

## 1. Introduction

1. The key areas of work for the Healthwatch Oxfordshire team since the last HOSC meeting in February 2016 have been:

- a. Working with Oxfordshire County Council on our new funding agreement.
- b. Restructuring the organisation to 3 full time and 2 part time posts.
- c. Developing our work plan for 2016-17 (including setting our budget)
- d. Progressing work on conversion to a charitable organisation.
- e. Submitting background evidence for the Health Inequalities Commission.
- f. Working with system leaders on a response to our discharge report.

## 2. Grant aided projects

a) Healthwatch is currently supporting six groups to produce reports on their service-user experience through our final tranches of our project grant programme:

- i. **SEAP (Support, Empower, Advocate, Promote)** is undertaking a project to determine the experience of gypsy and traveller communities trying to access services. This will be published in April.
- ii. **Oxford Parent and Infant Project (OXPIP)** is reviewing the experiences of parents
- iii. **Refugee Resource** is looking at access to primary care services of refugee and asylum seeker populations the report is expected in late spring / early summer.
- iv. **Oxford Against Cutting** is looking to evaluate people's experiences of current support services and identifying gaps in current services. This report is expected in summer.
- v. **Cruse Oxfordshire** is working on a project assessing experiences of bereavement services in the north of Oxfordshire. This report is expected in summer.
- vi. **Chalgrove and Watlington Patient Participation Group** is working in partnership with us to conduct focus groups with young people to better understand their experiences of GP services. This will be reported in summer.

## 3. Discharge Report Response

HWO reported that we had met with system leaders to discuss their response to Healthwatch's discharge report. The response is provided in the table below. The process has contributed to a much improved understanding Healthwatch Oxfordshire and the system.

NHS Response Improving Discharges	NHS response:
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<p><b>from hospital in Oxfordshire Healthwatch Oxfordshire Report recommendations</b></p>	
<p>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.</p>	<ul style="list-style-type: none"> <li>• It is important to understand that not all patients require an estimated date of discharge (EDD) to be set within 36 hours of admission. Many patients are admitted for less than 36 hours and for some complex patients it takes more than 36 hours to complete all the diagnostic tests required to allow the clinician to decide on how best to manage the patient.</li> <li>• However, it is the aim of all hospitals in Oxfordshire to ensure that a planned discharge date be set within 36 hours for all relevant patients</li> <li>• Patients are reviewed twice daily in what is known as ‘board rounds’ during which their EDD is reviewed. Regular audits take place to check the setting and accuracy of EDD.</li> </ul>
<p>2. Patients should be assigned a named discharge co-ordinator and be given the details of how to contact that person at the point of their estimated date of discharge.</p>	<ul style="list-style-type: none"> <li>• We do not agree that every patient requires an allocated discharge coordinator. The Discharge liaison nurses add value in supporting those very complex discharges through a case management approach. We are reviewing the way the current discharge liaison team functions to provide greater support across the trust for very complex discharges.</li> <li>• The named nurse should be identified to the patient and their family as a main point of contact in the event of any queries regarding discharge.</li> </ul>
<p>3. The planning for discharge ward poster produced by the OUHT should be redesigned as the leaflet 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.</p>	<ul style="list-style-type: none"> <li>• We are jointly reviewing discharge posters and leaflets for patients. The aim is to have a single comprehensive leaflet, which will include standard useful information, but will also include a section with personalised discharge information for that patient. Healthwatch approved the wording on the current poster and it is likely we will adopt the same language in the patient leaflet.</li> <li>• A discharge care plan will be developed for each patient, which will include the named nurse and provide contact numbers in the event of discharge queries.</li> </ul>
<p>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</p>	<ul style="list-style-type: none"> <li>• We don’t agree that every elective patient requires an allocated discharge coordinator. However, the named nurse will be identified to the patient as a point of contact in the event</li> </ul>

