Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 5 July 2012 at 9.30 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - District Councillor Rose Stratford

Councillors:	Jenny Hannaby Jim Couchman	C.H. Shouler Val Smith	Keith Strangwood Lawrie Stratford
District Councillors:	Martin Barrett Christopher Hood	Susanna Pressel Alison Thomson	
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes:

Date of next meeting: *27 September 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 - *Claire Phillips, Tel: (01865) 323967*
claire.phillips@oxfordshire.gov.uk

Peter G. Clark

Peter G. Clark
County Solicitor

June 2012

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 - 10)

To approve the minutes (**JHO3**) of the meeting held on 24 May 2012 and to note for information any matters arising from them.

4. Speaking to or Petitioning the Committee

5. Oxford Health (Pages 11 - 16)

9.45

Julie Waldron, Chief Executive Oxford Health will present a report **(JHO5)** on the key issues relating to the Oxford Health NHS Foundation Trust's (FT) progress with integration since the merger with Community Health Oxfordshire in April 2011.

6. Dental Services (Pages 17 - 22)

10.45

Nicky Wadely, Deputy Head of Primary Care Contracted Services and Amanda Crosse, Consultant in Dental Public Health will attend to present a report **(JHO6)** on dental services as a follow up to discussion by the committee in 2011.

The Local Dental Committee has also been invited to attend the meeting to give a provider perspective on local dental services.

7. Director of Public Health update

11.20

The Director of Public Health, Jonathan McWilliam will provide the committee with his regular report on matters of relevance and interest to the committee.

8. Accessible Care for Everyone (Pages 23 - 28)

11.45

Rachel Coney, Oxfordshire Clinical Commissioning Group and representatives from other partner organisations will attend the meeting to discuss performance and challenges for the Appropriate Care for Everyone programme **(JHO8).**

9. Oxfordshire LINk Group – Information Share (Pages 29 - 30)

12.15

Adrian Chant will be in attendance to provide an update on the work of Oxfordshire LINk **(JHO9)** and answer any questions that members may have. There will be a verbal update on maternity services work HOSC members are involved in**.**

Lisa Gregory will provide an update on the development of Healthwatch.

10. 111 non-emergency number (Pages 31 - 34)

12.30

Sarah Bright, Oxfordshire Clinical Commissioning Group will report on the programme for roll-out of the 111 NHS non-emergency number **(JHO10).** She will be joined by Pete McGrane, Oxford Health NHS Foundation Trust and colleagues from the South Central Ambulance Service who are partners in the 111 service.

11. Clinical commissioning update (Pages 35 - 38)

13.00

Alan Webb, Oxfordshire Clinical Commissioning Group will update the committee on progress **(JHO11)** in the lead up to its authorisation as a statutory NHS body in April 2013.

12. Chairman's Report

13.20

The Chairman and other committee members will give a verbal update on meetings attended since the last formal meeting of the Health Scrutiny Committee in May.

13. Close of Meeting

13:30

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

This page is intentionally left blank

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 24 May 2012 commencing at 10.00 am and finishing at 1.50 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Dr Christopher Hood (Deputy Chairman) Councillor Jim Couchman Councillor Jenny Hannaby Councillor C.H. Shouler Councillor Lawrie Stratford Councillor Susanna Pressel District Councillor Rose Stratford District Councillor Alison Thomson Councillor John Sanders Councillor Tim Hallchurch MBE
Co-opted Members:	Dr Harry Dickinson Dr Keith Ruddle Mrs Anne Wilkinson
Officers:	
Whole of meeting	Claire Phillips, OCC
Part of meeting	Dr Jonathan McWilliam, Joint Director of Public Health

Agenda Item	**Officer Attending**
10	Debbie Mars, John Nicholls and Aubrey Bell, South Central Ambulance Service
11	Riana Relihan, NHS Oxfordshire
12	Gareth Kenworthy, and Dr Peter von Eichstorff, Clinical Commissioning Group
13	Ben Threadgold, OCC
14	Adrian Chant and Sue Butterworth, LINk

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting [, together with a schedule of addenda tabled at the meeting/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

25/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Councillors Val Smith and Keith Strangwood. Councillor John Sanders substituted for Councillor Smith and Councillor Tim Hallchurch for Councillor Strangwood.

It was reported that Councillor Couchman would replace Councillor Seale on the Committee for 2012/13 and that Councillor Martin Barrett would replace Councillor Hilary Hibbert-Biles as the District Council member from West Oxfordshire.

The new members were welcomed and the outgoing members were thanked for their contributions to the work of the Committee.

26/12 ELECTION OF CHAIRMAN FOR THE 2012/13 COUNCIL YEAR
(Agenda No. 2)

RESOLVED – to elect Councillor Dr Peter Skolar as Chairman for the 2012/13 Council year

27/12 ELECTION OF DEPUTY CHAIRMAN FOR THE 2012/13 COUNCIL YEAR
(Agenda No. 3)

RESOLVED – to elect District Councillor Rose Stratford as Deputy Chairman for the 2012/13 Council year

28/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

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

Councillor Jenny Hannaby declared an interest as a member of the Wantage Hospital League of Friends

Councillor Alison Thomson declared an interest as a member of the Faringdon Health and Social Care Group.

Councillor Dr Peter Skolar declared an interest as a member of the British Medical Association and involved in the development Townlands Hospital in Henley.

29/12 MINUTES
(Agenda No. 5)

The minutes of the meeting on 19 January were agreed and signed.

30/12 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 6)

Dr Ken Williamson requested to address the meeting. The address was taken at the item, 12 Clinical Commissioning Group

31/12 PUBLIC HEALTH UPDATE
(Agenda No. 7)

Dr Jonathan McWilliam tabled a paper outlining Oxfordshire performance on key public health performance indicators. Dr McWilliam explained that Oxfordshire is now part of NHS South of England which extends from Kent to Cornwall and provides a wide base for comparing performance. He gave the committee an introduction summarising performance against key indicators. Councillors questioned Dr McWilliam and through the ensuing discussion the following points were noted;

- Cervical screening performance is poor this can be attributed to poor take up in the older student age group (20s), cultural issues – women are not in the habit of being screened and aren't aware of the importance of being screened.
- The importance of the practices in promoting take up of screening was emphasised.
- Members were surprised that there was no data about alcohol. Dr McWilliam explained that it is very difficult to collect good comparative data on alcohol, the most reliable measure being alcohol related deaths as alcohol related sclerosis can be skewed by the presence of a specialist unit in the area.
- Cllr Hood suggested that measuring smoking cessation at four weeks is not very reliable and would be better at 12 months. Dr McWilliam agreed but explained the difficulty in remaining in contact with quitters to continue to collect data.
- It was noted that in 2013 Public Health will move into the County Council but the responsibility for screening will remain in the NHS which will give local government greater ability to scrutinise.
- Oxfordshire performance on MMR immunisation is good but is not sufficient to create 'herd immunity' of the population for which 95% immunisation is required.
- Data on obesity is not included in the paper as this is an annually collected data set. It was noted that Oxfordshire has been bucking the national trend for childhood obesity.
- It was AGREED to provide the committee with the definition of teenage conceptions indicator following discussion on the range of circumstances in which teenage pregnancies occur.

32/12 JOINT HEALTH AND WELL BEING STRATEGY CONSULTATION
(Agenda No. 8)

Dr Jonathan McWilliam introduced the draft Health and Well Being Strategy which is being consulted on. He indicated that the strategy is a requirement on all upper tier local authorities and is designed to bring together the NHS and local government with the public voice.
The draft strategy has been developed through reviewing the Joint Strategic Needs Assessment, Director of Public Health's Annual Report and knowledge and views of board members. Proposed outcome measures have been drawn from the relevant national performance frameworks.

