**Form to be completed in response to Annex A questionnaire**

**UK COVID-19 Inquiry: Module 3 - Request for information**

*Please provide your organisation’s answers to the questions set out in Annex A, below. Please limit the response to all questions to no more than 2000 words in total if possible.*

**Name of organisation completing this questionnaire:** Oxford Health NHS Foundation Trust

**Question 1:** A brief overview of your organisation’s function and role in relation to healthcare

services and systems in the area in which you are based, and specifically in relation to the Covid-19 pandemic (for example if that function or role developed or changed).

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| Oxford Health NHS Foundation Trust provides physical health, mental health, learning disabilities and autism services and social care for people of all ages across the counties of Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and Northeast Somerset.    The Trust employs approximately 6000 staff members and delivers services from more than 150 different sites. Services are delivered at community bases, hospitals, clinics and in people’s homes.   * Bath and Northeast Somerset, Swindon and Wiltshire: mental health services for children and young people and eating disorder services * Buckinghamshire: mental health services for children, young people, adults and older people * Oxfordshire: physical health services, mental health and eating disorder services, learning disabilities and autism services for children, young people, adults and older people |

**Question 2** Specifically in relation to your organisation’s role or function delivering and/or

arranging for healthcare services (point 1 above) in your area, what your organisation

considers to be the key issues relevant to the matters set out in the provisional outline

of scope for Module 3.

This could include, but is not limited to:

**Question 2A** Responses to the pandemic - what went well and what did not go so well, and what you are most proud of;

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| Some examples of the specific changes and innovation include:   * Both the Buckinghamshire and Oxfordshire improving access to psychological therapies services expanded to help more people access mental health treatment to overcome the trauma of illness, loss of loved ones, lockdown and unemployment as a result of Covid-19. * The Trust became the highest user of digital consultations in mental health services across the county, completing more than 170,000 digital consultations in the year with patients or their families. This has revolutionised how we are able to work and provide care however also recognise there remains an important place for face-to-face contact and care for some patients and their families. * Oxfordshire CAMHS neurodevelopmental conditions pathway team developed an online observational video autism diagnosis tool in respond to the pandemic in order to continue to offer evidence-based assessments for autism spectrum disorder in children and young people. The new tool has had a positive impact on overall waiting time. * School nurses provided support to Oxfordshire secondary school pupils regardless of whether schools were open or not during the pandemic. They offered support for young people and parents via a number of ways including at the end of a telephone or web call. The nurses put together two special offers to help ease the strain of isolation and stress caused by living through the pandemic, including ‘wind down Wednesday’ a relaxion session for young people and a special service for parents to access. * Increased collaboration and working between organisations in Oxfordshire to improve care for patients and their families receiving end of life care at home. The community nursing services led on a number of initiatives for the system including use of oral end of life medicines that relatives could administer for symptom control, training of paid carers and care home on the use of IV cannulation and fluids and set up telephone lines for both staff members and patients and relatives. * Virtual visits were introduced on wards – a video messaging project which launched in community wards initially, with each patient bed assigned a table or iPad which was specially configured, secure and easy to use. * Letters to a love one scheme was established, to help when visiting was restricted, to ensure families and friends could keep in touch. * Virtual carer support groups were set up, free educational online seminars were held for carers and family members of patients on a number of topics such as understanding suicidal thoughts and self-harm behaviours, understanding anxiety, understanding depression and improved wellbeing for carers. * A Carer befriending line was set up which was run by a combination of volunteers and staff. * The physical disability physiotherapy service went digital to help people to stay active. An online service was created for people with Parkinson disease. The service also switched to online classes. * Two learning disability experts by experience from the community and patients from Evenlode ward recorded their Covid-19 experiences for an international book project, which was published online. * The Oxford Health charity used grants to help staff to buy bicycles as a sustainable and healthy way to commute to work   **Source: Quality Account, OHFT 2020/2021** |

**Question 2B** Examples of how the particular healthcare systems your organisation operated in worked effectively and efficiently;

