OxNa - December 2014		
Report recommendations	**Oxfordshire County Council Response**	**Progress report on action taken**
1. Recognise that the population of those with a neurological condition requiring long term support within the community is increasing and the capacity of existing statutory and voluntary sector services for this patient group therefore needs to grow to keep pace with demand. 2. Give greater recognition to informal carers, and care provided by the voluntary sector, and provide appropriate support for both. 3. Improve the joining up of care for this patient group, in particular where patients have more than one condition.	*Ben Threadgold by email 26/11/14* There is one recommendation about more specialist support for family carers which our compliance with the Care Act should address.	1. Can you outline any figures from the Care Act compliance monitoring to demonstrate increased levels of support? The Care Act places an obligation on local authorities to offer assessments and support to carers who meet nationally defined eligibility criteria for carers. In response to this, we reviewed our processes for supporting carers through annual grants administered via an application form. We introduced a more thorough assessment process and means of determining the level of support offered. An assessment form is available online that enables carers to assess their needs should they wish to do so. Since 1st April 2015, 4,000 carers were assessed for care and support and 1,152 of them were found to be eligible for a Direct Payment. The others received tailored information and advice. We are holding a Carers' Workshop to refine the online assessment process.

		2. The council continues to support carers in their role enabling them to continue to care for as long as they wish to and are able. We fund Carers Oxfordshire, who continue to offer a wide range of services to support people who provide unpaid care for their families, friends or neighbours, offering free information, advice and support. We pooled our budgets with Oxfordshire Clinical Commissioning Group to provide more coordinated support for carers. This also means carers do not need to contact their GPs and the council separately to get the support they need. 3. The Carers Oxfordshire contract now includes working with Rethink, who offers a range of carer support services. This means carers of adults who have mental health needs can contact Carers Oxfordshire to access appropriate support.

Sustaining Dementia Friendly Communities (ORCC)		
Report Recommendations	**Response**	**Progress on Action Taken**
1. To provide some ongoing professional community development support, training, and funding for volunteer recruitment and incidental costs to organisations that have undertaken dementia awareness training and are committed to providing support to dementia patients and their families. 2. To support these groups to make their services known to local GPs. 3. To encourage GP practices to have a named dementia lead, who drives the adoption in the practice of social prescribing to these local groups as part of the care prescribed to dementia patients and their carers.	***Email from Ian Bottomley (OCCG) 17/07/15*** Oxfordshire has been developing its approach to community based services that support people living with dementia and those who care for them. As I think you are aware OCCG and the County have worked with a wide variety of stakeholders to develop a new countywide Dementia Support Service which is designed to support people from diagnosis through the life course of their illness. I am pleased to say that the procurement of the new service (led by the County) is nearly complete and we should be in a position to announce the successful bid shortly. In developing the Dementia Support Service OCCG jointly with OCC identified the gaps as outlined in the report. In response the main purpose of the new Service will be the signposting and support of people with dementia and their carers to enable them to live independently in	1. Could you please update us on this service development and any anticipated impact of budget constraints in 2016? Age UK, in partnership with Young Dementia UK and Guideposts, have been awarded the dementia support service contract. The new service, Dementia Oxfordshire, provides a wide range of support services in the community for people living with dementia and their carers. Dementia Friendly Communities has been a highly successful initiative to increase awareness about dementia in local communities, which are taking these forward in various ways according to their needs. Dementia Oxfordshire continues to support local communities by providing information about dementia, how to get help locally and about staying independent.

	their own homes, with or without support. The service will involve the following elements: • Comprehensive assessment of service users' needs, and coordination of support and monitoring • Goal setting and support planning, in consultation and agreement with the service user, their carer(s) and other professionals as required. This will include liaison with GP practices. • Provision of on-going individualised support according to persons' requirements and needs. This could include phone or face to face support • Coordination, signposting and referrals to support service as required, as well as active provision of support services as necessary. • Monitoring and review of service users' progress towards and achievement of their personalised goals every 6 months. • Co-ordination and provision of dementia training to the carers as required. The people working in the new Service will be at the centre of all the support that is available for people with dementia. This	

	will include liaison and active involvement with those existing resources such as the Community Information Networks. There will be a named adviser for each person with dementia, as well as a named adviser for each GP practice. This will provide the recommended links between GP practices and the community support by offering an informed and knowledgeable link for people living with dementia and their carers'. OCCG and OCC have already piloted a social prescription and Guideposts Trust has been commissioned to develop, distribute and update the Oxfordshire Social Prescription Guide. As part of the implementation process it is planned for the dementia advisors to be working through this Guide with the person with dementia and their carers'. The guide enables the professionals to support the person with dementia and their carer with a social prescription where a pharmacological one is not available, increasing wellbeing and reducing crisis by providing the information to support people to live well with dementia.	

Carers in Oxfordshire (Guideposts)		
We said	**Response**	**Progress report on action taken**
The report identifies that carers feel there is: 1. Insufficient access to holidays for the carer and the cared for. 2. Insufficient provision of social activities for the cared for, which provide a break for the carer. 3. Insufficient access to care provided by others, outside the home, on a regular basis. 4. Demand for access to professional care at home, during the day and overnight, is highly valued and people would like more of it – particularly for people with dementia. 5. Access to information for carers of people with mental health issues is still not meeting their needs.	Report sent to Angela Strange (OCCG) and John Pearce (OCC). OCCG thanked us for the report, but felt the official response would be best to come from lead carers commissioner OCC. **No response received from OCC**	1. Carers are able to have breaks using their personal budgets. Their assessment takes into account the impact of caring on their wellbeing, and if they are eligible for support carers may have access to a personal budget of up to £600, which they can use in any way that they think would support their wellbeing. Carers Oxfordshire helps carers to find holidays if that is how they'd like to use their budget. 2. We are increasing befriending services and face to face support in our new contract with Carers Oxfordshire. The aim of this is to give the most vulnerable carers better access to support. 3. We are co-designing the respite model alongside carers who cared for adults over 18 and have received respite care, those who could not find respite and people paying for their own care. The carers co-design working group has produced • Quality Standards for respite • A gap analysis of respite in Oxfordshire

		• A future model for respite We will share this work with a wider group of people and organisations for feedback in January 2016. 4. We are changing the way we support people and their carers who live at home. Our new model focuses on outcomes for carers and people they care for rather than tasks. 5. The Carers Oxfordshire contract now includes services provided by Rethink to support carers who look after adults with mental health needs.
Families' experiences of ante and post-natal community services (Home Start)		
We said	**Response**	**Progress report on action taken**
1. GP practices consider parents of very young children a priority when offering appointments. 2. Midwives and Health Visitors be required to incorporate basic parenting and baby care as part of their routine support to all new parents. 3. Service providers prioritise continuity of care between	Email from Val Messenger (OCC) 04/09/15 Asked to share the report with NHS England as they didn't take over commissioning health visiting until 1/10/15. Email from Sarah Breton (OCC) 03/09/15 The report's main recommendations are to do with provider issues and	Health visiting service that was held by NHS England has been novated to Oxfordshire County Council from the 1st October. The contact runs until 31st March 2017 and is provided through Oxford Health Foundation Trust. The service consists of 119 health visitors, working in skill mixed teams that include nursery nurses, community staff nurses and training leads. The service is a universal service that is provided to all families from pregnancy through to age five.

individual staff and families, so that parents can develop productive and trusting relationships with those providing them with support.	suggested we await responses from OHFT for Health Visiting and OUHT for Maternity.	Between April and June of this year there were approximately 44,000 direct contacts made with families. The contract includes Family Nurse Partnership – an intensive home visiting service for a maximum of 200 teenage mothers. Two additional services that were already being commissioned by Public Health have been incorporated into the contract: a targeted breastfeeding support service and a housing and homelessness notification service.

Discharge Report		
We said	**Response**	**Progress report on action taken**
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[1]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day. 2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.	*Letter from Paul Brennan, dated 25th August:* • Suggested there were flaws in the data analysis • Asked for a further breakdown of data by organisation • Asked for chart colours to have consistence • Detailed a negative bias in the presentation of anecdotes • Significant numbers of statements were generalised • Asking for raw data to be shared with a multi-agency group in Oxfordshire *In a meeting on 13th October with system leaders it was agreed:*	

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[1] See Appendix 1 for the summary pathway

3. The “Planning for Discharge” ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan. 4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place. 5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about ‘involving’ others and not just about ‘informing’ them. 6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in	• Providers and commissioners will review the recommendations and come back to HWO with a view on what they can take forward from the report. This will be done privately. • We will then all meet again to discuss that, and once all parties are satisfied we will agree a joint statement on the actions that the system will take in response to the report. • **A joint system response to this report is expected before Christmas 2015. At the time of drafting this report it had not yet been received.**	

discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed. 7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services. 8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: - Patients should routinely receive 2 weeks’ worth of the medications they need 24 hours before they are discharged. - Discharge summaries should state clearly what changes have been made to prescriptions		

(start/ stop/ change/ continue) and why. - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself. 9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries. 10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a		

hard copy should be given to the patient and his/her carers when s/he leaves hospital. 11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs. 12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge. 13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care. 14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.		

