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

# Oxfordshire Joint Health Overview & Scrutiny Committee

## Thursday, 19 April 2018 at 10.00 am
## County Hall

**Membership**

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Monica Lovatt

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| *Councillors:* | Kevin Bulmer | Dr Simon Clarke | Laura Price |
| | Mark Cherry | Mike Fox-Davies | Alison Rooke |
| *District Councillors:* | Nigel Champken-Woods | Neil Owen | |
| | Andrew McHugh | Susanna Pressel | |
| *Co-optees:* | Dr Alan Cohen | Dr Keith Ruddle | Mrs A. Wilkinson |

***Notes:*** ***Date of next meeting:*** *21 June 2018*

**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 Arash Fatemian<br>Email: arash.fatemian@*oxfordshire.gov.uk* |
| Policy & Performance Officer | - | *Samantha Shepherd Tel: 07789 088173*<br>*Email: Samantha.shepherd@oxfordshire.gov.uk* |
| Committee Officer | - | *Julie Dean Tel: 07393 001089*<br>*Email: julie.dean@oxfordshire.gov.uk* |

Peter G. Clark
Chief Executive

April 2018

## 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 5 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 of the meeting held on 8 February 2018 (**JHO3**) and to receive information arising from them.

For ease of reference when considering any Matters Arising from the last meeting, an actions list for 8 February 2018 meeting is attached for information.

## 4. Speaking to or Petitioning the Committee

## 5. Forward Plan (Pages 15 - 18)

**10:15**

The Committee's Forward Plan is attached at **JHO5** for consideration.

## 6. Healthwatch Oxfordshire (Pages 19 - 22)

**10:25**

George Smith, Chairman and Rosalind Pearce, Chief Executive Officer, will be present to report on the views and latest activities of Healthwatch Oxfordshire (**JHO6**).

## 7. Care Quality Commission Local System Review (Pages 23 - 102)

**10:45**

The Chief Executives of Oxford Health Foundation Trust (OH), the Oxford University Hospitals Foundation Trust (OUH), and the Oxfordshire Clinical Commissioning Group (OCCG), together with Oxfordshire County Council's Director for Adult Services (OCC) will present for scrutiny Health & Social Care's response to the outcomes of the recent CQC Local System Review and subsequent Action Plan (**JHO7**).

***The Committee is RECOMMENDED to note the progress made and to provide any comments or observations that it believes may assist in assuring delivery of the agreed Action Plan.***

## 8. OCCG: Key and Current Issues (Pages 103 - 110)

**11:45**

The Oxfordshire Clinical Commissioning Group has been invited to give an update (attached **JHO8**) on its key issues and upcoming areas of work. This includes:

- An update on the West Oxfordshire Place based Plan
- An update of the Transformation Programme
- Integrated Care Systems – some reflection and learning from the Buckinghamshire experience (presentation)

## 9. Response to the IRP - Consultant-led maternity services at Horton (Pages 111 - 138)

**12:15**

Attached are proposals from this Council and the OCCG to address the IRP recommendations on the permanent closure of consultant-led maternity services at the Horton General Hospital (**JHO9**).

County Council recommendations:

***The Committee is RECOMMENDED: to***

***(a) note the IRP recommendations;***
***(b) note the requirements to form a new joint health scrutiny committee in response to the IRP recommendations, to be focused on consultant-led maternity services at the Horton General Hospital;***
***(c) request Oxfordshire County Council's Director of Law & Governance, in consultation with the Chairman and Deputy Chairman, to seek to negotiate the terms of reference for a new joint committee to be focused on consultant-led maternity services at the Horton General Hospital, to include a membership that is agreeable to all three Councils, for approval by the respective full Councils.***

OCCG recommendation:

**The Joint Health Overview and Scrutiny Committee are asked to agree the proposed approach**

**12:45: LUNCH**

## 10. Oxford Health (OH) Quality Account

**13:15**

The Committee will scrutinise key progress against OH stated priorities. A presentation will be given (**JHO10**).

## 11. Oxford University Hospitals NHS Foundation Trust (OUH) - Quality Account (Pages 139 - 152)

**13:35**

The Committee will scrutinise key progress against OUH stated priorities. A copy of the presentation that will be made to Committee is attached at **JHO11.**

## 12. HOSC & Health 'Ways of Working' workshop report and draft principles (Pages 153 - 164)

**13:55**

The Committee is asked to consider and agree a Protocol for HOSC and health and wellbeing commissioner and provider liaison (**JHO12).**

***The Committee is RECOMMENDED:***

***a) to note the progress made against addressing IRP recommendation and the committee's agreements made on the 8 of February 2018;***

***b) to agree the draft protocol outlined in Appendix A of this report; and***

***c) subject to agreement of the Protocol and the proposal, to establish a HOSC Planning Group and to request the HOSC support officers to negotiate terms of reference in order to ensure the Group meets to inform the next meeting of the committee.***

## 13. Chairman's Report (Pages 165 - 186)

**14:10**

The Chairman's report is attached a **JHO13** which includes an update on health and social care liaison.

# 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 Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

# OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Thursday, 8 February 2018 commencing at 10.00 am and finishing at 1.05 pm

**Present:**

| | |
|---|---|
| **Voting Members:** | Councillor Arash Fatemian – in the Chair |
| | Councillor Kevin Bulmer<br>Councillor Mark Cherry<br>Councillor Mike Fox-Davies<br>City Councillor Mark Ladbrooke (in place of City Cllr Susanna Pressel)<br>Councillor Laura Price<br>District Councillor Andrew McHugh<br>District Councillor Neil Owen<br>Councillor Jenny Hannaby (In place of Councillor Alison Rooke)<br>Councillor Ian Corkin (In place of Councillor Dr Simon Clarke) |
| **Co-opted Members:** | Dr Keith Ruddle and Anne Wilkinson |

**Officers:**

| | |
|---|---|
| Whole of meeting | Deputy Director of Public Health; Julie Dean and Sam Shepherd (Resources) |

*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.*

## 1/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Cllr Ian Corkin attended for Cllr Dr Simon Clarke, Cllr Jenny Hannaby for Cllr Alison Rooke and City Cllr Mark Ladbrooke attended for City Cllr Susanna Pressel. Apologies were received from Dr Alan Cohen, Cllr Monica Lovatt and District Cllr Nigel Champken-Woods.

## 2/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

## 3/18 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 16 November 2017 were approved and signed as a correct record.

## 4/18 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following members of the public addressing the Committee immediately prior to Committee discussion on the item itself:

- Agenda Item 7 - Jane Southworth and Brenda Churchill - representing Deer Park Patient Participation Group
- Agenda Item 7 – Yvonne de Burgo – a former patient of Deer Park Surgery speaking as a member of the public
- Agenda Item 9 – Anita Higham speaking on behalf of the Oxfordshire Locality Patient Participation Forums - regarding MSK Services.

## 5/18 FORWARD PLAN

(Agenda No. 5)

The Committee reviewed the latest Forward Plan (JHO5), adding the following:

- 21 June 2018 meeting – to receive a report on the Stroke Rehabilitation pilot as discussed at the September 2017 meeting;
- 21 June 2018 meeting – to receive a report on the transition of Learning Disability services from Southern Health to Oxford Health.

For action

- Issues of Homelessness to be reported to the Health Improvement Board for action;
- The Chairman to discuss with the Chairmen of the Health & Wellbeing Board and the Health Improvement Board about how public health issues cross over with this Committee and the most appropriate mechanisms which would give the most effective oversight and scrutiny.

## 6/18 HEALTHWATCH OXFORDSHIRE

(Agenda No. 6)

The Committee welcomed Professor George Smith, Chairman, and Rosalind Pearce Chief Executive Officer of Healthwatch Oxfordshire (HWO) to present the regular update of issues/activities since the last meeting (JHO6). They highlighted the following from their report:

- Musculoskeletal services – Healthshare – HWO was aware of the current issues and were meeting with Healthshare that afternoon to raise issues of concern which had been reported;
- HWO was launching a new website in the style of Trip Adviser which would give HWO direct feedback from the public on every aspect of health and social care. This in turn would serve to flag up areas for HWO to focus its attention; and
- Three further appointments had been made to the HWO staff roll – one of which was a project officer to work with groups that provided feedback on issues of concern from patients and the public. The aim was to raise the standard of HWO reports by giving a clear focus and to better co-ordinate the stakeholders involved.

Questions from Committee Members and responses received were as follows:

- In relation to an inquiry as to whether there were any safeguards in place to protect against fake reviews in respect of the new website, Professor Smith responded that HWO was very aware of this and employed a moderative stance. All comments were scrutinised, some of which were better re-directed to the complaints procedure and not placed on the website. This was an opportunity to pick up an issue which had attracted multiple reviews from patients and the public, and to comment back.

- Professor Smith and Rosalind Pearce were asked if there had, in their opinion, been any recent meaningful engagement with BOB regarding the STP and how HWO were managing to stay with the rapid progress in relation to Accountable Care systems. Rosalind Pearce responded that there had been no public engagement with BOB recently as Louise Patten, the new Chief Executive of the OCCG, had only just taken up her employment. HWO were however keeping a close eye on the situation as things were moving quickly and it was important to exert influence. She added that not all discussion was based on written reports but was verbal and engagement could take place at any time. HWO was keeping a watching and listening brief in the communities and there were, for example, two forthcoming events taking place in Wantage and Wallingford;

- With regard to a comment from a member of the Committee regarding the problems being experienced by some users of the new Musculoskeletal Service, Professor Smith stated that HWO was continuing to put pressure on the OCCG and the provider to respond to problems. He stressed the importance of the work being undertaken by the OCCG to put in place more standardised Patient Participation Groups (PPG) across the County - and in turn the work HWO was doing at a locality level with PPGs to help the OCCG to achieve this. This would serve to give a more effective public voice. Professor Smith added that HWO were very pleased to announce that a contract was now in place with the OCCG to provide support for each PPG Forum which would provide a synergy with the new website and an increase in the flow of information;

Professor Smith and Rosalind Pearce were thanked for their attendance.

## 7/18 RESPONSE TO IRP RECOMMENDATIONS (INCLUDING WEST OXFORDSHIRE LOCALITY PLAN; OUTCOMES OF INDEPENDENT REVIEW; AND OUTCOMES OF WAYS OF WORKING WORKSHOP)

(Agenda No. 7)

Prior to the discussion of this item the Committee was addressed by the following members of the public:

Brenda Churchill made the following points:

- She had been unable to find any trace of the content of the IRP report and recommendations in the Witney and its surrounds Locality Plan;
- The review of Locality Plan patient engagement was misleading. Two meetings had been held in Carterton and Witney and only 125 people had attended them. Some locals had been refused entry as they had failed to book a place at the venue – it was her view that it was an insult to those people who had found it necessary to book a place as they were local residents;
- It was misleading to call the Plan a review document. She had not been made aware that NHS England had employed people to review the Locality Plan – nobody had approached her about this; and;
- New houses were in the process of being built now and patients would have to cope with more and more demand for the existing primary care services. She implored the Committee to instruct the OCCG to do as the IRP instructed and refute the plan.

Jane Southworth

- It was now over a year since the OCCG's decision to close the Deer Park Surgery and seven months since the IRP had made its recommendations to incorporate patient views into the plan. Nowhere had the Deer Park Health Group been engaged in the co-production of the Plan to address and provide solutions to the current future health needs of the area;
- She made reference to a personal experience of misdiagnosis by a paramedic and subsequent shambolic access to GP appointments;
- She asked about a proposal to relocate the Nuffield Hospital – this had not been debated.

Yvonne de Burgo

- Had been a patient at Deer Park Surgery and a member of its PPG;
- As a patient suffering with complex health needs, she had always received good care from Deer Park Surgery;
- She recounted her recent experiences of patient care at the surgery of which she was now a patient and had found it wanting in a number of areas including a lack of monitoring or follow up care;
- She expressed her hope that Deer Park would re-open;

- She was very concerned and stressed about the new housing being built in the area and the resulting numbers of new patients; and
- In all, the above had caused her great distress and fear that her life could be cut short.

The Chairman welcomed Louise (Lou) Patten, new Chief Executive of the OCCG to the meeting, together with Catherine Mountford and Julie Dandridge, OCCG.

Catherine Mountford, in introducing this item stated that the main focus was about ensuring safe and sustainable primary care in Oxfordshire. The focus that day was on the changing needs and changing population in the West Oxfordshire area.

With regard to progress made on recommendations put forward by the Independent Reconfiguration Panel (IRP) on Deer Park Medical Centre, Catherine Mountford reported that there were still 285 people who had not yet registered with another practice. The OCCG had asked for guidance from NHS England as to whether it should re-allocate these people and the resulting advice was to re-allocate them to another surgery by the end of March.

The OCCG welcomed the review commissioned by NHS England and had expressed a wish to continue to engage with parties on how best to go forward. She added that the OCCG had learned from experience from one year ago and had given some examples to NHS England on their changes of approach. For example, Kennington Surgery had been taken over by another surgery but continued to provide some services on the original site. The consultation in relation to the future of Banbury Health Centre had been another example.

With regard to the development of a comprehensive plan for primary care and related services for Witney and its surrounds Catherine Mountford made the following points:

- She stressed that the OCCG acknowledged that there was more work to be done in relation to engagement and on the opportunities for co-production. This first version covered west Oxfordshire divided into two groupings, one for Witney and East and one for rural west Oxfordshire. She added that an urgent piece of work to be undertaken with the people of Witney was to review housing growth and what that would mean for primary care in terms of the location of surgeries;
- Consultation on the final version of the Plan would end in December 2018. In the intervening time ‘people friendly’ plans would be developed with the local Forum chairs; and
- The consultation report had been worked up alongside the local Forum in a round table format to ensure that all were given the opportunity to contribute. The workshop had proved to be very productive and useful with some very rich discussion and the OCCG looked forward to taking the work forward.

Lou Patten welcomed the review espousing a very different approach to engagement in the future. She stated that engagement could only be started with a clear vision and a clear strategy for patients, from which a development plan could emerge.

Moreover, there was a need to look at the Health & Care Strategy again and to refresh it with significant engagement.

A member commented that whilst she understood the need for vision, she wondered why services had been taken away when they were needed. Lou Patten responded that small GP practices had a fragility in the County due to demand on the doctors working in those surgeries. The viability of small practices was a challenge. In such instances conversations with local residents and with other GP practices in the area was needed. The Committee asked to see the resources available to the CCG for the significant changes required, together with a breakdown of how much money had been spent on each practice in the past, and how much was currently spent. Lou Patten responded that there had been no loss of resource and she would support that request, adding that the NHS Funding Formula was a national formulation, the money following the patient. She added that there would always be a negative definition as doctors still saw patients who were not registered anywhere. Furthermore, the way funding was allocated was not within the hands of the CCG – it was via the National Association of GPs and NHS England.

A member commented that the Committee had seen a significant improvement in engagement with patients and the public in relation to Banbury Health Centre with a subsequent positive outcome.

Lou Patten was also asked where the funding for the required 25% increase in GPs and other staff increases would come from, together with the money needed for surgery relocations. She was also asked for evidence that there was a planned approach for a sustainable integration of health and social care – and was the CCG prepared to share in that plan? Louise Patten responded that the intention of the Plan was to be reiterative, that there was no end point and the CCG would continue to build on it. There was a need to understand local health and social care needs, the needs of the local workforce and rurality issues, in order to undertake a realistic way forward. She recognised that there was a substantial amount of work to do in the future. Julie Dandridge added that there would be a need to visit practices, talk to the GPs and the other workforce. Currently there was nothing concrete. Preliminary discussions were taking place with PPG's and the public and the CCG could start to build a plan arising from these discussions.

Lou Patten confirmed that patients in the Deer Park Surgery who had not re-registered with another surgery would now be allocated to other practices. The CCG had undertaken a large amount of work to ensure a safe transfer by the end of March 2018 to another practice, in recognition of its duty to ensure these patients were safe and had access to important screening and immunisation processes. Moreover, other services such as those that were subject to referral to Social Care, were based on GP registration. Julie Dandridge gave her guarantee that if there was a need to re-register patients in the future, then those patients would be re-registered automatically according to their choice if given. She stressed that patients still had a choice to leave the practice that they were allocated to and to re-register elsewhere in the locality. This issue had formed part of the learning going forward.

In response to an enquiry about whether Phase 2 of the Transformation Plan would emerge in the near future as more localities worked out their requirements for primary

care services, or whether accountable care systems would replace this concept, Lou Patten responded that the term 'Integrated Care Systems' would replace 'Accountable Care' which was American in origin. She added that there were no plans for this as yet and in order to embark on Phase 2 of the Programme, it would be necessary to reflect on and learn the lessons from Phase 1 first – and in particular in light of the CQC report findings. She confirmed also that there were no current plans to consult. She explained that the STP was in existence to help Health to think about how to embark on what was required to meet the needs of larger populations in localities, such as how to tackle workforce issues by, for example, upskilling staff and making changes to training needs.

In response to questions from some members about whether the CCG was confident with the way in which it was going about the changes to GP services, Lou Patten stated that one of the things that the OCCG did in its role as commissioner when dealing with Bicester and Banbury Health Centres was to give clear statements that local providers would need to work together with other providers in order to ensure a satisfactory outcome from the changes.

At the close of the discussion, the Chairman, on behalf of the Committee thanked Lou Patten, Catherine Mountford and Julie Dandridge for their attendance. The Committee, whilst acknowledging that the plan was an iterative process **AGREED** to request the CCG to take the following actions:

(a) produce a response to the recommendations made by NHS England in their review of engagement on the West Locality Place Based Plan;
(b) report back to the Committee on actions taken in response to meetings it had undertaken with stakeholders in West Oxfordshire; and
(c) update the Committee at its next meeting on 19 April meeting about expectations in relation to the next part of the Transformation Programme - and to request the submission of a detailed plan in the future.

## 8/18 CANCER SERVICES AT THE CHURCHILL HOSPITAL

(Agenda No. 8)

In light of the recent focus in the press on cancer services at the Churchill Hospital, a report was requested from Health representatives on the provision of services at the Hospital and any actions taken to ensure the resilience of these services. This was attached at JHO8 for consideration.

The Chairman welcomed the following representatives from the OUH to the meeting:

Dr Andy Peniket – Clinical Lead for Haematology
Matt Akid – Head of Communications
John Drew – Director of Improvement & Culture

Matt Akid began by welcoming the approach made by the Committee to establish the facts behind the headlines, expressing his belief that communication was very important to the Service. He explained that the headlines had centred on one part of the patient pathway which was chemotherapy treatments given at day treatment units

at the Churchill Hospital and at the Brodie Centre at the Horton Hospital. Almost 100 patients a day received treatment at these centres combined, which was a 10-12% annual increase in patients receiving chemotherapy. People were living longer in Oxfordshire compared to other areas and therefore more treatment was being given in comparison with other areas. The specific challenge was not one of resources, rather it was one of provision of nursing staff to manage the service and how to maintain standards in patient care.

He added that the challenges faced by the Trust in relation to the recruitment and retention of staff were substantial. More money had been put into this area but there were still problems in recruiting. Despite this the number of complaints had fallen and standards of care had continued to be very good.

He outlined the innovative work being undertaken to increase the capacity of chemotherapy services which included:

- Improved training to aid staff retention;
- Weekly interviews for staff using social media for recruitment campaigns;
- Working hard at the standards of service to attract staff.

Dr Peniket highlighted the efforts taken by the oncology consultants in seeking constructive comments and ideas about alternative ways of giving palliative care in a bid to maintain services; given the premise that how one responded to cancer care was not an exact science. Matt Akid added that in this instance the email in question which asked for comments and ideas was leaked and the Times newspaper had led with a headline 'hospital cuts to cancer care due to lack of staff'. A statement had then been issued to the Times stating that this headline was untrue, no decision had been yet been made and explaining that the aim of the email was not to cut services, that no changes to treatment had been made and the Trust's priority was to its patients. He agreed that whilst the issue needed to be aired, the impact of the headline was damaging and upsetting to patients. The Trust's clinical head of service, Dr Hobbs, had spoken to the media reassuring patients and the public of this, stating that the area of challenge was in nurse recruitment. The situation was then discussed with patients and staff who were given a more balanced and accurate picture of the situation.

The Chairman thanked the representatives for their very informative explanation of the situation. Issues and comments raised by members of the Committee, and responses received, were as follows:

- When asked if anything could have been done to prevent the newspaper headline, Matt Akid responded that the NHS was always very high on the media's agenda and therefore there was no surprise at the provenance of the story. However, the Trust always liked to handle things in a better way if it could. Furthermore, debate/discussion in public was not unhelpful and it was believed that issues such as these should be talked about in the public domain;

- Dr Peniket confirmed that whilst it might be sensible for chemotherapy to be administered at home, in line with practice in some other countries, the

delivery of chemotherapy in the home environment was strongly regulated in this country;

- With regard to a question about whether the Trust would consider engaging with the district councils about the offer of housing packages and other incentives in a bid to provide more staff to the Trust's hospitals, Dr Peniket stated that should an opportunity arise, the Trust would consider this to be very helpful. Some local Cherwell District Councillors urged the Trust to take this action, stating that Cherwell District Council had won an award for finding innovative ways in relation to housing;

- In response to a question, Dr Peniket stated that the Trust was thinking about ways of making better use of staff and it had plans to upskill, and give a greater role to support and care workers, whilst always keeping safety in mind. The Trust was also offering incentives for staff to work additional shifts. In connection with this initiative, a member asked if home-helps and local pharmacists could be trained to administer the drugs. Dr Peniket responded that this point was well made and there was further work to be done in this area, adding that there were many new agents coming onto the market which were less toxic, for example, immunity and modulatory drugs;

- A member asked if more training would be given to staff when treating or caring for patients with mental health issues; also whether more assistance from relatives who often had a greater knowledge and understanding of the patient could be accessed. Dr Peniket and John Drew accepted this as an interesting observation and indeed a training issue, stating that the Trust only appointed psychiatric assistance to support patients who had solid tumours. They accepted that staff could be better aware of acting on this knowledge and the Trust was already working on staff training to accord with the area of illness. They also added that training was not a hospital-wide speciality as the training status for major specialists was becoming harder and harder. This in turn became a difficulty for smaller units. The Trust however was trying to do its best. The Horton Hospital, for example, now had a trainee registrar which in turn enabled nurses to train there.

The Chairman, when thanking Mr Akid, Dr Peniket and Mr Drew for their attendance asked them to come back to the Committee when they were further down the line with their innovations as outlined above. They accepted, stating that they would be happy to do this, welcoming the opportunity to maintain a dialogue with the Committee. They also offered to organise a visit for members to visit the chemotherapy units at the Churchill Hospital.

## 9/18 CHAIRMAN'S REPORT

(Agenda No. 9)

Prior to discussion of this item the Committee was addressed by Anita Higham OBE, Chair of the North Oxfordshire Locality Forum, on the subject of Physiotherapy as part of Musculoskeletal Services. She also spoke on behalf of the North East, City, West Oxfordshire, South West and South East Locality Forums.

She stated that across Oxfordshire, all six Locality Forum Chairs were receiving concerns expressed by many patients who were experiencing a significant and serious breakdown in the provision by Healthshare for their physiotherapy and muscoskeletal needs. Healthshare was contracted to provide services for GPs in primary care and patient self-referrals.

She pointed out the view that although there were examples of good services, these were overtaken by serious administrative and organisational difficulties which had led to enormous frustration. Patients had experienced extensive discomfort and further pain due to a lack of treatment long after they had been referred.

OCCG had previously had quite separate contracts with the OUH and OH to the usual physiotherapy for MSK or neurological issues following in-patient procedures. She asserted that Healthshare had inherited a very considerable backlog of untreated patients from the previous contract holders for GPs and self- referrals and had made seemingly very little improvement in managing this. Locations for patient appointments were also not within acceptable travelling distances from their homes.

The locality forums believed that this was a problem of inadequately challenged and poorly monitored performance against contract by the OCCG. They requested the Committee to seek answers to these matters by requesting an update from the OCCG on publicly-funded Healthshare's progress against their contractual requirements.

The Chairman proposed, and the Committee **AGREED** the establishment of a Task & Finish Group to look at questions of the performance of MSK services, to include the expressions of concern received by the Committee in respect of the above.

Cllr Jenny Hannaby, local member for Wantage, expressed her concern that the physiotherapy department had ceased to operate from Wantage Hospital. Instead people were being allocated to premises in Faringdon, to which there were no bus services. She had recently been informed that people could also go to Witney and Wallingford community hospitals to access these services. She stated that only the maternity facility remained at Wantage and was concerned for the Hospital's future. The Chairman noted these comments and referred them to the Task & Finish Group for further examination.

Cllr McHugh reported that he had received correspondence from a number of GPs regarding MSK services stating that now the administration had improved, letters of referral had been received by patients. He added however that the time - period for referrals for scans was unacceptable and that the referral form itself were too complex. These issues were also referred to the Task & Finish Group.

The Committee **AGREED** the following recommendations (made as part of agenda item JHO7);

(a) develop working principles that could be signed up to by this Committee and Health colleagues

(b) amend the change process to introduce a staged approach with different threshholds of change (ie, minor/temporary/significant;
(c) introduce more flexible ways of working to allow for early engagement, dialogue, feedback, evaluation (for examples, briefings, task and finish groups, reference groups, debriefs, visits, annual planning event and training;
(d) robust feedback and communications (for example, to ensure HOSC feedback is recorded and communicated); and
(e) set an evaluation and reporting back framework.

In addition to the actions referred to above, the Committee **AGREED** to note the Chairman's report.

..... in the Chair

Date of signing .....

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**HOSC Actions from 8th February 2018**

| Item no | Item | Action | Lead |
|---|---|---|---|
| 03/ 18 | Minutes | The Committee to receive a report at its June meeting on Stroke Rehabilitation pilot discussed at the September 2017 meeting of HOSC | Dominic Hardisty (OH)/ (Sam Shepherd to add to Forward Plan) |
| 05/ 18 | Forward Plan | Committee to receive a report on the transition of LD services from Southern Health to Oxford Health at June meeting | Chris Walking (OCCG) (Sam Shepherd to add to Forward Plan) |
| 05/ 18 | Forward Plan | Issues of homelessness to be covered by the Health Improvement Board | Sam Shepherd |
| 05/ 18 | Forward Plan | Discuss with Chairmen of the Health & Wellbeing Board and the Health Improvement Board how public health issues cross over and should be reported to appropriate Board/Committee for most effective oversight and scrutiny. | Cllr Arash Fatemian (Chairman) |
| 07/ 18 | Response to IRP Recommendations | Further meeting with local stakeholders and patients in Witney regarding the provision of primary care services in the town and surrounds. | Lou Patten (OCCG) |
| 07/ 18 | Response to IRP Recommendations | Provide a breakdown of the resources deployed in Witney GP surgeries before the Deer Park closure and the subsequent resource deployment following its closure. This is to include the patient numbers, the funds which follow them but also the services to be able to identify what (if any) provision has been lost for residents of Witney. | Catherine Mountford (OCCG) |
| 07/ 18 | Response to IRP Recommendations | Committee to see the OCCG response to the NHSE report along with a report back on the meeting with local stakeholders (action agreed above) and the breakdown of resource deployment pre and post the DPMC closure. | Catherine Mountford (OCCG) |
| 07/ 18 | Response to IRP Recommendations | Update on phase two of the transformation programme to be reported to the Committee on the 19th of April, with a detailed plan if available | Lou Patten (OCCG) |
| 08/ 18 | Cancer Services | • No need for OUH to return as planned to the April meeting of HOSC.<br>• OUH to come back to Committee when they were further down with their future service plans, including to provide chemotherapy within the home environment, when appropriate;<br>• To take back the observation from the Committee about the need for more staff training in Mental Health issues. | OUH/ Sam Shepherd to add to forward plan as appropriate |

**HOSC Actions from 8th February 2018**

| | | | |
|---|---|---|---|
| | | • OUH urged to discuss with Cherwell District Council innovative ways to provide staff housing; and<br>• The Committee welcomed the OUH's wish to maintain a dialogue in relation to other topics they wished to bring back; and welcomed also the offer of a visit to the Churchill hospital. | |
| 09/18 | Chairman's report | Establish a task and finish group to look at the provision of MSK services | Sam Shepherd |
| 09/18 | Chairman's report | Develop working principles (including more flexible ways of working) for sign up and agreement by the Committee on the 19th of April | Sam Shepherd |
| 09/18 | Chairman's report | Amend the change process to introduce a staged approach with different thresholds of change (i.e. minor/temporary/moderate/significant). | Sam Shepherd |
| 09/18 | Chairman's report | Set an evaluation and reporting back framework. | Sam Shepherd |

# HOSC Forward Plan – April 2018

The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The "PICK" methodology can help scrutiny committees consider which topics to select or reject. This is:

| | |
|---|---|
| **P**ublic interest | ➢ Is the topic of concern to the public?<br>➢ Is this a "high profile" topic for specific local communities?<br>➢ Is there or has there been a high level of user dissatisfaction with the service or bad press?<br>➢ Has the topic has been identified by members/officers as a key issue? |
| **I**mpact | ➢ Will scrutiny lead to improvements for the people of Oxfordshire?<br>➢ Will scrutiny lead to increased value for money?<br>➢ Could this make a big difference to the way services are delivered or resource used? |
| **C**ouncil performance | ➢ Does the topic support the achievement of corporate priorities?<br>➢ Are the Council and/or other organisations not performing well in this area?<br>➢ Do we understand why our performance is poor compared to others?<br>➢ Are we performing well, but spending too much resource on this? |
| **K**eep in context | ➢ Has new government guidance or legislation been released that will require a significant change to services?<br>➢ Has the issue been raised by the external auditor/ regulator?<br>➢ Are any inspections planned in the near future? |

| Meeting Date | Item Title | Details and Purpose | Organisation |
|---|---|---|---|
| June 2018 | Health Inequalities | • Review of progress in the Health and Wellbeing Board's progress with the Health Inequalities Commission recommendations.<br>(request made on 16/11/17 that progress be reported to HOSC every six months to ensure health inequalities remains a priority). | HWBB |

Updated: 04 April 2018

| Meeting Date | Item Title | Details and Purpose | Organisation |
|---|---|---|---|
| June 2018 | Transition of LD Services to new provider | • Update on the transition of LD services from Southern Health to Oxford Health which took place in July 2017. | CCG |
| June 2018 | Stroke Rehabilitation: Report on Pilot | • Report back on the performance, outcomes and next steps following the Stroke Rehabilitation services pilot<br>• From intensive care in hospital to home care – occupational therapy services and plans for expanding ESD service – seek further evidence, facts and figures about points from HWO. | CCG, OH |
| June 2018 | Health and social care workforce | • Impact of workforce shortages in reablement & domiciliary care on acute services<br>• Impact of ASC precept | OCC |
| **Future Items** | | | |
| | Health in planning and infrastructure | • How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding<br>• Learning from Healthy New Towns.<br>• Impact on air quality and how partners are addressing this issue.<br>• How can HOSC best support the planning function | CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure |
| | Health visiting services | • Impact of changes to children's centres on provision of health visiting service<br>• Scrutiny of newly commissioned service<br>• 0-5 health visiting services | PH & OH & CEF |
| | GP appointments | • Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored | CCG |
| | Anaesthetist training at the Horton General Hospital | • | OUH |
| | Healthcare in Prisons and | • More in depth information on performance and how | NHS England |



Updated: 04 April 2018

| Meeting Date | Item Title | Details and Purpose | Organisation |
|---|---|---|---|
| | Immigration Removal Centres | success is measured.<br>• New KPIs in place from April 2017 | |
| | Health and Wellbeing Board | • How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration?<br>• Is there effective governance in place to deliver this?<br>• How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for greater integration? | Whole System |
| | Pharmacy | • Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities | |
| | Social prescribing | • The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell) | |
| | School Health Nurses | • The impact of school health nurses in secondary schools and future service plans<br>• This is being recommissioned by PH by March 2018 | PH, OH |
| | Health support for children and young people with SEND | • How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care?<br>• Linked to outcomes of SEND Local Area Inspection | OH, OUH |
| | Priorities in Health – Lavender Statements | • How the CCG manages competing priorities – Thames Valley Priorities Forum | CCG |
| | Commissioning intentions | • Committee scrutinises the CCG Commissioning Intentions | CCG |



Updated: 04 April 2018

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Your voice on health and social care

# **Healthwatch** Oxfordshire Update April 2018

## 1. Introduction

The Healthwatch Oxfordshire (HWO) Board would have met on 17th April prior to the HOSC April meeting. Lou Patten, Chief Executive Officer and Dr Kiren Collinson, Clinical Chair of Oxfordshire Clinical Commissioning Group are guest speakers. They will give a presentation entitled 'The Oxfordshire Clinical Commissioning Group's change in approach to health transformation including joined up health and social care engagement and consultations'.