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| **Key learning across the system**  The devastating impact of COVID-19 has represented a challenge to our communities and across our services on a scale of which we have never seen before in our lifetime. However it has highlighted the incredible value we add when we work flexibly across health, local government, business, and the voluntary and community sector. This is especially the case when we join up preventative and capacity-building services with demand-led acute services in order to reduce the demand on acute services and, more importantly, to improve outcomes for Oxfordshire residents. This is the most important piece of learning for the system and work continues through the recovery stage to build upon this. Below outlines some of the other key learning points during COVID-19 from across health and care:   * **Teams at the OHFT and OUH have led the way, at a national level, in the roll-out of new digital services:** Patients were able to continue to access services during the COVID-19 lockdown without having to attend hospital, by using video consultations. Before the pandemic, very few departments at OUH were using technology to conduct remote consultations with patients. But since its launch in the middle of March 2020 (until 6 September) 17,278 such consultations have been carried out using the Attend Anywhere (AA) platform, allowing clinical teams - from cancer to paediatrics, from haemophilia to antenatal care - to continue delivering vital services to patients. Similarly OHFT were able to roll out digital consultations rapidly; as one of only seven mental health [Global Digital Exemplar](https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/exemplars/mental-health-global-digital-exemplars/) trusts, clinicians were already embracing digital innovation and had already started to trial digital consultations with patients. When COVID-19 hit, OHFT were therefore able to respond rapidly – in January nearly all consultations were in person (only 14% remote, 86% face to face), whereas now the majority are remote (53% remote versus 47% face to face) - remote includes phone, digital, email. This allows OHFT to continue to offer important therapy to patients, but to do so in a way that is as safely distanced as possible for patients and staff. OHFT has now surpassed 60,000 online consultations; it is believed OHFT has achieved the highest number of digital consultations in the country. * **Collaboration on research:** OUH, in collaboration with its academic partners, have led trials that are helping to shape the optimal treatment of COVID-19 throughout the world; and through the Jenner Institute OUH have supported the development of a vaccine that might stop its future spread. * **Supporting BAME communities:** as it became apparent that people from BAME communities were being more adversely affected by COVID-19 the NHS and local authorities further developed relationships and worked with community and religious leaders to raise awareness of staying safe during COVID-19; information was developed and distributed to support the Muslim community; primary care social prescribers focused on BAME needs and translation services available; this was also supported by Healthwatch reaching out to community links and providing community support. * **Data sharing / Health Information Exchange (HIE)**: HIE was launched; the system presents clinicians with information about their individual patients from both OUHT patient record and the Primary Care patient record. The view is live, which means the most up to date information is available to support direct patient care. For example, following discharge from hospital, GPs have direct access to test results from hospital rather than waiting for them to be sent. The tool also provides access to the Digital Care Plan and is accessible to GPs working in the COVID-19 clinics. The system has been in the planning for two years, it took 13 days of dedicated collaborative effort from a multi-disciplinary, cross-organisational team during the early days of the pandemic to make it available. * **Multi-disciplinary team / organisational approach**: for example there was a coordinated primary, acute and community care response across Oxfordshire to deliver COVID-19 clinics and a home visiting service to support people with coronavirus in the community. This rapid response brought together the people and resources of the Oxfordshire GP practices, Primary Care Networks, GP federations, acute and community teams from OHFT and OUH, supported by OCCG, Oxfordshire County Council and other partners, into one co-ordinated team effort.   **Source:** COVID-19 *Restart, Recover, Renew* Update for Oxfordshire Health Overview and Scrutiny Committee for meeting on 24 September 2020; written by Oxfordshire Clinical Commissioning Group |

**Question 2C** Examples of how the particular healthcare services your organisation delivered and/or arranged for were adversely affected; and