Dignity Report		
We said	**Response**	**Progress report on action taken**
1. Communication be improved between staff and patients and their families, understanding that this communication must be two-way. 2. Access to support services which facilitate dignified care be more widely promoted and offered. 3. Discussions about maintaining dignity be included in staff training and induction, and that this training should include: dementia awareness, limiting jargon and using plain English, two-way communication and a broader understanding of dignity. 4. Providers and commissioners work to ensure staff have the time to care, by increasing the proportion of time they spend with patients. This could be done through continued work to improve processes and paperwork, work to decrease staff sickness or through increasing allotted time for specific tasks.	**Oxfordshire County Council:** • Commission the Community Information Network which trains and supports volunteers to help people find out what is available in their own communities, making sure they have the opportunity to be active in their own wellbeing, independence and support when needed. • Are working with other commissioners to develop a model of co-production that will see service users directly involved in the design and commissioning of future services. • Are developing an e-marketplace that will offer individuals, carers and professionals the opportunity to choose and purchase good quality care and support services from providers specifically selected by the council. • Runs campaigns that promote access to support services and equipment which facilitate dignity in care. For example, their current assistive technology campaign promotes the availability of devices that can be used in a person's home to improve their quality of life and that of their	How do you monitor the success of the Community Information network? The contract is managed and monitored as any other agreement would be by our contract management team, based upon the requirements specified when it was tendered. The Community Information Network is extending its reach to include more young adults with disabilities. We receive data from them showing which parts of the service are used and how frequently. What is the progress on your co-production programme? The County Council has organised training for all commissioners of adult services, all of the Joint Commissioning Engagement Team, three Oxfordshire Clinical Commissioning Group commissioners, a member of the Quality and Contracts team, a member of the procurement team and a commissioner of children's services. This training starts in February 2016 and will be provided by the Social Care Institute of Excellence over a six month period. We

5. Commissioners and providers in Oxfordshire broaden the discussion on dignity in work places, so that it encompasses all elements of dignified care (the Dignity Do's can provide a guide) and that this discussion inform training and the development of care models or pathways. 6. Staff be helped to focus on the balance between patient choice and dignity, particularly when patients have a diminished capacity to make choices. 7. Providers do further work to develop an open culture that learns from complaints and isn't defensive so that patients and carers feel able to make complaints/report abuse without fear of repercussions.	carer, and help them maintain independence. • Commissioned a Community Information Network that operates across the county through information drop-ins, over the phone or visiting people at home, enabling individuals to access local support services, activities, financial advice and social care. • Commissioned an expanded advocacy service in response to the requirements of the Care Act 2014. • Have established a new contract for interpretation services as part of a consortium, led by the Oxfordshire Clinical Commissioning Group and including health providers. This will allow staff to access interpretation either face-to-face or over the telephone through a quick and easy online system. • Has run workshops on addressing the initial problems raised by carers about the new self-assessment process, and is meeting carers about the self-assessment forms, to work with them to make further improvements. • Hosts the Dignity and Dementia Champion Network, which examines the importance of dignity in the development of care models, and contributes to training.	already have some examples of co-production that we are delivering including the recommissioning of supported living services for people with learning disabilities and respite services. What is the status of the e-marketplace and what is in place for those unable to access it? We are developing the e-marketplace to be able to implement this by April 2016. For those unable to access it we produce the Oxfordshire Support Finder booklet which is distributed to GP surgeries and other public places. What reassurance can you give to access to interpretation services is widely advertised? Do you monitor take up? If so, has it improved? The new Interpretation Service has been operational since 1 September 2015 and is accessible to all council staff. The use of the service is monitored monthly and regular meetings are held with the organisation providing the service. LM What percentage of providers in the county are taking up support offered on recruiting people for values? In the region of ten home care providers are due to take up the council's offer of values-based recruitment and interviewing.

	• Remains committed to making sure that all visits for support at home are the right length for the person and provide the support they need, and in all cases are sufficient for care and support to be given with dignity and respect. All visits involving intimate personal care such as help with washing or using the toilet will be more than 15 minutes long. • Supports providers to recruit people for their desire to work caring for others, and their commitment to values such as dignity and respect. • Has developed Home Care Standards written jointly by people who receive care in their home and home care support agencies, and which require providers to meet dignity standards such as introducing themselves when they arrive and helping you at a pace that suits you. • Ran a workshop for residential care home staff to explore the need to share learning from complaints, and views complaints as a positive tool to promote improvement in services.	How do you monitor compliance with Home Care Standards? The County Council facilitated a set of events bringing together organisations providing home care and people using their services to agree on a co-produced set of standards. The service users are told what these standards are before they receive their care and are asked to contact their service provider (if they feel able to do so) or the Quality and Contract management team at the council if they feel that their care does not meet these standards. People using services were sent a survey based upon the agreed standards which allowed them to express their level of satisfaction with their care provider. This information was fed back to providers and two of the worst-performing providers are no longer contracted by the council. How many people attended your 'learning from complaints' workshop? The workshop was attended by six staff members, from the complaints team and other areas in joint commissioning. These were then able to relay the training they received to their respective teams.

Hearsay! 2015		
We said	**Response**	**Progress report on action taken**
1. The need for a joined up health and social care system that offers appropriate and adequate information, advice and communication, to offer a much more coordinated and integrated experience of health and social care. 2. The need for a personalised, holistic approach to care with an emphasis on maintaining a person's quality of life. 3. There are gaps in age appropriate services for younger people and working age adults. 4. There is not enough support for family members who are carers.	**What we will do:** **1.** We are consulting on an Information and Advice Strategy – the consultation is open from 13th July until 11th September. This strategy is our plan and sets out how we are responding to the information and advice requirements for local authorities as stated in the Care Act 2014. The consultation is open to everyone to respond and we are keen to hear your views. **a)** We will announce the outcomes from the Information and Advice Strategy and specialist advice service consultation in early 2016 and report back then about how responses will be taken forward. **b)** Evaluate the first pilots in delivering Integrated Locality Teams in October and December to find out their value and, if successful, these will be rolled out across the county. The second wave of pilots will be evaluated in April 2016. We will report	The evaluation of several pilots of new ways of working (including a senior practitioner and social workers working as part of community health teams; a Nursing Triage Hub in the West of the county; and weekly cross health and social care complex case meetings) have shown the following common themes: • Have avoided unnecessary calls and referrals to the social care duty desk, just got on and sorted it out • Avoided duplication • Issues resolved more quickly • Better understanding of social care issues and systems by health practitioners • Joint visits between social workers and nurses, which have led to speedier resolution • Individual patient outcomes which they have reported are better due to the joint working • Overcome former barriers and have built trust across a range of clinicians • People only have to tell their story once, as team working together, so less people having to come in to the patients home

	back on these after the evaluation results are analysed. The Oxfordshire Clinical Commissioning Group will provide updates on progress towards their 2018/19 plan via regular publication of newsletters and a web page on their website which is updated with progress. We are also reporting regularly through the Older People's Joint Management Group and to the Health and Wellbeing Board. **c)** Publish the results for Oxfordshire from the National Carers Survey in September 2015. **<u>Our response:</u>** **1.** The whole system is working towards an Oxfordshire Care Summary which would provide each organisation (County Council, Doctors, Hospitals, Community Health) with key information held by each organisation for consenting members of the public. This would allow professionals to see information collected through assessments, or on care being provided as recorded by colleagues, reducing the need for duplicate assessments.	• Clinicians are happier and feel they are working more effectively Change in practice has centred on the service user and their carers and resolving issues more quickly, not on organisations or systems change. Age UK have become a partner in the Integrated Teams, having care navigators, dementia support workers and carers outreach workers working in the locality integrated teams, to ensure good joined up support and speedy handover The work has shown that about 20% of people seen by adult social care are also being seen or need to be seen at that time by community health, and visa verse; Meaning that 80% of people do not require a joint response. All of the pilot work has become normal practice and is being rolled out across the county. There are several new pilots that are due to start in January 2016 that now include General Practice as part of the integrated team.

	2. Oxfordshire County Council supports the principle that good discharge planning should start at the point of admission. We have committed to attending daily rounds on key wards, in addition to weekly ward rounds and have provided our hospital staff with IT equipment to use whilst on the wards, thereby reducing delays in obtaining key information on discharge planning. **3.** Oxfordshire County Council is proud to have one of the highest numbers of Direct Payments in the Country. Direct Payments give the individual the most flexibility about the way in which their needs are met. We recognise that people want more say in how their needs are met. We are therefore changing the way that we work with our Home Care providers so that the person and the provider will agree the way in which the provider can support individuals to achieve what is most important to them. The contracts with providers are being recommissioned in October 2015 and users of the service, and their carers, have been offered the opportunity to	

	tell us what they would like to see implemented in future contracts. From last year's Hearsay! action plan, we committed to work with people who have support and care at home and with organisations providing the care to create Care Standards. The standards were created collaboratively: we asked organisations that provide support and care to develop their own customer service standards and send them to us; we identified common themes, drew up a set of common standards and circulated them for comment. We now include the standards in our contracts with organisations providing support and care, share them with people who have support at home, and use them to monitor the services provided. This innovative work to devise customer standards with people who receive care and providers, is being promoted nationally. The Dignity Care Network (individuals and organisations who work together to put dignity and respect at the heart of UK care services) has shared our work with all of its members.	

Healthwatch Oxfordshire's Voluntary Sector Conference held on 8th July 2015		
We said	**Response**	**Progress report on action taken**
Actions that came out of the voluntary sector conference for Oxfordshire County Council were: • To hold a workshop with voluntary sector organisations and carers to arrive at a local definition of prevention and carer in the context of the Care Act. • To hold a workshop to gather feedback on the online carers assessment tool. • To send information on the Pharmacy Health and Wellbeing Review service for carers to Healthwatch Oxfordshire to promote.	Email sent to John Pearce (6/8/15) no response received.	We are holding a workshop to gather feedback on the online carers assessment tool on 12 January 2016. We will use this opportunity and others to meet with carers to support greater understanding of how the council is ensuring its responsibilities for supporting carers are met. Although this is now in the context of the Care Act, the council's commitment to supporting carers has not changed. The work to set up and improve the new processes, focusing on individuals and what they want to achieve, continues to develop our approach. We continue to work with carers and others and encourage people to participate in consultation exercises. Prevention services and carers' services are a crucial part of the picture. In the context of the necessary budget savings, the council is committed to working closely with people who could be affected in making the difficult decisions we have to make. The Oxfordshire Clinical Commissioning Group have circulated information concerning the Pharmacy Health and Wellbeing Review.