<p>alternative care arrangements for those they are caring for can be put in place.</p>	<p>of discharge queries.</p> <ul style="list-style-type: none"> <li>• For elective patients - a pre-operative assessment processes will include a discussion on any caring responsibilities the patient may have and this will be incorporated into their admission and discharge plans. If necessary, a Section 2 referral can be made to social care for an assessment of need.</li> <li>• For patients admitted non-electively, then the admission assessment should include a question about any caring responsibilities and if necessary a S2 referral can be made to social care.</li> </ul> <p>New Contract (Carers' Support Services):</p> <ul style="list-style-type: none"> <li>• The contract will continue to be delivered through Carers Oxfordshire for the coming 3 years. It brings together a new alliance of the county's leading carer support providers Action for Carers Oxfordshire, Rethink and Guideposts into this new partnership. The support available to assist carers includes; Access to information, support and advice; Face to face support; Volunteer respite; Peer support and information and training.</li> </ul> <p>Carers' Assessments:</p> <ul style="list-style-type: none"> <li>• Carers are also invited to access Carers' assessments. These assessments are provided jointly by the Oxfordshire Clinical Commissioning Group (OCCG) and Oxfordshire County Council (OCC). Support plans, including relevant information, registration for the Emergency Care Support Service (ECSS) and potentially a 'one off Personal Budget to address health and wellbeing needs, will then be produced from these Carers' assessments.</li> </ul> <p>Respite:</p> <ul style="list-style-type: none"> <li>• Carers who care for someone who is eligible for social care may also benefit from respite care and support.</li> </ul>
<p>5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them.</p>	<ul style="list-style-type: none"> <li>• Each patient will have a named nurse who will be the main person to communicate with families. In the event of a patients having more complex discharge needs then one of the discharge liaison nurses will support the communications with families.</li> <li>• A Trust-wide multidisciplinary discharge workshop was undertaken in October 2015 which was well attended by large groups of staff. This included training in the management of complex discharges and communications with families as well as information on services available to</li> </ul>

	patients and their families. An ongoing program of discharge workshops is planned.
<p>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.</p>	<ul style="list-style-type: none"> <li>• The Trust agrees that for patients with complex or specific discharge needs a personalized discharge plan should be in place that the patient could take home. This will be included in the new patient discharge leaflet. For very simple discharges where the patient does not have any specific post discharge needs then standard discharge information will be provided.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• The Trust agrees that this is appropriate for patients with specific or complex discharge needs and this personalized information will be included in the patient discharge leaflets which they will take home.</li> </ul>
<p>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:</p> <ul style="list-style-type: none"> <li>• Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged.</li> <li>• Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Electronic prescribing and administration of medicines has been implemented across the OUH since May 2015 apart from JR maternity.</li> <li>• It is currently in place as part of the commissioning contract to prescribe 2 weeks take home medication on discharge.</li> <li>• The OUH has an electronic pharmacy tracking system. Ward staff are able to track at patient level through the prescribing, dispensing and checking process each patient's TTO is up to. This enables them to provide update to date information to the patient and to escalate any delays.</li> <li>• The Trust has agreed pharmacy turnaround times which are monitored through the Trust discharge assurance group.</li> <li>• Regular reports on prescribing are published on the Trust business information system and are available to all divisions. TTO prescribing performance is monitored through the Trust discharge assurance group.</li> </ul>

<p>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.</p>	<ul style="list-style-type: none"> <li>• The discharge summary is being redesigned with input from clinical staff including GPs and pharmacists.</li> </ul>
<p>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</p>	<ul style="list-style-type: none"> <li>• The discharge summary is sent electronically to GPs and is monitored</li> </ul>
<p>11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs.</p>	<ul style="list-style-type: none"> <li>• The Trust agrees this is good practice and consultants and senior nurses will regularly contact GPs to discuss individual patients on an individual basis where appropriate.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• Hospital doctors take responsibility for acting on tests they request as per GMC guidance. Some results may only be completed once the patient has been discharged and agreement will be made with the GP on how these results are followed up.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• Sharing agreement already in place.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• We review readmissions to hospital in a number of ways: <ol style="list-style-type: none"> <li>1. Readmission rates to hospital within 30 days are monitored every month.</li> <li>2. We use software to alert the hospital and CCG if any specialty appears to have an increased rate of readmissions and we investigate these alerts to make sure there are no patient safety issues.</li> <li>3. We undertake an annual readmission audit to ensure there are sufficient services in the community to support patients following</li> </ol> </li> </ul>

	<p>discharge from the hospital</p> <p>4. If a patient suffered harm as a result of being discharged too soon, the hospital would undertake an investigation to prevent similar incidents</p>
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#### 4. Outreach programme

- a. Since the end of October 2015, HWO Community Involvement Officer, Kanika Lang, has had a number of one-to-one meetings with a range of voluntary sector organisations. These have included conversations with staff members, volunteers, service users, or a combination of these. HWO hosted a conference for representatives of voluntary sector organisations in Oxfordshire, where they gathered feedback on pressing issues for the sector.

