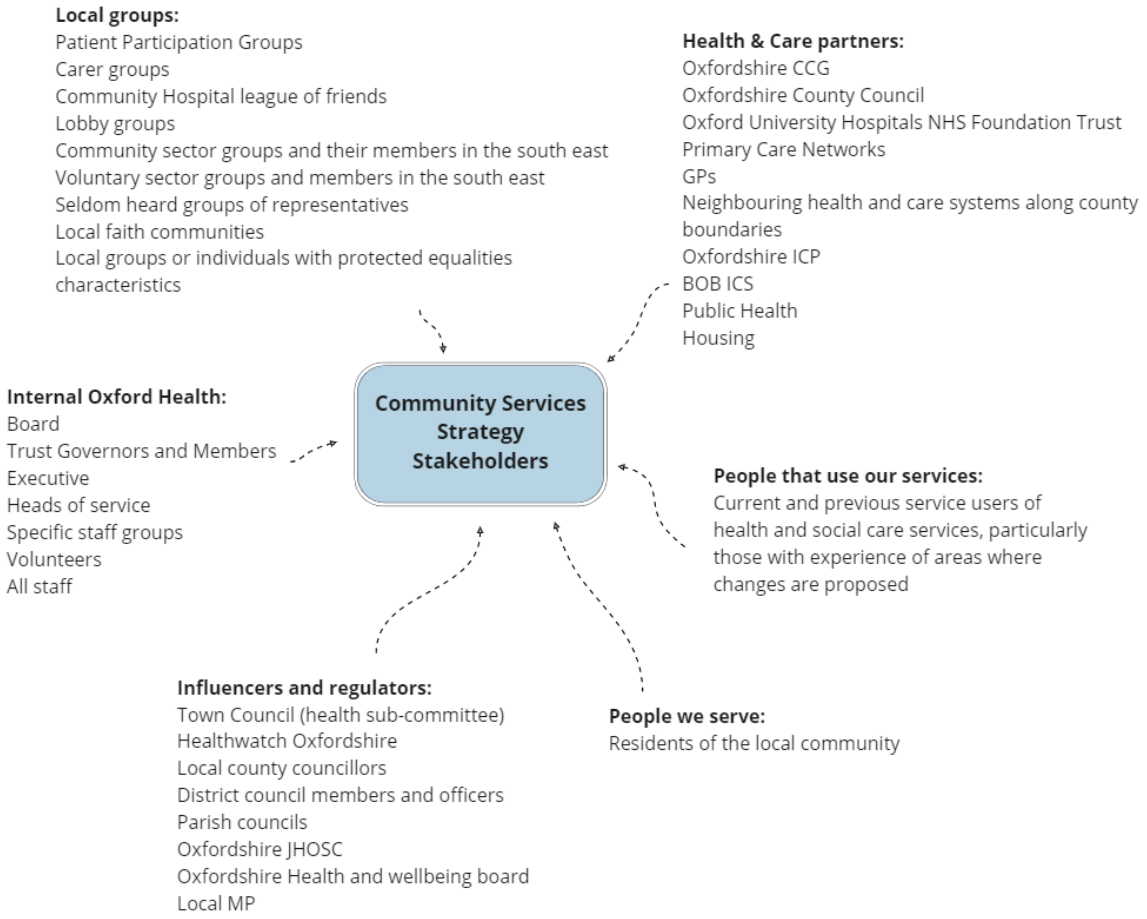
this existing work and focuses on learning from past engagement to understand how we can most effectively engage local communities to shape services.

Aim and objectives

The overarching aim of the communications and engagement plan is to ensure that those affected by future proposals have the opportunity to be involved in shaping these proposals. This will be achieved by:

- Listening to the views and experiences of local communities to design a set of principles and inform future decision making both regarding specific proposals and across the County more widely
- Ensuring staff understand the objectives of the strategy and have an opportunity to share their feedback to inform future plans
- Providing clear and consistent messages and information to all stakeholders
- Continually reviewing and developing this engagement plan to ensure it takes into account the views of all stakeholders
- Promoting any services delivered during pilots to relevant stakeholders to increase referrals and enable effective evaluation of impact

Stakeholders identified to date



Key messages

Messages should be underpinned by our absolute commitment to providing the best care possible for local people and to reassure people that the objective of the new service is to provide better quality care, delivered closer to home and out of hospital in local communities.

Detailed messaging in relation to specific proposals will be developed with relevant stakeholders. However, the overarching messages we want to communicate are:

- It is vital that patients, the public and stakeholders get involved in the shaping of outline options for discussion around the provision of local health and care services for their area
- Options appraisals will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified
- Proposals will be developed using evidence of current needs and future needs as population changes.

In relation to the pilot proposals, key messages include:

- Timescales and details of pilot proposals and what changes will be seen by the local community as a result
- This is a pilot and is not a fait accompli and feedback will be key to shaping future decisions on wider implementation
- How we are taking on board and responding to feedback

- The benefits to our patients, service users, communities and staff

Where a longer-term change is being proposed we will ensure that engagement is completed with stakeholders regarding;

- The process which will be followed and the type of engagement or formal consultation which will be completed before any decision is made
- The evidence base which will be used to make the decision
- Suggested decision criteria and how stakeholders will be able to engage in shaping these

Engagement types

Throughout the course of the development and implementation of the community services strategy the following types of engagement will be completed:

System led engagement;

- Public & wider stakeholder engagement; members of the public and special interest groups with an interest in the development of the strategy including those with a specific interest in Wantage community hospital

Oxford Health led engagement;

- Patient engagement; patients with experience of community services
- Carer engagement; carers for those who have used/currently use community services
- Staff engagement; staff who deliver community services
- Partner/provider engagement; working with partners and other service providers to explore options proposed and increase understanding of the implications

Key phases of engagement

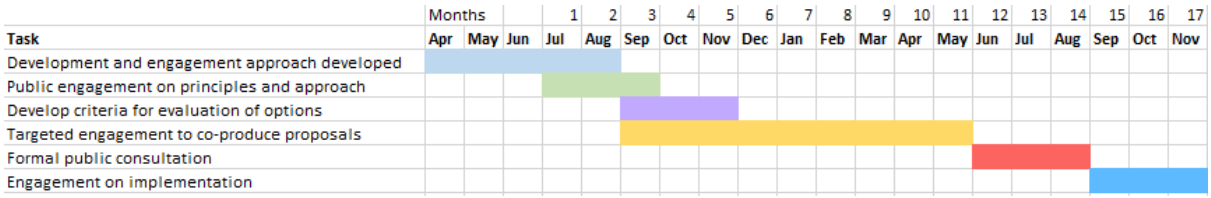
1. Initial information gathering
   - Review of historic engagement activity
   - Share outline proposals for initial review and comments to shape wider engagement approach
2. Key principles and approach for the strategy by September
   - Share proposals for how to shape the strategy
   - All stakeholders feedback on proposals
3. Development of evaluation criteria
   - Workshops held to gather the views of stakeholders on the criteria which will be used to assess options proposed for consultation
   - Agreement of weighting and methodology to be used
4. Public engagement on options
   - Engagement on change options identified as a result of the principles
   - Shaping of consultation papers to ensure they reflect stakeholder reviews
5. Patient and carer engagement on options
   - Co-production of proposals with patients and carers
6. Staff engagement on options
   - Co-production of service models with staff within community services
7. Provider and partner engagement on options
   - Sharing of proposals for feedback with system partners and other providers
8. Formal public consultation
   - Consultation process on substantial changes
9. Engagement on decision and implementation

- Feedback to all stakeholders on the decision resulting from the consultation process and implementation plan

Types of engagement will be shaped by Covid public health requirements but will include:

- Surveys
- Interviews with patients/carers/families/visitors
- Attendance at local meetings and community groups
- Public meetings
- Facilitated engagement sessions
- Focus group sessions
- Partner and stakeholder communications and newsletters
- Staff bulletin/intranet
- Team briefings
- Press releases and social media
- Website updates

Draft engagement timeline



Engagement evaluation

Success of the engagement relating to this strategy will be assessed based on the criteria including;

- Levels of and nature of feedback, complaints and compliments from patients and other stakeholders to explore how effective communications have been
- Levels of staff engagement and satisfaction
- Media coverage across Oxfordshire
- Feedback from professionals in order to understand the awareness, understanding and support for the service
- Reach of social media (including positive comments, sharing links, retweets, likes etc)
- Increase in number of job applicant

Request of Joint Health Overview and Scrutiny Committee:

Does Joint Health Overview and Scrutiny Committee support the outlined:

- Project timeline
- Evaluation approach
- Engagement plan

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Progress against Quality Priorities 2020-21 and Priorities for 2021-22

Professor Meghana Pandit
Chief Medical Officer
24th June 2021

Agenda Item 13

The Joint Health Overview and Scrutiny Committee. For Information June 2021

Our Strategic Framework 2020-2025

This is our strategic framework, developed by our staff and built on our vision and values

Oxford University Hospitals
NHS Foundation Trust

2020-21 Priorities

Patient Safety

- Implementation of the National Early Warning Scoring System (NEWS2).
- Safety Huddles.
- Medication Safety: Insulin Safety.

Clinical Effectiveness

- Improving the provision of psychological medicine to all OUH patients.
- Staff health and wellbeing (feedback from the Staff Survey).
- To minimise the occurrence of Nosocomial COVID-19 in OUH.

Patient Experience

- The Home Assessment Reablement Team (HART).
- Reducing the number of patients with an extended length of stay (LOS).
- Patients who have their procedure cancelled.

Did we achieve the 2020-21 Quality Priorities?

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PATIENT SAFETY:
Implementation of NEWS2

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Improves the earlier identification of deteriorating patients and facilitates standardisation.	Action 1. Deliver trust wide communication for the launch of NEWS2 during 2020-21. Action 2. Test and deliver the technical requirements for the deployment of NEWS2 within the System for Electronic Notification and Documentation (SEND) platform and the electronic patient record (EPR) during 2020-21.	Action 1: ***Partially achieved.*** Trust wide communication about the launch of NEWS2 and the subsequent changes to this have taken place in a timely fashion. This is an ongoing process due to the delay in introducing the system caused by the pandemic. Action 2: ***Partially achieved.*** The technical solution, including the fix of the problem experienced at the September 2020 launch, has been tested and was ready to be launched on 12th January 2021. However, it was considered that the launch of NEWS2 at this time would place an unacceptable stress on clinical teams tackling rising COVID-19 patient numbers and so, following an options appraisal, a decision to delay the launch was approved by the COVID-19 Steering Group until, at least, April 2021. The system went live in May 21.

Safety Huddles

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.	A standardised method to run and record safety huddles has been developed and implemented across the Trust. Action 1: Assess effectiveness (we would expect to see an increase in the numbers of incidents reported with a lower proportion of high harm incidents). Action 2: Assess the safety culture across the organisation using a validated tool.	Action 1: ***Partially achieved.*** The numbers of incidents reported have remained about the same over the last two years with the proportion of high harm incidents appearing to increase very slightly over that time. It is impossible to draw any meaningful conclusion from this. No commonalities or trends have been identified. Action 2: ***Partially achieved.*** The University of Texas Safety Attitudes Questionnaire (UTSAQ), used by the OxSTaR for our human factors programme, has been distributed and will inform ongoing safety interventions and we will revisit these teams in the coming year. The initial draft of the data analysis from the UTSAQ shows that feedback was limited, but when combined with course, effective.

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Insulin safety

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
One in six people in hospital have diabetes and this is increasing. 35% of people with diabetes in OUH are treated with insulin and will be treated in all areas of the Trust.	Action 1: We are going to cleanse our data to ensure it provides an accurate representation of our case mix. Action 2: Where the NaDIA harm criteria has been met there will be an investigation of what happened in order to learn and improve care. Action 3: Investigation templates for each of the harms will be produced and adapted as required to fit the needs of the investigations. Action 4: A multidisciplinary insulin safety group will be set up to review the NaDIA harm reports, identify learning and actions to improve care. Action 5: People with diabetes will be represented on the Insulin Safety group.	Action 1: ***Fully achieved.*** Previously identified incidents reviewed against nationally defined criteria to clarify baseline. Action 2**:** ***Partially achieved.*** Members of the Diabetes team are reviewing incidents while awaiting the formation of an insulin safety group. Action 3**:** ***Partially achieved.*** Literature search undertaken. The work to complete this action is in the very early stages. Action 4: ***Partially achieved.*** A planning meeting for the Insulin Safety Group has taken place and the aim is that the group will become more active once the pandemic allows. Divisional/wider representation will follow this. process. Action 5: ***Partially achieved.*** Candidates have been approached and provisional agreement has been obtained.

CLINICAL EFFECTIVENESS

Psychological medicine

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Improving mental health care in the ED was one of the 2019-20 priorities. At our Quality Conversation public event in January 2020 stakeholders asked that we develop this work to include all Trust inpatients	We aim to build on the already good level of 'mental health' care OUH offers its patients by enhancing it in several areas as follows: Action 1. We will improve access to psychiatry for inpatients at the Horton general Hospital by implementing tele-psychiatry for medical inpatients. Action 2. We will expand the provision of integrated psychiatry and psychology to cover more of the Trust's high need areas such as haematology and gastroenterology. Action 3. We will work with our partners Oxford Health to ensure that we deliver the nationally required Core 24 standard by ensuring that there is a rapid response to all emergency and urgent psychiatric referrals at nights and weekends as well as during weekdays.	Action 1: ***Partially achieved.*** We have enhanced tele-psychiatry provision for all medical inpatients (on all sites including the Horton) in part as a response of COVID-19. Action 2: ***Partially achieved.*** We have expanded Psychological Medicine to some, but not yet all, high need areas. Action 3: ***Fully achieved.*** OUH Psychological Medicine has extended provision to include weekend and bank holidays. OH continues to cover night-time emergencies (and ED). As a result, OUH now meets the NHSE Core 24 standard of delivering a rapid response to all emergency (1 hour) and urgent (24 hours) referrals every day in both ED and OUH wards.

Staff health and wellbeing

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
This was one of the suggested priorities that stakeholders voted to include into 2020-21 at our Quality Conversation public event in January 2020.	The aim is to provide an effective, safe and healthy working environment which will be reflected by an improvement in the staff health and wellbeing scores in the 2020 OUH Staff Survey. Action 1: Using staff survey data, engage with staff to identify and prioritise initiatives for implementation by end March 2021 to improve people's health and wellbeing. Action 2: A newly revised policy and procedure for managing stress in the workplace will be drafted ready for consultation by 31st March 2021. Action 3: Ensure the use of a recognised Health & Wellbeing Framework to support our work is in place by 31st March 2021.	Action 1: ***Action achieved.*** Health and wellbeing (HWB) has been a core priority throughout 2020/21. Our 2020 staff survey results showed a significant improvement in our wellbeing scores. Action 2: ***Action achieved.*** The 'managing stress in the workplace' policy has been drafted and is ready for consultation in April 2021. Action 3: ***Action achieved.*** The OUH Guide to Health and Wellness was launched in June 2020 and this comprised of six dimensions of wellness.

Oxford University Hospitals NHS Foundation Trust

To minimise the occurrence of Nosocomial COVID-19 in OUH

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
The aim of the project was to protect patients and staff by reducing the proportion of COVID-19 cases likely to have been acquired in hospital to as low as possible, and below the average proportion for similar acute Trusts.	Action 1**:** set up a database to monitor the proportion of cases likely to be hospital acquired and to act swiftly to work with clinical areas where an increased number of cases is noted. To submit data on nosocomial infection rates nationally as required. Action 2: To complete a gap analysis against the NHSE/I Infection Prevention and Control Board Assurance Framework document. Action 3: To work with all clinical areas to reduce opportunities for SARS-CoV2 transmission, considering both patients and staff (e.g. patient triage and pathways, diagnostics, patient placement, social distancing, cleaning, communications, education). Action 4: To support widespread testing of both patients (emergency, elective, regular weekly testing) and staff. To monitor the uptake of patient and staff regular testing. Action 5**:** To ensure staff are supplied with and trained to use PPE appropriate for the clinical area for their own and patient protection.	Action 1**:** ***Fully achieved*** Database set up and admission screening compliance can be accessed via the Orbit dashboard. Data continues to be reported nationally. Action 2: ***Fully achieved.*** The BAF was reviewed and updated following presentation to Integrated assurance committee (IAC) in February 2021 and will be provided to NHSE/I for assurance of IPC measures being undertaken in the Trust. No significant gaps identified. Action 3: ***Action on-going.*** Action 4: ***Action on-going.*** Action 5: ***Action on-going.***

Oxford University Hospitals NHS Foundation Trust

CLINICAL EFFECTIVENESS

HART

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
This was one of the 2019-20 priorities that stakeholders voted to continue into 2020-21 at our Quality Conversation public event in January 2020. As a Trust we recognise that hospital based care is the first part of the journey to recovery and that this journey continues at home.	In 2018 and 2019, the proportion of patients returned to functional independence following hospital discharge reablement was 57% and 59% respectively. By 31 March 2021 we aim to enable 50% of patients leaving any hospital bed base each month to not require any ongoing care and to further increase the percentage of all patients on the HART pathway who return to independent living to 63%. Action 1: Continue to recruit to Therapy posts to support discharge to assess (D2A) across the whole county- 8 whole time equivalents by 31st March 2021. Action 2: Train 'exercise and mobility champions' within the workforce to enhance reablement- 8 champions by 31st March 2021. Action 3: Undertake an evaluation of at least three different types of assistive technology to support independent living by 31st March 2021.	From Apr 20-Feb 21 57% of HDRS (Hospital Discharge Reablement Service) completed reablement episodes reached independence. ***Fully achieved.*** From Apr 20 – Feb 21 68% of HDRS completed episodes reablement discharged independent or with reduced care. ***Fully achieved.*** Action 1: ***Fully achieved.*** 8 WTE equivalent therapists are working within HART. Action 2**:** ***Fully achieved.*** 15 reablement support workers (RSW's) have received additional training and competencies to enhance their working practice as Therapy Champions carrying out individualised programmes with patients. Working with Oxford County Council team to use 'Just Checking' system with suitable patients. Action 3: ***Not achieved.*** Work has been delayed due to the pandemic pressures.