Outstanding from 2014 report - Hearsay!		
We said	**Response**	**Progress report on action taken**
	The following update was provided on 14/11/14 by e-mail: We are in the process of publishing performance of individual care agencies from the information we get through the monitoring of services, and asking service users how their agency performs against the care standards being developed below: **User Survey on Home Support Services** We are undertaking a comprehensive user survey to people who use home support services. This will help us identify key provider performance against the Home Support Customer Charter that we developed with service users and carers last year. Once this is complete we will make this information public. We will also extend our reporting to include making public contract monitoring information; this will be done by January 2015. **Co-producing guidance** We are committed to co-producing (working with a panel made up of service users, voluntary organisations, Healthwatch Oxfordshire and people working for the Community Information Network) documents and films that explain: Eligibility Criteria, Care Assessment, Financial Assessment, Benefits Information.	Can you update us on progress with publishing performance? The results of the survey completed by service users were shared with agencies so that they are able to consider their responses in terms of their services. The results of the previous survey will also be sent out to all participants of the upcoming user survey to take place in February 2016. The council will publish our survey on the performance of care agencies after the completion of the statutory survey of service users which will be completed in February 2016. It is hoped that the additional information and the elapsed time between the surveys will give us a clearer picture of the performance of our providers.

OxNa – December 2014		
Report recommendations	**Oxfordshire Clinical Commissioning Group Response**	**Progress report on action taken**
1. Recognise that the population of those with a neurological condition requiring long term support within the community is increasing and the capacity of existing statutory and voluntary sector services for this patient group therefore needs to grow to keep pace with demand. 2. Give greater recognition to informal carers, and care provided by the voluntary sector, and provide appropriate support for both. 3. Improve the joining up of care for this patient group, in particular where patients have more than one condition.	*Email from Richard Wood (OCCG) 2/12/14* The data from a patient subsection less able to communicate their views is incredibly useful and the 74% response rate is admirable in this patient group. Your report highlights themes very close to the heart of Oxfordshire CCG: managing multi-morbidity, more integrated care across multiple professionals, the importance of GPwSIs, the closer involvement of voluntary and other sectors, and of course a care that is planned around the patient and their carers. It is also useful to know that much of what we have already works for patients – we just need to see more of it.	The OCCG has focused first on those patients who suffer disabling headache, which is one the largest patient groups we have. Your report highlighted the need for greater GP education. We have now developed and released guidelines to GPs on a wide range of treatments and therapies (medical and non-medical) that can help patients with migraine. We have also provided clearer guidelines on when to refer, and what the patient will be offered on referral. This is part of a wider headache pathway redesign which is in progress. For this we have worked closely with the Thames Valley Strategic Clinical Network and the patient groups they resource. The vision of this pathway is for faster access to assessment and support for our patients with headache, through easier access to appropriate investigations, community headache clinics, and more support 'on the ground' for GPs needing rapid advice from experts, and for patients with headache who attend A&E. This pathway re-design is well into development stages.

		Other activity includes: 1) to review of the access points to neurology for GP referrals to aid more streamlined and prioritised referrals. 2) Dr Richard Wood has met with representatives from the voluntary sector (Oxford Neurological Alliance and MS Society) on multiple occasions to foster new relationships. We are currently in the process of developing business ideas for how best the third sector and the CCG can work together for the better of our patients
Alice's Report		
Report Recommendations	**Response**	**Progress on Action Taken**
1. Supporting the creation of a new organisation led by people who use the service to ensure Oxfordshire is delivering best practice in involving mental health service users in service redesign.	OCCG: - The OCCG has agreed to work with the partners to the MH Outcomes Based Contract to set up a conference to explore how service user involvement needs to develop in the context of this new contract. - OCCG has also pledged to involve the service user who researched and wrote the report in planning that event, and to ensure her proposals are debated as one of the possible ways forward.	The conference has been advertised and is scheduled for Tuesday 23rd February. The conference is being designed with the support of the author of the report and will explore the type of user engagement approach that we should use in Oxfordshire.

Sustaining Dementia Friendly Communities (ORCC)		
Report Recommendations	**Response**	**Progress on Action Taken**
1. To provide some ongoing professional community development support, training, and funding for volunteer recruitment and incidental costs to organisations that have undertaken dementia awareness training and are committed to providing support to dementia patients and their families. 2. To support these groups to make their services known to local GPs. 3. To encourage GP practices to have a named dementia lead, who drives the adoption in the practice of social prescribing to these local groups as part of the care prescribed to dementia patients and their carers.	*Email from Ian Bottomley (OCCG) 17/07/15* Oxfordshire has been developing its approach to community based services that support people living with dementia and those who care for them. As I think you are aware OCCG and the County have worked with a wide variety of stakeholders to develop a new countywide Dementia Support Service which is designed to support people from diagnosis through the life course of their illness. I am pleased to say that the procurement of the new service (led by the County) is nearly complete and we should be in a position to announce the successful bid shortly. In developing the Dementia Support Service OCCG jointly with OCC identified the gaps as outlined in the report. In response the main purpose of the new Service will be the signposting and support of people with dementia and their carers to enable them to live independently in their own homes, with or without support. The service will involve the following elements:	1. Could you please update us on the implementation of the Dementia Support Service The new Dementia Support Service commenced in November 2015. The service is provided by Age UK in partnership with other organizations. A formal launch with publicity is planned. The contract for the service is actually held by Oxfordshire County Council. If required more detail on the implementation could be supplied by the County. Oxfordshire County Council has proposed in its budget proposals that funding for the service may be withdrawn at the end of the 3 year initial contract (2018). OCCG is exploring the potential impact of this proposal with the County.

	• Comprehensive assessment of service users' needs, and coordination of support and monitoring • Goal setting and support planning, in consultation and agreement with the service user, their carer(s) and other professionals as required. This will include liaison with GP practices. • Provision of on-going individualised support according to persons' requirements and needs. This could include phone or face to face support • Coordination, signposting and referrals to support service as required, as well as active provision of support services as necessary. • Monitoring and review of service users' progress towards and achievement of their personalised goals every 6 months. • Co-ordination and provision of dementia training to the carers as required. The people working in the new Service will be at the centre of all the support that is available for people with dementia. This will include liaison and active involvement with those existing resources such as the Community Information Networks. There will be a named adviser for each person with dementia, as well as a named adviser for each GP practice. This will provide the recommended links between GP practices and the community support by offering an	

	informed and knowledgeable link for people living with dementia and their carers'. OCCG and OCC have already piloted a social prescription and Guideposts Trust has been commissioned to develop, distribute and update the Oxfordshire Social Prescription Guide. As part of the implementation process it is planned for the dementia advisors to be working through this Guide with the person with dementia and their carers'. The guide enables the professionals to support the person with dementia and their carer with a social prescription where a pharmacological one is not available, increasing wellbeing and reducing crisis by providing the information to support people to live well with dementia.	

Carers in Oxfordshire (Guideposts)		
We said	**Response**	**Progress report on action taken**
The report identifies that carers feel there is: 1. Insufficient access to holidays for the carer and the cared for. 2. Insufficient provision of social activities for the cared for, which provide a break for the carer. 3. Insufficient access to care provided by others, outside the home, on a regular basis. 4. Demand for access to professional care at home, during the day and overnight, is highly valued and people would like more of it – particularly for people with dementia. 5. Access to information for carers of people with mental health issues is still not meeting their needs.	Report sent to Angela Strange (OCCG) and John Pearce (OCC). OCCG thanked us for the report, but felt the official response would be best to come from lead carers commissioner OCC.	OCCG recognises the key role that carers play in supporting those who are no longer able to look after themselves. The CCG realises that involving carers in discussions and where appropriate decisions is key to achieving good patient care.

Discharge Report		
We said	**Response**	**Progress report on action taken**
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[2]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day. 2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission. 3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their	*Letter from Paul Brennan, dated 25th August:* • Suggested there were flaws in the data analysis • Asked for a further breakdown of data by organisation • Asked for chart colours to have consistence • Detailed a negative bias in the presentation of anecdotes • Significant numbers of statements were generalised • Asking for raw data to be shared with a multi-agency group in Oxfordshire *In a meeting on 13th October with system leaders it was agreed:* • Providers and commissioners will review the recommendations and come back to HWO with a view on what they can take forward from the report. This will be done privately. • We will then all meet again to discuss that, and once all parties are satisfied	Due to diary difficulties in organisations the meeting was rescheduled and a meeting to follow up the report with Healthwatch Oxfordshire has been arranged for January the 8th 2016. A joint system response to the report is being finalised.

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[2] See Appendix 1 for the summary pathway

Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan. 4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place. 5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about ‘involving’ others and not just about ‘informing’ them. 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	we will agree a joint statement on the actions that the system will take in response to the report. • A joint system response to this report is expected before Christmas 2015, but at the time of drafting this report it had not yet been received.	

carer every time this is updated and reviewed. 7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services. 8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: • Patients should routinely receive 2 weeks’ worth of the medications they need 24 hours before they are discharged. • Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why. • Patients’ nominated pharmacies should be emailed or notified		

electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. • Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself. 9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries. 10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital.		

11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs. 12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge. 13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care. 14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.		