Minutes of all Board Meeting in public are available on Healthwatch Oxfordshire web page:https://healthwatchoxfordshire.co.uk/our-reports/board-papers-and-minutes/

## 2. Care Quality Commission Oxfordshire Local System Review Report

Healthwatch warmly welcomes this report, with its emphasis on joined-up working and system integration. We will press hard for its full implementation. In a statement issued on 22nd March, much of which was shared by the Chair at the March 2018 Health and Wellbeing Board, the Healthwatch Oxfordshire Board expressed their concerns that the draft action plan in response to the CQC Report 'leaves many questions unanswered' including:

- Leadership – who is in the driving seat to manage the big changes that are being called for?
- Staff involvement – how is staff involvement to be managed throughout the process of change?
- Public involvement – what does 'co-production' mean in practice?
- External involvement – how will Oxfordshire learn from elsewhere in the country?
- Funding – there are no monies allocated in the draft action plan to implement changes, where will this come from?
- Communication – what steps are being taken to produce the plan in plain English?
- Outcomes – the draft plan does not identify outcomes expected, how these will be measure or what does "success" look like?

## 3. Health and Wellbeing Board Governance review

The Chair and Executive Director of Healthwatch met with the Leader of Oxfordshire County Council and the Chair of the Oxfordshire Clinical Commissioning Group as part of the HWWB's governance review. Our key messages were:

- Keep the main Board to maximum of 12 – 16 members including NHS Trusts
- Keep the Board focussed on strategy: delivery of the system working together
- Delegate routine matters as much as possible to the three sub-boards
- Meet more regularly in order to drive change forward
- Reduce the volume of board papers (we have reduced our report to lead the way!)
- This is an opportunity to explore new ways of involving wider representation

## 4. Healthwatch Oxfordshire website

In late February we launched our new website. The site offers a unique opportunity to service users to feedback their views, experiences and rate the services they have used. Services cover the whole range of health (hospitals, GPs, emergency, dentists) to care homes, home care, supported living and more. If a service is missing, then people can ask for it to be added. Information gathered will be analysed and reported to commissioners and service users. Service providers can respond to user comments. Follow this link: https://healthwatchoxfordshire.co.uk/services

On our website are two new pages – Supporting the Voluntary Sector and YouthWatch Oxfordshire https://healthwatchoxfordshire.co.uk/home/youthwatch-home/

YouthWatch Oxfordshire is part of our development in reaching out to young people – often seldom heard voices. YouthWatch will continue to be developed alongside young people and working with existing umbrella groups including VOXY (Voice of Oxfordshire Youth).

## 5. Bicester Town updates

Following the publication of our report Healthwatch Oxfordshire arranged a workshop in February. The attendees included local district and town councillors, Oxfordshire Clinical Commissioning Group, Locality Chair, Oxford Health NHS Foundation Trust, Oxfordshire County council, South Central Ambulance Service NHS Trust and Bicester Healthy New Town. Outcomes included agreement to meet again in 6-12-month time to review progress against agreed actions including:

1. Improved dental access for people in Bicester
2. Improved signposting for people to understand what service to access where
3. Plans to increase GP services in Bicester
4. A strategic plan for the community hospital in Bicester
5. Improvements in access to CAMHS

## 6 Project Fund

HWO Project Panel met in February and March and agreed to support five voluntary sector led proposals. These are:

1. Be Free Young Carers – research into the numbers, experiences, challenges and needs of young carers in Oxford City.
2. Oxford Community Aqua Wellbeing C.I.C – research into the development of champions and peer led aqua rehab sessions for MSK suffers in Oxford City.
3. Men's Health (East Oxford United) – research into men's access to health services through sports activity
4. CAB Oxford – explore patient experience of health and social care for people experiencing deprivation or other health inequality. To find out what works well, areas for improvement and provide practical, and ideally low cost, recommendations for change.
5. Rose Hill School Families' Health Consultation - How helpful parents/carers and 8 to 11-year-old children have found information they've accessed, where they perceive the gaps, and what they would like (from health care providers, support organisations and the school itself) in order to be able to adopt a healthier approach to nutrition and dental health.

**Filling the gaps…** our survey on people's views on NHS dentistry in Oxfordshire is live on our website until end April. People can also write into us or complete the free post 'Tell us' form to take part in this survey. As part of our research we are also surveying care and nursing homes to understand the level of access to NHS dentistry by residents of these homes. A full report will be available at the end May 2018.

## 7 Outreach activities

The focus of our activity in 2018 has been in Oxford City – particularly in Cowley, Blackbird Leys, Rosehill and Littlemore areas. Over two weeks in January and February, we made face to face contact with over 450 people. Individuals were able to share their experiences through talking directly to Healthwatch staff, by using our freepost 'Tell Us' forms at the time, or by completing a 'service review' on our website. We also spoke to individuals in more depth, at over 20 community groups we visited.

In total, we collected 315 'Tell Us' forms, in which people told us about their experiences both of specific services and broader health provision and pathways.

A report will be available in April.

The next town event will be in Wantage during May.

## 8 Voluntary Sector Forum March 2018 – Social Prescribing

The March Forum meeting focussed on social prescribing with speakers from the Oxfordshire Clinical Commissioning Group and patient participation groups involved in social prescribing initiatives throughout the county. Social prescribing is defined as "a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often

provided by the voluntary and community sector." How it is delivered varies across the country. A full report will be available on our website.

At our voluntary sector forum in December, HWO has made a commitment to improve our everyday engagement with the sector and launched a voluntary sector page on our website in April, which can be viewed by following this link https://healthwatchoxfordshire.co.uk/supporting-the-voluntary-sector/ The page includes links to the report on our Social Prescribing Forum held in March and a short video on social prescribing made at the Forum meeting.

## 9 Healthwatch correspondence

Since October 2017 HWO has formally written to:

- Oxford University Hospitals NHS Foundation Trust regarding A&E 4 hour wait
- Oxfordshire County Council regarding changes to adult daytime support services
- BOB STP Lead regarding Stakeholder Engagement – joint letter with four BOB Healthwatch
- Oxford University Hospitals NHS Foundation Trust and Oxfordshire CCG regarding winter pressures, bed closures and delayed transfers of care

All correspondence and replies can be found on our web site at:

https://healthwatchoxfordshire.co.uk/our-reports/campaigns-and-correspondence/

# Oxfordshire Joint Health Overview & Scrutiny Committee
# 19 April 2018

## Care Quality Commission Local System Review

## Report by Oxfordshire Heath & Social Care System Leaders

### 1. Introduction

This paper summarises the recent Local System Review of Oxfordshire completed by the Care Quality Commission (CQC). It provides a summary of the outcome of the review, the recommendations and the high-level action plan developed by system leaders in response to those recommendations, as well as setting out the proposed governance for ensuring the delivery of required actions.

In accordance with the CQC's Local System Review methodology, the Health and Wellbeing Board retains overall responsibility for delivery of the action plan, which was formally signed off by the Board on 22 March 2018. However, system leaders recognise the important role that the Health Overview and Scrutiny Committee can play in ensuring the Oxfordshire system is able to implement the agreed actions.

It is for this reason that HOSC are asked to note the progress made and provide any comments or observations that they believe may assist in assuring delivery of the agreed action plan.

### 2. Background

It was announced in the Spring Budget 2017 that councils would receive an additional £2 billion to support adult social care needs, reduce pressure on the NHS and stabilise the care provider market. Following this announcement, the CQC was asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 20 local authority areas, with Oxfordshire being selected as one of those areas.

The onsite review of the Oxfordshire Health and Social Care system took place in November with inspectors interviewing senior system leaders, holding focus groups with frontline staff and making visits to several health and social care services.

### 3. CQC Report

The CQC provided system leaders with a draft report on 22 January 2018 which detailed the findings of the review. Leaders were given five days to review the report and respond with comments regarding the factual accuracy of the report. 90% of the submitted comments were accepted and the final report was published by the CQC on Monday 12 February. The final report suggests fifteen areas for improvement as shown below. The full report is available in Annex 1.

On publication of their findings, the CQC's press release noted that:

*The review in Oxfordshire found that there was a strong ambition for partner agencies to work together and provide excellent services to the people of Oxfordshire but there was a lack of strategic planning. Despite this, health and social care professionals were highly dedicated to supporting people using services, their families and carers.*

*While Oxfordshire has a history of public engagement, feedback has sometimes indicated that this has not always been effective. This has been recognised by engagement leads and a dedicated Co-production Team has been set up to progress on the work required. The Social Care Institute of Excellence has reviewed the work of this team and confirmed that there is positive work taking place.*

*The Adult Social Care Outcomes Framework measures how well care and support services achieve the outcomes that matter most to people. The framework for 2016/17 showed that the percentage of older people who were satisfied with their care and support was slightly above average, but there was mixed feedback from people and carers about the quality of their experiences when the CQC spoke with them.*

*System leaders and frontline workers reported widespread issues in respect of recruitment and retention of staff across the system. In response there were plans to build affordable housing that would attract health and social care workers into the area, with a view to providing a more sustainable workforce. However, these plans would take some time to come to fruition and the CQC found that shorter term solutions were also being sought. There was a focus on job and career prospects, to manage and support the acute care system, and to provide seven-day care preventative services.*

*Across all areas of health and social care, a greater than average proportion of Oxfordshire services achieve a good or outstanding CQC rating, which is above the national average.*

*However there remain significant challenges to systematically join up services across organisations in Oxfordshire.*

The final report has provided a number of recommendations for system leaders in the NHS, social care and other bodies to act upon to make the whole health and care system work better

### 3.1 CQC recommendations

**Strategic Priorities**

a) System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. Whilst doing so, a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.

b) System leaders must address and create the required culture to support service interagency collaboration and service integration.
c) The Older Person's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the Older Person's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.
d) System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.
e) System leaders must evaluate their winter plans and demand pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.
f) System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.
g) System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

**Operational Priorities**

h) System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
i) System leaders should ensure that housing support services are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.
j) System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.
k) System leaders should review methods used to identify carers eligible for support, so that they are assured that carers are receiving the necessary support and have access to services.
l) System leaders should ensure that better advice to access information and guidance is offered to people funding their own care.
m) Continue to embed the trusted assessor model.

**Engagement Priorities**

n) System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.
o) Engagement and partnership working with the Voluntary Community and Social Enterprise sector should be reviewed to improve utilisation.

## 4. Local area summit and high-level action plan

On 29 January system leaders and major local stakeholders came together with CQC inspectors and representatives from the Department for Health, Social Care Institute for Excellence and NHS England to discuss the findings of the report and agree actions that would be taken in response. The system was required to develop and submit a high-level action plan to the CQC within 20 days of the report being published, which gave a deadline of 9 March.

The plan was developed by system leaders from across OCC, OCCG, NHS Foundation Trusts and GP Federations. It describes a number of high level actions that will be taken by the system in response to the areas for improvement identified in the CQC report. Each action is assigned an owner and timeframes are given for its completion. A number of the actions listed are already in progress through existing programmes of work or action plans. Where this is the case it has been referenced in the plan. The plan was approved by the Chair and Vice Chair of the Health & Wellbeing Board (HWB) ahead of its submission to the CQC on 9 March and was formally approved by the HWB on 22 March. The plan can be found in Annex 2.

The high-level plan will be supported by a more detailed plan which sets out the key milestones in each area and the progress towards these. A regular highlight report will be produced and submitted to the HWB for review. The report will highlight recent progress against all actions and planned activity for the coming period. It will identify and escalate any risks to delivery and mitigation steps taken.

## 5. Governance arrangements

In response to the CQC's recommendation that the system should review and simplify its governance structure, the Health and Wellbeing Board is undergoing a review of its functions, structure and governance. In accordance with the CQC's Local System Review methodology, the Health and Wellbeing Board retains overall responsibility for delivery of the action plan.

In addition, due to the multi-agency nature of this work, its urgency and its need to report to the HWB it has been necessary to create a dedicated HWB sub-group to ensure that the CQC action plan and related issues are delivered. It was agreed at the HWB on 22 March that the new HWB sub-group will adopt the following design principles:

1. To oversee a transformative programme of work between all NHS organisations and Adult Social care (including oversight of the CQC action plan).
2. To deliver the requirements set out in the Joint Health and Wellbeing Strategy for adults.
3. To deliver the requirements of the refreshed Older People's Strategy.
4. To provide a clear focus for strategic decision making for the NHS and adult social care in Oxfordshire.
5. To oversee the strategic integration of community services and urgent and emergency care services.
6. To oversee a shared workforce strategy for health and adult social care.

7. To seek the views of representatives of the public, patients and voluntary organisations.
8. To adopt a programme management approach to ensure that service delivery is achieved.

The new subgroup will also ensure that strategic decisions are clearly made in a single forum, thus reducing system complexity and streamlining decision-making processes. Terms of Reference for the subgroup are currently being written and the HWB chair and vice-chair will be asked to review and approve them this month.

**Responsible Officers**

**Kate Terroni** – Director for Adult Services - Oxfordshire County Council
**Louise Patten** – Chief Executive - Oxfordshire Clinical Commissioning Group
**Stuart Bell** – Chief Executive - Oxford Health NHS Foundation Trust
**Bruno Holthof** – Chief Executive - Oxford University Hospitals NHS Foundation Trust
**Will Hancock** – Chief Executive - South Central Ambulance Service

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# Oxfordshire

## Local system review report
**Health and Wellbeing Board**

Date of review:
27 November to 1 December 2017

## Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

## The review team

Our review team was led by:

- Head of local system review programme: Ann Ford, CQC
- Lead reviewer: Karmon Hawley, CQC

The team included:

- Three CQC reviewers
- One CQC analyst
- Five specialist advisors; one former local government director, one chief executive officer, one director of adult social care, one with a background in clinical nurse governance and one with a general practice background.

## How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive?**

We then looked across the system to ask:

- **Is it well led?**

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Oxfordshire County Council (the local authority), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford Health NHS Foundation Trust (OHFT),

Oxford University Hospitals NHS Foundation Trust (OUHFT), and South Central Ambulance Service NHS Foundation Trust (SCAS)

- Members of the Oxfordshire Health and Wellbeing Board (the HWB)
- Health and social care professionals including care home and domiciliary care agency staff, social workers, GPs, urgent care staff, reablement teams, and health and social care provider representatives.
- Healthwatch Oxfordshire and voluntary, community and social enterprise sector representatives
- People using services, their families and carers during our visits to day centres and support groups and in focus groups.

We reviewed 18 care and treatment records and visited services in the local area including OUHFT and OHFT sites, intermediate care facilities, care homes, a domiciliary care agency, a GP practice, an extra care housing scheme, out-of-hours services and the urgent care centre.

## The Oxfordshire context

**Demographics**

- 16% of the population is aged 65 and over.
- 91% of the population identifies as white.
- Oxfordshire is in the top 20% least deprived local authorities in England.

**Adult social care**

- 60 active residential care homes:
  - Two rated outstanding
  - 45 rated good
  - Five rated requires improvement
  - 8 currently unrated
- 74 active nursing care homes:
  - Four rated outstanding
  - 51 rated good
  - Nine rated requires improvement
  - Two rated inadequate
  - Eight currently unrated
- 113 active domiciliary care agencies:
  - Five rated outstanding
  - 81 rated good
  - Seven rated requires improvement
  - One rated inadequate
  - 19 currently unrated

**Acute and community Healthcare**

Hospital admissions (elective and non-elective) of people of all ages living in Oxford were almost entirely to:

- Oxford University Hospitals NHS Foundation Trust.
  - Received 92% of admissions of people living in Oxfordshire
  - Admissions from Oxfordshire made up 73% of the trust's total admission activity
  - Rated good overall.

Community services are provided by:

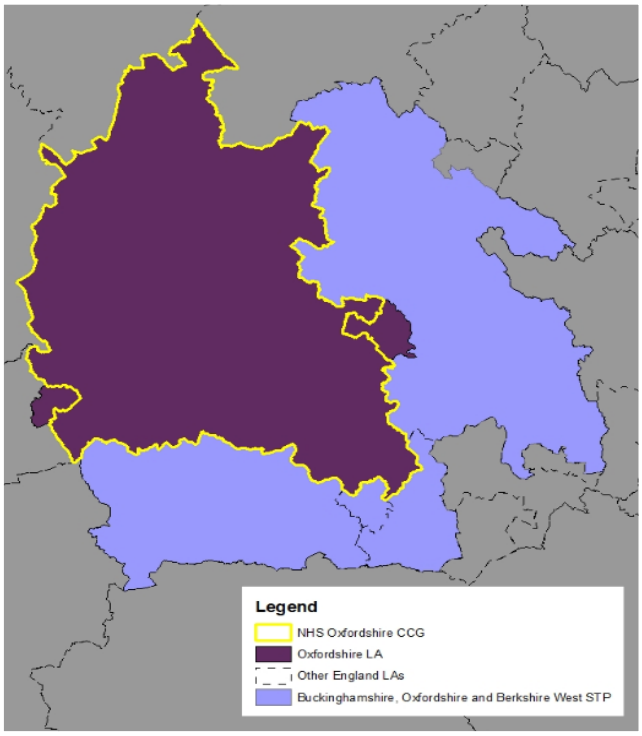
- Oxford Health NHS Foundation Trust
  - Rated good overall

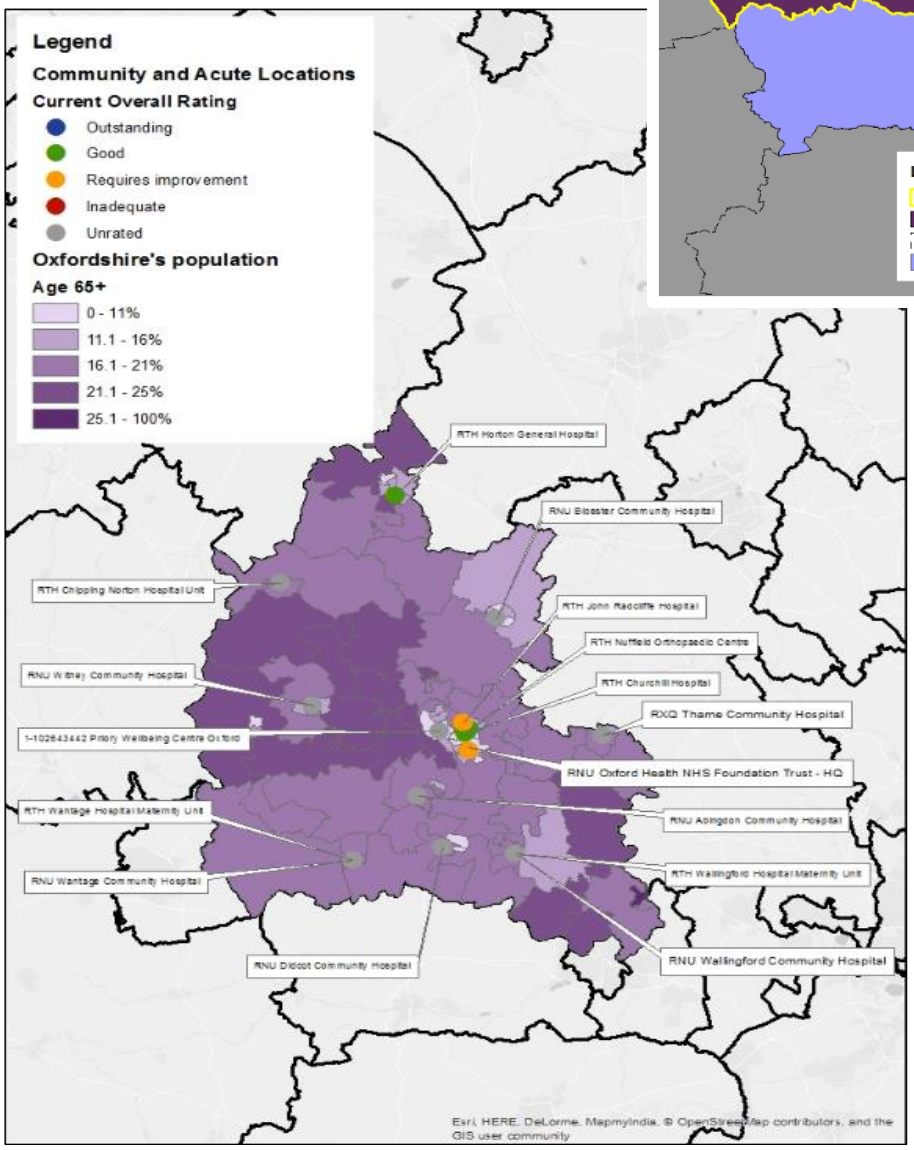
**GP Practices**

- 72 active locations:
  - Four rated outstanding
  - 64 rated good
  - Two rated requires improvement
  - One rated inadequate
  - One currently unrated

*Acute location ratings as at 01/07/2017. ASC and GP ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.*

Map one (right):
Location of Oxfordshire LA within Buckinghamshire, Oxfordshire and Berkshire STP.
NHS Oxfordshire CCG is also highlighted.




Map two (left):
Population of Oxfordshire shaded by proportion aged 65+. Also, location and rating of acute and community NHS healthcare organisations serving Oxfordshire.

## Summary of findings

**Is there a clear shared and agreed purpose, vision and strategy for health and social care?**

- In Oxfordshire we found that there was a lack of whole system strategic planning and commissioning with little collaboration between system partners. We could not find a compelling shared vision for the design and delivery of services. The significance of a shared vision is that it gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care .

- Although there was increased ambition to work together system leaders continued to face significant challenges in coming together to formalise their ambitions through a joint strategic approach.

- Leaders were not able to provide a comprehensive strategy for the transformation and delivery of integrated services which would consequently impact upon effective commissioning and delivery plans.

- A lack of collaboration had led to a fragmented system where there was duplication of effort and at times, a reactive tactical response to embedded performance issues such as delayed transfers of care (DTOC). System leaders were considering national targets but not always applying them to their community and what is required to meet the needs of the people of Oxfordshire, for example, the strategy for older people was out of date and had expired in 2016.

- There was too much focus on service delivery when a person was at the point of crisis and little attention to prevention and early intervention services for older people with social inequalities, seldom heard groups and for those who may not be known to the system.

- The Buckinghamshire, Oxfordshire and West Berkshire (BOB) Sustainability and Transformation Partnership (STP) had little impact in delivering pan-Oxfordshire transformation. The development of local strategies to support older people who lived in Oxfordshire was a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forwards in 2018, and so that process had not been completed at the time of the review.

- The Oxfordshire Health and Wellbeing Board (the HWB) did not have a clear role in influencing a strategic approach to support the joined up delivery of services. There was

recognition that the HWB required reconfiguration and a stronger sense of purpose. The chair and vice chair had a clear view for the development of the HWB and were keen to enact changes that would make it more effective and improve engagement with providers including the VSCE sector.

- The planned HWB review presented an opportunity for improved co-production, bringing together a full range of providers, and holding them to account for the delivery of the transformation programme, as well as providing clarity in respect of the interface with the wider STP.

- Relationships between Oxfordshire County Council (the local authority), Oxford Health NHS Foundation Trust (OHFT), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford University Hospitals NHS Foundation Trust (OUHFT).and South Central Ambulance Service NHS Foundation Trust (SCAS) had been difficult over many years and although we found evidence that these had improved, feedback to our relational audit demonstrated that some cultural issues remained. For example, a few respondents described contrasting organisational cultures and the emergence of a blame culture in some organisations. Organisational development was required to address these barriers and create the required culture to enable better collaboration and service integration.

- The challenge for this system was to articulate its medium to longer term strategic ambitions while remaining focused on delivering continuous improvements against current performance pressures.

- Significant strategic effort is needed to ensure housing growth meets the demand of the much needed recruitment and retention of health and social care professionals and related key workers.

- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives including working with education institutes to enable innovative approaches to growing the workforce.

**Is there a clear framework for interagency collaboration?**

- There was no clear framework for interagency collaboration.

- There were some agreed overarching programmes aligned to the STP such as workforce planning and urgent care performance. However, the Oxfordshire system had not yet articulated a central, unified approach for the meeting of local needs aligned to the STP's strategic aims for the wider geographical BOB STP area).

- While each individual organisation within Oxfordshire had its own governance and reporting structures there were limited joint governance arrangements in place with unclear lines of accountability between system partners. The long history of pooled budgets jointly led by the CCG and the local authority was a good platform for the sharing of targets, outcomes, risk and reward. However, arrangements to support the management of wider risks to delivery were not jointly owned, which meant that different components of the system could, and sometimes did, focus resources on managing individual organisational pressures and targets rather than seeking joint solutions.

- The recent refresh of the pooled budget (Section 75) agreements between the local authority and the CCG had provided greater clarity and focus on older people. There were some good but limited examples of joint working which were having a positive impact on people.

- System leaders told us that at a strategic level, plans for Improved Better Care Fund (iBCF) spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.

**How are interagency processes delivered?**

- There were some positive examples of effective partnership and collaborative working but it was widely recognised that some cultural and organisational barriers remained, which impacted on the ability to embed interagency processes. Organisational development work is required to address these issues if integration of service provision is to be realised.

- System leaders need to continue building cross-system relationships, articulating shared governance arrangements and jointly agreeing performance criteria.

- While we found some examples of staff working in an integrated way to deliver positive outcomes for people, the system remained fragmented and frontline staff reported multiple confusing access points into the system that impacted upon care delivery, and resulted in people who needed support having to fit into the system rather than receiving individualised care.

- System leaders acknowledged problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to a legacy of system challenges.

**What are the experiences of front line staff?**

- System leaders and senior managerial staff were visible and accessible. However some operational and frontline staff felt there was a need to improve and have effective conversations and co-production opportunities so that staff and people using services could influence and shape service design and delivery.

- Frontline staff were dedicated to providing high-quality, person-centred care and working in a seamless way with colleagues across the system. However they reported heavy workloads and recruitment challenges that did not support seamless care delivery. Workforce leads across the system cited work pressures at all levels as an inhibitor to integration.

- The incompatibility of IT systems was a common problem and frontline staff faced challenges when sharing information which impacted on the ability of staff to support people effectively.

**What are the experiences of people receiving services?**

- The experience of people receiving health and social care services in Oxfordshire varied. The Adult Social Care Outcomes Framework (ASCOF) measures for 2016/17 showed that the percentage of older people who were satisfied with their care and support was slightly above average. In addition, CQC's ratings of adult social care locations, which include feedback from service users, show that a higher proportion of locations in Oxfordshire are rated good and outstanding compared to the national average. However we received mixed feedback from people and carers we spoke with during the review.

- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.

- People were treated with kindness and frontline staff were dedicated to providing person centred care, going the extra mile for people they cared for. Better Care Fund (BCF) plans supported personalisation and choice through the development of alternative models of care and investment in more flexible budgets.

- Some older people were not always seen in the right place, at the right time, by the right person. People using services, their families and carers reported multiple points of access and a fragmented approach to service provision meant that the system was confusing for people to navigate.

- People using services were complimentary about their interactions with staff and some services they received. However some people had very poor experiences of discharge from

hospital. For example, one person told us they had been discharged without the necessary care package in place and we saw a case study where appropriate support from a community healthcare professional had not been arranged on discharge. People using services also told us they had been discharged from hospital in the early hours of the morning.

- Although there was an increase in provision of primary medical services, some people reported varied access to services that meant they could wait for an appointment for up to 2 weeks. As a result, people sometimes relied on emergency services including A&E. On attending A&E people sometimes faced a long wait, especially if arriving by ambulance due to delays in handover to A&E staff.

- Although our analysis indicated that the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014 and the average length of stay compared favourably against the national average, there were a significantly high number of delayed transfers of care. In addition the number of emergency readmissions was slightly higher than the national average.

- When people were admitted to hospital and needed a long term care package on discharge they were more likely to experience long delays, especially if they required complex support. People who experienced delays in moving to an appropriate care setting are at risk in terms of deterioration in their condition.

- The percentage of older people receiving reablement following discharge from hospital had decreased over the years in Oxfordshire and in 2016/17 was slightly below the national average. It also seemed that the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days following discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%,

- People who funded their own care experienced difficulties in accessing information in respect of support services available.

- While the ASCOF data and CQC provider ratings indicated that the percentage of older people who were satisfied with their care and support was above average, some carers we spoke with during the review felt the quality of domiciliary care was unsatisfactory, with staff not always appropriately trained to manage complex needs.

- People told us that they felt involved in their care and treatment but due to duplication in some roles and services some people had to tell their story more than once and were subject to multiple assessments.

- Some people experienced delays in social care needs assessments which impacted upon their health and wellbeing.

- The approach to co-production with people who use services, their families and carers was under developed. There were challenges engaging seldom heard groups and ensuring proactive engagement about things that mattered most to people living in the area.

- People who use services, their families and carers felt that the voluntary, community and social enterprise (VCSE) sector offered a good range of support services however concerns were raised by some carers that they were not receiving enough support and a reduction in day services had also impacted on this.

## Are services in Oxfordshire well led?

**Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?**

*As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.*

*The alignment with the STP and the Oxfordshire transformation plan had contributed to delays in the development of local strategies to support older people who lived in Oxfordshire. The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been competed at the time of the review.*

*The HWB was not fully effective in its function and had not supported a clear shared strategic vision for the future of health and social care services in Oxfordshire. System leaders recognised some organisational development work was required and agreed that a joint vision and strategy was a priority. It was anticipated that the restructure of the HWB would provide the vision for integrated systems and structures.*

*Historical relationship issues were being addressed and relationships being rebuilt between system leaders and political leaders to enable change.*

*There were some good examples of the system working together to engage with people who used services, their families and carers; however a stronger approach to co-production was required.*

*While there was a shared commitment among system leaders to tackle challenges jointly this was not always translated into action at an operational level. There were missed opportunities to improve the system via lessons learned. Meeting the level of housing growth needed in the area to meet demand would require a significant strategic effort across all organisations.*

**Strategy, vision and partnership working**

- There was a single local authority and a single CCG commissioning health and social care service for people in Oxfordshire and CCG commissioning services for people who lived in Oxfordshire was overseen by a single Health and Wellbeing board. There were five district councils which were responsible for services such as housing and waste collection.

- Oxfordshire was part of a wider Sustainability and Transformation Partnership covering the Buckinghamshire, Oxfordshire and West Berkshire (BOB) area footprint as a vehicle for wider system transformation planning and partnership.

- The Oxfordshire HWB was designated to provide the strategic oversight for the development of a strategy for health and social care services. The strategy at the time of our review covered the period 2015-19 and stated that it was "ultimately responsible for setting a direction for the County in partnership". At the time of our review the HWB was not working effectively and it did not set out a clear or compelling shared vision for the delivery of health and social care services. This would impact upon effective commissioning and delivery plans. Furthermore, a shared vision gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care .A number of system leaders agreed that developing a joint vision and strategy, owned by partners was a priority.

- Given its statutory role for system leadership the HWB is the right body to set, agree and lead this vision, linked also to the STP. The review of the HWB governance and membership being conducted at the time of our review presented an opportunity to reshape the HWB so it took centre stage for driving a shared vision for older people in Oxfordshire and a shared case for change. It also presented an opportunity for the system to address the challenges it faced in order to focus simultaneously on what is happening to improve the current positon, and also the improvements needed for creating the right future system.

- System leaders were considering national targets but not always relating them to their community and the needs of the people of Oxfordshire. For example, we were presented with a strategy for older people which had expired in June 2016. While work was underway to review this, we were told this would not be completed until June 2018, which meant that services for older people in Oxfordshire had operated and would continue to operate for two years without a clear strategy.