Oxford University Hospitals
NHS Foundation Trust

Reducing the number of patients with an extended length of stay (LOS)

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
This was one of the 2019-20 priorities that stakeholders voted to continue into 2020-21 at our Quality Conversation public event in January 2020.	We will achieve a reduction in the number of patients with an extended Length of Stay (LOS) of over 21 days, to fewer than 90 patients by 31 March 2021. Action 1: The Deputy Divisional Nurse will lead on this for each division. Action 2: A weekly discharge patient tracking list (DPTL) will be sent out every Thursday. Action 3: Each division will carry out a weekly review of this cohort of patients which will be documented on the patient's electronic record. Action 4: Monday to Friday all delays will be reviewed at the 12:00hrs huddle to resolve issues and reduce LOS.	In February 2021 the numbers of patients with an extended LOS was 114. This is above the target of 90. When compared with February 2020 there has been a 17% drop Year on year in the average daily LOS numbers. In March 2021 the average daily LOS numbers decreased to 104. Action 1: ***Fully achieved.*** Action 2: ***Fully achieved.*** Action 3: ***Fully achieved.*** Action 4: ***Fully achieved.***

Patients who have their procedure cancelled

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
This was one of the suggested priorities that stakeholders voted to include into 2020-21 at our Quality Conversation public event in January 2020. National surveys carried out in 2018 and 2019 found that the Trust was in the worst 20% of trusts where patients reported they had procedures cancelled. Feedback within the Trust found that if an operation is cancelled, patients would like an apology and explanation. During the period December 2018-19 there were a total of 75 cancelled appointments due to 'patient declining treatment on the day', this is an average of 6 a month.	The aim is to improve the position of the Trust regarding cancelled procedures in national surveys to the middle quartile by 31 March 2021. Action 1: We will ensure that all staff who are likely to be delivering this news are trained to do so appropriately. Action 2**:** We will explore the reasons for 'patients declining treatment on the day' and reduce the monthly average from 6 to 3 per month.	Action 1**: *Partially achieved.*** Discussions with Urology are on-going regarding a potential pilot site for this action. Work was delayed due to the pandemic pressures. Action 2**: *Not achieved.*** From August 20 – Jan 21 there have been 69 patient cancellations (on average 11 per month). This is for JR & WW theatres (no data for SUWON at present). The team have not had capacity to explore in depth with patients why they have declined their operation, however, COVID-19 is recorded as a detail for this on the data set. Further work on this was delayed due to the pandemic pressures.

Quality Priorities 2021/22

- The Quality Conversation Event scheduled for February this year had to be cancelled due to the COVID-19 pandemic. Discussion with internal stakeholders considered proposals with a focus on staff wellbeing and recovery in addition to which of the current Quality Priorities should be continued into 2021-22. These draft Quality Priorities were agreed by the trust management executive (TME) followed by the integrated assurance committee (IAC), Governors and external stakeholders.

Oxford University Hospitals
NHS Foundation Trust

Finalised Quality Priorities 2021-22

Patient safety

- Triangulation of complaints, claims, incidents and inquests
- Safety huddles.
- Medication safety – Insulin and Anticoagulants.

Clinical effectiveness

- To minimise the occurrence of *C.difficile* and MRSA in OUH.
- Transition of children to adult services.
- Clinical Activity Recovery.

Patient experience

- Digital innovations .
- Staff health and wellbeing: Growing stronger.
- Quality Improvement (QI) Stand Up.

OneTeamOneOUH

DRAFT

NHS
Oxford Health
NHS Foundation Trust

ANNUAL QUALITY ACCOUNT 2020 - 2021

CARING, SAFE, EXCELLENT

Table of Contents

1. About this report

This is the annual Quality Account about the quality of services provided by Oxford Health NHS Foundation Trust (OHFT). The Account is an important way for us to report on quality and show improvements in the services we deliver to local communities. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive and patient/ families experiences of the care provided.

Throughout the document we have used the terms patients, families, and carers to mean any person who has used or will use our services.

If you require any further information about the 2020/21 Quality Account, please email Jane.Kershaw@oxfordhealth.nhs.uk.

Acknowledgement

We would like to thank Becca an emergency nursing assistant on one of our Emergency Multidisciplinary Units for sharing her black and white photos which are dotted throughout the Account, to tell the story of the last year and the challenges faced through the COVID-19 pandemic.

2. Who we are

Oxford Health NHS Foundation Trust (OHFT) provide physical health, mental health, social care and learning disability services for people of all ages across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon & Wiltshire.

Our services are delivered at community bases, hospitals, clinics and in people's homes. We focus on delivering care as close to home as possible. We employ just over 6,000 staff (as of March 2021), deliver services from more than 150 different sites and on average treat more than 185,000 people a year.

We provide the following services in each county;

Bath and North East Somerset, Swindon and Wiltshire	Mental health services for children and young people and eating disorder services.
Buckinghamshire	Mental health services for children, young people, adults and older people.
Oxfordshire	Physical health services, mental health and eating disorder services, learning disability and autism services. For all ages - children, young people, adults and older people.

The main services we provide are listed below. We have also just welcomed the transfer of staff from OxFed (the Oxford Federation for General Practice and Primary Care) into OHFT, this includes 36 staff and the Oxfordshire Training Hub which will be hosted by our Learning and Development Team.

Physical healthcare services

- Community hospital wards
- District nursing service
- GP out of hours' service
- Minor injury units/ First aid units
- Hospital at home service
- Emergency multi-disciplinary units/
- Rapid access care unit
- Community dental service
- Health visiting service
- School nursing service
- College nursing service
- Podiatry
- Children's integrated therapies
- Children's community nursing
- Looked after children service
- Family support services
- Luther street GP for homeless people
- Children & adult bladder and bowel service
- Care home support service
- Chronic fatigue service
- Community diabetes service
- Adult community therapy service
- Nutrition & dietetic service
- Respiratory service
- Physical disability physiotherapy service
- Adult speech and language service

Mental Health & Learning Disability services

- Children and adolescent mental health community and inpatient service
- Children neuropsychiatry service
- Adult mental health community and inpatient service
- Older people mental health community and inpatient service
- Memory clinics
- Eating Disorder community and inpatient service
- Complex needs service
- Early intervention service
- Forensic mental health community and inpatient service
- Learning disability and autism community service
- Perinatal service
- Emergency psychiatric liaison service
- Improving access to psychological therapies (for mild or moderate conditions)
- Psychological therapy service (for severe/ complex conditions)

3. Introduction from the Chief Executive

Our vision is: outstanding care, delivered by an outstanding team.

I am pleased to introduce Oxford Health NHS Foundation Trust's (OHFT) 2020/21 Quality Account.

Hearing from patients

I want to ensure we deliver the best possible patient care and to do that we must have a strong patient voice, it is essential that we hear from those who use our services and enable them to help us to shape and improve the services that we provide. We have a number of mechanisms to help understand the experiences of our patients (some of these are detailed in section 8.3 below), highlighting what patients are positive about and where we need to improve. We also identified a number of quality objectives to improve patients and their families' experiences in 2020/21 which are reported on later in the Account in section 11. We recognise we need to do more to fully embed involvement and working in partnership with patients and their families in every decision we make to achieve our vision of outstanding care.

COVID-19 Pandemic

Little could we have imagined what has happened over the last 12 months as a consequence of the national COVID-19 pandemic, it has been the NHS' most challenging year in its 72-year history. As an organisation we have been responding and recovering at different times over the last year and we will continue to do this through 2021. The pandemic has impacted on everyone.

I am hugely grateful to everyone at OHFT for everything they have done to maintain our services, to support other colleagues and to deliver great care to our patients during the course of this most challenging of years. As is often the case in adversity we become creative and innovative and we have seen many opportunities created during the pandemic including a step change in the use of technology for digital consultations, meetings and training, and more collaboration with partners (more details in section 4).

The continuous stress and anxiety on staff at work and home caused by the impact of COVID-19 cannot be underestimated, so we have provided enhanced support staff which is detailed in section 11. Supporting our staff is crucial so this will remain an objective for us in 2021/22.

I believe there are reasons for us to be optimistic, with progress being made in the roll out of the vaccination programme (see section 4) and as a country we now have a better understanding about the virus and how to live with it.

Our Focus

I joined the Trust in June 2020 and have enjoyed my time this year immensely and want to thank everyone for making me feel so welcome. The organisation has many strengths including a talented workforce but we have more to do to realise our full potential.

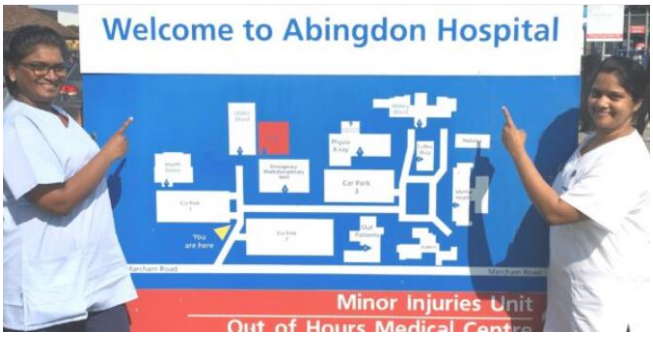
The results of the 2020 staff survey show we have improved in six key areas but there is more we can do to encourage staff to speak up when things don't go as planned and to support teams to

work more closely and to work towards common objectives. See section 8.6 for more about the annual survey results.

My focus is on the organisational culture to ensure that everyone feels engaged, valued and empowered to influence and improve the services they work in. Driving this agenda forward remains my top priority and something which the Trust's Board is fully behind. I believe also that our experiences through the COVID-19 pandemic so far have helped make the Trust a more connected place and seen a real strengthening in teamwork at many levels.

The Trust is moving to appoint a Chief People Officer to raise and develop the profile of human resources and workforce management within the Trust to reflect the key ambitions set out in the national NHS People Plan. We will build on our foundations and create an innovative and transformational approach to develop our workforce and make the Trust the best possible place to work. This role will be pivotal in creating a great culture that supports change but also in swift decision-making and the engagement and support of colleagues at every level throughout the organisation.

At OHFT we will continue our focus on the development of homegrown talent through our highly successful Thames Valley Nurse Cadets programme, nursing apprenticeship and nursing associate training programmes, through working with organisations like Oxford Brookes University. We also want to welcome experienced nursing colleagues who can immediately strengthen our workforce, providing resilience and flexibility which will have such a positive impact upon the wellbeing of our teams as well as improving the quality and continuity of care for our patients. The Trust embarked on an international recruitment drive in 2020/21 to attract highly skilled overseas nurses to work in community health and mental health wards. Already, 10 nurses from Nigeria, South India and Nepal have joined OHFT and embarked on roles in community hospitals in Oxfordshire.



I am passionate about the importance of team working and the impact this has on staff and the quality of care provided. In my experience, the best multi-disciplinary teams are characterised by strong relationships between all disciplines; relationships that are built on trust, confidence and respect.




When I look ahead to 2021/22 we must build on culture, effective teamwork and strong leadership, but also ensure that our quality improvement approach and commitment to research become "golden threads" that run through the organisation and are accessible to all. More about these golden threads is below (sections 6 and 7). These are essential to achieve the ambitions set out in the Trust's new five-year strategy, around four key strategic objectives;

- Quality – Deliver the best possible care and health outcomes
- People - Be a great place to work
- Sustainability – Make the best use of our resources and protect the environment
- Research & Education - Become a leader in healthcare research and education

NHS Long Term Plan

The NHS 10-year Long Term Plan[1] has been a catalyst for a number of actions at the Trust including;

- Developing the offer of an urgent community response and recovery support for people experiencing a sudden deterioration in their health to prevent unnecessary emergency admissions and to speed up discharges. This work is part of the Aging Well programme (see section 11)
- Enhanced care for people living in care homes, particularly timely access to out of hours support and end of life care
- Improving services for people with a learning disability and autism by helping to intensively support people in their homes and to avoid unnecessary admission to hospital.
- Establishing mental health support teams for schools across all the areas we serve. Most recently this has included the schools in Bath and North East Somerset, Swindon and Wiltshire.
- Developing new specialist perinatal mental health services
- Developing crisis resolution and home treatment services for young people and adults.

[1] More details about the NHS Long Term Plan can be found at NHS Long Term Plan.

- Expanding the service provided by mental health practitioners co-located with the South Central Ambulance Service to be available 24/7. This is in addition to mental health practitioners sitting alongside Thames Valley Police (called the street triage service) and psychiatric liaison services based with our acute hospital partner in Oxfordshire and Buckinghamshire.
- New mental health helplines across Buckinghamshire and Oxfordshire for both adults and children were set up from May 2020. The range of help and advice had a particular focus on those who may be experiencing problems relating to the pandemic and lockdown.
- Increasing access to Children and Adolescent Mental Health services (CAMHS). We are above the national average for number of young people treated and the timeliness of this, however young people in our local communities are waiting for care longer than we would like which we remain concerned about and continue to make every effort to reduce waiting times.
- Expanding our IAPT (Improving Access to Psychological Therapies) services with TalkingSpace Plus offering support to people in Oxfordshire and Healthy Minds caring for people in Buckinghamshire.
- Improving access to individual placement and support embedded within our adult mental health teams to help people to find and retain employment.
- Improving access for people experiencing a first episode of psychosis to a NICE approved care package within 2 weeks of referrals, the Trust has exceeded the national target of 60% throughout 2020/21.

Environmental Sustainability

The past year has not changed the fact that environmental sustainability is absolutely essential to the long-term future of the planet we live on.

The NHS aims to achieve net zero carbon emissions by 2040. Around 4% of the country's current carbon emissions are from the NHS. OHFTs biggest achievement to date is a 38% reduction in carbon emissions, exceeding the NHS target of 34% by 2020. The decarbonisation of heat within our buildings at the Whiteleaf Centre in Aylesbury and the Highfield Unit based at the Warneford Hospital together with transferring to electrical heating and installing high efficiency low energy lighting in buildings funded by NHS Improvement has contributed to this milestone.

In February 2021, at the virtual Zero Carbon Oxford Summit, OHFT along with 20 other major businesses and organisations in Oxford, signed the Zero Carbon Oxford Charter, agreeing our support to achieve net zero carbon emissions in the city by 2040.

On NHS sustainability day (26th March) the Trust joined in with the national tree planting day, adding four new trees to more than 800 trees we already have. The day was a chance to celebrate the importance of sustainable development, to champion green initiatives and raise awareness across the Trust.

Partnership working

Lastly, I wanted to mention the Trust's commitment to being an active and supportive partner to work in collaboration to improve the quality of services and improve care pathways for patients. Throughout the Account you will read about many examples of how we are working in partnership with other organisations. Some of the more formal arrangements include the Oxfordshire Mental Health Partnership, the Recovery Colleges[2] in Buckinghamshire and Oxfordshire, the Ageing Well programme and the NHS-led Provider Collaboratives in Mental Health Services. More information about the Provider Collaboratives is in section 11. We have also worked with Buckinghamshire health and social care organisations to develop a shared patient care record which went live in May 2020 so that professionals can more easily share key information about patients. A similar shared record is being developed in Oxfordshire in 2021.

It is an exciting time with the development of the Integrated Care Systems (ICS). The Trust is part of the Buckinghamshire, Oxfordshire and Berkshire West ICS, and the Bath and North East Somerset, Swindon and Wiltshire Partnership ICS. ICS have been established to strength partnerships between NHS organisations, local authorities and voluntary and social enterprise sector. The organisations in each ICS agree shared priorities for health and social care to meet the needs of local people to improve their quality of life and outcomes.

On behalf of the Buckinghamshire, Oxfordshire and Berkshire West ICS, OHFT has led on setting up and providing a mental health and wellbeing hub for health and social care staff within Oxfordshire and Buckinghamshire. The rationale is based on need due to COVID-19 but also evidence from beforehand of mental health need and delays in staff seeking help. The service was launched by care professionals for professionals from February 2021 to provide free, fast and confidential support and guidance.

I hope you enjoy reading our Quality Account.

XX add signature XX
Dr Nick Broughton
Chief Executive

This Account was approved by the Board of Directors on XXXX.

[2] Recovery Colleges are opportunities for patients, families and staff to learn about mental health and recovery. It is an educational approach to recovery.

4. The Impact and Opportunities of the COVID-19 Pandemic

In March 2020, in line with the rest of the NHS our activities have changed dramatically and we have been responding and recovering to the COVID-19 pandemic. We have cared for and treated 406 COVID-19 positive inpatients on our wards since the start of the pandemic and helped many more people in the community. Additional stringent infection, prevention and control measures were put in place which included our staff having to immediately use Personal Protective Equipment (PPE).

We are extremely proud of the way our staff mobilized to respond to the national crisis, showing dedication, compassion, resilience and innovation to continue to deliver high quality care despite the challenges and pressures we have faced.

Everyone working across OHFT has contributed to something extraordinary. Our success has only been possible with close collaboration with our partners including GPs, care homes, acute hospitals, the ambulance service, local councils, volunteers, Universities and third sector organisations.

Nationally a higher number of NHS staff from BAME[3] communities contracted the virus. Across OHFT we introduced a process to assess the level of risk for staff according to personal characteristics (e.g. age, ethnicity) and underlying health conditions. This resulted in a number of staff working in lower risk environments or from home during different points of the pandemic.

As an organisation we have sadly lost three of our colleagues from COVID-19 who we have spent time remembering and will not forget their contribution at the Trust.

With one in five people with COVID-19 developing longer term symptoms, we are working with Oxford University Hospitals NHS Foundation Trust to provide specialist help to patients suffering from Long COVID-19. The Trust established assessment clinics from January 2021 which takes referrals from hospital consultants and GPs for people experiencing prolonged symptoms such as brain fog, anxiety, depression, breathlessness, fatigue and other debilitating symptoms.

For more details about our performance and work around infection, prevention and control see the Trust's annual report to be presented to the Board of Directors in June 2021 and published with the board papers at; https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/.

[3] BAME is used to describe people from Black, Asian and Minority Ethnic groups.

Opportunities

As a result of what we have experienced, OHFT has become stronger, more agile and better connected. We want to build on this experience and ensure that the positive changes we have made as a result of responding to the pandemic are not lost. There include opportunities for more flexible working, fewer face-to-face meetings, greater use of technology and a more dynamic and less bureaucratic way of achieving our goals.

Some examples of the specific changes and innovation include:

- Both the Buckinghamshire and Oxfordshire Improving Access to Psychological Therapies (IAPT) services have expanded to help more people access mental health treatment to overcome the trauma of illness, loss of loved ones, lockdown and unemployment as a result of the COVID-19.
- The Trust is the highest user of digital consultations in mental health services across the Country. We completed more than 170,000 digital consultations in the year with patients or their families. This has revolutionised how we are able to work and provide care however we also recognise there remains an important place for face to face contact and care for some patients and their families.
- Oxfordshire CAMHS Neurodevelopmental Conditions Pathway team developed an online observational video autism diagnosis tool in response to the pandemic in order to continue to offer evidence-based assessments for autism spectrum disorder in children and young people. Over 40 assessments have been completed and the new tool has had a positive impact on overall waiting times.
- School nurses have been providing support to Oxfordshire secondary school pupils regardless of whether schools have been open or not during the pandemic. They have been offering support for young people and parents via a number of ways including at the end of a telephone or web call. The nurses have put together two special offers to help ease the strain of isolation and stress caused by living through the pandemic, these include 'Wind Down Wednesday' a relaxation session for young people and a special service for parents to access.