Dignity Report

We said	Response	Progress report on action taken
1. Communication be improved between staff and patients and their families, understanding that this communication must be two-way. 2. Access to support services which facilitate dignified care be more widely promoted and offered. 3. Discussions about maintaining dignity be included in staff training and induction, and that this training should include: dementia awareness, limiting jargon and using plain English, two-way communication and a broader understanding of dignity. 4. Providers and commissioners work to ensure staff have the time to care, by increasing the proportion of time they spend with patients. This could be done through continued work to improve processes and paperwork, work to decrease staff sickness or through increasing allotted time for specific tasks.	Oxfordshire Clinical Commissioning Group: • We welcome the recommendations made in the report. OCCG monitor all providers to see that dignity in care standards are being upheld and seek to ensure through their contracts that patients with additional needs are appropriately supported by services making reasonable adjustments, and are provided with advocacy and interpreting services when needed.	1. How is the CCG reassured that local providers are meeting dignity in care standards? Health providers set out their commitment to action in their response to the Healthwatch report. The CCG expects the Trusts from which it commissions health care to deliver care in line with the 6 Cs which are care, compassion, courage, communication, competence and commitment. Patients and service user should be treated with respect dignity and compassion. The CCG expects providers to deliver these standards with most patients reporting a positive experience.

5. Commissioners and providers in Oxfordshire broaden the discussion on dignity in work places, so that it encompasses all elements of dignified care (the Dignity Do's can provide a guide) and that this discussion inform training and the development of care models or pathways. 6. Staff be helped to focus on the balance between patient choice and dignity, particularly when patients have a diminished capacity to make choices. 7. Providers do further work to develop an open culture that learns from complaints and isn't defensive so that patients and carers feel able to make complaints/report abuse without fear of repercussions.		

Alice's Report		
Report Recommendations	**Response**	**Progress on Action Taken**
1. Supporting the creation of a new organisation led by people who use the service to ensure Oxfordshire is delivering best practice in involving mental health service users in service redesign.	We have recently been commissioned to deliver adult mental health services under the new Oxfordshire Mental Health Partnership (OMHP) and this will allow Oxford Health NHS FT and our five partner organisations from the voluntary sector (Connection Floating Support, Elmore Community Services, Oxfordshire Mind, Response and Restore) to formally work together these services across the county. One of the significant benefits of the partnership will be that it will allow us to deliver fully integrated services for both our service users and their carers and will offer them many more opportunities to be involved in how their care is delivered, and how we can support them towards meeting their personal recovery goals. Following the remodelling of our community services last year within Oxford Health we are now working towards having established service user and carer forums within each	1. Have any further actions been taken towards a service-user led group in Oxfordshire? *There is now an established service user working group who are taking the lead for moving this forward across the partnership. It has been agreed that Oxford Health FT will support this group to host a conference in April 2016 on service user involvement. This will be the first stage of looking at how the partnership can work better with our service users to ensure that we are working towards best practice in this area.*

	AMHT and on each of our inpatient wards. We acknowledge that at present, whilst we implement these they are being led by staff from the teams. However, we would be happy to see how going forward we can work with the people engaged with these services to see if they would want to lead their own user and involvement groups and how we could best support them to do this, for both the trust and other services across the new partnership.	

Families’ experiences of ante and post-natal community services (Home Start)

We said	**Response**	**Progress report on action taken**
1. GP practices consider parents of very young children a priority when offering appointments. 2. Midwives and Health Visitors are required to incorporate basic parenting and baby care as part of their routine support to all new parents. 3. Service providers prioritise continuity of care between individual staff and families, so that parents can develop	Letter from Stuart Bell (OHFT) 25 Sept 2015 1. **Availability of Appointments –** the health visitors have done a lot of work on this area and where possible appointments are made a mutually agreed times and are planned to allow enough time to cover identified needs, including basic care of a young baby. 2. **Availability and consistency of information and advice –** We have	1. What percentage of OHFT’s Health Visitors are baby-friendly trained? *This training is part of the package of mandated training for health visitors. All health visitors who have been in post for more than 6 months have been trained and those that are still outstanding (that is, those new to the Trust) will receive the training in February 2016.* *Oxford Health FT are booked to have our Stage 2 assessment for the UNICEF UK Baby Friendly*

productive and trusting relationships with those providing them with support.	recognised the need for consistent advice about breastfeeding. We have ensured that all of our HVs receive the UNicef Baby friendly training in May this year. The aim of providing this training was for all staff to provide a consistent approach to feeding method and subsequent support for mothers. This is an ongoing area of training to maintain this position. 3. **Enhancing continuity of care –** In order to address this issue each family is allocated a named health visitor. Parents are provided with contact details for that named staff member in written format. That health visitor works as part of a health visiting team, enabling cover at times of leave / sickness. Teams have case discussions where that is appropriate, ensuring all staff are fully informed and can support families where needed.	*Initiative standards on the 3rd and 4th February 2016.* *This follows on from achieving Stage 1 in May 2015. In preparation for this assessment there will be a clinical effectiveness update session delivered to all teams in January 2016. There is also a rolling programme of annual updates in place.* *Link to standards: (http://www.unicef.org.uk/BabyFriendly/Health-Professionals/New-Baby-Friendly-Standards)*

Discharge Report		
We said	**Response**	**Progress report on action taken**
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[3]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day. 2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission.	*Letter from Paul Brennan, dated 25th August:* - Suggested there were flaws in the data analysis - Asked for a further breakdown of data by organisation - Asked for chart colours to have consistence - Detailed a negative bias in the presentation of anecdotes - Significant numbers of statements were generalised - Asking for raw data to be shared with a multi-agency group in Oxfordshire *In a meeting on 13th October with system leaders it was agreed:* - Providers and commissioners will review the recommendations and	We take the importance of robust discharge arrangements seriously and are actively involved with partners in the health and social care system to work towards timely and safe discharge planning. Patient flow is monitored daily by the trust and our partners. The recent CQC inspection of all community hospitals in Sept/ Oct 2015 noted the following positive practice; - evidence seen by the inspection team of good attention to discharge planning which patients have been seen to have been actively involved in. - Use of FIM to assess fitness for discharge in relation to mobility - MDT meetings observed on two wards with extensive discussions regarding discharge - evidence of active discharge planning and how we work with GPs on discharge planning - evidence of relatives involvement in discharge planning

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[3] See Appendix 1 for the summary pathway

3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan. 4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place. 5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them. 6. That the Discharge Co-coordinator should formally record the involvement	come back to HWO with a view on what they can take forward from the report. This will be done privately. - We will then all meet again to discuss that, and once all parties are satisfied we will agree a joint statement on the actions that the system will take in response to the report.	A description of the processes and systems in place to monitor and act on delays is described in the embedded document. Processes in place to monitor and act on de Our key priority is to develop and introduce an Alliance Programme with the OUH to transform urgent healthcare services for older people and adults who have complex health problems across Oxfordshire, covering both bed and community services. Work has been underway for the last year and we hope to sign the alliance in 2016. Work as part of the 'winter pressures' in 2015/16 has started to include sharing the delivery of services between ourselves and OUH to support patient flow and effective discharge planning. Both our community hospitals and adult acute mental health wards use the nationally recognised quality improvement methodology of 'breaking the cycle' each year, where senior clinicians across multi-agencies work very closely together for a week to deliver the perfect pathway and care for every patient across the system, by identifying issues and addressing these immediately. The outcomes

of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed. 7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services. 8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: • Patients should routinely receive 2 weeks’ worth of the medications they need 24 hours before they are discharged. • Discharge summaries should state clearly what changes have		and learning from these weeks are used to change routine systems and processes.

been made to prescriptions (start/ stop/ change/ continue) and why. - Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. - Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself. 9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries. 10. The electronic discharge summary should be sent to the GP, the patient's		

nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital. 11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs. 12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge. 13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care.		

14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.		
Dignity Report		
We said	**Response**	**Progress report on action taken**
1. Communication is improved between staff and patients and their families, understanding that this communication must be two-way. 2. Access to support services which facilitate dignified care be more widely promoted and offered. 3. Discussions about maintaining dignity are included in staff training and induction, and that this training should include: dementia awareness, limiting jargon and using plain English, two-way communication and a broader understanding of dignity.	**OHFT:** • Will be consulting on a revised patient experience and involvement strategy from November 2015. • Has introduced the use of the recovery star which supports the identification of joint goals and joint monitoring of progress across all community adult mental health teams, with training for all staff. • Has developed a full programme of initiatives designed to embed personalised care and improve patient and carer involvement in planning their own care across all the Trust's services. • Is working with Age UK to help older people to stay as independent as	The initial consultation process for developing our Patient Involvement and Experience Strategy is in progress, started in November 2015. There have been extensive discussions with stakeholders and we have held a series of workshops in Dec 2015 and are planning more with service users, carers and staff. The initial consultation document has also been shared widely and has been placed on the internet as well as tweeted. Following this the next steps are that we will have a follow up workshop in January 2016 to feedback to service users/ carers our progress to date and to prioritise the suggested objectives for the draft strategy. The draft strategy will then be shared widely for comment in Feb and March 2016 before being approved by the Trust Board in April 2016.