In the ensuing discussion the following points were made on the draft strategy,

- Input into the strategy from health providers is important – this is planned through the consultation phase
- Targets are only for one year – some would appear easy to achieve and others very challenging in the timescale
- Proposed targets for healthchecks for people with severe mental illness and learning disabilities are not equitable – more emphasise should be made on improving healthchecks for people with learning disabilities
- It was noted that Oxfordshire generally has high levels of satisfaction and interest in how carer satisfaction will be monitored. The satisfaction with provision of information was not considered to be a priority
- Poor performance on delayed transfers was noted as a priority and there were concerns about whether there is sufficient staffing for the reablement service
- The priorities for Children and Young People don't take into account the current bulge in primary age children and the potential impact on attainment in the future
- There was concern about the target to reduce the number of people permanently admitted to a care home which has a implications on those people who are kept at home who may be at risk of social isolation
- The proposed target to increase the number of schools rated good or outstanding by Ofsted was considered unachievable in the timescale
- The lack of data available on ethnicity makes it hard to set targets on inequalities
- Exercise referral and healthy schools should be seen as useful way to tackle obesity
- The focus of the strategy is public health and as such is not enough to provide a framework for commissioners. It was emphasised that the strategy is about what can be done in partnership rather than a strategy setting out what individual partners should do
- There was concern about what the Health and Well being Board would be able to achieve given that it only meets three times a year
- The importance of hearing public opinion through the Public Involvement Network and sub boards was considered.
- The challenge of holding commissioners to account was discussed and the benefit of pooling funds to enable effective joint commissioning

33/12 LEARNING DISABILITY HEALTHCHECKS
(Agenda No. 9)

It was noted that there was no-one available from the PCT to speak on the item and the intention to have an item on primary care at a future meeting where this could be picked up with GP practices.

It was agreed that Claire Phillips would circulate an email from My life My Choice about the PCT report to the committee.

34/12 SOUTH CENTRAL AMBULANCE SERVICE PERFORMANCE

(Agenda No. 10)

Debbie Mars, John Nicholls and Aubrey Bell from South Central Ambulance Service (SCAS) presented the report on performance of the service in Oxfordshire.

In the presentation the following points were made

- SCAS experiences 5/6% increased demand on their services year on year but demand is now back to its seasonal average having seen particularly high demand between January and March this year.
- South Oxfordshire performance has improved which reflects the steps that have been put in place. There is better linkage with resources at the southern border around Henley and Reading so it is possible to pull up a response vehicle from south of Oxfordshire.
- Targets are set nationally
- Ambulance services are provided more dynamically now than in the past where there was a reliance on fixed ambulance stations. The location of vehicles in the best locations to respond to calls is key. Crews now start and end their shifts at larger resource centres.
- SCAS are increasing their 'See and Treat' responses which reduce the pressure on Accident and Emergency departments and improves the service's availability to respond calls as the need to transport to hospital is reduced.
- The need to do more to reduce overall demand on the emergency care system was identified. The introduction of the 111 non-emergency number was to help in this respect.
- A recent campaign to warn people to use 999 appropriately had resulted in an increase in demand.
- SCAS has been working closely with the new Chief Matron and Chief Operating Officer at the Oxford University Hospitals Trust to address the issues that arose when demand remained so high at the start of the year which included at the back door as well as the front.

Following the presentation the item was opened up to questions and discussion with members. The following points were made,

- SCAS is involved in a pilot for 111 with Oxfordshire Health to handle calls. It was noted that there will be an item on 111 at the next HOSC meeting.
- SCAS will have access to all 111 services with the intention of reducing the need to go to hospital.
- The SCAS board will be considering how to manage volunteer first responders who currently do not get travel costs. The committee felt that this would be a useful incentive to encourage people in communities to volunteer for this service.

- The range and location of vehicles is improving coverage of the service and location in places close to likely events is helping to reduce response times.
- SCAS are reviewing rotas based on past demand patterns to ensure that they are best placed to meet demand but this must be balanced with HR regulations on reasonableness.
- There was suggestion from the committee that an effective 'see and treat' approach may lead to increased demand on 999 services as the public see this to be effective rather than using more appropriate services. In response SCAS said it hoped that the 111 service would mitigate this but that there is a risk.
- The committee was concerned that it could not see actual response times performance as this was concentrated on the 8 minute and 19 minute targets. Whilst performance against the 8 minute target appears poor in parts of Oxfordshire members were keen to see how much the target was missed by. SCAS AGREED to provide further detail of response times in graphical format.
- The committee were keen to encourage SCAS to do more than the national campaigns to inform the public about the appropriate use of 999. A recent You Tube video for young people and fleet advertising were cited.
- Cllr Couchman asked how big a problem nuisance calls were. John Nicholls responded that whilst all nuisance calls are unwanted this was not a big problem in Oxfordshire especially compared to the metropolitan areas. SCAS work with the Police and telephone companies to identify and prosecute offenders.
- SCAS noted that in the early days of the new GPs out of hours contract an increase in demand for 999 services was seen but that this has settled down. There are good relationships with the local out of hours service and activity is shared between each other.

35/12 COMMUNITY HOSPITALS IN BICESTER AND HENLEY
(Agenda No. 11)

Riana Relihan, Project Director NHS Oxfordshire updated the committee on the progress of the community hospital redevelopment projects in Bicester and Henley. She outlined that they are being consulted on with the public at the moment and that planning will be submitted in June/July.

In response to a question from Cllr Lawrie Stratford Riana Relihan confirmed that there would be one planning application and that there have been discussions with the district and county councils in particular on highways before the preferred bidder was selected.

It was confirmed that the model for these projects is different to that used in Chipping Norton in that service and building contracts are separate with service contracts already being in place.

36/12 CLINICAL COMMISSIONING GROUP
(Agenda No. 12)

Dr Ken Williamson, GP and co-chair of the Oxfordshire Keep our NHS Public Group addressed the committee. Dr Williamson welcomed the single clinical commissioning group for Oxfordshire. He spoke of the need to keep out private providers which are present in neighbouring areas. He was keen that the CCG adopt the principles of the Fair Commissioning Charter which include operating in a fair and transparent manner.

Dr Williamson spoke of the need for the CCG to take account of the relationship between GPs and their patients and the tensions that will become apparent when people find that some services are not available.

The committee thanked Dr Williamson for his comments.

Gareth Kenworthy, Interim Chief Finance Officer and Dr Peter von Eichstorff. Oxford Locality Lead for the Clinical Commissioning Group introduced the item by giving an outline of progress in developing the CCG.

They identified that 20% savings from Secondary Care are required in the next four years. They stated that these will be sought by moving services closer to home rather than cutting services. Further savings will be considered by reducing wastage for example in hip and knee operations where some people do not see any improvement as a result of the operation.

It was noted that satisfaction in Oxfordshire is high and the outlook is good. Clinical leadership and management from the PCT to support the work of the CCG is strong and the CCG is working to improve patient engagement.

The item was opened up to questions from the committee during which the following points were noted,

- In future there is the possibility that voluntary sector providers will bid to run services. These may include British Heart Foundation, Age UK. There was some concern about organisations potentially taking on too much. It was noted that NHS South is doing some mapping work to identify where the voluntary and community sector makes an impact.
- The Fair Commissioning Charter is currently being considered. The CCG is committed to working with the NHS charter and being as transparent as possible.
- GP referrals should include choice but this doesn't have to include private options.
- Enthusiasm of GP practices to engage is variable but the message that all have a responsibility to manage spending public money wisely is being pushed.
- The committee emphasised that the success of the new clinical commissioning model is yet to be seen when GPs become directly accountable for spending decisions. There will be a tension for GPs in dealing with the patient in front of them compared to the wider population for whom they are responsible for commissioning.
- The potential for savings in prescribing was raised in particular through rural dispensing practices. The CCG acknowledged that this would be looked at and that the performance of the medicines team is good.