- Increased collaboration across the system has resulted in improved care for patients and families receiving end of life care
- Virtual visits were introduced on wards - a video messaging project which launched in community wards initially, with each patient bed being assigned a tablet or iPad which has been specially configured, secure and easy to use.
- 'Letters to a loved one' scheme was established to help when visiting was restricted to ensure families and friends could keep in touch. We have received over 100 messages which have helped patients during this difficult time. Members of staff and volunteers delivered these letters to patients on the wards.

- A number of virtually carer support groups were set up monthly. In addition, free educational on-line seminars were held for carers and family members of patients on a number of topics i.e. understanding suicidal thoughts and self-harm behaviours, understanding anxiety, understanding depression and improving wellbeing for carers.
- A Carers befriending line was set up, ran by a combination of volunteers and staff.
- The Physical Disability Physiotherapy Service went digital to help people to stay active. A special on-line service was created for people with Parkinson's disease. The service switched to online classes and run a number of groups. They continue to provide one to one sessions as needed.
- Two learning disability experts by experience from the community and patients from Evenlode ward have recorded their COVID-19 experiences for an international book project, which was published online.
- The Oxford Health Charity used grants to help staff to buy bicycles as a sustainable and healthy way to commute to work.

COVID-19 Vaccinations

In line with Joint Council for Vaccinations and Immunisations (JCVI) all front-line staff fall within priority group 2 and the Trust is required to formally report on the percentage of staff who have received a vaccine. As of April 2021:

- 77.8% of all staff have been vaccinated
- 82.6% of front-line staff have been vaccinated

Nationally we have seen the disproportionate impact on BAME communities from Covid-19 and we have worked with our Equality, Diversity and Inclusion colleagues across the Trust to ensure all staff have timely access to the vaccination and encourage uptake for all communities. The uptake of the vaccination amongst our BAME staff remains lower than other groups with 73.1% of front-line BAME staff. The Trust has developed a vaccine hesitancy task group to lead on actions to help improve the uptake of the vaccine from BAME staff.

National Vaccination Centres

OHFT is operating three of the national NHS Mass Vaccination Centres (MVC) for communities in Berkshire, Buckinghamshire and Oxfordshire to deliver the COVID-19 vaccine and be part of the biggest immunisation programme in our history. The first centre opened on 25th January 2021 and we have delivered more than 100,000 vaccinations so far.

Sir Simon Stevens, Chief Executive of the NHS, visited staff at one of the centres at the Kassam Stadium to see the success of the delivery.

5. Key Achievements and Awards

Below are some of our outstanding achievements which took place during 2020/21.

Community Hospitals Association's (CHA) Innovations and Best Practice Awards

Creating with Care, the innovative arts programme run at OHFTs six community hospitals, won the Innovation and Best Practice improving Patient Care award at the Community Hospitals Association's (CHA) Innovations and Best Practice Awards 2020. The judging panel said:
"'Therapeutic joy' sums up this project. It is such an impressive piece of work, impacting positively on patients, families, staff and the environment. This work is an example of innovation and creativity at its best. You should all be so proud of developing and delivering this work. Impressive, joyful, person-centred, effective, evidence based and fabulous!"

50th Anniversary of the Community Hospitals Association's

The first community hospital in the UK was **Wallingford community hospital**. The hospital helped to mark the 50th anniversary of the community hospital association in 2020. There are now over 500 community hospitals across the UK.

Our Health Heroes Awards

Community support worker **Thomas Gregory-Smith** from the City Older Adults Community Mental Health Team pocketed silver in the national Our Health Heroes Awards, organised by Skills for Health. Tom was nominated because:

"It has been a joy to see our service users benefiting from Tom's psycho-spiritual work, and service users and colleagues alike have benefited from Tom's musical abilities. It's rare to see someone contribute to a team in such wonderfully varied ways. Tom is truly one of a kind and I'm delighted that he has been recognised in national awards. Well deserved!"

NHS Parliamentary Awards

Buckinghamshire Perinatal Mental Health Service was named regional South East winner of the NHS Parliamentary Awards in the Excellence in Mental Health Care category in November 2020. The specialist service provides assessment and treatment to women with complex and severe mental health problems during and after pregnancy. The service launched in May 2019 and brings together OHFT and Buckinghamshire Mind professionals to provide care and support for mothers and their babies.

Royal College of Psychiatrists Poster Prize

Dr Kah Long Aw was named the overall winner of South Eastern Division Poster Prize at the Royal College of Psychiatrists South Eastern Division & London Division Autumn Conference in November 2020. The prize was awarded for his submission 'Schizophrenia and COVID-19: Are standards being met during the COVID-19 Pandemic?' Kah was a Foundation Year 1 student in the Oxford Deanery and was working on Opal Ward at OHFTs Whiteleaf Centre in Aylesbury.

Finalist in National BAME Health & Care Awards

OHFTs Head of Inclusion **Mohamed Patel** was shortlisted for the Compassionate and Inclusive Leader award in the National BAME Health & Care Awards. This award is for a leader who "creates a culture where staff feel safe to be themselves and where everyone feels inspired to achieve their best."

Portraits for NHS Heroes

Karl Ellis a healthcare assistance on our learning disabilities Evenlode ward gave his photo to artist Tom Croft to paint, little did he imagine his portrait would adorn the cover of Portraits for NHS Heroes.

Thames Valley Nurse Cadets shortlisted for Pilot Project of the Year

Thames Valley **Nurse Cadets** programme was shortlisted for the Pilot Project of the Year award in the HSJ (Health Service Journal) Value Awards in March 2021. The programme is a collaboration of four NHS Trusts and three higher education institutions with the ambition to grow the next generation of healthcare professionals. It gives young people aged 16-19 years old their first step into working in a healthcare setting with a clear path to further career development.

Current partners in the programme are OHFT, Central and North West London NHS Foundation Trust, The Hazeley Academy, Milton Keynes University Hospitals Foundation Trust, Milton Keynes College, Bucks Healthcare Trust and Bucks Community College. The pilot has been funded by Health Education England.

'A good night's sleep' shortlisted for multiple awards

A digital care innovation to improve patient care at **Vaughan Thomas Ward** was shortlisted for the HSJ Awards 2020 for the Mental Health Innovation of the Year. The Trust's entry, 'A good night's sleep in hospital – A new standard in mental health' shines a light on the Oxevision platform. Previously known as Digital Care Assistant, Oxevision enables staff to gather observations from mental health inpatients without waking them at night.

Developed in collaboration with Oxehealth, an Oxford University spin-out, Oxevision observation technology was launched in summer 2019 on the acute inpatient Vaughan Thomas Ward at

Warneford Hospital, Oxford. In September 2020, the innovation was shortlisted for Nursing Times Awards 2020 in two categories: Nursing in Mental Health and Technology and Data in Nursing.

Community Respiratory Team

OHFTs **Community Respiratory Team** has been part of an innovative project that was shortlisted in the HSJ Partnership Awards for the Best Pharmaceutical Partnership with the NHS. Submitted by Oxfordshire Clinical Commissioning Group and the pharmaceutical company Boehringer-Ingelheim, the entry is titled 'An enhanced integrated multi-disciplinary respiratory team'. The Integrated Respiratory Team (IRT) brought together experts from Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Foundation Trust, OHFT and Oxfordshire County Council to pilot the project in the Banbury and Oxford areas, supported by pharmaceutical company Boehringer-Ingelheim. The winners are scheduled to be revealed in June 2021.

One of the respiratory nurses won the 2020 HSJ patient safety award for her work and vision which has resulted in lives being saved and good practice developed in Oxfordshire becoming a national standard. She developed a risk assessment tool to help find and mitigate risks in the homes of patients who need oxygen therapy to help with a range of medical conditions.

Rapid roll-out of digital consultations shortlisted for IT & Digital Innovation Award

OHFT's **digital consultations** project – entry titled '100,000 digital consultations: making life easier for staff and patients during the pandemic' – was shortlisted for the IT & Digital Innovation Award in the HSJ Value Awards.

The project was set up in March 2020 to support clinicians and patients to respond to the COVID-19 crisis. Assembled in just one week in March 2020, the project team engineered a systematic and seamless transition from face-to-face appointments to a Trust-wide digital offer.

As we marked the one-year anniversary of the start of the first lockdown, the Trust had surpassed 170,000 digital consultations. Throughout the pandemic, digital consultations enabled patients to access health care from the safety and comfort of a place of their choosing. Patients also reported good satisfaction as digital consultations remove the stress, time and cost often associated with travelling to face-to-face appointments. The awards ceremony is scheduled at the end of June 2021.

Staff Equality Networks

In 2021 we celebrated our 'Five Year Anniversary' of our **Disability, LGBT+ and Race Equality Staff Networks** which have been running strong since March 2016. We were delighted to welcome the new Gender Equality Staff Network on International Women's Day this March 2021.

During 2020/21 the Trust Board made a commitment to improving Race Equality and to that end signed off an ambitious 'Race Equality Framework for Change' programme which is being led by the Chief Nurse and one of our Service Directors alongside our Equality and Diversity Lead.

6. Our Focus on Quality Improvement

Our commitment to quality improvement is seen in the investment and establishment of the Trust's Oxford Healthcare Improvement Centre which provides leadership, training and coaching to develop capability to apply a consistent approach to continuous Quality Improvement (QI).

The Centre is currently developing their strategy and key objectives include:

- developing patient co-production in all QI work,
- implementing a redesigned training model based on three levels,
- developing a QI network for trained staff,
- rolling out QI Hubs in each clinical directorate,
- improving how the outcomes of QI projects are shared using Life QI software,
- developing QI cafes to support local projects and build on relationships with external organisations.

Below are some of the current QI projects underway:

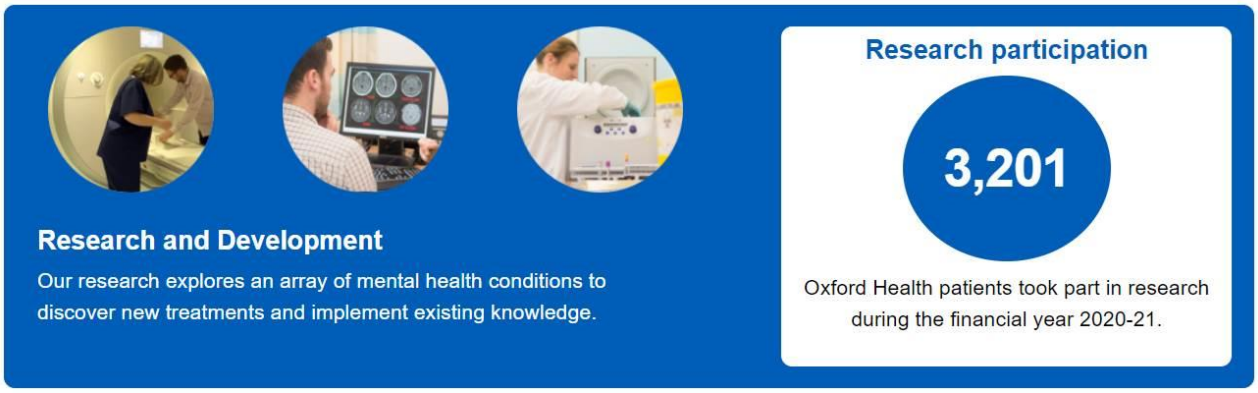
National Projects:

- Improving Sexual Safety on Wards
- Ligature Harm Minimisation
- Suicide Prevention
- Positive and Safe – reduction in restrictive practice

Wider Trust projects:

- Red2Green (to improve flow through inpatient services) Oxon Adult MH wards and Bucks Older Adult MH wards
- Improving the Physical Health monitoring of patients with severe and enduring mental illness
- Trauma Informed Care
- Integration of Psychological Services
- Risk Assessment formulation and documentation
- Working with families and carers
- Measuring success of race equality framework for change
- Personality Disorder pathway evaluation Bucks

7. Research and Development



Clinical Research is crucial to improve the quality of patient care we provide and to discover new treatments and interventions, as well as a key plank to improving the retention and recruitment of our staff. The Trust is a leading research-active organisation with strong strategic research links to both the University of Oxford, which is the top-rated University in the World University Rankings and Oxford Brookes University. On average we have 100 studies open at any one time – ranging from small student projects to psychological interventions, to highly complex clinical trials of new medicines.

The Trust has set a strategic objective to become a leader in healthcare research and education, to build on the work already achieved, not least our relationships with the University of Oxford and Oxford Brookes University together with our Biomedical Research Centre (BRC). We are one of only two BRC's in the country currently which focuses on mental health. The aspiration is for all staff within the Trust to be research active.

This year 3,201 patients took part in research and we have published 35 on-line news items over the year covering diverse topics including:

- a BRC supported event at the Oxford Asian Cultural Centre to mark International Women's Day
- the opening of the Oxford Brain Health Centre,
- and frequently updated coverage of the BRC's COVID-19 research.

A huge global achievement was for our Clinical Research Facility being used to support the Oxford AstraZeneca and Novavax Covid-19 vaccine trials. We are participating in Virus Watch and we have set up PRINCIPLE - a priority one urgent public health COVID-19 trial to evaluate treatments that can be delivered at home for COVID-19 in people aged over 50.

An exciting new partnership was confirmed in March 2021 with a new agreement between the Trust, the University of Oxford, the University of Toronto and the Centre for Addiction and Mental Health. This partnership will enhance the existing relationships and help realise the benefits of the complimentary capabilities of the organisations. More information can be found here New transatlantic partnership to transform research and clinical landscapes in mental health | Oxford Health NHS Foundation Trust

Our website at OHFT Research and Development details much more on our research activities.

8. National Quality Indicators

8.1 Our Performance against the NHS Oversight Framework

The NHS Oversight Framework replaced the provider Single Oversight Framework and informs the assessment of providers. The Framework is intended as a focal point for joint work, support and dialogue between NHS England and NHS Improvement, commissioners and providers.

Table 1 shows the Trust's performance against the indicators in the framework, this is reported regularly to Trust Board.

Overall our performance is positive with the majority of indicators consistently achieved over the past 12 months. The exception is the number of inappropriate out of area placements in both Oxfordshire and Buckinghamshire, further details in relation to this are below.

Table 1. Trust performance against the indicators in the Single Oversight Framework

This year, the NHS Oversight Framework indicators that have targets are;	Target	National position	Trust Position
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	85.4% (Apr)	95.7% (Mar)
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral	56%	67.8% (Dec)	78.6% (Mar)
(N3) Data Quality Maturity Index	95%	68.5% (Dec)	98.1% (Dec)
(N4) Percentage of people completing a course of Improving Access to Psychological Therapies (IAPT) treatment moving to recovery	50%	47.2% (Dec)	57% (Dec)
(N5) Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	92.6% (Feb)	98.5% (Feb)
(N6) 18 weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	95%	98.6% (Feb)	99.8% (Feb)
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - Buckinghamshire	103 bed days (month 12)	n/a	630 bed days (month 12)
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – Oxfordshire	91 bed days (month 12)	n/a	996 bed days (month 12)

Eliminating inappropriate adult acute out of area placements

Out of area placements mean admitting someone to a ward outside the services provided by the Trust. An out of area placement is categorised as inappropriate if the rationale for placing the person relates to bed pressures or absence of community or social care support.

In early 2020 the Trust was on a trajectory of eliminating inappropriate out of area placements, however due to the impact of the COVID-19 pandemic we have not been able to achieve our target in 2020/21. We had to introduce essential infection, prevention and control measures in line with national guidance from March 2020 across all wards, which has meant the Trust has been operating throughout the year with up to 15% less inpatient capacity. The interim closure of beds to manage inpatient isolations and social distancing has resulted in additional out of area

placements which the Trust has mitigated by purchasing a block contract of 10 beds with an independent sector provider.

Other national indicators

In this section we will report on the following national quality indicators:

- Care Quality Commission inspection rating
- Patient and carer/ families experiences (including the national survey)
- NHS Improvement Standards for people with a Learning Disability and/ or Autism
- Patient safety incidents and Serious Incidents
- Staff experiences (including the national survey)

8.2 Care Quality Commission Inspection Rating

We are registered without any conditions by the Care Quality Commission (CQC) which is responsible for ensuring health and social care services meet essential standards of quality and safety. The CQC last inspected services at OHFT and published their findings in December 2019 when we received a **'Good'** rating for our quality of services. The full report can be found at https://www.cqc.org.uk/provider/RNU. We have not had an inspection during 2020/21.

8.3 Patient and Carer Experiences (including national survey results)

The Trust has a two-year Patient Experience and Involvement Strategy and we have recently revised our 2017 Carers, Friends and Family Strategy, which was co-developed with carers/ families and is due to be published shortly.

The strategies help to identify and set out our priorities with the patients and carers we work with and to provide a way to measure our progress. Both of the strategies aim to improve how we involve and work in greater partnership with patients and their families, so that care is personalised, care and treatment decisions are made with patients, and the services we provide meet people's needs. Our newly revised strategies will have a clearer focus on improving equality of access and inclusion to reduce health inequalities which have been highlighted more than ever during the COVID-19 pandemic.

The current strategies are available at OHFT Patient and Carers Strategies.

In 2020/21 we identified four quality objectives to improve patient's experiences (E1, E2, E3 and E4), progress against these is detailed below under section 11.

We use a number of ways to measure and use patient and their carers/ families experiences of services to improve. Some of the ways we gather feedback include:

- patient groups and councils, concerns raised through the Patient Advice and Liaison Service,
- volunteers collecting feedback, complaints, compliments, patient stories,
- peer review visits to teams,
- telephone surveys,
- feedback from voluntary/ charity organisations,
- social media posts,
- national surveys, and
- our local standardised paper and electronic survey provided by an external company, ***I Want Great Care.***

The Trust's annual complaints report will be presented to the Board of Directors in June 2021 and published with the board papers at: https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/. We are developing some customer service work to try and resolve some of the common concerns raised in relation to staff communication and behaviours.

Below is a summary of some of the feedback we have received.

The feedback tells us we need to improve how we involve patients and carers/ families, listen to them, and enable them to make shared decisions about their care and treatment. This feedback comes through surveys, complaints and other investigations the Trust undertakes.

A Quality Improvement programme has been initiated in relation to improving patient and family involvement in care.

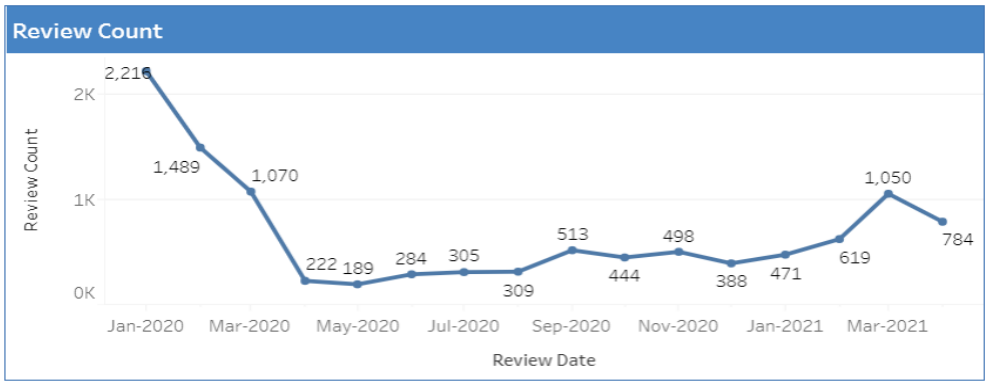





Local Survey Feedback

The number of responses received via survey feedback collected by I Want Great Care is shown in the below graph. We have seen a significant reduction in the number of responses received in 2020/21 which we understand to be owing to some of the infection prevention and control restrictions including a reduction in face to face appointments and opportunities to complete the survey responses.