4. Providers and commissioners work to ensure staff have the time to care, by increasing the proportion of time they spend with patients. This could be done through continued work to improve processes and paperwork, work to decrease staff sickness or through increasing allotted time for specific tasks. 5. Commissioners and providers in Oxfordshire broaden the discussion on dignity in work places, so that it encompasses all elements of dignified care (the Dignity Do's can provide a guide) and that this discussion inform training and the development of care models or pathways. 6. Staff be helped to focus on the balance between patient choice and dignity, particularly when patients have a diminished capacity to make choices. 7. Providers do further work to develop an open culture that learns from complaints and isn't defensive so that patients and carers feel able to	possible, to ensure they have the information they need and to introduce initiatives such as having volunteers working as care navigators at some of the community hospitals and dementia advisors working alongside staff in memory clinics. • Has extensive relevant training programmes in place and will be making an additional recommendation to the next Learning and Advisory Group in December 2015 that the Dignity Do standards are taken into account when they design and review training courses going forward. • Will review the current trust-wide core questions used across all patient surveys to include a specific question around dignity in care so that they can monitor and target improvements. • Will continue the practice that all wards complete at least a 6-monthly review of the amount of direct care time spent with patients split by registered and unregistered staff, and will continue to present the results to the board of directors and to publish them, as well as asking each ward team to review the detail of their results to identify and make improvements.	The '10 Dignity do's' have been shared with all staff as part of our monthly update on patient experience and are included in our training for the Care certificate for Health care Assistants. *2. How many care navigators are in hospital and what is the take up of the service?* There are two different projects which are being trialled to help patients to access information and support in their community. One is provided by Age UK as part of the Circles of Support and the other is being piloted by GPs in Oxford City. Staff from the Circles of Support visit the community hospital wards and care navigators employed by the GPs are contacted by telephone, which is facilitated by community hospital staff. In addition to care navigators each Community Hospital uses a number of volunteers to support patient care and has monthly PALS visits to help sign post and provide information for patients. *3. Can you update us on any review of trust-wide feedback questions?* We review our Trust core questions every financial year and will be including a question about dignity from April 2016. We will be

make complaints/report abuse without fear of repercussions.		asking out Taking Action from Patient Feedback Group to agree the question to propose to the Trust Board for approval. 4. *Are there any improvements of direct care time to report given your ongoing review?* There are a number of wards that have been reviewing their direct care time for some time and have been able to show that by changing some practices they have been able to increase the amount of face to face time staff have with patients. As a trustwide exercise, however, we have only completed it with all wards once, providing a benchmark, and are due to undertake it again by the end of January 2016. Whilst we have asked wards to reflect on the outcomes of the first review, we will not be able to demonstrate any changes until after the second review.

Outstanding from 2014 report

We said	**Response**	**Progress report on action taken**
	1) **What is the current trend (over the last 6 months) in terms of waiting times and what progress has been made towards meeting targets?**	1. *Can you update us if this has improved or worsened?*

	The percentage of young people having their first routine appointment within 12 weeks of referral for April to Nov 2014 was 63% against target of 75%. The main pressures are in Tiers 2 and 3, which are being monitored and efforts made to address. These reflect an increase in demand which is being mirrored nationally.	The PCAMHS (tier 2) and Tier 3 community mental health services for children and young people remain under great pressure as referrals have increased by 49% over the last 3 years. Currently, 50% of new referrals are being seen within 12 weeks against a 75% target (based on referrals made in August 2015). The services are employing locum staff to help support a waiting list initiative. There are ongoing discussions with the Oxfordshire commissioners on how this can be addressed in the longer term. The waiting times continue to be closely monitored and reported to the CCG.

Alice's Report		
Report Recommendations	**Response**	**Progress on Action Taken**
1. Supporting the creation of a new organisation led by people who use the service to ensure Oxfordshire is delivering best practice in involving mental health service users in service redesign.	We have recently been commissioned to deliver adult mental health services under the new Oxfordshire Mental Health Partnership (OMHP) and this will allow Oxford Health NHS FT and our five partner organisations from the voluntary sector (Connection Floating Support, Elmore Community Services, Oxfordshire Mind, Response and Restore) to formally work together these services across the county. One of the significant benefits of the partnership will be that it will allow us to deliver fully integrated services for both our service users and their carers and will offer them many more opportunities to be involved in how their care is delivered, and how we can support them towards meeting their personal recovery goals. Following the remodelling of our community services last year within Oxford Health we are now working towards having established service user and carer forums within each	5. Have any further actions been taken towards a service-user led group in Oxfordshire? *There is now an established service user working group who are taking the lead for moving this forward across the partnership. It has been agreed that Oxford Health FT will support this group to host a conference in April 2016 on service user involvement. This will be the first stage of looking at how the partnership can work better with our service users to ensure that we are working towards best practice in this area.*

	AMHT and on each of our inpatient wards. We acknowledge that at present, whilst we implement these they are being led by staff from the teams. However, we would be happy to see how going forward we can work with the people engaged with these services to see if they would want to lead their own user and involvement groups and how we could best support them to do this, for both the trust and other services across the new partnership.	

Families' experiences of ante and post-natal community services (Home Start)

We said	**Response**	**Progress report on action taken**
1. GP practices consider parents of very young children a priority when offering appointments. 2. Midwives and Health Visitors are required to incorporate basic parenting and baby care as part of their routine support to all new parents. 3. Service providers prioritise continuity of care between individual staff and families, so that parents can develop	Letter from Stuart Bell (OHFT) 25 Sept 2015 1. **Availability of Appointments –** the health visitors have done a lot of work on this area and where possible appointments are made a mutually agreed times and are planned to allow enough time to cover identified needs, including basic care of a young baby. 2. **Availability and consistency of information and advice –** We have recognised the need for consistent advice	1. What percentage of OHFT's Health Visitors are baby-friendly trained? *This training is part of the package of mandated training for health visitors. All health visitors who have been in post for more than 6 months have been trained and those that are still outstanding (that is, those new to the Trust) will receive the training in February 2016.* *Oxford Health FT are booked to have our Stage 2 assessment for the UNICEF UK Baby Friendly*

productive and trusting relationships with those providing them with support.	about breastfeeding. We have ensured that all of our HVs receive the UNicef Baby friendly training in May this year. The aim of providing this training was for all staff to provide a consistent approach to feeding method and subsequent support for mothers. This is an ongoing area of training to maintain this position. 3. **Enhancing continuity of care –** In order to address this issue each family is allocated a named health visitor. Parents are provided with contact details for that named staff member in written format. That health visitor works as part of a health visiting team, enabling cover at times of leave / sickness. Teams have case discussions where that is appropriate, ensuring all staff are fully informed and can support families where needed.	*Initiative standards on the 3rd and 4th February 2016.* *This follows on from achieving Stage 1 in May 2015. In preparation for this assessment there will be a clinical effectiveness update session delivered to all teams in January 2016. There is also a rolling programme of annual updates in place.* *Link to standards: (http://www.unicef.org.uk/BabyFriendly/Health-Professionals/New-Baby-Friendly-Standards)*

Discharge Report		
We said	**Response**	**Progress report on action taken**
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[4]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day. 2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission. 3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all	*Letter from Paul Brennan, dated 25th August:* - Suggested there were flaws in the data analysis - Asked for a further breakdown of data by organisation - Asked for chart colours to have consistence - Detailed a negative bias in the presentation of anecdotes - Significant numbers of statements were generalised - Asking for raw data to be shared with a multi-agency group in Oxfordshire *In a meeting on 13th October with system leaders it was agreed:* - Providers and commissioners will review the recommendations and come back to HWO with a view on	We take the importance of robust discharge arrangements seriously and are actively involved with partners in the health and social care system to work towards timely and safe discharge planning. Patient flow is monitored daily by the trust and our partners. The recent CQC inspection of all community hospitals in Sept/ Oct 2015 noted the following positive practice; - evidence seen by the inspection team of good attention to discharge planning which patients have been seen to have been actively involved in. - Use of FIM to assess fitness for discharge in relation to mobility - MDT meetings observed on two wards with extensive discussions regarding discharge - evidence of active discharge planning and how we work with GPs on discharge planning - evidence of relatives involvement in discharge planning

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[4] See Appendix 1 for the summary pathway

patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan. 4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their admission so that alternative care arrangements for those they are caring for can be put in place. 5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them. 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	what they can take forward from the report. This will be done privately. - We will then all meet again to discuss that, and once all parties are satisfied we will agree a joint statement on the actions that the system will take in response to the report.	A description of the processes and systems in place to monitor and act on delays is described in the embedded document. Processes in place to monitor and act on de Our key priority is to develop and introduce an Alliance Programme with the OUH to transform urgent healthcare services for older people and adults who have complex health problems across Oxfordshire, covering both bed and community services. Work has been underway for the last year and we hope to sign the alliance in 2016. Work as part of the 'winter pressures' in 2015/16 has started to include sharing the delivery of services between ourselves and OUH to support patient flow and effective discharge planning. Both our community hospitals and adult acute mental health wards use the nationally recognised quality improvement methodology of 'breaking the cycle' each year, where senior clinicians across multi-agencies work very closely together for a week to deliver the perfect pathway and care for every patient across the system, by identifying issues and addressing these immediately. The outcomes and learning from these weeks are used to change routine systems and processes.

planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed. 7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services. 8. The pharmacy pathway should be reviewed, in order to address points in the pathway that are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: • Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged. • Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why.		

• Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. • Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself. 9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries. 10. The electronic discharge summary should be sent to the GP, the patient's nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient		

and his/her carers when s/he leaves hospital. 11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs. 12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge. 13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care. 14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.		