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| **Difficult aspects of the response:**   * The ownership of the local response was given to the ICSs. The ICS have no legal status as they are not a statutory body although CCGs are a Category Two responder and SCAS are a Category One responder under the Civil Contingencies Act (CCA) 2004. There had been no prior training or exercising of this command structure. * Information came in avalanches and was a scatter gun approach. Information was received too quickly and too late. It was received from NHSE/I, Ministry for Housing, Communities and Local Government (MHCLG), the Strategic Coordination Group (SCG) /Tactical Coordination Group (TCG), the Department of Health & Social Care (DHSC) and PHE. * EPRR led the command and control, coupled with the ICS locally leading the health response, this was not the normal chain of command, the communication flows had not been rehearsed, and the ICS was ill prepared to resource and lead the health response locally. * National and regional guidance changed frequently, even on the same day it was produced. Some of this had poor details of the originator, governance and version control. * Some organisational resourcing and partnership working initially got overwhelmed. * Over time the ICS supported by NHSE/I got to grips with the management and leadership of the local health response and communications between partner agencies improved. * There was no consistency in the representation of health into the TV LRF structure that was put in place apart from the SCG/TCG, which meant there was a variation in approach and the level of input/expertise plus the communications lines were blurred.   Why did these difficulties arise?   * The command structure through EPRR and the local leadership through the ICS was a regional decision made by the SE Incident Director. * The uniqueness of this particular pandemic simultaneously being global impacted on the availability of PPE supplies as much of the UK stock is made abroad. We were in unknown territory in a response of this nature, particularly as there is no vaccine or anti-viral available. * Different information sources through LRFs dealing with MHCLG and producing the Common Operating Picture, and DHSC through NHSE/I also producing its own situation reports. * From the start the HM Government introduced the process of Contain, Delay, Mitigate and Research. These were overlapping processes but were completely new and different to the established Detection, Assessment, Treatment, Escalation and Recovery (DATER) principles which were the foundation of all outbreak and pandemic planning. * The sheer volume of information in a fast-moving environment accounted for different guidance being communicated.   **Source:** Thames Valley Local Health Resilience Partnership Covid-19 Response Phase One - Debrief Report, July 2020, Gail King, Head of EPRR, NHS England and NHS Improvement – South East (HTV) |

**Question 2D** How particular groups of your organisation’s local population, patients or staff were adversely affected.

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| National a higher number of NHS staff from BAME communities contacted the virus. Across Oxford Health NHS Foundation Trust (OHFT) we introduce a process to assess the level of risk for staff according to personal characteristics (e.g. age, ethnicity) and underlying health conditions. This result in a number of staff working in lower risk environments or from home during different point of the pandemic.  **Source:** page 10, OHFT Quality Account 2020/2021 |

**Question 3** Following on from the previous question, a brief summary of any key lessons learned

that your organisation identified in relation to its responses to the Covid-19 pandemic,

including the impact on healthcare services you operate and healthcare systems your organisation operated within, and how any lessons might apply in the future.

