Oxfordshire Integrated Improvement Programme
HOSC 14th July 2022

Programme Directors	Helen Shute, Programme Director, Oxfordshire Community Services
	Lily O'Connor, Oxfordshire Director for Urgent Care
System Executives / Senior Responsible Officers	Sam Foster, Chief Nurse, Oxford University Hospitals FT
	Dr Ben Riley, Executive Managing Director, Oxford Health FT
	Karen Fuller, Interim Corporate Director of Adult Social Care, OCC
	Matt Powls, Executive Place Director, BOB ICS

Contents

Executive Summary

- Since the last time the Community Services Strategy was presented to HOSC in March, considerable work has been undertaken to develop the strategy to improve the health, wellbeing and independence of Oxfordshire residents and to optimise the use of our community-based workforce, buildings and resources. Throughout the development of the Programme we are presenting today, we continue to reference the eleven principles that were developed through public engagement last autumn and ratified by the Board at its December 2021 meeting.

- This report outlines the progress made on the programme of work to deliver these objectives and principles. Recognising the overlaps and synergies that existed across multiple community-based projects and services, the system partners have agreed to bring together the Community Services Strategy work and Urgent and Emergency Care work into a single Integrated Improvement Programme for Oxfordshire. This report details the programme's priorities and scope, governance arrangements and sets out the next steps for delivery.

- The need for transformation in both Community Services and Urgent and Emergency Care is widely accepted and much work is already underway to develop and deliver this, based on local and national priorities. As teams across Oxfordshire have come together over the course of the last 18 months, it has become increasingly clear:

    - That the scale of transformation we need, across the spectrum of health and social care providers, requires a single, dedicated Programme Management Office at place level to act as 'air traffic control' and support the successful delivery of a diverse yet interconnected set of transformative programmes
    - That the historical separation of 'Routine Community Care', 'Urgent and Emergency Care' and 'Preventive Care' is artificial and increasingly unhelpful, especially when we consider them through the eyes of the local population, and that we need to consider their development and integration in the round to achieve the best outcomes for our citizens, our workforce and from our resources. This is key to deliver the principles the public strongly support to improve the experience of care, provide more joined-up services, and to deliver more resilient care closer to home.

Following detailed consideration and design, a new, integrated strategy, the Integrated Improvement Programme, has been developed with key strategic priorities, priority programmes and a focused set of projects for the coming 12-18 months. More detailed work is now underway to map existing workstreams and resources into the programme.

In future, our Community Services and Urgent and Emergency Care priorities will be reported through the lens of the Integrated Improvement Programme (IIP).

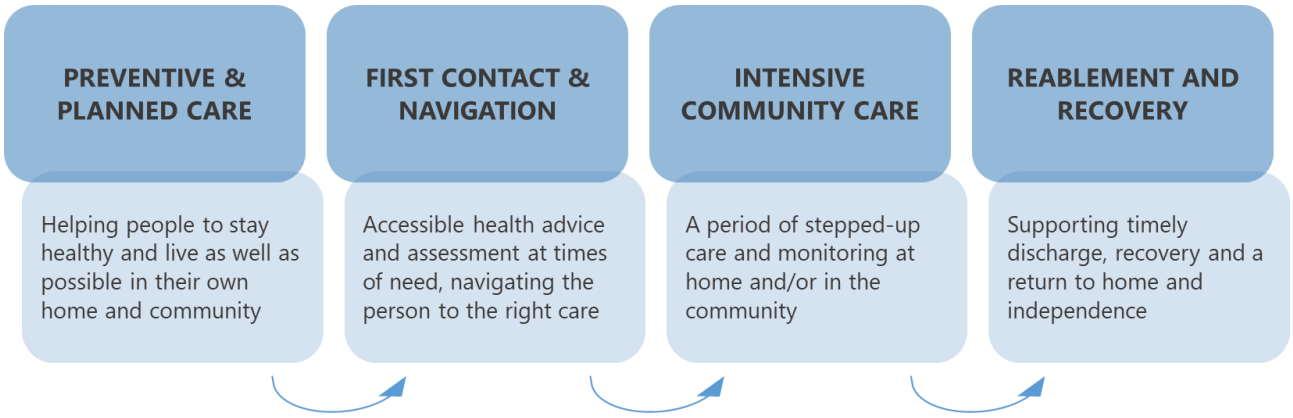
Defining the Services and Activities in scope

It is important that, as system partners, we have a common understanding of the scope and purpose of the Community Services and Urgent & Emergency Care (UEC) pathways. When we talk about the scope of work of the Integrated Improvement Programme, we are considering a range of health, social care and voluntary sector services across Oxfordshire, which include:

- Services that deliver preventative and proactive care and support in home and community settings, which aim collectively to maintain health and wellbeing, optimise the management of long-term health conditions and prolong independent living

- Urgent care delivered in homes and community settings that reduces the need for ED attendance and ambulance conveyance, including (not exhaustively) urgent 'first contact' assessment and triage 24 hours a day for people experiencing a health or care crisis; this includes urgent assessment and responses (health and social care), ambulatory care, minor illness and injuries, virtual wards and hospital at home services
- The services we traditionally associate with the care of older people in the community, such as district nursing and therapy, care home support, community hospital care and care during the last phase of life

These services can be illustrated as:



In addition to the services, we also need to include the supporting infrastructure in our scope and definition:

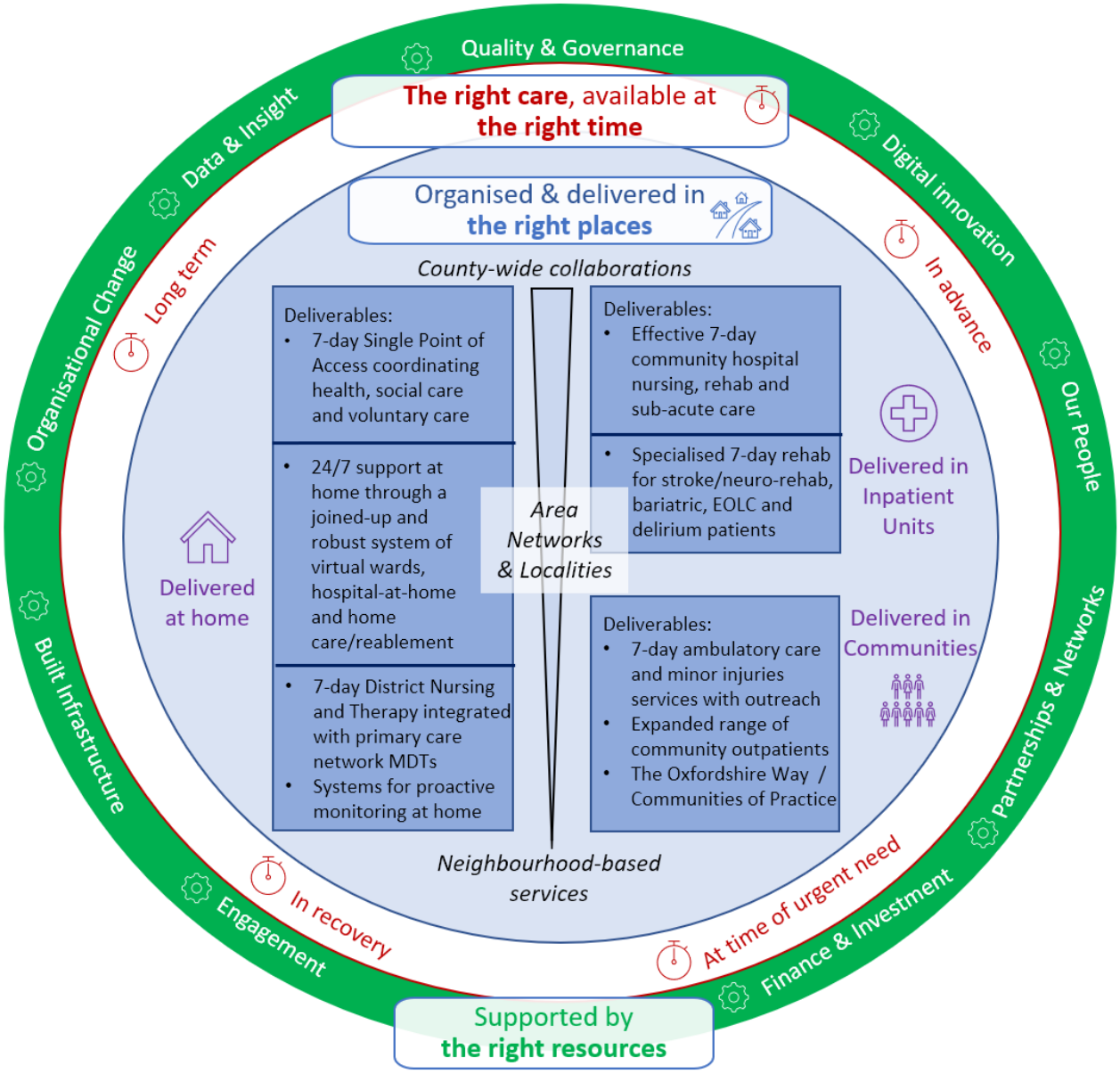
- The integrated leadership, management, coordination and enabling resources and infrastructure for all these services, in order to deliver a more effective, personalised and joined-up experience of care for residents and families.