Dignity Report

We said	Response	Progress report on action taken
8. Communication is improved between staff and patients and their families, understanding that this communication must be two-way. 9. Access to support services which facilitate dignified care be more widely promoted and offered. 10. Discussions about maintaining dignity are included in staff training and induction, and that this training should include: dementia awareness, limiting jargon and using plain English, two-way communication and a broader understanding of dignity. 11. Providers and commissioners work to ensure staff have the time to care, by increasing the proportion of time they spend with patients. This could be done through continued work to improve processes and paperwork, work to decrease staff sickness or through increasing allotted time for specific tasks.	**OHFT:** • Will be consulting on a revised patient experience and involvement strategy from November 2015. • Has introduced the use of the recovery star which supports the identification of joint goals and joint monitoring of progress across all community adult mental health teams, with training for all staff. • Has developed a full programme of initiatives designed to embed personalised care and improve patient and carer involvement in planning their own care across all the Trust's services. • Is working with Age UK to help older people to stay as independent as possible, to ensure they have the information they need and to introduce initiatives such as having volunteers working as care navigators at some of the community hospitals and dementia advisors working alongside staff in memory clinics. • Has extensive relevant training programmes in place and will be	The initial consultation process for developing our Patient Involvement and Experience Strategy is in progress, started in November 2015. There have been extensive discussions with stakeholders and we have held a series of workshops in Dec 2015 and are planning more with service users, carers and staff. The initial consultation document has also been shared widely and has been placed on the internet as well as tweeted. Following this the next steps are that we will have a follow up workshop in January 2016 to feedback to service users/ carers our progress to date and to prioritise the suggested objectives for the draft strategy. The draft strategy will then be shared widely for comment in Feb and March 2016 before being approved by the Trust Board in April 2016. The '10 Dignity do's' have been shared with all staff as part of our monthly update on patient experience and are included in our training for the Care certificate for Health care Assistants. *6. How many care navigators are in hospital and what is the take up of the service?*

12. Commissioners and providers in Oxfordshire broaden the discussion on dignity in work places, so that it encompasses all elements of dignified care (the Dignity Do's can provide a guide) and that this discussion inform training and the development of care models or pathways. 13. Staff be helped to focus on the balance between patient choice and dignity, particularly when patients have a diminished capacity to make choices. 14. Providers do further work to develop an open culture that learns from complaints and isn't defensive so that patients and carers feel able to make complaints/report abuse without fear of repercussions.	making an additional recommendation to the next Learning and Advisory Group in December 2015 that the Dignity Do standards are taken into account when they design and review training courses going forward. • Will review the current trust-wide core questions used across all patient surveys to include a specific question around dignity in care so that they can monitor and target improvements. • Will continue the practice that all wards complete at least a 6-monthly review of the amount of direct care time spent with patients split by registered and unregistered staff, and will continue to present the results to the board of directors and to publish them, as well as asking each ward team to review the detail of their results to identify and make improvements.	There are two different projects which are being trialled to help patients to access information and support in their community. One is provided by Age UK as part of the Circles of Support and the other is being piloted by GPs in Oxford City. Staff from the Circles of Support visit the community hospital wards and care navigators employed by the GPs are contacted by telephone, which is facilitated by community hospital staff. In addition to care navigators each Community Hospital uses a number of volunteers to support patient care and has monthly PALS visits to help sign post and provide information for patients. *7. Can you update us on any review of trust-wide feedback questions?* We review our Trust core questions every financial year and will be including a question about dignity from April 2016. We will be asking out Taking Action from Patient Feedback Group to agree the question to propose to the Trust Board for approval. *8. Are there any improvements of direct care time to report given your ongoing review?* There are a number of wards that have been reviewing their direct care time for some time and have been able to show that by changing

		some practices they have been able to increase the amount of face to face time staff have with patients. As a trustwide exercise, however, we have only completed it with all wards once, providing a benchmark, and are due to undertake it again by the end of January 2016. Whilst we have asked wards to reflect on the outcomes of the first review, we will not be able to demonstrate any changes until after the second review.
Outstanding from 2014 report		
We said	**Response**	**Progress report on action taken**
	2) **What is the current trend (over the last 6 months) in terms of waiting times and what progress has been made towards meeting targets?** The percentage of young people having their first routine appointment within 12 weeks of referral for April to Nov 2014 was 63% against target of 75%. The main pressures are in Tiers 2 and 3, which are being monitored and efforts made to address. These reflect an increase in demand which is being mirrored nationally.	2. *Can you update us if this has improved or worsened?* The PCAMHS (tier 2) and Tier 3 community mental health services for children and young people remain under great pressure as referrals have increased by 49% over the last 3 years. Currently, 50% of new referrals are being seen within 12 weeks against a 75% target (based on referrals made in August 2015). The services are employing locum staff to help support a waiting list initiative. There are ongoing discussions with the Oxfordshire commissioners on how this can be addressed in the longer term. The waiting times continue to be closely monitored and reported to the CCG.

OxNa - December 2014		
Report recommendations	**OUHFT Response**	**Progress report on action taken**
1. Recognise that the population of those with a neurological condition requiring long term support within the community is increasing and the capacity of existing statutory and voluntary sector services for this patient group therefore needs to grow to keep pace with demand. 2. Give greater recognition to informal carers, and care provided by the voluntary sector, and provide appropriate support for both. 3. Improve the joining up of care for this patient group, in particular where patients have more than one condition.	In November 2014, Healthwatch Oxfordshire in collaboration with the Oxfordshire Neurological Alliance published the results of a survey on the care of patients with neurological conditions in Oxfordshire. We would like to make the following comments – both relating to the report, and also as an update to the recommendations as stated below in italics. ***General comments*** • The range of "neurological conditions" is wide, and it is difficult to put all of these under one heading. For example, the type of care required for patients with migraine will be different from that for patients with epilepsy or motor neuron disease. While some general principles may apply, it is not possible to generalise "neurological care". This concern is fully in keeping with Healthwatch's recommendation to emphasize the needs of the individual person.	1. The population is ageing, diagnostic facilities are improving, as are medical treatments. There is therefore little doubt that the prevalence of chronic disease is increasing across all categories, including neurological conditions. Some aspects of the care of a chronically ill person will be generic across specialties, but other aspects will require specialist input. This is where disease specific services and support will be required to support informal and voluntary carers, and patient care in the community. We outline neurology specific input below. 2. Recognition of and support for carers is provided in various ways by the different specialist services within neurology. A large part rests on the Specialist Nurses, some of whom are based in the Community, and others in the Hospital, with close links with each other.

	- While we agree that many patients will require a multidisciplinary approach, we would nevertheless like to point out that for some of the conditions mentioned in the Healthwatch Survey, there is not usually a neurologist involved in the patient’s care or care pathway, e.g. in head injury or for most stroke patients. As we are providing this report as the Department of Neurology, we may not be best placed to comment on the care of these patients. ***Our comments regarding Healthwatch’s recommendations (shown in italics):*** *1. Recognise that the population of those with a neurological condition requiring long term support within the community is increasing and the capacity of existing statutory and voluntary sector services for this patient group therefore needs to grow to keep pace with demand.* *2. Give greater recognition to informal carers, and care provided by the voluntary sector, and provide appropriate support for both.*	Many of the Specialist Services run information events for patients and carers. These include, amongst others, Seminars for Parkinson’s Disease (aprogramme called “First Steps”, supported by Parkinson’s UK), courses for patients with recently diagnosed multiple sclerosis - including educational days for children who have parents with MS. Relatives and carers for patients with chronic neurological conditions are always encouraged to come along to clinic appointments with doctors or specialist nurses to gain more information, and to find answers to any questions they may have. Patients and carers are provided with contact information, so they know who to get in touch with, and how, if there is a problem. This will often be the specialist nurse, who will either be able to answer the query her-/himself, or to identify the specific support that is required, including medical advice if needed. Our specialist services work closely with the relevant voluntary sector organisations, such as the Motor

	3. *Improve the joining up of care for this patient group, in particular where patients have more than one condition.*	Neuron Disease Association, Parkinson's UK, or MS Trust/ Society, amongst others. 3. Many chronic neurological conditions affect different body systems. For example, patients with motor neuron disease can develop breathing problems, and will often also require specific procedures to ensure adequate nutritional intake. Such multiple requirements are usually met in the multidisciplinary clinic and service, for example, in our clinics for motor neuron disease, multiple sclerosis, neuromyelitis optica, neurofibromatosis type 2, or multisystem atrophy. It would be desirable for patients to have joint up care for unrelated health conditions – for example, a patient with Parkinson's Disease may also have heart problems. An overall care coordinator may be helpful here. We are currently not aware of any such developments in the Oxfordshire CCG. Overall there are now developments that will bring the care for

		neurological conditions, and the involvement of neurology services closer to the community. While neurology was so far specialty commissioned, from the next financial year a large part of neurology commissioning will be provided by the CCG, providing an opportunity for closer linking up of services. Similarly, Oxford University Hospitals has over the past year acquired Foundation Trust status, and is also under new leadership, with a renewed commitment to providing services closer to the community. This will undoubtedly also have an effect on the provision of neurology services. We are working closely with the CCG to enhance accessibility and community availability.

Families' experiences of ante and post-natal community services (Home Start)		
We said	**OUHFT Response**	**Progress report on action taken**
1. GP practices consider parents of very young children a priority when offering appointments. 2. Midwives and Health Visitors be required to incorporate basic parenting and baby care as part of their routine support to all new parents. 3. Service providers prioritise continuity of care between individual staff and families, so that parents can develop productive and trusting relationships with those providing them with support.	**Parenting and baby care:** There is a discharge proforma that covers a range of issues to do with parenting including co-sleeping. The maternity service understands the need for a flexible approach to antenatal care provision and offers drop in services in children's centres, midwifery led units and local hospitals. They also offer home visits and an evening service in certain locations. In the postnatal period the midwives have to prioritise needs of individuals in planning care. The aim is for all women to be risked assessed at home and an appropriate care package agreed in consultation with the mother. To provide a flexible service to fit around the needs of the woman and her family, care is provided in variety of local settings to i.e. Home and in drop-in clinics at children's centres and local hospitals / midwifery led units	1. To be completed by GP practices.