- Elements of the health and wellbeing strategy, such as the integration of health and social care services, had not materialised. System leaders told us this was in part due to the development of the STP and the Oxfordshire transformation plan. 'The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been completed at the time of the review.

- The CCG established an Oxfordshire Transformation Board in partnership with the local authority, OUHFT, OHFT, SCAS and the GP federations in 2015 to consider the transformation of services over five years. In the response to the System Overview Information Request (SOIR) system leaders indicated changes were already underway through the Oxfordshire Transformation Programme which was in two parts. Firstly, in working towards an accountable care system, and secondly, to better integrate primary, secondary care and social care services. At the time of the review there was no overarching vision for an accountable care system, and there was no evidence of commitment from partners to drive this, or a plan to achieve it.

- Work was needed to build positive relationships both politically and organisationally to reach agreement regarding transformational change. Phase one of the transformation programme could not be fully progressed because there was an ongoing judicial review of maternity services.

- System leaders recognised that there was a need to continue to improve relationships. We were told that recent changes in leadership had produced a more open culture that was more responsive to change and supportive of transformation. Although these were developing and system leaders were committed to serving the people of Oxfordshire well, feedback from 253 respondents in our relational audit showed some deep rooted issues in respect of organisational culture, trust, as well as communication and personnel challenges. For example, a lack of joint working created difficulties with communication across different organisations affecting the quality and continuity of care.

- Within Oxfordshire, leaders felt that the system was effective at addressing issues such as commissioning new services in response to the latest national initiatives. However we found that this reactive approach meant partners did not often have capacity to reflect, set plans and develop actions in a considered way to establish how they fitted with wider strategic objectives.

- There were some examples of good individual services in health and social care, and jointly commissioned services, including the Home Assessment Reablement Team (HART).

However, overall there was a lack of integration, and lack of a shared and understood joint workforce strategy.

- There were mixed views regarding the effectiveness of winter planning. Although system leaders were cautiously optimistic about their capacity to manage winter pressures, clinicians we spoke with were less so. Some of the measures put in place to manage discharges as part of winter planning such as 'one stop' ward rounds taking into account arrangements such as medicines to take home, were standard good practice and should be embedded in day to day discharge management rather than being seen as something new and innovative. Similarly, an improved approach to discharge planning was anticipated but far from embedded in the acute setting with limited evidence of the wider application of the high impact change model.

- Some leaders and front line staff we spoke with voiced concerns that planning for winter had been left too late and although bids for funding to support the management of winter pressures had been put in place there was little confidence in the system's ability to cope during this period.

- The recent refresh of the pooled budget between the local authority and the CCG provided greater clarity and focus on older people, and greater transparency regarding the overall spend. The review of the HWB, along with the existing pooled budget arrangements provided the system with a good opportunity to shape a shared vision, agree priorities and develop a communications narrative to galvanise the system into joint actions.

- The level of housing growth needed in the area to meet demand requires a significant strategic effort across all organisations, with the requirement for particularly strong partnerships between Oxfordshire County Council, the district councils and the Local Enterprise Partnership. This would help with the delivery of affordable and supported accommodation, which was much-needed to support older people, and the recruitment and retention of key workers in the Oxfordshire area.

- Local housing managers talked confidently about the initiatives to support this including extra care housing and efforts were predicated on the need for up to 100,000 additional new homes. A new project had started with a stock transfer partner to look at a bespoke model of "retirement living" to reduce costs and induce people into the area.

**Involvement of service users, families and carers in the development of strategy and services**

- Oxfordshire has a history of public engagement and co-production. However we received feedback indicating that it has not always been effective and local people felt that they had limited influence on the design and delivery of services.

- Challenges with public engagement were recognised by the system's engagement leads. The need to do more and to use new and proactive measures for working with underrepresented groups such as black and minority ethnic groups and travellers was recognised. This was corroborated as concerns were raised about ensuring engagement took place with underrepresented groups locally, to establish what mattered to them. System leaders told us there was a commitment by the local authority to embed a culture of co-production with people who use services, their families and carers across all adult services within the next two years. A dedicated team had been deployed to undertake this work which had been reviewed by the Social Care Institute of Excellence (SCIE) and which confirmed that positive work had been taking place and that the system were committed to the programme.

- There were some good examples of the system working together to engage with people who used services, their families and carers in the development of services, for example, around community beds (at Townlands Memorial Hospital), and carers, with – 'Oxfordshire commitment to carers' (Oxfordshire Carers' Strategy - 2017 to 2020). These examples involved working closely with the local community and ongoing engagement including stakeholder reference groups. System engagement leads felt they had made positive progress but there had been no formal evaluation or lessons learned review at the time of our review.

- The OHFT Dementia Strategy had been developed in partnership with people living with dementia, their families, the voluntary sector and OHFT staff. This strategy aimed to support OHFT to provide excellent and innovative specialist care to people with dementia and those supporting them throughout their journey. However, people's experiences differed with some people who use services and carers reporting a good service and others stating that insufficient support services were offered.

- SCAS representatives attended various patient forums and patient events including working with Oxfordshire Dignity and Dementia Champions Network. It had with an established dementia lead in post and a trust wide dementia strategy, which was underpinned by the clinical strategy 'Future opportunities and priorities to further care in the community'.

- The local authority worked closely with Healthwatch Oxfordshire to disseminate and cascade information and use feedback to inform how they designed, commissioned and delivered services. However, we were told that not all feedback was used to support service design and there were times when services such as daytime support had been reduced despite very positive feedback about its effectiveness in supporting carers.

- Providers had systems in place within their individual organisations to engage with people and obtain feedback. OHFT used a range of approaches to engage, involve and listen to older people as part of service delivery, which included patients, carers and public governors co-producing strategies. They had also made a five-year commitment to rolling out the online patient feedback tool 'IWantGreatCare' across all services which the system envisaged would provide rich, real-time feedback at service, team and clinician level. OUHFT had also undertaken a large number of engagement events, for example, the Quarterly Patient and Public Forum and Annual Quality Conversation with patients and members of the public.

**Promoting a culture of inter-agency and multidisciplinary working**

- System leaders recognised the need to improve the culture of interagency and multidisciplinary working. The Joint Strategic Needs assessment (JSNA) informed the vision and priorities of the Oxfordshire system towards new models of care, admission avoidance and discharging people from hospital as quickly as possible. The older people's strategy was being refreshed and would be completed in June 2018.

- Although jointly commissioned services were limited, there were some examples of good services in health and social care working together. For example the project groups working on DTOC and 'stranded patients'. However, many new initiatives were being developed without a shared approach, which resulted in silo working and a need to encourage a culture of inter-agency and multidisciplinary working to provide seamless care and avoid duplication of effort.

- In the response to the SOIR, system leaders told us that at a strategic level plans for iBCF spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.

- While there was a shared commitment among system leaders to tackle challenges jointly however this was not always translated into action at an operational level.

- There was evidence of staff working collaboratively across some organisations to deliver care, for example in community hospitals/frailty units, staff worked with medical staff from OUHFT. There was also integrated health and social care provision for mental health services. The 'Joint Enterprise' was being created between Oxford Health and the County's GP federations to look to integrate neighbourhood multidisciplinary teams across primary and community care, informed by the National Association of Primary Care 'primary care home' model.

- More work was required to ensure all providers felt like system partners and that they had representation on decision making groups. While some social care providers were positive about their relationships with commissioners, concerns were expressed in respect of commissioners understanding the limitations of what their services were able to provide and about variance in support offered to providers.

**Learning and improvement across the system**

- Previous reviews of the problems of DTOC in Oxfordshire had included looking at complicated pathways, workforce and service provision, and some progress had been made to address these known issues. Some pressure points had been reviewed by various elements of the system, rather than by the system as a whole, which had encouraged a fragmented, reactive response. The system was frequently in escalation which had resulted in this becoming normalised among frontline staff who accepted performance levels as a consequence of a pressured system. There was a need for more evaluation of the contributing factors to the escalation and de-escalation processes so lessons could be learned, continuous improvements made and shared system wide.

- Each organisation had sight of their own incidents and incident management but there was no single, coordinated approach to ensure lessons were shared widely across the health and social care interface. Safeguarding and Serious Incidents were appropriately managed via the Oxfordshire Safeguarding Adults Board and the Care Governance Framework.

- Although governance arrangements were in place, there were mixed views regarding how well the system was learning and improving. Concerns were raised from some system leaders, political leaders and social care providers in respect of the transparency of the system, listening to concerns when they were raised and taking positive action in response. People we spoke with felt there was a lack of ownership and acceptance of some of the issues which impeded improvements. Furthermore people felt there were limited assurances due to the fragmented system and silo working. Staff reported that issues were discussed at so many different meetings and different decisions made, it was challenging to understand and maintain governance. The system had not explored what it could do differently to improve leadership, reduce over-prescribed care and bring people who used services to the forefront of service design, delivery and outcomes.

- There was evidence of joint learning in some areas, for example the sharing of best practice in the use of the electronic system (CERNER sites) and collaboration and shared care guidance for the Oxfordshire area prescribing committee.

**What impact is governance of the health and social care interface having on quality of care across the system?**

*We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.*

*There were governance arrangements across the health and social care interface to assess, monitor, share and mitigate risks but further development was needed. There were clear lines of reporting between organisations and up to system level arrangements and the STP. There was a strong demonstration of commitment in respect of the HWB and it was expected that once this had undergone reconfiguration it would become more effective in its role. Partnership boards such as the Joint Management Group had been established to encourage interagency working. A lack of digital interoperability was a barrier to providing fully integrated systems, however there was a commitment across system leaders to improve this.*

**Overarching governance arrangements**

- The Oxfordshire Transformation Programme was the Oxfordshire component of the STP which was aligned with the HWB. The STP set out the strategic vision, delivery plans and provided an oversight of performance via the A&E Delivery Board.

- There were governance arrangements in place to support the planning and delivery of integrated care, particularly since the establishment of the Transformation Board. The Transformation Board existed to drive forward the long-term transformation of the health and social care system. The Transformation Board and A&E Delivery Board both benefitted from attendance by wider system partners including, Age UK, the Oxfordshire Association of Care Providers (OACP) and Healthwatch Oxfordshire.

- The HWB, together with its three sub-groups provided the joint forum for all aspects of the population's health and wellbeing and was chaired by the Leader of Oxfordshire County Council. Although the board was embedded in the wider system, it was due to undergo a restructure of membership. There were mixed views in respect of the effectiveness of the HWB, the level of challenge it provided and the ways in which it was aligned to and drove the system.

- The HWB had resolved to undertake a governance review with a view to exploring the potential of an Accountable Care System for Oxfordshire. This would be done in conjunction with other coordinating bodies such as the Transformation Board. The planned review of the HWB presented an opportunity to do this. Therefore the review should focus on setting a shared vision for the system and the relationship between the HWB, the Oxfordshire Transformation Programme and the STP. This would be particularly important if the HWB is to become the locus for the journey towards an Accountable Care System. This being the case, the review also offers an opportunity to co-produce and to engage care providers and the other stakeholders, such as VCSE sector organisations.

- System leaders told us that the JSNA and the health and wellbeing strategy provided oversight of further integration of health and social care, promotion of preventative services and re-shaping of NHS services outlined in the emerging Sustainability and Transformation Partnership. It also monitored related key outcomes and performance measures; however the older people's strategy was out of date.

- The long history of pooled budgets and the recent review of these was a platform for developing shared targets, outcomes, and risk strategies. The BCF Joint Management Group (JMG) monitored the resources that delivered the elements of the strategy that were within the scope of the pooled budget and provided assurance to the HWB. To provide the HWB with assurance around capacity and delivery, the revised scope of the pooled budget for 2017/18 had extended the reporting requirements of the JMG to include system indicators that were not strictly within the contracts commissioned from the pooled budgets but which the local authority and the CCG had responsibility for delivering in contracts outside of the pooled budget agreements.

**Risk sharing across partners**

- There were pooled budget systems and financial risk-sharing arrangements in place. However finance leads felt that should any unforeseen spending eventuality arise, there was not, at the time of our review, a robust contingency plan in place to manage overspend.

- There was evidence that the new iBCF monies had been spent on short-term solutions to target improvements against DTOC. Resources had also been used to offer incentives to care providers to enhance capacity however it was not clear that this spend was part of an overarching strategy to improve performance in the medium to long term. Although there was evidence that the more longstanding BCF had been structured strategically with financial risk sharing arrangements between the CCG and the local authority, there was less evidence on how these arrangements would be used to improve system integration or performance against DTOC under the remit of the Health and Wellbeing Board.

- All risks within the BCF were considered to be shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was sometimes reactive and Oxfordshire was frequently responding to escalated risk. We were told these procedures did not always work and alleviate pressures as they ought. System leaders were aware of this and told us NHS England was imminently due to support an evaluation of escalation procedures to try and put a structure in place as well as address any identified gaps.

**Information governance arrangements across the system**

- The incompatibility of IT systems was the most common problem cited by the 97 respondents to our relational audit who supplied free-text comments. Frontline staff told us that the inability to share information electronically was a barrier to supporting people effectively. There was potential to streamline the system and improve flow and productivity through better use of technology. Some good work had been done with access to GP records but this needed to develop further to include providers such as 'hospital at home' teams, ambulance services and district nurses so that professionals have access to the same records and are enabled to assess and plan care and support needs effectively.

- System leaders told us they had established information sharing protocols as part of the Oxfordshire Information Sharing Framework. This was an overarching agreement which set the standards by which information could be shared, and it was developed by a multi-agency information governance steering group. All statutory organisations had agreed to the framework and in the past two years, all GP practices had also adopted this agreement.

- System leaders acknowledged the problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to legacy system challenges. However both OUHFT and OHFT had been awarded Global Digital Exemplar status [1] under the national NHS programme and were well-positioned to enable this integration.

- While much had been achieved to date in Oxfordshire to enable information sharing, further significant developments were planned as part of the Oxfordshire Local Digital Roadmap (LDR). A key strategic work-stream in the LDR is 'Records Sharing', with an improved Oxfordshire Care Summary being one of the first deliverables. The Oxfordshire Care Summary is a Health Information Exchange; a real-time view of information held in disparate clinical systems across Oxfordshire about patients registered at Oxfordshire GP practices.

**To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?**

[1] A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

*We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.*

*Oxfordshire was particularly challenged by workforce issues across the system and countless concerns about this were raised during our review. There were strategic plans at organisational level and STP level to align the workforce to future demand and collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. The current workforce challenges resulted in heavy workloads for staff and impacted upon seamless care delivery and integration of services.*

*There were some examples of innovative approaches to responding to workforce capacity and skill set, looking at new roles and models of care. System leaders were working to develop the workforce* through integrated working and initiatives including working with education institutes.

*However, at the time of our reviews this work had not yet had a positive impact and workforce remained a key risk to service delivery and the meeting of need. In addition some social care providers told us they did not feel engaged in the workforce strategy and felt this was a planning omission.*

**System level workforce planning**

- The system in Oxfordshire was particularly challenged by the issues of workforce retention and recruitment across all professions and staff grades, especially acute hospital staff (with the exception of medical and dental staff, where the turnover rate was below the national average) and in the domiciliary care market. This resulted in staff shortages, heavy workloads and impacted upon seamless care delivery and integration of services. The system completed two comprehensive studies (in 2013/14 and in 2017) of Oxfordshire's adult social care workforce in order to better understand the fundamental cause of this issue. As a result, there was recognition among system leaders that the most likely route to resolving recruitment and retention issues was through joint working across the system, and through the Oxfordshire Transformation Programme aligned with the STP and the HWB. Models of care and the unqualified workforce were being jointly explored with the STP in a bid to address a potentially unsustainable workforce. At a more local level work had taken place between the local authority, OUHFT and OHFT to look at a joint workforce strategy, also linked in with the CCG and quality committee, and this was being tested.

- Collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway led by Oxfordshire Association of Care Providers along with career structure pathways, accreditation and a bid to promote the image and profile of working in the health and social care sector. System leaders should continue to work with all partners to align and address the system-wide challenges and ensure that strategic plans are supported by data and timescales for delivery.

- Working with Health Education England, system leaders in health and social care had been trying to build on the skills of those already living in the community and work with local colleges and universities. They had also been working with district councils to address the issue of affordable housing in an attempt to encourage the workforce into the county.

- Social care providers were not always engaged in a meaningful and true partnership way. Some care providers told us they did not feel engaged in the workforce strategy and wanted to be more involved. System leaders told us they had regular contact with them and social care providers had named officers they could build links with. They felt this, along with regular meetings helped them keep up to date with the workforce strategy and oversight of workforce. Independent providers had also been able to advertise for staff on the local authority's website.

**Developing a skilled and sustainable workforce**

- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives with education institutes. We found positive examples of innovative approaches to growing the workforce by, for example, working with local colleges and universities to support those students keen to pursue a career in health and social care.

- However, countless concerns were raised in regard to recruitment and retention and the impact this had on developing a skilled and sustainable workforce. It was expressed that there was too much fragmentation and more needed to be done to increase professional development and the care industry becoming professionally recognised.

- Social care providers were working together to share what was working well in an effort to harness some of the skills about retaining staff and offering training and information. The system leads for Quality and Contracts had been matching poor performing providers and good performing providers to enhance the training of the workforce.

- There was a positive emphasis on training for staff across all sectors and there was evidence of joint training events taking place, although social care provider awareness of this service was variable. Workforce leads across organisations showed determination to work across the system and they should be encouraged by senior leaders to find the space and time to develop their plans. They all cited pressure of work at all levels as being an inhibitor to integration.

- Staff experienced heavier workloads due to recruitment issues. System leaders had been looking at capabilities and the competencies of the workforce for example, delegated health

care tasks and the use of passports to allow best use of resources and reduce pressure on staff.

- Electronic Staff Record data for 2016/17 showed that the staff turnover rate for NHS staff at Oxford University Hospitals NHS Foundation Trust was higher than the national average across all staff groups, with the exception of medical and dental staff. Adult social care workforce estimates from Skills for Care showed that staff turnover rates had previously been below England and comparator averages in 2013/14, at 20.5%, but then increased over the next two years to 31.2%; above the comparator group average of 28.9% and the England average of 27.4%. Staff vacancy rates in adult social care were at 7.3% in 2015/16, which was in line with comparator averages of 7.2% and England average of 7%. It was expressed by system leaders, frontline and operational staff that the workforce challenges, cost of living and housing all had a significant impact on staff recruitment and retention.

**Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?**

*We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.*

*Commissioning strategies, underpinned by the JSNA and future projections had supported a joint approach to managing the care market and commissioning services and this provided a good platform to move forward with service and operational integration. Oxfordshire faced significant social care market issues and the system needs to make sure there is sufficient capacity and resilience to cope with an anticipated increase in demand. Given that a larger proportion of people in Oxfordshire funded their own adult social care than across comparator areas and England averages overall, the system faced challenges when negotiating care fees on a county wide basis or individual care package basis.*

*The system had developed an integrated commissioning function with a pooled budget but there was little evidence that much more shared working was planned. System leaders were aware of the challenges they faced and as a result of this a number of developments had taken place in regard to market shaping and models of care.*

**Strategic approach to commissioning**

- The BOB STP outlined the strategic vision, delivery plans and provided an oversight of performance across the STP footprint. While there were some overarching programmes such as workforce and A&E systems the strategic approach to commissioning was undertaken at a local level. However the HWB did not fully set out the strategic ambition of system integration, including integrated commissioning.

- The Oxfordshire Transformation Board which comprised system leaders from the local authority, the CCG, OHFT, OUHFT, SCAS, GP federations in Oxfordshire and Healthwatch was put in place in March 2015 to consider the transformation of services over five years and bring together health and social care partners with a focus on those programmes of work that will deliver significant improvements in the Oxfordshire health and care system.

- There were some positive examples of strategic approaches to commissioning which were effective, and had enabled some co-location of multidisciplinary professionals such as the 'virtual bed' (a specialist multidisciplinary team provided care in the person's own home, while an acute bed was held for a week to ensure if the person's health deteriorated there was an allocated bed space in the community setting for them to return to) and the admission avoidance services.

- While the absence of a specific focus on an older people's strategy made it difficult to articulate joint goals, commissioning plans were focused on the JSNA and projections about future demands on the profile of the population, which was incorporated into the joint Market Position Statements. There was an intended focus on prevention and place-based models of care designed to keep people well at home. However the preventative agenda was currently underdeveloped and leaders stated that the need for public consultation to had delayed fully integrated systems and structures.

- There was a commissioning model for domiciliary care and the system had reduced the number of providers. System leaders felt this gave a clear approach to providing assurances around income streams, ability to guarantee working hours as well as improving the terms and conditions of care workers. The CQC rating for quality for providers in Oxfordshire is higher than the national average; 88% of social care providers are rated as good or outstanding compared to 80% of providers nationally. However, during the review we found that social care providers felt there were some complex commissioning arrangements and contracts that were impacting upon their ability to provide a quality service. Commissioners should evaluate the commissioning arrangements to prevent agency failures.

**Market shaping**

- The response to the SOIR outlined that the local authority and the CCG worked jointly together and co-produced with providers to incorporate data in the JSNA and projection of future population demand into the joint Market Position Statements (first published in 2014). This outlined their understanding of the market, expectations about future demand, future purchasing intentions and represented the shared approach to purchasing and market pressures. However, the Market Position Statements did not fully set out a clear vision so commissioners and providers could use them to plan and deliver the services required to meet people's complex needs or ensure market shaping for capacity and workforce.

- Some social care providers felt they had not been involved in market shaping and they reported concerns of conflicts of interest and mixed messages in regard to building care home capacity when some care homes had more than 10% spare capacity.

- Oxfordshire had social care market capacity challenges as seen elsewhere in the country, particularly in regard to domiciliary care but there were differing views on how to address this, and continuing issues about affordability – pay was a common issue.

- The numbers of people being supported by the local authority for adult social care was comparatively low and a higher proportion of people funded their own social care compared to the comparator and England averages. This provided different challenges for commissioners who did not have as much influence when negotiating care fees on an individual care package basis. In light of the concerns raised by some social care providers and system leaders, commissioners needed to manage relationships and negotiations in a different and more collaborative way to secure the best rates for the local authority and best quality for people. This would ensure the system was fully assured of capacity and resilience in the market. This should be reviewed as a matter of priority to ensure there is clear view of capacity in the adult social care market.

- System leaders were aware of these challenges and the longstanding pooled commissioning budgets held by the local authority and the CCG had supported a joint approach to managing the care market and as a result of this, a number of developments had taken place in regard to market shaping. For example, the local authority and the CCG jointly fund a specialist dementia nursing home from the BCF pooled budget using social care and continuing healthcare (CHC) funding to create a 25-bed block.

- The local authority had also introduced a Dynamic Purchasing System for care homes to improve access to the care home market at more affordable prices, and the CCG had supported the development of this. The fragility of the domiciliary care provider market in Oxfordshire had partly been addressed through use of iBCF funding to improve provider prices. System leaders told us that fewer agencies had exited the market since March 2017 and there had been a realignment of providers on an approved list. However social care providers reported conflicts in respect of commissioning costs despite the local authority and the CCG paying the highest rates in the country for home care.

- To make best use of resources, there was a vision to move from a bed based model to the virtual beds and the service provided by the Integrated Liaison Team. Furthermore, although not a long term model, interim beds, hub and block beds to guarantee access to affordable and quality services, were available. This model had helped develop capability and capacity in the market, especially around the needs of people with the most complex

needs. System leaders acknowledged there was a need for further specialist capacity to support people with dementia. There were plans to increase capacity and a joint tender process put in place to create more specialist nursing care beds was set to conclude by January 2018.

**Commissioning support services to improve the interface between health and social care**

- System leaders acknowledged the review of the pooled budget arrangements challenged the approach to market management and its efficiency to deliver the outcomes and objectives set out in the Oxfordshire health and wellbeing strategy and the BCF plans.

- This had led to a number of initiatives to improve the capacity and capability of the nursing home market, joint purchasing of complex care and hospital admission avoidance from care homes. However some of these initiatives were not fully embedded or working as effectively as they were intended; for example there were a variety of services commissioned with health and social care providers to prevent admissions to hospital and to facilitate timely discharges, such as the HART, Reablement Outreach Team and trusted assessor models. But the effectiveness of these was hindered by workforce challenges, complex pathways and delays in assessments.

- Although the analysis we undertook showed the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014, there were a significantly high number of delayed transfers of care. System leaders were aware of the challenges and there was system wide recognition that the discharge pathway was complex. Therefore system leaders had mapped out the pathways in an expectation of streamlining the discharge pathway to offer the right support services and improve the interface between health and social care. The local authority and the CCG had jointly commissioned a Hospital Discharge and Reablement Service and a Community Reablement Service to bring several services together to provide a single pathway.

- There was a targeted, reactive approach to wider system pressures, resulting in preventative commissioning being under-developed. There was a lower uptake of direct payments and personal health budgets for NHS funded CHC, and a need to better utilise the VCSE sector, especially to support people ready for discharge from hospital.

- Although there were provider forums, communication between some social care providers and commissioners was reported as difficult at times and engagement was sometimes problematic. Social care providers felt they needed to be more involved in commissioning at an early stage, so that effective incentives could be discussed and for their concerns about commissioning to be listened to and responded to in a more proactive way. It was felt this would improve relationships, commissioning arrangements and service availability.

**Contract oversight**

- There were comprehensive systems in place to monitor the performance of commissioned services and a good response to quality issues. Commissioners were able to provide examples of how they evaluated the quality of service provision across the health and social care sector and how this helped improve activity and hold providers to account where required.

- System leaders monitored services to ensure care was appropriate and that providers delivered a quality service which met the contractual terms and conditions as well as the needs of people using services. Quality monitoring was risk based and there was shared quality monitoring between the CCG, the local authority and CQC. The system were able to demonstrate some positive outcomes as 50% of acute hospital core services, 47% of adult social care locations and 57% of primary medical locations within Oxfordshire had improved following a CQC re-inspection, which was better than both the comparator group average and the England average.

- The Oxfordshire Care Homes Association provided business intelligence and marketing information from across Oxfordshire to the system. This provided a mechanism to feedback any information or concerns. Information about people's experiences were also gathered from a range of national and local surveys, however system leaders acknowledged that they did not have the mechanisms to monitor and collate the total user experience through their pathways.

**How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?**

*We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.*

*Although there were clear lines of reporting between organisations with embedded risk sharing arrangements, due to system changes, governance arrangements were continuing to develop. There had been a long history of collaborative approaches and risk sharing arrangements, which were reviewed in line with system commitments to provide the necessary assurances.*

- System leaders told us that due to a range of strategic challenges a formal review of the pooled budget arrangements took place in 2017 which concluded that the pooled budget arrangements should be re-framed. Therefore the pooled budget structure for 2017 to 2019 had been changed and system leaders set themselves strategic performance indicators relating to flow, user and patient experience and quality that would support system transformation. There was evidence of commitment from system leaders to join up their

commissioning and use resources flexibly for the benefit of people who needed health and/or social care and evidence there had been a move towards operational integration with a commitment to build multidisciplinary teams.

- The BCF pooled budget for 2017/18 had been reviewed and brought together key budgets in relation to care homes, hospital avoidance and prevention. Our analysis showed that there were far fewer residential care home beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (nearly 50% fewer - 1523 per population in Oxfordshire compared to 3049 across comparator areas and 3043 across England) with only a 1% increase in the number between April 2015 and April 2017. In contrast, there was a much higher number of nursing beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (3864 per population in Oxfordshire compared to 2750 across comparator areas and 2710 across England). The number of nursing beds had increased by 6% between April 2015 and April 2017. The number of domiciliary care provider locations per population aged 65+ in Oxfordshire was slightly above the number across comparator areas and the England average (113 compared to 99 and 110 respectively) and this number had increased by 4% between April 2015 and April 2017.

- Rates of admission to residential and nursing care homes to provide long term support for older people had been consistently lower in Oxfordshire compared with its comparator group and the England average and had reduced further in 2016/17 to 484 per 100,000 from 530 per 100,000 the previous year. Avoiding permanent admissions is a good measure of delaying dependencies.

- The system faced some significant financial challenges. OUHFT made a small surplus, but did not achieve its financial control total. The CCG was reporting a balanced budget for 2017/2018 and the local authority faced significant financial challenge across its whole budget, although social care as a whole was likely to break even. It is likely that further financial challenges will need to be tackled in future years.

- System leaders were realistic about how this would be managed. System leaders also acknowledged the difficulties faced due to a higher number of people funding their own social care and the changes in the care market with a need to manage relationships and negotiations in different and more sophisticated ways than in the past to secure the best rates for the local authority and best quality for all people.

## Do services work together to keep people well and maintain them in their usual place of residence?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence**

**Are services in Oxfordshire safe?**

*There was a commitment at all levels across the system to proactively maintain people in their usual place of residence; however services to prevent people from needing to access secondary care were underdeveloped and some people experienced delays in social care assessments. Systems and practices were working well for the majority of people, but more was needed to be done to ensure there was a shared view of who in Oxfordshire was at risk of hospital admission and that pilots and initiatives were fully evaluated and embedded.*

- Some people experienced a delay in receiving social care needs assessments, resulting in a reliance on other services which were not best placed to meet their needs. Further concerns were raised about the effectiveness of the assessments and review processes in identifying people's complex needs. Case studies provided by local partners reflected these concerns and identified that some people in social housing were living in poverty or those with a social inequality were not identified early enough to prevent a crisis. It was only at the point of crisis that help and support was given which had a detrimental impact on people.

- A clear, in depth proposal to pilot a new frailty pathway to identify and support elderly and frail people to live well in their own homes had been drafted and was due to commence in December 2017. Oxfordshire GP federations and OHFT were also developing a joint enterprise to deliver joined-up primary and community care services through integrated neighbourhood teams. It was anticipated this would define a system wide frailty pathway, with a clear directives running through all parts of the system to care for people close to their homes.

- In an attempt to respond to system challenges, community based services such as care home support and an urgent visiting service (focussing on those at risk of admission to hospital) were available to identity those people who were frail, had complex needs or were at risk of deterioration.

- There was evidence within the case files we pathway tracked that some multidisciplinary assessments were undertaken and support put into place to keep people safe and maintain their health and wellbeing in their usual place of residence. There was universal positive feedback about these services from people, carers, families, system leaders and frontline staff.

- Care home and nursing home providers were supported to maintain people safely in their usual place of residence in a number of ways. Care Home Support Service nurses visited care homes and focussed on early intervention, prevention and improving quality of life. Formal structured teaching sessions were also offered focusing on subjects such as; recognising deterioration, falls prevention, prevention of dehydration, and pressure damage to the skin.

- A medicine optimisation initiative was in place to make more efficient the use of medicine and preventing admissions to hospital due to medication errors. The care home support service employed nurses specialising in medicines contributing to falls and pharmacists were offering additional support and training for GPs, nursing and residential home staff. GP surgeries employed pharmacists and further support was available from the CCG pharmacists. This included a pharmacist specialising in frail and elderly who was involved supporting care homes.

- Data from NHS England's Ambulance Systems Indicators showed that the SCAS routinely identified a higher proportion of calls to the ambulance emergency service as being from people for whom a locally agreed frequent caller procedure is in place than any other ambulance service in England. When these callers are identified, the SCAS team signposted them to the correct services so they received care at the right time, in the right place by the right person. The ambulance staff also worked with care homes staff who frequently used the service with a view to offering them training and support.

**Are services in Oxfordshire effective?**

*Sometimes people did not receive a multidisciplinary approach when requiring additional support services. There were multiple and complex access points which caused confusion for people using services, carers and some frontline staff. There was some success with admission avoidance projects and services. There were widespread workforce issues across the system impacting on service delivery and staff workloads. Work was taking place in regards to recruitment and retention of staff. IT systems did not always communicate effectively which created additional workloads, reduced efficiency and put people at risk of avoidable harm as key information about their care and treatment was not easily accessible.*

- A framework for an Oxfordshire Extra Care Housing Strategy for Oxfordshire County Council (January 2008) set out a commitment to invest in housing related support, extra care housing and assistive technology would support people to maintain their independence in their local community for as long as they were able and wished to do so. Although the framework had not been updated we found that investment had been forthcoming and when we visited a scheme, people using the service were positive about their experiences and told us that this enabled them to maintain their independence.