##### 1. Who we have spoken to:

Organisations:

1. **SeeSaw**- Grief support for children and young people following a bereavement;
2. **Terence Higgins Trust** - provide HIV support service and preventative measures;
3. **Oxford Council of Faiths** - a network of different leaders from different faith communities in Oxford;
4. **Oxfordshire Mind housing services** which provides transitional housing- with the aim of moving people into their own more permanent housing eventually;
5. **Yellow Submarine** - work with young people (from 11+) and adults with learning disabilities and autism providing activities, clubs and training and employment opportunities;
6. **Oxfordshire Bereavement Alliance** - organisations that provide support to people who are bereaved in Oxfordshire;
7. **SEAP** - provide NHS complaints advocacy;
8. **Archway Foundation** - works with people who are suffering from isolation and loneliness with a befriending scheme and social groups;
9. **Crisis Skylight Oxford** works with people who are homeless or vulnerably housed, offering training courses and support.

10. **Vale Disability Access Group** works across the Vale of White Horse District to promote good quality disabled access in all the public areas of the market towns and the rural areas between;

11. **Sobell House Hospice** offer specialist palliative care and support to adult patients and their families, carers and friends;

12. **Oxfordshire Sexual Abuse and Rape Crisis Centre (OSARCC)** offer support to survivors of sexual abuse, rape, domestic abuse, and harassment;

13. **Unison** (retired members) Oxford;

14. **Citizens Advice Bureau** (Thame);

15. **Oxfordshire Advocacy**- the organisation's Cancer, Older people and Advocacy Project.

## **II. What we have heard:**

### **Mental Health services:**

- Widespread concerns have been expressed about how difficult it is for people to access mental health services when needed in a timely and effective manner. They report seeing increasingly unwell people who are turned away from services as the threshold to access mental health services rises ever higher.
- At the same time, organisations are also seeing mental health professionals stretched beyond capacity resulting in high staff turnover and a consequent lack of continuity of care for patients. An example was given of the Warneford Hospital where the consultant psychiatrist keeps changing for one patient with no notice given to carers. As a result there is a lack of continuity of care, no involvement of carers in the patient's care and no information given to carers about staff changes.
- There are very long waiting times to access Child and Adolescent Mental Health Services (CAMHS) and Primary CAMHS (PCAMHS) and patients say there is such a high threshold to be able to access these services now as staff are so stretched already. There is a massive waiting list and sessions are limited to 6 only. Waiting times of 9 months are not unknown. The earlier a child is seen the better the outcomes.
- Access to school counselling services for young people may not work very well for those who have suffered a bereavement as it can be perceived a service that is didactic and directive.
- For people dealing with complicated grief, mental health services are assessing people as 'not ill enough' so often people are coming to

bereavement services where there is actually a need for mental health services.

- Discharge at the Warneford - examples were given of being discharged from the Warneford even though someone is homeless and had nowhere to go to and the staff were aware of this. It was felt that there is a vicious cycle of going into a hospital like the Warneford and then being discharged onto the street only to end up eventually in the Warneford again. Finding accommodation to move on to after the hospital is hard if you're vulnerably housed to start with and can often delay discharge.
- Some survivors of sexual violence are unable to engage with mental health services as they don't fit the criteria or are discharged too early from the services. Some survivors report that the underlying trauma is not dealt with by the mental health services. Organisations say it is important to try and create a safe space to facilitate disclosure about sexual violence that may be underlying mental health issues.
- Staff at the CABs are seeing the impact of the lack of support for people with mental health issues- people in financial difficulties as a result of mental health problems, people who are becoming homeless as a result of these problems. Mental health services are not adequate to support some very vulnerable people.
- People with mental health needs sometimes don't get their physical needs met. Organisations suggest that physical health checks should be routinely offered to those with mental health issues. Health professionals who come in contact with isolated and vulnerable people should have a way to flag up physical health concerns sooner.
- On a positive note, with the new Mental Health Partnership it was felt that there is more support for people in need in the evenings and at the weekends. More can therefore be done to avoid hospitalisation.