Although many of these services cater predominantly for older people, including those with frailty or multiple health conditions, primary care and many community-based urgent care services take a population-based approach and provide care for people of all ages, including children and young people.

Our Strategic Priorities

Although our ambition for Oxfordshire is broad, it can be distilled into four high level, essential strategic themes:

The right care, at the right time, in the right places, supported by the right resources



A. The Right Care at the Right Time – 'keeping people safe at home'

- We need to work in a more integrated way to deliver care interventions which are more efficient and effective. This means thinking more clearly in service design about the benefits of the interventions our services provide and what current evidence and technology enables us to do and not do - as well as the enablers (processes, structures) they require
- We need to develop our skill mix and working practices to ensure that our workforce has the skills and experience required to deliver evidence-based care interventions at the point of need, reducing delays or the need for ED attendance or onward referral
- We need to focus on delivering interventions that lead to measurable improvements in outcomes not process-based numbers
- We need to provide more proactive and preventative care 'upstream', shifting focus and resources into this area to delay and reduce health crises for patients and improve system sustainability
- We need to find ways to reduce time spent in bed-based rehabilitation pathways to improve independence.

What this programme will involve:

- This programme focuses on the design, modelling and implementation of more integrated, joined up and cost-effective professional and clinical care pathways delivering improved health outcomes relevant to UEC and community care. It considers this aspect of service transformation through the lens of *when* patients need support:
    1. In Advance
        - Preventive and planned care pathway (including the Oxfordshire Way, health improvement and wellbeing, social prescribing, long-term condition care, proactive care for complex patients, and voluntary sector support)
    2. At Times of Need
        - First contact and navigation - including initial assessment, triage and signposting through 111, single point of access, OOH GP services, Urgent Care Centres, minor injuries units, triggering a coordinated response
        - Intensive community support – provision of a coordinated and effective response in the community, including acute Virtual Wards, integrated hospital at home services, ambulatory care units, urgent community response, End-of-Life care (e.g. RIPEL)
    3. During Recovery
        - Community rehabilitation and recovery pathway (including community inpatient and bed-based care, home reablement and 7-day-a-week rehabilitation). Patients who require support to return home either with reablement or long-term care are discharged on Pathway 1. Pathway 2 is for those requiring 'stepdown' bed-based rehabilitation.

- We are bringing all three of the above workstreams under a single programme due to their interdependency; better preventative care will reduce health crises and the corresponding demand. Better deployment will support this shift to proactive and preventative care.
- A reduction of lengths of hospital stay across pathway 1 (reablement at home) or pathway 2 (bed-based rehabilitation) will result in greater capacity to reduce the number of people ready to leave bed-based care who are either in acute or rehabilitation beds.
- This programme of work starts with a population-based approach to prevention and self-care, to target support for people with long term physical and mental health conditions and finally supporting people with complex care requirements and/or at higher risk of deterioration. While services for older people will naturally be favoured through this approach, the services and the proposals will apply across adult services
- The local Multidisciplinary team can access the available population-based data to identify the people who would benefit from an initial intensive assessment followed by interventions to promote wellbeing and improved independence.

- The new integrated pathway includes same day emergency care, short term and anticipatory care planning for the local population, including those in care homes. It is based on the development of teams across primary care, community nursing, specialist nursing, social care, therapists, pharmacists, RIPEL (EOL), and access to acute specialists, all working as an MDT to support Primary Care Network populations.
- A central transfer of care team will also be developed where patient transfers are coordinated to increase the number of people returning home who require either no ongoing care or a discharge to assess pathway home. A focused approach to discharge to assess at home will start with the general medical and trauma wards at the JR and HGH sites. This will continue to be developed across all beds bases in Oxfordshire.
- The combined digital and physical Single Point of Access (SPA) is a key enabler.

B. The Right Places – enabling people to be assessed and treated in their own home

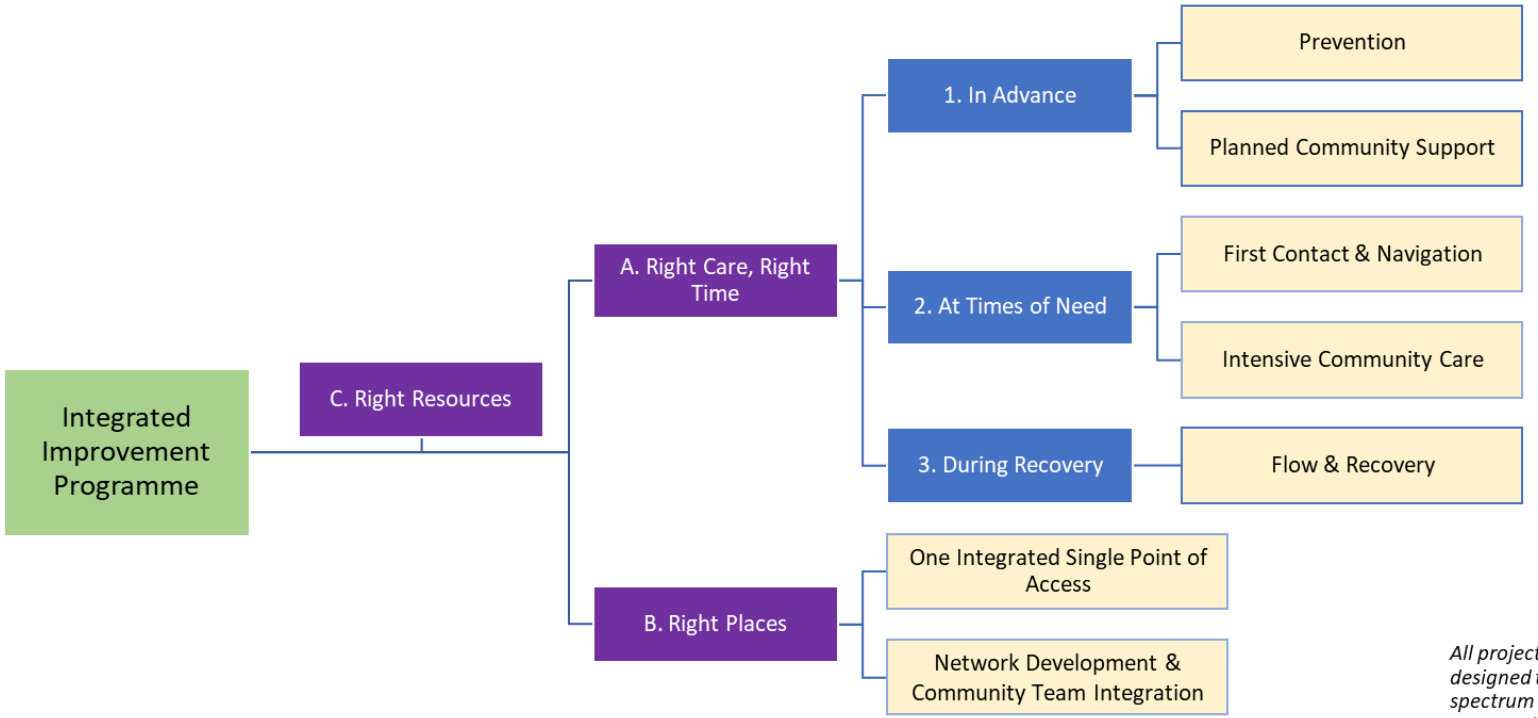
- We need to shift care closer to home – it's better for the patient and more deliverable for the system – with knock-on benefits for, for example, staff, morale and efficiency. This means both care in people's homes and where we offer services across the county
- In the urgent and emergency care (UEC) pathway, staff currently work in a fragmented way across the three Oxon Hospital @ Home teams and an Urgent Community Response team with medical oversight and daily MDT from the acute physicians, plus complex referral systems with social care and primary care colleagues
- This programme focuses on re-imagining *where* services should be delivered, turning the concept of North, City and South Area Networks into reality and considering the projects and support PCNs need to take on the role envisioned in the NHS Long Term Plan
- In addition, the creation of a truly integrated Single Point of Access (SPA) team will be scoped and developed to support the Right Care, Right Time programme across the county
- To reduce the need for hospital-based UEC, assessments using diagnostics and treatment that would normally take place in secondary care are carried out in the patient's own home
- An integrated team bringing together hospital at home and the acute virtual ward will support and treat the person in their own home until they are ready to be transferred to their primary care team and Neighbourhood-based preventive care
- Oxfordshire has acute digital virtual wards being set up but requires an SOP for admitting / discharging patients with responsibility to ensure it is maintained and kept up to date. It will hold a central list of all those on the virtual ward
- Examples of the care that can be delivered in the person's own home range from point of care testing, 24-hour infusions to lung/cardiac ultrasound. If a person requires further diagnostics, they can have these carried out either on the day or the following day in a Same Day Emergency Care unit (SDEC)
- To develop this at pace it requires further integration of all the teams working in a collaborative way and for 999 crews and the control room to be able to refer directly to the virtual ward pathway(s)

C. The Right Resources – making Oxfordshire 'ICS-ready'

- This is an overarching facilitation programme focused on enablers under the principle of 'do once', whether that is providing information to support decision making or aggregating needs from each of the workstreams to consider (and deliver) them in the round
- We need to support this work holistically to provide teams with the right input and support to design and deliver integrated, transformation in community services, whether that's a need for data, engagement, workforce, technology, estates or myriad other interdependent activities necessary to meet our goals
- Part of this programme is the need for a full, funded *organisational change* programme. We cannot achieve transformation without it. This needs to be properly funded and everyone needs to understand this goes far beyond the legal requirements into a hearts and minds transformation.