- Plans were in place to build and adapt properties that could remain a person's home for life and support longer term independence. Similarly plans to build affordable housing that would attract care and support workers in to the area were underway again with a view to providing a workforce that could support and maintain independence in a person's usual place of residence. It was important that this work continued at pace.

- Analysis of ASCOF data for 2016/17 identified that the number of people aged 65 and over entering care homes for support for long-term needs per 100,000 population was lower in Oxfordshire (484) than its comparator group average (525) and the England average (611) and had reduced over the last three years. Various pilots and projects had taken place or were underway as part of the admission avoidance work, for example, OUHFT and OHFT were running a pilot where cognitive behavioural therapy training was provided for professionals to improve medicines adherence. This pilot was in its infancy but early feedback suggested this was having a positive impact.

- Services designed to improve flow through the system and to keep people at home were evidence based but the service provision was fragmented, with multiple interfaces that increased the risk of delays in accessing services and confusion for people professionals and carers. There was not a single point of access for health and social care services, there was however a single point of access (SPA) for health services, which provided health professionals with an alternative referral route for patients needing community health services in Oxfordshire. We found that referrals were responded to in a timely way to provide support to people at risk of deterioration and avoid admission to hospital. The single point of access for health services took referrals from GPs, health professionals and more recently the general public but was separate to the social services access desk. There was a strong argument to make the single point of access more comprehensive and include adult social care services as people using services and some frontline staff, felt that there were multiple confusing access points.

- The SPA team was able to evidence positive examples of when they had utilised the trusted assessor model effectively across the system. But there was a need to work with other parts of the system to enhance the implementation of the model and fully integrate health and social care locality teams. For example, there were three Hospital at Home (H@H) services which operated to different specifications – frontline staff and social care providers felt it was sometime difficult to understand the different services offered by these teams and that further clarification was needed. This resulted in some people receiving an inconsistent multidisciplinary approach that was complex and disjointed. Case files that we pathway tracked and reviewed supported these findings.

- Access to primary care had been extended through the hub working approach, with all GPs

that were part of the GP federations working collaboratively to provide services to patients at the evenings and weekends. While this had yet to be fully stress tested, it enabled greater resilience and flexibility within the service and extended people's access to weekend and evening appointments. Our data analysis showed the provision of GP extended access was greater in Oxfordshire than in comparator areas and the England average. As at March 2017, only 2.9% of the 70 Oxfordshire GP practices surveyed offered no provision of extended access, while across comparator areas this was at 14% and across England was at 12.3%. Our analysis also showed that GP funding per patient in Oxfordshire had stayed above the England average from 2013/14 to 2015/16, and in 2015/16 was above its comparator group average (£145.76 compared to £143.67).

- There was an agreement in the BCF return for the delivery of a seven day service across the health and social care system. OUHFT was a national early implementer of seven day working and had facilitated system changes to extend routine working across a seven day week.

- The CCG had been working with the VCSE sector and OHFT to provide weekly falls prevention services to older people and was planning to extend services to begin focussing more on supporting people with long term conditions to improve health outcomes.

- System leaders and frontline staff reported widespread issues in respect of recruitment and retention across the system. In response to these challenges the local authority set out in the BCF plan that they had established a two year workforce programme, funded from the adult social care precept. There was a focus on job and career prospects and investment in additional long term staffing to manage and support the intermediate and acute care system, and to provide seven day prevention services. Despite this, staff in the acute setting continued to report heavy workloads with additional pressures of meeting targets. As the NHS England Five Year Forward View promotes a diversified skill mix in practices, some GPs had employed nurses or paramedics to do many regular reviews and some GP visits.

- Although frontline staff in health and social care services had the right skills and were provided with regular training and development, some social care providers told us they were unaware of training on offer from the local authority and CCG to support social care staff in reducing admissions to hospital.

- To some extent, staff were able to use computer systems or software to exchange and make use of information within the system; however these were not always effective, which impacted on the ability of staff to share information, especially between organisations as staff felt the risk of duplication and errors was too high to share cases.

**Are services in Oxfordshire caring?**

*People living in Oxfordshire were involved in discussions about their care and treatment. People felt there was not enough support provided to people living with dementia and further information and support was required for carers. A commitment to personalisation was articulated in the BCF plan and the future strategic vision and staff at all levels demonstrated commitment to providing person centred care.*

- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.

- Age UK had methods to provide people with access to networking and keeping up to date with what was happening in the health and social care sector. Support was also offered to carers, families and advocates so they too could make informed choices about future plans. However representatives in the VCSE focus group told us that there were approximately 62,000 carers a year not receiving the support they required and they had recognised they needed to be more creative and reflective.

- People were treated with kindness when they moved between health and social care services. Frontline staff were dedicated and provided person centred care, going the extra mile for the people they cared for. BCF plans supported personalisation and choice through development of alternative models of care and investment in more flexible budgets.

- Funding for day centres and community support had been reduced. This impacted on some people's wellbeing as they felt these had provided a vital service, providing a sense of purpose and reducing social isolation. This had an additional impact on carers as some felt that they needed additional support, especially as they may have difficulty accessing respite services.

- Oxfordshire's ASCOF performance in 2016/17 compared well against the England average, with the exception of DTOC. A higher percentage of older people were receiving direct payments and a lower rate of older people was being permanently admitted to residential and nursing care.

- Integrated community care teams and the H@H service provided timely support to people with a long-term condition to effectively manage their health and improve their outcomes and experience. Our analysis of data from 2011/12 to 2016/17 measuring how successfully people with long-term conditions felt the NHS supported them demonstrated that a consistently higher percentage of people in Oxfordshire felt they received sufficient support

than across comparator areas and the England average. Furthermore, 2016/17 data for the health related quality of life score for people with long-term conditions in Oxfordshire was above both the comparator and England average (0.77 compared to 0.76 and 0.74 respectively).

**Are services in Oxfordshire responsive?**

*System leaders and frontline staff had a shared vision that a person's own home was the best place for them. However, there were multiple confusing access points into the health and social care system and the VCSE sector were keen to develop networks and referral systems. Admission avoidance processes were in place, but further work was needed to embed them, as some were being developed in silos rather than strategically across the system.*

- Social care providers reported variable experiences and outcomes and a lack of enhanced health care support. However, the GP federations were working well and being embedded. One of the aims was to try and maintain people in their normal place of residence and keep them out of hospital by use of various initiatives such as early visiting services.

- System leaders acknowledged that primary care was under significant pressure with a reduction in the number of practices and capacity challenges. People using services told us that it was difficult to get non-urgent access to GPs and they sometimes had to wait for approximately two weeks for appointments. However the GP hub now offered a seven days a week service, increasing access to a GP. The GP hub was working well and had resulted in better use of resources. Although not the only solution and professionals who may be able to help, this may address the concerns that people identified with access.

- Engagement between the VCSE sector, primary health services and acute health services was disjointed and difficult with no direct route to the hospital.

- Our data analysis of the rate of A&E attendances per 100,000 population aged 65+ who were referred by the GP without follow up showed that this was significantly lower in Oxfordshire than the England rate and had been consistently so for the past three years. Also the rate of A&E attendances from care homes per 100,000 population aged 65+ at 475 was lower than the comparator average of 878 and the England average of 979.

- Emergency admissions of older people were below the England and comparator averages. Analysis undertaken by the Department of Health showed that the rate of emergency admissions per 100,000 population aged 65 and over between March 2016 and February 2017 was lower than the national average at 22,112 in Oxfordshire compared to 24,092 across England.

- This hospital avoidance was also in part was due to initiatives such as the Emergency

Multi-Disciplinary Units (EMUs), H@H, ambulatory units and the Rapid Access Care Unit (RACU), which provided rapid support to people at risk of deterioration in their own homes to prevent avoidable admission to hospital.
    - The EMUs provided a 'one stop shop' seven days a week for patients with urgent sub-acute health and social care needs to avoid an acute admission.
    - H@H provided by OHFT aimed to improve the healthcare of patients registered with an Oxfordshire GP within the patient's own home to provide a community sub-acute alternative to non-elective acute admission.
    - The RACU and ambulatory services provided an integrated, multidisciplinary care to sub acutely ill patients.
    - The H@H team worked closely with the ambulatory units to support the safe transfer of care to the person's own home and avoidance of hospital admission.

- We found some good work in place around admission avoidance but some projects were being developed in silos rather than strategically across the system detracting from the effectiveness of services. There was an urgent need to review all services offered and arrive at a coordinated strategy for service design, delivery and outcomes.

- A Practice Care Navigator role was used to signpost people to services. This had been piloted and rolled out successfully as an effective way to improve, protect and maintain the health of older people and vulnerable patients through integration of care. People using services and multidisciplinary professionals offered positive feedback about this service as well as the community services.

- SCAS offers an accessible community-based First Aid Unit to people in the Chipping Norton area. There are similar units run by OHFT in Wallingford and Henley. These services signposted people to available services or advice. SCAS has also set up with OUHFT a service where gerontologists who were able to give advice to nurses and GPs supporting people in nursing homes.

- The Integrated Liaison Team facilitated person centred care in people's own homes. Care was delivered according to people's needs rather than them having to 'fit' to the services available. People using services provided positive feedback about this service. There was evidence to demonstrate that this team worked in a multidisciplinary way with other professionals to keep people at home wherever possible.

- Case files we reviewed demonstrated these services were effective and admission avoidance had taken place where possible by use of these services. GPs felt these services were useful for patients who would otherwise be admitted to hospital and frontline staff and system leaders spoke positively of these initiatives and felt the ambulatory care was a flag ship service.

- GPs felt that the care and support provided to people living with dementia was very positive. The Age UK website signposted people towards relevant information and identified service availability. The BCF outlined how the system intended to continue to build capacity for GP diagnosis and management of dementia, raising GP awareness of post-diagnostic support services, establishing strong links between primary and secondary care and developing a model of specialist nurse support in the community.

- Availability of ambulance transport impacted on the ability to discharge people in a timely fashion. Frontline staff told us transport arrangements were often a problem which meant people could not benefit from ambulatory care due to their discharge being delayed. This on occasion also resulted in staff having to wait with patients to return home after the service had closed.

## Do services work together to manage people effectively at a time of crisis?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management**

**Are services in Oxfordshire safe?**

*Although there was a shared view of risk taking which was monitored closely, the escalation processes in the acute setting had to be used frequently. The handover times for ambulances in the A&E department impacted on the ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment.*

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. This enabled a shared view of risks to deliver services to people in crisis and was monitored closely. Dashboards regarding flow, safeguarding and incidents were provided daily to system leaders and frontline staff who told us these helped with managing escalation and staffing. However frontline staff in the acute setting told us they had to use escalation procedures frequently due to system pressures.

- During November and December 2017 Oxfordshire was at level three OPEL escalation status for 47 of the 61 days (77%). Level three OPEL status indicates that the system is 'experiencing major pressures comprising patient flow and continues to increase and that further actions are required across the system by all A&E Delivery Board Partners.'

- During the same period the system was at level four OPEL status for 2 days (3%). Lever

four OPEL status is the highest escalation level and indicates that there is 'pressure in the system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety'.

- There were also significant handover delays at OUHFT and OHFT. Data provided from SCAS for November 2017 showed that in 1080 out of 3119 cases the 15 minute handover time had not been met, representing 34.6% of the total. This impacted on the ambulance turnaround time and the ability to respond to further emergency calls. Furthermore the A&E four hour target was also increasingly being breached. Our data analysis showed that the percentage of patients seen within four hours in Oxfordshire was 86.1% in 2016/17 compared to the England average of 89.1% and the standard target of 95%, and performance had been declining over the previous two years resulting in longer waits for patients to be assessed.

- Some staff we spoke with accepted escalation and sub optimal performance as being inevitable in a pressured system.

- Senior leaders within the acute setting had begun to look at patient flow in the context of providing assurance that internal resources were being effectively maximised during periods of escalation and pressure, however at the time of our review this work had yet to be evaluated and its impact was unknown.

**Are services in Oxfordshire effective?**

*When a person was in crisis and transferred to hospital, systems and processes were in place to prevent unnecessary admission and long lengths of stay. There were multiple pathways at the point of crisis. The introduction and investment in these pathways was helping to prevent admissions to hospital but work was required to increase staff understanding and confidence in the capabilities of different services to ensure the whole system was working effectively during surges of demand.*

*There were known environmental issues which had an impacted on patient flow once in the A&E department at the John Radcliffe Hospital. The lack of digital interoperability sometimes impacted on information sharing and communication.*

- Although there were complex and multiple pathways when someone experienced a crisis, there were effective admission avoidance systems in place, such as the Urgent Care Centres and Minor Injuries units triaging process.

- The Thames Valley Integrated Urgent Care Service (TVIUC) was launched in September

2017. System leaders told us the recent introduction of 'Enhanced 111', presented further opportunity for collaboration between 111, OUHFT and OHFT clinicians, delivering best patient outcomes, operational performance and value. Ambulance staff told us this had seen a reduction in referrals from 999 to 111 but it was too early to provide an in depth update of the effectiveness of this service. In July 2017 SCAS's percentage of 999 calls resolved with telephone advice was 13% and the percentage of patients seen by crew without transferring to hospital was 41%, both of which were above the England average.

- Admission avoidance services had been invested in such as the ambulatory assessment unit. Frontline staff told us that if a patient needed more support and rapid diagnostics, a referral to the Emergency Admissions Unit (EAU) or EMU could also be made with the intention that the patient would be treated within a day and returned home. However, bed occupancy for Oxfordshire was often at or above the England average level throughout 2016/17 and was at 90% in the first quarter of 2017/18.

- Our analysis of HES data showed that Oxfordshire had a good performance in regards to length of stay. The Department of Health's analysis of data between March 2016 and February 2017 showed that 90% of older people admitted as emergencies in Oxfordshire were discharged within 18 days, which was below the length of stay of any of its comparator areas and in each quarter of 20161/7 the percentage of emergency admissions of older people that lasted longer than seven days was significantly lower than the national average (25% in the last quarter of 2016/17 compared to comparator average of 33% and England average of 32%). If older people were admitted to hospital from a care home, they were also likely to have shorter lengths of stays than comparator areas or the England average with 28% of emergency admissions lasting longer than 7 days in the last quarter of 2016/17 compared to the comparator average of 37% and the England average of 36%. This meant that when people were in hospital, most were only in for short periods of time.

- Due to physical space and capacity issues, there were plans to make alterations to the environment at the OUHFT John Radcliffe A&E department. The current environment did not aid flow which resulted in overcrowding in the unit. SCAS told us they experienced frequent problems with capacity as it was not uncommon for multiple ambulances to arrive at the same time. During our visit to this unit we saw people who had been brought to the department by ambulance waiting to be moved to an appropriate space in the department.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways and access points, provided by different staffing groups. Frontline staff reported multiple confusing access points into the system and told us that which one they would use depended on individuals' knowledge of the options. This could mean that people do not receive individualised care, and could also mean more people are sent to A&E.

- Frontline acute staff felt the pathways and access points were clear, whereas some system leaders acknowledged getting specialist support such as general medicines was more difficult. If further treatment was necessary, there continued to be multiple pathways, such as the EAU, EMU and the RACU, hospital wards or transportation home with a care package. Therefore there is a need to ensure that these pathways and access routes are well defined and communicated across the system.

- OHFT trust figures between April and October 2017 demonstrated the effectiveness of the EMU units. For example, during October 2017 690 patients out of 729 required no further treatment. Data provided from the system also demonstrated the effectiveness of the EAU for those requiring medical care; on average only 60% of the people seen in EAU were subsequently admitted to a hospital ward. The Ambulatory Assessment Unit pathway enabled multidisciplinary professionals to seek clinical advice and avoid using A&E when this wasn't needed. Frontline staff confirmed the effectiveness of these services in reducing hospital admissions. The co-location of a social worker supported decision making with non-medical issues in these departments, and GPs were also working in ambulatory care, which the GP Federation and LMC described as having a positive impact.

- If admission to hospital was not necessary people may have been sent home with additional support from the acute H@H or HART. There were missed opportunities to streamline these services as staff told us that there were three hospital at home teams and these services sometimes overlapped and duplicate calls were a problem. We saw within one case file we reviewed that at the point of crisis this system had been utilised effectively and they had been supported by the hospital at home team and a relevant care package to prevent admission to hospital. Staff also felt that inappropriate referrals were sometimes made to the HART service and the criteria were circumvented. Figures provided by system leaders at the time of our review showed that the presenting needs of people using this service remained high with 43% of hours spent on complex cases and the average hours for completed packages remaining above the expected levels.

- There was some interoperability between health and social care to allow staff to share information across the system. However concerns had been expressed by some frontline staff about accessibility to these at the point of crisis. There were a number of meetings which enabled effective communication and information sharing at strategic and operational levels. However, some social care staff reported ineffective communication when people were admitted to or discharged from hospital. For example social care providers not being informed when someone was being discharged from hospital, or not receiving essential information at the point of discharge.

**Are services in Oxfordshire caring?**

*Frontline staff understood the importance of involving people and their families in decisions about their care. People's experiences at the time of crisis did not always promote their health and wellbeing or protect their privacy and dignity. Carers faced additional challenges and required more support at the time of crisis.*

- System-wide initiatives including a 'knowing me' passport across OUHFT and OHFT were completed for all patients with dementia and remained with the patient on discharge. Our review of case files while in the acute setting showed holistic assessments of people's needs and multidisciplinary input. There were examples of carers and relatives being involved in decision making at the time of crisis and that their views and opinions were taken into account in respect of any decisions made. This ensured that the person's best interests were established and the best outcome for the person achieved with minimal distress. However, people were undergoing multiple assessments which resulted in them telling their story more than once.

- Some people's experiences at the time of crisis did not always promote their health and wellbeing, for example, we saw instances where people's privacy and dignity were compromised in the A&E department at John Radcliffe Hospital; and one person told us that although they had been seen in A&E quite quickly, they had to wait a long while for their subsequent operation. A case file pathway tracked, showed a patient had a positive, patient centred episode of intervention when admitted to hospital but, they had a 15 day delay in hospital due to waiting for HART services.

- Carers were not always fully supported at the time of crisis. Although there was a five day emergency service they could access, carers told us this did not cover out of hours and this could result in challenges for them. Nevertheless positive feedback was received about this service.

- Carers of people who were funding their own care also faced challenges at the time of crisis in securing respite services. They told us there was a lack of support from the local authority in respect of navigating the system. System leaders advised that information was on the Live Oxfordshire website for people to access should this be required.

**Are services in Oxfordshire responsive?**

*People living in Oxfordshire did not always receive the right services during times of crisis due to the multiple confusing access points. Triaging took place on arrival to A&E and there were some responsive community-based services, which people were referred to if required such as EAU, RACU and the ambulatory services which reduced some of the pressures on the hospital. However at times, people stayed on EAU for longer periods than expected and transfers to appropriate wards were delayed.*

- System leaders and front line staff shared a vision of moving from bed based care to alternative models. There were systems in place to support this and prevent people being admitted to hospital at a time of crisis. For example, the H@H team could provide intravenous support at home and the SPA and the Integrated Locality Team could also help avoid admission to hospital. There was feedback from frontline staff that the SPA was dealing with calls in a timely way and making the necessary referrals to other services. Also the enhanced 111 service had employed more GPs and mental health care staff, along with pharmacists in the call centres to ensure correct streaming and advice was given.

- However due to multiple pathways at the time of crisis there were mixed views about how to access and navigate the admission pathways and the impact this had on patients, especially when someone required specialist care. The case notes we reviewed confirmed the multiple pathways and the impact these had on the patient.

- Nevertheless on arrival to A&E there were effective triaging systems and a frailty service to ensure appropriate support was sourced. The therapy team based at the John Radcliffe Hospital A&E worked with other multidisciplinary professionals to avoid admission wherever possible and accessed community beds if appropriate. Also at Horton General Hospital a coordinator managed and had oversight of the unit and the A&E nurse lead told us the impact of this was that assessments were rapid. The triaging practice at the John Radcliffe Hospital was due to change imminently and everyone arriving at the department would be triaged by a nurse who would signpost them to the different departments, such as minor injuries, Ambulatory Assessment Unit and GP streaming.

- We found when visiting the John Radcliffe Hospital that some people were staying in EAU for longer than the expected timeframe and there was a delay in transferring them to the relevant ward. While there was a reason for this in some cases, staff told us that sometimes people stayed longer if they felt they could discharge them home after the key performance indicator time rather than admitting them to a ward. We also found that people were sometimes supported at the end of their life on this unit. While in some cases this may not be avoidable, frontline staff and hospice staff based in EAU told us there were insufficient end of life beds in the community which resulted in people dying in hospital.

- System leaders told us they were investing resources in the ambulatory assessment units so they could stay open later and provide more capacity to move patients from A&E. System leaders must ensure when investing in this model that they consider the effectiveness of this service and to ensure this doesn't become another holding area.

- System leaders told us the local authority commissioned an urgent response service to provide social care for up to five days in emergency situations; including when a person

was at risk of hospital admission. In addition, the local authority contracted for a Telecare service for approximately 4000 service users; this also included an urgent response element.

## Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence**

**Are services in Oxfordshire safe?**

*Some people had poor experiences on discharge home from hospital which impacted upon their health, safety and wellbeing. There were low levels of trust in discharge and medicine information due to widespread concerns in regard to its quality and timeliness.*

- People did not always experience safe discharges home. People using services and social care providers raised concerns about people's experiences of discharge. We were told of examples of some people being discharged home late at night - between 02:00 and 03:00, which was unacceptable. Another person told us they were discharged home with a care package supposedly in place, only to find this was not the case when they arrived home and there was no one to provide the support they needed. They said eventually help arrived several days later but this had impacted on their confidence to be at home on their own.

- There were also widespread concerns regarding the quality and accuracy of discharge information, or about not getting any discharge data at all. This resulted in social care providers having to contact the hospital to gather more information and clarify if information was correct. Further concerns were also expressed about social workers providing information which was out of date, which provided an inaccurate picture of placement requirements. This sometimes resulted in a lack of risk sharing and responsibility and breakdown of care placements as people required more significant care than the service provider was led to believe. These findings were supported in the responses we received from registered managers of social care providers to our discharge information flow tool. Although we only received16 responses, just over half said they received discharge summaries on 50% or fewer of the occasions that people were discharged from hospital into their care, with registered managers of domiciliary care agencies in particular reporting that they rarely received discharge summaries.

- There were also concerns about medicine management and optimisation across the system with social care providers reporting concerns such as, lack of information, delays in

receiving medicines and prescription information detailed incorrectly. The medicine optimisation team also reported poor quality discharge letters from OHFT, and gave examples of when no indication had been given that medicines were being discontinued. This would impact upon medicines administered after discharge and could impact upon a person's health and wellbeing.

- Work had taken place in the acute setting with system leaders to facilitate more effective processes. Pharmacy leads told us that new processes were in place where the pharmacist drove the processes, drug-listing the discharge summary and preparing the prescription. Patients could only be discharged once the summary was checked by a doctor. They reported this had drastically reduced errors and also the time taken to process medicines for discharge had reduced by 90 minutes.

- While the length of stay was shorter, our analysis showed that emergency readmission rates for older people had been higher than comparator and national averages throughout 2016/17 and in the last quarter of the year, the percentage of older people in Oxfordshire requiring emergency readmission within 30 days of discharge from hospital was 19.5% compared to the England average of 18.6% and comparator average of 17.7%.

- Our analysis also shows that the percentage of older people receiving reablement services following discharge from hospital was lower than the England average in 2016/17 with Oxfordshire at 2.5% per 100,000 population and the England average of 2.7%. The percentage of older people receiving reablement following hospital discharge had reduced steadily over the previous five years from 4.4% in 2011/12. It also seemed the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days after discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%, and Oxfordshire's performance on this measure had worsened over the last two years.

**Are services in Oxfordshire effective?**

*There had been considerable drive at a system level to address the issues of performance in relation to delayed transfers of care in the acute and community settings, but the number of delayed transfers of care remained high at the time of our review.*

*The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in starting the discharge process. Reablement services were usually achieving good outcomes for people although performance was declining. Although people's lengths of stay in hospital were shorter, readmissions to hospital were higher indicating that some discharges may have happened too soon and people experienced delayed transfers of care if they required longer term placements.*

- Social care providers and frontline staff voiced concerns about the consistency in beginning the discharge process on admission and felt that the CHC assessments were a contributing factor to DTOC. Case files we reviewed demonstrated that the time discharge planning commenced was variable and the level of detail was inconsistent. We also found a case where a person was unable to be returned home as they were waiting for CHC funding, despite having undergone several assessments. The urgent care leads told us that although discharge information was discussed frequently it may not always be recorded and this was something they were looking to improve. They also told us that lengths of stay may vary on wards and there could be delays in discharge due to patient and family choice of available care packages.

- DTOC data we analysed covering February to April 2017 (the period of time used by the Department of Health in the DTOC analysis that was used to select areas for this review) did show that delays due to patient or family choice in Oxfordshire were higher than both the comparator (1.6) and national average (1.5) rates, accounting for an average daily rate of 2.9 delayed days per 100,000 population, although it was not one of the top three reasons for delays in Oxfordshire during this time period. Later analysis covering July to September 2017 showed that delays due to patient or family choice had increased in Oxfordshire to an average daily rate of 4.4 delayed days to be the third main reason for delays.

- Efforts had been made to improve system flow and reduce DTOC. For example, Oxfordshire System Flow Executive held weekly meetings to discuss issues with system flow, stranded patients, and lengths of stay and provided oversight of bed capacity. There were daily meetings to discuss transfers of care where ongoing support was required. The system was also trying to work more proactively with tertiary areas and there was to be a change in policy about managing these DTOC.

- However there were multiple out of hospital discharge pathways and our review of case files showed estimated discharge dates were not being discussed early enough and there was a lack of strategic oversight of the discharge process. The trusted assessor model, discharge coordinators and flow leads roles were not fully effective and people still experienced delays in their discharge, especially at weekends.

- Our analysis of DTOC between April 2015 and July 2017 showed that the rate of DTOC in Oxfordshire was consistently, and often significantly, higher than average. Delays reached their peak in June 2017 at an average daily rate of 39.9 delayed days per 100,000 population aged 18 and over (compared to national rate of 13.8) and while there had been a reduction to 34.7 delayed days in July 2017 (the most recent data analysed at the point of this review), this was still over double the comparator average of 16.1 and England average

of 13.5 delayed days. More recent DTOC analysis shows performance has continued to improve in Oxfordshire, with delays dropping substantially in August 2017 to an average daily rate of 26.3 delayed days and continuing at a much lower rate than in previous months, although still higher than national or comparator rates.

- System leaders were aware of the challenges the system faced. The CCG had undertaken site visits to OUHFT and Horton to assess the Safer, Faster, Better assurance and identify blocks in the system and in July 2017, pathway workshops were held. The System Flow Executive accepted the broad conclusions from the pathway workshops and authorised the development of a pathway programme on 4 August 2017; the programme was under development at the time of our review.

- The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in commencing the discharge process on admission and communication at the point of discharge. Social care providers and frontline staff expressed concerns and gave an example where a district nurse had not been informed of a medical need they needed to follow up and support the person with. This could have had serious consequences for the patient and resulted in readmission to the hospital.

- Systems leaders were aware that the HART needed further development and alignment and a recovery plan and mitigating actions had been discussed during recent A&E delivery board meetings. The HART staffing trajectory was not on track and there was a gap in the projection against what the service was able to deliver. The A&E delivery board performance dashboard showed that in September 2017, HART was performing consistently below the expected delivered hours which were 8440. In September 2017 HART achieved only 6848 hours. However delivered hours had increased in November 2017 to 7343 hours.

- A lack of digital interoperability did not support frontline staff to make timely decisions as IT systems were not compatible. Frontline staff told us the current IT systems were not fully effective in supporting communication and information sharing which impacted on the discharge process.

**Are services in Oxfordshire caring?**

*People who use services, their families and carers were not involved early enough in the discharge process. People who were funding their own care experienced difficulties in accessing essential information and were therefore not always aware of what was available to them. While VCSE organisations were supporting people on discharge, more could be done if there were better links between the acute setting and the VCSE sector. Some people were not able to access hospices and as a result died in hospital rather than their place of choice.*

- Our review of case files showed a person-centred approach was adopted and wherever possible people's preferences were documented and the right people were involved in conversations about their care. However, some records showed these discussions were not always started early enough and this had impacted upon their discharge and length of stay.

- People funding their own care faced barriers to accessing advice, information and guidance about services and costs and were not always at the centre of their care and support when moving through the health and social care system. Furthermore social care providers also told us there was a lack of support for financial assessments and costs of care were not always made clear.

- There were missed opportunities for the VCSE sector to be involved in the discharge process to make it more effective and person centred. The VCSE sector felt they could do more but there were barriers to them doing so due to insufficient links with acute hospital services.

- People at the end of their life who were admitted to hospital via A&E did not always experience a rapid transfer home or to a place of preference**.** Frontline staff we spoke with demonstrated compassion and a good understanding of support needed for people at the end of their life and stated there were good relationships with the local hospices and care homes. However they felt there was an insufficient number of hospice beds to transfer people to if this was their preference. This meant that people sometimes died in the EAU. Staff told us they did try to make this a peaceful and compassionate experience.

- Assessment and referral conversion rates for standard CHC assessments were above the England average in the first quarter of 2017/18 with Oxfordshire's conversion rate for assessments and referrals performing at 37% compared to the England average for assessments at of 31% and referrals at 25%. However the rate of assessment and referral conversion rates for Fast Track CHC (usually used for people at the end of their life) was lower, at 89%, than the England averages of 99% and 85% respectively, which may impact on the person being transfer to their preferred place to end their life.

**Are services in Oxfordshire responsive?**

*There were multiple pathways to facilitate discharges from the acute setting and support people to remain as independent as possible. However, people experienced a high number of delayed transfers of care. Due to system challenges and conflicting information in regard to availability of care home packages in the community it was difficult to establish if there was sufficient capacity within the market to cope with the increase in demand. A higher number of CHC assessments were undertaken in an acute setting which could lead to delays and this needs addressing as a matter of urgency.*

- The views of frontline staff in respect of CHC assessment varied; some felt the process worked well, whereas others felt this contributed to DTOC. Our analysis of NHS CHC activity in the first quarter of 2017/18 showed that 36% of decision support tools were completed in an acute setting in Oxfordshire compared to the England average of 27%. A higher percentage assessments being completed in acute settings can contribute to delays. Nevertheless, the rate of NHS CHC referrals exceeding 28 days was 5.87 per 50,000 compared to the England average of 10.27.

- There were discharge coordinators in post, a discharge assurance group, and daily multidisciplinary meetings to support patients to achieve rehabilitation goals. However, Oxfordshire had a long-term problem with DTOC. In 2016/17 over 51,000 beds days were lost to delays, which while a slight improvement on the previous year (59,000 bed days lost) meant that it still was the 4th highest rate in the country and nearly three times the national average. Our data analysis of DTOC per 100,000 population aged 18+ between February and April 2017 showed that the main responsible organisation for DTOC was the NHS, accounting for an average of 16.3 delayed days per 100,000 population aged 18+, while a further 13.1 delayed days were attributed to both the NHS and social care and 4.2 delayed days were attributed to just social care. By far, the main reason reported for delayed transfers of care in Oxfordshire over this time period was “awaiting care package in own home”, accounting for an average daily rate of 15.8 delayed days per 100,000 population aged 18+.

- System leaders felt there were not enough care packages, and dementia packages for those with moderate to high needs in social care settings and this lead to delays in transfers. Frontline staff were also of the same view and there was a consensus that there was a significant delay for people with complex or mental health care needs. There were also significant issues with care packages in the community and although there had been some reconfiguration of the commissioning of these, social care providers told us they had vacancies. This did not correlate with the data held by the system and therefore the delays could not be fully understood. Acute frontline staff also told us there were issues with care packages if they needed to start midweek.

- The Department of Health’s analysis of activity showed between October 2015 and September 2016 the proportion of older people discharged over the weekend in Oxfordshire was similar to its comparator areas at 20%. However, social care providers were less likely to accept discharges over the weekend, which meant this figure was unlikely to increase.