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| **Learning**  Some key changes we can learn from include:   * changes to inspections and revalidation, and regulatory obligations freed up time to focus on urgent patient care and the response to the pandemic. * optimising data requests and data sharing. The pandemic saw the suspension of certain data requests from national bodies such as NHSE/I, NHS Digital and the CQC. We worked with Commissioners to reduce the data we sent locally.  This has raised questions about how we can optimise the value of our data through focussing on collecting the most important information and enabling it to be shared widely and used many times, thus minimising time-consuming or duplicative data requests. * providing support via better use of digital tools. The pandemic saw teams innovate and accelerate the use of digital tools to an unprecedented extent. Alongside the progress made through virtual consultations and appointments, we saw simple innovations help manage bureaucratic burdens and Trust meetings continue through the use of technology. * streamlining of recruitment and onboarding processes. Temporary changes to onboarding and recruitment requirements helped to manage resource flexibly * mission-orientated decision making. During COVID-19 there has been clear guidance from the centre about what to prioritise, allowing organisations to make their own decisions empowering executive staff and their expertise to move processes forward more quickly. This has also helped to frame collective objectives and responsibilities shared by all staff within the organisation. * single view of staff.  Work has been initiated to develop a single view of a staff record given the challenges experienced, including the inability to automate reporting during the pandemic.  The oversight of completion of risk assessments, vaccination records and establishing characteristics such as ethnicity and other risk factors was labour intensive due to how staff data is currently held.     The last 12 months have empowered leadership teams across the Trust to make dramatic changes to the way they operate. This has sharpened and accelerated decision-making and radically altered working cultures.  We all want to encourage leaner and lighter governance structures, with fewer committees, shorter and simpler Board reporting, which look forward and plan for the future, and spend less time assuring and looking backwards.  Some bureaucracy will always exist due to the complexity, and risk of healthcare but the Trust will aim for ways of working to become more efficient and flexible, representing the current and future needs of health and care. For this necessary bureaucracy, ongoing investment in digital technology and flexible working practices will make processes more streamlined, intelligent and accessible to those who need care.  The COVID-19 pandemic has shown us that streamlining bureaucratic processes can release time for our workforce to prioritise care. The NHS has introduced changes within weeks that that have been talked about for years. Managers and regulators have paused some data requests and streamlined inspections, liberating and empowering frontline staff to focus on delivering the best care possible. Now is the time to capitalise on these experiences by creating an environment and culture where staff are released from unnecessary bureaucratic burdens, leading to better outcomes and experience for patients and care users.  A supportive culture, at every level, is just as important as specific actions to streamline bureaucracy. In fact, the success of the improvements we want to continue will be impacted by how leadership at every level of the Trust embraces them. Each team must question and call-out organisational habits or local rules which increase excess bureaucracy. Everyone needs to play their part in achieving ‘enabling’ governance systems.  **Source:** AC 13/2021 COVID-19: Changes in governance and the risks of the pandemic report to the Meeting of the Oxford Health NHS Foundation Trust  Audit Committee on 24th February 2021 by Kerry Rogers, Director of Corporate Affairs & Company Secretary |

**Question 4 (Please note you are not limited to the number of rows set out below)**

A **list** of key documents or categories of documents that your organisation has produced which you consider to be most relevant to points 1-3 above and the provisional outline of scope for Module 3 .

Please provide a brief description of the document/categories of documents and the reasons why you consider them to be particularly relevant. *For example, these could be Incident Team meeting action logs, Executive/Board minutes and reports, Serious Incident Reports, papers relating to key*

*internal policy and/or procedure changes etc.*

*We are not asking for day to day types of documentation relating to treatment of patients such as patient records, theatre lists or staff rotas as we know these will exist. We also do not need published guidance from public bodies such as PHE (now UKSHA) or NHS England.*

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| **Categories of document or key document produced by your organisation including document title and date (with link if publicly available)** | **Brief description** | **Why it is particularly relevant** |
| See table below | See table below | Describes OHFT response to Covid-19 pandemic |

Covid-19 documents have been collated from various sources listed below:

* Audit committee
* Board
* Communications bulletins
* Covid-19 risks
* Debrief reports
* Data protection impact assessments
* Ethics groups
* Psychosocial response group
* Recovery group
* Strategic meeting minutes
* Tactical incident management team meeting minutes

Other sources include:

* all emails from [emergency.response@oxfordhealth.nhs.uk](mailto:emergency.response@oxfordhealth.nhs.uk) inbox
* incidents stored in the Trust incident reporting system