- In response to a question from Cllr Barrett it was noted that this committee does not have direct responsibility for holding underperforming GP practices to account.

37/12 EQUALITY ACT AND EQUALITY DUTY

(Agenda No. 13)

The committee thanked Ben Threadgold for his report. It was noted that the report focused more on local government, members requested that Claire Phillips get details of the NHS approach to equalities legislation and circulate to the committee.

There was discussion about the NHS collection of ethnicity data and the difficulties in collecting this from GP practices.

It was noted that through the act the burden is on public bodies to prove that they are not discriminating.

It was AGREED that Claire Phillips would undertake to find out more about the NHS approach to equalities and circulate this to the committee.

38/12 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 14)

Adrian Chant and Sue Butterworth from LINk presented the proposal for a review of maternity services to involve members of the HOSC.

There was discussion on the focus of the review and whether it should be on ante natal or post natal services. The committee emphasised that the report should not be based on anecdote and that there should be consultation/ feedback data available from the hospital which would avoid the need to do further consultation work.

It was AGREED that Cllr Jenny Hannaby and Alison Thomson would represent the HOSC in the review. LINk would arrange a meeting in the coming weeks to agree the scope of the review and report back at the next meeting.

The aim is for the review to be completed in six months as LINk will be transitioning to the new Healthwatch arrangements in 2013.

Sue Butterworth also reported that the feedback report and action plan from the mental health Hearsay event is being finalised with the commissioner and providers and will be available shortly.

It was also reported that LINk is working with the Clinical Commissioning Group to increase the number of patient involvement networks.

Sue Butterworth updated the committee on the development of Healthwatch. The specification for the service has been written but the contract will likely be delayed as the regulations are not likely to be published until July.

A new local cooperative has been developed between Oxfordshire Rural Community Council, Oxfordshire Community and Voluntary Action and Oxfordshire Wheel.

It was noted that there is a military representative on the Public Involvement Network.

39/12 CHAIRMAN'S REPORT
(Agenda No. 15)

40/12 CLOSE OF MEETING
(Agenda No. 16)

13:50

..... in the Chair

Date of signing .....

This page is intentionally left blank

Oxford Health NHS
NHS Foundation Trust

Oxfordshire Health Overview and Scrutiny Committee, 5 July 2012

---

1. Context

This briefing outlines key issues relating to the Oxford Health NHS Foundation Trust's (FT) progress with integration since the merger with Community Health Oxfordshire (CHO) in April 2011.

This paper does not represent a full review of the merger but is intended to highlight to members areas of progress, performance since the merger and next steps and challenges.

2. Introduction

The importance of better integrating services around the needs of patients has been identified both nationally and locally. Nationally the 2012/13 Operating Framework identifies integration as key to sustainable improvement, while locally the Appropriate Care for Everyone (ACE) programme board has determined that the integration of services is essential in ensuring improvement in the delayed transfers of care issue.

Within Oxford Health NHS FT integration has been prioritised through the creation of the Oxford Health NHS FT Integrated Care Programme Board. The Oxford Health Integrated Care Programme Board is chaired by Dr Clive Meux (Medical Director and Director of Strategy) and provides trust wide (and beyond) strategic coordination and engagement to drive the integration agenda.

The vision for the Oxford Health Integrated Care Programme Board is:

"To ensure that holistic and coordinated care is provided across clear pathways for all of our patients."

The integrated care project board oversees all integrated care initiatives that Oxford Health NHS FT is delivering. This involves integration between:

- Community services and primary care
- Community services and social care
- Physical health and mental health
- Community services and the acute sector
- Internal integration within Oxford Health NHS FT divisions

3. Key Messages

- **Integration of Community Services.** Established community localities (physical health, mental health and social care services) co-terminous with the six CCG sub localities.
    - Closer working in place with social care teams.
    - Integration action plans developed in each locality.
    - Clinical workshop planned with CCG, OUH, OCC and Oxford Health NHS FT on 26th July to agree vision for fully integrated community localities.

- **Move on Team** established. A multi-agency (Oxford Health, OUH, OCC and Primary Care) clinical decision making group for enabling discharges from acute care (operational since 12th December 2011).
- **Single Point of Access** into Oxford Health NHS FT Community Health Services. A patient bureau type service, with the key objective being to ensure the seamless and safe management and referral of patients who would benefit from community service intervention, either to prevent an admission or to support early discharge (operational since 30th April 2012).
    - Oxfordshire County Council to join the single point of access in summer 2012
    - The Single Point of Access to be extended to integrate with Older People's Mental Health services by Autumn 2012

- **111 service.** The community services division has been at the heart of the ongoing plans to develop the 111 service for Oxfordshire in partnership with South Central Ambulance Service. The national 111 number will come into effect by April 2013 and Oxfordshire will be an early adopter. The 111 number will be an easy to use access point for the public for all their urgent care needs.

- **Hospital at Home.** The Urgent Care team has taken on the management of the new Hospital at Home service in the south and west of the county is instrumental in working with Principal Medical Limited to run a similar service in the north of Oxfordshire. The team's remit is admission avoidance to acute care, and it has worked successfully, particularly with primary care colleagues, to see an increasing number of people diverted away from a hospital admission in order to be cared for closer to home/at home.

- **Integration with Mental Health**
    - **Grass roots integration:** Joint ward meetings established between community hospitals and older adult mental health wards; buddy system established and therapies providing some cross ward support for annual leave, sick cover etc.
    - **Pathway design**: Opportunities for greater use of community services for mental health discharge becoming evident. Projects in progress include: falls, care home support services and end of life
    - **Reviewing Dementia pathway across Trust:** Audit of dementia care across both community and mental health hospitals in progress.
    - **Developing Skills and Knowledge:** Joint training now offered (e.g. Dementia training). Scope of work completed to assess skills gap across community and mental health wards and community teams.

- **Personal Health Budgets.** During 2011/12 county wide services have seen the successful implementation of Personal Health Budgets into NHS continuing healthcare processes as part of national pilot. Every new person entering NHS continuing healthcare is now offered a personal budget, 12 months ahead of the national deadline.

- **Care Home Support Service.** The Care Home Support Service is a two year pilot that has seen a specialist nursing and therapy team supporting all the care homes in Oxfordshire for the over 65s. It is helping stop inappropriate admissions to hospital, shorten lengths of stay in hospital and improve the quality of care within the care homes.

- **Long Term Conditions.** Oxford Health NHS FT has **s**ecured Department of Health funding for two joint projects with the 'Improving Access to Psychological Therapies' services. The projects will test a new approach to delivering integrated physical and psychological care to patients with long term conditions, many of whom suffer from depression and anxiety.

- **District Nursing Review.** A review of district nursing across the county took place in the autumn of 2011 led by the service itself. The service undertook some peer review as part of the process. The terms of reference were to identify where and how the service needs to modernise, including opportunities for integration, managing greater demand and complexity of care needed in patients' own homes, and improving clinical standards.

- **End of Life Care. E**stablishment of a new service, with 4 community matrons supporting people in the last year of their life. The matrons use a case management approach in their work and are part of a wider strategy around end of life care in the county.

- **Diabetes and Depression.** Oxford Health NHS FT is running innovative projects with Oxford University. Research nurses have been integrated into the community diabetes and community COPD teams in order to conduct research on diabetes and depression and the use of technology with patients who have COPD.