The Integrated Improvement Programme in detail

Programme Structure



All projects and teams will be designed to incorporate the full spectrum of health, social, community and voluntary sector inputs and outputs

Summary of priority programmes, projects and objectives

Strategic Aim	Programme	Programme Objective	Project	Project Objective
The Right Care at the Right Time	A. Prevention	A targeted population health programme to enable people and families to stay healthy and live as well as possible in their own homes. We will achieve this by strengthening preventative services and activities to ensure we are providing earlier support to people, carers and families closer to where they live, through stronger community networks	A1. Extending the LiveWell online resources	To develop, promote and maintain a centralised, easily accessible online resource to support self-help and signposting to relevant community services across Oxfordshire.
			A2. Activating our communities to improve health (including the Oxfordshire Way)	To promote wellbeing and independence for the people of Oxfordshire by improving co-production, establishing local communities of practice and healthy, active communities. Will enable identification, assessment and delivery of support and other interventions for higher risk people and families
			A3. Integrated population health and vaccination service	To integrate multiple existing community child/adult vaccination and health promotion services into a single, integrated vaccination and population health service that will deliver at-scale programmes for population immunisation, reduction of health inequalities and improving the health of cohorts with outlying clinical outcomes
	B. Planned Community Care & Support	A programme to support patients, carers and families to live more independently at home for longer. We will do this by delivering planned care and support to individuals in a more integrated and personalised way, mobilising the full range of formal and community networks to prevent health crises and reduce demand on formal healthcare services	B1. Extending Enhanced Healthcare in Care Homes	To build on existing care home support to deliver a comprehensive care and support package for care home residents, including 24/7 urgent and emergency care, intensive community care, preventive, planned and End of Life care.
			B2. Delivering sustainable 7-day planned community care	To design and implement the new process and costed plans for commissioning and delivery of sustainable planned community care, including the wraparound enablers for effective 7-day working and resilient staffing
			B3. Expanding community outpatients	To develop and pilot and expanded range of outpatient service provision at community sites, to benefit local residents and improve health and wellbeing outcomes
	C. First Contact & Navigation	To deliver more streamlined access to health advice, assessment and services when they are needed, 24 / 7	C1. A 24/7 integrated first contact and navigation pathway for Oxfordshire	To deliver a 24-hour, 7-day first contact care and navigation pathway for the Oxfordshire population (all ages) that is able to provide effective triage, assessment and initial treatment/support and consistently. This will safely navigate people with further needs to the right care, at the right time, in the right places.
	D. Intensive Community Care	To manage acute deterioration by providing a period of stepped-up	D1. Implementing a 24/7 integrated	To deliver an integrated system of inter-connected services that provide the care that enables a person experiencing an urgent

		care and monitoring at home and / or in the community, providing treatments that would traditionally take place in hospital where it is in the patient's best interest to do so.	intensive community care and support pathway for Oxfordshire (including Acute Virtual and Virtual Care Wards)	health or care need to remain at home (with a more intensive level of support for a period of time), when they are at risk of being admitted to a hospital bed unnecessarily.
			D2. Implementing an integrated, multi-provider End of Life Care pathway that dovetails with First contact, ICC and planned care pathways	To deliver an integrated approach to the planning, provision and management of EOLC in Oxfordshire
	E. Flow & Recovery	To build on existing system work to deliver a more effective patient discharge pathway that reduces unnecessary hospital stays, promotes recovery at home and increases the long-term independence and wellbeing of Oxfordshire residents.	E1. Developing a new Discharge to Assess (D2A) pathway, bed base and MDT	To redevelop the Hub beds into a D2A service with a larger MDT inputting into them to keep LOS at a minimum, leading to reduced time in secondary care and supporting the person to be assessed in a more appropriate setting, dovetailing with the CH rehab pathways
			E2. Optimising Community Hospital In-patient rehabilitation and nursing care	To develop costed plans and options for Community Hospital inpatient pathways that address changing population needs, best practice, workforce and financial sustainability challenges and sets out a development plan for Oxfordshire's Community Hospitals* *including the future of Wantage CH inpatient unit
			E3. Developing a system-wide Transfer of Care Hub	To create a single integrated Transfer of Care Hub/Team across the partner organisations / different inpatient settings to streamline flow, discharges and provide a joined-up view on the best use of available beds and resources
			E4. Implementing a Reablement Task Force	To reduce the duration of the reablement journey (in both P1 and P2), by creating a task force to increase capacity in the pathways and focus on reducing time in and dependency on reablement services.
	F. One Integrated Single Point of Access (iSPA)	To develop a unified, integrated Single Point of Access for Oxfordshire, providing residents and professions with 7-day access to and coordination of the full range of health, social and voluntary sector services, whenever they need them,	F1. Development of a phased and costed programme plan for the development of a unified, integrated Single Point of Access for Oxfordshire	To work with partners to identify the access priorities for each organisation and residents - and the opportunities to consolidate resources and deliver services more effectively through a new SPA, to develop a PID/delivery plan.

The Right Care in the Right Places		and serving as a virtual and physical hub for an integrated, multi-disciplinary workforce		
	G. Network Development and Community Team Integration	To establish the networks, structures and resources required for partner organisations, residents and other stakeholders to engage, plan and work together successfully at appropriate levels of scale and deliver their objectives to improve the health and wellbeing of the population	G1. Area Network Development (North / Central / South)	To develop Network Areas as an organised grouping of local health and care services, voluntary and community groups, Primary Care Networks, Community Hubs, secondary care and Local Authority teams, who work closely together to improve the health and wellbeing of their population.
			G2. Developing the integrated Neighbourhood Team	To develop the local multi-professional and multi-agency community team with responsibility for planning and delivering the care of older, frail or LTC patients within a defined population or geography (e.g. the residents of one or more PCNs).
The Right Resources	H. Cultural and Organisational Change	To deliver a comprehensive organisational change programme across organisations and teams to facilitate and embed place level transformation	H1. System Level Change Management	To provide joined-up, practical support tailored to teams across all levels of organisations to break down barriers and transition to new, shared ways of working
			H2. Extended Programme Teams	To change ways of working to integrate wider support teams into the programme to deliver specialist practical support and prioritisation and ensure the enablers to delivery are proactively planned for and in place

This is a summary of a working document and may be updated in response to local and national priorities.

Delivering the change

Much of the work that sits under our priority projects is already underway and delivery of our key national priorities (such as the Urgent and Emergency Care priorities) have not been lost. Rather, we are taking this opportunity to work across system partners to map existing projects and to consider what we need to:

- Start – what are our gaps – or where do we need to think differently / more strategically now we are focused on our key priorities
- Stop – what doesn't fit within our programme, needs to be done differently, or duplicates other work / services
- Continue – what is already underway, in the right way, that delivers our programme and national priorities?

As part of this process, we are mapping the resources already dedicated to these projects so we can consider how best to use / redeploy what we already have and where our gaps in expertise, capacity or experience lie. This is a complex piece of work across all partners and work is already underway to complete the exercise. Once we have finalised this work we intend to 'lift and shift' the work that forms part of the programme under the leadership of the PMO. Engagement around this will be key and it is important we give these teams the right experience as we ask them to work differently. This is a key focus of our work to get the governance (see below) and processes right before we make the change.

In future, many of the projects that have been reported separately will be reported through the lens of the Integrated Improvement Programme. We will have a single reporting structure, including highlight reports, that ensure teams can focus more of their efforts on delivery of the projects, spending less time duplicating work for different Boards.

This structure and process is a key marker of our approach in future. The work we capture in this programme determines our scope, our priorities and our work plan. This does not prevent improvement work taking place within individual organisations, rather it ensures a clear and deliverable plan for integrated improvements across partners. Over time, new priorities (national and local) will emerge. To be included in this programme, the Board will review both fit with our strategic priorities and whether they can be integrated into existing projects and programmes. This will ensure we minimise duplication and maximise resources.

