***Notice of Meeting*** Public Document Pack

# Oxfordshire Joint Health Overview & Scrutiny Committee

## Thursday, 10 November 2011 at 10.00 am
## County Hall

**Membership**

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Dr Christopher Hood

| | | | |
|---|---|---|---|
| *Councillors:* | Jenny Hannaby<br>Don Seale | C.H. Shouler<br>Val Smith | Keith Strangwood<br>Lawrie Stratford |
| *District Councillors:* | Hilary Hibbert-Biles | Susanna Pressel | Rose Stratford |
| *Co-optees:* | Dr Harry Dickinson | Ann Tomline | Mrs A. Wilkinson |

***Notes:***

***Date of next meeting:*** *19 January 2012*

**What does this Committee review or scrutinise?**

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

**How can I have my say?**

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

**For more information about this Committee please contact:**


Chairman - Councillor Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk

Committee Officer - *Roger Edwards, Tel: (01865) 810824*
*roger.edwards@oxfordshire.gov.uk*


Peter G. Clark.

Peter G. Clark
County Solicitor

November 2011

## About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

## About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

## What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

**If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting**

**A hearing loop is available at County Hall.**

# AGENDA

## 1. Apologies for Absence and Temporary Appointments

## 2. Declarations of Interest - see guidance note on the back page

## 3. Minutes (Pages 1 - 14)

To approve the minutes (**JHO3**) of the meeting held on 15 September 2011 and to note for information any matters arising from them.

## 4. Speaking to or Petitioning the Committee

## 5. Public Health (Pages 15 - 22)

**10.10**

The Director of Public Health will bring the Committee up to date on progress in the development of the Oxfordshire Health and Wellbeing Board. A paper (**JHO5**) is attached.

## 6. Appropriate Care for Everyone (ACE) Programme (Pages 23 - 30)

**10.30**

The aim of the ACE programme is to bring health and social care organisations across Oxfordshire together to deliver and commission health and social care services that would provide every adult with care that is acceptable and appropriate to their needs in the 21st century.

The expected outcomes are:

- A viable community provision that would avoid admissions and deliver a comprehensive Early Supported discharge service across the county for the 18+ population
- Reduced over-dependence on acute care and bed based long term care in Oxfordshire
- Improved and increased utilisation of community staff and a reduction in the quantity of acute provision
- A fundamental change in culture and practice and in the way providers work with each other, especially across the integrated clinical pathway approach
- A joint health and social care approach that would be delivered and sustainable

Alan Sinclair, Lead Commissioner Social Care for Adults and Fenella Trevillion, Head of

Partnerships at the PCT will explain the programme and outline the practical implications for care services across Oxfordshire.

A paper (**JHO6**) is attached.

## 7. Oxford University Hospitals NHS Trust - strategy update (Pages 31 - 40)

**11.30**

The Oxford University Hospitals NHS Trust is currently in the process of updating its strategy. The strategic review is taking place within the context of the recent integration with the Nuffield Orthopaedic Centre NHS Trust, the strengthening of the relationship with the University of Oxford and other health and social care and academic partners and the preparation of the Trust's foundation trust application.

A paper (**JHO7**) is attached that provides an update on the emerging themes from this review of the Trust strategy. The paper:

- Identifies the drivers for changes faced by the Trust.
- Summarises the key emerging strategic themes and objectives.
- Identifies potential service changes.
- Describes how the Trust intends to ensure there is full stakeholder engagement

The Chief Executive of the Trust, Sir Jonathan Michael, and Mr Andrew Stevens, Director of Planning and Information, will explain the strategy and answer questions.

Members of the public and councillors from Banbury will address the Committee to explain concerns that they have over the future direction of services at the Horton General Hospital.

Mr Ian Davies, Chair of the Community Partnership Network (CPN) for Banbury and the surrounding area, will also be in attendance to talk about the future plans for consultation between the NHS and the CPN.

## 8. Chipping Norton Hospital Staffing (Pages 41 - 44)

**12.40**

At their last meeting the Committee agreed that the question of the employment of nurses at Chipping Norton Hospital should be revisited at this meeting. That was because the Chairman was waiting for a reply to a letter that had sent to the Secretary of State in July seeking Independent Reconfiguration Panel involvement as an "honest broker".

That reply has now been received and a copy is attached (**JHO8a and b**). Mr Alan Webb (PCT Lead Director) will report on the PCT's latest position on this matter and he will be joined by Mrs Olga Senior (SHA Director of Corporate Affairs) who will represent

the SHA to explain what they have been doing with the PCT to find a solution to this issue.

## 9. Oxfordshire LINk Group – Information Share (Pages 45 - 48)

**13.00**

The regular update from the Oxfordshire LINk is attached (**JHO9**). Sue Butterworth, Chair of the Oxfordshire LINk, and Adrian Chant, LINk Locality Manager, will attend to answer questions. Alison Partridge, Engagement Manager for Oxfordshire County Council will talk about the development of HealthWatch.

## 10. Chairman's Report

**13.20**

The Chairman will report on meetings etc that have taken place since the previous HOSC meeting.

## 13.30 Close of meeting

# Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

**The duty to declare …**
You must always declare any "personal interest" in a matter under consideration, i.e. where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

**Whose interests are included …**
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

**When and what to declare …**
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

**Taking part if you have an interest …**
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

**"Prejudicial" interests …**
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

**What to do if your interest is prejudicial …**
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

**Exceptions …**
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

**Seeking Advice …**
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Thursday, 15 September 2011 commencing at 10.00 am and finishing at 12.45 pm

**Present:**

| | |
|---|---|
| **Voting Members:** | Councillor Dr Peter Skolar – in the Chair |
| | District Councillor Dr Christopher Hood (Deputy Chairman)<br>Councillor C.H. Shouler<br>Councillor Keith Strangwood<br>Councillor Lawrie Stratford<br>Councillor Val Smith<br>Councillor Jenny Hannaby<br>District Councillor Hilary Hibbert-Biles<br>District Councillor Rose Stratford<br>Oxford City Councillor Susanna Pressel |
| **Co-opted Members:** | Dr Harry Dickinson<br>Mrs Ann Tomline |
| **Other Members in Attendance:** | |
| **By Invitation:** | |
| **Officers:** | |
| Whole of meeting | Roger Edwards; Dr Jonathan McWilliam; Dr Shakiba Habibula |
| Part of meeting | As shown in the agenda |
| **Agenda Item** | **Officer Attending** |

*The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.*

## 49/11 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Don Seale and Mrs Anne Wilkinson.

## 50/11 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Councillors Rose Stratford and Lawrie Stratford declared an interest as Chairman and member of the Bicester Hospital League of Friends.

## 51/11 MINUTES

(Agenda No. 3)

The minutes of the meeting held on July 7th were agreed and signed following the addition of the name of Councillor Val Smith to those in attendance.

## 52/11 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

There were no requests to speak or petitions to present.

## 53/11 PUBLIC HEALTH

(Agenda No. 5)

The Director of Public Health, Dr Jonathan McWilliam, updated the Committee on the latest developments with the restructuring of the NHS in Oxfordshire.
Strategic Health Authorities are to be "clustered" with South Central going into a new South of England cluster that will stretch from Kent to Cornwall and up to north Oxfordshire. It is still planned that SHAs would be abolished at end of March 2013.
Oxfordshire PCT staff not in Public Health will be divided between the PCT cluster and the Oxfordshire Clinical Commissioning Group (CCG).
Dr Mary Keenan, Lead GP for the North locality and county lead for planned care, has been appointed to the position of Deputy Leader for the Oxfordshire CCG.
On being transferred to the local authority, Public Health will take on responsibility for sexual health and drugs and alcohol action. There is to be a national model for the public health of 0 – 4 year olds but how this would be dealt with locally remains unclear.
There is continued uncertainty around how much funding will be provided to local authorities when Public Health transfers from the PCT. A national data collection exercise is ongoing to identify how much Public Health costs now and it is likely that, from that, a formula would then be created to allocate funding.
The aim is that shadow budgets would be in place by the end of the calendar year to be followed by HR guidance.
The powers of Health and Wellbeing Boards (HWB) are to be strengthened so that the HWBs have a role in signing off CCG structures and would receive an annual report on the CCG.
The HWB would produce an annual plan based around the agreed Joint Strategic Needs Assessment and the CCG would have to provide an explanation if they were to stray away from the plan.

The Deputy Director, Dr Shakiba Habibula, presented a series of health profiles to the Committee. The profiles provide a picture of health in the individual district council areas of Oxfordshire. Dr Habibula reported that Oxfordshire is a healthy county. The City and Cherwell district lag behind the other districts in some areas but in general health indicators are good in all areas. Red indicators were highlighted and Dr

Habibula explained why they were red and what is being done to improve performance.

Members thanked Dr Habibula for the presentation.

## 54/11 SOUTH CENTRAL AMBULANCE SERVICE - UPDATE ON PERFORMANCE
(Agenda No. 6)

The Chief Executive of the South Central Ambulance Service (SCAS), Mr Will Hancock, reported on response times and new national service indicators.