Figure 1.



In the last 12 months we have received 5,854 survey responses. The average rating across all questions (looking at involvement, being listened to, the kindness from staff and information provided) has been **4.69 out of 5.0** with **93.6% of people reporting a positive experience**. Below is a word cloud based on all the responses received to the open text question asking why the person rated their experience as they did. The bigger the word the more times it has been used in the surveys.

The Trust asks the national patient experience question in our structured surveys. The question was changed from 1st September 2020 to ask about a person's overall experience of using the service. In response to this question on overall experience - **82.4% of patients/ families have rated their experience as 5 out of 5 (outstanding),** 11.6% as 4 (good) and 6% between 1-3 (satisfactory/ poor). The average is a rating of 4.73.

Figure 2.

National Survey Feedback

The Trust participated in the annual national community mental health survey, whereby 1250 randomly selected patients aged 18 and above were sent a survey between February to June 2020. The full results are available at OHFT board papers Jan 2021. There were several positives in the results where we have improved since 2019 or the comparator information indicates the Trust is above the national average score. However, there are still many improvements to make.

The Trust scored well in relation to questions on:

- involving family members,
- how to contact your Care Coordinator,

- ❖ how well the Care Coordinator organised their care, feeling treated with dignity and respect,
- ❖ how NHS therapies were explained and
- ❖ how a patient was asked how they are getting on with their medicines.

The key improvements areas are:

- ❖ patient involvement in care,
- ❖ knowing who to contact in a crisis,
- ❖ offering help with finding/ keeping work,
- ❖ supporting with physical healthcare needs, and
- ❖ increasing how often patients are asked for their feedback on care.

The actions we identified following the survey were:

- to identify experience and involvement champions in each team,
- ensure local patient forums were held regularly by teams,
- development and delivery of co-production training,
- patient involvement in the mental health services transformation work,
- appointment of additional employment specialist posts,
- to embed annual comprehensive physical health assessment (see quality objective S5), and appointment of new physical healthcare roles.

8.4 NHS Improvement Standards for people with a Learning Disability and/ or Autism

The national quality improvement standards were developed with a number of outcomes created by people and families in 2018. The full details about the standards can be found at Improvement standards for people with a LD or Autism and are included in the NHS Long Term Plan.

The four standards are as follows and under each there are a number of improvement measures:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Specialist learning disability services standard

The Trust is using the standards and measures to improve the quality of services we provide. In 2020 we completed the annual national benchmarking exercise against the standards which involved an organisational level self-assessment, a staff survey and a patient survey. The benchmarking results for 2020/21 have not yet been shared or published. However, we are using the self-assessment to identify the actions we still need to take. Some of the work is included below in section 11, under the quality objectives E3 and E4.

In June 2020 the Trust's Learning Disability services helped to keep people informed, engaged and safe during the pandemic. It compiled over 400 COVID-19 Hospital Passports for people with learning disability which included brief summaries of medical conditions, medicines, dietary requirements, eating and drinking difficulties, and communication preferences. These were sent to our neighbouring acute hospital, Oxford Universities Hospital NHS Trust to be appended to patient records. The service also identified patients at very high risk and checked with them and their GP what arrangements should be put in place should they contract COVID-19, and what their wishes would be.

8.5 Patient Safety Incidents

It is crucial that we learn from every patient safety incident and to that end we encourage our staff to report all incidents so that we can use these as an opportunity to identify any patterns which might need more attention. The 2020 staff survey results showed our staff reported a positive safety culture, with an improvement from 2019 and a better result than the national average. Further detail about how we are learning from deaths is below in section 10.

The Trust reports all Patient Safety Incidents (PSI) through the National Reporting and Learning Service. PSI are nationally defined as an unintended or unexpected incident which could or did lead to harm of a patient. The below graphs shows the number of incidents and incidents by level of harm for the last 12 months.

In 2020/21 - 57% of the PSIs resulted in no harm, 38% resulted in minor harm and 5% resulted in moderate, severe harm or death. This is generally in line with the national picture in which 56% of community health PSI and 61% of mental health PSI were graded as no harm.

The majority of incidents relate to self-harm (33%), followed by patients resisting treatment, medical administration, falls and skin integrity (pressure ulcers). The type of incidents where there is the highest amount of moderate or severe harm is within skin integrity, relating to category 3 or 4 pressure ulcer incidents developed in service.

Our work on reducing pressure ulcers is detailed below under section 11, quality objective S4. The Trust reviews all incidents to take immediate actions and consider safeguards for patients, as well as senior clinicians reviewing the incidents on a weekly basis and quarterly we identify learning and broader areas for improvement.

Figure 3. Number of patient safety incidents in 2020/21

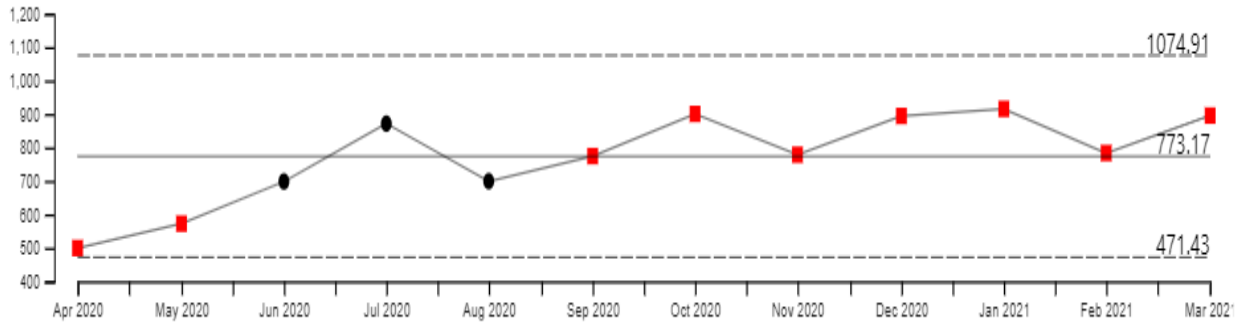
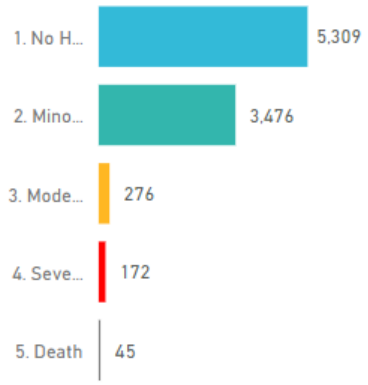


Figure 4. Level of harm for patient safety incidents in 2020/21



The National Reporting and Learning Service issues a number of national safety alerts from reviewing incidents submitted by all NHS Trusts. In 2020/21 eight national patient safety alerts were issued, of which four were relevant to services provided by the Trust (2020/005, 2020/006, 2020/008 and 2021/001). The actions for the four alerts have been completed within the national deadlines set.

In line with national guidance Serious Incidents (SI's) are reported and an in-depth investigation completed to maximise learning and to prevent a similar incident reoccurring. Every investigation is shared with our commissioner for review. Information on the number of serious incidents and our learning is reported to every Trust Board meeting. Two reoccurring issues have been identified in 2021 for additional focus through Quality Improvement methodology with support of the Oxford Healthcare Improvement Centre. These issues are:

- Communication and involvement of family members during care
- Risk assessment and formulation including documentation

These Quality Improvement projects are in the planning stage and being led by a Clinical Director with the Chief Nurse as the Executive Lead.

8.6 Staff Experiences (including national survey results)

It has been more important than ever during 2020/21 that we understand the experience of staff working for OHFT in order to inform how we support in the year ahead. As we continue to care for people through the pandemic while delivering our core services we need to ensure we enable people to live and thrive at work, despite the challenges we all continue to face. In 2020 – 3,464 staff took part in the annual national survey to tell us about their experience (53% response rate).

From previous surveys we took actions to improve staff wellbeing and reduce stress including the procurement of an Employee Assistance Programme[4] and the introduction of face-to-face Schwartz Rounds[5].

69% of staff said they would recommend the Trust as a place to work and **75% said they would be happy if a friend of relative needed treatment from us** and the quality of care they would receive from us. In both these questions we have seen an improvement from 2019. The results show we have improved in six key areas but there is still more we can do to encourage staff to speak up when things don't go as planned and to support teams to work more closely and to work towards common objectives.

In responding to the survey results, three areas will be focused on from a Trust-wide perspective;

- ❖ Developing Teams
- ❖ Listening to our people
- ❖ Development Conversations (to help staff to develop their careers)

Following feedback from the survey the Trust has also approved funding to provide enhanced Musculoskeletal support to staff.

[4] The Employee Assistance Programme is delivered by an external provider which provides a helpline staffed by counsellors to help staff to deal with personal problems that might adversely impact on their work, health and happiness.

[5] Schwartz Rounds are confidential forums for staff from all disciplines to come together to reflect on the emotional challenges of working in healthcare, to boost wellbeing and reduce stress and isolation.

9. Supporting Staff to Speak Out

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts in England to report annually on staff who speak up (including whistle-blowers).

To enable a more open and supportive culture that encourages staff to raise any concerns over the quality of care, patient safety or bullying and harassment we have developed a number of ways staff can speak up and to ensure those who do speak up do not suffer repercussions, these are detailed below.

In 2020/21 no serious patient safety concerns have been raised, although some issues relating to level of demand and work pressure have been raised. The annual 'Freedom to Speak up Guardian' report provides more detail and there is a link to this below. The annual national staff survey results ask a range of questions about the safety culture of an organisation including fair treatment for staff involved in incidents, an organisations openness to learn and take actions, and how safe staff feel about raising concerns. The results in 2020 gave the Trust a score of 7.1 out of 10. This is better than 2019 and above the national average - however every member of staff needs to feel safe to speak up and learn when things go wrong.

Staff have opportunities to raise concerns through:

- A staff member's line manager to discuss what happened and to agree how they would like to be supported
- The Freedom to Speak Up Guardian provides independent and confidential support to staff who wish to raise concerns and to promote a culture of openness. The guardian's annual report in November 2020 is available here OHFT Freedom to Speak up Guardian 2020. In 2021 the Trust has recruited more resource for dedicated Guardians.
- The Guardian of Safe Working Hours for junior doctors, which promotes a culture for trainee doctors to raise concerns and do not fear adverse repercussions. The Guardian's annual report in September 2020 is available here OHFT Guardian of Safe Working Hours 2020
- The Human Resources Department, who also manage the whistleblowing process overseen by the Executive Team.
- Fair treatment at work facilitators, this innovative role has been introduced across the Trust led by the Head of Inclusion. This is a service made up of more than 14 staff to provide one-to-one support to staff who have experiences or have concerns about bullying and harassment in the workplace. The facilitators have received specialist training by the Advisory, Conciliation and Arbitration Service.
- Staff side representatives are available to offer advice and support.

- ❖ During 2021/22 the Trust is embarking on implementation of the Restorative Just Culture approach spearheaded by Mersey Care NHS Foundation Trust with significant improvements in a number of areas related to staff experience.

10. Learning from Deaths

The Trust provides care for people of all ages covering mental health services across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset plus learning disability services and physical health services in Oxfordshire – in some areas this includes both community and inpatient care. We regularly review information on the deaths of both current patients and patients discharged from the Trust who die within 12 months of their last contact including inpatients and those seen as outpatients. This is to e sure we have a robust opportunity to identify and learning and opportunities to improve from such sad events.

Internal Oversight and Governance

The Medical Director is the lead Executive Director responsible for the learning from deaths and chairs the Trust's Mortality Review Group, which meets at least quarterly and includes representatives from our Trust Governors. Every meeting involves each clinical directorate reporting back on key learning and actions following reviews into patient deaths.

The Trust has a three-step approach to the review of patient deaths as detailed in the Trust's mortality review guidance. This includes:

- An initial screening completed by at least two senior clinicians which includes speaking to the bereaved family where possible
- Scrutiny including an initial review report and discussion within the directorate's weekly safety review
- All unexpected deaths, suspected suicides, expected deaths where there are any care concerns identified, all learning disability deaths, all mental health inpatient deaths, all COVID-19 inpatient deaths and all deaths of a patient detained are reported on to the Trust incident reporting system, Ulysses.

In relation to the number of deaths reported onto Ulysses for further review this varies by type of service with on average the Learning Disability and Forensic services reporting 92% of deaths (30 deaths a year), the mental health services reporting 30% (400 deaths a year) and the community physical healthcare services reporting 5% (5,000 deaths a year including GP Out of Hours Service). An in-depth investigation and/ or declaration as an SI may then be declared as a way of learning. The mortality review process and guidance was last reviewed and approved by the Trust's Mortality Review Group in November 2020.

Members of the Trust are also involved in the following multi-agency mortality review processes:

National

- ❖ Child Death and Overview Process (CDOP)
- ❖ Learning disability mortality review process (LeDeR)
- ❖ Children's Serious Partnership Reviews/ Partnership Reviews
- ❖ Adult Safeguarding Adult Reviews
- ❖ Domestic Homicide Reviews
- ❖ Mental Health Homicide Reviews
- ❖ Coroner Inquests

Local

- ❖ Oxfordshire vulnerable adults mortality forum, enhanced in 2020/21 with rapid reviews driven by COVID-19
- ❖ Oxfordshire homeless mortality review process
- ❖ Regional Oxford Academic Health Science Network Mortality Review Group
- ❖ A joint Mortality and Morbidity forum with Oxford University Hospitals NHS Foundation Trust to review deaths in community hospitals

We also submit information to the following national confidential enquiries to aid national learning:

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and
- National Confidential Enquiry into Patient Outcome and Death Long Term Ventilation.

<u>Headlines for 2020/21 (data source: national DBS trace)</u>

There has been little variance in the number of deaths over time, with most deaths for patients with an open referral (88%) aged 75 and over. Except for significant peaks in April 2020 (n=892 deaths) and January 2021 (n=686 deaths) for patients aged 75 and above with an open referral - related to deaths as a result of COVID-19.

The figures below show the number of deaths by month and number of deaths by age band. Our trend over time mirrors the national pattern from 2016 to 2021 including the peaks in April and January. In the Trust the peak in April 2020 was followed by a lower-than-average number of deaths June to Sept 2020.

Figure 5. Number of deaths by month

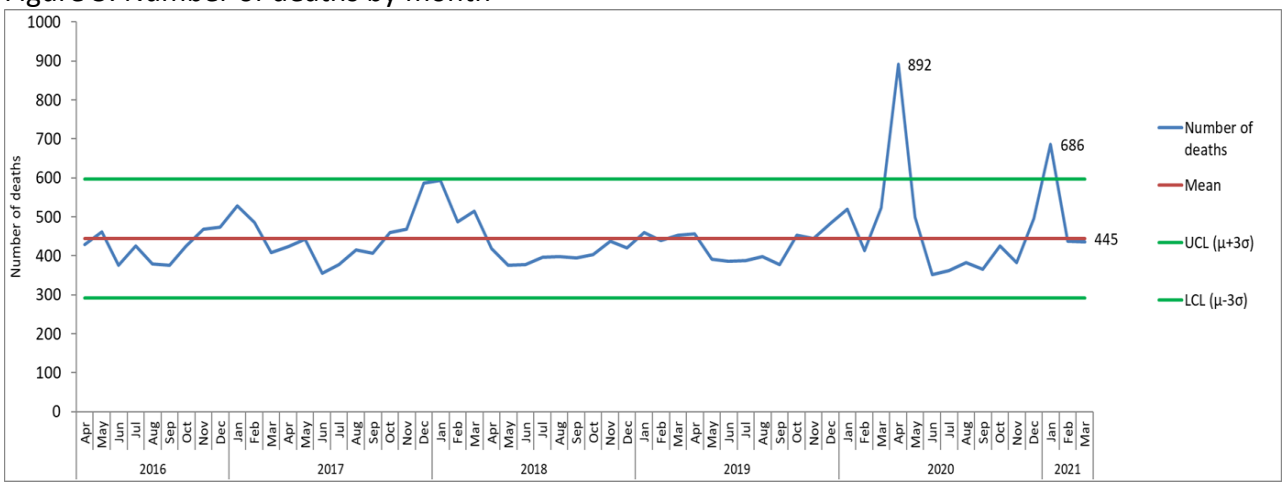
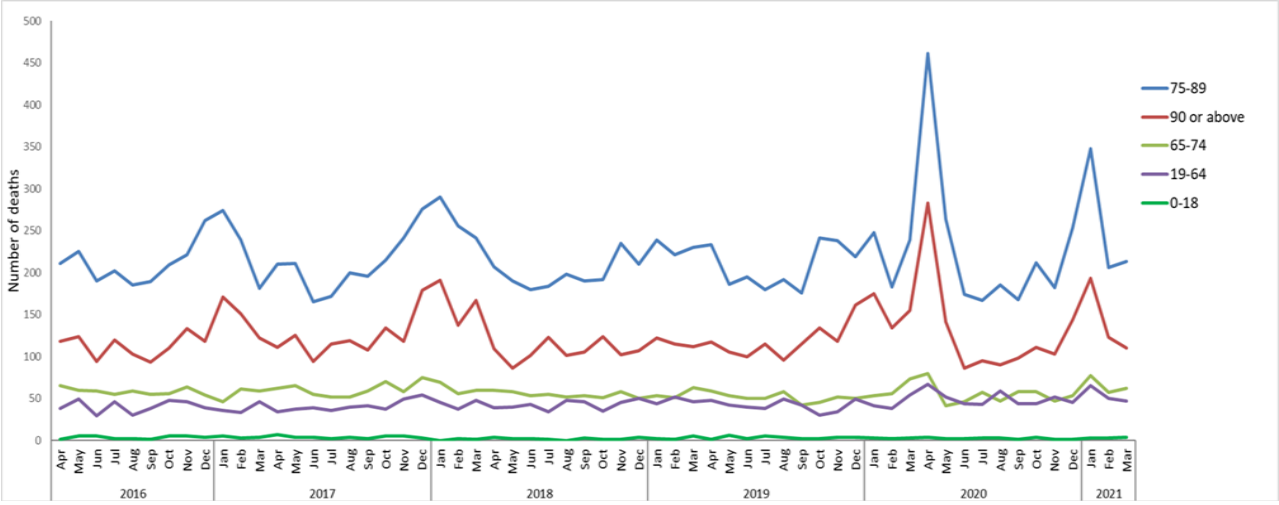


Figure 6. Number of deaths by age band



We have seen above average number of deaths for patients aged 19-64 from March 2020-March 2021, mostly relating to patients aged 50 and above with higher variances in April 2020, August 2020 and January 2021. Most of these patients were last seen by a physical healthcare service such as District Nursing. The increase seems to be related to COVID-19 and a combined increase in suspected suicides (further details on suspected suicides below).