Joining the dots

There are many projects already underway that HOSC members will be familiar with from previous discussions. While we do not intend to go through all of these in detail here, there are two particular areas we would like to draw attention to:

1) For the avoidance of doubt, the new Integrated Improvement Programme includes the work on Community Bed Reconfiguration (Project E2. Optimising Community Hospital In-patient rehabilitation and nursing care) and Outpatients (Project B3. Expanding Community Outpatients). Further information on the Community Beds work and the Wantage out-patient pilots can be found at Appendices 2 and 3)
2) The Urgent and Emergency Care priorities that were presented at the May HOSC meeting also form part of the Integrated Improvement Programme (IIP) and come under the programme umbrella. The work will continue through the IIP and future reporting will be through these programme updates and the structure laid out in this paper.

Dedicated resources

In addition to existing project resources that are being mapped and redeployed as part of the exercise outlined above, the Oxfordshire Integrated Improvement Board (OIIB) have approved the appointment of a small, core team of specialists to resource the System Programme Management Office (PMO). Recruitment processes are now underway. These are not roles that have existed before and they are crucial to the success of this new structure and approach.

The remaining resource gap we need to fill is from our support teams. The new approach requires us to fully integrate the specialist teams who support our services (not exhaustively, finance, HR, estates, quality, data, IT). The scale of transformation we need to deliver means new ways of working not just for our clinical teams but those who will need to adapt to everything from pooled budgets, to shared HR contracting, cross-organisation estates, aligned QC systems and robust 24/7 IT support). We need to identify system representatives (with ringfenced time) for each of these functions who play the following key roles:

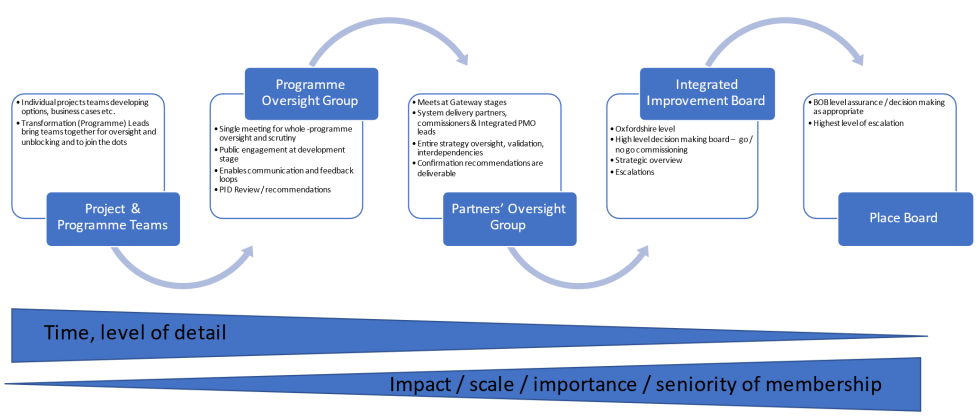
- System representative and decision maker on key groups and Boards. (This will require a mandate from, and robust communication and feedback loops with, their peers)
- Deployment of specialist support into project teams
- Aggregation of project and programme asks for validation, prioritisation and approval

The Oxford Health / Oxford University Hospitals Provider Collaborative has identified helping unblock some of these conversations and sticking points to be a key role they can play in supporting the delivery of the outcomes we need.

Programme Governance

Across Oxfordshire we are agreed we need to better empower teams and enable them to take decisions more quickly. As a team of system partners we have identified a number of ways to do this:

1) Act in concert:
    a. 'Team Oxfordshire'. Agreement across system partners that we commit to this shared process and act as one
    b. Joint communications to our organisations and teams to ensure there's no room for dilution or confusion
2) A new approvals and flow process (a larger scale copy is available at Appendix 1)



For each group, between the project and programme teams to OIIB (Oxfordshire Integrated Improvement Board), we are defining:

- Why: Clear purpose and accountabilities
- When: Meetings will be synchronised to ensure enough time for each stage to consider proposals and make amendments before paper deadlines for escalation. We will work back from established Place Board dates
- What: Clearly defined delegation that is consistent and everyone understands – spanning both that in PIDs (Project Initiation Documents) and parameters for improvement projects for existing services. Not every decision needs to go to every stage.
- Who: Membership that is appropriate to the stage in the process and the expertise / input we need. This includes fuller engagement with PCNs and earlier stage involvement for citizens and representatives of groups such as Healthwatch

Engagement

We are mindful of the need to begin more detailed public engagement. We believe the foundational work we are doing now to finalise the detail, put in place the scaffolding roles for the PMO (Programme Management Office) and set up the governance to create a single line of sight will stand us in good stead to create the narrative and specifics we need to gain meaningful input into our work. This single programme and narrative will enable a much more cohesive and powerful conversation with our citizens than the fragmentation we previously saw and our communications team is in the early stages of developing engagement proposals for this autumn.

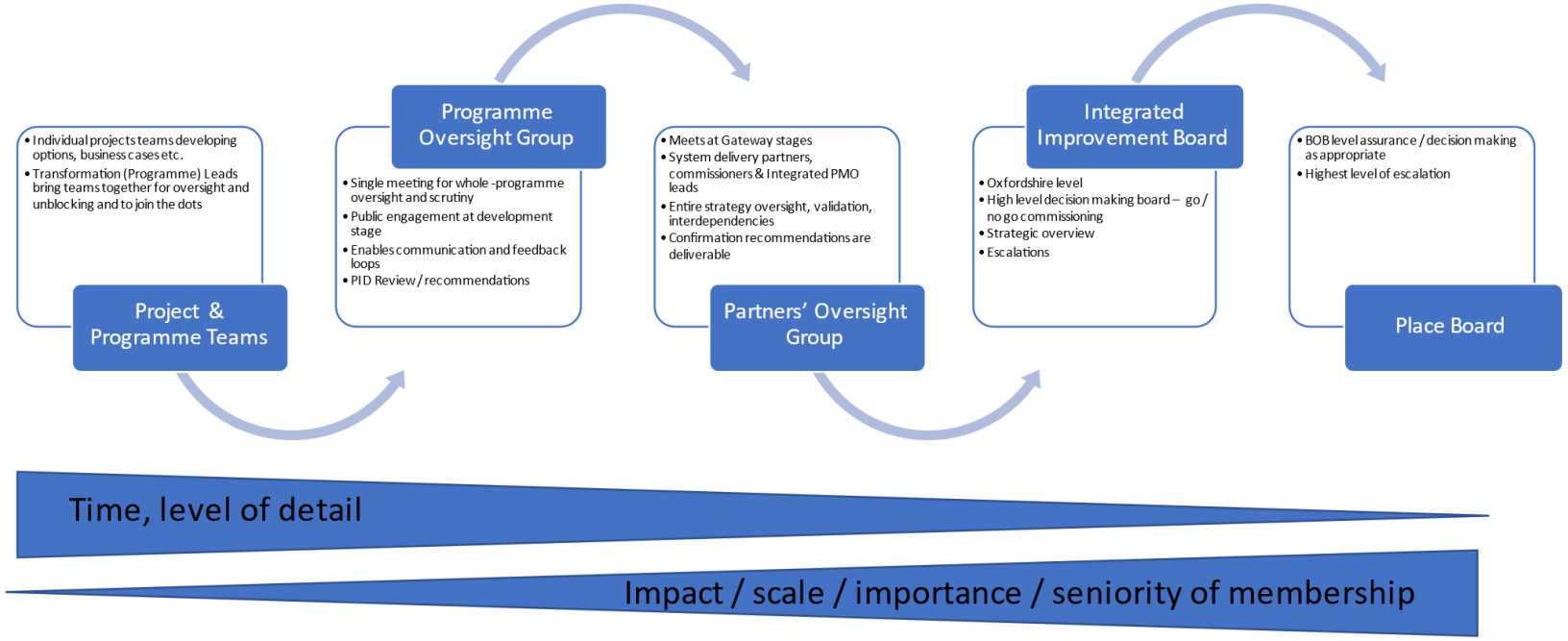
Conclusion

Much has been achieved over the last few months and while there is still much to do we have a clear plan to achieve it. The pace of progress will depend on how quickly we can fill the core PMO roles. Once it is in place, monthly reporting will be streamlined and we will be able to present regular, clear and comprehensive reports on progress.

Appendix 1

Approvals and flow

Enabling rapid decision -making and scrutiny appropriate to scale / importance of decision. Each level has focused membership, ToR and Scheme of Delegation. Timings are synchronised to minimise delays while ensuring join-up.