Childrens and Families Services

- **Locality working**. All children's community services have now been moved to a locality model co-terminous with local authority children's services and children and young people's mental health services

- **Mental Health**. PCAMHS and CAMHS have been brought under single management in order to close gaps in the mental health care pathway and ensure that young people are able to access to the right service first time.

- **Infant Parent Perinatal Service** – collaboration of mental health, health visiting, midwifery and GPs to address mild to moderate ante and post natal depression. Training programme across county working into children's centres.

- **Universal children's health service** delivering into health promotion services for young people into children's hubs

- **Health Visiting**. Early Implementer site for the national health visitor programme. One of the outcomes this year is ensuring that all children have a quality 2 year check to ensure robust foundation for good health and well-being for life and that children are able to start school ready to learn.

- **Urgent Care** – development of integrated care pathway across community children's nursing and acute care to prevent inappropriate admission and support early discharge of young people with complex health needs.

- **Integrated Children's Community Therapies Service (ICCTS)**. (Physio, OT, Speech, Language and Communication). Single point of access in place. One point of contact for parents
    - **ICCTS Integration within Oxford Health**
        - Therapists input into training for universal services in order to support awareness, early identification and appropriate referrals.
        - Therapists are working with universal services around the development of 2 year checks.
        - OT worked with OTs in neuropsychiatry, CAMHS and LD CAMHS to develop clinical pathways to ensure services and parents are clear about who to refer to and what services have available.
        - Health Action Plans: training for therapists and clinical nurse specialists within special schools to standardise practice
    - **ICCTS Integration with other NHS providers**
        - Physiotherapy has joint pathways with the OUH/NOC physiotherapy department for all childhood orthopaedic conditions ensuring that children and families receive the same advice and treatment wherever they enter the system. Shared information leaflets for all these conditions have been produced.
        - Shared protocols with the OUH/NOC orthotics department support appropriate referral and smarter practice, e.g. phoning through repeat orders rather than requiring an appointment.
        - Joint orthotic clinics in special schools to save these children having to be taken out of school to go to appointments.
        - ICCTS led the development of an integrated pathway across the whole system for management of children at risk of fractures due to Low Bone Mineral Density. This collaboration involved paediatric and orthopaedic surgeons and dieticians as well as community therapies.
        - The pathway with the wheelchair service aims to improve communication between services and ensure effective clinics for children with mobility support needs in special schools

    - **ICCTS Integration with local authority/partner agencies**
    - Working with the Oxfordshire SEN officers to identify issues early and develop joint solutions, including an information pack for therapists developed by therapists, SEN Officers and LA Solicitor.
    - Working with children's centres in developing Payment by Results outcomes re communication and "school readiness".
    - Transition work continues to develop a process for transition from Children's Therapies to Adult services. In the first phase we are rolling out a localised version of

'Health Action Planning 'to support young people transitioning from Oxfordshire special schools to adult services.

- Housing and adaptations work is integrated with OCC and District Councils in order to access the Disabled Facilities Grant and maintain liaison with surveyors, architects and builders from the county council and housing associations

Specialised Division

- **Offender Health teams Integration.** Full Integration of the offender health teams into the Specialised Services Division.

- **Prison Health Service**. Single management structure running all prison health services within Oxford Health across six prisons.

- **Integrated Forensic Mental Health Pathway**. Integration of primary, secondary and forensic mental health into single pathway nearing completion.

- **Faster access to services**. Patient access to services faster and increased quality of care resulting from better and faster information flow between all health teams

4. **Performance since the merger**

The services previously managed by CHO have integrated into three of the Oxford Health NHS FT Clinical Divisions (the majority of former CHO services for adults are managed within the Community Services Division).

This makes direct comparisons of performance at a high level difficult with only comparisons at service line level demonstrating accurately 'like for like' comparative data.

However, the table below compares at a high level some of the key indicators of performance between the former Community Health Oxfordshire services and services managed by the Community Services Division of the Oxford Health NHS FT.

High Level Performance – CHO 2010/11 and Community Services Division 2011/12

	CHO 2010/11	**Community Services Division 2011/12**
Year End KPI Performance	90% achieved or exceeded	93% achieved or exceeded
Patient Satisfaction (average score)	88	86.2
Staff Satisfaction (trust score – higher the better national average)	3.56	3.65
Clostridium difficile infection	16	15
Incidents (year end)	3403	3061
Serious Incidents Requiring Investigations (year end)	122	37

This page is intentionally left blank

NHS
Buckinghamshire and Oxfordshire Cluster

Oral Health in Oxfordshire

Report to the Health Overview & Scrutiny Committee

5th July 2012

An Oral Health Needs Assessment was carried out from January 2010 – May 2010 and the final report was completed in September 2010. It aims to inform the delivery of oral health promotion and dental treatment services in Oxfordshire from 2011.

Key findings:

• Studies have shown that there are higher levels of oral disease in populations which are socioeconomically deprived. While Oxfordshire is a relatively affluent county and the majority of areas are in the least deprived quartile for England, there is 3% of the county which features in the most deprived quartile. Key wards within Oxford City and Banbury have higher levels of social deprivation and child poverty.

• Oxfordshire has an ageing population. By 2031 there could be an additional 61,500 people in Oxfordshire aged over 65, and 18,400 more people aged 85 years and over. As oral health continues to improve it is expected that by 2026, only 4% of adults will have no natural teeth. This has significant implications on dental services as more people will be maintaining teeth that have already been heavily restored.

• Key populations within Oxfordshire are at risk of poor oral health due to poor diet and nutrition, poor oral hygiene, lack of exposure to fluoride, tobacco and alcohol use and injury. Other public issues such as obesity or alcohol share these risk factors and their underlying determinants and therefore the common risk factor approach provides a rationale for linking oral health improvement into other joint strategic health improvement work and working in partnership to ensure consistent messages are relayed to the public.

• In Oxfordshire, access to NHS Dental services is improving and Mosaic data would suggest that services are addressing the needs of people who are more socially deprived. However, access for adults still lags behind other PCTs in the rest of England.

• Key population groups including older people, rural populations, children in deprived areas, certain ethnic minorities and vulnerable groups such as people with learning disabilities, drug and alcohol users and travellers continue to be at risk of poor oral health due to a number of factors including lifestyle behaviours, a lack of oral hygiene and less frequent use of dental services. Common barriers include lack of awareness of local NHS dental services or a lack of NHS services, distance to travel, language & cultural differences.

• A good range of services are now delivered in primary care and by salaried dental services, meeting the needs of a diverse range of patients and there is on-going work to develop a clinical network to ensure that treatments such as restorative dentistry, including endodontic treatment, continues to be available in primary care. GDPs and salaried services should ensure that they stress the importance of regular dental check-ups and preventative care for all and are sensitive to the cultural norms of different ethnic groups. Further work should be done to ensure that all GDPs are easily accessible to populations at risk, to reduce inequalities in oral health.

Ethnicity and oral health

There is no predisposition in any particular ethnic group to better or worse oral health. However there is a link between ethnicity and socio-economic deprivation which in turn has a link with poorer oral health.

In 2007 it was estimated that around 7% of Oxfordshire's population was non–British, with Oxford having the most ethnically diverse population with 17% of people from non-white ethnic groups. Asian or Asian British and Chinese accounted for the largest non-white ethnic groups.

A mosaic profiling tool has been used to help identify which areas in Oxfordshire have higher or lower proportions of black and minority ethnic groups. Mosaic profiling of the BME population reflects the information from the National Insurance Recording System and School Census Data that the majority of the BME population in Oxfordshire is resident in Oxford, followed by Cherwell and South Oxfordshire.