88% of deaths are for current patients. The number of deaths of patients who have been discharged and then die within 12 months is low and there has been little change in trend since April 2016 except for a small increase in April 2020 and January 2021. Most of the deaths for discharged patients were reported by the Improving Access to Psychological Therapy service who provide short term talking therapies for people with mild anxiety and depression.

In 2020/21 there were 30 deaths for patients aged under 18 compared to 38 in 2019/20. Most deaths were for patients open to services at the time of their death (93%) and most commonly last seen by the Health Visiting Service (48%) or Children's Community Nursing Services. All child deaths are reviewed through the multi-agency Child Death Overview Process (CDOP) led by the local Children's Safeguarding Board and in some cases will also have a children's serious partnership review/ serious incident investigation. System-wide recent themes for learning have been in relation to co-sleeping on sofas, window safety and safety around open water.

We have had 111 inpatient deaths in 2020/21 including patients who have died within 2 days of a ward stay and any patients on Section 17 leave or a Community Treatment Order at the time of their death. Most inpatient deaths occur in the community hospital wards (98 deaths = 88%) for patients aged over 80 and the death has been expected (67 expected, 5 unexpected, 26 COVID-19 related). The number of inpatient deaths has declined over the last 3 years despite there being 32 COVID-19 inpatient deaths across the Trust from March 2020. In addition, we had 2 patients who died in the acute hospital after recent transfer from one of our wards. In 2020/21 there has been 1 suspected suicide on a mental health ward, plus a possible further suicide although cause of death has not yet been confirmed.

The figure below shows the number of suspected and confirmed suicides from April 2017 to March 2021. In 2020/21 there have been 72 suspected or confirmed suicides, of which 45 patients had an open referral at the time of their death. When looking at a longer time period there has been an increase in suspected suicides in March 2020 and then between July-Sept 2020.
The effect when someone sadly takes their own life is unimaginable to families and loved ones and the Trust held a mental health summit led by the Chief Nurse, Medical Director and Executive

Managing Director for Mental health and Learning Disability, in November 2020, to identify themes and local actions we could take to address the increase.

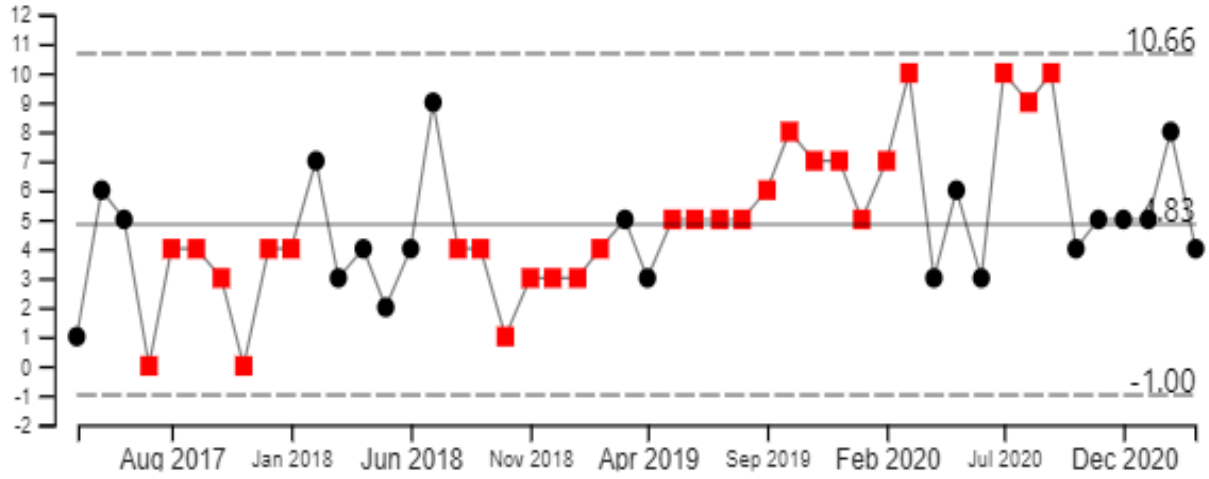
Areas of focus included:

- embedding safety plans developed with patients and their families,
- development of suicide prevention champions within teams and
- additional staff training and seminars to improve skills

The Trust is involved in multi-agency work in each County to prevent and reduce suicides. The Trust introduced a Family Liaison Service from November 2020 to provide compassionate support, signposting and practical advice to families and carers who have been bereaved by the suicide of a loved one who was under our care or recently discharged, and families/carers who are involved with Serious Incident Reviews following incidents that resulted in harm to a patient.

During 2021/22 we are reviewing the 10 steps to safety identified by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness to ensure we have routinely embedded each step.

Figure 7. Number of suspected suicides April 2017 to March 2021



The Thames Valley Real Time Surveillance System data collected by the Police for County populations, shows by calendar year an increase in suspected suicides from 2017 to 2020 for Oxfordshire and Buckinghamshire. In 2020 the number in Oxfordshire was 64 suicides and Buckinghamshire 55. There has been a higher increase in Buckinghamshire over the years. Between January up to 24th March 2021 there have been 11 suicides in Oxfordshire and 3 suicides in Buckinghamshire.

Key learning

The Trust has been issued with two Preventing Future Death notices from the local Coroner in 2020/21 relating to two patient suicides. The concerns being addressed are:

- lack of a clear written plan
- the risk assessment not being updated timely
- involvement of their families in care
- timeliness of allocating a care co-ordinator when the patient was an inpatient

Actions have been identified for each area of concern which have been shared with the Coroner, CQC and local commissioner.

We have identified two main issues from our reviews of patient deaths for additional focus in 2021/22 and progress against these will be supported by the Oxford Healthcare Improvement Centre. These issues are:

- communication and involvement of family members during care,
- and risk assessment and formulation including documentation.

These Quality Improvements projects are being led by the Chief Nurse and Clinical Directors and are currently in the planning stage.

11. Progress on Quality Objectives in 2020/21

We identified, consulted on, and finalised 17 quality objectives for 2020/21. The objectives were identified following a review of our risks, themes from quality information, learning from wave 1 of the COVID-19 pandemic and feedback from stakeholders. However, due to the pressures created by COVID-19 they were finalised much later than usual years, in September 2020. A senior leader was identified to lead on each objective. We recognise we were being ambitious and setting ourselves quite a challenge in 2020/21 to achieve the below objectives during an uncertain and unprecedented time.

More effort and resources than ever could have been predicted over the last year has been focused on our response to the COVID-19 global pandemic in order to maintain critical services, ensure stringent infection, prevention and control measures as well as rapidly establishing new services and ensuring continued support for our staff. As a consequence, we have not progressed as much as we would have liked against the quality objectives. However, we have made a start with many of the objectives and are proud of our teams in what they have achieved alongside managing the challenges faced.

Table 2 details our progress against each quality objective. Out of the 17 objectives only one has been fully achieved which was the implementation of the Provider Collaboratives to improve care pathways and outcomes for patients.

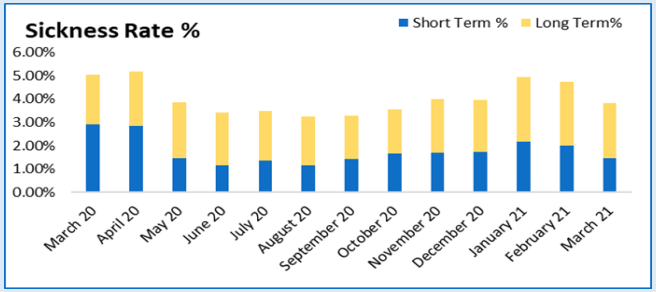
The NHS Long-Term Plan sets an ambition for the development of NHS-led Provider Collaboratives in Mental Health Services designed to manage whole pathways of care on regional footprints for specialised services. Under these arrangements, identified lead providers take clinical pathway and financial responsibility for the delivery of services with the intention of improving access, developing community alternatives to admission and where admission is clinically appropriate, ensuring community support post-discharge. The Trust is the Lead Provider and has established three of the Collaboratives. All three were successful in their application to progress to Provider Collaborative status in July 2019 and have been operating in “shadow form” with contracts remaining with NHS England Specialised Commissioning. The Thames Valley and Wessex Adult Secure (Forensic) and Thames Valley Tier 4 CAMHS Provider Collaboratives, were placed on the fast track workstream to go live as of 1st April 2020. However, the Forensic Provider Collaborative actually went ‘live’ in May 2021. The HOPE Adult Eating Disorders Provider Collaborative was placed on the development track workstream to go live later in 2021.

Table 2.

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
Leadership	L1. Develop and embed the use of a Restorative Just Culture approach	Trust-wide (physical health and mental health care services)	Number of staff trained in restorative just culture – target 20 staff in year 1. Staff report feeling able to raise concerns about practice more than 81%	Mersey Care NHS Foundation Trust and the University of Northumbria trained 8 staff in the Restorative Just Culture approach held in March 2021 and further training is planned for approx. 19 staff in September 2021, against a base line of 0 in March 2020. The initial focus will be to roll out the approach for disciplinary cases. The Trust has already seen a reduction in the number of staff who are suspended. 79% staff felt able to raise concerns (2020 staff survey, n=3464) an improvement from 2019 - 75.6% however we did not achieve our target of more than 81%. 7.1/10 staff report on safety culture, (6 questions in 2020 staff survey, n=3464) and improvement from 2019 6.9.	Full year targets not achieved. **Objective to be rolled into 2021/22.**
	L2. Achievement of the Race Equality Framework for Change – 5-year programme	Trust-wide (physical health and mental health care services)	Actions identified in year 1 2020/21 to be completed Staff report not experiencing discrimination from managers or colleagues more than 9.5/10	The framework and priorities for year one were agreed in October 2020. A number of priority actions have been identified for 2021 and being overseen by the Race Equality Delivery Group. One action has included the introduction of a reciprocal mentoring programme started in February 2021. Staff rated equality, diversity and inclusion as 9.2 out of 10 staff based on responses to 4 questions in staff survey 2020 n=3464 (slight improvement from 2019 - 9.1). There is a range of training offered to staff including Religion and Culture, Positive Action,	Target not achieved. **Objective to be rolled into 2021/22.**

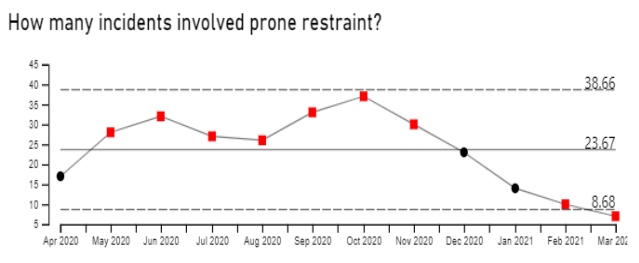
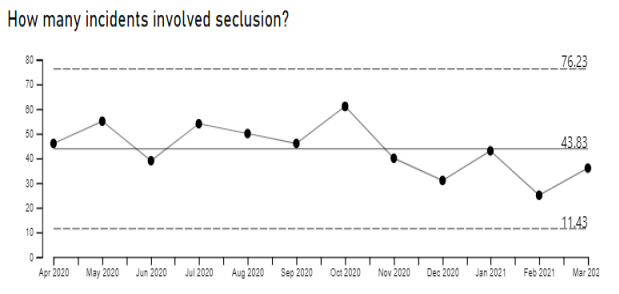
Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				Unconscious Bias, Gender Identity, Equality Analysis and Awareness of the Equality Act 2010. Staff rated 9.3 out of 10 in relation to not experiencing discrimination from managers/ team leader or other colleagues (slight improvement from 2019 - 9.2)	
	L3. Continue to support and improve staff wellbeing	Trust-wide (physical health and mental health care services)	Staff engagement index score (9 questions) target 7.5/10 Reducing staff absence less than 3.5% (excluding COVID-19 sickness)	A significant amount of has been work completed. As part of the emergency planning in response to the pandemic work a Psychosocial Response Group was set up to organise and lead on enhanced support for staff during these challenging and unprecedented times. Some of the actions have included; - Care packs being distributed regularly from March 2020 to each team designed to give staff a small treat and boost during the working day. We received many generous donations from organisations, small businesses and local crafters to include in the packs and offer as prizes. - Free lunch was provided to inpatient staff, night staff and GP Out of Hours services - seven days a week for much of the year - Developing staff support resources collated in health and wellbeing pages. - Specific resources were put in offering both practical and psychological support to individuals and teams as well as guidance and support specifically for managers.	Many achievements have been made. Supporting our staff is crucial particularly following the challenges of COVID-19. **This remains a priority and the objective will remain in 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				Home/remote working guidance and support both in relation to equipment and costs were offered. Resources were made to help our staff who were home schooling and/or had carer responsibilities. - Embedding the Employee Assistance Programme - Introduction of a new Mental Health and Wellbeing Hub (You Matter) for staff which offers rapid mental health assessment if required and/ or signpost to alternative offers of support - Recovery and renewal days were set up to give staff the opportunity to reflect and plan their recovery in a supportive environment - Schwartz rounds were modified and moved to being delivered on-line to provide emotional support - Staff were also recognised and rewarded for their efforts responding to COVID-19 which included an additional days annual leave in 2021/22 and a voucher The Employee Assistance Programme has received 591 calls in the last 12 months, with anxiety being the most common reason related to work, relationships or property. We have seen a reduction in presenteeism and work distress, and an increase in work engagement and increased life satisfaction from April 2020 compared to March 2021.	

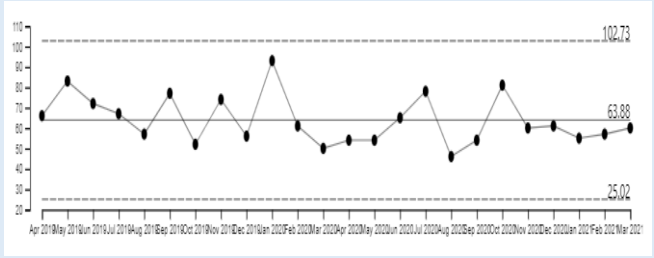
Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				7.2/10 on staff engagement, 9 questions in staff survey 2020 n=3464 (same as 2019 - 7.2) 6.4/10 on staff health and wellbeing, 5 questions in staff survey 2020 n=3464 (improvement from 2019 - 6.0) Sickness in March 2021 was at 3.82% against a target of less than 3.5%. The most common reason for sickness was a headache/ migraine (21%). Sickness dropped to below target levels from June-October 2020, graph below. We introduced FirstCare in February 2021 a new 24/7 absence management system, which we need to embed further. So far FirstCare has received over 5,000 calls. The system includes coaching and training sessions for line managers and actioning alerts to support staff in the informal stages of the absence management process. Additional support is being provided to employees with Long COVID-19. 	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
Safety	S1. Minimising nosocomial infections (hospital acquired)	Inpatient services Trust-wide	Number of cases of preventable hospital acquired infections. Target less than 3 based on 2019/20 outturn (prior to COVID-19)	It has been a very unusual year due to the pandemic. The Trust has maintained surveillance of mandatory reportable infections and completed detailed root cause analysis on all cases, of which all were unavoidable. The full details of the work completed are detailed in the annual report presented in June 2021, available at https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/. Throughout the COVID-19 pandemic there has been extensive work around infection, prevention and control including daily nosocomial sitrep reporting. The second wave of the pandemic, between October 2020 - January 2021, identified the emergence of a more transmissible variant strain. This resulted in outbreaks of infection, which was reflected nationally, and 94 definitive hospital acquired onset cases after admission were identified across the Trust. We have reviewed each case to identify immediate actions and learning to take forward.	Target not achieved. **Objective to be rolled into 2021/22.**
	S2. Reducing restrictive practice through introducing a Positive and Safe approach	Mental Health Inpatient services	Reduction in use of prone restraint by 50% over 2 years (25% in year 1, less than 240) Reduction in the numbers of seclusions by 30% over 2 years (less than 402 in year 1)	The Trust held a delayed launch of the Positive and Safe initiative in March 2021 involving more than 75 staff and involved personal experiences from experts by experience and staff. It also included keynote speakers from other Trusts where they have significantly reduced the use of restrictive practice. In the first wave 12 wards will be supported to identify how they will reduce seclusion, restraint and restrictive practices. Encouraging ward teams to think	Target not achieved. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				more broadly about their environment and intervening at an earlier stage. We know that using restrictive practices has a traumatic impact on patients and also staff. The Trust is part of a national Quality Improvement project in this area however, the work was paused during pandemic. In 2020/21 we reviewed our training which in April 2021 is going through accreditation with the Reducing Restrictive Intervention Network. The revised training reduces the reliance on physical interventions by identifying triggers, early warning signs, preventive interventions and verbal de-escalation. In relation to all types of restrictive practice our data indicates there are a small number of complex patients involved in a higher number of restrictions which require careful individual care planning and delivery. Complex care panels are convened to ensure there is expert advice from senior clinicians to support staff with plans to reduce restrictive practice as far as possible. The use of prone restraint creates increased risk for patients so the Trust's strategy is to reduce the use of prone restraint. The majority of prone restraint is used when undertaking rapid tranquilisation. Since October 2020 we have seen a decline in use of prone. In	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				2020/21 there were 284 uses of prone restraint. Our target of less than 240 was not met but initial work through the Positive and Safe Forums is having an impact.  Use of seclusions is slightly lower in 2020/21 (n=526) compared to 2019/20 (n=557). The number of different patients involved has also slightly reduced. Our target of less than 402 was not met, however work has now started and is gathering pace.  	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
	S3. Improve sexual safety in mental health inpatient settings	Mental Health Inpatient services	Evidence of debriefs and review of care plans after any sexual safety incident Increase in reporting of sexual safety incidents, as there seems to be current under-reporting.	CAMHS Marlborough House (inpatient ward) have been engaged in the QI project with the national collaborative, in 2020 the collaborative was paused due to COVID-19 but recommenced in February 2021. The wider mental health national QI workstream is scheduled to launch at the end of 2021, which will incorporate all wards. Work is at an early stage and improvements cannot be demonstrated yet. The team has been testing two change ideas around better reporting of sexual safety incidents using postcards and education for staff in how to talk to YP about sexual safety. In 2020/21 - 102 sexual safety patient incidents have been reported. In 2019/20 there were 91 incidents reported.	Target not achieved. **Objective to be rolled into 2021/22.**
	S4. Improve tissue viability and reduce avoidable harm in pressure damage	Physical health services (inpatient and community)	Reduction in pressure ulcer categories 3 and 4 where they were avoidable. 2019/20 – 10 were reported.	The Trust has a steering group that oversees the themes from pressure ulcer incidents and the Trust's improvement plan. In wave 1 of the pandemic we saw an increase in pressure damage, as a result we took a number of actions including to work more closely with families to escalate concerns and to optimise the use of pressure relieving aids, as well as more frequent reviews of patient's risk profile to compensate for a reduction in face to face contact.	We have not seen a reduction in serious pressure ulcers developing in service. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				We had a focus on equipment to ensure the appropriate pressure relieving aids were delivered timely to patient's homes, that supply was closely monitored as issues were anticipated and we identified/ trained local clinical development leads to assess and approve the use of higher-level equipment. In subsequent waves of COVID-19 we have not seen the same increase in pressure damage as in wave 1 in early 2020. In relation to the pressure ulcers developed in service most are reported within the District Nursing Service (579 incidents last 12 months) and Community Hospital wards (112 last 12 months). There has been no significant variation over time in the number of pressure ulcers developed in service in 2020/21 (categories 1,2,3 and 4) with one-off spikes in July 2020 (related to category 1) and October 2020 (related to category 2).  In 2020/21 we identified 12 avoidable category 3 and 4 pressure ulcers; 10 in District Nursing and 2	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				Community Hospital wards. All are being investigated as serious incidents. This compares to 10 in 2019/20 and 9 in 2018/19. Our target to reduce avoidable serious pressure ulcer damage has not been achieved in 2020/21.However it is important to note that it has been recognised nationally the vascular impact of COVID-19 on skin integrity and pressure ulcers.	
	S5. Continue work to improve physical healthcare for patients with a severe mental health illness	Community Mental health services	Improved completion of the annual Lester physical health assessment Tool for people with enduring serious mental illness (covers smoking status, lifestyle, BMI, blood pressure, glucose and cholesterol) Targets- Community adult mental health teams more than 75% Early Intervention in Psychosis teams more than 90%	A recovery plan is in place being implemented by a task and finish group. In the last national clinical audit of psychosis in Early Intervention in Psychosis teams (EIP) in 2019/20 the Trust showed poor performance and was identified by the Royal College of Psychiatrists as an outlier (September 2020) in relation to patients not receiving a comprehensive physical health review annually. We are also aware that our performance in our adult mental health community services is also below expectation. A new strategy with embedded workplan and trajectory for recovering our position has been developed. Key actions include: recruiting new physical health leads and other dedicated roles including working in partnership with MIND in Oxfordshire, embedding consistency across the physical health clinics and ensuring teams have the appropriate monitoring equipment. There is also work	Target not achieved. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				underway to improve the access to data so that teams can monitor their performance more easily. The actions so far have led to an improving performance across both the EIP and adult mental health community services since October 2020. This is in line with our trajectory, but further work is required and our targets have not been met. As of March 2021; Buckinghamshire community teams 50%, Buckinghamshire EIP 33%, Oxfordshire community teams 29% and Oxfordshire EIP 45%. This position has improved again in April 2021.	
Experience	E1. Ensure we have strong patient/ family voices as part of developing and improving services	Trust-wide (physical health and mental health care services)	Number of patient safety partners employed to be part of the governance structure. Year 1 - 2 partners. Number of service change projects and significant quality improvement projects that patients and families involved as partners in co-production. More than 60% of projects.	We have a renewed focus on involvement and co-production. Lots of individual pieces of work happening however we need a more coordinated approach embedded in everything we do. Co-production training has been developed and co-delivered with patients/ carers through the Recovery College which went live from March 2021. In addition, training on co-production with patients/ carers has been delivered to 121 leaders in 2020/21. A specific Quality Improvement programme identified in relation to improving family involvement in care, following a theme identified from serious incidents, inquests and complaints. The work is at a planning stage.	A number of actions have been taken however we have not seen the impact of these yet and continued work is needed to achieve true partnership working. **Objective to be rolled into 2021/22**.