Appendix 2

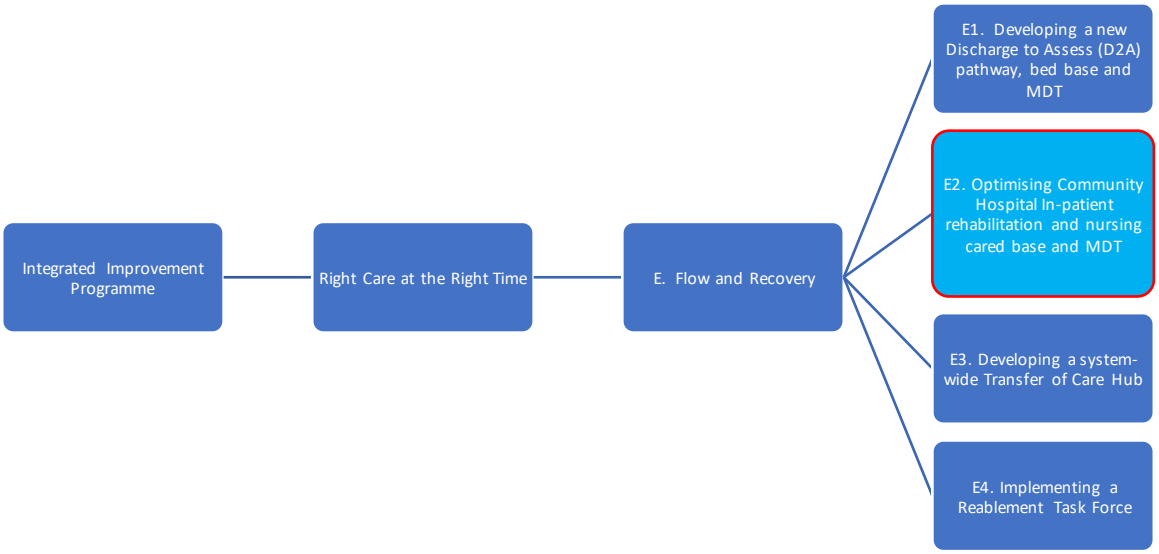
Project E2: Optimising Community Hospital In-patient rehabilitation and nursing care

Introduction

To help bring the strategy to life, we are providing a high level update on the community beds project. We trust this will also reassure you the development of the umbrella programme has not prevented progress on our key priorities.

Community Hospitals and the Integrated Improvement Programme

The Integrated Improvement Programme (IIP) allows us to take a complete overview of the work, and interdependencies we need to transform the Oxfordshire health and care system. In future we will report each of the projects and programmes through the lens of the IIP to provide a holistic picture of progress. As illustrated below, our work on Community In-patient Rehabilitation is part of our Flow and Recovery Programme.



Progress to date

Considerable background work has been undertaken to date covering:

- The role of Community Hospitals in the wider system
- The care people receive both in in-patient units and other community beds
- Mapping current provision, both in numbers and locations of community beds
- An analysis of the current in-patient model in relation to both patient needs and staffing requirements
- The geographical spread of current in-patients in relation to distance from their homes

Using this information, a working group has begun to identify more detailed design principles and to develop recommendations for further exploration. The following section sets out an improved model for community hospital-based care, with more focused and streamlined rehabilitation pathways, in order to provide better outcomes and experiences for patients and a more sustainable service.

Design principles

As a general principle, Community Hospital beds are best used to provide a period of expert therapy and nursing care which cannot be delivered effectively or safely in the home or a day care setting. This includes people with a 24-hour nursing need or a therapy need which cannot be delivered at home; such as where an individual does not have the space for essential equipment or requires intensive support from multiple staff members.

The working group agreed that admission to a community bed should be based on:

- The identification of a care, reablement or therapy need that cannot be met in the patient's usual home environment
- The frequency and intensity of health care needs, i.e. how often the individual needs care
- Diagnostic certainty and relative medical stability, i.e. how confident professionals are that the needs of the patient are understood and likely to remain consistent

In order to manage discharge to the community, a 7-day therapeutically-focused approach should be implemented. This will reduce the extent to which discharges would be affected by the time and day on which a patient is due for discharge. For example, currently there are fewer patients discharged over the weekend period and planning for discharge is largely carried out within the day, this can delay the discharge of patients. In addition, a target estimated (currently called anticipated) discharge date will be agreed at point of admission and regularly reviewed through the Multi-disciplinary team (MDT) discharge process.

As noted, the high level of demand for services within Oxfordshire means that it is important we are confident that beds are being used appropriately, alongside both acute care and care at home. For this reason, the following approach to determining whether someone's needs are best met within a community bed is recommended:

- We will always consider first whether someone can return home and if their needs could be better met within the community.
- No one whose care and health needs can be met at home at the time of discharge should be placed in a community bed. To inform this decision making, it is recommended that a frailty score could be used to assess the needs of each patient.
- We will minimise wherever possible delays which result in people remaining in the bed when it is not the right place for them.

It is recognised that patient choice is important and should be considered as part of any decision making. However, choice will need to be balanced against the needs of all patients within the system. To ensure that both the patient and family are clear about how long a patient should remain in a community bed and how decisions on discharge are made, it is essential that staff work really closely with families to set expectations and be realistic about care goals. This will ensure that everyone is clear about what support is most appropriate. Community Hospital beds should not be used to provide respite provision as this is better provided within another setting, such as a care home.

Partnership between all staff involved in the care of the patient as well as close working with patients and their carers is key. This will need to include considerations around housing and where the patient is from. It is important that consideration is given to all organisations who can support strength-based approaches to community living, including the voluntary sector. Consideration will also be given to how we can support both formal and informal carers.

Staff will aim wherever possible to discharge people home with care rather than waiting until they can go home without a care package; it is recognised, however, that this is dependent on the capacity of home care and visiting services.

Overview of the proposed community hospital inpatient pathways

The working group have recommended further work is undertaken on the following suggested pathways for Community Hospitals in Oxfordshire. These pathways form part of a continuum of service provision that spans home, community and hospital settings; they require suitably resourced and staffed community inpatient units to meet the needs of certain patients, in order to deliver the therapeutic interventions and outcomes that require a focused period of inpatient care. These recommendations are interdependent with other projects in the Integrated Improvement Programme alongside the need for extensive work through our 'Right Resources' programme and the below forms the framework for the next stage of work.

In summary, six potential updated Community Hospital inpatient care and rehabilitation pathways have been identified:

1. Sub-acute medical care and stabilisation
2. Strength-based rehabilitation for people in recovery
3. Specialist rehabilitation for people with bariatric needs
4. Specialist rehabilitation for people experiencing acute confusion
5. Specialist stroke and neurological rehabilitation
6. Specialist care at the end of life

The following section describes the intended benefits of the care pathways in more detail. They were derived from the analysis of patient outcomes, experience, service data and clinical expertise.

1. Sub-acute medical care and stabilisation

- **The need:** People who become unwell, injured or whose health deteriorates and who have frailty, multimorbidity or complex needs, may require an actively managed period of stepped-up medical assessment and monitoring, medical treatment, nursing care or therapy in an inpatient unit until they are stabilised; but don't need the facilities of an acute hospital
- **Location**: Patients in this pathway require rapid assessment in an ambulatory care or same day emergency care unit, following by a period of monitoring and treatment from a suitably trained multi-disciplinary team of medical, nursing and therapy professionals. They also require access to diagnostic and imaging services, such as x-ray, and so these facilities should be co-located together. Because of these essential needs, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.
- **Examples of patients supported**:
    - An older person who is unable to walk due to unexplained weakness and has become slightly confused
    - A person with multiple health conditions who has become gradually more breathless and fatigued over the past week
    - A person with frailty who has been seen in an acute hospital and is well enough to return home, but requires a specific treatment and re-assessment by clinical team the following day

2. Strength-based rehabilitation for people in recovery

- **The need:** A proportion of people who have had a significant period of illness or immobilisation, including some people who are recovering from injury or surgery, need expert inpatient rehabilitation and/or nursing to reach strength-based goals within a target timeframe.
- **Location:** A period of bed-based reablement or rehabilitation is required by approximately 4% of all acute hospital discharges according to national models and should be made available to patients in all Network Areas of the county through a series of well-resourced, equipped and suitably staffed Community Hospital inpatient units.

- **Examples of patients supported**: People with multiple care needs and diagnoses (co-morbidities) who require full time care and therapy to be rehabilitated. Examples might include a person who was:
    - Admitted to hospital following a fall which caused multiple fracture admitted for rehabilitation. Rehabilitation limited due to pain and postural hypotension
    - Admitted to an intensive care unit and is recovering from post ICU deconditioning in addition to having general frailty
    - Admitted following a fall with a history of reduced mobility and who also has a learning disability
    - Admitted with respiratory issues post COVID-19 and associated pneumonitis, struggling with fatigue and multiple wounds/pressure ulcers.

