1. Introduction

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

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

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

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

2. Community Hospitals

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

Concerns raised are threefold:

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

2.2 Supply vs. need

Healthwatch will be asking OCC and OCCG formally for:

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

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

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

We hope that HOSC will endorse our request.

2.3 Strategy

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

Healthwatch will be asking OCC and OCCG formally whether:

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

We hope that HOSC will endorse our request.

2.4 The tone of the conversation

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

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

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

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

For example:

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

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

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

Healthwatch believes that:

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

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

2.5 The Big Plan

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

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

The concerns raised with us are that:

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

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

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

We hope that HOSC will endorse our request.

3. Improving discharges from hospital in Oxfordshire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Feedback from OCCG locality forum Chairs

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

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

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

South East has made two statements:

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

West was:

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

Appendix One – Discharge report, see separate file.

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

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John Jackson, Director Adult Social Care
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June 23rd 2015

Dear John,

The Big Plan

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

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

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

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

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

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

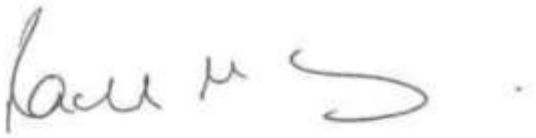
Quality of service provision
Whilst all concerned applaud the ambition of people with learning disabilities receiving their services from mainstream providers alongside everyone else, there is a very real concern that this will quickly lead to an assumption that this patient/user group do not require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

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

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

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

Yours sincerely



Rachel Coney
Chief Executive

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

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John Jackson, Director Adult Social Care
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July 3rd 2015

Dear John,

The Big Plan

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Rachel Coney
Chief Executive

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

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John Jackson, Director of
Adult Social Services

6th August 2015

Rachel Coney
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Dear Rachel,

The Big Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

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