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				The new Carer, Family and Friend strategy and objectives have been co-developed with carers over 2020/21 and is due to be launched in July 2021. The experience and involvement team have been working with the service change team to ensure patient/ carer involvement is part of all projects as much as possible. In 2020/21 - 75% of projects (n=21) related to changes to patient services have involved patients in some way. The level of involvement has included consultation, engagement asking for feedback and some co-production. The OHI centre will continue to work with patients and carers as part of improving care. The Trust-wide experience and involvement forum was re-launched with the first meeting set for May 2021 which will be a mixture of patients and staff to oversee the implementation of the strategy objectives. No progress has been made in 2020/21 on recruiting new safety partners, so this will be undertaken in 2021/22. The national target has been delayed until June 2022. We will also seek to employ experts by experience to help embed patient/ carer involvement in 2021.	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
	E2. Continue our focus on improving personalised care planning	Trust-wide (physical health and mental health care services)	95% of patients involved in the development of their care plan	Improvements have been made however the target has not been met. The Trust recognises this is a key focus area for 2021/22 and employing people with lived experience will be a catalyst to this improvement. Care Programme Approach community mental health audit Q3 86% demonstrated patient involved in creating their care plan. N=304 (this was 85% in Q1 and 90% in Q2). 83% had a personalised crisis plan. Baseline in Q4 2019/20 was 84%. Mental health inpatients essential standards audit 90% patients report being involved in care planning in Dec 2020. This is an improvement from the last 3 audit cycles. Baseline in Feb 2020 83%. Second measure – care plan up to date 86% in Dec 2020, similar to baseline in Feb 2020 85%. The Community Hospital inpatients essential standards audit and End of Life Care audits were paused more recently due to the pressures of COVID-19. When comparing the clinical audit results to feedback received from patients through IWGC, in 2020/21 out of 5,292 responses patients said they rated their involvement in care as 4.70 out of a maximum of 5. This is similar to the baseline in 2019/20 when the rating was 4.79.	Target not achieved. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
	E3. Developing easy read versions of publicly available quality papers	Trust-wide (physical health and mental health care services)	Increase in easy read reports	A few reports have been presented in easy read to Trust Board and the Council of Governors, however work needs to continue. All Trust Board agendas are now being provided in easy read. We have purchased software to access a wider range of photo symbols and staff training on developing easy read materials has been delivered. Over the last year the Trust has developed a wide range of easy read materials, particularly in relation to Covid-19 and these are available on the website at OHFT easy read materials	There has been an improvement in the accessibility of published documents but we have more to do. **Objective to be rolled into 2021/22.**
	E4. Develop and launch a new e-learning course for all staff on an introduction to autism	Trust-wide (physical health and mental health care services)	% staff completed the on-line autism training. Year 1 - 30% of clinical staff in non-LD services (baseline 0%)	Tier 1 on-line training on autism awareness has been developed and the proposal is this will be mandatory for all patient facing staff. The training is due to be launched shortly in 2021. The Trust is also part of the national pilots for tier 1 (patient facing but not direct care givers) and tier 2 (for direct care givers) autism training which will become mandated in 2022 – we have identified more than 40 staff across the Trust to be involved in the national pilots. The Trust has also developed an autism masters module launching in September 2021.	Target not achieved as training is only just being launched. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				The Reasonable Adjustment Service is also available to support mental health clinicians to better understand the needs of autistic individuals with reasonable adjustments and adaptions. Some examples from teams who have been supported to make the following adjustments; - Changing the environment to minimise background noise i.e. a ticking clock - Providing more information in advance appointments including the questions that will be asked to reduce uncertainty - Developing guidance and raising awareness with staff on accepting autism e.g. not expecting eye contact, allowing processing time and using techniques like 'take away' information - An autism passport is being piloted as a tool to help understand a person and their autism and how to make adjustment for them to services are more accessible. Other actions taken in line with the NHS Improvement Standards for people with a Learning Disability and/ or Autism are; a specific section on the Trust's website for resources, an increase in published resources in easy read including the Trust Board, Council of Governors and Annual General Meeting agendas, introduction of sensory boxes to our community hospital wards, a diabetes toolkit in an accessible format has been developed (this is in addition to the epilepsy toolkit	

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				already in place), and a new masters Positive Behavioural Support course has been developed with Oxford Brookes University for staff to access. The initial feedback to this has been extremely positive.	
Clinical Effectiveness	CE1. Improve end of life care planning	Trust-wide (physical health and mental health care services)	100% of patients at end of life have a care plan that reflects their needs	The Oxfordshire system has worked in a very collaboratively way to support those at the end of their lives during COVID-19. A system review of the care pathway is currently underway. Training in the personalisation of care at the end of life and the embedding of the individual End of Life and Palliative care plans has been well received. Our main monitoring arrangement (a monthly end of life care clinical audit) of the personalised care plan was paused for most of 2020/21 due to the pressures of COVID-19 however this is restarting in 2021. We have also been working on new end of life care plans 'Priorities and Wishes' and 'personalised assessment and care planning' based on a survey with staff and feedback from third sector organisations (Age UK). The new care plans aim to help health care professionals and patients have a wider conversations about the persons wishes. The care plans were launched during Dying Matters week in May 2021. The second round of the National Audit of Care at the End of Life showed the Trust was above the national average for identifying when patients were at the end of life and working with families. There was also an	A huge amount of system work has happened during the pandemic to improve the experience of patients/ families during end of life care. However we have more work to do on personalised care planning so **the objective will be rolled over into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				improvement in use of an individualised care plan (OHFT 7.4/10 compared to the national average 7.2). Our work was presented at the Community Hospitals Association. Although we recognise we have more work to do so that every person has a personalised care plan which they and/ or their family have been involved in developing. Children's Community Nursing advanced care planning audit in 2020 showed 86% of child's wishes and 88% of families wishes were documented (n=16) similar results to 2019.	
	CE2. Support the delivery of a 'home first' approach including discharge to assess	Physical health services (inpatient and community)	Number of community and home response visits within 2 hours or less/ providing an alternative to admission. Reduce LOS in community hospital rehab beds (as patients are supported to go home quicker).	Following a successful bid to become a national Ageing Well accelerator site OHFT has been implementing initiatives supported by system partners to develop and deliver an urgent community response and offer enhanced care into care homes. The urgent community response is the collective name for a range of services who respond quickly to people's care needs following sudden changes in their health or circumstances to help prevent an unnecessary emergency admission or to facilitate a quicker discharge home. The urgent community response service is delivering crisis response interventions however the implementation of the 2-day pathway is in planning stage.	The delivery of the NHS Long Term Plan objectives in relation to Ageing Well and specifically the introduction of an urgent community response approach has been started but further work is planned. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				'Home First' is a new service started from June 2020 supporting people to return home after a period of being unwell in hospital so that they can keep a greater level of independence. The service is a collaborative implementation of the Hospital Discharge Policy with the following organisations working in partnership; OHFT, Oxfordshire County Council, Oxfordshire Clinical Commissioning Group, Age UK, and Oxford University Hospitals NHS Foundation Trust. Around 1,500 residents have been supported by the service to date. Additional winter funding enabled our community hospital therapists to provide a seven-day rehabilitation service across the eight wards to facilitate more timely discharge of patients home when they are ready. This resulted in a reduction in the length of stay in Community Hospitals. This winter the average was 29 days compared to 36 days in 2019. Work is underway with internal working groups and discussion with our commissioner to fund a seven-day model as business as usual.	
	CE3. Implement the Provider Collaboratives to improve care pathways and outcomes for patients	Inpatient Mental health services	Move into full commissioning role	On 1st April 2021 the Thames Valley CAMHS Tier 4 Provider Collaborative led by OHFT achieved its ambition to become 'live'. We are now lead provider for the provision of Tier 4 (inpatient) children and adolescent mental health services across; Bath and North East Somerset, Berkshire, Gloucestershire, Oxfordshire, Swindon and Wiltshire.	**Target achieved.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
				The Thames Valley Adult (forensic) Secure Provider Collaborative was slightly delayed and went 'live' in May 2021. The Eating Disorder Provider Collaborative (HOPE) will move into going 'live' in 2021.	
	CE4. Develop the consistency and application of staff supervision	Trust-wide (physical health and mental health care services)	Clinical and management supervision completion rate more than 85%.	Supervision is a key component of ensuring a safe and high-quality service and we acknowledge we are behind in terms of evidencing this. We are now recruiting for a permanent supervision lead to help embed supervision structures, to develop the quality of sessions and to improve recording. NHSE/I are funding Professional Nurse Advocates (PNAs) across most of our specialities and we have a range of nurses on these courses which will support embedding of Restorative Supervision across our Trust. In the meantime we are identifying different ways and activities to raise awareness and support staff/ managers. Clinical Directorates; •59% clinical supervision in March 2021 (2019/20-50%) •55% management supervision in March 2021 (2019/20-42%)	Target not achieved. **Objective to be rolled into 2021/22.**

Domain	Objectives	Relevant service(s)	Measure/ Target	Achievements and Impact	Level of Achievement
	CE5. Improve clinical documentation and practice in relation to the Mental Capacity Act (MCA)	Trust-wide (physical health and mental health care services)	Improvement in Mental Capacity Act (MCA) documentation on CareNotes	A baseline survey was completed by staff in 2020 to identify what actions were needed. A baseline clinical audit was completed across the mental health wards and community teams in December 2020 which identified early improvements however there is a need to fully embed the use of the MCA tab in CareNotes. A new MCA Assessment and Best Interests form has been uploaded onto CareNotes (Mental health and community) in March 2021. A 'Word' version of the same form has been shared with those services not using CareNotes. The form has been designed to be reportable so that usage can be monitored through audit. MCA training sessions are continuing to be delivered for community hospital staff by the Associate Director of Social Care.	Target not achieved. **Objective to be rolled into 2021/22.**

12. Quality Improvement Plan for 2021/22

Significant effort and capacity has been focused on the Trust's response and recovery to COVID-19 throughout 2020/21. Our plan is to harness and build on the opportunities, collaborations and new ways of working developed during this time but also to support our staff to reflect and start to recover.

Owing to the limited progress against the 2020/21 quality objectives (described in table 2) the majority of these will be rolled over into 2021/22 to continue our work and to achieve what we set out to do. The one objective which was achieved in relation to the implementation of the Provider Collaboratives (reference CE3) will therefore not be rolled over into 2021/22. The rationale for continuing with the other quality objectives is that the progress and relevance of the objectives have been reviewed and these remain key areas for us to make improvements and to address our key risks and challenges. The objectives align with national drivers set out in the NHS People Plan, National Patient Safety Strategy, National Quality Board goals and the NHS Long-Term Plan. We have also embedded these quality objectives into the Trust's new Strategy for 2021-2026 to achieve our vision of outstanding care by an outstanding team.

We remain committed to continually make improvements to the quality of services and set out the below quality improvement plan (table 3). All of the objectives are aimed to be completed by 31st March 2022 and progress will be monitored by the Trust's Quality Committee quarterly. The Trust will publish our progress against each objective in our Quality Account next year.

In addition to the below improvement plan we have started the following Trust-wide Quality Improvement programmes in 2021/22 around specific areas:

- Risk assessment formulation and documentation
- Working with families and carers in their care
- Trauma Informed Care
- Ligature harm minimisation (we are leading a workstream and are part of a national initiative in relation to this)
- Suicide prevention (we have joined a national improvement collaborative)

Table 3.

Domain	Objective	Executive Director Lead
Leadership	L1. Develop and embed the use of a Restorative Just Culture approach	Chief People Officer
	L2. Achievement of the Race Equality Framework for Change – 5-year programme	Chief Nurse
	L3. Continue to support and improve staff wellbeing	Chief People Officer
Safety	S1. Minimise nosocomial infections (hospital acquired)	Chief Nurse
	S2. Reduce restrictive practice through introducing a Positive and Safe approach (part of national project)	Chief Nurse
	S3. Improve sexual safety in mental health inpatient settings (part of national project)	Chief Nurse
	S4. Improve tissue viability and reduce avoidable harm in pressure damage	Chief Nurse
	S5. Continue work to improve physical healthcare for patients with a severe mental health illness	Chief Nurse
Experience	E1. Ensure we have strong patient/ family voices as part of developing and improving services	Chief Nurse
	E2. Continue our focus on improving personalised care planning	Managing Directors
	E3. Develop easy read versions of publicly available quality papers	Chief Nurse
	E4. Develop and launch a new e-learning course for staff on an introduction to autism (those not working in learning disability services)	Chief Nurse
Clinical Effectiveness	CE1. Improve personalised care planning for patients at end of life	Managing Director – Primary and Community Services
	CE2. Support the delivery of initiatives within the Ageing Well work	Managing Director – Primary and Community Services
	CE4. Develop the consistency and application of staff supervision	Chief Nurse
	CE5. Improve clinical documentation and practice in relation to the Mental Capacity Act (MCA)	Chief Nurse

13. Glossary

In order of appearing in the document.

OHFT: Oxford Health NHS Foundation Trust

CAMHS: Children and Adolescent Mental Health services

IAPT: Improving Access to Psychological Therapies

NICE: the National Institute for Health and Care Excellence

ICS: Integrated Care Systems

BAME: used to describe people from Black, Asian and Minority Ethnic groups.

JCVI: Joint Council for Vaccinations and Immunisations

CHA: Community Hospitals Association

HSJ: Health Service Journal

IRT: Integrated Respiratory Team

QI: Quality Improvement

OHI: Oxford Healthcare Improvement Centre

BCR: Biomedical Research Centre

A&E: Accident and Emergency

OAP: Out of Area Placements

CQC: Care Quality Commission

PSI: Patient Safety Incidents

DBS trace: Demographics Batch Service (national check of patient deaths)

CDOP: child death and overview process

LeDeR: Learning disability mortality review process

IWGC: I Want Great Care (external company used to gather patient and family feedback)

EIP: Early Intervention in Psychosis service

MCA: Mental Capacity Act

Annex 1. Statements from our partners on the quality report and account

To follow once the Account is finalised.

Buckinghamshire and Oxfordshire Clinical Commissioning Groups

Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC)

Trust Governors (written by Lead Governor)

Healthwatch Oxfordshire

Report to the Oxfordshire Joint Overview Scrutiny Committee

June 2021

Table of Contents

1 Healthwatch Reports

Full and summary sheets of all reports, plus responses from commissioners and providers available on: https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/ . We have recently published:

1.1 Experience of using pharmacists in Oxfordshire in 2020.

We heard from 370 people between February and September 2020 about their experiences of using pharmacies in the county. Respondents valued the role, service, and presence of community pharmacies, particularly important during COVID-19, although there was some anxiety about need to queue and social distance, and initial delays to medications.

Using pharmacies for advice varied - 52% respondents 'sometimes' asked the pharmacy for advice, and 30% 'never' used pharmacy for advice. People are not always clear who they are talking to in the pharmacy, and have a sense of 'too busy' to talk. If aspirations for role of pharmacies in NHS Long Term Plan are to be fulfilled, more needs to be done to:

- Educate the public and communicate the pharmacist's role in support of minor conditions, advice, and prevention along with specialist commissioned roles.
- Provide clear information in the pharmacy about the role, qualification, and expertise of pharmacists to provide information and support.
- Clearly signpost pharmacist personnel within staff team at pharmacies - including availability of confidential space
- Actively encourage the public to 'ask your pharmacist'.
- Address issues highlighted with repeat prescriptions including delays, errors, and reliability.