- Overall 999 and Urgent demand continues to trend upwards
- Overall Red Call performance has held well and shows improvement over the last year – remaining above the national Standard for the PCT area.
- Good improvement in the Red 8 minute performance can clearly been seen in each of the individual districts
- In early July 2011 the new Emergency Control room computer system (CAD) was introduced into Bicester. This is the final phase across SCAS and now means that all three control rooms operate on the same CAD, allowing true integration and resilience across the whole of SCAS.
- Early September saw the switching on of a single virtual telephony platform across all three control rooms, providing even greater resilience and patient safety.
- The CAD installation was wholly successful and performance during the critical 3 months post implementation (during which time staff will become fully efficient) has been significantly above planned levels.
- The expectation is that the improvements (seen particularly across West Oxfordshire and South Oxfordshire during the first part of this year) will be recovered quickly in the second half of this financial year.

**Chipping Norton First Aid Unit Update**

The First Aid Unit (Chipping Norton Hospital) pilot is coming to an end. This pilot has seen an Emergency Care Practitioner based at the new Hospital every week day evening and during a long day on both Saturdays and Sundays.
Its use has been pleasing, with the vast majority of patients who presented themselves being managed locally.
9 Patient experience surveys have so far been returned, with overwhelming support for the service.

**Other Developments**
Since April this year 11 new indicators have been introduced covering the three quality domains of safety, experience and clinical effectiveness. They are:

**Service Experience Indicator** – Patient satisfaction surveys – how ambulance trusts find out what people think of the service they offer and how they are acting on that information to improve patient care.

**Outcome from acute ST-elevation myocardial infarction (STEMI) indicator** - STEMI is a type of heart attack. For many conditions recovery will be more likely and quicker following early treatment. Measuring patient outcomes in this way will allow services to place performance in context and stimulate discussion on how to continually improve.

**Outcome from cardiac arrest: return of spontaneous circulation indicator** – This indicator will measure how many patients who are in cardiac arrest (i.e. no pulse and not breathing) but following resuscitation have a pulse/ heartbeat on arrival at hospital.

**Outcome from cardiac arrest to discharge indicator** – This measures the effectiveness of the whole system in managing those patients who are in cardiac arrest. That is the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.

**Outcome following stroke for ambulance patients' indicator** –This indicator will require ambulance services to measure the time it takes from the 999 call to arrive at a specialist stroke centre.

**Proportion of calls closed with telephone advice or managed without transport to A&E indicator –** Ambulance crews are often able to treat patients without the need to take them to an A&E department. Also, alternatives to A&E may be more appropriate for the patient. This indicator should reflect how the whole urgent care system is operating, rather than simply the ambulance service or A&E, because it would reflect the availability and provision of appropriate alternative urgent care destinations and treatment of patients in the home.

**Re-contact rate following discharge of care indicator** – To ensure that ambulance trusts are providing safe and effective care first time; every time, this indicator will measure how many callers or patients call the ambulance service back with 24 hours of the initial call being made.

**Call abandonment rate** –This indicator will measure how often people who phone 999 are not able to get through.

**Time to answer calls** – This indicator will measure how quickly 999 calls received by the ambulance service get answered.

**Time to treatment by an ambulance-dispatched health professional** – This will measure how long it takes for an ambulance-trained healthcare professional to arrive at the patient 9note; not necessarily an ambulance).

**Category A, 8-minute response time** –This indicator measures the speed of ambulance responses to the scene of potentially life-threatening incidents.

A discussion then took place in which the following points were made:

It is pleasing to see the new emphasis on clinical indicators and indicators that cover the whole patient experience. Work is going on between SCAS and clinical colleagues to improve services particularly by ensuring that patients get to the right place at the right time.

It is good to see improved times and the development of the first responder programme.

There should be more ambulance coverage in rural areas to ensure that all patients have an equal chance of recovery regardless of where they live. There should be more joining up with the Out of Hours service.

Some members questioned whether it was reasonable to expect the same service in rural areas as in urban settings.

More data on “just missed times” (i.e. more than 8 minutes) would be useful.
The number of calls taking more than 30 minutes has been reduced and rural performance has improved with 75% of calls in West Oxfordshire taking 7 minutes or less.
Ambulance demand has doubled in the last 10 years.
It is hoped that the new non-emergency 111 service, which SCAS is bidding to run, will improve the Out of Hours situation as all calls will be brought together to one call centre.

Members thanked the Chief Executive and his colleagues for attending the meeting.
The Chief Executive agreed to provide "meaningful information" on the new performance indicators as soon as it becomes available, probably early next year. He also agreed to let members have information relating to the actual length of time for calls that exceed 8 minutes. Also, the Committee will be kept informed of the outcome of discussions with the PCT about the Chipping Norton FAU pilot (since the meeting the life of the FAU has been extended to the end of January 2012).

## 55/11 RIDGEWAY PARTNERSHIP MERGER/ACQUISITION

(Agenda No. 7)

The Chief Executive of the Ridgeway Trust, Mr John Morgan, together with the Lead Commissioner and SHA lead for the merger process took the Committee through the present situation of the Ridgeway Trust and what is happening to secure its future.
Due to the more challenging financial environment the Trust would be unable to meet Monitor’s financial criteria to achieve Foundation Trust status. Hence they are going through the merger and acquisition process in order to join up with another organisation to achieve sufficient volume to satisfy Monitor.
A lot of interest has been shown in merging and a short list of six bidders has been put together. This will be whittled down to one preferred bidder by January. The successful bidder would then have to provide a business case to satisfy Monitor, the Co-operation and Competition Panel (CCP) and the Secretary of State. The Ridgeway Trust would then be dissolved and absorbed into a new Trust. The exercise is being driven by one overall aim – to find a secure home for services.
Stakeholders, including staff, service users and commissioners, have been involved at all stages of the process and their involvement will continue.

In response to members’ questions the following points were made:

There is no choice about seeking Foundation Trust status; it is a requirement by the Government. The benefits are mainly around greater public engagement in the running of the Trust; the ability to borrow money and a little more independence from the Department of Health e.g. around staff terms and conditions.
The Co-operation and Competition Panel will examine whether there would be any loss of competition and/or choice due to a merger.
It is essential to get on with the process so that service users can be secure and know what is to happen.

The Chairman thanked the presenters, stated that the Committee would note the report, wished them well for the future and congratulated them on the stakeholder engagement.

## 56/11 RECONFIGURATION OF THE GYNAECOLOGY SERVICE AT THE HORTON HOSPITAL

(Agenda No. 8)

The Gynaecology Service at the Horton General Hospital (HGH) delivers elective and emergency care to the local population north of Oxfordshire and the surrounding counties. The Oxford Radcliffe Hospitals Trust recently announced a number of changes to the service.

This is a complex issue that relates not just to change in gynaecology services but also to the much wider issues of reducing activity in acute hospitals, cutting down on numbers of beds, developing day services and/or outpatients for procedures that previously would have required hospital admissions and providing services closer to home.

The Trust has stated that the aim is to create a dedicated gynaecological Day Surgery and Diagnostic Suite that will ensure the following:

- Fewer women living in Banbury and surrounding areas having to travel to the John Radcliffe Hospital due to the expanded and improved volume of services provided locally at the Horton General Hospital
- The creation of new outpatient clinics, including tertiary level services.
- Performing less invasive laparoscopic surgery.
- Avoiding or minimising the need for admission to hospital unless clinically necessary.
- Improving the quality of care for women needing treatment

**Service structure**

- Inpatient and day case surgery will continue to be performed at the Horton General Hospital.
- New diagnostic services will be set up at the Horton General Hospital, including outpatient hysteroscopy clinics, mirroring those running at the John Radcliffe Hospital. This represents an expansion of the existing services provided at the Horton General Hospital and will avoid the need for women to travel to the Women's Centre in Oxford as is currently the case for such procedures, minimises in-patient stay and reduces waiting time for surgery.
- Clinics such as the hysteroscopy clinic will enable procedures to be performed on an outpatient basis as opposed to having to go to theatres and in some instances, avoid the need for an anaesthetic.
- New urodynamic clinics will be set up at the Horton General Hospital. These will match those running at the John Radcliffe Hospital and will benefit women living in Banbury and the surrounding areas, who also currently have to travel to Oxford for this diagnostic service.
- Specialised tertiary clinics such as Reproductive Medicine will commence on the

Horton site, strengthening the relationship between the Horton and the University and enabling local access to highly specialised skills.

- Late terminations of pregnancy due to foetal abnormality will be performed under the care of maternity services at the Horton General or John Radcliffe Hospitals in line with agreed clinical pathways.
- There will be no reduction in the budgeted number of medical staff or changes to their working hours. It is anticipated that the creation of new services will help to recruit medical staff into long-term vacancies, thereby minimising the need for agency staff and improving the continuity and quality of medical support.

**Inpatient beds**

- Advancements in surgical techniques mean that many procedures, which previously necessitated an inpatient admission, can be performed as a day case or outpatient procedure. This has reduced the overall need for inpatient admissions and therefore the number of beds required for the service.
- Gynaecology patients requiring admission will have access to 6 beds on an inpatient ward. These beds can be 'flexed' up or down dependent on clinical need, in line with current practice adopted by all specialities across the Oxford Radcliffe Hospitals.
- It would not be possible for these beds to be ring fenced to the detriment of emergency admissions as this could compromise clinical safety at the Horton General Hospital. As is currently the case, this is managed on the basis of clinical risk, patient need and overall demand for particular specialties. This may mean that emergency cases are on occasions managed between the John Radcliffe Hospital and Horton General Hospital. This is normal practice currently and does not reflect a change in service provision.
- The inpatient beds identified at the Horton General Hospital have three side rooms which have en-suite facilities. This is the same number as on G Ward. Every endeavour will be made to accommodate patients undergoing sensitive procedures i.e. miscarriage into a side room as is current practice across Women's Services.