#### **GP services:**

- People with limited physical mobility often struggle to access their GPs, particularly if they have to see them regularly. Organisations that support isolated and vulnerable people feel that more home visits by GPs could be greatly beneficial to such people.
- When GP practices merge, this needs to be communicated well to patients with enough information on who the new doctors would be, who the patient's named doctor would be and what options patients have if they are uncomfortable with the merger.
- People with specialist or minority conditions may struggle to get adequate support and advice from their GPs and one said that you often have to know more than the GP to guide them and proactively drive your own care.
- Many people have commented on how long you have to wait to see a GP of your own choice, sometimes 3 weeks or longer and this was a common theme across the County. For people with specialist conditions who particularly need continuity of care, this is a challenge.



- Luther Street Medical Practice was praised as a very good medical practice for people who are experiencing homelessness, including a very good dentist. The fact that patients can stay at the Luther Street Medical practice for 6 months after finding accommodation, for consistency and continuity in care was felt to be a very good thing.
- Where GPs keep a good overview of a patient's care, liaising and communicating well with hospitals and other services, this is much appreciated. Where a patient who is vulnerable or isolated falls under the radar of their GP, they may struggle to receive the care they need. Organisations working with isolated or lonely people have noted the need for one health care professional, like a person's GP, to keep an overview of their health and social care needs to ensure they get the care they need.
- GP surgeries could do more to be responsive to the needs of their patients- one person noted that at their surgery a patient's turn to see the doctor is announced via names displayed on an electronic board in reception which cannot be seen by people with a visual impairment and the receptionists refuse to call out the person's name as they say they are too busy. The same surgery insists on doing prescriptions by email only even though this person cannot use email and has to rely on family members to help out.

#### Hospital services:

- Poor communication around appointments, diagnosis and treatment is a recurrent theme.
  - e.g. one person went in to have a procedure at the John Radcliffe but was told at the last moment, when in hospital, that he would now receive a different procedure, with no explanation for the change given. He was not even included in the letter following treatment sent by the consultant, so a month after treatment he still had no idea why treatment was changed and this has considerably increased his anxiety.
  - Another person reported being sent from department to department with no explanation about the reason for referrals and no solution as yet to the medical problem he sought advice for.
  - Others have commented on the lack of communication between different departments of the same hospital, so that patients have to take the lead in coordinating their own care.
  - Cancellation of surgery at the last minute for a child with no explanation for the reason and no date set for future surgery caused considerable anxiety to the child and parents.
  - One patient had to call several times to try and rearrange a date for a procedure, as the only response received on the first three attempts was an answerphone which did not yield any call back.
  - Several people mentioned that it was hard to reach anyone at the John Radcliffe's Patient and Advice Liaison service.

- Concerns around discharge:
  - People cited delays in discharge due to the lengthy waiting times in getting medicines from the hospital pharmacy.
  - One person's neighbour was discharged from hospital without a care package even though she had dementia and could not dress or feed herself and could only manage in the short term with support from her neighbour.
- Changing or bringing forward appointments was cited as really difficult to do even when there was a medical need to do so.
- Parking at all the hospitals- this has come up repeatedly as being a huge source of stress for patients and their family members/carers.
- The physiotherapy departments at Abingdon hospital and the Nuffield were praised as excellent.

#### **Bereavement services:**

- There is a gap in access to age-appropriate bereavement services for older teenagers and there is a need to understand how they want to be supported and in what form (online for example, via a website).
- There is a gap in bereavement services for young adults who are moving away from home and starting working life. They may not want one to one referrals or to wait 6-8 weeks to be seen.
- There are not enough support services for surviving parents. The functioning of the surviving parent is one of the most significant factors for a child's outcomes post-bereavement but there aren't enough support services to signpost parents to.
- There is a gap in access to bereavement support services for non-Christian, Black Minority Ethnic families though bereavement support organisations are starting to work with these communities.
- There is a gap in drop in services for bereaved people- where they can meet and get support from other bereaved people.

#### **Housing services:**

- Organisations supporting vulnerable people, those on housing benefits and those with mental health issues report that there is real difficulty for such people in finding good quality private rented accommodation particularly in Oxford city.

#### **Prisoners' medical needs:**

- Organisations working with prisoners report that the medical needs of prisoners are not always met adequately. For example, medication is often not administered according to need, but according to staff availability- people who need regular medication may not get it on time for e.g. a 'night' dose may be given at 3.30pm instead of at night based on staff availability.