3. **Specialist rehabilitation for people with bariatric needs**
    - **The need:** There is an increasing number of people with a high BMI who require specialised equipment, facilities and professional input to enable them to experience safe and effective rehabilitation, so they can return home and access appropriate support for weight management as well as other health and wellbeing needs
    - **Location:** This cohort requires use of specialised equipment, premises adaptations and staff trained in providing care for plus-sized people. As a result, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.
    - **Examples of patients supported**:
        - A person with a BMI of 40 who has had a fall causing toe fractures and is immobile. Previously transferred with pivot transfer but unable to do so with fractured toes so needs significant support.
        - A person with a high BMI who is recovering from a below knee amputation.
        - A person with a high BMI and complex diabetes and a skin infection

4. **Specialist rehabilitation for people experiencing acute confusion / delirium**
    - **The need:** People experiencing an acute confusional state, also known as delirium, (which is often caused by a combination of acute illness and dementia) can require inpatient care from specialist staff and resources, as they are often unable to engage successfully with 'standard' therapy in a traditional ward setting. These patients more frequently wander, are at increased risk of falls, and can exhibit challenging behaviours or distress. An acute ward environment is often suboptimal as it can cause additional confusion and distress for the person and their family. Skilled assessment is often required to provide evidence that the delirium will resolve with treatment and to establish clear goals to enable people with underlying permanent confusional states (e.g. advanced dementia) to move onto appropriate long-term care placements.
    - **Location:** This service would be best developed at a site with suitable facilities, layout and staffing to provide the appropriate environment for people with acute confusion to receive effective care and maintain their dignity. A site with close links to Adult Mental Health expertise and support would be ideal.

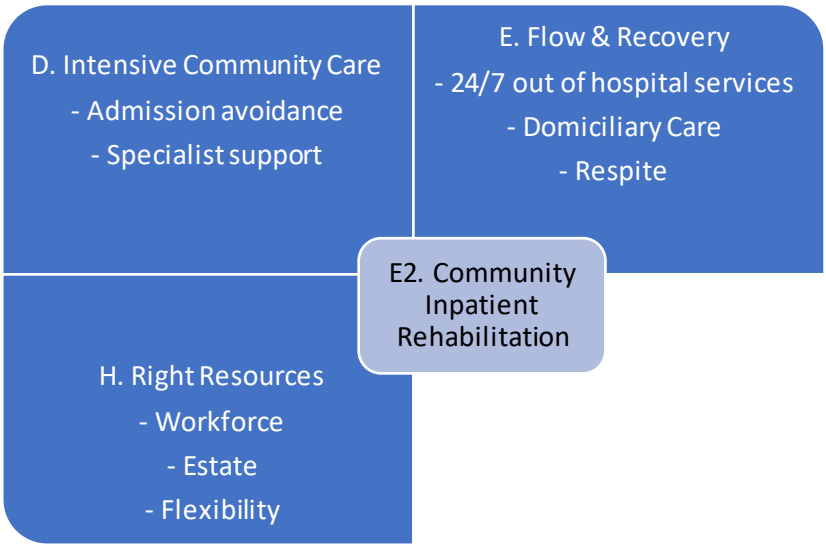
5. **Specialist stroke and neurological rehabilitation**
    - **The need:** A significant proportion of people who have had a stroke require a period of targeted rehabilitation in an environment with specialised staff and facilities, in line with national stroke guidance.
    - **Location:** Specialist stroke care is provided at the Oxfordshire Stroke Rehabilitation Unit (OSRU), located at Abingdon CH

- **Examples of patients supported**:
    - A person who has had a stroke and needs intensive therapy to help them to regain the ability to eat, speak and move themselves. This might include speech therapy, support from a dietitian and therapy to improve movement.
    - A person who needs 2:1 care following a stroke to support them with eating drinking, washing, dressing, toileting and overnight needs. They also may need dietitian and specialist support to feed including starting up Peg feeding and NG tube feeding and support to learn to feed themselves prior to returning home.
    - Inpatient care and rehabilitation for those with level 2 neuro-rehabilitation needs (as defined in national guidance) could be co-located with Stroke rehabilitation to enable sharing of specialist resources, facilities and expertise and a more sustainable staffing model

6. **Specialist care at the end of life**
    - **The need:** Most people prefer to die at home when nearing the end of life and this aim will be supported through enhanced community-based end-of-life-care services and primary care, in partnership with the hospice charities. Much care for people in the last year of life will continue to be provided in Community Hospitals with the aim of restoring their independence and enjoyment of life at home for as long as possible. However, a small number of specialist palliative care beds is necessary to support some people at the end of life when it is not possible to provide them with adequate symptom control at home or when other factors mean an admission is necessary to ensure safety or minimise distress. Not all patients admitted to one of the specialist palliative care beds will die there; some will have a planned return home once stabilised.
    - **Location:** Specialist end-of-life care is best provided in a purpose-built facility that provides a calm environment, enables family members to stay on site and where staff can develop specialist skills in palliative care.
    - **Examples of patients supported**:
        - A patient with hard-to-manage symptoms for whom a period of in-patient care would be preferable to care at home. The reasons for this can include carer fatigue or distress; the patient lives alone without support between carer visits; there is no suitable hospice placement available
        - A patient who prefers not to live their last days in the family home; the patient may be a parent of young children; there may be symptoms which could be more easily stabilised in an in-patient environment; or they may require additional nursing support or treatment in their last days.

Dependencies

The following dependencies have been identified which will need to be taken into consideration when developing the new community hospital inpatient beds model. These include health, social care and voluntary sector contributions. Each of these dependencies is being addressed through the wider Integrated Improvement Programme as illustrated and the below diagram is designed to show how the wider health and care ecosystem needs to work together to transform care for citizens in Oxfordshire.



D. Intensive Community Care:

- **Developing the intensive community care pathway to support admission avoidance**
  The intensive community care pathway, of which the urgent community response is part, will reduce the number of people who require admission to an acute hospital bed. This will therefore have a significant impact on the way in which people are supported within their own homes and reduce the need for community inpatient rehabilitation.
- **Access to specialist support such as hospital at home**
  Community based interventions such as hospital at home which is a service to enable people with complex health needs to remain at home, have a significant role in enabling admission avoidance.

E. Flow & Recovery

- **Expanding the 'out of hospital' 7-day community services**
  Community beds make up only a small part of the community services offer. Services in people's homes are central to supporting the wider population to remain as healthy as possible and reduce lengths of stay in acute hospitals. Any future model of beds needs to consider the way in which beds fit into the wider community therapy and nursing offer to enable more people to be supported at home.
- **Domiciliary care & respite beds and support for informal carers**
  By strengthening both the domiciliary and respite care within the community the number of people needing to be admitted to a community bed and also the length of stay of those who have been admitted can be reduced.
- **Providing more night-sitting and live-in carers**
  A number of patients are currently admitted to a community bed because they are not safe to return home and be alone during the day or overnight. Development of a night sitting offer and strengthen live in carers would reduce the number of community beds required.

H. The Right Resources

- **Workforce recruitment and retention**
  Where a ward has only a small number of beds it is much harder to maintain a core team to provide sustainable staffing, which can impact on the ability of that environment to provide optimal care. To ensure wards can be staffed appropriately to meet patient needs, consideration needs to be given to a viable ward size and smaller units have higher running costs on average. The Lord Carter review

(2018) noted that "a much clearer idea of 'what good looks like' is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure"[1].

- **Flexibility and responsiveness to system need**
  The need for any delivery model to provide flexible bed and staffing numbers to meet changing patient need; for example, there has tended to be an increase in demand for bedded care over the winter period and at peak times during the pandemic. This means that any future model must include a degree of flexibility in numbers to allow for this variation Sustainability of staffing for small rehabilitation wards and challenges around recruitment.
- **Physical estate**
  A number of community bed sites have limitations relating to their physical estate including parking, building size, design and age, and requirements to share space with other services. Future co-design of options and subsequent decisions on the optimum location for community beds will need to include a review of the physical estate constraints for each ward as well as consideration of any capital works which could be completed to mitigate these.

Next Steps

The Community Hospital Rehabilitation project and the interdependent projects and programmes around it are being wrapped into the Integrated Improvement Programme as laid out in the wider HOSC update paper. As this mapping is completed, and resources identified, a clear timeline for the interdependent work will be able to be identified and planned for.

In future, all projects under the Integrated Improvement Programme will be reported under that umbrella with regular Highlight Reporting to demonstrate both progress and any challenges encountered to enable targeted discussions and interventions to keep projects on track.

[1] Lord Carter review (2018)https://www.england.nhs.uk/wp-content/uploads/2019/09/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental_....pdf

Appendix 3

Wantage Community Hospital Outpatient Pilot Interim Evaluation – June 22

Introduction & Background

In summer 2021, it was agreed to trial a range of outpatient clinics within Wantage community hospital. The aim was to evaluate the benefits and feasibility of providing additional services to the population of Wantage who would otherwise have had to travel to Oxford. The pilot services are being provided in the clinical space previously used for the in-patient unit, which has remained closed pending the outcome of the Oxfordshire-wide review of Community Services now underway.

The following services are included within this pilot:

- Ophthalmology (eye assessments and treatments)
- Ears, Nose and Throat (ENT)
- A range of community Mental Health services

Prior to the launch of the pilot services, the clinic rooms were refurbished to bring them in line with current best practice and standards. This work was designed to be fully reversible so as to not pre-judge the outcome of the community services review relating to the inpatient unit and any public consultation arising from this work.