**Women's Day Surgery and Diagnostic Suite**

- The Women's Day Surgery and Diagnostic Suite will initially be open between 7:30am and 8:00pm.
- There will be 9 day case trolleys and 3 treatment rooms on the unit.
- Patients who require admission to an inpatient bed following day surgery will have their admission organised by the Duty Operational Manager for the Horton General Hospital as is current practice.
- It is not anticipated that patients will travel during rush hour times, as per current practice, and therefore patient travel times will be kept to a minimum. If a patient chooses to have their procedure performed at the Horton General Hospital and their travel time is over 1 hour this will be considered by the listing surgeon when assessing an individual suitability for day surgery.
- The Horton General Hospital currently performs day surgical procedures for patients as far afield as Swindon who choose to attend the Horton General Hospital.

**Emergency Gynaecology patients and clinic**

- The Urgent Gynaecology Clinic will be open between 8:30am and 4:00pm, with the last booked appointment at 2:00pm. This is in line with the hours of service of the clinic at the John Radcliffe Hospital.
- Emergency patients admitted outside of the scheduled opening hours will be seen and assessed in the Emergency Department following discussion between the GP and the Registrar/Consultant. This is in line with the current emergency patient pathway.
- If patients are discharged and require a follow up, an appointment can be made in the Urgent Gynaecology Clinic for the following day.
- Any patient requiring admission to hospital following assessment by the gynaecology medical team will be admitted into an inpatient bed, in line with current practice.
- Hyperemesis (extreme morning sickness) patients requiring admission will be admitted to either a gynaecology inpatient bed or the maternity unit in line with clinical policy, as is current practice.

**Outpatient diagnostic clinics**

- Urodynamic (how the bladder and urethra perform their job of storing and releasing urine) and Menstrual Disorder clinics will be run from the Women's Day Surgery and Diagnostic Suite at the Horton General Hospital. This will expand on the range of service offered at the Horton General Hospital. Patients currently requiring urodynamic assessment have to travel to the John Radcliffe Hospital to have this specialist service performed.
- The new hysteroscopy (the inspection of the uterine cavity by endoscopy) clinic will allow patients to be assessed and treated in an outpatient setting, improving patient experience and matching the service offered at the John Radcliffe Hospital. Patients are currently undergoing this procedure in theatre.
- By treating patients in an outpatient setting as opposed to theatre, patients will benefit and it is anticipated this will assist in reducing surgical waiting times for other gynaecology patients.

Staff and local residents question whether it is all good news. They have raised a number of doubts and queries around the loss of beds throughout the hospital and whether the proposals take sufficient account of knock-on effects elsewhere.

In order for the HOSC to be seen to be acting openly and fairly in this matter the Chairman proposed that a toolkit meeting should take place to ascertain whether there should be full public consultation. It was proposed and agreed that a group of members of the HOSC should be delegated to meet ORH managers and clinicians, staff representatives, members of the Community Partnership Forum from Banbury and the LINk in order to come to a conclusion. No changes would take place at the Horton until after the meeting.

The meeting would take place on October 4th at the John Radcliffe Hospital and the outcome would be made public and reported to HOSC members.

**57/11 SAFE AND SUSTAINABLE REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND**
(Agenda No. 9)

The Chairman reported that Safe and Sustainable have published the results of the initial consultation on the proposals for Children's Congenital Heart Services in England. While the generally preferred choice was option B, that which contains Southampton and the one supported by the HOSC, the Joint Committee of PCTs (JCPCT) has still to meet to come to their decision. Therefore it is important that support for the option should be reiterated.

Caroline Langridge, representing the Young Hearts charity, reported on two positive developments. Firstly that a recently published letter from the Safe and Sustainable secretariat to Sir Neil McKay, the Chair of the JCPCT, had stated the following:

*In October 2011, when the JCPCT next meets, the secretariat will advise the JCPCT that there is no available evidence that could reasonably suggest that a retrieval team from London or Bristol could reach the Isle of Wight in compliance with the time limits stipulated by the PICS standards [Paediatric Intensive Care Society standards for the care of critically ill children], even if the Isle of Wight is considered to be a 'remote area' and measured by the higher time threshold of 4 hours.*

*The secretariat will further advise the JCPCT to take these conclusions about retrievals from the Isle of Wight into account when considering the outcome of public consultation as part of the committee's deliberations to agree an eventual configuration option, and in any necessary re-scoring of options. paper had stressed that the necessary 4 hour retrieval time to get a child to hospital in an emergency could only be guaranteed if Southampton was to be the receiving hospital.*

Secondly Sir Neil McKay had "expressed an interest" in hearing more about the network idea being led by Southampton and Oxford.

Following publication of the consultation report, HOSCs were being given an opportunity to add to their earlier submissions – the closing date for these further statements being October 5th. The Committee agreed that this opportunity should be taken and that Roger Edwards should respond to Safe and Sustainable on behalf of the HOSC. The submission should stress that the best outcomes for quality and safe clinical outcomes could only be achieved by the adoption of Option B.

The Chairman thanked Caroline Langridge for her contribution and the Committee unanimously thanked Young Hearts for their hard work and the hugely important contribution that they had made to the campaign to protect vital services for children in and around Oxfordshire.

**58/11 CHIPPING NORTON HOSPITAL - UPDATE ON POSITION FOLLOWING THE LETTER TO SECRETARY OF STATE**
(Agenda No. 10)

The Chairman explained that Chipping Norton Hospital has been on the HOSC agenda on a number of occasions over the years. Previously it had been agreed by the PCT that, with regard to the employment of nursing staff at the hospital:

i. To enable staff at the Hospital to decide which choice was better for them as individuals, they would be given the option of whether to remain as NHS employees and be seconded to the Orders of St John (OSJ) for a period of three years or to transfer under TUPE to the OSJ
ii. The PCT would not indicate a preference with regard to the above options
iii. In the event that an NHS employed staff member was to leave during the three year period, their replacement would be placed on NHS terms and conditions for the remainder of the three years.

At the end of the three years a review would take place.

The transfer of existing staff has happened in accordance with the first two statements above and all nurses employed in the hospital chose to be employed by the NHS. However the PCT decided that new staff employed during the three year period following the opening of the new hospital would be employed by the OSJ.

At their July meeting HOSC members had agreed to bring this matter to the notice of the Secretary of State for Health and seek his advice on whether or not the Independent Reconfiguration Panel could be invited to review the position.

Following the Chairman's opening remarks the Director of Communications for the PCT, Ronan O'Connor, reported that the PCT was proposing to bring forward the review of the new Chipping Norton Hospital from three years to two and that any staff employed during that time would be employed as NHS staff.

Before discussing the PCT's latest position the Chairman reported that there had been no reply yet from the Secretary of State to the latter sent on behalf of the HOSC in July.

Councillor Biles stated that, in her opinion, the HOSC should wait for the Secretary of State to reply before agreeing anything with the PCT. She considered that it would be reasonable for a review to commence three months before the three years were up.

The Chairman asked members to consider whether what the PCT was suggesting was reasonable.

Councillor Pressel stated that she would agree with the compromise suggested by the PCT but would insist that no change should take place until the review was completed.

Mr O'Connor stated that local GPs considered the two year offer to be a reasonable compromise. He further said that the PCT would consider Councillor Pressel's point.

Councillor Stratford suggested that Mr O'Connor should take the HOSC's views back to the PCT, gat an answer and come back to the HOSC in November by when, it is to be hoped, the Secretary of State might have got around to replying.

**The Committee supported Councillor Stratford's proposal and Mr O'Connor agreed to come back in November.**

Councillor Shouler proposed that HOSC members should visit Chipping Norton Hospital to see how such a modern facility operates. Mr O'Connor agreed to arrange a visit.

## 59/11 FUTURE WORK PROGRAMME

(Agenda No. 11)

Two possible items were considered for the work programme; Drug and Alcohol Addiction Services and GP services for prison inmates.

Members agreed to set up a working group to consider the former item but not to purse the latter.

Councillors Smith and Hannaby and Dr Dickinson agreed to participate in the working group.

Councillor Hannaby proposed and the Committee agreed to add maternity services as an item for a future HOSC meeting.

Councillor Pressel wished to see regular updates on waiting times at the Oxford Radcliffe Trust hospitals. It was pointed out that this information is available regularly via the Trust's website.

## 60/11 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 12)

Mr Adrian Chant, the LINk Locality Manager for Oxfordshire, reported that the transition to HealthWatch is moving forward. The LINk Steering Group is to hold a stakeholder event on 28th November. Mr Chant will provide members with further information.

The LINk is to undertake a review of continence services and will meet parents an carers in early October. The Adult Services Scrutiny Committee will consider the LINk report.

The LINK would wish to liaise with the Committee on the maternity review when the time comes.