More recently the main group of migrants into the PCT has been from Poland and the Slovak Republic, in the Cherwell almost half of all registrations were by Polish nationals. People from Eastern Europe may not have enjoyed the same access to dental services in their own country and consequently may experience a higher level of unmet need which potentially can place a greater burden on local dental services.

Population changes and Oral Health

Oxfordshire has a steady population growth which is predicted to reach 680,000 by 2016. Oxfordshire also has an aging population with the largest growth expected to be within older age groups. The population of over 50's is predicted to rise over the next ten years by 27.5%. By 2031 there could be an additional 61,500 people in Oxfordshire aged over 65, and 18,400 more people aged 85 years and over. Projections up to 2016 show that while there will be an expansion of the over 50 year olds there will be some contraction of the population under 50.

As oral health continues to improve it is expected that a decreasing number of older adults will have no natural teeth. This has significant implications on dental services as more people will be maintaining teeth that have already been heavily restored.

For those people under 45, the likelihood of retaining not just some teeth, but a considerable number of healthy teeth through the whole of a long life, is now very high. In particular, the prospects for young adults aged 16 to 24 look better than they have ever been. For those aged over 45, the legacy of higher disease levels earlier in the life course and different patterns of dental care remain visible in the form of far fewer teeth and fewer sound teeth, but this generation still has a better outlook than their predecessors.

Population growth is not predicted to be the same across all local authority areas. Within Oxford, for example, there will be a steady growth in the number of children while in the more rural districts there are predicted decreases within this age group, more reflective of the ageing population profile.

There is predicted a large growth within the pre-school population in the central Oxfordshire area, with a 17% increase. The other two areas (north and south) should remain stable. All of Oxfordshire will see pressure on the primary school age population; a 23% increase in the central area and 10% rises in the other two areas.

Deprivation and oral health

Studies, including local and national data have shown that there are higher levels of oral health disease in populations which are socio-economically deprived and that these patients are less likely to have a regular dentist and/or access routine dental services. Data from the Index of Multiple Deprivation shows that Oxfordshire is relatively well off on average and scores better than most places. However, distribution of wealth is uneven across the county and there are pockets of deprivation. 10 super output areas are in the 20% most deprived nationally and these areas are in Oxford City and Banbury.

Overall Oxfordshire enjoys better oral health than the rest of the country. In the 2007/2008 BASCD national dental survey 74 per cent of five year olds were caries free compared to 72 per cent in South Central Strategic Health Authority and 69 per cent in England. The average number of decayed, missing and filled teeth (measured as dmft) for Oxfordshire five year olds was 0.86 compared with averages of 1.0 and 1.1 for the SHA and England respectively. Inequalities in oral health are found, however, in the more deprived areas of Oxford City and Banbury. This survey indicated that children living in Oxford City and Cherwell Vale had higher than average levels of tooth decay than children in other areas of the county; a dmft of 1.32 and 1.2 compared to 0.63 in West Oxfordshire, 0.59 in the Vale of White Horse and 0.47 in South Oxfordshire.

Targeted interventions

Prevention

Oxfordshire PCT has a planned programme of oral health promotion which is aimed at improving oral health and reducing oral health inequalities. This is a targeted programme of activities, delivered through community and practice based schemes, which aims to give the most improvement to those groups of people likely to suffer the worst oral health.

The major determinants of oral health such as diet, smoking and lifestyle factors are also those affecting other areas of health and are best tackled using the Common Risk Factor Approach. Any public health programmes aimed at tackling, for example obesity, coronary heart disease and cancer will also address oral health problems such as dental decay, periodontal disease and oral cancer.

As well as this Oxfordshire PCT is undertaking specific oral health improvement interventions with a number of targeted groups which support the recommendations of the Oral Health Needs Assessment 2011/12

Oral health promotion programmes for children in areas of deprivation and with higher than BME population average include:-

The PCT has commissioned a dental practice in Blackbird Leys to provide a school based Oral Health Promotion and a Fluoride varnish programme. To date eight primary schools have been visited and tooth-brushing books provided alongside signposting letters to parents about accessing NHS dental services to encourage uptake.

A Community based Fluoride varnish scheme in areas of deprivation in OX4 and OX16 areas has been set up with Oxford Health FT. 4386 children across Oxfordshire have been given Oral Health advice, including the use of fluoride toothpaste, in the last year. 92% of the children in Wood Farm have been consented to take part in the Fluoride Varnish programme

and 96% in Orchard Fields in Banbury. Accreditation for Children Centres Healthy smiles programme has been awarded to North Banbury and the Leys Children Centres.

As part of the Care Home support service training has been provided to support improvement of oral health care for older people in residential settings.

Training on Oral health advice and signposting to NHS dental services has been provided to the Health Advocates team who work with ethnic minority groups.

Oral Health Promotion team have run a roadshow as part of National Smile month giving out oral health advice and signposting to NHS dental services via the dental helpline. They also attend the Oxford Gay Pride Festival, Witney Carnival, Oxford United FC on match days, Oxford Active and undertook joint visits with the Playbus to Bloxham Travellers site.

Access

The availability and supply of dental services in Oxfordshire has been increased and targeted at areas of greatest unmet need. However the utilization of services does not necessarily reflect a health care need and demand for services is often higher in areas that have a low health need. What is important is that people are able to see a dentist when they need to and that these services are easily accessible and are available, affordable, acceptable and appropriate.

There is an important element of self- determination in service use and even in areas where the supply of dental services is excellent people may still choose not to go.

In the last year Oxfordshire PCT has continued to implement a number of initiatives to increase the availability of dental services, remove barriers, such as cost, that may stop patients accessing services and to improve information for patients who are seeking care. To support this aim a voucher scheme offering free dental check-ups to people who had not attended a dentist for more than two years not only removed the barrier of cost for some patients it also identified a high percentage of callers that were on low incomes and who were unaware that they were exempt from charges.

As of March 2012, 47.5% of the adult population in Oxfordshire saw an NHS dentist in the last 24 months, compared with England average of 52.8%[1]. When asked as part of the latest GP survey 97% of respondents who tried to get an NHS appointment were successful[2]. For those that did not try to get an NHS dental appointment this was because of a range of reasons as detailed in Table 1. below. The most common reasons for not seeing an NHS dentist stated by Oxfordshire residents were that they either preferred to see their private dentist or stayed with their dentist who opted out of NHS provision

Not needed to visit a dentist	No longer have any natural teeth	Not had time to visit a dentist	Don't like going to the dentist	Didn't think they could get an NHS dentist	On a waiting list for an NHS dentist	Stayed with their dentist when changed from NHS to private	Prefer to go to a private dentist	Find NHS dental care is too expensive	Another reason
14%	5%	2%	5%	18%	0%	21%	23%	4%	9%

Table 1.

Following Social Marketing research, that identified the need for more proactive approaches to improve dental access in areas of low take-up, Berkshire & Oxfordshire PCTs have commissioned with neighbouring PCTs a mobile dental service pilot. The service will visit the more deprived wards, also areas where there is low uptake of dental serivces and rural areas focusing on assessing dental needs, signposting to services and raising awareness of oral health messages.

A scheme has been offered to Care Homes to screen residents and provide dental care, particularly for those unable to attend a dental practice. 15 homes have taken part in the pilot and 242 residents have been screened to date.

Additional access has been commissioned in Carterton to support the increase in population in part due to the transfer of military personnel and their families following the closure of other air force bases. Information about how to access NHS dental services is provided by the Forces Families Welfare teams.

Additional surgery capacity has been commissioned in Bicester to accommodate the increase in the local population.