#### **Carers:**

- While there is good support from voluntary sector organisations for carers, certain kinds of carers may be overlooked such as those who care for people with acute episodes (rather than chronic conditions) and may not even identify as carers. More work is needed to provide support to them.

#### **Training for health care professionals:**

- Voluntary sector organisations working with survivors of sexual violence feel medical staff across the board need training in sexual violence and recognising the signs to enable them to make people who have suffered from this feel safe.
- Based on their clients' experiences, other organisations have felt the need for additional training for medical staff to ensure difficult diagnoses are communicated sensitively achieving the right balance between providing all the information necessary and not bombarding people with technical information.

#### **Impact of the cuts**

There are a number of organisations reporting adverse impacts as a result of budgetary cuts:

- **Mental health services:**
  - Organisations report seeing more and more people with mental health issues- very vulnerable people with nowhere else to go for help to get their voice heard- people turned away by mental health services. Also staff working in mental health services are more stretched and overloaded and just can't deliver services necessary sometimes.
  - Many organisations note that with mental health services, there is no intermediate care anymore- either you are well or you're at crisis point. They report that you have to be very ill to get support.
  - Organisations report working with bereaved people who are in need of mental health services but the services are so overstretched that they are being told they are not ill enough to be able to access the services.
- **Services for those with learning disabilities and autism:**
  - Concerns have been expressed about the impact of the cuts on day services for people with learning disabilities and autism.
- **Transport:**
  - With the withdrawal of subsidised bus services it is very hard for people in rural areas to access health services, to get to their GPs and hospital appointments.

- **Closure of children's centres**
  - Concerns have been repeatedly expressed that closures will leave vulnerable families, who struggle to access other networks of support, without any support and further aggravate pre-existing mental health issues within the families. People struggling with multiple issues will struggle even more to get help in any other way.
- **Sexual health services**
  - The loss of funding to organisations that provide sexual health services, often particularly to the Lesbian, Gay, Bisexual and Transgender communities in Oxford, has raised big concerns about the health of these communities and for the services they currently use that will be withdrawn.
- **Loss of voluntary sector organisations and their services**
  - There are huge anxieties expressed by voluntary sector organisations about the impact of funding cuts on their services, with some stating they will have to close down and will be unable to continue to provide support to very vulnerable communities in Oxfordshire.
  - Other have stated that with funding challenges come the pressure to move people on from their services, even if they may not be ready to move on and may not have other sources of support in place.
- **Day centres:**
  - With the proposed closures of day centres there is increasing anxiety around the loss of opportunities for people who use these services to establish and maintain social networks.

**Additional challenges faced by voluntary sector organisations as providers of health and social care services:**

In addition to the negative impact of the cuts on their ability to deliver services, voluntary sector organisations are also concerned about:

- **The commissioning process** - Some voluntary sector organisations want the commissioning system to allow Oxfordshire providers to tender for bid but feel the commissioning process can have the opposite effect. It forces organisations into consortia, as bids are often set up so only 1 bidder can win which makes it very hard for smaller charities. There are often very short deadlines for bids - 5 weeks is not uncommon. This approach has been termed short-sighted because local expertise, local skills are being lost when big, out of county providers get contracts.
- **Co-design not participation** - voluntary sector organisations say they are often asked to join the process of service design or redesign too late. They say they know their communities well and do a lot of preventative work and therefore should be involved earlier in the care and design pathways.
- **Increasing demand for services** - even when funding levels are maintained many organisations report large increases in the demands for their services with no additional increase in resources. This makes it difficult for organisations to provide services at the same level as before.

- **Changing profile of service users** - organisations report dealing with more people with increasingly complex needs and having to respond to these in an environment of budget cuts and increased demand.

### III. Next steps

- To continue a programme of outreach with voluntary organisations across the County providing a variety of health and social care services to ensure we are hearing from groups whose feedback may not be captured by other outreach mechanisms. The hope is to develop relationships so that we are regularly hearing from a range of partners and their members.
- To spread the word about HWO by meeting voluntary sector organisations and sharing information about us with their members.
- To explore further ways of working with some organisations to ensure feedback on specific services reaches appropriate commissioners and providers. This could be in the form of co-producing reports for example.
- To close the feedback loop with voluntary sector organisations by including feedback gathered from them in our planned monthly 'this is what we've heard this month' reports on our website.
- To continue to build our knowledge of the voluntary sector health and social care services available so we can signpost members of the public to appropriate services.