The Pilot launched on 4 October 2021. The reception is open from 8am until 6pm Monday – Friday. Both Receptionists are local to the area and are able to walk to work. The site has a facilities team who maintain the site along with their colleagues who ensure infection control is in place. As part of the pilot, there are now 5 clinical rooms, 3 therapy rooms and a waiting room. All of the clinical rooms are identical, and all of the therapy rooms are identical, other than the size. Structural and permanent changes were not made to the rooms so that they can deliver the services determined by the outcome of the revie w. It was necessary to improve the facilities for the staff and an additional staff break and wellbeing room was created. In addition, the garden was upgraded with the support of the local garden centre and donations from the Oxford Health charity and this is available for patient and staff use. (A floor plan and pictures of the renovations can be found at Appendices 1 & 2)

Work is ongoing on the optimal use of Community Hospitals across the county; this report assesses the impact of the additional outpatient services so far and is intended to inform discussions on whether these pilot services should be continued while the long-term future of the inpatient unit is being considered an determined.

Services included in the outpatient pilot

Ophthalmology

Ophthalmology which is provided by Oxford University Hospitals NHS Foundation Trust (OUH) joined the team on 17 November 2021. The team consisted of a visions team, nurse and orthoptist/visual fields technician. They have delivered the service three days per week since that date and continue to have full clinics each day.

Mental Health

The Oxford Health Mental Health teams joined Wantage on 12 October 2021 and have slowly, due to the COVID guidelines and hybrid working, increased the teams and now use the majority of the three therapy rooms. Currently the rooms are used by Neuro Development, Talking Space, Adult Mental Health, Psychological Therapies, Children's Mental Health, Adult Eating Disorders across Monday to Friday.

Audiology & Ear, Nose & Throat (ENT)
We have an NHS Provider audiology organisation that use a room for a full day each month. 7 patients a day (for Audiology) all over the age of 55 with an average appointment lasting one hour. The appointments are in high demand and the hospital is very popular and well liked. Patients occasionally need follow up, however generally one appointment is sufficient, and this also helps reduce waiting times. Most patients come from Wantage or Faringdon.

OUH provided ENT haven't yet joined the Wantage team as they have experienced resource and recruitment issues. Part of the plan is to install a hearing booth to support the ENT clinics which we hope to have in place by the end of the summer. Once this is in place, ENT will use four rooms on Tuesdays all day.

GP clinics
On four occasions to date the local GP practice have seen patients on site due to room shortages at their practice, while their extension is being developed. We aim to continue to offer ad-hoc room bookings for local healthcare providers to expand local healthcare provision.

Existing outpatient services
Wantage Community Hospital has a history of offering outpatient services and also continues to host these outpatient services and teams:

- Podiatry
- Adult Speech and Language
- Children's Integrated Services
- MSK/Physiotherapy*
- School Nursing Team
- Maternity Unit

* The MSK contract has recently been re-procured by OCCG and a new county-wide provider has been appointed. The Community Hospital administration team is holding discussions with the new MSK provider to facilitate the continuation of the service at Wantage Hospital.

Additional planned services
We plan to implement a further update to one of the rooms which involves improved filtering and ventilation to enable intravitreal (eye) injections to be carried out by the Ophthalmology team. This is hoped to be in place in July 2022 with 5 rooms Mon, Wed-Fri to Ophthalmology (1 room on Tuesdays).

Evaluation of the pilot

As set out within the HOSC update on the community services June 2021, the evaluation of services has been carried out against a range of criteria (see appendix 3) to assess the benefit and impact of this pilot from both a patient and staff perspective.

Quality and safety of care

All services provided within the inpatient pilot are registered under the Care Quality Commission and are delivered to the standards required under the relevant commissioning framework. Staff training is carried out by each provider organisation to ensure that all staff have the required competencies to deliver the service.

Following investment to upgrade the facilities at the community hospital, services delivere d align with current best practice and quality standards. The final service which is planned (Eye injections) is due to start

providing appointments in July 22 following further upgrades to air-conditioning to meet the required standards for this service.

Patient contacts

Summary footfall of patients from 4/10/21-25/5/22

Service	Attended appointments
Ophthalmology	1105
Adult Mental HT	70
Psychological Therapies	70
Adult Eating Disorders	53
Talking Space	48
GP Health Centre	22
Perinatal	17
Neuro Development	37
NHS Provider audiology	23
TOTAL	**1,445 + additional remote patients**

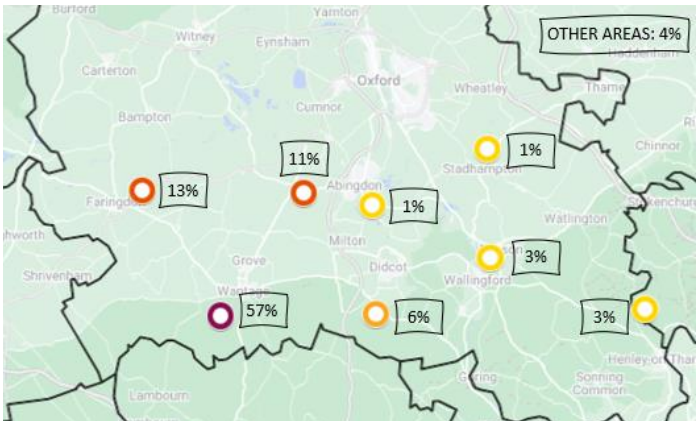
At present, the pilot rooms have a 50% utilisation rate (a detailed breakdown can be found at Appendix 4). This is projected to rise to 56% in August. This indicates that at full capacity, pilot services could be expanded to benefit around 50% more residents than the currently.

Alongside the pilot of face-to-face services, teams have also used the community hospital facilities to provide virtual appointments. This hybrid way of working has been received positively by patients and has provided continuity of care so is expected to continue across outpatient services.

Location and Patient Benefit

One of the key themes that came up several times in the original criteria was that of population needs and patient locations. 68% of patients seen at Wantage Community Hospital during the pilot came from OX12 & OX13 postcode areas. With a total of 87% from within around a 20-minute drive time.

Postcode area	% of patients
OX12	57
OX13	11
OX10	3
OX11	6
OX14	1
OX44	1
RG9	3
SN7	13
Other	4



Patient feedback

A full breakdown of patient feedback from this survey can be found at appendix 5.

During the pilot period, patients have been asked to provide feedback through a patient feedback survey. The following response were received in answer to the question 'how was your experience?'. A total of 401 surveys were completed (ca. 28% of those attending pilot services). These can be broken down into:

- 331 people gave positive feedback including:
  - Brilliant(10) Good (60) Efficient (16) Very easy (19)
  - Wonderful (2) Quick (17) Great/friendly/helpful staff (17) Easy access (6)
  - Prompt (3) Excellent (34) Kind (5) Easier than the JR (11)
  - Fantastic (3) Fine (13) Great (7) Very good (79)
- 32 people gave negative feedback:
  - 21 involved distances from their home (5.2% of all comments)
  - 11 involved parking being unavailable (2.7% of all comments)
- 38 mixed negative/positive comments

Staffing implications

As has been well documented in both the local and national press, we have experienced a number of challenges in staffing some services during the pilot period. This remains one of the biggest risks associated with delivering services though we are pleased to highlight the expansion of services this summer as we have successfully addressed vacancies and are expanding services as outlined in this report. Workforce plans are in place to strengthen the staffing of these services as part of Trust work to implement both the NHS People Plan and Promise. Local staff have been hired to provide reception services.

Looking ahead, the lessons from Wantage will be vital as we progress the preventive and planned care parts of the Integrated Improvement Plan. Service staffing costs, numbers and vacancy rates will all be considered as part of the wider review, options and recommendations.

System benefits

The capital investment in Wantage to upgrade the clinic rooms was provided through an Oxford Health capital funding bid. The revenue cost of running these services is equivalent to that of the other Oxfordshire Community Hospitals. As part of implementing this outpatient pilot, a review of the financial implications of running outpatient services at our community hospitals across Oxfordshire has been completed. As a result a partnership working agreement has been put in place to provide improved clarity of costs to ensure that these services are budgeted for appropriately and are sustainable.

As part of the ongoing Covid-19 recovery process, demand for outpatient clinics remains high. The services put in place as part of this pilot have seen a high level of demand, in particular, mental health services have seen a significant increase in demand since the pandemic. By providing these services within Wantage Community hospital we have been able to increase the number of appointments closer to patient's homes.

Recommendation & next steps

Lessons have, and continue to be, learnt from the Wantage Outpatient Pilots. It is clear from the activity data and overwhelmingly positive feedback that the pilots are fulfilling a useful service function, are very popular with local people and the vast majority of patients who have benefitted from them live locally (i.e. within OX12 or the neighbouring postcodes).