The practice in Cowley Centre has been relocated which now provides modern and expanded facilities alongside other surgery improvements have been supported using a capital grant scheme.

However, not everyone wishes to visit the dentist regularly or access dental services in the same way and some patients will only seek care when they have a problem. The 2009 Adult Dental Health Survey found that almost two-thirds (61 per cent) of dentate adults said that the usual reason they attended the dentist is for a regular check-up. Furthermore, 10 per cent said that they attended for an occasional check-up. Twenty seven per cent, however, said that they attended when having trouble with their teeth, and two per cent said that they never attended the dentist.

To meet the needs of this group of patients Oxfordshire PCT commissions both out of hours and urgent care services. In addition many practices now offer extended opening hours in the evening to improve access for patients who may have difficulty visiting the dentist during normal working hours.

Access to information is important for patients wishing to use dental services. The PCT continues to run a dental helpline which provides up to date information about practices offering NHS dental care 01865 337267. Information about NHS dental services can be found on the PCT website http://www.oxfordshirepct.nhs.uk/local-services/dentists/default.aspx

Improving access to specialist dental services

As more people keep their teeth for longer and as more patients access NHS dental primary care there is likely to be an impact on specialist dental services such as oral surgery and restorative dentistry. A collaborative programme across Berkshire, Oxfordshire and Buckinghamshire has reviewed the services available and where necessary redesigning services, in order to ensure there are appropriate care pathways in place for these patients in the future.

Collaborative working in the future.

During the next nine months the NHS organisational architecture is changing and responsibility for commissioning dental services will rest with the NHS Commissioning Board. There will be a Local Area Team covering the counties of Berkshire, Oxfordshire and Buckinghamshire with a Dental Local Professional Network (LPN) who will guide the local strategic development of services. Dental public health consultants will be part of Public Health England.

From April 2013 Local Authorities will also have a key role in commissioning oral health promotion and epidemiology services and there are opportunities to improve oral health and reduce oral health inequalities through close working relationships with these other organisations.

Amanda Crosse
Consultant in Dental Public Health

Nicky Wadely
Deputy Head of Primary Care Commissioning

Data source

1. http://www.ic.nhs.uk/webfiles/publications/007_Primary_Care/Dentistry/Dental_stats_11_12_q3/NHS_Dental_Statistics_for_England_2011_12_Q3_Annex_2_PCT_SHA.xls
2. http://transparency.dh.gov.uk/2012/06/14/dental_gp-patient/

Oxfordshire Clinical Commissioning Group

NHS

Report on the Appropriate Care for everyone (ACE) Programme

1. Background

The ACE programme is a partnership programme focused on determining and delivering fundamental and permanent changes to the ways in which local health and social care organisations work together, in order to reduce the number of delayed transfers of care in Oxfordshire.

Partners to the programme are Oxfordshire Clinical Commissioning Group (OCCG) , Oxfordshire County Council (OCC), Oxford University Hospitals Trust (OUHT) and Oxford Health Foundation Trust (OHFT). The Programme Board is chaired by Dr Stephen Richards.

HOSC received an update on the work of the ACE in November 2011, and asked that an update report be brought in 6 months time. This report forms that update.

2. Delays

Delays in the system were steadily reducing in late April and May, but the trend in June has been upward again, and at June 17th stood at 152. The principal reasons for delay at the beginning of June were:

- 39 people awaiting community hospital beds
- 32 people waiting for a care home placement
- 24 people awaiting the completion of assessments
- 22 people awaiting re-ablement
- 19 people were choice delays
- 10 people awaiting long term home care packages
- 3 people delayed by housing related issues
- 2 people waiting for equipment
- 0 people waiting for intermediate care bed

3. Improvement trajectory

All parties have signed up to a contractual arrangement (a CQUIN) which will reward OUHT and OHFT if they deliver a reduction in delays to:

- 146 by July 1st
- 103 by September 30th
- 72 by January 10th

- Maintained at monthly average of 72 by March 31st

Ultimately we want delays sustained at around no more than 40 per week.

4. Key issues

Key issues that need to be resolved to achieve a sustainable solution are that:

4.1 The number of people referred to community hospital from OUHT continues to exceed capacity to receive those referrals, with associated bottlenecks in the system – so we need to get demand for community hospital beds down.

4.2 More people go to a care home from hospital in Oxfordshire than in most other parts of England, and we need to reduce this percentage so that more people go straight home from both acute and community beds.

4.3 The time taken to place people in hospital into care homes, reablement or home with care remains too high and this needs to be significantly reduced.

5. Current ACE programme content

The programme currently comprises the following projects – all of which are county wide in their remit, and all of which are designed to reduce the primary causes of delay identified above and to improve flow through the system :

5.1 *Improving the reablement service*: This project requires OHFT to focus on minimising delays caused by waits for reablement or waits at the end of a period of reablement. It should double the number of new episodes of reablement care available each week by September. It is not currently on track to achieve this, although delays at the end of a period of reablement have substantially reduced and steps are being taken to ensure overall performance improves. These include a new contract based on payment by results, regular monitoring of performance and development of an OHFT improvement action plan. Partnership work is also being undertaken by OUHT and OHFT to co-ordinate rehabilitation and reablement services.

5.2 *Supported Hospital Discharge:* This project enables OUHT to provide 2 weeks of domiciliary care to patients, while a permanent home care package is being put in place. It is designed to reduce delays caused by waits for simple, single hander home care packages. It is not currently meeting its targets because it has not yet got its

staffing levels up to contracted levels, but does appear to be impacting positively on excess bed day numbers.

5.3 *Social services crisis response team*: This new team has been commissioned by OCC to provide social care within four hours and for up to three days , to avoid a hospital admission that may be triggered by the need for social services support, whilst permanent care arrangements are put in place. GPs can refer to this service directly, but referral rates have been considerably lower than expected and work is ongoing to re-promote the service and also to redirect this social care capacity.

5.4 *Domiciliary care delays*: This OCC led project is designed to build the capacity of the domiciliary care market and to improve the response time of providers once assessment has been completed. Some of the changes required by this project will take time to impact because they depend on the ability of the market to recruit and retain additional carers. It is having a positive impact and waits for domiciliary care are no longer a major contributory factor.

5.5 *Care Home Placement delays:* This OCC led project is designed to reduce delays caused by waits for permanent care home placements. The focus of the project has been on understanding the demand for care home placements and trying to find solutions to reduce that. To ease the issue extra care home capacity has been commissioned as a temporary measure, and 10 new placements per week are now being purchased, which should be sufficient to meet current demand. This increase is funded until September, but is not sustainable in the long term. Further work is being undertaken to try and identify how to get the rate of referrals to a care home from hospital closer to the national average, and to provide viable care alternatives, so that the number of new placements purchased per week can be safely reduced again without risking a resulting increase in delays. There will be an additional one off purchase of 26 placements per week, to clear the backlog of patients waiting. It can take some time to finalise a permanent placement because the individual and their family will want to be happy with what is likely to be their final home. However, it is not appropriate for them to stay in a hospital bed. We will continue working to move people on a temporary basis to a suitable home whilst their permanent move is finalised – where that is necessary.

5.6 *Move on team*: This joint OHFT, OUHT, OCC project seeks to streamline clinical decision making about fitness for discharge from hospital, so that delays are not caused by the wait for multiple assessments by different clinical disciplines. In addition provider partners are working together to improve team working, trust and joint decision making across organisational boundaries, in recognition that this team has not been as effective in making final decisions on discharge as had been anticipated. Providers are undertaking an organisational development project, with external support, to improve risk management, clinical decision making and clinical leadership. It is anticipated that, as a result, the Move on Team can be stood down in the autumn.