- Patient transport accessibility also impacted on people’s experiences and resulted in delayed transfers of care. A number of these issues were caused by the OUHFT and OHFT

discharging planning process as this caused an issue with the timeliness of discharge and use of resources. Although services such as the EMU were reducing the pressures on admissions to hospital, these services were short term and reactive and frontline staff told us this did not always work well as transport services required advanced booking. These delays meant that new patients could not be admitted to the service and could result in them being referred to emergency services.

- System leaders in the ambulance service stated there were challenges due to the number of unplanned discharges. Data supplied by SCAS showed that in October 2017, 28.6% of transfers were planned and 71.4% were short notice. When a 'breaking the cycle' week had been held from 6 to 12 November 2017 the figures were 29.5% planned and 70.5% short notice. The target for short notice discharges had recently been reduced to 30%, these figures corroborated that the majority of discharges were not planned in a timely manner. Also at times there was ineffective use of transport resources, for example, there had been occasions when the ambulance service arrived on the ward but OUHFT had also booked their own transport. Frontline staff at OUHFT advised this was to ensure the patient got transferred home; if there had been delays then they would also book their own transport , but this was unwarranted and an inefficient use of resources which added to the complications of the discharge system.

- System leaders told us there had been changes over the last 20 months as they were trying to move from bed based care. They had reduced bed base by 110 beds and invested in a range of ambulatory and home based services. This meant there were a variety of services available to support people to access reablement to help them to return home including step down, hub beds and the community reablement service, which followed a discharge to assess model. However people were getting stuck in reablement beds causing a holdup in the system. Frontline staff felt this was because these beds were used inappropriately which caused additional pressure and waiting lists in some areas. HART was commissioned to deliver a discharge to assess model. However, an increase in acuity and dependency had resulted in capacity issues due to increased episode hours. The system had put in place mitigating capacity in support of this and commissioners and providers were continuing to work jointly to address the acuity and dependency issue.

- The hospital at home teams for the north and south and the Acute Hospital at Home Team were in place to facilitate discharge. However these teams created some overlap in services and staff told us that sometimes more than one member of staff arrived from different teams to support the person. Also due to insufficient packages of care in the community, people could be using this service for months and staff within this team felt that the main reason for DTOC was waiting for care packages.

- Community rehabilitation pathway 'virtual beds' were being trialled on community hospital

wards to support early discharges. This enabled the person to go home with support from the multidisciplinary team while their bed remained open. This meant if the person was unable to manage at home they still had a rehabilitation bed to come back to if needed. During our visit we observed a multidisciplinary meeting where these people were discussed to ensure their needs were being met in the community or if they needed to return to the unit.

## Maturity of the system

**What is the maturity of the system to secure improvement for the people of Oxfordshire?**

- There was a lack of whole system strategic planning and commissioning with little collaboration or a shared compelling vision for the design and delivery of services.
- Some strategies were not regularly refreshed and updated according to people's needs.
- We found that services for older people in Oxfordshire had operated for two years without a clear and current strategy. It was not evident that identified priorities from the JSNA were aligned with the STP and BCF priorities. The system had recognised this was a shortfall and were attempting to address this through the transformation plans and the refresh and refocus of the HWB.
- There were some positive examples of relational working and collaboration in the interests of the population's defined needs. However, overarching strategies had yet to be defined and co-production with the local population remained an area requiring further development.
- There was limited evidence of system-wide multidisciplinary team working for effective outcomes. There was some work in place regarding discharge from hospital and the community services, but there was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health and wellbeing maintenance.
- A large proportion of decision making still sat separately within individual organisations but there was evidence of system wide approaches in respect of managing particular issues and challenges such as DTOC. In these instances there were shared metrics and systems for the oversight of performance and delivery.
- Historically relationships between leaders across the system had been poor, with a high

level of mistrust. Although these were developing positively the relational audit demonstrated that work was still needed to engage and include system partners, frontline staff and other key stakeholders.

- There had recently been changes in leadership in several organisations within Oxfordshire and this had encouraged an increased willingness to build trust and to work collaboratively going forward.

- The Oxfordshire Transformation Board had supported a joint approach in managing the local care market and commissioning services. The Transformation Board was seen to be providing a positive platform to support operational integration however; there was little evidence that a wider approach to full integration was planned.

- Oxfordshire was particularly challenged by workforce issues across the system. There were strategic plans at organisational levels and STP level to align the workforce to future demand and work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. However recruitment challenges continued to have an impact on the care market. There were challenges in recruiting staff in a number of key service areas with the high cost of housing and accommodation cited as a barrier to staff retention and recruitment.

- Strategic effort was required to provide more affordable housing at pace to support the supply and maintenance of a sustainable workforce.

- System leaders acknowledged that incompatible information sharing systems were a barrier to seamless working across agencies and were committed to providing integrated care records by way of digital interfaces.

- Both OUHFT and OHFT had been awarded Global Digital Exemplar status under the national NHS programme and consequently were well-positioned to enable this integration. Further developments were planned as part of the Oxfordshire Local Digital Roadmap.

## Areas for improvement

**We suggest the following areas of focus for the system to secure improvement**

**Strategic priorities**

- System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. While doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.

- System leaders must address and create the required culture to support service interagency collaboration and service integration.

- The older people's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the older people's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.

- System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.

- System leaders must evaluate their winter plans and pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.

- System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.

- System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

**Operational priorities**

- System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.

- System leaders should ensure that housing support services are included within

multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.

- System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.

- System leaders should review methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.

- System leaders should ensure that better advice, information and guidance is offered to people funding their own care.

- Continue to embed the trusted assessor model.

**Engagement priorities**

- System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.

- Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.

# CARE QUALITY COMMISSION
# OXFORDSHIRE LOCAL SYSTEM REVIEW
# (November 2017)

# ACTION PLAN

## Background

Following the announcement in the Spring Budget 2017 that councils would receive an additional £2 billion to support adult social care needs, reduce pressure on the NHS and stabilise the care provider market, the CQC were asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 20 local authority areas. The onsite review of the Oxfordshire Health and Social Care system took place between 27 November and 1 December 2017 with inspectors interviewing senior system leaders, holding focus groups with frontline staff and making visits to several health and social care services.

On 29 January 2018 system leaders from across Oxfordshire County Council (OCC), Oxford University Hospital Foundation Trust (OUHFT), Oxford Health Foundation Trust (OHFT), South Central Ambulance Service (SCAS) and GP Federations, and major local stakeholders came together with CQC inspectors and representatives from the Department for Health, Social Care Institute for Excellence and NHS England to discuss the findings of the report and agree actions that would be taken in response. This action plan was developed following those initial discussions and describes the actions that will be taken by the system in response to the areas for improvement identified in the CQC report.

Oxfordshire System Leaders have approached this System review and the development of the action plan as a real opportunity to galvanise, improve and enhance system working. The review has reflected back to the system the challenges which are well understood locally, such as workforce, it has provided the catalyst for finalising the single vision for health and social care in Oxfordshire and challenged the system to progress further and faster with an integrated offer to our population. System Leaders were supported in developing the plan by Deborah Rozansky from the Social Care Institute for Excellence.

## Action Plan

This action plan contains high-level actions and should be read in conjunction with the Accident and Emergency Delivery Board (AEDB) Improvement Plan (see embedded document below). The AEDB Plan describes the tactical and operational priorities for a specific area of the system (A&E performance and hospital flow).


AEDB Improvement Plan.pdf

The Action Plan will be approved by the Oxfordshire Health and Wellbeing Board, which will be responsible for assuring its delivery.

Key to initials used in the action plan:

| Initials | Name | Role | Organisation |
|---|---|---|---|
| BH | Bruno Holthof | Chief Executive Officer<br>Chair of Accident and Emergency Delivery Board | Oxford University Hospitals NHS Foundation Trust (OUHFT) |
| BL | Benedict Leigh | Deputy Director Joint Commissioning | Oxfordshire County Council (OCC) |
| DHa | Dominic Hardisty | Chief Operating Officer | Oxford Health NHS Foundation Trust (OHFT) |
| DHe | Diane Hedges | Deputy Chief Executive Officer | Oxfordshire Clinical Commissioning Group (OCCG) |
| JMW | Dr Jonathan McWilliam | Strategic Director for People | Oxfordshire County Council (OCC) |
| IH | Cllr Ian Hudspeth | Leader of the Council<br>Chair of Health & Wellbeing Board (HWB) | Oxfordshire County Council (OCC) |
| KC | Dr Kiren Collison | Clinical Chair<br>Vice Chair of Health & Wellbeing Board (HWB) | Oxfordshire Clinical Commissioning Group (OCCG) |
| KT | Kate Terroni | Director for Adult Services | Oxfordshire County Council (OCC) |
| LP | Louise Patten | Chief Executive Officer | Oxfordshire Clinical Commissioning Group (OCCG) |
| PB | Pauline Brown | Local Director | Health Education Thames Valley (HETV) |
| SF | Sam Foster | Director for Nursing | Oxford University Hospitals NHS Foundation Trust (OUHFT) |
| SW | Sula Wiltshire | Director of Quality | Oxfordshire Clinical Commissioning Group (OCCG) |
| TB | Tim Boylin | Director for Human Resources | Oxford Health NHS Foundation Trust (OHFT) |



| Strategic Priority | Key actions | Accountable | Responsible | Completion date | Current progress |
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| A) System leaders must improve how they work together to plan and deliver | **A1) Agree the refreshed vision for Health & Wellbeing in Oxfordshire** | IH / KC | JMW / LP | 31/05/18 | Paper in development for March Health & Wellbeing Board. Meeting with OCC co-production board to discuss approach to strategy development. |

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| health and social care services for older people in Oxfordshire. Whilst doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery. | **A2) Review and revise the Oxfordshire Health & Wellbeing strategy to ensure that is co-produced and owned by all key stakeholders and aligned with individual organisational strategies and informed by evidence and best practice** | IH / KC | JMW / LP | 19/07/18 (HWB) | As above |
| | **A3) Develop a co-produced older people's strategy that delivers the Oxfordshire Health & Wellbeing vision and strategy and which is owned by all key stakeholders and aligned with individual organisational strategies** (see C) for detailed actions) | IH / KC | KT / LP | 15/11/18 (HWB) | As above |
| | **A4) Review and simplify the system governance structure to clarify accountability and reduce overlap**<br><br>i. Full review (membership, frequency, Terms of Reference etc.) of Health & Wellbeing Board<br><br>ii. Redesign of system programmes/boards to ensure delivery of Health & Wellbeing, refreshed strategic objectives to consider the development of an | IH / KC | JMW / KT / LP | 22/03/18 (draft for HWB)<br><br>May 2018 (final) | Engagement with stakeholders carried out by Chair and Vice-Chair during February 2018. |

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| | integrated care system for older people in Oxfordshire | | | | |
| | **A5) Review impact of changes to strategy and accountability within 12 months of implementation to ensure maximum effectiveness** | IH / KC | JMW / KT / LP | July 2019 | |
| B) System leaders must address and create the required culture to support service interagency collaboration and service integration. | **B1) Review the relational audit carried out by CQC and invest in organisational development to address specific issues** | Chief Executives | Chief Executives | 30/04/18 | Five senior commissioners from OCC and OCCG to jointly attend the NHSE commissioning capability programme |
| | **B2) Establish a set of principles, behaviours and narrative to support shared purpose around the needs of the individual and delivery of strategy** | Chief Executives | Chief Executives | 30/04/18 | Initial principles agreed 26/1/18 |
| | **B3) Agree a shared accountability framework.** | Chief Executives | Chief Executives | 30/09/18 | |
| | **B4) Develop a major programme of substantial inter-organisational activities to cascade, embed and monitor impact of these principles and behaviours in delivery of our strategy** | Chief Executives | Chief Executives | 30/09/18 | Early Stage Quick Wins<br>• The New Team Hunter project: Inter-organisational approach to "Home First" and right destination first time – OCC, OH and Age UK are embedded on short stay wards at John Radcliffe Hospital to improve flow. At midway review this was showing positive |

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| | | | | | impact and there is continued commitment to the project.<br>• There is a dedicated Emergency Department worker from OCC to gather early intelligence and reduce admissions where possible.<br>• Creation of a number of joint commissioning posts between OCC and OCCG<br>  - Childrens Lead<br>  - Care Home Commissioner<br>  - Home Care Innovation Officer |
| C) The Older People's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the Older People's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society. | **C1) Develop a co-produced older people's strategy that delivers the Oxfordshire Health & Wellbeing vision and strategy and which is owned by all key stakeholders and aligned with individual organisational strategies**<br>i. The development of strategy will build upon current diagnostics<br>ii. It will be co-produced and be based on a review of older people's experiences including what people say about the services they currently receive | IH / KC | KT / LP<br>KT / LP<br>KT / LP | 15/11/18 | Paper on scope and process for development of Older People's Strategy to go to March 18 HWB.<br>Joint Strategic Needs Assessment (JSNA) has been refreshed and is going to HWB 22.03.2018<br>Older Peoples specific JSNA currently in development<br>Meeting held with OCC Co-Production Board (TeamUp) to inform design of co-production model for strategy development. |

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| | iii. A whole system approach will be taken in developing a frailty pathway that will be tested, implemented and evaluated<br><br>iv. The development of the strategy will be used to refresh JSNA for 2019-20 | | DHa / BL / DHe<br><br>JMW | November 2018<br><br>March 2019 (HWB) | Draft frailty pathway in place – the actions in this section will build on the work already undertaken in this area |
| D) System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement. | **D1) Agree and implement an effective escalation framework and protocols so partners can prioritise activity and make a single consistent set of deployment resource decisions during escalations. It will include the ability of the system to prioritise activity and capacity at times of pressure across different providers to maximise flow.**<br><br>i. Share learning within system partners and implement change accordingly<br><br>ii. Develop a mechanism to collate learning from work carried out during escalations<br><br>iii. 6 monthly system wide review meetings, supported by the STP Urgent Emergency Care group, for mop-up and future plan adjustment | BH | System Flow Executive | AEDB April 18 | Escalation processes reviewed by System Flow Executive as part of reflection on the deployment of the winter plan and in the development of the Easter Plan which was agreed on 02/03/18. This will be consolidated into the winter plan 2018/19 which will be completed by 30/4/2018. |

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| E) System leaders must evaluate its winter plans and demand pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand. | **E1) Implement the Oxfordshire AEDB Urgent Care Improvement Plan (appended). Plan is monitored monthly at AEDB and has been developed in response to external analysis commissioned by NHSE/I.** | BH | System Flow Executive | See AEDB Plan appended. | The AEDB Urgent Care Improvement Plan to be finalised at AEDB March 2018.<br><br>Easter plan agreed 02/03/18. Plan focuses on ensuring improved access to GP appts and adequate Out of Hour, Community and Social Care capacity. In addition, the plan includes short term actions to improve out of hospital flow and is looking at reviewing smaller care packages, improved flow through the Hub and Community Hospitals. |
| | **E2) Agree and implement effective reporting and oversight of the AEDB plan at HWB to assure system accountability for the delivery of these plans** | IH / KC | JMW | 22/03/18 | |
| | **E3) Evaluate the current plan to identify and implement any changes and lessons learned at system level and incorporate any changes into 2018/19 plans**<br><br>i. Review access to capacity during high demand periods<br><br>ii. Review constraints in Hospital Discharge and Reablement Pathway | BH | System Flow Executive | 30/4/18 (NHSE ops planning) | Learning from 2017/18 plan and subsequent holiday surge escalation to be written into 2018/19 winter plan which will be developed by 30/04/18. |

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| | iii. Home needs in relation to admission and discharge identified at an early stage, allowing referrals to be made promptly<br><br>iv. Ensure CHC process is as streamlined as possible<br><br>v. Implement all whole system agreed recommendations of Carnall Farrar and Hunter reports<br><br>vi. Review current approach to primary prevention<br><br>vii. Review current approach to secondary prevention | | | | Discussion on priorities for future work in primary prevention scheduled at Health Improvement Board in May 2018 |
| F) System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of | **F1) We will develop a system wide approach to provider market management, including non-commissioned services such as voluntary and charitable services** | IH / KC | KT / LP | 19/7/18 | OCC-OCCG joint Care Home commissioner post commenced March 18.<br><br>Care Home review commissioned from external agency to report back March 18 |
| | **F2) We will engage our market in developing a shared understanding of system needs and market capacity and capability.** | IH / KC | KT / LP | 15/11/18 | Paper in development for March HWB. Meeting with OCC co-production board to discuss approach to strategy development. |

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| domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market. | **F3) We will develop commissioning intentions with providers in a co-produced model to create a sustainable market with the capacity and capability that is aligned to the Health & Wellbeing and Older People's strategy.**<br><br>i. We will deploy a Provider Collaborative framework for CCG commissioned services to be agreed at CCG Board and shared with OCC commissioners<br><br>ii. Review market position statements in conjunction with providers, ensuring they set out a clear forward vision.<br>iii. Review all potential bed capacity across the system and work with providers to develop a solution for escalation | IH / KC | KT / LP | 15/11/18 | Older People's Strategy will reflect the demand and capacity work phase 2 commissioned by NHS England Mar-June 2018 |
| G) System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a | **G1) Set up a Local Workforce Action Board (System Workforce Action Board) which is aligned to the BOB STP workforce strategy reporting through the HWB governance structure.** | IH / KC | SW | April 2018 | Paper on recommendation for System Workforce Action Board was approved by System Flow Executive and then submitted to CEO's for final sign off – Dec 2017<br><br>First meeting of System Workforce Action Board held – Feb 2018 |

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| competent, capable and sustainable workforce. | | | | | This work will link to the existing Oxfordshire Training Network<br><br>Action Plan agreed Jan 2018 |
| | **G2) Agree Oxfordshire System Unregistered Workforce – Action Plan – Key actions:** | IH / KC | | | |
| | i. Complete the first phase and evaluate the joint recruitment campaign | | KT | March 2018 | First phase of the joint recruitment campaign completed and reviewed the impact |
| | ii. Develop a joint identity and brand for the sectors unregistered workforce | | KT | September 2019 | |
| | iii. Introduce a range of 'valuing staff' initiatives, exploring options for staff incentives | | TB | March 2019 | |
| | iv. Investigate whether Home Share/Shared Lives schemes present an opportunity to link care staff with lower cost accommodation | | BL | March 2019 | |
| | v. Identify further innovations to increase home care capacity – exploring personal health/social budgets and micro providers, creation of local social capital and maximising the use of technology | | BL | August 2018 | Commencing May 2018, a 12-month Wellbeing teams pilot to explore different ways of employing home care staff. |

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| | vi. Deliver a skills and leadership development programme for care providers | | PB | March 2019 | |
| | vii. Shape a career pathway for unregistered care workers | | SF | March 2019 | Initial Non-Registered System Workforce Workshop held 30/1/18 |
| | **G3) Develop and improve workforce links with provider forums – help to live at home, care homes, supported living, CCG mental health and Extra Care Housing** | IH / KC | BL / DHe | November 2018 | Engagement with providers started Feb 2018 |
| | **G4) Review provider relationships in relation to workforce nationally to learn from best practice** | IH / KC | BL / DHe | July 2018 | |
| | **G5) Evaluate and build on work already carried out with ADASS and Skills for Care on Value Based Recruitments** | IH / KC | BL | December 2018 | Evaluation of the impact on practice and the return on investment of this work is ongoing.<br><br>Engaging with other Local Authorities in the South East via ADASS Workforce Group<br><br>Further meetings set-up for May and June 2018. |
| | **G6) Review of Log on to care** | IH / KC | BL | March 2019 | Analysis completed in Jan 2018 |

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| | **Look at next steps to encourage providers to use this tool and link this to the care certificate.** | | | | |
| | **G7) Work with Skills for care/providers and contract managers to obtain better representative data across the sector, e.g. Turnover, retention, qualifications, sickness, demography** | IH / KC | BL | March 2019 | Joint initial workshops in 2017 to encourage and support an increased response rate. Discussions have taken place with Skills for Care to provide additional workshops and support.<br><br>Contracts now specify National Minimum Dataset (NMDS) data to be completed for domestic care providers.<br><br>Consulted with providers (as part of the annual rates review - Feb 2018) on how we could facilitate increased response. Learning expected March 2018 and will be incorporated into future plans. |
| H) System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well | **H1) Implement the Oxfordshire AEDB Urgent Care Improvement Plan to improve system flow to be monitored monthly at AEDB. The AEDB Plan (appended) has been developed in response to external analysis commissioned by NHSE/I.** | BH | System Flow Executive | As per AEDB implementation plan | NHSE commissioned demand and capacity work to be delivered by June 18. Pathway mapping for key services to be completed by 23/03/18. |
| | **H2) In addition to the tactical priorities identified in the AEDB improvement plan we will undertake a comprehensive co-produced** | BH | System Flow Executive | In-line with frailty pathway | See AEDB Plan |

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| defined, communicated and understood across the system. | **review of all pathways with patients, users, clinicians and voluntary and community services into and out of the health and social care system to identify streamlined processes that:**<br><br>i. keep people at home living as independently as possible for as long as possible<br><br>ii. provide timely response to people at risk of admission<br><br>iii. ensure that people who are in hospital return home when they are well enough to do so | | | | |
| | **H3) We will create a series of priorities from the review that will identify how we will measure and monitor improvement.** | BH | System Flow Executive | TBC subject to completion of review | See AEDB Plan |
| | **H4) We will strengthen the reporting and oversight of the AEDB plan at HWB to assure system accountability for the delivery of these plans.** | IH / KC | JMW | 22/03/18 | See AEDB Plan |
| I) System leaders should ensure that housing support services | **I1) Appoint dedicated social care and community health staff to identify and manage housing related issues in community hospitals.** | System Flow Executive | System Flow Executive | Nov 2017 | In place Nov 17 |

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| are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals | i. Work with Oxford City Council to deliver the Trailblazer initiative which is working into OUH, supporting Emergency Department and discharge teams with dedicated advice and support from housing professionals<br><br>ii. Age UK to support Short Stay wards as part of a Home First initiative in OUH which is flagging housing needs earlier in the discharge planning process. | | | Jan 2018<br><br>Jan 2018 | In place Jan 18<br><br>Pilot in place Jan 18 |
| | **I2) Hold a series of strategic housing workshops.** | IH / KC | KT | August 2018 | First meeting held December 2017 (Next meeting May)<br><br>One on one meetings with districts Jan 2018 |
| | **I3) Use key findings from Oxon health and social care working and living survey to inform the outcomes within the business case to identify sustainable solutions to the housing challenges** | IH / KC | KT | December 2017 | Survey completed in Sept 17 – reported in Dec 17 |
| | **I4) Get feedback from ADASS Working Group Network Enquiry** | IH / KC | KT | May 2018 | Completed March 2018 |

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| | **and put into summary report. Use it to inform business case and discuss further at May workshop** | | | | |
| | **I5) Meet with district council to discuss key workers housing data, key findings and agree next steps.** | | KT | August 2018 | Held initial group meeting – Dec 17<br><br>Further one on one meeting to take place – Jan – Mar 18<br><br>Further meetings option following May workshop. |
| J) System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure | **J1) A review of commissioned services considering their design, delivery and outcomes will be carried out to improve their effectiveness, and reduce and avoid duplication** | IH / KC | BL / DHe | November 2018 | Supporting People to Live at Home board (OCC, OCCG, and VCS reps, inc. Healthwatch) met 23rd January. Covering research and innovation around home care, wellbeing pilots, home care strategy and market stabilisation. Meetings occur bi-monthly<br><br>Joint appointment of Care Homes Commissioner for OCC & OCCG, March 2018.<br><br>System review of discharge-to-assess, post hospital reablement and community reablement (HART) reporting 23rd March to System Flow Executive.<br><br>Shared market position statements to be reviewed under the management of the pooled budget officers group to start April 2018. |

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| resources are used effectively. | **J2) As part of the system flow work in (h) we will review the way in which we carry out assessments. This will include reviewing the progress of our Trusted Assessor Model to ensure this is fully implemented and confirm that it follows patients through their journey.** | KT | System Flow Executive | September 2018 | Pilot of Trusted Assessors in intermediate care beds is ongoing.<br><br>Training for home support providers in new delegated health tasks, with plans to extend this to other provider organisations |
| K) System leaders should review methods used to identify carers' eligibility for support so that they are assured that carers are receiving the necessary support and have access to services. | **K1) We will work with carers and carer organisations in a review of how we identify carers using national standards and best practice across health and social care organisations.** | Chief Executives | KT/LP | 15/11/18 | Paper in development for March HWB. Meeting with OCC co-production board March 18 to discuss approach to strategy development. Carers' needs highlighted by board. |
| | **K2) As part of the development of the older people's strategy we will ensure we have a variety of mechanisms in place to assist carers in how to find and access services. We will co-produce these with carers to ensure they are appropriate and provides them with the information they need.** | IH / KC | KT/LP | 15/11/18 | As above |

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| L) System leaders should ensure that better advice to access information and guidance is offered to people funding their own care. | **L1) System wide agreement on roles and responsibility to support people who fund their own care** | IH / KC | Chief Executives | May 2018 | |
| | **L2) As part of the review of assessment processes set out in (j) we will ensure we identify a person's funding status at an early stage and that the appropriate information is available to them to support a timely decision around next steps.** | IH / KC | KT/LP | 15/11/18 | |
| | i. Creation of brokerage service for self -funders | | | January 2019 | Creation of a brokerage and care support team delivering to self-funders and organisations including Adult Social Care from 1st April 2018, this is the first stage of developing the offer.<br><br>Planned system review of support to self-funders to come to SFE for June 2018 |
| | ii. Review the information currently being provided to self-funders | | | April 2018 | Review of information on the OCC public website underway January 2018 |
| M) Continue to embed the trusted assessor model. | **M1) As set out in (j) - We will review the way in which we carry out assessments and identify opportunities to move towards a** | BH | System Flow Executive | As per AEDB implementation plan | Pilot of Trusted Assessors in intermediate care beds is ongoing. |

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| | **comprehensive trusted assessment model which follows patients through their journey.** | | | | Training for home support providers in new delegated health tasks, with plans to extend this to other provider organisations |
| N) System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced | **N1) We will commit to develop and implement a best practice model of continuous co-production across commissioner and provider organisations. We will scope the potential to develop established bodies that can inform this process.** | IH / KC | KT | 19/7/18 (HWB strategy) | Co-production champion training with SCIE advertised and due to take place 5th/6th June - this is the first step in creating a whole system champions network. |
| | **N2) This model will ensure service users, patients, their families and carers are engaged from inception and throughout the development and implementation process when reviewing strategies, integrated systems and structures using co-production principles.** | IH / KC | KT | 19/7/18 (HWB strategy) | |
| | **N3) This approach will be deployed in the development of the Health & Wellbeing and Older People's strategy and in the development of accountability structures set out in this plan.**<br>i. As part of this work we will establish a process to identify and take proactive measures to | IH / KC | JMW / KT / LP | 19/7/18 (HWB strategy)<br>15/11/18 (OP strategy) | |

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| | engage with under-represented groups in society. | | | | |
| O) Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation. | **O1) Map the current role and impact of voluntary sector and local communities within Oxfordshire's services and in support of strategic development.** | IH / KC | KT | 19/7/18 | |
| | **O2) In all pathway redesign and strategy development we will value and draw in the expertise in the Voluntary sector, providers and Districts. Co-designing in our provision the knowledge and connection of the local areas in Oxfordshire to offer solutions to gaps - especially care at home – working together to maximise social capital** | IH / KC | BL / DHe | November 2018 | An LGA Peer Review of the work carried out with the Voluntary Sector is planned to take place 20 - 22 March 2018 |
| | **O3) Review and develop activities to strengthen the capability and capacity of the voluntary sector and local communities as part of the Health & Wellbeing accountability structures, involvement in strategic planning and delivery of support to people as part of the Health & Wellbeing and Older Person's Strategy.** | IH / KC | KT / LP | 15/11/18 | |

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NHS
Oxfordshire
Clinical Commissioning Group

**Oxfordshire Joint Health and Overview Scrutiny Committee**

**Date of Meeting:** 19 April

**Title of Paper:** Oxfordshire Clinical Commissioning Group: Key & Current Issues

**Purpose:** The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

- West Oxfordshire Locality Place Based Plan
- Oxfordshire Transformation Programme

**Senior Responsible Officer:** Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group

# Oxfordshire Clinical Commissioning Group: Key & Current Issues

## 1. West Oxfordshire Locality Place Based Plan

In Witney, following an unsuccessful procurement process, Deer Park Medical Centre closed on 31 March 2017. Its patient list was dispersed to surrounding practices. Oxfordshire Joint Health and Overview Scrutiny Committee (JHOSC) referred the matter to the Secretary of State for Health on the grounds that the closure was a substantive change in service and no consultation had taken place. As a result the Secretary of State (SoS) passed the referral to the Independent Review Panel (IRP) in March 2017. The IRP undertook an initial review and made recommendations to the SoS. On 25 July 2017 NHS England wrote to OCCG confirming expectations that the CCG would address the recommendations from the IRP and in particular:

- The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible
- The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. This needs to be linked to, and integrated with, the wider CCG and STP plans for the whole of Oxfordshire. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future.

The work undertaken by OCCG to address the IRP recommendations was presented to the JHOSC at the meeting on 8 February 2018. The JHOSC acknowledged the work undertaken. As per the IRP recommendations to the SoS, NHS England (NHSE) commissioned a third party independent review of this work, which was completed by North East London Commissioning Support Unit (NELCSU). The report from NEL CSU is available here. The findings from the external review were jointly presented by NHSE and NEL CSU to the JHOSC at the same meeting. NHSE confirmed that in their view the CCG had met the recommendations of the IRP. The committee received the report and welcomed the findings.

A specific action, from NHSE, required of OCCG was to ensure that the remaining unregistered patients were allocated to other practices as soon as possible; this process is complete.

NHSE will be reviewing actions taken to address recommendations from the third party review at its quarterly assurance meeting to held at the end of April.

The key recommendations from the third party review are set out below:

1. ***Improving the detail contained in the Locality Place based Plan documentation to provide greater clarity and increase likelihood of active stakeholder management***

Feedback received from the engagement undertaken has been that the plan was draft plan was too detailed and complex. As a result supporting documents such as the approval processes and prioritisation for funding have not been included in the first iteration of the plan. Instead, for those interested, they can be found in the on OCCG's website: http://www.oxfordshireccg.nhs.uk/get-involved/opcc-committee.htm

Our next step is to produce a public facing summary of the plan. This is being developed together with Locality Forum Chairs[1] (members of the public leading locality Patient Participation Groups). We hope this summary will be published on the CCG's website by end of April.

As described previously the plan will be iterative and will be updated on an ongoing basis. We will use the learning from this review as we update our other five locality plans.

2. ***The need for Oxfordshire CCG's engagement to include all groups likely to be affected by any proposed changes, as identified through an equalities impact assessment***

OCCG continues to strengthen its approach to identifying groups affected by proposed changes. For small and large development projects alike (across Oxfordshire) an equalities impact assessment will be undertaken. This will be supported by a detailed stakeholder analysis which will inform how best to engage with affected groups. Work is also underway to integrate the CCGs engagement team with its equality and access team to ensure established networks and relationships are used to support engagement with seldom heard groups.

3. ***Developing a local vision for Witney, that is owned by the Locality, it needs to be easily articulated and aligned to the vision for the wider STP and the Oxfordshire Primary Care Framework***

The West Oxfordshire Place based Plan is in line with the Oxfordshire Primary Care Framework. OCCG is keen to progress a locality approach to developing services in the future taking into account factors such as local demographics, rurality etc. However, as identified by the Care Quality Commission (CQC) Local System Review, there are many visions and strategies in Oxfordshire. We need to develop a system wide vision and strategy for health and social care in Oxfordshire as a framework to deliver services at a local level.

4. ***That any options within the plan should be co-produced with patients. OCCG needs to be clear about their local definition of co-production and how this would work***

[1] In Oxfordshire, OCCG has six PPG Locality Forums, they are voluntary non-statutory groups, each with an elected Chair in accordance with the Forum's terms of reference, to bring the patient voice into commissioning decisions.