The latest LINk update had been circulated to HOSC members and the next Steering Group will be held in October. The outcome of the meeting will be included in the next update.

## 61/11 CHAIRMAN'S REPORT

(Agenda No. 13)

The Chairman reported that informal meetings had taken place with the Chief Executive and Directors of the ORH and the Chairman and Chief Executive of the PCT.

He also reported on a meeting that had taken place with PCT commissioners in connection with ambulance patient transport. This is the service that transports patients to hospital for outpatients appointments (i.e. not the emergency service). The commissioners reported that, in order to reduce costs, they were to begin enforcing criteria that had been in place for some time but which had been interpreted loosely. This had led to a situation where patients who were able to get to the hospital under their own steam had been using the service. In future only those patients whose medical needs require it would be able to use the service. They had consulted widely on this matter and would ensure that the changes would be well publicised before they were implemented. On that basis, and bearing in mind that no patient with a genuine need would lose the service, the Chairman had agreed that no formal consultation would be required. The Committee endorsed this action.

The Chairman had attended a meeting with colleagues from Buckinghamshire and the PCT to discuss the matter of "Any Qualified Provider". This is a Government initiative intended to increase patient choice. Any provider of NHS services will need to be qualified and registered to deliver a range of specified services within a community setting. They will have to meet certain standards for the quality of the care they offer. This will not be based on price - a single price for services will be paid to all qualified providers of that service.

Nationally eight community and mental health services have been selected and each area has to identify three of these for change to be in place by September 2012. Other services which are of higher local priority may be chosen, if there is a clear case based on the views of service users and potential gains in quality and access.

The eight services are:

1. Musculoskeletal services for back and neck pain
2. Adult hearing services in the community
3. Continence services (adults and children)
4. Direct access diagnostic tests
5. Podiatry services
6. Wheelchair services (children)
7. Leg ulcer and wound healing
8. Primary care psychological therapies for adults

Locally the following services have been identified by the PCT as priorities:

1. Adult hearing services in the community
2. Direct Access diagnostics
3. Podiatry

The PCT states that these services have been chosen because they believe that there is real potential to improve local access, the care pathways are relatively simple, and the current contract commitments mean that change can be achieved within the timescales set by the government.

The Government had instructed PCTs that they should undertake local engagement over the proposals (but not consultation). The Committee agreed that they would accept the action being taken by the PCT.

..... in the Chair

Date of signing .....

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# OXFORDSHIRE JOINT HEALTH AND OVERVIEW SCRUTINY COMMITTEE

## THURSDAY 10 NOVEMBER 2011

## Developing Oxfordshire's Health and Well Being Board

### Introduction

This paper sets out proposals for establishing a Health and Wellbeing Board for Oxfordshire. Health and Wellbeing Boards are a significant element in the Government's strategy of joining up the health policy of the NHS and Local Government, working alongside other partners including the new Healthwatch organisations. Upper tier Local Authorities will be required by statute to create Health and Wellbeing Boards once the new Health and Social Care Bill is enacted. The responsibilities proposed by Government for Oxfordshire's Board can be summarised as:

- preparing a Joint Health and Wellbeing Strategy (JHWS) for the whole population of Oxfordshire, covering all age groups. This will drive the development and delivery of services to meet agreed priorities;
- ensuring that there is a Joint Strategic Needs Assessment (JSNA) that provides for the Board a strong evidence base and a clear analysis of population need. This will help in agreeing priorities and objectives, for the Board.
- having oversight of the joint commissioning arrangements for health and social care across the County;
- building on and developing further a range of partnership arrangements to drive the strategy and service delivery;
- having in place robust arrangements for the involvement of Healthwatch in establishing and agreeing the Board's objectives and priorities.
- oversight of the involvement of the new Clinical Commissioning Groups (i.e. the new GP commissioners) in joint planning across the County

The Board will be the only structure with responsibility for the health and wellbeing of people in a defined geographical area. The welcome decision of Oxfordshire's GPs to have a single Clinical Commissioning Group for the county means that this responsibility is shared. This degree of co-terminosity is rare in England, and gives a good basis for effective and efficient partnership working across local government and the NHS.

The Government stresses the importance of partnership and joint working as being fundamental to achieving better and more efficient use of resources and meeting peoples' needs. The improvement and further development of partnership working across Oxfordshire will be a fundamental objective for the new Board. There are already extensive partnership arrangements between the NHS and Local Government covering services for children and young people, older people, people with a learning disability and mental health services. They include pooled budgets and joint or lead commissioning arrangements.

The new Board will actively review these arrangements and propose any developments that are necessary to ensure that the Board's objectives are met, that services are delivered, and that all the available resources are used in the most efficient and effective manner. This is likely to lead to new and exciting partnership arrangements between the NHS and Oxfordshire's Local Authorities.

**Current Arrangements in Oxfordshire**

The County has had a Health and Well Being Partnership since September 2007. It has taken a broad overview of the major challenges facing the County in achieving key health improvement targets, ensuring that there is an overarching framework for services for older people and people as they age, and considering service initiatives across the NHS and local government.

The County's Children's Trust has been established since April 2006. During this time it has developed and agreed a single multi-agency Children and Young People's Plan (CYPP), it has provided performance challenge through the CYPP Dashboard (including Local Area Agreement targets), it has overseen the delivery of joint commissioning initiatives in key areas, and it has championed involvement of young people, parents and carers in partnership working

The arrangements for the Children's Trust and the Health and Well Being Partnership placed them as two of a range of partnerships working within the overall objectives established by the Oxfordshire Partnership Board and the Public Service Board.

The District Councils have had, and will continue to have, a very significant and substantial role in the development and delivery of a range of services that are central to achieving the public health objectives for Oxfordshire. The proposals outlined in this paper build on this and see it as one of the cornerstones of the new arrangements.

The experiences of the Health and Well Being Partnership, the Children's Trust and other important local partnership arrangements, and the extensive use of formal partnership agreements, give a breadth and depth of experience from which to develop. However the Health and Wellbeing Board is a new enterprise and it will not be merely a series of adjustments to the current arrangements. The experiences of the current arrangements across the county are important, particularly for understanding what works and what should be improved in county-wide partnership working, but the Government's proposals mean that there are now new opportunities to be grasped.

**A New Board and New Opportunities for Changing Times**

Times are increasingly challenging in the public sector.
Finances are tight for everyone and the NHS and local government are facing unprecedented change. At the same time demographic pressures mean that we must find new ways of working together and must create new solutions to old problems: we cannot go on as we are. A new generation of services based on the principles of prevention, the engagement of communities and joint effort between organizations must be found. At the same time, the expectations of the public are increasing and a new style of locally and individually responsive services is required.

There has never been a time when it is more important for the public sector, independent sector- and people of Oxfordshire themselves - to pull together for the common good and find new ways of combining our efforts to maximize both taxpayer's money and the aspirations of local people themselves.

Challenges must be turned into opportunities - opportunities which well-crafted Health and Wellbeing Board arrangements can capitalise on.
Among these are:

- The opportunity presented by more decentralization, fewer top-down targets and the ability to set our own agenda for Oxfordshire, concentrating on the results we think are important for our population.
- The opportunity to create a meaningful strategy for health in Oxfordshire which selects a limited number of key outcome measures to be focused on by all partners.
- The opportunity to use the local knowledge of GPs and who have been given considerable power to commission around half a billion pounds worth of services each year. GP sensitivity to local issues and what actually works on the ground can now be harnessed in our joint efforts.
- The opportunity to work in partnership with the largest GP-led Clinical Commissioning Group in the country which is almost coterminous with the County boundary.
- The opportunity to strengthen the governance of our considerable pooled budgets and to bring these into the mainstream of our joint commissioning activity.
- The opportunity to solve once and for all long-standing management problems such as delayed transfers of care.
- The opportunity to break the cycle of deprivation and improve life chances for children and young people across the County, building on initiatives such as family intervention the new children and young peoples' hubs.
- The opportunity to integrate locality working with top-down oversight of County outcomes
- The opportunity to work in partnership with the public, service users and carers to create a single county strategy for health and well-being capitalising on new ways of harnessing the power of Healthwatch and scrutiny committees
- The opportunity to strengthen the good work of the existing Children's Trust
- The opportunity to find new and effective ways of working with the voluntary sector as it develops its functions of advocacy and service provision.
- The opportunity to review and reduce the plethora of joint meetings spawned over the years.
- The opportunity to find new ways to engage clinicians and service providers in strategic discussions
- The opportunity strengthening our joint work on public health and health improvement by aligning the efforts of the public health team more closely with district councils and other partners

In short, if we can grasp these opportunities in designing the new Health and Wellbeing arrangements we can bring the dream of 'One Oxfordshire' a step closer.

**We Are Already Well-placed to Move Forward In Oxfordshire**

The structures we have created and the shared experience we possess means that we are well-placed in Oxfordshire to grasp these emerging opportunities.

The recipe for success is likely to lie in:

- Building on what already works well
- Revising existing arrangements while maintaining stability
- Giving the new arrangements more teeth to deliver on what really matters for Oxfordshire.
- Establish the new Board as a body with executive oversight while keeping the requirement for delivery local
- Incorporating new responsibilities while streamlining over-complex and inefficient ways of working

This goal of keeping the best of the old while achieving a gear-shift in terms of delivery has shaped the proposals that follow.