1.2 Seeing a dentist during COVID-19

Overall people who responded said they had had access to timely emergency and routine care from dentists during COVID-19. However, some face continued challenges in accessing emergency care and NHS dentists. Our report on *Access to Oxfordshire Dental Services during Covid 19 Restrictions* captured people's experiences of dental care from later in the pandemic:

- Restricted access has meant that people who cannot see a dentist for urgent care have been left in pain or with worsening oral health.

- While wealthier people were able to access treatment during this time by paying privately, this effectively excludes those on lower incomes.
- People told us they wanted more and fairer access to dental care across public and private sectors, especially for urgent or emergency treatment.

Despite NHS England targets being imposed, we continue to hear that many people are still finding it difficult to get a dentist appointment. **Full report and response** from NHS Dental Commissioner available on our website.

1.3 Voices of the loved ones of care home residents during the Covid-19 Pandemic

Between November 2020 and the end of February 2021 59 people told us about their personal experiences of having a family member living in a care home during the COVID-19 pandemic. This report sets out what we heard and the strong themes that appeared, which we believe are reflections of others' experiences.

The personal stories shared were powerful, often painful and intimate.

> *"Nearly a whole year of not hugging/kissing mum is breaking my heart"*

What we heard:

- There is little consistency across care homes for supporting relatives.
- Relatives and residents find visiting often upsetting, challenging, distressing, stressful and frustrating due to the COVID-19 constraints.
- The impact on families has led to intense feelings of loss, fear, and distress, and some relatives believe the impact on residents has been detrimental to their physical and mental health.
- Generally, relatives are very positive about the carers looking after their loved ones but there is a sense of sadness and envy that their close relationships have transferred from relative to carer.

> "It's heart-breaking not being able to touch or get close to my husband. He doesn't understand why I can't come in and feels abandoned. It's cruel beyond belief."

Strong themes appeared in what we heard from relatives that we believe are experienced more widely. We would like to see more flexibility around visiting and discussions around how relatives can be treated as part of the caring team.

We have called a round table meeting on June 23rd of organisations involved in commissioning and regulating care homes in the county, along with local care providers. We want to hear their responses to the report and initiate work on how Oxfordshire care homes can become exemplars of good practice in valuing the role of families of care home residents.

Responses received to the report:

- Eddy McDowall, Chief Executive of Oxfordshire Association of Care Providers (OACP), who said: "We very much hope that the learning we have all had, coupled with continued partnership working across all of our health and care system, will support a way back to normal as soon as possible". Read his response in full here. (pdf)
- Suzanne Westhead, Interim Deputy Director, Health, Education & Social Care Commissioning at Oxfordshire County Council, who has said they would like to work with Healthwatch Oxfordshire to respond to the findings and will attend the round table event.

1.4 The Covid-19 vaccination programme in Oxfordshire – what we heard.

We ran two surveys from January to March 2021

- General public survey was open to anyone whether vaccinated or not.
- Survey for people who attended the Kassam Stadium vaccination hub.

People who took part in the surveys

- General survey: 512 people responded.
- Kassam survey: 104 people responded.
- Most respondents were older, white British - a group generally known to be supportive of the vaccination programme.

Views about the Covid-19 vaccine

- Overall, respondents were very positive about the benefits of vaccines in general and were in favour of the Covid-19 vaccine.
- A small number in the general survey said they were hesitant about the vaccine or would refuse it.
- The main reasons for hesitancy or refusal were:
    - distrust in the vaccine or the clinical approval process
    - uncertainty about safety or efficacy
    - fear of possible side-effects
- Other barriers that might prevent people having the vaccine included:
    - Access to transport
    - Distance to the vaccination centre
    - Hesitancy to use public transport.

Information and communication about the Covid-19 vaccine

- Most people felt that information and communication about Covid-19 vaccines was clear, understandable, and effective.
- People generally felt able to distinguish between scientific information and misinformation often published on social media.
- People found Government 'mixed-messaging' about the vaccines and sudden changes in decisions confusing and unhelpful.
- Accurate and consistent information needs to be clearly communicated for people to know what to do.
- People from vulnerable groups (especially ethnic minority and people with underlying health conditions or allergies) need easy access to information about vaccine safety and possible side-effects.

Experiences of getting the vaccine Covid-19 vaccine.

- Most feedback very positive:
  - vaccination centres well-organised and safe
  - vaccination process clear and efficient
  - staff and volunteers friendly and helpful
- A few criticisms:
  - difficulty booking appointments (getting timeslots or trying to book for two people)
  - too many people in the vaccination centres and little social distancing

Healthwatch Oxfordshire are attending the Oxfordshire Vaccination Delivery Board meeting in middle of June to present the report.

1.5 Didcot - April 2021

146 people shared their opinions of living in the Didcot area and their experiences of accessing health, social care, and community services.

We heard that:

- Overall people are positive about living in the area.
- Almost a quarter of respondents complained about access to GP practices and health service appointments.
- Many people travelled out of the area to see a dentist due to lack of NHS provision in Didcot.
- 42% complained of traffic and poor road conditions.
- 15% said lack of provision and facilities for young people and families was a problem in the town.
- We also heard concerns about the impact of housing growth on infrastructure and health services.

Our call to action:

Those public bodies and partnerships responsible for planning and delivering services to the Didcot communities must work together with these communities to

ensure that population growth in the area is sustainable and supported with adequate infrastructure. We have invited stakeholders to a roundtable meeting in June 2021 to build on existing discussions and develop relationships.

1.6 GP website check-up April 2021

During the 2020 COVID-19 pandemic, patients were recommended not to attend surgeries for appointments. Healthwatch Oxfordshire heard from patients that it was taking longer to get in touch with their GP surgeries using their surgery websites and by telephone. Given that patients were being recommended to use their practice website we wanted to find out how easy websites were to navigate for patients. All 67 Oxfordshire GP practice websites were surveyed between November 2020 and January 2021 to assess the ease of use and clarity of information on the site.

The survey was carried out by Patient Participation Group Chairs and Healthwatch Oxfordshire volunteers. We found:

All 67 Oxfordshire GP surgeries have a website, information on these sites was often:

- Inconsistent across different web pages.
- Out of date.
- Links to internal and external pages not working.
- Links led to pages with no content.

Requirements to complete registration at the practice included:

- 43 practices asked for patient identification.
- 43 practices required proof of address.

Recommendations

1. All GP surgeries must review and update their websites by **the end of July 2021**. This review must include checking accessibility, translation, checking that links to other sites / documents work, information on how to make a complaint. Healthwatch Oxfordshire will carry out a second review of all GP websites during August 2021 and report back to GP surgeries, Oxfordshire Clinical Commissioning Group, and Care Quality Commission.

2. All GP surgeries must make information about how to register with the practice easy to find on the website and accessible.

3. Information about how to register with the practice must be clear and in line with the NHS guidance and documentations. This can be found here:

https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/

4. The registration document must be the NHS GMS1 registration form. This form together with guidance on completion can be found here https://www.gov.uk/government/publications/gms1

5. A clear statement must be posted saying that:

Anyone in England can register with a GP surgery.

You do not need proof of address or immigration status, ID or an NHS number.

If you have problems registering with a GP surgery:

Call the NHS England Customer Contact Centre on 0300 311 22 33

or

Contact Oxfordshire Clinical Commissioning Group (contact details included)

or

Contact Healthwatch Oxfordshire (contact details included)

6. Easy to find and updated information on what a Patient Participation Group (PPG) is, how to join it, and how to make contact. This should be done in conjunction with the practice PPG.

The report was circulated to all Oxfordshire GP practices, the Oxfordshire Clinical Commissioning Group, the Care Quality Commission (CQC), and Patient Participation Groups. Each surgery received a copy of the assessment of their website.

1.7 Ear wax removal services in Oxfordshire – summary of survey results

Background

Healthwatch Oxfordshire have been contacted by many people over the past few years and more so over the past 6 months raising concerns about the availability of ear wax removal by GPs. We decided to find out if this was a county wide issue and understand further what the impact has on individuals.

NICE guidelines (2018) recommend that appropriate primary or community care settings provide earwax removal services when it is contributing to hearing loss or other symptoms. Thames Valley Priorities Committee Commissioning Policy Statement (published February 2020) says patients **may** be offered irrigation or

microsuction[1] **IF** they have "exhausted" self-care options **AND** have hearing loss because of ear wax.

Survey details

- Open from 12/04/21 – present
- 130 completed questionnaires
- 64% aged 65 and over
- 87% white British
- Responses received for services across 26 Oxfordshire postcodes, most commonly OX2 (n=10, Oxford), OX11 (n=14, Didcot area), OX29 (n=23, Witney area)

Interim results

People reported experiencing a range of problems because of excessive ear wax:

- Hearing problems/hearing loss
- Tinnitus
- Dizziness, nausea
- Earache, headache
- Problems sleeping
- Isolation – not being able to hear is debilitating

Most people (57%) had seen their GP about their ear wax problem. However, 43% had not consulted, mainly because the GP practice had told them that the GP/NHS no longer provide ear wax removal service.

Around half (52%) of people who saw their GP were advised to use ear drops, 29% were recommended ear irrigation, and 26% microsuction.

Treatment costs varied depending on whether one or both ears needed cleaning. Private treatment through high street providers (e.g. Specsavers) cost from £50-£100, and higher in private health practices, sometimes more than £100.

General/other comments:

- Despite NICE & CCG guidelines above, most patients experiencing hearing loss because of ear wax advised to self-care or seek private treatment. Few of those who meet the CCG criteria are being offered treatment at their GP practice.
- People feel disappointed and angry at being told the service is no longer provided at the GP practice

[1] Microsuction involves using a microscope and a small device to suck the earwax out of the ear.

- They don't understand why a relatively straightforward, effective treatment is not routinely provided on the NHS. They feel that it should be available at their local GP practice, especially for elderly people and others with mobility difficulties.
- Some people were unsure about what to do or where to go for treatment when finding that the service is unavailable at their GP practice. Some did not seek treatment or opted for self-treatment, usually ear drops but a few people bought microsuction kits on Amazon.
- Some people said that referrals are inconvenient and delay treatment, often costing the NHS more if the problem is not resolved.
- Although most people were happy with treatment provided by private providers, some were concerned about safety, hygiene or competence of providers, despite higher costs.

1.8 Ongoing research includes:

- Involved in wider group looking at **vaccine hesitancy** and ways forward (convened by Oxfordshire Clinical Commissioning Group) and have supported system linking up to Boater community and other seldom heard groups.

2 Overview of 2020 -21 activity

Our Annual Outcomes and Impact report 2020-21 is due to be published at the end of June 2021. This will be distributed to all Board members.

A quick summary of what a difference our work has made between January and March 2021 shows:

- We helped members of the asylum community to access a COVID-19 vaccination after asking Luther Street Medical Centre if they could attend the vaccination clinic the practice was already running for homeless people. So far, we know that at least 10 refugees have taken up the offer of attending this drop-in vaccination clinic.
- We informed members of the local boating community about a national research project being carried out for NHS England, enabling them to share their views on how access to health services could be improved.
- We continued to seek responses from service providers for patients who gave a review via our Feedback Centre. We published 7 provider replies to people this quarter.
- Oxford University Hospitals cite our coronavirus web page as one of six trusted sources of information they link people to.

Despite spending most of the year unable to work face-to-face in the community we have still heard directly from **7,697** people. This has largely been using social media channels, online meeting spaces, and other electronic means of communication.

Where possible and following COVID-19 protocols we have continued to meet groups in the community, have carried out one Enter & View visit plus some outreach work in Didcot.

3 Wider Healthwatch Oxfordshire Activity

Continued events for Patient Participation Groups (PPG)
https://healthwatchoxfordshire.co.uk/what-we-do/ppgs/ including:

- On 30th April PPG members came together to talk and share ideas about how to recruit new members. The PPG Chair from Hightown Surgery, Banbury told us about how the PPG worked with their surgery to promote the PPG to new patients.
- Fortnightly newsletter for PPGs

We are supporting 5 **Community Researchers** to undertake training and small research projects (Community Participative Action Research), via funding from Health Education England and Public Health South-East and separately the Care Quality Commission. They are at the stage of identifying area of focus and will develop skills in research in their communities over the coming year.

Oxfordshire Wellbeing Network (OWN) events including:

- Community outreach workers to support information sharing and networking which was held on 19th May and 30 people attended. A full report will be available in the coming weeks.
- Planning another event on the 24thJune for community groups to discuss the Wellbeing in communities report and share their experiences.

Planning for the next year and beyond with our focus being on listening to seldom heard communities across Oxfordshire, digital exclusion to accessing health and care services. Our goals and strategy for 2021-22 can be found here

https://healthwatchoxfordshire.co.uk/about-us/our-priorities/

To support our strategy of working alongside seldom heard communities to have their voice heard Healthwatch Oxfordshire are now beginning to work alongside and support five **community researchers** in the County. These are part of two projects supported by funds from Care Quality Commission, and Health Education England / Public Health England.

We continue to support the development of Patient Participation Groups, Primary Care Networks, and the Oxfordshire Wellbeing Network.

Oxford Health NHS Foundation Trust

Oxfordshire Adult Eating Disorder Service
Members' briefing for Oxfordshire HOSC

May, 2021

Introduction

All eating disorders are a group of severe mental health disorders which have the highest risk of mortality of all Severe Mental Illness (SMI). Comorbid alcohol and substance misuse, type 1 diabetes and a history of self-harm increases the risk of mortality in all diagnostic groups.

Most adults with eating disorders have complex physical and psychiatric comorbidities which have a major impact both on risk and treatment outcomes and need to be treated according to the relevant NICE guidelines.

The most common mental health comorbidities in anorexia nervosa include depression (40-70%), anxiety (50-70%), obsessive compulsive disorder (OCD) (30%), and post traumatic stress disorder (PTSD) (20-30%).

Up to 35% patients with chronic anorexia nervosa are on the autistic spectrum and these patients need a specific treatment pathway. Physical risks are related to acute and chronic malnutrition, which often cause admission to acute medical hospitals.

Research suggests that 80-90% of people with eating disorders are not known to specialist services. There are challenges inherent to the care and treatment of people with an eating disorder which lead to delays in accessing specialist help.

Strategic and national context

In the NHS Long Term Plan there is commitment across multiple stakeholders to improve both timely access to, and the quality of evidence-based treatment for people across all age groups in the provision of eating disorder services.

In 2019, NHSE published the commissioning guide for adult eating disorder services, which is the blueprint for developing Adult Eating Disorder Services (AEDS) as part of the Long Term Plan (LTP). This guidance established a clear rationale for localities to focus on improving care for adults with eating disorders as outlined below:

NHSE AED Commissioning guidance (2019)

Community Eating Disorder (ED) services should:

1. Provide evidence-based treatment, care and support for the full range of eating disorder diagnoses, including binge eating disorder and Other Specified Feeding or Eating Disorders (OSFED).

2. Accept all presentations from people who present for the first time to those with long-term problems, regardless of weight or BMI (body mass index).
3. Have the skills to provide care across the lifespan, from younger people to older adults.
4. Provide medical monitoring.
5. Offer intensive community treatment, or be able to support day patient treatment, to reduce unnecessary or inappropriate inpatient admissions.
6. Be proactive in engaging people in treatment as soon as possible, as well as those who are returning to active treatment following a period of recovery.
7. Support and empower families, partners, carers and the person's support network.
8. Offer advice, support and consultation to other services involved in a person's care.
9. Provide coordinated care (see Section 2.4) work with other services to reduce and prevent gaps in care during service transitions (age-related, geographical or community to inpatient transitions); using clear protocols and joint working agreements.
10. Respond appropriately to issues relevant to competence, capacity, consent, safeguarding and information-sharing.
11. Have clear processes around managing risk and safety as well as unattended appointments (including clear follow-up protocols to engage a person and prevent inappropriate discharge).
12. Provide appropriate clinical supervision to ensure professionals remain competent to deliver evidence-based treatment.
13. Improve awareness of the service in the community, the importance of early identification and reduce the stigma around eating disorders to increase help-seeking in the local population.

Key principles of the LTP relevant to individuals with eating disorders are:

1. Community-based care closer to home
2. Increasing access to psychological therapies (IAPT).
3. Personalised and trauma-informed care.
4. Improved physical health care.
5. Better integration of health and social care systems (towards ICSs and PCNs) to maximize continuity of care.
6. New focus on those too severe for IAPT but not severe enough to meet secondary care thresholds (this includes ED)
7. Aiming to eliminate exclusions based on diagnosis/complexity and avoid unnecessary repeat assessments or referrals.
8. Particular attention to those 18-25 needs lead not age led care (role out of FREED model).
9. Workforce expansion and integration with primary care

Service overview

Local context:

Oxford Health NHS Foundation Trust offers a wide range of specialist eating disorder services across all ages and different localities. The Oxfordshire community AEDS Team is one of the services commissioned to provide a specialist eating disorder service by the CCG. There is no specified activity level in the current contract though the number of referrals accepted by the service is disproportionally high relative to the local population.

1. The Adult Community ED service has seen year on year increase in the rate of referrals since 2016,
2. Historically, the service was commissioned for moderate to severe eating disorders until 2020, at which point all ED presentations were considered for acceptance to the service, since early intervention yielded better long-term outcomes.
3. Due to high demand and insufficient capacity, the service has been in business continuity measures since March 2020 (this coincided with the pandemic) and only those patients presenting with severe and extreme eating disorders would be treated by the team, (with some supporting consultations offered to GPs since March 2022). At the time, the service had 5 whole time equivalent staff and approximately 500 referrals, with an existing caseload of over 500 patients and 40-week treatment programmes, and this put unrealistic demands on the service. This is clearly not an ideal position and not part of a long-term plan.
4. Despite the exclusion criteria, referral rates remain high, suggesting increasing morbidity since the pandemic. This is reported elsewhere in the UK.

The impact of the pandemic

The COVID-19 pandemic has further compounded the existing challenges. Services across the South East are reporting that referrals of eating disorders and/or the acuity of presentations have significantly exceeded pre-COVID levels. Increases in the acuity and levels of risk in those presenting to ED (Eating Disorders) services across the lifespan resulting in increasing waiting times for admission to specialist hospitals have placed extreme pressures on community ED services and acute hospitals.

Locally this has been our experience and the service has seen both increased acuity and late presentations contributing to complex and high risk caseloads along with reduced capacity in the workforce due to a number of factors, including infection control measures, staff shielding or quarantined, high sickness levels, and high turnover.

A further factor has been accessing appropriate space to use whilst maintaining social distancing and staff/patient safety. The impact of COVID-19 has led to higher risks in the service and longer waits for treatment as therapists time is dedicated to risk management and care co-ordination resulting in capacity not meeting demands.