5.7 *Assessment and discharge planning improvements*: OCC have recruited an additional hospital based social work team which should significantly enhance the rate of hospital based assessments that it can complete, so reducing delays caused by waits for social care assessment. A contractual incentive is in place for OUHT to deliver a ward management improvement programme, and it is hoped that this will lead to improved discharge processes. Further work is also being developed to streamline assessment processes and to identify further improvements that can be made to discharge planning. A key recommendation of the recent peer review comparing processes in Buckinghamshire and Oxfordshire , is that Oxfordshire should put in place a system wide discharge policy, but agreement has not yet been reached on how to take this forward. This is a priority for further debate at the ACE Programme Board.

5.8 *Integration of health and social care community services on a locality basis:* This project will provide a single point of access for referring GPs or discharging hospital clinicians to community based health and social care services. It will provide an integrated physical health, mental health and social care assessment for patients leading to an integrated care plan and the appointment of a named lead professional responsible for ensuring that the care plan is delivered by a locality based team (as far as is practically possible). This OHFT/OCC project will significantly speed up the process of discharge and contribute to admission avoidance, simplify the pathway and deliver improvements to patients' experience of care. We expect that, over time, this will lead to rationalisation of the multiple services currently available within the community, but as an important first step it provides a simple one stop shop for referees, rather than requiring them to navigate the maze of existing services. In May 109 referrals were made through the service from 17 different referral routes. Approximately two thirds were from GPs and inpatient care teams.

5.9 *Development of shared information systems*: This OCC led project is developing a close to "real time" tracker that shows where patients are in the system and what their anticipated needs are. It will allow all organisations who will be involved in providing care for a patient to see that information so that they can be planning in advance and therefore be ready to meet a patient's needs, when that patient reaches their part of the system. A specification is currently being defined.

6. Additional development plans

In addition to the projects outlined above further work is being undertaken by NHS and local authority commissioners and providers.

6.1 The function and purpose of community beds will be looked at, as well as the skills and workforce of clinicians providing medical support (both within Community Hospitals, Intermediate care and for unstable frail older people living at home).

6.2 Commissioners will jointly evaluate the effectiveness and efficiency of the Reablement Services (provided by OHFT), the Supported Discharge Service (OUHT), and the Crisis Response Service (commissioned by OCC from a private sector provider) alongside the home care services available in Oxfordshire. This review will ask: How can we improve performance of these services, in particular the reablement service? Should these services be used in a different way for the benefit of patients and to use public resources better? A key element of this will be to ensure that there are sufficient care workers with appropriate expertise available in the right services.

6.3 Commissioners are working to develop a joint health and social care older people's commissioning strategy. This will identify any further changes required in the system to reduce delays.

6.4 Providers have very recently proposed a suite of additional collaborative projects, which were discussed at the ACE Programme Board on June 11th, and which will go to Provider boards for ratification in July – these will include looking at how we can ensure patients do not remain in NHS beds whilst waiting for their preferred home or community location to become available.

This page is intentionally left blank

Oxfordshire Local Involvement Network
Update for Joint Health Overview and Scrutiny Committee meeting 5th July 2012

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 brief update refers to LINk projects which mostly have a Health remit only, unless there is joint interest, or commissioning, with Social Care services

LINk Core Group

All members are welcome to attend the next Core Group meeting in public, which will take place at **Wallingford Methodist Church** on **Thursday 12th July from 1.30pm** (networking) – meeting from **2.00pm until 4.00pm**.
Agenda topics will include updates from earlier LINk involvement with Oxford University Hospitals Trust who will discuss their recent work on:

- The Productive Ward initiatives
- Food and Nutrition
- Discharge Planning

The LINk will be presenting their **Annual Report for 2011-12** and promoting support for improving and developing public engagement through **Patient Participation Groups** in collaboration with local representatives and the PCT/CCG. The LINk has developed a PPG 'Toolkit' for this purpose which will be used in partnership with the PCT/CCG's support programme.

Ongoing Health projects and engagement:

Mental Health 'Hearsay' engagement: An action plan for the year has now been received and is being agreed with Oxford Health and the PCT Commissioner. The delayed report will be published in mid-July and a feedback event planned with service users and carers for later this year, provisionally in October. The main themes from the event fall under the following headings, which will be reflected in the detail of the action plan and will be considered by the Joint Management Group (JMG) and the Better Mental Health in Oxfordshire Board (BMHO) at their next meetings, and where they will agree how the Hearsay engagement could relate to the BMHO's wider engagement activities:

- Pathway of care and access to services;
- Relationships (between physical and mental health services, and between different services, service users, carers and families);
- Carers and support;
- Confidentiality;
- Communication and information

A **Maternity Services review**, focusing on post-natal care, has been agreed by the LINk Priorities Group in collaboration with a HOSC working group, Commissioners and OUH. There will be a verbal report from the first project meeting due to be held the day before this Scrutiny Committee meeting.

The first formal meeting for the **Patient Participation Group** attached to Luther Street Medical Centre has taken place. Although low in attendance, the positive responses received are being used to further develop engagement, with LINk facilitation, through existing support groups within the homelessness hostels. Information collected will be fed back to Luther Street and the PCT/CCG.

Other projects

'Enter and View' visits to Care Homes

The second series of visits to 26 care homes has been ongoing from April 2012 with a report due later in the year. The proposed timescale will see the visits concluded during July with a draft report being available for consideration by the Enter and View Group in September and publication towards the end of that month.

'Assuring Quality in Externally Provided Social Care'. LINk has been invited to contribute to this joint ASSC / SCS working group, specifically to add to the monitoring of concerns raised by carers and recipients of externally provided social care services. LINk is collaborating in the development of an action plan, to include knowledge and feedback gained from Care Home visits and other information collected from SCS Hearsay and the SDS Forum.

Self Directed Support (Personal Budgets)

Following LINk support for the SDS event held in March and delivered in partnership with Oxfordshire Wheel and Oxfordshire Family Support Network, information & feedback obtained from service users and carers from this event has been compiled into a report. There are recommendations contained within the Hearsay report which are related to SDS and together with contributions from the SDS Forum, the various sources of information will reflect a wide consensus of recent views about the effectiveness and implementation of Personal Budgets. Responses to issues raised will be requested from SCS.

Local HealthWatch

An update on the procurement process and developments will be provided by the LINk lead officer for the County Council.

Adrian Chant (LINk Locality Manager)
01865 883488 Update 22/06/2012

Oxfordshire Joint Health Overview and Scrutiny Committee – Thursday 5th July, 2012

NHS 111 in Oxfordshire

1. Introduction

The NHS 111 service is being introduced to make it easier for the public to access healthcare services when they need medical help fast, but it is not a life-threatening situation. The NHS 111 service is part of the wider revisions to the urgent care system to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.

In future if people need to contact the NHS for urgent care there will only be three numbers; 999 for life-threatening emergencies; their GP practice; and 111.

2. Background

Research with the public has made clear for some time that the public find it difficult to access NHS services when they develop unplanned, unexpected healthcare needs. Changes in the way in which services are delivered have added to the complexity of the urgent healthcare system.

The result is that many people are unclear which services are available to meet their urgent, unplanned needs and how they should be accessed, especially outside normal working hours when GP practices are closed or when they are away from home.

NHS reviews have also found that patients want better information and more help to understand how to access the best care, especially urgent care, when they need it.

It was identified that the introduction of a three-digit number could provide significant benefits, not only to the public, but to the NHS as well.

The coalition government stated its commitment to a national roll-out of the new NHS 111 service as part of an integrated 24/7 urgent care service in the document *The Coalition our programme for government* and the White Paper *Equity and excellence: Liberating the NHS*.