**Developing the Health and Wellbeing Board and Partnership arrangements.**
The proposals put forward for Oxfordshire are in summary:

1. To establish a small, strategic **Health and Wellbeing Board** which steers practical Partnership work on health and wellbeing across the County and ensures service improvement through demonstrable improvement in outcomes. This will be a formal committee of the County Council.

2. To establish three Partnership Boards to deliver the service change required and to deliver improved outcomes through partnership working. The three Partnership Boards will include NHS Trusts, local authorities, clinicians, and voluntary organisations in their membership. The proposals for the three Partnership Boards are as follows:

   - To establish a new **Health Improvement Board** - This board will take forward a work programme to develop health in the broadest sense, incorporating, the new Local Authority responsibilities for Public Health, housing issues, recreation, leisure, use of green spaces etc. This agenda builds on work that has partly been carried out by the existing Health and Wellbeing Partnership and also by Local Strategic Partnerships. This is a very broad agenda which requires local leadership and it is therefore proposed that the Chairmanship should be from the district councils on a rotating basis. It is expected that this agenda will be developed fully during the next year. The board will wish to consider how it works with Local Strategic Partnerships & GP clinical commissioning localities. This will help us to take forward much existing work for example work with sports partnerships, housing associations, support for older people in rural areas and regeneration programmes.

   - To consolidate the existing Section 75 and other health and social care partnership groups into a new **Adult Health and Social Care Board** - This board will commence work as soon as possible as it is proposed that it will responsible for delivery of existing key performance targets for the NHS and County Council and for the joint governance of pooled budgets.

   - To incorporate the existing Children's Trust into a **Children and Young Peoples' Board**. This board will be established quickly and will continue and develop the existing work programme of the Children's trust.

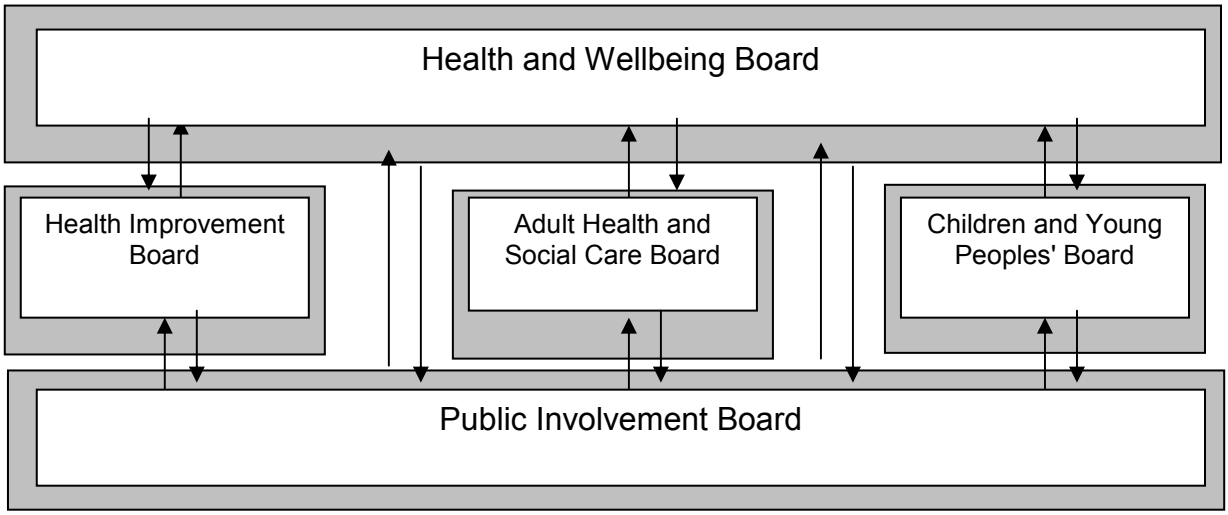
3. To establish a new **Public Involvement Board** under the guidance of the new Healthwatch organisation (LINk in the interim). The detailed development of the Public Involvement Board is proposed to take place over the next year. This will incorporate Healthwatch, service users, the advocacy role of the voluntary sector, advocacy groups and the carers' voice. This is seen as a real step-change and will become an innovative way of strengthening and formalising the voice of the public in service planning and overall strategy.

In summary, the proposed Boards, their major responsibilities and Chairing arrangements are:

| Board | Main roles and tasks | Chairing Arrangements |
|---|---|---|
| Health Improvement Board | ➢ Delivery of outcomes and targets allocated by the HAWB.<br>➢ Public health responsibilities.<br>➢ Recreation, and housing issues,<br>➢ Factors which contribute to health in the widest sense e.g. planning and design of roads, green spaces, cyclepaths etc. | District Councils as Chairman and vice Chairman (using the existing Countywide agreement for District Council rotation) |
| Adult Health and Social Care Board | ➢ Delivery of outcomes and targets allocated by the HAWB.<br>➢ delayed transfers of care, control of demand for services,<br>➢ use and governance of adult pooled budgets<br>➢ development of joint care pathways | County Council cabinet member for Health and Social Care as chairman.<br>GP commissioner as vice-chairman |
| Childrens' and Young Peoples' Board | ➢ Delivery of outcomes and targets allocated by the HAWB.<br>➢ Education issues,<br>➢ Inequalities<br>➢ safeguarding issues<br>➢ development of joint care pathways and services. | County Council cabinet member for Children, Education & Families as Chairman.<br>GP commissioner as vice-chairman. |
| Public Involvement Board | ➢ Ensuring that the views of the public, service users, carers and advocacy groups are a full part of service and strategy development. | Healthwatch (LINk in the interim) |
| Health and Wellbeing Board | ➢ Creation and oversight of a Joint Health and Wellbeing Strategy based on the JSNA<br>➢ Agreeing outcome measures for the supporting boards to achieve. | Leader of County Council as Chairman, Leader of GP Commissioners as vice- |

| | | |
|---|---|---|
| | ➢ Performance monitoring<br>➢ Governance<br>➢ Statutory HAWB responsibilities. | chairman. |

The overall governance structure would be as follows:




**Membership**
The detailed membership of the 3 Partnership boards will require further discussion and debate over the next few months.

Membership of the Public Involvement Board will be guided by Healthwatch (LINk in the interim)

To keep the membership of the Health and Wellbeing Board tight and effective while meeting the Government's minimum requirements, membership is proposed to be:

- County Council Leader as Chairman (reflecting the requirement for the HAWBs to be a committee of the upper tier LA)
- Chairmen of the Public Involvement Board and the 3 Partnership Boards (i.e. 1 x District Council Leader , Healthwatch (LINk in the interim) and the County Council Cabinet members for Adult Social Care and Children, Education and Families .
- Vice Chairman of the Health Improvement Board (District Council Leader)
- 3 General Practice Representatives in their roles as vice-chairmen, including the Lead for the Oxfordshire Clinical Commissioning Group (Required by statute and highly desirable as a way to achieve GP support and also reflect GP locality views.)
- The Directors for Children and Young People, Adult Social Care and Public Health (Government requirements).

- And, in attendance, Chief Executives of the Oxon/Bucks NHS cluster (as a transitional arrangement until April 2013) and County Council (to ensure effective performance and implementation of plans)

**Scrutiny**
These arrangements will be subject to existing scrutiny mechanisms with Oxfordshire's Health Overview and Scrutiny Committee providing a lead role.

**Timetable and next steps**

The timetable for establishing a Health and Wellbeing Board will be as follows:

**September-October 2011**
Discussion and debate with leadership groups across the County and NHS Cluster.

**November 2011**
Final arrangements confirmed by the County Council

**November - December 2011**
First meeting of the Health and Wellbeing Board.

**January -March 2012.**
First meetings of the Public Involvement Board and the 3 supporting Boards

**Conclusion**
The establishment of Health and Wellbeing Board arrangements holds significant opportunities for Oxfordshire.
It is proposed that we draw on our considerable shared experience of working together to create new arrangements which will be more effective than ever before.
This paper sets out proposals for achieving this change in Oxfordshire.

**20th September 2011**

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**Oxfordshire 'ACE' Partnership Programme**

*"The right care for Mrs Oxfordshire in the 21st Century"*

# Report to Health and Overview Scrutiny Committee 10th Nov 2011

## The ACE – Appropriate Care for Everyone – Programme

### Introduction

1. The two current public sector commissioning organisations, NHS Oxfordshire and Buckinghamshire Cluster (OBC) and Oxfordshire County Council (OCC) have come together with the three main health providers, Nuffield Orthopaedic Centre (NOC), Oxford Radcliffe Hospital Trust (ORH) and Oxford Health Foundation Trust (OH), alongside the Oxfordshire Clinical Commissioning Group (OCCG) to form a new partnership.

2. This commitment came out of a meeting of the lead clinicians and managers in each of these organisations on July 7, 2011. This meeting brought together for the first time the new OCCG with the five other organisations to analyse from each other's perspective the issue of delayed transfers of care (DTOC).