There has been a considerable amount of work and effort across the organisation in engaging and involving patients and the public across projects. Despite the success of many of these, the overall perception of many is that OCCG is not doing enough to engage early enough or in a meaningful way. We are progressing a piece of work to review OCCG's approach to patient and public engagement which will culminate in a new communications and engagement strategy. The review will give us, along with stakeholders, the opportunity to:

- Reflect on the patient and public involvement structure and how the public voice can influence business / decision making currently
- Look at different ways the public voice influences decision making going forward
- How can the OCCG demonstrate / show the public voice has been heard
- Look at details on different levels of representation

Through this work OCCG will clearly define what it means by co-production and what this looks like in practice.

In the meantime the first version of West Oxfordshire Locality Plan was published in January 2018. It incorporated views that were heard during the engagement period and highlighted where further work is needed. The plan will remain iterative and we will continue to work with patients and clinicians to ensure that primary care remains responsive, accessible and of high quality. Any options being developed going forward around specific changes (such as site options for a relocated and/or new practices) will be done in co-production with the local community – this also relates to the Oxfordshire Transformation Programme (see below). OCCG will continue to work with the West Public Locality Forum[2] going forward to design any engagement for the locality.

### *5. The need for more detailed definitions of the changes patients may see and the benefits these would bring should be provided*

One of the objectives for the public facing summary of the plan, mentioned above, is to highlight what changes patient may see as plans are implemented including the impact / benefit to them.

## 2. Oxfordshire Transformation Programme

The Oxfordshire Transformation Programme has been running since 2015 and was taking a phased approach to developing, managing and consulting on its service change proposals.

During 2017 the main area of focus was on the consultation and decision making on the Phase One proposals. The first phase focused on those areas where there were the most pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have been made) or where the proposed changes have been piloted. These included:

[2] In West Oxfordshire, the PPG Locality Forum is known as Public & Patient Partnership West Oxfordshire (PPPWO).

- Critical care facilities;
- Stroke care;
- Changes to bed numbers in order to reduce delayed transfers of care and move to an ambulatory model of care;
- Obstetric Services.

Phase One also included proposed changes to the delivery of Planned Care services at the Horton General Hospital. Whilst OCCG Board took decisions on the areas covered by Phase One these were subject to challenge so have not been implemented. The proposed scope for Phase Two, that included both acute and community services was planned to follow-on. However having taken into account the outcome of the challenges and other feedback OCCG Board have agreed a different way of taking forward what would have been Phase Two.

### 2.1. Phase One

Whilst the OCCG Board took decisions on Phase One of the Oxfordshire Transformation Programme on the 10 August 2017 these were subject to challenge (two referrals to the Secretary of State and a Judicial Review). The status of these challenges is summarised below.

A. Judicial Review

The application for the Judicial Review was lodged by Cherwell District Council, South Northamptonshire District Council, Stratford upon Avon District Council and Banbury Town Council as the Claimants. Keep the Horton General was an Interested Party to the Judicial Review. The Judicial Review covered a number of grounds including the split of the public consultation, the adequacy of the public consultation and the additional NHS England Bed Test.

The Judicial Review Hearing was held at the High Court on 6 and 7 December 2017. Both sides presented their arguments to Justice Mostyn and the judgement was published on 21 December 2017. Justice Mostyn did not uphold any of the grounds by the Claimants and refused leave to appeal his ruling. The Interested Party has submitted an application to the Court of Appeal to determine if an appeal might be permitted.

B. Referrals to the Secretary of State

In August 2017, the Oxfordshire Joint Health Overview and Scrutiny Committee (Oxfordshire JHOSC) referred the OCCG proposals on a permanent change to Obstetrics services to the Secretary of State for Health and Social Care. The Secretary of State has received advice from the Independent Reconfiguration Panel (IRP) and has written to the Oxfordshire JHOSC and to OCCG (on 7 March 2018); this letter and the IRP advice are attached as Appendix 1. The letter from the Secretary of State and IRP advice have covered the issues raised in the referral made by Stratford-on-Avon District Council in April 2017 as well as that from the OJHOSC.

The IRP concluded that further work was required locally and their advice has been accepted by the Secretary of State. A paper relating to the outcome of the IRP recommendations is available within the JHOSC papers (19 April 2018).

### 2.2. Phase Two

At the beginning of March the NHS in Oxfordshire issued a joint statement from the System Chief Executives[3] signalling a change to the approach to service transformation. This resulted from a significant amount of reflection on the experience of running Phase One of the Oxfordshire Transformation Programme, a commitment to learn from the experience and to approach the improvement of local services in a very different manner that is more in line with integrated care systems.

Alongside this, the CQC Local System Review has emphasised the need for much better health and social care planning together as a system rather than individual organisations and the need for an overarching vision and strategy for health and care in Oxfordshire.

The Five Year Forward View describes the traditional divides between primary care, social care, community services and hospitals as increasingly being barriers to the personalised and coordinated health and care services that patients need.

As a result there is now wide consensus that we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does and services need to be integrated around the patient.

It is clear from the national Vanguard sites (where health and social care transformation has been enabled to move at a faster pace and learning shared) that the best service improvements are those where patients, the wider public and key stakeholders (including local authorities, the voluntary sector and social care partners) work together to co-design services based upon the health and care needs of the local population. Whilst there clearly needs to be some sense checks against quality of care and affordability at county scale, evidence suggests that a more place based approach to health and care planning enables improved leverage of local facilities and supporting infrastructure.

Building on this, we are reviewing our transformation programme and intend it to concentrate on developing place based approach which will be set in local discussions that address the needs of the local population, taking into account geography and available services.

This is likely to involve gradual change and testing of new service models locally, involving the public at the earliest opportunity, taking into account factors such as rurality and local community assets. This is a completely different approach to the previous large-scale county wide consultation on specific services.

In order to take this approach forward, we have reviewed the proposed Phase Two of the previous approach to transformation. This was necessary in order to offer

[3] The System CEOs consists of: The CEOs of the Oxfordshire CCG, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, South Central Ambulance Services NHS Foundation Trust and Oxfordshire GP Federations

clarity to our public, stakeholders and the wider system about exactly what we are or are not taking forward. We have heard from key stakeholders that the messages about whether we are or are not undertaking phase two remain confusing at present.

The NHS organisations have reviewed the broad service areas that had originally been proposed for inclusion in Phase Two and the Board of OCCG has agreed the following:

1. The **Emergency Department** and associated services provided at the Horton General Hospital will remain. Furthermore, there is a real opportunity to integrate the GP Out of Hours service, enhanced primary care access and GP streaming so that patients attend only one 'front door' to all the services, with the clinical and non- clinical staff working as one team to ensure patients get the right service first time.
2. The **Paediatric Services** at the Horton General Hospital should remain in place. Clinical Commissioners see this as an opportunity to utilise this relatively costly resource through improved linkage to Primary Care in order to enhance learning and wider clinician support. An example of where this shared resource has been successful is the Taunton and Somerset NHS Foundation Trust, winners of an HSJ Award in 2017 for their primary care paediatric service.
3. The three freestanding **Midwife Led Units** (in Chipping Norton, Wantage and Wallingford) will remain. The operating model for these units is cost effective and mothers continue to choose to use these facilities.
4. The **community hospitals** must be considered within the context of the health and care needs of the local populations they serve, the state of the actual buildings, the rurality and size of the local population (including growth). The CCG and OHFT have agreed that discussions need to be more about what services are required in localities and how best the community hospitals might support, rather than a county – wide consultation on whether they should be removed or remain.

### 2.3. Next Steps

The move to a more place based approach for our health and care service planning sits within the wider context of developing more cohesive system collaboration.

In line with the CQC recommendations, the Health and Wellbeing Board will hold the single over-arching strategy for integrated care. Over the next few weeks, as a system, we will describe how we plan to work with the public and other stakeholders at a more local level in looking at the population's health and care needs so we may co-produce a health and social care system that is fit for the future.

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# Oxfordshire Joint Health Overview and Scrutiny Committee - 19 April 2018

# Response to the Secretary of State and Independent Reconfiguration Panel (IRP) recommendations

**Report of the Director of Law &Governance**

1.0 Purpose

1.1 This report outlines the suggested response for Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) to respond to the Secretary of State and Independent Reconfiguration Panel (IRP) recommendations in relation to the closure of consultant-led maternity services at the Horton General Hospital.

2.0 Introduction

2.1 In response to the Committee's referral of Oxfordshire Clinical Commissioning Group's decision to permanently close consultant-led maternity services at the Horton General Hospital, the Secretary of State passed the matter to the IRP for initial assessment.

2.2 The Secretary of State wrote to Oxfordshire JHOSC on the 7 March 2018 to state that "*The Panel considers each referral on its merits and concludes that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire*". The Secretary of State confirmed his support of the following recommendations:

1. A further, more detailed appraisal of the options, including those put forward through consultation, is required and needs to be reviewed with stakeholders before a final decision is made. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future.

2. The further detailed work on obstetric options at the Horton, advised above, is required. In parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stakeholders.

3. It is important that consultation about the future of services, on whatever scale, takes account of patient flows and is not constrained by administrative boundaries.

4. It is self-evidently in the interests of the health service locally that all stakeholders should feel they have been involved in the development of proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward.

5. The experience of the Phase 1 consultation provides cause for some reflection and the need to learn from the experience for the NHS, the JHOSC and other interested parties. This requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services. It is in everyone's interest that the next phase is commenced as soon as is practicable.

6. HOSC and the CCG to work together to invite stakeholders from surrounding areas that are impacted by these proposals to participate in this debate going forward. This should include the consideration of forming a joint oversight and scrutiny committee covering a wider area (for example all of the local authorities that took part in the consultation) which would help meet the concerns expressed in the IRP's report of their review.

7. Where the CCG consults more than one local authority about a proposal, they must appoint a joint overview and scrutiny committee for the purposes of the consultation.

8. HOSC and CCG to develop a joint proposal for tackling the issues.

## 3.0 Oxfordshire HOSC response

3.1 In regard to recommendations listed above and on the basis that the CCG proposes to consult on proposals impacting on residents beyond the Oxfordshire border, and in line with the statutory provisions, Oxfordshire is obliged to set up a joint oversight and scrutiny committee. We therefore need to set up a joint committee for this specific issue, covering areas of patient flow for the Horton General Hospital obstetric services.

3.2 The area of patient flow for obstetric services at the Horton General Hospital is from Oxfordshire, Northamptonshire and Warwickshire. According to 2015/16 figures, of the 1466 births at the Horton General Hospital, 4% came from women with Warwickshire post codes and 14% from Northamptonshire post codes[1].

3.3 The authorities holding health scrutiny powers for this patient flow geography are the upper-tier authorities of Oxfordshire County Council, Warwickshire County Council and Northamptonshire County Council. The health scrutiny powers are:

- Respond to proposals in a consultation
- Require the provision of information about a proposal
- Require the member or employee of the relevant health service to attend before it to answer questions in connection with the consultation
- The power to refer to the Secretary of State.

[1] Figures contained within OUH Board report from 31st August 2016: http://www.ouh.nhs.uk/about/trust-board/2016/august/documents/ContingencyPlanforMaternityandNeonatalServicesv19Final.pdf

3.4 Areas of patient flow are likely to be those which border Oxfordshire and covered by the district authorities of South Northamptonshire District Council and Stratford-Upon-Avon District Council. These authorities do not hold health scrutiny powers and it would be a matter for respective upper tier authorities as to whether they wish to delegate to the district authorities concerned.

3.5 This proposal requires Oxfordshire County Council and its counterpart authorities in Warwickshire and Northamptonshire to delegate powers of health scrutiny of this specific issue to be delegated to a new joint committee. Scrutiny of all other issues would remain with the respective, established health scrutiny committees. The powers of the new joint committee would therefore be in regard to the proposals and consultation of consultant-led obstetric services at the Horton General Hospital and means:

- Only the new joint committee may respond to the consultation;
- Only the new joint committee may exercise the power to require the provision of information;
- Only the new joint committee may exercise the power to require attendance; and
- The new joint committee would hold the power to refer to the Secretary of State only on the consultation of consultant-led obstetric services at the Horton General Hospital.

3.6 The specific Terms of Reference for the new committee would need to be discussed, negotiated and agreed with Oxfordshire, Northamptonshire and Warwickshire County Councils. The following principles will be proposed to the relevant authorities regarding the governance of the new joint committee:

a) The new committee would have ten members having regard to the levels of patient flow. This is likely to mean there would be eight members from Oxfordshire and one member from Northamptonshire and one from Warwickshire.
b) Membership would be appointed from the respective authorities from the membership of their scrutiny committees.
c) The Chairman of the new committee would be appointed by its Members. The Chairman is likely to reflect the proportionate membership of the committee.
d) The administrative support in terms of coordination, setting up and clerking of meetings and associated costs would be borne by Oxfordshire County Council.

3.7 The joint committee would need to be agreed by the full Council of each of the respective authorities and Members appointed before it could formally operate.

4.0 Recommendations

Oxfordshire HOSC is therefore **RECOMMENDED**: to

(a) note the IRP recommendations;
(b) note the requirements to form a new joint health scrutiny committee in response to the IRP recommendations, to be focused on consultant-led maternity services at the Horton General Hospital;
(c) request Oxfordshire County Council's Director of Law & Governance, in consultation with the Chairman and Deputy Chairman, to seek to negotiate the terms of reference for a new joint committee to be focused on consultant-led maternity services at the Horton General Hospital, to include a membership that is agreeable to all three Councils, for approval by the respective full Councils.

NICK GRAHAM
Director of Law & Governance

Contact Officers: Sam Shepherd, Senior Policy Officer/ Glen Watson, Principal Governance Officer Tel: 07776 997946

April 2018

NHS
Oxfordshire
Clinical Commissioning Group

**Oxfordshire Joint Health and Overview Scrutiny Committee**

**Date of Meeting:** 19 April

**Title of Paper:** Oxfordshire Clinical Commissioning Group response to the Secretary of State and Independent Reconfiguration Panel (IRP) recommendations

**Purpose:** To provide the Oxfordshire Joint Health and Overview Scrutiny Committee (JHOSC) with a proposed response to the Secretary of State and Independent Reconfiguration Panel (IRP) recommendations on obstetrics at the Horton General Hospital.

**Action:** The JHOSC are asked to agree this proposed approach.

**Senior Responsible Officer:** Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group

NHS
Oxfordshire
Clinical Commissioning Group

# Oxfordshire Clinical Commissioning Group response to the Secretary of State and Independent Reconfiguration Panel (IRP) recommendations

## 1. Background

In August 2017, the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) referred the OCCG proposals on a permanent change to Obstetrics services to the Secretary of State for Health and Social Care. The Secretary of State has received advice from the Independent Reconfiguration Panel (IRP) and has written to the JHOSC and to OCCG (on 7 March 2018); this letter and the IRP advice are attached as Appendix 1. The letter from the Secretary of State and IRP advice have covered the issues raised in the referral made by Stratford-on-Avon District Council in April 2017 as well as that from the OHOSC.

The IRP concluded that further work was required locally and their advice has been accepted by the Secretary of State.

## 2. Summary of requirements

The following actions need to be taken:

- OCCG must undertake a more detailed appraisal of the options which needs to include:
    - A consideration of what is desirable for the future of maternity and related services and all those who need them across the wider area of Oxfordshire and beyond.
    - An assessment of the potential activity from the area served by services provided from the Horton General Hospital(particularly South Warwickshire and South Northamptonshire)
    - The view of mothers, families and staff who have been involved in the temporary arrangements
    - Addressing the recommendations from the Clinical Senate report of 2016
- Consideration of what dependency, if any, exists between these services and other services provided from the Horton General Hospital
- The options appraisal needs to be reviewed with stakeholders before a final decision is made
- Those Local Authorities that consider the proposal to be a substantial change in NHS services are required to form a Joint Overview and Scrutiny Committee; the Chairman of Oxfordshire JHOSC has this action in hand and OCCG will work very closely with this Joint Overview and Scrutiny Committee
- **Whilst this work is undertaken no permanent changes to services will be made.** Although a temporary closure of the obstetric unit at the Horton

General Hospital is currently in place, there must be continued attempts to recruit medical and nursing staff until a final decision is made.

## 3. OCCG proposed response

OCCG are working up an outline plan with timescales for the further appraisal work, this will include plans to involve stakeholders and the public. The first part of this is to determine the scope of the review and OCCG will share the plan at an early stage with the Joint Overview and Scrutiny Committee and the Secretary of State/IRP to ensure that this meets the requirements of the advice.

Once the approach has been agreed then OCCG will implement the plan. OCCG propose that the plan and delivery are reviewed on a regular basis by the Joint Overview and Scrutiny Committee and that in essence there will be a series of "gateways".

We acknowledge that whilst this work is undertaken no permanent changes to services will be made. The CCG is working closely with Oxford University Hospitals to ensure that active recruitment of medical and nursing staff continues.

The OCCG Chief Executive has committed to take personal responsibility for ensuring that this work is taken forward in a way that ensures all stakeholders feel involved and informed. Oversight will be maintained through the OCCG Board.

## 4. Outline timescale

OCCG has set-up a small working group and mapped out the work that is required; this is outlined in the table below;

| | **OCCG Working Group** | **Engagement** | **External dependencies** |
|---|---|---|---|
| **April 2018** | Develop outline plan including<br>Context<br>- Scope<br>- Criteria<br>- Long list<br>- Option appraisal<br>- Timelines | | Discuss with Clinical senate their requirements and timelines |
| **May 2018** | Review activity and population growth for catchment population.<br>Develop staff and patient survey | | Agree plan with joint OSC |
| **June 2018** | | Run surveys<br>Engagement on long list of options and criteria | |
| **July 2018** | | | Gateway review with joint OSC |
| **August 2018** | | Option appraisal | |
| **September 2018** | | | |
| **October 2018** | | | Gateway review |

| | | | |
|---|---|---|---|
| | | | (option appraisal) with Joint OSC |
| **November 2018** | OCCG Board review and decision | | |

The timing for delivery has three external dependencies which could impact on the outline timeline above:

- The timescale required by the Clinical Senate to review the work and provide advice
- Establishment of the Joint Overview and Scrutiny Committee
- Agreement to our proposed approach from the Secretary of State/IRP

Department of Health

Oxfordshire CCG

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

POC_1097166

Dr Kiren Collison
Clinical Chair
Oxfordshire Clinical Commissioning Group
Jubilee House
5510 John Smith Drive
Oxford Business Park South
OX4 2LH

- 7 MAR 2018

Dear Dr Collison,

**Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital**

As you know, Oxfordshire Joint Health Overview and Scrutiny Committee's letter of 30 August - about the proposed permanent closure of consultant-led maternity services at the Horton General Hospital - was referred to the Independent Reconfiguration Panel (IRP), to undertake an initial assessment.

The IRP has now completed its initial assessment and shared its advice with me.

**IRP advice**

The IRP have advised me that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.

They also concluded that:

- a more detailed appraisal of the options and should incorporate the findings of the latest Clinical Senate review considering the temporary Horton MLU and dedicated ambulance service. Equally important, there is an opportunity to learn from the experiences of mothers, their families and staff who have been involved in the temporary arrangements for more than a year now. This work should also address all the recommendations of the original Clinical Senate Report from November 2016 and the implementation issues that have been left outstanding, in particular how antenatal care is organised and how recommendations to address travel and parking issues will be carried through

in practice. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future;

- further detailed work on obstetric options at the Horton is required. In parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stakeholders;
- consultation about the future of services, on whatever scale, should take account of patient flows, and not be constrained by administrative boundaries;
- it is self-evidently in the interests of the health service locally that all stakeholders should feel they have been involved in the development of proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward;
- this requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services. It is in everyone's interest that the next phase is commenced as soon as is practicable.

I have accepted the IRP's advice.

I am particularly keen that the OSC and CCG work together to invite stakeholders from surrounding areas that are impacted by these proposals to participate in this debate going forward. This should include the consideration of forming a joint oversight and scrutiny committee covering a wider area (for example, all of the local authorities that took part in the consultation), which would help meet the concerns expressed in the IRP's report of their review.

A copy of the full advice is appended to this letter and will be published on the IRP's website at https://www.gov.uk/government/organisations/independent-reconfiguration-panel.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to the Oxfordshire Joint Health Overview and Scrutiny Committee. I look forward to seeing your joint proposal for taking this work forward.

Yours sincerely

Jeremy Hunt

**JEREMY HUNT**

*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

The Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

9 February 2018

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital**
**Oxfordshire Joint Health Overview and Scrutiny Committee**

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Arash Fatemian, Chairman Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC)[1]. NHS England South East (Thames Valley and Hampshire) provided assessment information. A list of all the documents received is at Appendix One.

The IRP has assessed the referral, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

**The Panel considers each referral on its merits and concludes that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.**

**Background**
The history of events leading up to the referral of 14 February 2017 by the Oxfordshire JHOSC regarding the temporary closure of consultant-led maternity services at the Horton General Hospital ('the Horton') is described in the IRP's advice of 21 August 2017 to the Secretary of State, attached at Appendix 2. That advice concurred with *"the JHOSC's inference that a closure for this length of time* [since October 2016] *exceeds what can reasonably be considered to constitute a temporary closure"*.

In parallel with the events previously described, during 2016 work on developing a strategic vision for the future provision of health services across Oxfordshire was progressed. The Oxfordshire Clinical Commissioning Group (CCG) established the Oxfordshire Transformation Programme, which among other workstreams, incorporated a strategic review of services at the Horton Hospital by Oxford University Hospitals

[1] The Oxfordshire JHOSC consists of councillors from Oxfordshire County Council, the County's four District Councils and Oxford City Council.

Foundation Trust (OUHFT). Preparations were made for a public consultation on an Oxfordshire Health and Care Transformation Plan to be led by the CCG. Discussions with the JHOSC during the autumn of 2016 led the CCG to conclude that, in view of the wide scope of the transformation plans and the JHOSC's desire to see consultation on bed numbers begin in January 2017, the consultation should be split into two phases. This approach was agreed by the JHOSC when it considered the CCG's consultation plan at its meeting of 17 November 2016 and was formally approved by the CCG Board on 29 November 2016. Thames Valley Clinical Senate undertook a review to provide clinical assurance of the proposals, assessing their clinical quality, safety and accessibility. The 'Phase 1' proposals were formally considered by NHS England on 5 December 2016 and a letter confirming that the proposals had passed the NHS England assurance process was sent to OCCG on 10 January 2017.

The first phase of the public consultation, titled *The Big Health and Care Consultation Phase 1* was launched on 16 January 2017 to run to 9 April 2017. Phase 1 covered proposals for the following:

- Critical care at the Horton
- Acute stroke services across Oxfordshire
- Changes to bed numbers and increasing care closer to home in Oxfordshire
- Planned care services at the Horton including elective care, diagnostics and outpatients
- Maternity services – the consultation included a preferred option to create a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital in Oxford which would also be the base for the special care baby unit and emergency gynaecology services; a permanent midwife-led unit (MLU) would be provided at the Horton (as a consequence of this proposal consultant-led maternity services at the Horton would cease permanently)

The JHOSC scrutinised the consultation proposals at a special meeting of the Committee on 7 March 2017 taking into account submissions from interested parties including local MPs, Warwickshire County Council, Northamptonshire County Council, and Cherwell and South Northamptonshire District Councils. The JHOSC provided a formal response on 13 March 2017. Amongst a number of observations made, the response commented on *"an ambiguous picture for the future of maternity services, particularly in the north of the county"* as well as *"interdependencies between Phase 1 and Phase 2"*, notably the possible effect of removing consultant-led services on the sustainability of other related services at the Horton.

On 30 March 2017, permission for a judicial review of the consultation process for Phase 1 of the CCG's Transformation Programme was sought by Cherwell District Council, South Northamptonshire Council, Stratford-upon-Avon District Council and Banbury Town Council. Permission, considered on papers, was not granted.

On 25 April 2017, Stratford-upon-Avon District Council wrote to the Secretary of State to make a referral under Regulation 23(9)(a) of the health scrutiny regulations on the basis that *"...in the District Council's opinion, the consultation process by Oxfordshire CCG was seriously flawed and that the consultation be withdrawn"*.

An independent analysis of the consultation responses, commissioned by the CCG, was completed in June 2017 and was considered by the CCG Board on 20 June 2017. The Board requested additional information with further testing of the obstetric options, including those identified during the consultation, to provide assurance that all variant options had been considered. This work informed the production of a decision making business case (DMBC) containing recommendations relating to each of the proposals consulted on.

On 1 August 2017, the Chair of the Warwickshire County Council Adult Social Care and Health Overview and Scrutiny Committee (ASCHOSC) wrote to the Secretary of State to offer support for the representations made by Stratford-upon-Avon District Council in that council's letter of 25 April 2017.

The DMBC was shared with the JHOSC at its meeting on 7 August 2017. The JHOSC supported proposals for critical care subject to assurances that there would be no 'knock-on' effects for the Horton. Proposals for stroke services were supported subject to clarification on ambulance response times and availability of rehabilitation beds in addition to those at the John Radcliffe Hospital in Oxford. The Committee supported plans to close 110 beds but did not support further changes without seeing improvement on delayed transfers for care and plans for community hospitals. The principle of planned care changes was supported and further discussion was invited when a fully developed plan was available. The JHOSC opposed the recommendation to close permanently consultant-led maternity services at the Horton and resolved, that should the CCG approve that recommendation, it would refer the matter to the Secretary of State.

The DMBC was considered by the governing body of the CCG on 10 August 2017. All recommendations were approved including the creation of a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital in Oxford and to introduce a permanent MLU at the Horton (and permanently close consultant-led maternity services at the Horton).

The JHOSC wrote to the Secretary of State on 30 August 2017 referring the decision to close permanently consultant-led maternity services at the Horton.

The claimants seeking a judicial review of the consultation process applied for an oral permission hearing which was held on 6 September 2017. The judge granted a full review to be heard on 6 and 7 December 2017. The claimant's case asserted that the consultation was unfair and defective. It cited six main grounds in support of that position and sought a ruling that the consultation be declared unlawful and re-run with *Phases 1 and 2* merged. The approved judgment of the Court was published on 21 December 2017 in which the judge dismissed grounds for the claim.

The Secretary of State wrote to the IRP Chairman, Lord Ribeiro, on 10 January 2018 to commission advice on the referral from the JHOSC. The commissioning letter specifically asked the IRP to consider:

- The scope of enquiries in relation to neighbouring local authorities
- Correspondence relating to Cherwell District Council and from Stratford-upon-Avon District Council and Warwickshire County Council

- The issue of which local authorities have oversight and scrutiny responsibilities and how CCGs can address challenges arising
- Whether the proposals for consultant-led maternity services at the Horton need to be looked in the wider context of changes across the STP generally and, if so, how that could be done

**Basis for referral**

The Oxfordshire JHOSC Chairman's letter of 30 August 2017 states that:

> *"...it is with the deepest regret that I am writing to you again following a special meeting of the OJHOSC held on Monday 7 August 2017. At that meeting, the OJHOSC unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) proposal to permanently close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton') to you, as the Secretary of State for Health, should the OCCG Board agree the proposal at its meeting on Thursday 10 August. The proposal was subsequently agreed by the Board, therefore the OJHOSC makes this referral pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013."*

**IRP view**

With regard to the referral by the Oxfordshire JHOSC, the Panel notes that:

*Regulatory issues*

- The 2013 Regulations and associated guidance set out how the NHS must consult local authorities with powers of health scrutiny including where proposals affect more than one such local authority
- A joint health scrutiny committee of all the affected local authorities was not formed – scrutiny was instead delivered through the Oxfordshire JHOSC

*Consultation issues*

- The JHOSC agreed a two stage consultation with the CCG
- The two stage process for consultation, focussing on five separate proposals in Phase 1, has been challenged by various parties and through a judicial review
- The JHOSC opted not to refer the decisions about four of those proposals and resolved only to refer the proposal concerning the future of obstetrics at the Horton

*Issues relating to obstetrics at the Horton*

- Since 2008, training accreditation for junior doctors has been removed from the Horton and other staffing models attempted – the failure of these models to provide a sustainable service led to the temporary closure of obstetrics at the Horton from October 2016
- The JHOSC believes that alternative models suggested through consultation have not been properly considered

*Issues relating to the future of the Horton's services and more widely*

- The implications of the changes proposed at the Horton for other services are strong features of the consultation response – the future of the Horton in general is a significant local concern
- In the light of its experience with the Phase 1 consultation, the CCG is considering how better to progress the work of the Oxfordshire Transformation Programme

**Advice**

The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel considers that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.**

*Regulatory issues*

The Secretary of State asked the IRP to consider the issue of which local authorities have oversight and scrutiny responsibilities. Given the Panel's remit, we have only considered powers of *health* scrutiny. In doing so, we do not offer a legal opinion and rely on our understanding of the relevant regulations and Department of Health guidance on the subject.

The Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and associated Department of Health guidance, *Local Authority Health Scrutiny* (June 2014) describes those local authorities that have powers of scrutiny, essentially those councils with social services responsibilities[2]. These are "upper tier" authorities and include *"county councils, district councils (other than lower-tier district councils) and London Borough councils"*. The Panel understands that lower tier authorities including, for example, Stratford-upon-Avon District Council, do not have powers of health scrutiny vested in them by the 2013 Regulations unless a local authority that does hold health scrutiny powers has arranged for those powers to be discharged to another local authority. In this case, Warwickshire County Council (which holds health scrutiny powers) has confirmed that it did not make such an arrangement with Stratford-upon-Avon District Council. It is, therefore, unclear to the IRP how Stratford-upon-Avon District Council came to the conclusion that it had powers of referral as stated in its letter to the Secretary of State of 25 April 2017. The letter of 1 August 2017 from Warwickshire County Council ASCHOSC does not appear to be a referral in its own right since it professes only to offer *"support for the representations made to yourself by Stratford-upon-Avon District Council"*. However, the Panel, in offering its advice on the referral by Oxfordshire JHOSC, has taken note of the contents of both letters.

Regulation 23(1) of the 2013 Regulations requires that where the NHS has under consideration "*any proposal for a substantial development of the health service in the area of the authority or a substantial variation in the provision of such a service*", it must consult the authority. Regulation 30(5) requires that *"Where a responsible person* (normally the NHS body) *consults more than one local authority pursuant to regulation 23, those local authorities must appoint a joint overview and scrutiny committee for the purposes of the consultation..."*.

In this case, the proposals consulted on by the CCG in Phase 1 impacted not only on the services and residents of Oxfordshire but also those of Warwickshire and Northamptonshire and possibly elsewhere. In the Panel's view, while the Oxfordshire JHOSC was the primary body to consult, the other affected authorities with powers of health scrutiny should have

[2] Regulation 20(1)(b) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
Local Authority Health Scrutiny: Guidance to support local authorities and their partners to deliver effective health scrutiny (June 204), paragraphs 1.2.1 and 2.1.1.

been engaged with the requirement to form a joint scrutiny committee. It is unclear to the Panel where responsibility lies for appointing an appropriately constituted joint health scrutiny committee but the wording of the Regulations suggests that it lies with the local authorities themselves.

The CCG's consultation plan states that it had shared information with Warwickshire and Northamptonshire County Councils. However, there is insufficient evidence for the IRP to assess whether the CCG contacted all potentially affected local authorities with health scrutiny powers or whether those authorities considered the requirement to form a joint committee. In the event, scrutiny was delivered through the Oxfordshire JHOSC which sought and received submissions from, among others, the Warwickshire County Council ASCHOSC, of which Stratford-upon-Avon District Council is a member. As a constituent member of the JHOSC, Cherwell District Council was part of the body consulted under the 2013 Regulations and, in conjunction with South Northamptonshire Council, made its own submission to the JHOSC.

The paragraphs above suggest misunderstanding about the process for consulting with affected local authority scrutiny bodies on the Oxfordshire Health and Care Transformation Plan. That plan is, of course, only one part of the wider Sustainability and Transformation Partnership (STP) covering Oxfordshire, Bedfordshire and Buckinghamshire. The complexity of consulting on issues on this scale is not to be underestimated and requires a level of preparation, co-operation and exchange of information that many NHS bodies and their local authority counterparts may not previously have faced. As has always been the case, it is important that consultation about the future of services, on whatever scale, takes account of patient flows and is not constrained by administrative boundaries.