The multi-provider nature of the services has meant that there are some areas where the evaluation on the impact is not yet fully complete, due to data challenges. In addition, staffing restrictions and the challenges presented by COVID-19 mean we have been unable to fully assess the costs and benefits of the approach and there is room for further learning and analysis to assess:

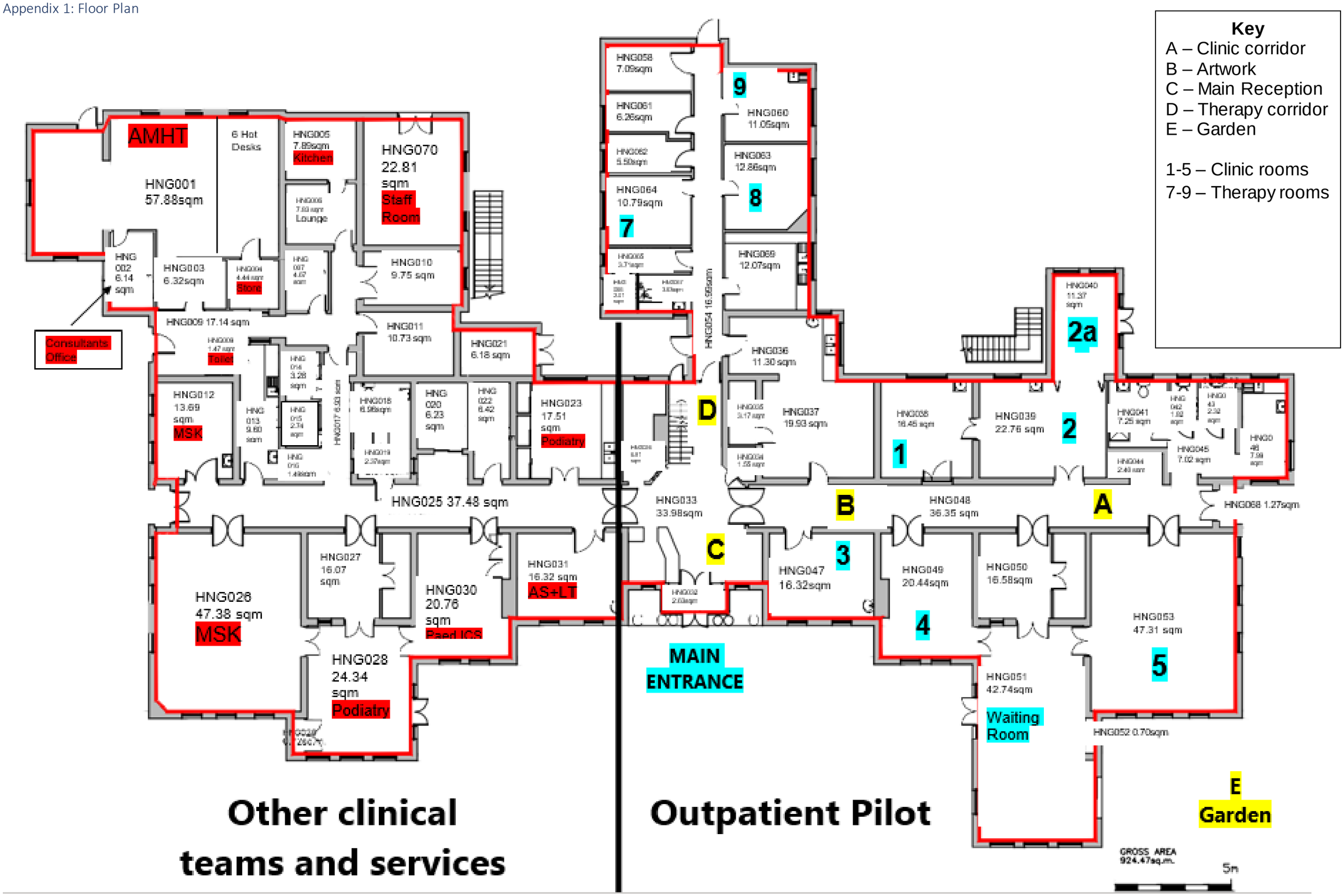
- The impact of services that have yet to start
- The identified expansion of services (e.g. eye treatments)
- The opportunities presented by the spare capacity in the clinical rooms
- The changing economic environment where the cost of travel to appointments further away for patients is becoming more challenging

We therefore propose to continue and expand the pilot to continue to benefit residents and to inform the work of the Oxfordshire Integrated Improvement Programme. It is important to note, however, that the longer-term future of the inpatient unit at the hospital remains under review and so no permanent commitment to delivering these services can be made at this time. An update on the community hospital inpatient pathway planning work has been provided along with this paper.

The patient feedback and review completed to assess this pilot will be taken into consideration as part of the work being carried out within the Oxfordshire Integrated Improvement Programme. This Programme is responsible for completing the work to determine the longer-term optimum model for community services Oxfordshire as a whole as well as for Wantage based on resources and local needs.

Appendices

Appendix 1: Floor Plan



Appendix 2: Picture of the renovations

Before renovation

After renovations – September 2021

Artwork from a local school – asked for seasonal or healthcare related pictures, plus others from school topics





Appendix 3: Evaluation criteria

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.

Appendix 4: Outpatient usage chart

	Room 1 Standard Room	Room 2 Standard room	Room 2a	Room 3 Standard room	Room 4 Standard room	Room 5 Standard / meeting room	Room 7 Therapy room	Room 8 Therapy room	Room 9 Therapy room
Mon AM	Ophth visions	Available	Available	Available	Ophth diag.	Private ENT (wk 2) Available wk 1,3,4	Talking space +	AMHT	AMHT
Mon PM	Ophth visions	Available	Available	Available	Ophth diag.	Private ENT (wk 2) Available wk 1,3,4	Talking space +	AMHT	AMHT
Tues AM	Available	ENT (From August)	ENT (From August)	ENT (From August)	ENT (From August)	ENT (From August)	Available	AMHT	AMHT
Tues PM	Available	ENT (From August)	ENT (From August)	ENT (From August)	ENT (From August)	ENT (From August)	Available	AMHT	AMHT
Wed AM	Ophth visions	Available	Available	Available	Ophth diag.	Perinatal (wk4) Available wk 1,2,3	Available	AMHT	AMHT
Wed PM	Ophth visions	Available	Available	Available	Ophth diag.	Perinatal (wk4) Available wk 1,2,3	Available	AMHT	AMHT
Thur AM	Ophth visions	Available	Available	Available	Ophth diag.	Adult Eating Disorders	Talking space +	AMHT	Psychological therapies
Thur PM	Ophth visions	Available	Available	Available	Ophth diag.	Adult Eating Disorders	Talking space +	AMHT	Psychological therapies
Fri AM	Available	Available	Available	Available	Ophth diag.	AMHT	NDC Available alt wks	NDC	Psychological therapies
Fri PM	Available	Available	Available	Available	Ophth diag.	AMHT	NDC Available alt wks	NDC	Psychological therapies
Usage %	**60%**	**20% from August**	**20% from August**	**20% from August**	**80% (100% from August)**	**50% (70% from August)**	**50%**	**100%**	**100%**

Appendix 5: Detailed patient feedback

573 responses received

Questions asked

1. Date attended - 19/11/21-17/5/22
2. Email and name
3. Service attended – Ophthalmology, Mental Health Services, GP, Audiology
4. Method of travel

Drove / were driven	Bus	Cycled	Hospital Transport	Walked	No response
495	27	2	7	18	24

5. Were the services at Wantage Community Hospital suitable for you?

Yes	No	Maybe	Blank
503	11	21	38

6. What was your experience?

In total 400 comments were left

- 331 positive comments including:
  Brilliant Good (60) Easy and efficient Positive Wonderful Quick Great staff Easy access Uncomplicated Friendly and prompt Excellent (34) Helpful Kind Fantastic experience Fine (13) Great Very good (79) Very easy (19) Easier than the JR (11)

- 42 negative comments
  - 21 involved distances from their home
  - 11 involved parking being unavailable
- 27 mixed negative/positive comments – available for review
- 173 no comment left

7. Were you treated with dignity and respect?

Yes	No	Maybe	Blank
546	0	3	24

8. Did you feel involved enough in the decisions about your care?

Yes	No	Maybe	Blank
432	3	20	118

9. Did you receive timely information about your care and treatment?

Yes	No	Maybe	Blank
511	3	22	37

10. Overall score about your experience of this service (1-5 with 1 being low and 5 being high)

5	4	3	2	1	Blank
465	42	8	0	3	55

11. Is there anything we could have done better?

152 comments

94 positive

58 suggesting improvements/change including

Appt at the local hospital Refreshments available

Better parking/more spaces Improved instructions

12. Would you recommend this service to your Friends and Family?

Yes	No	Maybe	Blank
488	11	30	44

13. Would you recommend having an appointment at Wantage Community Hospital – OPD?

Yes	No	Maybe	Blank
408	10	26	129

14. Would you like to attend a patient feedback event with Oxford Health?

Yes	No	Maybe	Blank
56	380	87	50