3. All the national literature and local reports agreed that delayed transfers of care (DTOC) can only be reduced by doing 3 things:

   - Adjusting present capacity levels in acute and post-acute care
   - Adjusting the discharge process
   - Avoiding the initial admission

4. Within the recommendations of these reports, there were 3 key themes that came out as means to reducing DTOC rates.

   - The need for the right information to the right people – both in the form of information for patients and front line staff about the whole process, as well as robust and relevant data for management from which they can base strategic decisions.
   - The importance of Whole System Working at all levels (not just Whole system working between senior players).
   - Key service changes within the discharge process within acute and community hospital care.

**Aims**

5. All the organisations across Oxfordshire working together delivering and commissioning health and social care, so that every adult can say they are receiving care that is acceptable and appropriate to their needs in the 21st century. Delivered by a systematic, step change approach, signed up to by all partners, that delivers a 'no delay' resilient and responsive integrated health and social care community system.

- To deliver a viable community provision to avoid admissions and to deliver a comprehensive Early Supported discharge service across the county, for the 18+ population.

- To reduce the over dependence on acute care and bed based long term care in Oxfordshire, due to a lack of viable alternative capacity which has led to Oxfordshire becoming stuck in a cycle of risk adverse practice, relying on difficult to access, fragmented provision in the community.

- To utilise the new commissioning levers (e.g. changes in tariffs and new national investment), to allow the development and up-skilling of community staff in a step change approach whilst down-sizing the acute provision.

- To make the substantive change, there is a requirement for a fundamental change in culture and practice and in the way providers work with each other, especially across the integrated clinical pathway approach.

- Ensuring the joint health and social care approach is delivered and sustainable.

**Summary of the ACE Programme - the Five Workstreams**

**6. Model of Care**

The clinical delivery areas it covers are:

- Admission Avoidance (Help keeping me out of hospital)
  Hospital at Home
  Crisis Home Support Service
  Care Home Support Service
  Single Point of Contact and the new 111 service
  Rapid Intervention Service for End of Life Care
  Community End of Life Care Matrons
  GP Triage of Ambulance Cases
  Frequent attenders

- Integrated Community Teams (I know where to go to get the help I need)
  Physical and mental health community teams
  Adult Social Care Locality Teams

- Short Term Community Bed Based Care (When I can't be treated or cared for at home, I go to the right place).
  This is mostly focussed on more effective use of the current 300 beds in community hospitals and intermediate care.

- Maintaining Independence / Long Term Care (I get all the help I need with everyday living)
  Personal Health Budgets and Social Care Budgets
  Respite Care
  Long Term Conditions
  Support at Home
  Self Care
  Re-ablement

- Acute Services (If I need to go to hospital, I get the right care while I'm there and only stay as long as I need to.)
  Early Supported Discharge
  Elective Pathway
  Pathways into hospital
  Pathways during stay in hospital
  Urgent Care Pathways
  Acute / Community Interface: Whole System Pilots North and South
  ORH Discharge Planning

- This will be supported by Workforce Development and culture change

**7. Re-alignment of community bed based care**

In 2010, the criteria for bed based care in community hospitals was taken away, and since then individuals with no further rehabilitation potential have been transferred into community hospitals. This means that at any one time up to 30% of the community health bed stock can be filled with individuals waiting for placement in a care home, and not requiring medical treatment or rehabilitation. Therefore work is underway to develop inclusion criteria for community health beds and community short stay social care beds, to ensure individuals are transferred from acute care into the right place for their needs; this will also reflect the resources these two types of beds are set up for. It is anticipated that the flow through the community health beds will be improved, with more people being able to access these beds each month.

8. Agreement on the transfer of the £6.1m funding from health to social care

Agreement on the areas in which the new money to social care should be utilised was agreed in August, and is already showing results. There is now no individual waiting for funding for support at home, the wait now is for capacity in some areas of the county.

9. New social care emergency/crisis home support service

   The proposal for an emergency/crisis home support service was agreed at September's Older Persons Joint Management Group. With fast track procurement, it is anticipated that this will be up and running in December 2011.

**10. Finance and Governance**

The aim of this work stream is to review, re-align and develop the section 75 pooled budgets that support the delivery of care and support for older people and people with physical disabilities and to ensure the governance of finance and decision making is robust and is led by the Health and Well Being Board.

It has been agreed to develop two commissioning strategies one for older people and one for people with physical disabilities/long term conditions. It is also intended to separate the older people and physical disability elements of the current pool for April 2012 and to review the addition of all Acquired Brain Injury money and some of the neurological money into a physical disability pool. It will also be looking to identify other funding and services that could and should be part of the pooled budget arrangements

**11. Communication**

The aims of this work stream are to

- have a single voice across all the organisations to the public on our commitment to develop the care and services required to abolish avoidable delays
- To have taken the learning that patients and the public have given us over the last four years, and put it into the ACE work
- To have engaged with the people of Oxfordshire to ensure that we have their endorsement of any new plans
- To have engaged with all our stakeholders, so that they have been informed and contributed to the ACE programme
- To have an open and transparent communication delivery by keeping a proactive approach by a live web page and regular briefings / newsletters to all stakeholders including the press

**12. Metrics and Evaluation**

The aim of this work stream is to achieve an alignment of informatics information across Oxford Radcliffe Hospital Trust, Oxford Health Foundation Trust,

Oxfordshire County Council and NHS Oxfordshire and Buckinghamshire Cluster, to reflect the real position on patient flows across Oxfordshire. It will also agree the data set to be used and to have a real time reporting mechanism that demonstrates the time between each step of a patient's journey.

This will mean the whole system has accurate real time information on which to base decisions on and the whole system changes can be monitored over time.

There will also be an external evaluation of the changes and improvements across the whole system in Oxfordshire.

**13. Contracts and Tariff Changes**

The aim of this work stream is to investigate and collate the information on proposed tariff changes in April 2012, to inform the ACE Programme Board of implications so that they can agree the appropriate arrangements to maintain good quality services and patient flows

Alan Sinclair

Lead Commissioner Social Care for Adults

Fenella Trevillion

Head of Partnerships – PCT

1st November 2011

## Appendix One

### ACE Programme Governance

### Terms of reference of Programme Board – September 2011

**Core members**

- Alan Webb – NHS Oxfordshire
- David Bradley – Oxford Health Foundation Trust
- Paul Brennan – Oxford Radcliffe Hospital Trust
- John Dixon – Oxfordshire County Council
- Stephen Richards – Oxford Clinical Commissioning Group

**Associated clinical members**

- Dr James Price – Clinical Director. Medical and Ambulatory Directorate ORHT
- Dr Joe McManners – GP, Consortium Locality Lead
- Pete McGrane – Interim Clinical Director Oxford Health Foundation Trust

**Supporting officers**

- Alan Sinclair – Adult Social care
- Fenella Trevillion – NHS Oxfordshire
- Programme Lead – NHS Oxfordshire
- Sarah Adair – Head of Communication NHS Oxfordshire

**Programme Board responsibilities for the re-design**

- Describe, agree and communicate widely the long term vision
- Be the champions of the change programme
- Develop other people's capacity to be change champions
- To hold to account those delivering the granular plan to deliver the long term vision
- Ensuring continuous communication with all those who can assist in making the changes happen
- Drive the decision making at local operational levels to deliver the change and delegate the responsibility to make it happen
- Drive the use of IT to provide critical information and aid decision making both at the strategic level and at the team delivery level
- Be mindful of reaction of the majority of staff to change causing insecurity, and agree strategies to reduce the impact as far as possible
- Will be the sign off Board for the graduated change programme

**Current day to day leadership**

Will be the responsible cross organisational board for the monitoring on a day to day basis of the system delays – DTOC position and live interventions or changes that need to be agreed and acted on

**Meetings**

To be held monthly, in the week before the Joint Management Group for the Older Peoples and Adults with Physical Disability Section 75 Pooled Budget

When a core member is unable to attend they must send a deputy who authorised is to take decisions

There will be a tele-conference in the intervening weeks between meetings – at the two week mark between the core members and the programme lead

No decisions to making changes affecting the whole system can be made without the approval of all the core members

The programme lead will produce a report for each meeting on the programme progress by each work stream and any other reports requested by the Board meeting – all papers will be sent out one week before Board meetings

**Governance**

Each member is a senior executive of their own organisation and as such will take the responsibility to report regularly to their organisations Boards

The lead representative from each organisation will need to have the authority to make decisions on behalf of their organisation in relation to the programme

This Board will report bi-monthly to the Creating a Healthy Oxfordshire (CAHO) Board, and monthly to the Joint Management Group of the Older Peoples and Adults with Physical Disability Section 75 Pooled Budget. The Board will also report to the Health Liaison Board and to the Strategic Health Authority on request.