In the Panel's view, the health scrutiny regulations provide the means to engage with health scrutiny effectively when properly understood and followed. Nevertheless, lack of knowledge or inexperience seems to be preventing this in some places. It is essential moving forward that all parties are aware of their responsibilities and follow the relevant regulations and associated guidance. The Department of Health and NHS England should consider whether the regulations and guidance are sufficiently understood and used effectively by all parties, particularly in the current context of STPs and "systems of care" rather than "organisations".

*Consultation issues*

Oxfordshire JHOSC has referred this matter to the Secretary of State on two grounds – that the consultation undertaken was inadequate and that the proposal would not be in the interests of the health service in its area. In considering issues of inadequate consultation, the 2013 Regulations relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders. The concerns expressed by the JHOSC and others about the lack of consultation with interested parties are addressed in this advice on the basis of their not being in the interests of the health service generally. The Panel's comments in this section are offered in the knowledge that the judge presiding over the judicial review dismissed grounds for the claim of an inadequate *public* consultation.

The JHOSC contends that the CCG failed to engage with local partners, including with Cherwell District Council in which the Horton is situated. A failure to engage with partners is different to and separate from the requirement to consult the relevant local authorities holding scrutiny powers. Nevertheless, it is self-evidently in the interests of the health service locally that all stakeholders should feel they have been involved in the development of proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward.

The JHOSC further contends that the two phase consultation process was inadequate. Yet documentation confirms that the Committee agreed this approach at its meeting of 17 November 2016 prior to the consultation launch. The findings of the judicial review, published on 21 December 2017 and which considered the public consultation process as a whole rather than just the future of obstetrics at the Horton, rejected the assertion that the public consultation – including the two stage process and the consultation with south Warwickshire residents – was either unfair or defective. The Panel notes that four of the five proposals consulted on have not been disputed, albeit that further work is required. As previously commented, consulting on multiple issues across a wide geographical area is a complex undertaking. While holding one large consultation covering all issues may appear desirable, the rationale for splitting matters into discrete packages and consulting in two phases equally holds some logic.

In this case, with the benefit of hindsight it might have been better to have divided the issues up between phases in a different way, in particular, whether it would have been more sensible to consult on obstetrics services at the Horton as part of Phase 2. As it is, splitting the consultation in the way that was done has added more to the confusion and suspicion than helped move matters forward. In the Panel's view, decisions about the future of obstetrics at the Horton must inevitably influence proposals that remain to be consulted on, including around the future provision of MLUs in Oxfordshire. As the JHOSC commented, a clear picture is lacking for countywide maternity services as result of the two-phased consultation. The same is true with regard to the future provision of children's services at the Horton as indeed is an overall vision for the Horton moving forward.

*Issues relating to obstetrics at the Horton*

The IRP notes comments from various quarters that the needs of mothers (to be) in north Oxfordshire and the surrounding areas have not changed since the Panel's review of 2008. The Panel conducts its reviews on a case-by-case basis taking account of the circumstances present at the time. The needs of the population are one of several variables to be considered. That was true of our 2008 review and remains true in offering this advice.

The heart of the matter for the JHOSC regarding the future of obstetrics at the Horton is that not all options have been properly explored in the context of maternity services across the county. In considering this issue, the Panel's view is based on two observations about the current circumstances. First, that action to consider alternative options is needed because the problems with sustaining the obstetric service at the Horton that led to its temporary closure in 2016 are real and the prospects for returning to the earlier status quo are poor given a national shortage of obstetricians, exacerbated by the local workforce recruitment challenges. Secondly, that this consideration must be driven by what is desirable for the future of maternity and related services and all those who need them

across the wider area of Oxfordshire and beyond rather than a search for any possible way to retain an obstetric service at the Horton. This necessarily brings into play potential trade-offs between meeting the needs of higher risk mothers in specialised services, access to more local services, sustainability of staffing and the best use of finite NHS resources.

The consultation response provided a number of suggested options which can be characterised as arguing for a larger volume of births at the Horton (through population growth and an artificial shift of catchment south towards Oxford) to provide a platform from which to recruit and retain the medical staff required on a sustainable basis. The CCG decided to examine the options, using the same criteria as they had for the consultation options, before making its final decision. The results of this evaluation are recorded in the DMBC. The IRP recognises that a considerable amount of work has been done but whether the analysis underlying the conclusions reached has drawn on all the available evidence and been explained sufficiently is less clear. In this respect, the Panel agrees with the JHOSC's view that the consideration of options between consultation and decision fell short.

In the Panel's view, a further, more detailed appraisal of the options, including those put forward through consultation, is required and needs to be reviewed with stakeholders before a final decision is made. This appraisal should incorporate the findings of the latest Clinical Senate review, now underway, considering the temporary Horton MLU and dedicated ambulance service. Equally important, there is an opportunity to learn from the experiences of mothers, their families and staff who have been involved in the temporary arrangements for more than a year now. This work should also address all the recommendations of the original Clinical Senate Report from November 2016 and the implementation issues that have been left outstanding, in particular how antenatal care is organised and how recommendations to address travel and parking issues will be carried through in practice. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future.

The Panel appreciates the desire of many to reach a final decision on the future of obstetrics at the Horton following the extended period of uncertainty both for the CCG and OUHFT and for local users of maternity services. The obstetric unit has been closed since October 2016 and must remain closed unless sufficient doctors with the necessary skills and experience can be recruited. The Panel accepts that this will be difficult in the current climate but attempts to recruit should continue until a final decision is made.

*Issues relating to the future of the Horton more widely*

While this referral from Oxfordshire JHOSC has focussed on the future of obstetrics at the Horton, it appears to the Panel that the key question for the population of Banbury and the surrounding area is '*what does the future hold for the Horton?'*

The proposals consulted on in Phase 1 are at the same time only one part of the Oxfordshire Transformation Programme and, only one part of the future of the Horton Hospital. The Panel's view is that both these need to be pursued in tandem and, building on work done already, brought to a conclusion. The 2016 OUHFT Strategic Review provides a comprehensive view of the Horton's services and offers a coherent vision for the future of the hospital which needs to be debated and, if necessary, refined. Unsurprisingly, lifting the

obstetric element out of this approach has raised questions about the impact on other services.

The Panel has noted, both in documentation provided by the CCG and in the Court judgment, the view that a decision to close the obstetric service at the Horton does not undermine decisions yet to be made about other services provided at the Horton. Whilst this is one view of the issue, the Panel considered an alternative perspective. Following consultation, were the decision to be taken to retain an obstetric service at the Horton, this would influence decisions about other services since, for example, it would be necessary also to seek to sustain paediatric services on the same site. In the Panel's experience of examining these matters, obstetrics and paediatrics in district general hospital settings are services that 'travel together'. A decision about the future of one necessarily influences the future of the other. If the effect can be said to flow through also into A&E services, then the picture of what the Horton will look like in the future remains unclear, at least to the residents of Banbury and the surrounding area who continue to be concerned that issues of population growth and access to services have not been fully taken into account.

The decision by the CCG, with JHOSC support, to include obstetrics at the Horton in the first of a two stage consultation - thus separating it from the future of paediatrics and other related services at the Horton along with maternity services elsewhere in the county - has served to highlight the interdependencies that must be tackled together to move forward successfully. Under all scenarios, the further detailed work on obstetric options at the Horton, advised above, is required. In parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stakeholders.

The question that then remains for the CCG and its partners is how to link further work and a final decision about maternity services to the next steps for the future of the Horton's other services and the rest of the Oxfordshire Transformation Plan. The experience of the Phase 1 consultation provides cause for some reflection and the need to learn from the experience for the NHS, the JHOSC and other interested parties. It is the Panel's view that the challenges facing the health and care system in Oxfordshire, in terms of the sustainability and quality of services, must be confronted honestly by all parties. This requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services. It is in everyone's interest that the next phase is commenced as soon as is practicable.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Oxfordshire Joint Health Overview and Scrutiny Committee**

1 Letter to Secretary of State for Health from Cllr Arash Fatemian, JHOSC Chairman, 30 August 2017
Attachments:
2 The Oxfordshire Big Health Care Consultation Document Phase 1
3 OJHOSC minutes of meeting, 17 November 2016
4 OJHOSC minutes of meeting, 02 February 2017
5 OJHOSC minutes of meeting, 07 March 2017
6 OJHOSC chronology of Oxfordshire Transformation Plan scrutiny
7 OCCG - Phase 1 - Decision Making Business Case
8 Mott MacDonald Integrated Impact Assessment Report
9 Mott Macdonald - hospital car parking survey
10 Healthwatch Oxfordshire – people's experiences of travelling to hospitals in Oxford and Banbury (Travel Parking Survey Report)
11 OJHOSC letter to Oxfordshire CCG - Phase 1 consultation proposals, 13 March 2017
12 Oxfordshire CCG response to HOSC on consultation, 23 March 2017
13 Draft OJHOSC minutes of Oxfordshire Transformation Plan consultation discussion at meeting, 22 June 2017
14 Draft OJHOSC minutes of meeting, 07 August 2017
15 OJHOSC notification to Oxfordshire CCG of intention to refer Horton maternity decision, 10 August 2017

**NHS**

1 IRP template for providing initial assessment information
Attachments:
2 Clinical Senate report, 30 November 2016
3 Pre-consultation business case, 10 January 2017
4 The Big Health and Care Consultation
5 Paper outlining consultation methodology
6 The Big Health and Care Consultation report, May 2017
7 Decision making business case, 10 August 2017
8 Cover paper to Board with DMBC, 10 August 2017
9 NHS England Stage two Assurance Checkpoint Review letter, 10 January 2017
10 NHs England Patient care test letter, 31 July 2017
11 Minutes of Oxfordshire CCG Board meeting, 10 August 2017
12 Oxfordshire Maternity Strategy, 15 August 2016
13 report on the Contingency Plan for Maternity and Neonatal Services, OUHFT Board paper, 31 August 2016
14 OUHFT Horton Strategic Review, Additional Obstetric Options Table, May 2016
15 Equality Impact Assessment, Horton Hospital
16 Care Quality Commission report
17 Strategic Review of the Horton General Hospital, October 2016, OUHFT
18 PCBC Appendix 7.6. Clinical evidence base and best practice for maternity services, Oxfordshire CCG

19 Letter to Cherwell District Council and South Northants Council from Oxfordshire CCG, 1 September 2017
20 Maternity Group obstetric Phase 1 evaluation

**Other evidence submitted**

1 Letter to Secretary of State for Health from Cllr Tony Jefferson, Chairman Overview and Scrutiny Committee, Stratford-upon-Avon District Council, 25 April 2017
2 Letter to Secretary of State for Health from Cllr Wallace Redford, Chair Adult Social Care and Health Overview and Scrutiny Committee, 1 August 2017
3 Letter to Oxfordshire CCG from Legal Service Manager, Warwickshire County Council, 25 May 2017
4 Stratford-on-Avon District Council Response to the Oxfordshire Clinical Commissioning Group's Big Consultation Stage 1 Process, 06 April 2017
5 Letter to Secretary of State for Health from Victoria Prentis MP for Banbury, North Oxfordshire, 18 September 2017
6 Approved judgment in the High Court of Justice, Queen's Bench Division Administrative Court before Mr Justice Mostyn between Cherwell District Council & Others and Oxfordshire CCG, 21 December 2017
7 Copy of email exchange between officials from NHS England regarding status of Stratford-on-Avon District Council, 11 January 2018
8 Briefing note for Department of Health from Oxfordshire CCG re Transformation Plan Phase 1, 11 October 2017
9 Letter to IRP Chairman from Victoria Prentis MP for Banbury, North Oxfordshire, 26 January 2018

**APPENDIX 2**

*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

21 August 2017

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral of the temporary closure of consultant-led maternity services at the Horton General Hospital**
**Oxfordshire Joint Health Overview and Scrutiny Committee**

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Yvonne Constance OBE, Chairman Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). NHS England and Oxford University Hospitals NHS Foundation Trust provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review.**

**Background**
Horton General Hospital ('the Horton') in Banbury, Oxfordshire is part of the Oxford University Hospitals NHS Foundation Trust (OUHT) along with the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre in Oxford. The Horton provides a range of district general hospital services for approximately 170,000 people in north Oxfordshire, south Northamptonshire and south Warwickshire.

Maternity services for Oxfordshire are provided by OUHT on five sites. The John Radcliffe Hospital provides obstetric care and also has an alongside midwifery-led unit (MLU). Obstetric care was provided at the Horton until its temporary cessation on 3 October 2016. The hospital currently provides a midwifery-led service only. There are three other stand-alone MLUs in Oxfordshire, at Wallingford and Wantage to the south of the county and at Chipping Norton in the north. Beyond Oxfordshire, maternity services are available in neighbouring counties including in Cheltenham, Warwick, Northampton and Milton

Keynes. Prior to its temporary closure, the obstetric unit at the Horton was one of the smaller units in the country. In 2015/16, there were slightly over 1,400 deliveries at the hospital, of which approximately 400 required obstetric-led care.

Maternity and related services at the Horton have been the subject of a referral to the Secretary of State for Health previously. In 2006, the then Oxford Radcliffe Hospitals NHS Trust proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the special care baby unit from the Horton to the John Radcliffe Hospital. Oxfordshire JHOSC referred the proposals and the Secretary of State commissioned a review from the Independent Reconfiguration Panel. The IRP's report, submitted on 18 February 2008 recommended that the Trust's proposals be rejected because they failed to provide an accessible or improved service for local people. The Panel recommended that further work be carried out to identify the arrangements and investment necessary to retain and develop the services involved at the Horton. The Secretary of State accepted the Panel's recommendations in full.

Consequently, consultant-led maternity services were maintained at the Horton supported by a training programme for junior doctors working in obstetrics. However, in 2012, post-graduate obstetric training accreditation at the Horton was withdrawn predominantly because of the low numbers of births at the hospital which resulted in only limited exposure to complex cases for those on the programme. A Clinical Research Fellow programme, based on eight posts, was then developed by the Trust in conjunction with the University of Oxford to support consultant-led services but the programme closed in December 2015 due to difficulties in recruiting staff to fill the posts. In April 2016, a new nine person, middle grade obstetric rota was developed allowing participating doctors the opportunity to get experience at the John Radcliffe Hospital as well as at the Horton. Despite advertisements for obstetricians being placed both nationally and internationally at monthly intervals from April 2016 onwards, and offering an enhanced remuneration package, difficulties in recruiting staff continued. Alternative solutions, including rotating staff between the John Radcliffe Hospital and the Horton and the employment of locum staff, were attempted but maintaining the rota of nine doctors required to staff the Horton unit safely on a consistent basis remained problematic.

In July 2016, in light of continuing recruitment difficulties and the resignation of existing staff, OUHT prepared contingency plans for the continued provision of maternity services at the Horton. Staff working in the maternity unit were briefed on 18 July 2016. On the same day, the JHOSC Chairman held an informal meeting with the Trust Director of Clinical Services to be advised of the immediate pressures affecting obstetrics services at the hospital and the contingency plans to be put in place. The Chairman was advised that of the eight resident doctors at the Horton specialising in obstetrics only three would still be in place by October 2016 following a number of resignations. Adverts for agency staff were being placed to recruit to vacant posts and midwives at the Horton would be trained in a midwifery-led approach to providing care should the consultant-led service have to cease. It was agreed that an update on the situation should be provided to the next JHOSC meeting in September 2016.

Workshops attended by representatives of the district and county council, local MPs and GPs, the Oxfordshire Clinical Commissioning Group (CCG) and local public and patient

groups were held on 20 July and 24 August 2016 to discuss the issue. During August 2016, further meetings took place with local MPs and GPs and representatives of the public including members of the Keep the Horton General Campaign. The Trust attended a public meeting in Banbury on 25 August 2016 and also responded to direct communications from the public.

An Extraordinary Meeting of the OUHT Board was held on 31 August 2016 to consider the single issue of maternity and related services at the Horton and to discuss the contingency plans. The plans included:

- The temporary establishment of a midwife-led birth unit (MLU) at the Horton
- The temporary cessation of obstetric care at the Horton and its transfer to the John Radcliffe Hospital
- The temporary cessation of the special care baby unit at the Horton and its transfer to the John Radcliffe Hospital
- The temporary cessation of the inpatient emergency gynaecology service and the establishment of a seven day ambulatory emergency gynaecology unit at the Horton
- The temporary withdrawal of the dedicated obstetric anaesthetic rota from the Horton General Hospital

The Trust Board was advised that the CCG, the Care Quality Commission and NHS Improvement had been advised of the risks posed by impending shortages of medical staff. The Board heard from clinicians that impending staffing shortages in the obstetric services at the Horton represented a risk to patient safety. It was reported that the Trust already had experience of running MLUs with protocols in place for safe operation of the service and that the temporary establishment of a MLU at the Horton would offer choice for local pregnant women whose deliveries had been assessed as low risk. Evidence of the efforts to recruit both permanent and locum staff was presented and further urgent work would be undertaken to review the enhanced remuneration package already available to aid recruitment. As part of the contingency plan, an ambulance would be available 24 hours a day at the Horton to ensure quick and safe transport of any woman requiring transfer to the John Radcliffe obstetric unit. Arrangements would be put in place for the John Radcliffe Hospital to accommodate up to an additional 1,000 births.

The Trust Board voted unanimously:

- *"that the continuation of the services of the Obstetric Unit at the Horton General Hospital was unsafe beyond 3 October 2016"*
- in favour of *"the temporary establishment of an MLU at Horton General Hospital from 2 October 2016"*
- to approve *"the Report on the Contingency Plan for Maternity and Neonatal Services"*

At a meeting of the Oxfordshire JHOSC on 15 September 2016, OUHT representatives presented the contingency plan and informed the Committee of the intention to temporarily close consultant-led maternity services at the Horton with effect from 3 October 2016. The Committee requested that OUHT representatives attend a special meeting of the JHOSC on 30 September 2016 to discuss specific issues including travel times, recruitment options and reasons for the observed decrease in birth numbers at the hospital.

The JHOSC Chairman met informally with the Trust Director of Clinical Services on 27 September 2016 to discuss the items for presentation at the forthcoming meeting.

The JHOSC meeting on 30 September 2016 further scrutinised OUHT's contingency plan. This included evidence of the Trust's efforts to maintain consultant-led maternity services at the Horton and discussion of the impact of the temporary closure and associated risks. The Committee accepted that the Trust had provided satisfactory reasons for invoking the temporary closure of consultant-led maternity services at the Horton without prior consultation. On the basis of the evidence provided, assurances given by the Trust that the closure would be temporary and the plan to increase staffing levels by March 2017, it was agreed that the matter should not be referred to the Secretary of State at that stage. The Committee requested that regular updates be provided to monitor service provision and recruitment progress.

Updates on maternity services at the Horton were provided by OUHT on 10 November, 5 December and 23 December 2016. The update of 23 December 2016 stated that, with three obstetricians in post at that time and the maximum number of doctors likely to be in post by March at five, there would not be enough experienced and skilled medical staff in post to reopen the Horton obstetric unit in March 2017 as planned.

At a meeting of the JHOSC on 2 February 2017, members considered the continued temporary closure of the Horton obstetrics unit and the proposals contained within Phase 1 of the Oxfordshire Transformation Plan (see below). A motion was unanimously agreed to refer the temporary closure of the consultant-led obstetrics unit at the Horton to the Secretary of State for Health. OUHT was notified by email of the JHOSC's decision on 3 February 2017. A letter of referral was sent to the Secretary of State on 14 February 2017 stating that the JHOSC believed the material grounds for not referring the matter had changed, that is, that the Trust's recruitment plan had failed and the closure would be longer than envisaged. Clarification of the procedural steps taken by the Committee to comply with the requirements of the 2013 Regulations was sought by the Department of Health by letter of 10 April 2017. The JHOSC Chairman responded providing additional information in a letter of 26 April 2017.

In parallel with the actions and events described above, the first phase of a public consultation on the Oxfordshire Health and Care Transformation Plan, led by Oxfordshire CCG, was launched on 16 January 2017. A two-phase approach to consultation had previously been agreed with the JHOSC in autumn 2016. The consultation included a preferred option to create a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital which would also be the base for the special care baby unit and emergency gynaecology services. A permanent midwife-led unit would be provided at the Horton. The JHOSC scrutinised the consultation proposals at a special meeting of the Committee on 7 March 2017. The Chairman of the Council responded to the consultation on 3 April 2017 expressing its opposition to the proposals and rejecting the consultation. A decision-making business case, including a recommendation to remove obstetric care from the Horton and provide a permanent midwife-led unit, was presented to the governing body of the Oxfordshire CCG on 10 August 2017. All recommendations were approved including the one relating to maternity care at the Horton. Were such a

decision to be made, the JHOSC had already declared at its meeting on 7 August 2017, to refer the matter to the Secretary of State and this is now awaited.

**Basis for referral**
The JHOSC Chairman's letter of 14 February 2017 states:

*"... at its meeting on 2 February, the Committee resolved to refer the matter to the Secretary of State under Regulation 23(9)(b) of the 2013 Regulations and to ask that you refer the issue of provision of maternity services at the Horton General Hospital to the Independent Reconfiguration Panel."*

The JHOSC Chairman's letter to the Department of Health dated 26 April 2017 cites the grounds for referral as:

*"(1) the Committee believed that the material grounds for not referring the matter had changed, ie the Trust's recruitment plan had failed and the closure would now be longer than envisaged; and*
*(2) it considered that nothing could be gained by further discussion at a local level with the Trust."*

**IRP view**
With regard to the referral by the Oxfordshire JHOSC, the Panel notes that:

- Referral is made under Regulation 23(9)(b) of the 2013 Regulations relating to not being satisfied with the reasons given for not consulting with the JHOSC
- The JHOSC had previously accepted the reasons put forward by OUHT but asserts that the material grounds for not referring have changed – due to the failure of the recruitment plan and extended closure of the obstetric unit
- The obstetric unit at the Horton was closed on 3 October 2016 on grounds of safety due to the inability to recruit and retain sufficient doctors with the necessary skills and experience
- Failure to recruit additional staff meant that the obstetric unit could not be reopened in March 2017
- Safety of services must always be the primary consideration for any healthcare provider
- Events have now been overtaken by the decision of the CCG governing body to permanently locate obstetrics at the John Radcliffe Hospital and replace consultant-led maternity care at the Horton with a midwife-led service
- The JHOSC has declared its intention to refer this decision to the Secretary of State

**Advice**
The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review in relation to this referral would add any value.**

The Oxfordshire JHOSC has chosen to refer this matter under the somewhat obtuse Regulation 23(9)(b) of the 2013 Regulations. Regulation 23(1) requires NHS bodies to consult relevant scrutinising authorities on any proposal for a substantial development of the health service or a substantial variation in the provision of the service. Regulation 23(2)

provides for circumstances in which an NHS body makes a decision without prior consultation with the scrutinising authority because of a risk to safety or welfare of patients or staff. Regulation 23(9)(b) states that *"in a case where paragraph (2) applies, the authority* [may make a report to the Secretary of State where it] *is not satisfied that the reasons given by R* (a responsible person, that is, the NHS body) *are adequate"*. This regulation was relevant in autumn 2016 when the decision was taken by OUHT, without prior consultation with the JHOSC, to introduce a temporary cessation of consultant-led maternity services at the Horton on grounds of patient safety. The Committee scrutinised that decision in September 2016 and accepted that the reasons for doing so were valid. Whether the same regulation continued to be relevant in February 2017, when this referral was made, is for legal minds to ponder rather than the IRP. However, the Panel recognises that, faced with the prospect of the Horton obstetric unit remaining closed for more than six months, local concern about if and when the unit would reopen inevitably grew. That concern developed not least because a consultation was launched during the same period by the CCG that contained a preferred option to close the unit permanently.

In the circumstances, it is not surprising that scepticism exists in some quarters about the extent of the Trust's efforts to attract the skilled and experienced staff required to reopen the unit. As recorded in the background section to this advice, several creative staffing models have been used since the IRP's report in 2008. Whether more could have been done is, for now, a matter of speculation.

The obstetric unit at the Horton has, at the time of writing, been closed for some 10 months. The July report to the OUHT Board indicated that seven posts had been filled. This represents progress but still falls short of the nine required to fill the rota and safely staff the unit. Safety must always be the primary consideration in the provision of healthcare. The Panel accepts, as did the JHOSC in September 2016, that the Trust was correct to close the unit in the absence of enough doctors to staff the unit safely and that the unit could not be reopened until sufficient staff had been recruited. Nevertheless, the Panel concurs with the JHOSC's inference that a closure for this length of time exceeds what can reasonably be considered to constitute a temporary measure.

Subsequent events have now overtaken the substance of this referral. The governing body of the CCG decided on 10 August 2017 to remove obstetric care from the Horton and replace it with a permanent midwife-led unit. The Panel understands from press reports that the Oxfordshire JHOSC has declared its intention to refer that decision to the Secretary of State. When that referral materialises, the IRP stands ready to offer advice if requested.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Oxfordshire Joint Health Overview and Scrutiny Committee**

2 Letter to Secretary of State for Health from Cllr Yvonne Constance OBE, JHOSC Chairman, 14 February 2017
Attachments:
2 Oxford University Hospitals NHS Foundation Trust (OUHT) report to JHOSC Contingency plan for maternity and neonatal services, September 2016
3 Oxford University Hospitals NHS Trust updates on maternity at the Horton General Hospital, 10 November 2016, 5 December 2016 and 23 December 2016
4 Oxfordshire JHOSC minutes of meetings, 15 and 30 September 2016
5 Oxfordshire Health and Care Transformation Phase 1 consultation document
6 Letter to Department of Health Cllr Yvonne Constance OBE, JHOSC Chairman, 26 April 2017
Attachments:
7 Note of meeting between JHOSC chair and NHS official, 18 July 2016
8 Note of meeting between JHOSC chair and NHS official, 27 September 2016
9 Oxfordshire JHOSC minutes of meeting, 2 February 2017
10 Email to NHS representatives notifying of intention to refer matter, 3 February 2017

**NHS**

1 IRP template for providing initial assessment information
Attachments:
2 Contingency plan for maternity and neonatal services
3 OUHT equality analysis for maternity services
4 Geography of Oxfordshire and Oxfordshire CCG
5 OUHT minutes of Extraordinary Trust Board meeting, 31 August 2016

**Other evidence considered**

1 OUHT briefing on obstetrics at the Horton General Hospital in Banbury, Oxfordshire, 7 February 2017
2 OUHT Trust Board update paper, 12 July 2017
3 Decision-making business case, CCG governing body meeting, 10 August 2017

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# Oxford University Hospitals NHS Foundation Trust: Progress against Quality Priorities described in the Quality Account 2017-18 and feedback from 'A Quality Conversation' event January 2018



## The Joint Health Overview and Scrutiny Committee For Information April 2018

Oxford University Hospitals NHS
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# Did we achieve the 17/18 Quality Priorities?

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# 2017/18 Priorities- a reminder

- Partnership working
- Safe discharge
- Preventing patients from deteriorating – delivering time critical care [heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and Documentation (SEND)]
- Mental health in patients coming to our hospitals
- Nationally recognised iPad based track and trigger SEND project
- Cancer pathways
- Go Digital
- End of Life Care: improving people's care in the last few days and hours of life
- Dementia care
- Learning from complaints

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# Partnership working

| Priority One: Partnership working | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| This was the top choice from our patient and public consultation event in January. It is also a major strategic aim for the Trust to work with system partners across Oxfordshire in areas such as the sustainability and transformation project (STP) across Buckinghamshire, Oxfordshire and Berkshire. We also recognise the value of our services that provide national and international expertise and will work to enhance care in this area particularly for rare diseases. Our CQUIN (Commissioning for Quality and Innovation) programme this year includes partnership networks with other local/regional hospitals to deliver best quality care together for spinal surgery, infection of the liver from a virus (hepatitis C), specific blood disorders and chemotherapy etc. | We will evidence the benefit to patients from taking a whole system approach to our strategy including the University of Oxford, our commissioners, other trusts, our STP area, Oxford Academic Health Science Network and stakeholders.<br><br>Home Assessment and Reablement Team (HART) service development: we will ensure that the 50% of time is specifically for patient contact. This figure is derived by taking into consideration staff annual leave, sickness, maternity leave and travel time between each patient in the community as well as non-patient facing organisational activities.<br><br>By ensuring the Operational Delivery Networks (ODNs) - collaborations of doctors, nurses, managers and allied professionals - offer opportunities to share learning and develop solutions within and across networks at regional and national levels, to build collaboration and accelerate change for patients. This will be evaluated via achievement of the CQUIN requirements.<br><br>By fully embedding the OUH Public Health/ Health and Wellbeing Strategy we will continue to improve the organisational infrastructure that underpins staff health and wellbeing. We will implement a management development programme to equip line managers with the skills and capabilities to manage teams and services. This will provide managers with the tools to help create a healthy workplace for staff. | STP: We Achieved this.<br><br>Home Assessment and Reablement Team (HART) service development: We achieved this.<br><br>Operational delivery networks (ODN):<br>We expect to partially achieve this. The regional Spinal network holds regular MDT meetings and the network has produced regional policies to manage spinal emergencies including emergency imaging and transfer.<br>The hepatitis C ODN has a greater than 98% cure rate.<br>Haemoglobinopathies: By the end of Q3, 70% of patients had received an MDT review.<br><br>We achieved this: We implemented a management development programme. |

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# Safe discharge

| Priority Two: Safe discharge | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| Patients have told us that delays caused by their medicines not being ready when they expect to leave the hospital are a source of frustration. We have also had feedback from GPs that this is an area we can improve upon. This was the favourite new priority identified at our patient and public event and will build upon work we did last year to improve medicines safety. | Our aims are to improve the experience of discharge and the accuracy of discharge communication for future medication.<br>• We will bring forward the time medicines to take home are reconciled/written, significantly increasing the number of patients discharged before 12 noon, and reduce the number of changes needed on medicines to take home so they are ready at the time of discharge.<br>• Furthermore we aim to reduce the overall time it takes to turn around discharge medicines and ensure availability to the patient when they are ready to go home.<br>• We will aim to increase the percentage of patients discharged before noon from 8% to 30%. We will examine information from our electronic system (Cerner) and carry out audits to check our results. | We will partially achieve this.<br>Analysis of January and February 2018 discharges before noon show an increase to 22.5% (average). |

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# Priority Three: Preventing patients from deteriorating

| Priority Three: Preventing patients from deteriorating – delivering time critical care [heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and Documentation (SEND)] | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| This was the third most popular priority to continue at our patient and public consultation event and is a theme from our analysis of incidents or near misses in 2016/17. | • Through a programme of changes supported by the monitoring system SEND and as part of the cardiac arrest reduction strategy we expect to achieve a 10% reduction in cardiac arrests in 2017/18 from 2016/17. | Reduction in cardiac arrests: We achieved this. There is a 20% decrease in the instance of cardiac arrest in general ward areas between April 2017 and Feb 2018 when compared with the same period the previous year. |
| | • We will establish an education and communication programme to fully inform our staff about rapid response treatment for time critical diagnoses which may cause deterioration in hospital. | Education and communication programme: We partially achieved this. The number of midwives completing the recognition and treatment of the acutely ill and deteriorating patient (RAID) assessor training has increased and RAID assessments are now underway in maternity. This subject has also been included in all medical induction sessions since August 2017 (646 doctors). The groundwork is now complete for the e-learning package for time critical illnesses and the anticipated go live date for the training is by 31st May 2018. |
| | • We will work to achieve national priorities to improve care for patients with sepsis as described in the 2017/18 CQUIN. | Sepsis CQUIN: We fully achieved the screening element and partially achieved the intravenous antibiotics within an hour element (70% versus a target of 90%). |

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# Priority Four: Mental health in patients coming to our hospitals

| Priority Four: Mental health in patients coming to our hospitals | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| We know that the Emergency Department (ED) is not the best place to care for patients with mental illness and we will be working with Oxford Health NHS Foundation Trust to find ways to prevent the need to come to ED for some of these patients. We will also work on further improving care for those with mental illness complicating physical illness who are admitted to our hospitals. This was the second most popular suggested new priority at our patient and public event. | • For patients attending ED we will collaborate with Oxford Health to achieve the CQUIN target for 2017/18. We aim to reduce by 20% the ED attendances of those within a selected cohort of frequent attenders in 2016/17 who would benefit from psychiatric and psychological interventions.<br><br>• For inpatients, our Psychological Medicine team will identify, train and support medical and nursing champions for psychological and psychiatric care of our patients in all key Trust services. | Mental health in ED CQUIN: We have achieved this with a 46% reduction in attendances since April for this patient cohort.<br><br>Education/ training quality initiative: We have fully achieved this. |