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| Source | Document | |
| **Audit committee** | 24/02/2021 13 AC Covid-19 Changes in clinical and corporate governance and associated risks | |
| **Board** | 26/11/2020 79 BOC Legal and regulatory update  26/11/2022 26 RR App 27 BOD Legal regulatory update appendix | |
| **Communications** | 03/02/2022 – 25/05/2022 152 bulletins | |
| **Covid-19 risks** | C19\_1\_TRR\_PPE\_1.0  C19\_1\_TRR\_PPE\_1.1  C19\_1\_TRR\_PPE\_1.2  C19\_1\_TRR\_PPE\_1.3  C19\_1\_TRR\_PPE\_1.4 MC amendments  C19\_2\_TRR\_staff wellbeing\_2.0  C19\_2\_TRR\_staff wellbeing\_2.1  C19\_2\_TRR\_staff wellbeing\_2.2  C19\_2\_TRR\_staff wellbeing\_2.3  C19\_2\_TRR\_staff wellbeing\_2.4  C19\_2\_TRR\_staff wellbeing\_2.5  C19\_3\_TRR\_MHA\_3.1  C19\_3\_TRR\_MHA\_3.2  C19\_3\_TRR\_MHA\_3.3  C19\_4\_TRR\_data risk\_4.2  C19\_4\_TRR\_data risk\_4.3  C19\_4\_TRR\_data risk\_4.4  C19\_4\_TRR\_DPIA\_draft\_2  C19\_4\_TRR\_DPIA\_draft\_3 C19\_4\_TRR\_DPIA\_draft\_4  C19\_4\_TRR\_DPIA\_draft\_5 | C19\_5\_TRR\_Physical Healthcare on wards\_5.0  C19\_5\_TRR\_Physical Healthcare on wards\_5.1  C19\_5\_TRR\_Physical Healthcare on wards\_5.2  C19\_6\_BAME Staff\_6.0  C19\_6\_BAME Staff\_6.1  C19\_6\_BAME Staff\_6.2  C19\_6\_Risk to Staff\_6.1  C19\_7\_Learning Disabilities\_7.0  C19\_7\_Learning Disabilities\_7.1  C19\_8\_Infection Prevention and Control\_8.0  C19\_8\_Infection Prevention and Control\_8.1  C19\_8\_Infection Prevention and Control\_8.2  C19\_8\_Infection Prevention and Control\_board assurance\_1.0  C19\_9\_Return to Work\_9.1  C19\_9\_Return to Work\_9.2 |
| **Debrief reports** | 22/06/2020 OHFT debrief command and control  29/07/2020 TV LHRP Executive debrief report  09/03/2021 Local outbreak management plan response OHFT  01/04/2021 Local outbreak management response health protection board  19/04/2021 OHFT Provider debrief slide deck  10/06/2021 BOB ICC Debrief  25/06/2021 TV LHRP BMG reflections on phase one Covid-19  08/2021 46 (ii)\_AC\_OH Covid-19 review final report  08/2021 Final TV LHRP Debrief report covid 19 Wave 2 v1.0 | |
| **Data protection impact assessments** | 33 documents | |
| **Ethics group** | 12 documents | |
| **HSE investigations** | 4 documents | |
| **Psychosocial response group** | Documents from March 2020 to March 2021 | |
| **Recovery group** | Documents from April 2020 to November 2020 | |
| **Strategic group** | Minutes 09/11/2020 - 07/01/2022 | |
| **Tactical group** | Minutes 10/02/2020 – 28/01/2022 | |

**Question 5 (Please note you are not limited to the number of rows set out below)**

A **list** of any key articles or reports your organisation has published or contributed to, and/or evidence it has given in public regarding the matters set out in the provisional outline of scope for Module 3. *Please note that we are* ***not*** *requesting copies of the documents at points 4-5 at this stage. However, it would assist the Inquiry if you could provide hyperlinks for those documents that are publicly available.*

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| **Document title and date (with link if publicly available)** | **Brief description** | **Why it is particularly relevant** |
| Please see response to question 4 |  |  |

**Question 6** Any other points that you wish to raise in relation to the issues identified in the

provisional outline of scope for Module 3 that your organisation considers would assist the Inquiry to understand those issues more effectively.

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**Thank you for providing your response! The Inquiry is grateful for the information you have provided. Please ensure you include your organisation’s name at the top of the response and send it to solicitors@covid-19.public-inquiry.uk**