There will be an agreed matrix of cross governance with the QIPP Programme Boards as an appendix to the terms of reference

**August 2011**

**To be reviewed February 2012**

**Appendix Two**

# When we get it right for Mrs Oxfordshire

She will have a local support system

She will feel safe receiving Treatment in her own home

Her home will be fit for her needs

She won't feel imprisoned In her home, she can get Out and about

She can manage herself or know how to get help for things of everyday life

When she become unwell services can go into her home. If she needs to go into hospital, it will just be to sort things out and she will then recover at home

She will know who to ring if things go wrong, and get a response and support quickly

**Health Overview & Scrutiny Committee: 10 November 2011**

| | |
|---|---|
| **Title** | **Oxford University Hospitals NHS Trust - Strategy** |

| | |
|---|---|
| **Purpose of paper** | To update the Health Overview and Scrutiny Committee on the development of the Trust strategy. |
| **Board Lead(s)** | Mr Andrew Stevens, Director of Planning & Information |

| **Key purpose – make bold the relevant words(s)** | **Strategy** | Assurance | Policy | **Performance** |
|---|---|---|---|---|
| **Strategic Objectives** | **SO1 To provide high quality general acute healthcare services to the population of Oxfordshire**<br><br>**SO2 To provide high quality specialist services to the population of Oxfordshire and beyond**<br><br>**SO3 To be a patient-centred organisation providing high quality and compassionate care – "delivering compassionate excellence"**<br><br>**SO4 To be a partner in a strengthened academic health sciences system with local academic, health and social care partners**<br><br>**SO5 To meet the challenges of the current economic climate and the changes in the NHS and become a resilient, flexible and successful Foundation Trust**<br><br>**SO6 To achieve the integration of the ORH and the NOC during 2011/2012, realising the benefits as set out in the business case** | | | |

**Oxford University Hospitals NHS Trust - Strategy**

**Report to the Health Overview & Scrutiny Committee on the emerging themes within the Trust's updated strategy and the identification of potential service changes**

**Introduction**

1. The Oxford University Hospitals NHS Trust is currently in the process of updating its strategy. The strategic review is taking place within the context of the recent integration with the Nuffield Orthopaedic Centre NHS Trust, the strengthening of the relationship with the University of Oxford and other health and social care and academic partners and the preparation of the Trust's foundation trust application.

2. The purpose of this paper is to update the Health Overview and Scrutiny Committee on the emerging themes from this review of the Trust strategy. The paper:

    - Identifies the drivers for changes faced by the Trust.
    - Summarises the key emerging strategic themes and objectives.
    - Identifies potential service changes.
    - Describes how the Trust intends to ensure there is full stakeholder engagement.

**Drivers for change**

3. The Trust strategy needs to comprise a robust and effective response to the key drivers for change faced by the Trust over the next five years. These key drivers are summarised in the table below.

| DRIVER FOR CHANGE | IMPLICATIONS FOR OUH |
|---|---|
| Safety and quality standards | • The need to maintain and strengthen the safety and quality of patient care services while responding to strategic challenges.<br>• Participation in service rationalisations/reconfigurations.<br>• Ensuring integrated services across the Trust that achieve evidence-based practice. |
| Financial environment | • £20bn NHS savings to 2014/15<br>• Annual cost improvement requirement for ORH of between 5-6% |

| | |
|---|---|
| Public expectations | • Continued rise in public expectations<br>• Localism agenda |
| Demography and epidemiology | • Ageing population with co-morbidities<br>• Lifestyle influences – especially obesity<br>• Increases in key areas of need and demand:<br>  • Falls<br>  • Cancer<br>  • Coronary heart disease<br>  • Stroke<br>  • Dementia<br>• Areas of high population growth e.g. Milton Keynes |
| Commissioner Strategies | • Cutting out non-essential care<br>  • Demand management<br>  • Procedures of limited clinical value<br>• Intended reduction in acute sector<br>  • Through alternatives and control of flows in and out of acute care<br>• Primary care efficiency/effectiveness |
| Medical workforce issues | • Reduction in the number of training posts<br>• Continued move towards specialisation of medical workforce |
| Reconfigurations | • Safe and sustainable – regional<br>  • Trauma<br>  • Vascular<br>  • Stroke<br>• Safe and sustainable – national<br>  • Paediatric cardiac surgery<br>  • Paediatric neurosurgery<br>• National and regional initiatives<br>  • Emergency and out of hours care<br>  • Sustainability of the current model of the district general hospital<br>• Other<br>  • Neonatal services |

| | |
|---|---|
| Competition | • The need to respond to the any qualified provider policy |
| Technology | • Continued moved towards day case/minimally invasive surgery<br>• Development of drug technologies<br>  • Cost<br>  • Individualised patient drugs<br>• Continued growth of genetics<br>• Informed patient choice |

**Strategy**

4. The Trusts emerging strategy seeks to ensure that the Trust is well positioned to respond effectively to the external environment summarised in the section above.

5. The Trust has developed a set of strategic objectives. These are:

- To provide high quality, general acute healthcare services to the population of Oxford.
- To provide high quality, specialist services to the population of Oxfordshire and beyond.
- To be a patient centred organisation providing high quality and compassionate care – "delivering compassionate excellence".
- To be a partner in a strengthened academic health sciences system with local academic, health and social care partners.
- To meet the challenges of the current economic climate and changes in the NHS and become a resilient, flexible and successful foundation trust.
- To achieve the integration of the ORH and the NOC during 2011/12 realising the benefits as set out in the business case.

6. Within this overall strategic framework, the Trust will, over the next five years, be seeking to deliver increased value to patients, to taxpayers and to its partners. The Trust will seek to:

- Reshape "local" services.

- To deliver alternatives to admission and post admission care.
- To eliminate delays.
- To reduce its bed base.
- To concentrate services into the most suitable buildings.

- To grow clinically and financially sustainable specialist services.
  - To implement the planned reconfigurations.
  - To ensure that all specialist services have a clinically and financially sustainable critical mass.
  - To consolidate and grow the Trust's catchment population for clinical services.

- Develop the academic health sciences system to progress parallel and synergistic strategies for research and development and education and training.
  - To continue to develop the biomedical research centre and biomedical research unit.
  - To continue to provide "bench to bedside" innovation.

7. These high level strategic objectives will need to be underpinned by a step change in efficiency. The strategy will seek to achieve this through.

- Working with partner organisations in the health and social care economy to secure a significant and sustainable reduction in the delayed transfers of care.
- To move towards full seven day working patterns.
- To achieve major productivity gains in areas such as theatre utilisation and length of stay.
- To achieve optimal utilisation of the Trust's estate. This will involve reviewing the site cover on each of the Trust's four sites and seeking to maximise the use of the better accommodation across the Trust.

These efficiency gains will be mirrored by improvements in patient care by ensuring that patients are cared for in the most appropriate environment and that pathways are streamlined.

**Potential service changes**

8. The potential service changes that will result from the implementation of this strategy are identified and summarised in the paragraphs below.

9. The changes will be taken forward collaboratively with the Trust's partners. These partners include the Clinical Commissioning Groups and Primary Care Trusts in their role as commissioners and with GPs, Oxford Health, other NHS Trusts and social care as providers of complementary components of patient care pathways.

10. For the Trust and the wider health and social care community to achieve their joint strategic objectives, it is imperative that there is a significant and sustainable reduction in the numbers of delayed transfers of care. This is required both to ensure that the quality of care is improved with patients receiving their care and treatment in the most appropriate clinical environment. It is also essential in order for the health and social care system to achieve operational efficiencies and reduce the costs associated with patients being treated in inappropriate and often the most expensive parts of the service. A range of measures are currently being progressed by both the Trust and its partners. These include the Trust's supported discharge service and the PCT's hospital at home initiative. These projects, if successful, will result in a significant number of patients transferring from the Trust (and also from Oxfordshire Health and Community Hospital beds) to more appropriate care settings. This will enable the Trust to close beds both at its Oxford sites and at the Horton General Hospital.

11. The Trust is currently considering a number of service relocations that are designed to move services out of the poorer accommodation on the Churchill Hospital site. Current moves under consideration are:

    - Urology services into the new Churchill Hospital
    - Respiratory medicine and infectious diseases services into the John Radcliffe Hospital

    Both of these moves would not only provide better patient accommodation for the services concerned but would also improve a number of important clinical adjacencies.

12. The future configuration of head and neck cancer services is currently under consideration. Within the original business case for the new development on the Churchill site, it was envisaged that both inpatient and outpatient head and neck cancer services would transfer to the new development. However, in the light of changing circumstances the Trust Board has initiated a review of potential options. The factors that have led to this review include:

    - The additional cost associated with the original plans and the deterioration in the wider financial environment within the NHS
    - Capacity issues from the Churchill site particularly in relation to the theatres and intensive care
    - Site cover arrangements
    - The continuing need to balance the interests of all patients

13. A process and timetable for the review has been agreed. The review will evaluate three options.

    Option A – the existing plan to move all head and neck cancer inpatient and outpatient services to the Churchill Hospital.

    Option B – an integrated head and neck inpatient and outpatient service in the new West Wing at the John Radcliffe Hospital.

    Option C – a split site model with outpatient services at the Churchill Hospital and inpatient surgery continuing at the John Radcliffe Hospital.

14. The future of the Horton General Hospital will continue to be considered as part of the development of the Horton vision that is taking place in parallel with the review of the Trust's overall strategy. This work has been undertaken in conjunction with local stakeholders and the Community Partnership Network. The seven key themes of this vision are:

    - 24/7 acute cover
    - Development of tertiary services
    - Secondary/primary care interface
    - Intermediate care

- Education and training
- Research and development
- Patient and public involvement

15. Changes at the Horton have been progressed where they have been seen to be:

    - Strengthening and expanding the services available to the people of Banbury and the surrounding areas.
    - Ensuring that services are provided in line with modern best practice.
    - In line with the Independent Reconfiguration Panel's recommendation that there should be more integrated models of care between Oxford and Banbury.
    - In line with the emerging strategic principles identified above.