On 1st October 2011 the Prime Minister, David Cameron and the Secretary of State for Health, Andrew Lansley announced that the NHS 111 service would be operating across England by April 2013.

3. How the NHS 111 service works

The NHS 111 service is available via an easy to remember, three-digit number – 111. Calls from landlines and mobile phones are free and the service is available 24 hours a day, 365 days a year to respond to people's healthcare needs, when:

- they need medical help fast, but it is not a 999 emergency;
- they do not know who to call for medical help or do not have a GP to call;
- they think they need to go to A&E or another NHS urgent care service; or
- they require health information or reassurance about what to do next.

Callers to 111 are put through to a team of highly trained call advisers, who are supported by experienced nurses. They use a clinical assessment system and ask questions to assess callers' needs and determine the most appropriate course of action, including:

- callers facing an emergency will have an ambulance despatched without delay;
- callers who can care for themselves will have information, advice and reassurance provided;
- callers requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs; or
- callers requiring services outside the scope of NHS 111 will be provided with details of an alternative service.

4. Service specification for NHS 111

The NHS 111 service operates according to the following core principles:

- Completion of a clinical assessment on the first call without the need for a call back.
- Ability to refer callers to other services for definitive clinical management.
- Ability to transfer clinical assessment data to other providers and book appointments where appropriate.
- Ability to dispatch an ambulance without delay.

5. Benefits

The introduction of the new NHS 111 service is expected to provide key benefits to the public and the NHS:

- Improve the public's access to urgent healthcare.
- Help people use the right service first time including self care.
- Provide commissioners with management information regarding the usage of services:

6. Implementation in Oxfordshire

- We are aiming for a July launch date in Oxfordshire.
- The 111 service in Oxfordshire has been developed by Oxfordshire Clinical Commissioning Group and Oxfordshire Primary Care Trust in partnership with South Central Ambulance Service and Oxford Health NHS Foundation Trust.
- In conjunction with the Department of Health we are following a four stage assurance process which will ensure robust testing of the 111 system before we go live.
- The 111 number will be available to callers living in or visiting Oxfordshire. However initially, the Thame area and some other border areas may not be able to access 111.
- A communications and marketing plan is being implemented, including:
    - In September there will be a mail-drop to relevant postcode areas in Oxfordshire
    - Press adverts during September
    - Further marketing is being planned by the Department of Health for November to cover the Christmas period.
    - Information will also be shared with the public via posters and leaflets being displayed in GP practices and other health service sites.

7. Further information

A dedicated email address has been set up for 111 queries. Please contact this address for any further questions you may have: NHS.111@oxnet.nhs.uk

This page is intentionally left blank

Oxfordshire Clinical Commissioning Group

NHS

Update on the development of the Oxfordshire Clinical Commissioning Group

1. Introduction

The following paper gives an update on the progress of Oxfordshire Clinical Commissioning Group (OCCG) in the lead up to its authorisation as a statutory NHS body in April 2013.

2. The authorisation process

OCCG has been successful in its application to be considered in Wave 1 for authorisation. There will be three further waves of authorisation to help spread the work involved at the NHS Commissioning Board. OCCG believes that it is a real benefit to be part of Wave 1 as this will mean we will have completed the process by October leaving the organisation free to concentrate on ensuring we have achievable plans in place for 2013/14 and have time to address any conditions before taking full responsibility in April 2013.

For OCCG this means all evidence needs to be submitted to the NHS Commissioning Board (NHSCB) by Monday 2 July 2012. The information submitted will then be reviewed by an assessment team appointed by the NHSCB using the six domains:

1. A strong clinical and multi-professional focus which brings real added value.
2. Meaningful engagement with patients, carers and their communities.
3. Clear and credible plans which continue to deliver the Quality, Innovations, Productivity and Prevention (QIPP) challenge within financial resources, in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies.
4. Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commissioning all the services for which they are responsible.
5. Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.
6. Great leaders who individually and collectively can make a real difference.

Within these domains there are 118 criteria being used to ensure the CCG is ready to be authorised.

The initial review will result in feedback to OCCG with an indication of the key lines of enquiry that will be used during the next stage of the assessment at a site visit during September.

The CCGs going forward in wave 1 are expecting to have confirmation of their authorisation in October 2012 before becoming a statutory organisation on 1 April 2013.

3. Stakeholder survey

Ipsos MORI have coordinated the stakeholder survey which is being used by the NHSCB as one piece of evidence for authorisation. The stakeholders identified by OCCG included several members of Oxfordshire Health Overview and Scrutiny Committee, District, City and County Council representatives and LINks. Other stakeholders included local NHS providers and all 83 GP practices in Oxfordshire.

The overall response rate for OCCG was 60% and it is understood that there were several reports of technical difficulties which meant Ipsos MORI conducted some interviews by telephone. Thanks go to all those who completed a survey.

4. Governing Body appointments

The appointment of the Chair, Accountable Officer and Chief Finance Officer for CCGs is being managed through a national process.

Stephen Richards has been confirmed as appointable to the post of Accountable Officer- this will be finally confirmed by the NHSCB following the authorisation process. Confirmation is expected soon for the Chief Finance Officer appointment.

Recruitment to the post of Chair has resulted in two candidates being put forward for the national assessment. Assuming both are appointable, the governing body will then make a decision about which to appoint.

Three other directors are currently being recruited: Director of Quality and Innovation, Director of Partnerships and Development and the Medical Director. These posts were advertised nationally and interviews take place later in June. It is likely that the names of the new post-holders will be able to be confirmed at the HOSC meeting.

Two lay members have been recruited following an open process that resulted in almost 80 applications interested in one of the lay posts (including the Chair). Ros Avery and Louise Wallace have been confirmed into these posts.

5. Structure of OCCG

An outline structure of the organisation has been published and consulted on with staff. Following appointment of the Directors, the Assistant Director posts will be recruited, initially allowing applications from existing staff across Oxfordshire and Buckinghamshire PCT Cluster. The more detailed structure of the organisation will then be determined which will also confirm which

functions will move to the Commissioning Support Organisation (initially to be hosted by the NHSCB).

6. Developing localities

The six localities are building their engagement with practices and all have monthly meetings with their practice leads. There has been a need to focus some of their time on considering the governance arrangements and other requirements for establishing a new organisation. This includes a constitution that describes the way the organisation will work.

They are currently developing Locality Plans which will begin to demonstrate the true value of clinical commissioning where plans are developed with a bottom-up approach. These locality plans may vary across localities as this is an opportunity to reflect the issues that are local to them. There is also a need to continue to deliver the savings required under the Quality, Innovation, Productivity and Prevention (QIPP) agenda and locality plans will demonstrate how this challenge will be addressed.

This shadow year is important for demonstrating capability to address some of the most challenging issues for Oxfordshire.

7. The Governing Body

The Governing Body for OCCG has 20 members:

- Chair (lay)
- 2 other lay members (one for audit, one for PPI)
- 7 Locality Clinical Directors
- Accountable Officer (clinical)
- Medical Director
- Nurse Director
- Secondary Care Doctor
- Chief Finance Office
- Director of Quality and Innovation
- Director of Partnerships and Development
- Practice Manager (non-voting)
- Director of Public Health (non-voting)
- Director of Social Care (non-voting)

There are eleven clinicians and six non-clinicians (three of whom are lay) with voting rights which provides a clinical majority.

A constitution for the Governing Body has been discussed with practices and following amendments made as a result, it is now agreed. The first meeting in public will take place on 4 September 2012.

15 June 2012

This page is intentionally left blank