There is increased demand on primary care for the physical health components of care resulting in a fragmented service that is unable to meet the complex needs of this group.

Inpatient referrals have increased, reflecting the increase in
acuity and lack of capacity to deliver effective treatment in the community.

Expansion

The Oxfordshire AEDS service has some key strengths. The service is well known for its expertise in Cognitive Behavioral Therapy for Eating Disorders (CBT-ED) and has strong links with the CBT-E centre CREDO and University Department of Psychiatry.

The team has multiple staff members who are highly experienced in working with eating disorders. The team is delivering internal training to all new staff as well as participating in the HEE funded AEDS whole team training programme, which started in March 2021.

The community team has strong historical links with the inpatient unit, Cotswold House at Warneford Hospital, Oxford, which is commissioned by NHS Specialist Commission. In recognition of long-term underfunding, the team received additional investment in 2020 with the aim of improving service provision and enabled a plan for expansion, however this also collided with the onset of the COVID-19 pandemic and a surge in the number of referrals as well as the lack of suitable staff to recruit.

In March 2020, the team consisted of 5.5 wte establishment following several resignations, through retirement, promotions, family circumstances and other issues within the team. The financial resources were to fund the additional posts which would increase the whole establishment to 17.3wte and expand the multi-disciplinary professional representation.

There have been challenges to recruitment of the identified posts and there remain some gaps in the service although there has been some greater success in recruiting by the end of May 2021. Some of the post descriptions have been changed due to inability to fill the original type but the overarching plan to develop the service through team expansion remains the same.

Referrals and waiting times

The 2019 NHS Digital adult prevalence data suggest that more than 17200 people in Oxfordshire suffer from an ED. The Oxfordshire AEDS only received about 500 referrals in recent years but since March 2021 has been closed to ED of lower acuity.

This local referral data corresponds with the literature, which suggests up to 90% of patients with ED are not known to secondary services. This highlights that the demand may increase significantly in the years to come.

The numbers of adults presenting with ED in Oxfordshire are disproportionally high and the presence of two large universities will increase numbers. A survey of Oxford University suggested that up to 1,800/30,000 Oxford students may have an ED, but only about 80/1,800 students get referred to the Oxford adult ED service per year.

There has been a rising trend in referrals between 2013-2020, averaging around 11% a year, prior to the introduction of business continuity measures in 2020. The table below shows

referrals over the past 3 years including number referred and numbers accepted (Source: TOBI):

Financial year	Total referrals	Total actioned	% accepted	% change
2016/17	397	337	85%	
2017/18	406	290	71%	+2%
2018/19	413	327	79%	+2%
2019/20	523	364	70%	+27%
2020/21*	467	313	67%	
Projected 21/22	644	**547 .4**	Based on 85%	2019 plus 2 11% increases

***decrease due to COVID and national trend of MH downturn Q1/Q2 pandemic as well as restrictions on referral acuity**

Comparing 17/18 to 20/21 shows a 14% increase in referrals, more realistic comparison is 17/18 to 19/20 with a 22% increase.

There are still considerable waits for treatment. It is difficult to pull this data from the Trust's Carenotes system in a meaningful way as those patients who are on the waiting list are actively monitored until formal treatment starts.

For the patients that are waiting, all high-risk patients are offered regular physical monitoring (weight check) plus brief psychoeducation/mental health review in addition to a risk management session while they wait for evidence-based treatment.

Details of waits for formal psychological treatments:

The service currently has substantial waiting lists for NICE-concordant psychological intervention.

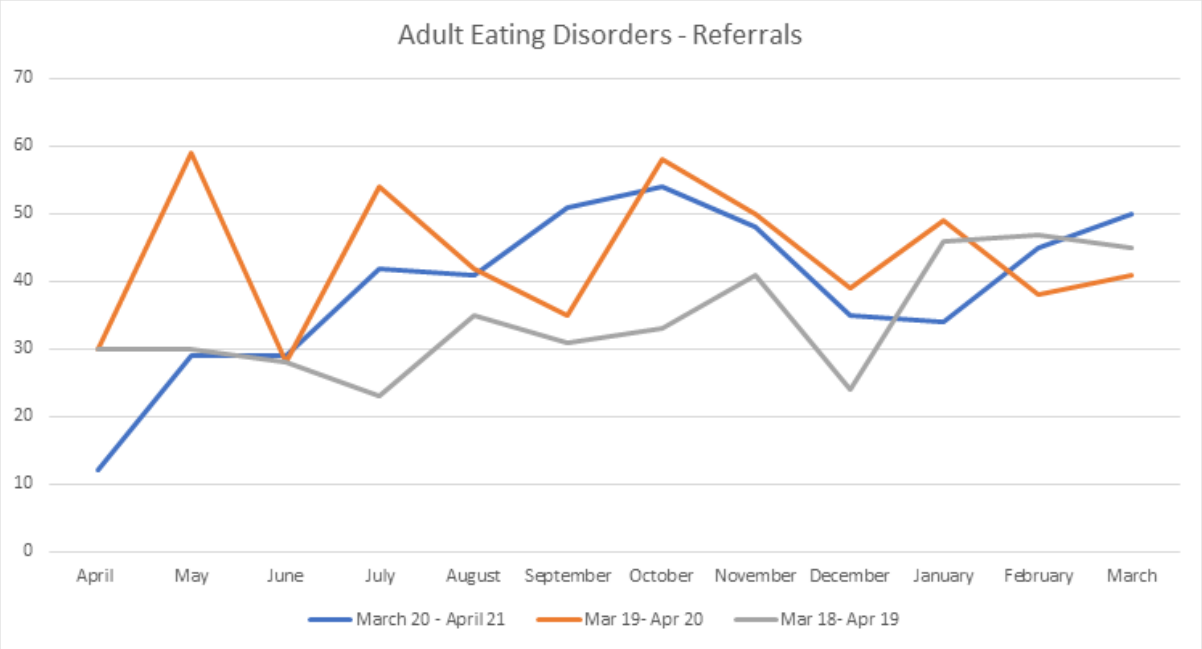
- As of March 2021, 47 individuals with **severe and high-risk eating disorders (priority group)** are waiting for NICE-concordant psychological interventions. 77% have a diagnosis anorexia nervosa (including atypical) & 23% have a diagnosis of bulimia nervosa or binge eating disorder. The expected waiting time for this group is currently 18 months. The longest wait is from June 2019. (23 months)
- A further 93 individuals who have **moderate severity** are waiting for NICE-concordant psychological interventions. The expected waiting time for this group is 24 months. The longest wait is from February 2019.
- There are also 13 individuals waiting for guided self-help, longest wait is from May 2020. Due to the severity of presentation, many individuals require active support and

monitoring by staff to mitigate risk. This leaves extremely limited capacity to deliver the psychological interventions that this cohort are waiting for.

There is limited evidence supporting the effectiveness of waiting list interventions, but we are looking at models being delivered across the country.

The Eating Disorders charity BEAT offers waiting list interventions and we are investigating if this would be something that could be commissioned to provide a service.

We are also considering other models being delivered across the country and exploring every opportunity that will provide patients with the best available treatments that are being developed and researched.



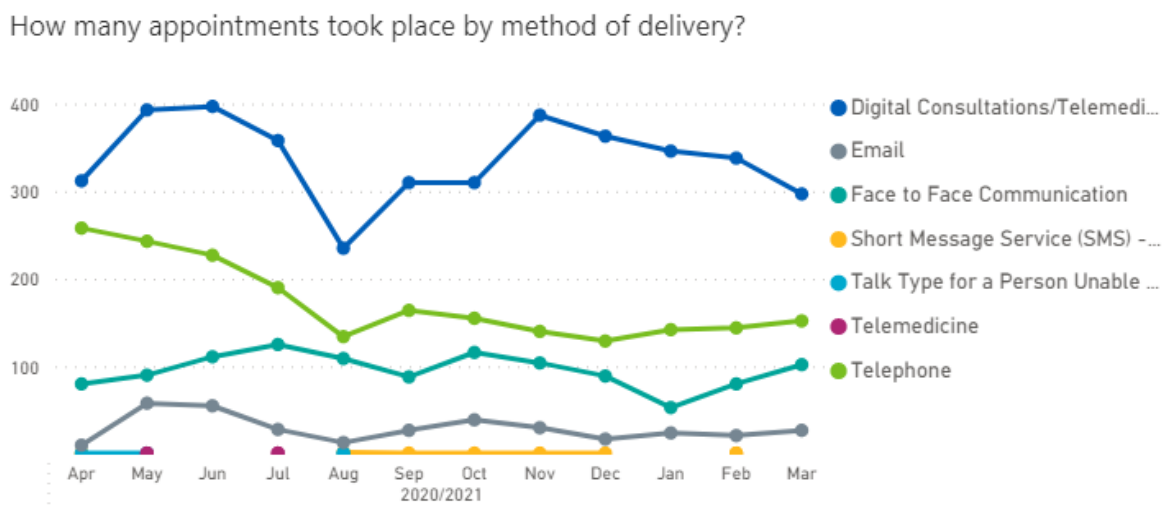
Team Activity

The contractual commissioned annual target for direct and indirect contacts per annum is in total 4,577 below shows that we exceeded that target for 2019/20

Year	Number of total Contacts Delivered
19/20	4681
20/21	4467

Digital Working

Throughout our response to COVID-19 the Trust rapidly introduced digital consultations via Microsoft teams. This enabled service provision to continue through COVID-19 restrictions.



Developments to date

In 2020, the Mental Health Investment Standard (MHIS) provided £500K of recurrent funding which allowed for significant development in terms of initiating the major transformation of the service model for Oxfordshire Eating Disorder Services, but this only went some way in developing the service as is needed.

Ongoing challenges to recruitment and retention in a specialist field that is in high demand (especially from the private sector) has led to creative ways to recruiting to posts and achieving the key roles to meet the service needs.

Some gaps still remain and an experienced locum psychiatrist has now been appointed, following a long period without a consultant medic within the community team, and we are

also looking to recruit an additional GP liaison role which will add considerable value to the medical input within the team.

We have appointed a permanent, experienced team manager, as well as an experienced senior psychologist. This is in addition to several key therapy roles, a lead nurse role, and development posts across a range of professional backgrounds to ensure there is a good career structure for staff and development opportunities for training within this specialist area of working.

It is important to ensure that the provision for this patient group considers the physical, functional, mental health and medical needs within the staffing structure and how the patient pathways support those needs.

The current position with staffing is 13.68 wte (whole time equivalent) in post and 7.4 wte vacancies.

All patients waiting for treatment are contacted six weekly for a check in and offered self-help guidance. If there are any concerns re their eating disorder presentation, patients are advised to see their GP for a physical health check. There is also a high-risk clinic that is available for complex patients.

In addition, we are looking at other opportunities: -

- considering online therapy offers.
- Gaining support from adult colleagues to use therapists time offering therapy to patients on the waiting list.
- The service has developed in-house training and participates in national training.
- The service has good links with the university: opportunity for building on CBTE, QI and innovation.

Summary of MDT capacity review

To deliver enough therapy contacts alone to provide NICE-concordant psychological treatment to those waiting and based on current referral trends would require 446 appointments per week. This is only a part of NICE-concordant care for adults with eating disorders.

Considering assessment appointments, care-coordination activities, joint appointments, support, and monitoring for those with longstanding eating disorders, medical and psychiatric reviews, attendance at tribunals, carer support etc. would require at least a 25% increase to this figure (558 total).

Based on referrals and those current waiting for treatment, recurrent investment in staffing capacity modelled on around 550 referrals a year would create an initial opportunity to deliver treatment to the patients on the waiting list at the same time as offering treatment at the current referral levels, allowing for a rise in referrals once business continuity measures

are lifted, further yearly increases, and the introduction of
FREED (First Episode Rapid Early intervention for Eating Disorders).

FREED

The **First Episode Rapid Early Intervention for Eating Disorders** (**FREED**) is an innovative service model that has offered support to over 1,200 16 to 25-year-olds. The FREED programme represents a key priority for implementation within Year 1 and 2 of the LTP ICS-wide CMHT plan. FREED is an early intervention service, based on the staging model and has been developed specifically to target adolescents and young adults (16-25 years) in the early stages of an ED (less than three years illness duration).

The FREED service model includes a rapid and proactive referral process, a holistic and non-stigmatising assessment (within two weeks of referral) based on a bio-psycho-social approach, followed by an evidence-based treatment plan (within two weeks of assessment). FREED has been shown to reduce total treatment costs and improve outcomes in young adults presenting with an ED.

In 21/22 we propose to capture baseline data and to establish FREED for those aged 17.5-21 in the first instance. Based on 2019 data this would equate to around 53 eligible referrals based on current AED referral criteria.

NICE-concordant treatments for Adults with ED range between 20 and 40 sessions in length depending on diagnosis. Modelling using the CReST tool (Demand and Capacity Tool) would suggest that for to offer an average of 30 session treatments, starting within 4 weeks of referral, the service would need capacity to offer around 40 NICE-concordant therapy contacts per week.

This is in addition to staffing the non-clinical aspects of FREED which include awareness raising, liaison with key stakeholders e.g., primary care and education and data tracking.

Clinical needs/pathways within the AEDS

Longstanding/Complex Pathway/ASD/Diabetes/High Risk

Service users with a severe and enduring or more complex presentations requires specific provision tailored to their needs. Individuals with autism spectrum disorder (ASD) or diabetes require management specific to their co-occurring conditions. Those with longstanding EDs are currently offered regular psychological support and monitoring appointments. This intervention is not time limited and is focused on improving quality of life, monitoring of eating disorder symptomatology (alongside the individual's GP) and preventing repeat hospital admissions.

These groups often require joint working with adult mental health teams around co-morbidities. Recent interviews with individuals who have experience or a longstanding ED and extended or multiple episodes of care suggest this group value (i) access to medical

monitoring (ii) peers support groups/links and (iii) support work to improve quality of life and (iv) access to formal psychological interventions if and when appropriate.

Adults with Eating Disorders in Acute Medical Settings

There has been recent reporting of year on year increases in bed use by eating disorder patients. This coupled with the fact that most adults want, and should, be treated in the community means that community services nationally are under increasing pressures and Oxfordshire Eating Disorder Service is no exception.

Individuals who are identified as requiring an inpatient admission will typically be very low BMI (under 14), often with abnormalities on bloods and other physical health investigations.

Therefore, the service is managing physically very unwell patients with the current challenges in capacity and without sufficient medical or dietetic input in the team. This can result in significant anxiety for staff in the eating disorder service, carers and the patient's GP, as bloods and other physical checks at this stage of the illness will need to be frequent, which can present a challenge of capacity to GPs. Interpretation and management of physical health at this stage can also present a challenge to GPs.

Proposed staffing and investment for 21/22

A further business case has been submitted to continue the work that has been started to meet the NHSE standards. This will continue in the forthcoming years and transform the Specialist Eating Disorder Services into a bespoke service meeting the needs of the population of Oxfordshire. The staffing structure is based on the ED capacity modelling and existing FREED implementation sites.

ED HOPE Tier 4 Provider Collaborative

In 2018, Oxford Health NHS Foundation Trust (OHFT) formed the Tier 4 Adult ED HOPE (Health Outcomes for People with Eating Disorders) Provider Collaborative (PC).

The PC is in shadow form currently until October 2021, NHS England South East are the commissioners until the PC goes live.

Upon go live, OHFT will be the lead provider for the Thames Valley Tier 4 Adult ED HOPE Provider Collaborative, covering; Buckinghamshire, Oxfordshire, Gloucestershire, Berkshire West and BSW (BaNES, Swindon & Wiltshire) partners include:

Current Inpatient Partners	Current Community partners
1. Oxford Health NHS FT 2. The Priory Group	1. Gloucester Heath and Care NHS FT 2. Berkshire Healthcare NHS FT 3. Oxford Health NHS FT

The inpatient units/beds within the provider collaborative footprint include:

- 8 bed Adult Eating Disorder unit in Marlborough, Wiltshire. (OHFT Provider)
- 14 bed Adult Eating Disorder unit in Oxford. (OHFT Provider)
- 8 bed Adult Eating Disorders Beds Priory Marlow (Independent Sector), NHSE commissioned 8 beds April 2021)

The Provider Collaborative will continue to develop a whole system, integrated approach which spans across health and social care. By managing the care pathway, we will be able to ensure that patients are cared for in an inpatient setting or via an 'out of hospital' service as close to home as possible. This will:

- Improve patient outcomes
- Reduce the burden on patient and families to travel long distances.
- Enhance continued engagement with community clinical teams.
- Encourage early therapeutic home leave.
- Minimise length of stay.
- Avoid admission.
- Increase patient flow and volume.

The Provider Collaborative will ensure that community and inpatient provision continue to work as an integrated pathway ensuring patient care is seamless, timely and appropriate to meet needs. Ensuring that the Provider Collaboratives multiagency approach supports developments to provide alternatives to admission and admission prevention.

Alternatives to admission

The Provider Collaborative clinical model includes the development of a number of alternatives to admission that will form part of the investment strategy for the PC, to invest funds where beds are not available to meet the demand by offering alternative evidence based approaches.

The Stepped Care Model approach is being considered for the provider collaborative, a CBT-E model intensity is chosen to meet patients individual needs (community, intensive home treatment or hospital treatment). It is a stepped care approach to meet the needs of each patient, reducing inpatient admissions and length of stay.

Our team in Oxford has been working on adopting the model

Table 1. Summary of the stepped care CBTE model

Recovery focus:

1. to restore to a **healthy weight**
2. to identify and correct the mechanisms that maintain the **psychopathology**
3. to ensure that the changes achieved are **lasting**

Principles

1. Least restrictive
2. Patients are treated as adults
3. Staff and patients work towards a common goal
4. Whole system – stepped care – based on evidence based psychological treatment
5. Time limited admission (13 weeks for full weight restoration and 7 weeks day treatment for stabilisation – followed by outpatient CBTE (in total 40 sessions as per NICE Guidelines)

Cost/Benefit Analysis

Benefits of investment

This will deliver increased quality through providing a service response time that ensures equity with Children and Young Peoples services of 1 week from referral to treatment for urgent cases and 4 weeks for routine. There will then be access to a range of evidence-based treatment pathways including individual and group therapy.

The clinical benefits of this model will include:

- Increase in provision to meet the demand of projected 548+ referrals per annum.
- Increase in service user, carer, GP/referrer and staff satisfaction.
- Parity between CYP EDS and adult EDS
- Improvement in clinical outcomes across all presentations
- Reduced pressure on GPs, advice on interpretation and management available
- Meeting core functions of an effective AEDS as outlined in NHSE Guidelines.
- Offering FREED pathway that will provide the service with an early intervention focus that should support savings further on as people will not have a lifetime of experiencing acute mental health services.
- Meeting the need of SEED individuals
- Offering effective student pathway
- Offering carers' support
- The backlog of referrals will be addressed.