16. An example of such a change has been the recent proposals for changes to gynaecology services at the Horton General Hospital.

17. As noted earlier there are a number of service configurations being pursued across the region. These include safe and sustainable reviews undertaken by the Strategic Health Authority in trauma, vascular and stroke services. In each of these areas the preferred model involves the Oxford University Hospitals NHS Trust becoming a major hub within a wider service network. A similar review has been undertaken of neonatal services with again the OUH identified as the provider of the highest level of neonatal intensive care linked into a clinical network with surrounding district general hospitals. In all of these areas business cases are being developed to expand services in Oxford.

18. At a national level reviews are being undertaken of both paediatric cardiac surgery and paediatric neurosurgery. In the case of paediatric cardiac surgery the Trust is seeking to develop an integrated service with Southampton. A similar approach is being taken to paediatric neurosurgery services with Oxford serving as the lead surgical base.

19. As part of the development of the Trust's strategy further opportunities to pursue new and innovative models of care will be identified and pursued.

**Engagement**

20. As the strategy develops, the Trust will be progressing a high level engagement strategy that will be linked in to the stakeholder engagement forming part of the wider foundation trust application. The Trust will continue to utilise its various engagement channels to promote dialogue on the emerging strategy. These channels include presentations to the Health Overview and Scrutiny Committee, regular stakeholder bulletins, both formal and informal meetings with stakeholders, the Trust's own patient panel, the foundation trust membership and the formal public consultation that will be undertaken as part of the foundation trust application.

21. As noted earlier, a number of these changes represent responses by the Trust to commissioning strategies of PCTs and clinical commissioning groups. Commissioners will be undertaking their own engagement activities to obtain feedback on their proposed plans to which the Trust will be responding.

22. In addition to this high level engagement activity, individual service changes will be discussed with relevant stakeholders. In the case of the Horton, the Community Partnership Network will continue to be used as a key communications and engagement vehicle. For other individual service changes, specific mechanisms will be established. For example, in the case of head and neck services, arrangements are being put in place to secure the input of relevant patient groups into the planned option appraisal.

**Conclusion**

23. This paper has sought to describe the strategic context within which the Trust is currently developing a new strategy. The emerging themes from this strategic review have been summarised and potential service changes identified. The Trust will continue to maintain a dialogue as the strategy is further developed.

**Mr Andrew Stevens, Director of Planning and Information**

**Oxford University Hospitals NHS Trust**

**31 October 2011**

*From the Rt Hon Andrew Lansley CBE MP*
*Secretary of State for Health*

DH Department of Health

POC1_647546

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*Tel: 020 7210 3000*
*Mb-sofs@dh.gsi.gov.uk*

Councillor Dr Peter Skolar
Chairman
Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford OX1 1ND

17 OCT 2011

Dear Dr. Skolar,

Thank you for your letter of 14 July about the employment of nursing staff at Chipping Norton Hospital. Please accept my apologies for the delayed response. I appreciate the time you have taken to outline the concerns members of *The Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC)*. I also recognise that this is a particularly emotive issue for local people in the Chipping Norton Community.

It is clearly in the interest of all the parties involved that this matter is resolved with the best interests of patients in mind. Although local health organisations are generally better placed to make decisions about the health services within their community, it is also important that local concerns are taken into account and that staff are consulted properly. The situation at Chipping Norton Hospital is no exception.

We have spoken with the Chair of South Central SHA, Dr Geoffrey Harris, who agrees that it is important that a pragmatic solution is found that does not detract from the quality of services Chipping Norton Hospital provides. Dr Harris is working with Oxfordshire PCT and other parties towards this end, and recently wrote to David Cameron outlining a proposal by the PCT to ensure that new recruits will receive NHS terms and conditions until a review of the current arrangements has taken place. I understand that this proposal will be discussed in detail at a meeting with the HOSC on 10 November.

Your letter also sets out a proposal to ask members of the Independent Reconfiguration Panel to visit Chipping Norton to act as an 'honest

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broker' in this matter. While I welcome suggestions to mediate the issue, given the above development it will not be necessary take this forward.

I hope this response provides you with some reassurance about this issue. I have asked Dr Harris to meet with you and colleagues, should you wish, to answer any other concerns or queries you may have.

I do hope that this is helpful.

Yours ever.

**ANDREW LANSLEY CBE**

CC: Dr Geoffrey Harris – South Central SHA

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**Oxfordshire Local Involvement Network**
**Update for Joint Health Overview and Scrutiny Committee meeting 10th November 2011**

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. Further Health and Social care issues will be prioritised during this year.
**N.B. The following more concise update refers to LINk projects which have a Health remit only, unless there is crossover, or joint commissioning, with Social Care services**

**LINk Core Group**

A meeting in public was held in Witney on 21st Sept, with approximately 20 participants, who contributed to sharing information about ongoing LINk projects and heard how the LINk prioritises work programme proposals through the new Project Pack and application process. (All information is on the LINk website and is being promoted to other groups and organisations). Copies of the Project pack will be available for members. All members are welcome to attend the next Core Group meeting, which will take place at Cornerstone Art Centre in Didcot on **8th December from 1.30pm – 4.00pm.**

**Ongoing Health projects and engagement:**

**Health Hearsay – update from Nuffield Orthopaedic Centre to the 'Making Change' LINk report**
Following the first update from the NOC on what work has been carried out on the five issues identified in the report, an action plan has been agreed with the NOC and progress against this is published within the update paper. The five priorities are:

- Time spent at Pre-Operative Assessment Clinic Appointments
- Discharge Care Package and Communication with GPs
- Cancellation of operations and last minute arrangements
- Disabled access – car parking, toilets and provision of hoists
- Explanation of processes at the hospital and consistent communication

The full update paper is available from the LINk office on request and copies will be available for members at the meeting.

**Podiatry**
The Podiatry information resource and directory has been incorporated into the LINk website and is now online. This will enable updates to the Podiatry practitioners directory to be made on an ongoing basis and also to invite other providers of these services to be listed if they so wish.

**Mental Health**
A Mental Health 'Hearsay!' event is being planned for mid-January, which will become a replacement for the Mental Health 'Sounding Board' – a feature of Social and Community Services engagement over the last 2 years. In order for the recommendations and comments from service users and carers, obtained through recent Sounding Boards, to have a more consistent and robust means of follow up with service providers and commissioners, it was proposed that the Hearsay model be incorporated into the current structure. Concerns
which have arisen from comments collected by the LINk together with issues received from earlier Sounding Boards will be considered in partnership with Directors and Service Leads from Oxford Health and Social Care. Date and venue will be notified shortly.

**New LINk Project Work**
New project proposals have been received, or are proposed, from: Young Dementia UK, OxSun (Mental Health), Family Support Network and Omega (ME support). These will be considered for future LINk support at the next Priorities Group meeting in late November.

**HealthWatch**
LINk has been taking part in a series of OCCG events around the County to encourage as many as possible to join a consultation on the future of public engagement and to provide information on what is known to date about HealthWatch. The PCT has been collecting views on their draft Communications and Engagement Strategy for OCCG and how public and patients should be involved in decisions about local services.

*Adrian Chant (LINk Locality Manager)*
*01865 883488*
*Update 31/10/2011*

Additional report from the Engagement Team, Social and Community Services:

**HealthWatch Update for Oxfordshire LINk to HOSC Meeting**

HealthWatch is to be a new independent 'consumer champion' for users of health and social care services. Oxfordshire County Council (OCC) has responsibility for commissioning Local HealthWatch, drawing on the significant experience of existing providers (e.g. LINks and others). It will launch in October 2012.

Locally, Oxfordshire HealthWatch will:

- Support children, young people and adults to share experiences, views and be involved in shaping policy and services
- Make those views known and influence decision-making through representation on the new Health & Wellbeing Board and the chairing of the Public Involvement Board
- Provide advice and information about access and choices
- Provide an advocacy and complaints service (from 2013)

OCC was successful in its bid to set up a Local HealthWatch pathfinder and aims to agree a model for commissioning through an extensive engagement exercise, developed with the Interim Steering Group (which includes LINks, PCT and users/carers).

The consultation will run through late October to December. It will include:

- Café-style workshops for children, young people and adults (users and carers or otherwise)
- Focus groups for stakeholders
- A questionnaire (through the OCC e-portal, Facebook and partners routes)
- Debate at Oxfordshire Youth Parliament and Children's Parliament
- Outreach to targeted groups, (e.g. Age UK, Unlimited, Children in Care Council)
- An OCC Members' Drop-in session

A Stakeholder Event will be held on 28th November to draw together what has been learned and develop more detail of the model for Oxfordshire HealthWatch. Findings will be collated through December and final commissioning specifications agreed in January.

An independent consultant, with extensive experience in supporting LA's to develop HealthWatch, has been employed to support and advise the Interim Steering Group in shaping the process.

Members and the public can get more information by contacting:
Alison Partridge (Engagement Manager) - Alison.partridge@oxfordshire.gov.uk
Lisa Gregory - Lisa.gregory@oxfordshire.gov.uk
Rosamund Southgate - Rosamund.southgate@oxfordshire.gov.uk

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