	In the antenatal period, parent education classes are provided to pregnant women focusing on a range of issues including birth preparation, feeding and some aspects of parenting care. In addition, other groups have been set up to support some of the more vulnerable pregnant women in the community across the county. These groups will focus more on parenting and baby care. Midwives visit women for a short period of time after birth (usually up to 10 days). In the postnatal period, the staff endeavour to work with new parents to provide basic parenting and baby care. The community have maternity support workers who are able to give additional support to any vulnerable women or mothers who have been identified as requiring further assistance. **Continuity of Care:** Where possible, continuity of care is provided. If a patient is with a consultant team, there will be a linked Advanced Nurse Practitioner who cares for the family. There are a range of specialist teams including Diabetes, cleft palate,	

	Cardiology, cystic fibrosis, spina bifada, orthopaedics. However, continuity of care is not always possible due to an increasing number of part-time workers, flexible working arrangements, annual leave and sickness. Midwives are linked to GP practices and the teams support families within communities.	

Discharge Report

We said	**OUHFT Response**	**Progress report on action taken**
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	*Letter from Paul Brennan, dated 25th August:* • Suggested there were flaws in the data analysis • Asked for a further breakdown of data by organisation • Asked for chart colours to have consistence • Detailed a negative bias in the presentation of anecdotes	The Trust is collating comments from Oxford Health, Oxfordshire Clinical Commissioning Group, and Oxfordshire County Council, to provide a response to Healthwatch. The collated response will be sent to Healthwatch as soon as possible.

of the local pathway[5]. Only 9% (6) patients who were in hospital when they participated in the study and 29% (37) of those who had already left hospital reported having their EDD discussed with them for the first time on the day of admission or the next day. 2. Patients should be assigned a named Discharge Co-ordinator and be given the details of how to contact that person at the point their Estimated Date of Discharge is set or on admission. 3. The "Planning for Discharge" ward poster produced by OUHT should be redesigned as a leaflet that is given to all patients and their families. Their Discharge Co-ordinator should discuss it with them. This leaflet should include a space for the name and contact details of the Discharge Co-ordinator and information on who to contact if a patient is unhappy about their discharge plan. 4. For patients who are also carers admitted on a planned care pathway, a Discharge Co-ordinator should be assigned before their	• Significant numbers of statements were generalised • Asking for raw data to be shared with a multi-agency group in Oxfordshire *In a meeting on 13th October with system leaders it was agreed:* • Providers and commissioners will review the recommendations and come back to HWO with a view on what they can take forward from the report. This will be done privately. • We will then all meet again to discuss that, and once all parties are satisfied we will agree a joint statement on the actions that the system will take in response to the report. • **A joint system response to this report is expected before Christmas 2015. At the time of drafting this report it had not yet been received.**	

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[5] See Appendix 1 for the summary pathway

admission so that alternative care arrangements for those they are caring for can be put in place. 5. That Discharge Co-ordinators should have training in communicating with patients and families so that communication is two-way. It is about 'involving' others and not just about 'informing' them. 6. That the Discharge Co-coordinator should formally record the involvement of the patient and his/her carers in discharge planning and decision-making. A written copy of discharge planning decisions (in plain English) should be given to the patient and the carer every time this is updated and reviewed. 7. These notes on discharge planning decisions should include clear information about what services and equipment the patient will be getting, who will be providing them, when they will start and how to use any specialist provision, and whether there might be any costs to patients for these services. 8. The pharmacy pathway should be reviewed, in order to address points in the pathway that		

are causing delays leading to patients waiting for medications upon discharge and to spread good practice. Specifically: • Patients should routinely receive 2 weeks' worth of the medications they need 24 hours before they are discharged. • Discharge summaries should state clearly what changes have been made to prescriptions (start/ stop/ change/ continue) and why. • Patients' nominated pharmacies should be emailed or notified electronically at admission so that dosette boxes can be suspended and emailed or notified electronically again on discharge with a copy of the discharge summary. • Trusts should urgently identify processes in the discharge pathway which are causing delays, such as the timing of when prescriptions are sent, or capacity issues within the dispensing itself. 9. The electronic discharge summary report should be redesigned with input from hospital staff, GPs, care providers and pharmacists. Hospital staff should be trained in how to write any new summaries.		

10. The electronic discharge summary should be sent to the GP, the patient’s nominated pharmacist, and any care provider on the day of discharge, and a hard copy should be given to the patient and his/her carers when s/he leaves hospital. 11. Wherever appropriate and possible, discharging clinicians should also phone and speak to the GP particularly when discharging patients with complex care needs. 12. Hospital doctors should take responsibility for chasing results of tests they order before discharge and communicating the results to GPs and patients after discharge. 13. A protocol for hospitals sharing information with care providers should be agreed, for the situations when a patient from a care home or with an existing package of care is admitted to hospital - and its use should be enforced so that care providers have time to arrange changes to care. 14. Trusts should undertake a root cause analysis of a random sample of patients re-admitted within 72 hours and review findings relevant to improving the discharge process.		

Dignity Report		
We said	**OUHFT Response**	**Progress report on action taken**
8. Communication be improved between staff and patients and their families, understanding that this communication must be two-way. 9. Access to support services which facilitate dignified care be more widely promoted and offered. 10. Discussions about maintaining dignity be included in staff training and induction, and that this training should include: dementia awareness, limiting jargon and using plain English, two-way communication and a broader understanding of dignity. 11. Providers and commissioners work to ensure staff have the time to care, by increasing the proportion of time they spend with patients. This could be done through continued work to improve processes and paperwork, work to decrease staff sickness or through increasing allotted time for specific tasks. 12. Commissioners and providers in Oxfordshire broaden the discussion on dignity in work places, so that it encompasses all elements of dignified care (the Dignity Do's can provide a	**OUHFT:** • Has co-produced a new Privacy and Dignity Policy with voluntary and partner organisations. • Delivers a Trust wide weekly compassionate care training programme which is aimed at providing participants with an appreciation of the impact of behaviour and attitudes on the patient, and an understanding of effective communication styles with those who are vulnerable. A total of 322 employees have currently attended the training. • Will review advocacy arrangements at the Trust with a view to ensuring that access to advocates and other support is improved. For example, information will be put in patient packs to promote Oxfordshire Advocacy services more widely. • Is undertaking a new piece of work with Independent Mental Capacity Advocates (IMCA) - to raise profile of IMCA services with consent to	1. What progress has been made in putting the privacy and dignity policy into practice? The policy has been ratified and widely disseminated internally and externally. 2. How many members of staff have now attended compassionate care training? 536 members of staff to date (16 December 2015). 3. What was the outcome of the advocacy review? There will be a full advocacy review in 2016. 4. What specific actions have been taken to raise the profile of the IMCA advocates? There was a nursing grand round on the 15th December which discussed the role of IMCA, the Mental Capacity Act, Restraint and Deprivation of Liberty Safeguards.

guide) and that this discussion inform training and the development of care models or pathways. 13. Staff be helped to focus on the balance between patient choice and dignity, particularly when patients have a diminished capacity to make choices. 14. Providers do further work to develop an open culture that learns from complaints and isn't defensive so that patients and carers feel able to make complaints/report abuse without fear of repercussions	treatment and moving residents. • Includes training on dignity and respect its Induction Day for all staff and will review this session and other training on dignity and respect. • The Trust implements a 3 tier approach to delivering Dementia training to staff, ranging from simulation training using actors (Tier 2) for those staff working with patients with dementia every day, to awareness training at tier 1 for all staff in the Trust. There is eLearning to support all the face to face training. There is a cohort of Dementia Leaders (24) who were trained through a university short course so that they can in turn provide training to other staff in the Trust. • The Trust is also in the process of implementing a means by which it can understand exactly how much 'direct' and 'indirect' time (i.e. managing a complex discharge process) Nurses and Nursing Assistants spend with patients. • The Trust has recently implemented a new PALS escalation system for Inpatients in order to resolve issues speedily. • The Trust is piloting and evaluating a regular Carers' Surgery, whereby	5. Has the review of induction training occurred? What was the outcome? What is the feedback from staff on the training? The Trust will review the relevant parts of the induction programme, particularly in relation to safeguarding, privacy and dignity, in 2016. 6. What percentage of staff have completed the Dementia Awareness training, and what is the feedback from staff on the training? Approximately 6000 have been trained so far. The feedback is the training is relevant. People say it makes them think about dignity of the person with dementia and the effect the dementia has on the families. 7. Please update us on the implementation of the review of direct and indirect care time. The tool for reviewing indirect and direct care time is ready to go and the Trust will be commencing data collection early in 2016. There is still no National directive on this from NHS England.

	Carers Oxfordshire are working in the JR for 21 hours a week on hospital wards offering support, advice and signposting for carers so that they can gain information and support.	8. How has the carers' surgery pilot been received? What has been the uptake of the service? Carers, therapists, ward staff, and the social work team have all received the service very positively and have welcomed the additional support. The Outreach Worker has held 4 surgeries to date, the first held on the 1st December on the Stroke Ward at the John Radcliffe. In total, the outreach worker supported 16 carers during these surgeries. Discussions are underway to have a similar sessions on the Gerontology wards. During December, 6 referrals were made by staff to the Outreach Worker, who then contacted the patient or carer to provide further support. The support provided included a manual handling session, a carers' assessment, and signposting to other organisations. Overall, the Outreach Worker has had contact with 23 carers in December.

		In 2016 Carers' Policy will be developed within the Trust, in cooperation with Carers Oxfordshire, Carers Voice, Oxfordshire County Council, and Oxford Health NHS Foundation Trust.

Appendix 1 – Service provision for patients with Motor Neurone Disease

- The Oxford University Hospitals NHS Foundation Trust (OUH) Motor Neurone Disease (MND) clinic works very closely with voluntary and community services.
- Each new patient has an average of 5 referrals.
- Community neurology nurses are situated in Oxford Centre for Enablement (OCE) and work in the community.
- The MND clinic has very close links with the motor neuron disease association, locally and nationally, which provides carers' grants and information for carers and patients.
- The local MND association has recently offered OUH a service for new patients to support them filling out applications for benefits.
- The MND clinic has put a traffic light respiratory care plan in place, which aims to identify respiratory issues at the earliest point, to avoid a hospital admission. The MND clinic team also works very closely with the respiratory team.
- The MND clinic team has been successful in administering Percutaneous Endoscopic Gastrostomy (PEG) tubes in the community, which are well supported by Abbot nurses and community dietitians.
- The MND lead practitioner is currently upskilling an agency to specialise in MND support. Training has been given in moving and handling, PEGs, and management of MND.
- The MND team provides holistic support to the whole family and acknowledges that the condition has a huge impact on carers. Signposting, information, and 1-1 support is provided.

111 – response to Telegraph Article

We said	Response	Progress report on action taken
Following the publication of a Daily Telegraph report, detailing an undercover investigation and the statements issued by your organisation in response, we wrote to you to request the following information: • What is the procedure when ambulances are stacked? Are ambulance’s always sent to people who have symptoms indicating a heart attack and /or not breathing as the investigation revealed this may not always be the case. What assurance have we got ambulances are sent when required? • Your recent report for Bracknell Forest Council Health Overview and Scrutiny panel suggests a rise in “hear and treat” and a decline in “see and treat” and also “see, treat and convey”. Is this due to a lack of paramedics, changes in policy, changes in the script meaning less ambulances sent or staff interpretation and manipulation of the callers? • Red 1 and Red 19 figures. What is the audit process for checking any times have been changed within the system? The report suggests times of arrival can be changed.	No response received	

- How many private ambulances and crews are currently being used by SCAS within the Thames Valley and how are their calls handled and monitored? - Human Resources. What is the procedure for recruiting staff and what checks are made? We require this information for both the call centre staff and for clinicians? - Whilst we accept some people do not necessarily require an ambulance the report suggests call handlers manipulate conversations to make callers answer "no" to certain questions. How is this practice being addressed?		
999 - call response delays		
We said	**Response**	**Progress report on action taken**
At a recent event in Carterton three incidents were reported to us: - A patient with a suspected heart attack waiting an hour for an ambulance at Brize Norton - A child with a dislocated knee waiting an hour for an ambulance at a school - A child with a fracture waiting over 1/2 an hour for an ambulance at the Cotswold Wildlife Park	**Letter from Will Hancock dated 10th November 2015** The performance call answer information above is for the Trust as a whole as we do not have a call centre for Oxfordshire and do not have data solely for this area. SCAS operates a virtual call centre telephony platform. This means that all calls are answered irrespective of the location of the patient or the Emergency Call Taker (ECT) and are presented automatically to the first available agent for assessment. We have 2 Emergency Operations Centres (EOC'S), one	1. Has performance improved with the implementation of the strategy mentioned?

In addition we have recently had 2 reports of 999 calls not being responded to. A member of the public called on behalf of patient in Oxford City Centre under the influence of alcohol, it took 15 minutes for the call to be picked up and no ambulance was despatched. A patient on Blackbird Leys had their 999 call go through to an answerphone, and so had to go into the local GP surgery to get them to try and call 999. **Please can you let me know whether your internal performance monitoring suggests a deterioration in call pick up and ambulance dispatch times in Oxfordshire in the last 3 months, and if so what steps are being taken to address this?**	located in Bicester and the other in Otterbourne, Hampshire. We have not been routinely achieving the 5 second standard; however, the difference between the formal standard and the patient experience is likely to be no more than one or two rings. For the period from May our call answer has been: May: 6 seconds, June: 12 seconds, July: 6 seconds, August: 11 seconds and September: 5 seconds. It might also be useful for you to know we monitor the number of calls that are abandoned before being answered which would give you a further guide to any potential impact of this delayed call answer. Year to date in Oxfordshire the performance levels have been: Red 1 71.78% Red 2 71.54% Red 19 93.38% Green 30 82.34% Green 60 90.72% We do recognise that the 999 service remains under pressure, partly due to workforce challenges and the continuing need to make financial savings. We have a clear strategy to	

	integrate our services further with our partners to ensure best use if made of front-line ambulances whilst other patients receive the right advice and referrals where appropriate.	
Outstanding from 2014 - Further Investigation into Mental Health and A&E Experiences of Students in Oxford - October 2014		
We said	**Response**	**Progress report on action taken**
Improve the 111 telephone screening process in emergency situations and improve publicity around the service to ensure students know how and when it can be used	SCAS will ask the University if they identify any specific gaps to inform us.	Was this request made?

Outstanding from 2015 **Sign Lingual - Access to Healthcare Services for Deaf People - June 2014**		
Report commendations	**Actions promised**	**Update on action promised**
This project revealed that there are a significant number of issues currently being experienced by Deaf people in accessing healthcare services throughout Oxfordshire, and that these are leaving them at a disadvantage compared to hearing patients living within Oxfordshire.	1) Has additional training been developed and or delivered? Please give details. This will be actioned in early 2015.	What action was taken in early 2015?
Oxford Family Support Network - A Local Experience of National Concern - May 2014		
Report recommendations	**Actions promised**	**Update on action promised**
The report set out a very detailed set of recommendations to	Lay presence at Board. We have not progressed this to date. We hope to develop this over the coming year.	Has any progress been made on this?

commissioners of services for people with learning disabilities, mental health needs and challenging behaviours. Southern Health was asked to respond as a key provider of these services.	HEF – this has been trialled in Hampshire but not utilised yet in Oxfordshire.	

OxNa - December 2014

Report recommendations	NHS England Response	Progress report on action taken
1. Recognise that the population of those with a neurological condition requiring long term support within the community is increasing and the capacity of existing statutory and voluntary sector services for this patient group therefore needs to grow to keep pace with demand. 2. Give greater recognition to informal carers, and care provided by the voluntary sector, and provide appropriate support for both. 3. Improve the joining up of care for this patient group, in particular where patients have more than one condition.	***Email from Eva Morgan (NHS England) 7/11/14*** We are also currently running an audit with headache patients to understand their experiences of services both in primary and secondary care; the analysis should be completed by the end of November so it may be useful to share this with Heath Watch Oxford as well as Oxford Neuro-Alliance	1. What was the outcome of this review? 2. Was the report sent to OXNA?

Formal letters

NHS England - Campsfield House, PPF GP contract

We said	NHS England Response	Progress report on action taken
To Sue Staddon from Rachel Coney by letter on July 29th 2015 Dear Sue, Concerns re healthcare provision at Campsfield House As you are aware Healthwatch Oxfordshire has been alerted by local voluntary organisations to the possibility that the provision of healthcare in Campsfield House may not be meeting Home Office Detention Service Orders. As a result I know you are actively investigating a number of possible safeguarding issues, and that you will in due course be reporting to the Oxfordshire Adult Safeguarding Board on those individual cases. I recently toured the centre, and met with several of the staff as well as the centre manager and Home Office officials. The question that no-one has been able to answer to my satisfaction, is how NHS England, as the commissioners, assures itself that the service is being delivered in line with all aspects of the	*Sue Staddon by email on 10th September 2015* The Campsfield contract and performance is monitored in the same way that they are at all our prisons, police custody suites, SARCs, SCH and for Liaison and Diversion Schemes: Each provider completes the Health and justice Indicators of Performance and these are checked by the lead commissioner monthly. Each lead commissioner meets with the providers on a quarterly basis to ensure that the service specs are being adhered to and that the services are of the applicable quality. Our partners (in this case Mitie and the HO) are invited to attend those meetings. A report is prepared for the quarterly partnership boards where performance and quality are discussed. Any actions from an HMIP or IMB report is discussed at the partnership boards.	

service specification and is meeting appropriate quality standards. This letter is therefore a formal request that you explain to Healthwatch Oxfordshire, in detail, how you monitor this contract and what systems of checks and balances you have in place to assure yourself that the providers declared contract compliance is accurate and truthful. I look forward to receiving your response within the statutory 30 working days. In the meantime the offer I made at the stakeholder group to advise with your team on developing KPIs for this contract remains open, and I would be happy to meet with Liz in September to progress this. To Sue Staddon from Rachel Coney by email on 18th August 2015 Dear Sue, Thank you for this summary of your contract management process. It appears that there is no service user feedback built into these contract monitoring processes, and I would be grateful if you could explain how you gather and use patient/service user experience data to verify provider's reports and assure yourselves that the performance as reported by the provider, matches patient reported experience of services.	A schedule of Quality Visits has been drawn up for all our establishments and Campsfield is on the list though, due to capacity in the Nursing and Quality Team there is no date for that to take place yet. Thank you for your offer to help with KPIs – unfortunately we have had to publish these with the advert for procurement but your input to review in 2017 would be very helpful. I am working with the Oxford Safeguarding team regarding the issues raised. Unfortunately there was little evidence or information provided but we are confident that they have been addressed. I hope that assures you. *From Sue Staddon by email on 10th September 2015* Health and Justice are always very keen to get feedback from service users. Providers are expected to carry out patient satisfaction surveys and the NHS Friends and Family test. Complaints and compliments are reported to the Partnership boards. HNAs and our internal quality visit includes focus groups with prisoners and detainees as do the HMIP and CQC inspections. Campsfield has its own challenges due to the number of different languages but our provider reports in the same way as our other providers. I also understand the healthcare provider attends the weekly detainee consultative committee.	