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# Cancer pathways

| Priority Five: Cancer pathways | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| We plan to review cancer pathways with a focus on reducing the number of, and time between patient encounters (coming to hospital as an in- or outpatient or for tests) in order to consistently improve patient experience, meet cancer targets and provide diagnosis and treatment in a timely manner. | We aim to improve patient experience by increasing the numbers of individuals who are diagnosed and treated for cancer within target. We also aim to avoid unnecessary delays and we have a programme for quality in each cancer pathway. We will<br>• Increase the timeliness of first contact or visit for individuals with a suspected cancer so that >93 % of referrals are seen within 14 days.<br>• Increase the number of individuals confirmed with cancer who are treated within 62 days from 2 week wait referral to treatment start (Aim: >85% in 2017/18).<br>• Increase the number of patients who are treated within 31 days of decision to treat (Aim: 96% or greater in 2017/18). | We partially achieved this.<br>The table provides the trend data: |

| Target (%) | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 |
|---|---|---|---|---|---|---|---|---|---|---|
| 2ww (93) | 92 | 92 | 97 | 96 | 97 | 98 | 98 | 97 | 95 | 96 |
| 62 day (85) | 86 | 83 | 83 | 85 | 85 | 85 | 82 | 82 | 87 | 82 |
| 31 day first (96) | 98 | 97 | 98 | 98 | 96 | 97 | 96 | 96 | 97 | 94 |

Oxford University Hospitals NHS
NHS Foundation Trust

# Go Digital

| Priority Six: Go Digital | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| We have been named a 'global digital exemplar' which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. As a digital exemplar, we have ambitious plans to accelerate the opportunities that digital technology offers, in line with the ambition of the NHS to be 'paper-free' and for patient records to be held electronically and accessible across different systems. We will leverage electronic health records, data and technology to innovate and join up how we provide patient care across organisational boundaries and support self-care and research. We are committed to ensuring these processes improve our safety, effectiveness and patient experience. | • We will establish a Patient Portal to be used for appointment booking, receipt of letters and review of parts of the clinical record (for limited numbers of patients).<br><br>• We will deliver a major project for Core Clinical Documentation: this major project will be accelerated to deliver the capability providing the outstanding online documentation required by clinical staff to document electronically in real time into the patient record. It includes Care Plans, Assessments, Decision Support Rules, extended catalogues of orderables (clinical referrals), and 'best practice' clinical pathway guidance. | Patient portal: We did not achieve this. Preparatory work to facilitate this has been undertaken by the OUH, in partnership with Cerner, and this will be adopted for next year's priorities.<br><br>Core Clinical Documentation: We partially achieved this. The latest documentation standards for Nursing Care Plans, Assessments, and Clinical Referrals went live as planned across the Nuffield Orthopaedic Centre (NOC) on 19th February 2018. A decision on the rollout approach to remaining OUH sites will be based on learning from live use at the NOC. |

Oxford University Hospitals NHS
NHS Foundation Trust

# End of Life Care

| Priority Seven: End of Life Care: improving people's care in the last few days and hours of life | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| This was the second most popular priority to continue when we asked our patients and the public at our event in January 2017. We agree that while we achieved a lot last year we can still do more to develop our end of life care in 2017/18. | • We will implement further improvements in end of life care as described in our work plan for 2017/18. The work plan is based on our End of Life Care (EOLC) Strategy and builds on last year's work plan. | We completed the EOLC work plan. |
| | • We will deliver and learn from the daily palliative care input to the Emergency Department (ED) and Emergency Admissions Unit (EAU) as part of the End of Life Care Project funded by Sobell House Hospice Charity. | Palliative care input to ED and EAU: We achieved this. |
| | • We will increase the number of wards with enhanced skills in supporting end of life care. | Increasing ward accreditation: We will partially achieve this. Juniper, Laburnum and the Critical Care Unit at the Horton are currently preparing to accredit as is the Emergency Admissions Unit (EAU) at the JR. This should be complete early in 2018/19. |
| | • We will continue to gather feedback from bereaved families to understand their experience of care in the Trust and incorporate learning in the work plan. | Bereavement survey: We achieved this. |

Oxford University Hospitals NHS
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# Dementia Care

| Priority Eight: Dementia Care | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| We are committed to providing an excellent standard of care for all patients but we know that we particularly need to ensure that those who are vulnerable and frail are getting the best possible care. Dementia is an increasingly common condition and we want to continue to build on last year's progress in this area. | • We will implement a paperless process for cognitive screening. A uniform core electronic clerking pro forma should help improve screening because junior doctors will then become familiar with using the same core form regardless of specialty.<br><br>• We will modify our consent forms to prompt consideration of the need for a capacity assessment prior to consent.<br><br>• We will design electronic systems to trigger individualised nursing care plans/bundles once the cognitive screen has been completed and it is positive. | Paperless cognitive screening assessments are in place.<br><br>Consent forms: We achieved this modification. The modifications to the consent forms have been approved by the Clinical Governance Committee (CGC) and will launch shortly.<br><br>Individual care plans: We partially achieved this. A new form to record the assessment of the patient's mental capacity has been agreed for use once the cognitive screen is positive however the roll out of the triggered individualised nursing care plans/ bundles will not take place before 31st March 2018. |

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# Priority Nine: Learning from complaints

| Priority Nine: Learning from complaints | | |
|---|---|---|
| **Why we chose this priority** | **How we will evaluate success** | **Evaluation March 2018** |
| It is fundamental that we listen to our patients and learn from their experiences therefore we want to make this an explicit priority this year. Communication is one of the top three themes from complaints and this will be an area of focus. | • We will carry out an in-depth review of 2016/17 complaints related to communication to better develop actions and stories which will have the greatest impact for staff.<br><br>• We will also review complaints about access to treatment to ensure the Trust is listening to the patient's views on what aspects of access really matter for their experience. This will be used to understand where improvements can be made. | Completed a review of complaints about communication.<br><br>Access to treatment: We partially achieved this. A programme of work led by the Director of Nursing is underway and will complete after 31st March 2018. |

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Oxford University Hospitals NHS
NHS Foundation Trust

# ‘A Quality Conversation’ event January 2018

- Almost 100 patients, Foundation Trust governors and members, and staff took part in an event on Tuesday 16 January 2018.
- A showcase of the achievements of the equality priorities was held in Tingewick Hall prior to table discussions of possible future quality priorities.
- The four priorities the audience chose to carry forward to next year were:
- a) Partnership working
- b) End of life care
- c) Preventing patients from deteriorating and
- d) Go Digital
- The feedback from the event was very positive with 88% finding the event useful or extremely useful.
- 98% of attendees felt they were able to contribute to decisions about the future quality priorities and 96% found the table discussions useful or extremely useful.

Oxford University Hospitals NHS
NHS Foundation Trust



John Radcliffe Hospital

Nuffield Orthopaedic Centre

Churchill Hospital

Horton General Hospital

**FOUR HOSPITALS, ONE TRUST, ONE VISION**

# HOSC and Health 'Ways of Working' Workshop Report and draft Protocol

**Joint Health Overview and Scrutiny Committee**
**19th April 2018**

## 1.0 Purpose

1.1 The Independent Reconfiguration Panel (IRP) made recommendations to Oxfordshire following a referral by the Oxfordshire Joint Health Overview and Scrutiny Panel (HOSC) on Deer Park Medical Centre in 2017. JHOSC and health partners were advised to consider how they can *"work together differently to command public confidence and maintain an open relationship"*. The purpose of this report is to outline the progress and next steps to respond to this IRP recommendation.

## 2.0 Context

2.1 In response to advice from the IRP, two 'Ways of Working' workshops have been held between HOSC and health representatives.

2.2 The first was held in January 2018 reported to the committee on the 8th of February 2018 with the following recommendations agreed:

| No | Action | Timeframe |
|---|---|---|
| 1 | Develop working principles that can be signed up to by HOSC and health colleagues. | April 2018 |
| 2 | Amend the change process to introduce a staged approach with different thresholds of change (i.e. minor/temporary/moderate/significant). | June 2018 |
| 3 | Introduce more flexible and different ways of working to allow for early engagement, dialogue, feedback, evaluation (for example, briefings, task and finish groups, reference groups, debriefs, visits, annual planning event and training). | April 2018 |
| 5 | Robust feedback and communications (e.g. ensure HOSC feedback is recorded and communicated). | February 2018 |
| 6 | Set an evaluation and reporting back framework. | June 2018 |

2.3 To progress the recommendations, a further workshop was held on the 21st of March 2018 to discuss a draft Protocol between HOSC and health partners.

2.4 The document attached at Appendix A of this report is the result of that work which the committee are invited to consider and agree.

## 3.0 Next steps

3.1 Once the committee is content with its content and agrees the Protocol, it will be shared for note at the relevant Boards of the primary commissioners and providers that have regular engagement with HOSC.

3.2 Following agreement of the Protocol, a Terms of Reference for the HOSC Planning Group would be drafted and a meeting of the Group brought together to begin to inform the HOSC Forward Plan.

## 4.0 Recommendations

4.1 It is recommended that HOSC:

1. **NOTE** the progress made against addressing IRP recommendation and the committee's agreements made on the 8th of February 2018.

2. **AGREE** the draft protocol outlined in Appendix A of this report.

3. Subject to agreement of the Protocol and the proposal to establish a HOSC Planning Group, **ASK** the HOSC support officers to negotiate terms of reference and ensure the Group meets to inform the next meeting of the committee.

# DRAFT Protocol between the Oxfordshire Joint Health Overview and Scrutiny Committee and health and wellbeing providers and commissioners serving the population of Oxfordshire

## 1.0 Introduction

1.1 This Protocol applies to how Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) will work together with bodies who commission or provide health, social care and wellbeing services to the population in Oxfordshire.

1.2 The Protocol sets out some working principles which guide and support the relationship between the scrutiny body and those commissioning or providing health, social care and wellbeing services.

1.3 It sets out a way of working when changes are proposed to health and wellbeing services which require consultation and engagement required by legislation. The Protocol also applies to developments that affect smaller numbers of patients, smaller geographical areas or specific services.

## 2.0 Purpose of the protocol

2.1 The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards which set out how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and communities across Oxfordshire.

## 3.0 Aims and responsibilities of health scrutiny

3.1 The guidance on health scrutiny, published by the Department of Health in June 2014, stated that:

> *"the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe."*

3.2 In Oxfordshire, health scrutiny is the statutory duty of Oxfordshire County Council whose constitution states it has:

> *"responsibility to "review and scrutinise any matter relating to the planning, provision and operation of the health services in its area" and to make referrals to the Secretary of State about proposals where it considers proposals for service change, or consultations, have been inadequate. It discharges that responsibility to the Oxfordshire Joint Health Overview and Scrutiny Committee ('the Committee')"*

3.3 The Oxfordshire HOSC Terms of Reference[1] sets out its responsibilities for reviewing or scrutinising services commissioned and provided by all relevant

[1] https://www2.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/corporategovernance/constitution/Constitution2015/Part2Article8The_Oxfordshire_Joint_Health_Overview_and_Scrutiny_Committee.pdf

NHS bodies and health service providers. This includes GP practices and other primary care providers such as pharmacists, opticians and dentists and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority, including public health and social care services.

3.4 References to 'health and wellbeing' commissioners or providers in the remainder of this document is used as a term to include all public, private or voluntary organisations which fall under the Terms of Reference[1] of Oxfordshire HOSC.

## 4.0 Understanding of the role of the scrutiny relationship

4.1 All parties recognise the role of Oxfordshire HOSC in reviewing or scrutinising any issues relating to the commissioning and provision of health and wellbeing services to the local population.

4.2 The bodies involved acknowledge the role of scrutiny in giving the public confidence of effective oversight of their health and wellbeing services. They also recognise the challenges facing the health, care and wellbeing system and that no single organisation can solve these alone.

4.3 HOSC provides health and wellbeing commissioners and providers with a clear governance framework, transparency and a critical friend to integrated solutions.

## 5.0 Application of the Protocol:

5.1 This Protocol is an agreement between Oxfordshire's Joint HOSC which represents the interests of all Local Authorities and residents across Oxfordshire and those bodies who commission and provide health and wellbeing services for the population. It covers health, wellbeing and social care commissioners or providers under the Care Quality Commission (CQC) regulation. CQC regulation, monitoring and inspection is of the following activities:

- Treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services.
- Treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
- Services for people whose rights are restricted under the Mental Health Act

5.2 The Protocol is a living document so can include those commissioners or providers who may be involved, now or in the future, in the planning, provision, or operation of health and wellbeing services. It applies to the resident population of Oxfordshire and therefore accordingly where commissioners and providers are serving Oxfordshire residents across the county boundary.

5.3 Where necessary, and in-line with the committee's Terms of Reference[1], joint health scrutiny committees may be formed across a different geography where a relevant body or service provider is required to consult more than one local authority's health scrutiny function about substantial reconfiguration proposals. This Protocol applies specifically to Oxfordshire HOSC activities but in such circumstances, would be used as a good practice example around ways of working for any other committees discharging the functions of health scrutiny.

## 6.0 Shared goals and working principles:

6.1 The following describe the shared goals and agreed principles by which all organisations covered by this Protocol agree to work:

**Shared Goals**

- Deliver high quality, sustainable health and wellbeing services that meet the needs of the Oxfordshire population.
- Improve the health and wellbeing outcomes for local people, including ensuring activity addresses health inequalities and aligns with the Oxfordshire Health and Wellbeing Strategy.

**Working principles**

1. There is a "no surprises" approach between the organisations concerned. This builds collaboration whilst also allowing scrutiny to constructively challenge strategic decisions.
2. There is a climate of mutual respect and courtesy, noting one another's independence and autonomy.
3. Proposals and recommendations are based on appropriately sourced, recognised and clearly presented evidence. This includes relevant clinical evidence.
4. The views and priorities of local people are gathered and considered in the development of proposals, in scrutiny and in decision making.
5. The overview and scrutiny approach is transparent, collaborative, constructive and non-confrontational. It is based on asking challenging questions and considering evidence.
6. There is recognition and respect for the difference which may arise around what constitutes 'best outcomes' for the local population.
7. Feedback from overview and scrutiny to health and wellbeing organisations is documented and well communicated.

## 7.0 The ‘no surprises’ approach

7.1 In support of the first working principle, to have a ‘no surprises’ approach. The HOSC forward plan is informed and developed with regular dialogue with lead commissioners and providers to help in scoping and planning the work of the Committee.

7.2 This work takes place through a bi-monthly meeting between the Chairman and three other Members of HOSC and Oxfordshire CCG called a ‘HOSC Planning Group’. Notes from the HOSC Planning Group are taken, and reported formally to the Committee at its following meeting in the HOSC Chairman’s report with relevant items added to the Committee’s Forward Plan.

## 8.0 Service variations and assessing change

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8.1 In circumstances where there are variations or developments to health and care services, relevant organisations will work in accordance with the working principles above to assess how significant the variation is.

8.2 Whether a development or variation is substantial is not precisely defined and judgement is required. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- The number and vulnerability of the people affected by the proposed change.
- Changes in accessibility of services (both in terms of location and quantity of service available) such as reductions, increases, relocations or withdrawals of service.
- Impact on the wider community and other services such as transport and regeneration and economic impact
- Impact on patients – the extent to which groups of patients are affected by a proposed change.
- Methods of service delivery – altering the way a service is delivered. The views of patients and Healthwatch are essential in such cases.

8.3 The following describes and gives examples of the levels of change, variation or development which may occur in in health and wellbeing service for Oxfordshire:

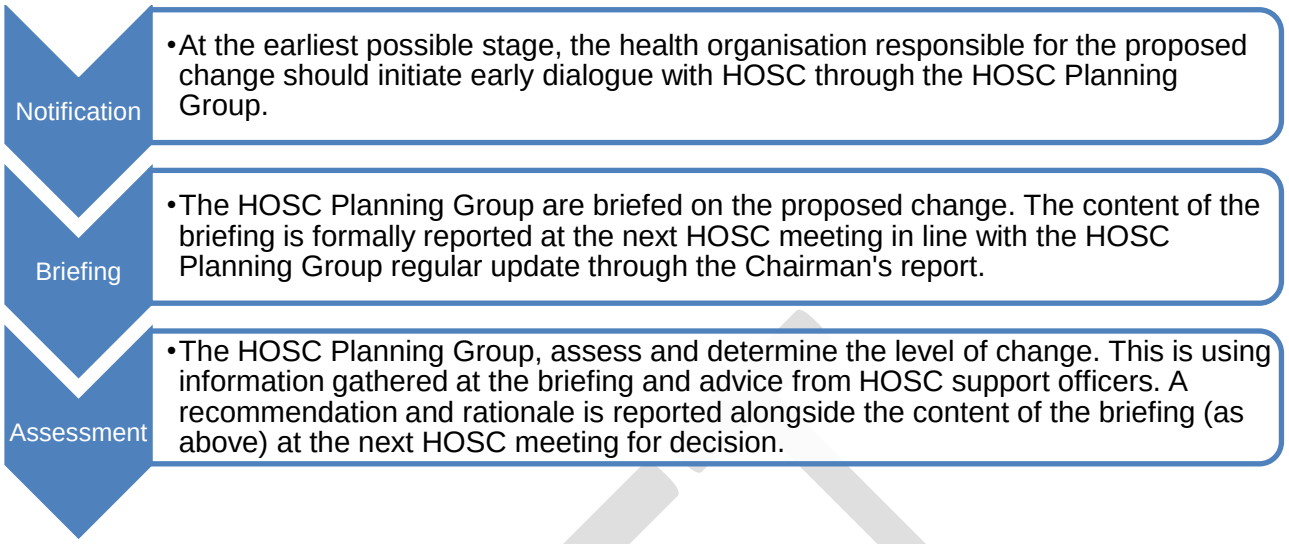
**Levels of change**

8.4 The 'levels' of change which may occur are:

| Level | Category | Description | Example(s) | Action required |
|---|---|---|---|---|
| 1 | Minor | When the proposed change is **minor** in nature | A change in clinic times, the skill mix of particular teams, or small changes in operational policies. | Committee would not routinely be notified or become involved. |
| 2 | Moderate | Where the proposed change has **moderate** impact or consultation has already taken place on a national basis | Rationalising or reconfiguring Community Health Teams.<br>Policies that will have a direct impact on service users and carers, such as the "smoke free" policy.<br>This does not include where there is:<br>• Reduction in service<br>• Change to local access to service<br>• Large numbers of patients being affected | The responsible commission notifies the HOSC Planning Group at an early stage.<br>HOSC Planning Group determine whether a fuller briefing is required in accordance with the Committee's stage one assessment process described below.<br>The Committee will wish to ensure that the Healthwatch and other appropriate organisations are notified by the responsible commissioner or service provider concerned. |
| 3 | Substantial | Where the proposal has **substantial** impact and is likely to lead to –<br>• Reduction or cessation of service<br>• Relocation of | Major review of service delivery, reconfiguration of GP Practices leading to practice closures, or the closure of a particular unit. | • The responsible commissioner(s) notify the Committee and formally consult the Committee. The Committee will expect to see formal consultation plans. The Local Ward Councillors concerned will be informed of the proposal.<br>• The responsible commissioner(s) notify and discuss with the appropriate local authorities on service developments.<br>• The responsible commissioner(s) follow the NHS duty to consult patients and the public.<br>• The Committee consider the proposal formally at one of |

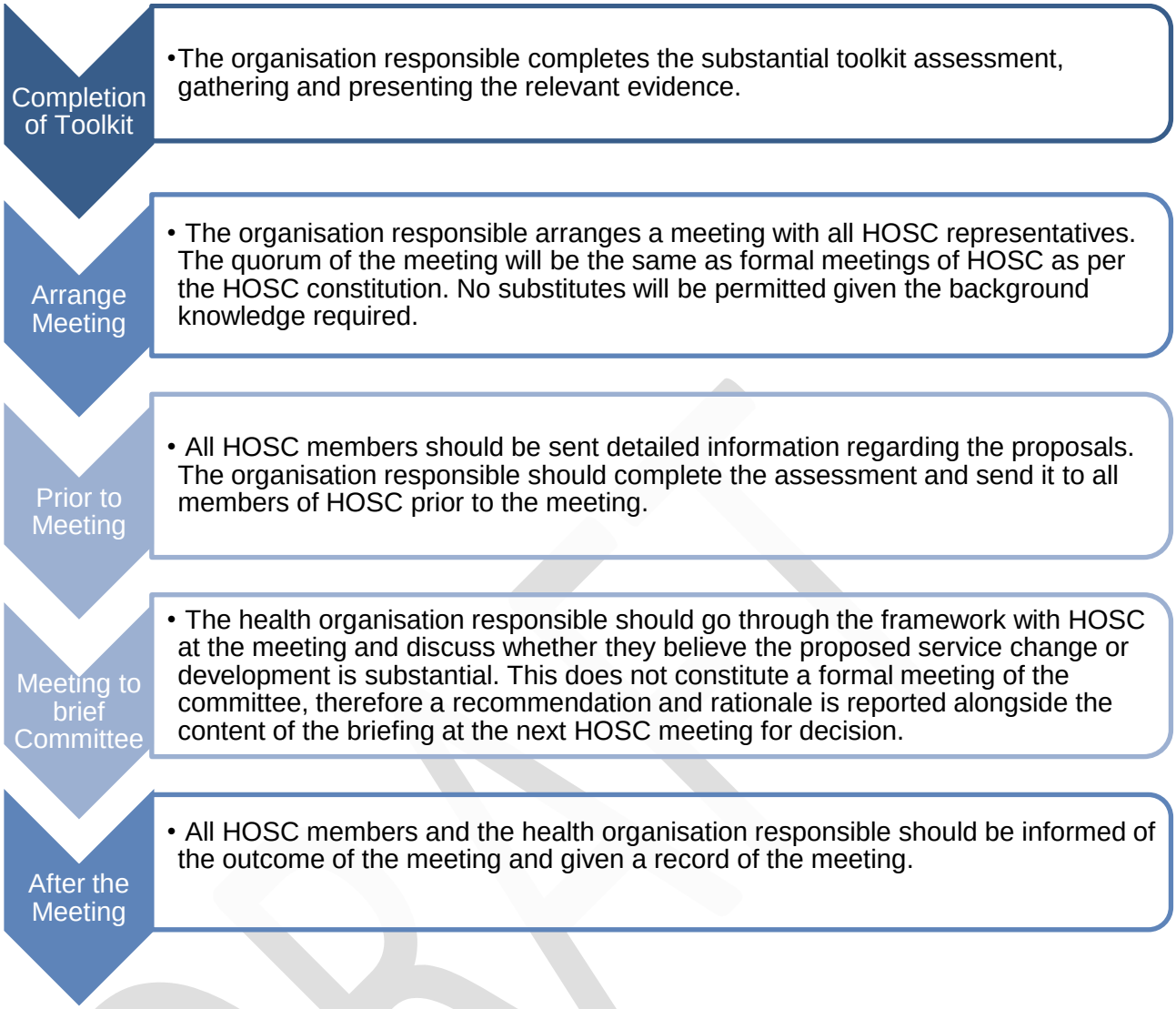
| Level | Category | Description | Example(s) | Action required |
|---|---|---|---|---|
| | | service<br>• Changes in accessibility criteria<br>• Local debate and concern | | their meetings.<br>• Officers of the responsible commissioners and service providers work closely with the Committee during the formal consultation period.<br>• The Committee responds within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence. |

**Stage one:**




**Stage Two**

8.5 Where there is no clear answer or disagreement on which 'level' of change is proposed, the following process takes place:




**A final say**

8.6 Should there still be disagreement over whether a service change or variation is substantial at the end of a stage two assessment; it is the view of HOSC which prevails. The HOSC view therefore determines whether a service variation is substantial and requires commissioners to consult.

**Exemptions:**

8.7 The following are exemptions of when the Committee will not need to be consulted:

- The Committee will only be consulted on proposals to establish or dissolve a NHS trust or CCG if this represents a substantial development or variation to the provision of health services.

- The Committee does not need to be consulted on proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997 as these are the subject of separate legislation.

- A responsible commissioner will not have to consult the Committee if it believes that a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be anticipated and reported in advance; making unanticipated situations the absolute exception. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers.

## 9.0 Consulting with the Committee

9.1 As identified in the table above, where a 'Level 3' or substantial service variation is identified, the responsible commissioner(s) will notify the Committee and formally consult HOSC. This is in addition to discussions between the responsible commissioner(s) and the appropriate local authorities on service developments. It is also additional to the NHS duty to consult patients and the public.

9.2 The Committee has the responsibility to comment on:

- Whether as a statutory body the Committee has been properly consulted (in addition to the public consultation process).
- The adequacy of the consultation undertaken with patients and the public.
- Whether the proposal is in the interests of health services in the area.

9.3 Oxfordshire County Council and the other Oxfordshire district and city councils have delegated their power of referral to the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC). This means that HOSC may refer proposals for substantial service developments or variations to the Secretary of State where it is not satisfied that:

- Consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed.
- The proposal would be in the interests of the health service in Oxfordshire.
- A decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate.

**Oxfordshire Joint Health Overview & Scrutiny Committee.**
**19 April 2018**

# Chairman's Report

## 1. Health and Social Care Liaison

1.0 The following meetings were held with the Chairman and HOSC members since the last meeting of the Committee.

- **6 March – 'Buckinghamshire, Oxfordshire and Berkshire West' (BOB) Scrutiny Chairmen's meeting.**
  *The Deputy Chairman attended an informal meeting with the scrutiny chairmen from Buckinghamshire, Reading, West Berkshire and Wokingham to hear of developments, exchange views and ask questions about progress with the 'BOB' Sustainability and Transformation Partnership (STP). The key points were:*

  - New leadership of the BOB STP is now in place with Fiona Wise. STP leaders had reviewed and redefined the role of the STP and had identified the importance of working at a local level, then at scale where it makes sense. They identified the need to work with neighbouring STPs where appropriate.
  - The STP will focus on more strategic collaboration, sharing local learning and continue a 'bottom up' approach through the Integrated Care Systems (ICS (formerly Accountable Care Systems)) to provide solutions to tackle local issues and that this could then inform best practice across the STP BOB area.
  - The Government's national planning guidance was clear that areas such as cancer, urgent care, primary care, mental health and maternity services should be led at the STP level.
  - Government funding is increasing being allocated at an STP level.

- **21 March 2018 – Ways of Working Workshop**
  *In response to advice from the IRP, the second 'Ways of Working' workshop was held on the 21st of March at the Kings Centre, Oxford with HOSC members and health representatives to consider a draft Protocol. A Protocol will be considered for agreement and adoption by the Committee on the 19th of April 2018.*

- **28 March 2018 – Response to the IRP**
  *In response to advice from the IRP, a meeting between the Chairman of HOSC, the Chief Executive of the CCG and supporting officers was held on the 28th of March to consider a joint response to the Secretary of State, in-line with advice received. A proposal will be considered for agreement by the Committee on the 19th of April 2018.*

## 2. Referral to the Secretary of State: permanent closure of consultant-led maternity services at the Horton

2.0 Following a decision by Oxfordshire CCG to permanently close obstetrics at the Horton General Hospital in Banbury (as part of Phase one of its Transformation Programme), the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) referred the decision to the Secretary of State. The referral was on the basis of:

- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents; and
- Regulation 23(9)(a) – the content of the two-phase consultation is inadequate.

2.1 In response to the committee's referral of the CCG's decision the Secretary of State passed the matter to the Independent Reconfiguration Panel (IRP) for initial assessment. The Secretary of State received the IRP report on the permanent closure and wrote to Oxfordshire JHOSC on the 7th of March 2018 to state that "*The Panel considers each referral on its merits and concludes that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire*".

2.2 The full letter from the Secretary of State, along with the IRP recommendations can be found in Appendix A and B of this report. The response to these recommendations will be considered by the committee during its meeting of the 19th of April.

## 3. Task and Finish Group

3.0 At the committee's meeting of the 8th of February, a decision was taken to establish a Task and Finish Group to look in detail at Musculoskeletal Services (MSK).

3.1 A draft Terms of reference for this group has been developed and is attached to this report in Appendix C.

Department of Health

*From the Rt Hon Jeremy Hunt MP*
*Secretary of State for Health and Social Care*

*39 Victoria Street*
*London*
*SW1H 0EU*

*020 7210 4850*

POC_1097166

Councillor Arash Fatemian
Oxfordshire Joint Health Overview and Scrutiny Committee,
County Hall,
New Road,
Oxford,
OX1 1ND

- 7 MAR 2018

Dear Cllr Fatemian,

**Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital**

As you know, your Joint Health Overview and Scrutiny Committee's letter of 30 August - about the proposed permanent closure of consultant-led maternity services at the Horton General Hospital - was referred to the Independent Reconfiguration Panel (IRP), to undertake an initial assessment.

The IRP has now completed its initial assessment and shared its advice with me.

**IRP advice**

The IRP have advised me that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.

They also concluded that:

- a more detailed appraisal of the options and should incorporate the findings of the latest Clinical Senate review considering the temporary Horton MLU and dedicated ambulance service. Equally important, there is an opportunity to learn from the experiences of mothers, their families and staff who have been involved in the temporary arrangements for more than a year now. This work should also address all the recommendations of the original Clinical Senate Report from November 2016 and the implementation issues that have been left outstanding, in particular how antenatal care is organised and how recommendations to address travel and parking issues will be carried through in practice. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future;

- further detailed work on obstetric options at the Horton is required. In parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stakeholders;
- consultation about the future of services, on whatever scale, should take account of patient flows, and not be constrained by administrative boundaries;
- it is self-evidently in the interests of the health service locally that all stakeholders should feel they have been involved in the development of proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward;
- this requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services. It is in everyone's interest that the next phase is commenced as soon as is practicable.

I have accepted the IRP's advice.

I am particularly keen that the OSC and CCG work together to invite stakeholders from surrounding areas that are impacted by these proposals to participate in this debate going forward. This should include the consideration of forming a joint oversight and scrutiny committee covering a wider area (for example, all of the local authorities that took part in the consultation), which would help meet the concerns expressed in the IRP's report of their review.

Where the CCG consults more than one local authority about a proposal, they must appoint a joint overview and scrutiny committee for the purposes of the consultation.

A copy of the full advice is appended to this letter and will be published on the IRP's website at https://www.gov.uk/government/organisations/independent-reconfiguration-panel.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to the Oxfordshire Clinical Commissioning Group. I look forward to seeing your joint proposal for taking this work forward.

Yours sincerely

Jeremy Hunt

**JEREMY HUNT**

*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

The Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

9 February 2018

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital**
**Oxfordshire Joint Health Overview and Scrutiny Committee**

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Arash Fatemian, Chairman Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC)[1]. NHS England South East (Thames Valley and Hampshire) provided assessment information. A list of all the documents received is at Appendix One.

The IRP has assessed the referral, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

**The Panel considers each referral on its merits and concludes that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.**

**Background**
The history of events leading up to the referral of 14 February 2017 by the Oxfordshire JHOSC regarding the temporary closure of consultant-led maternity services at the Horton General Hospital ('the Horton') is described in the IRP's advice of 21 August 2017 to the Secretary of State, attached at Appendix 2. That advice concurred with *"the JHOSC's inference that a closure for this length of time* [since October 2016] *exceeds what can reasonably be considered to constitute a temporary closure".*

In parallel with the events previously described, during 2016 work on developing a strategic vision for the future provision of health services across Oxfordshire was progressed. The Oxfordshire Clinical Commissioning Group (CCG) established the Oxfordshire Transformation Programme, which among other workstreams, incorporated a strategic review of services at the Horton Hospital by Oxford University Hospitals

[1] The Oxfordshire JHOSC consists of councillors from Oxfordshire County Council, the County's four District Councils and Oxford City Council.

Foundation Trust (OUHFT). Preparations were made for a public consultation on an Oxfordshire Health and Care Transformation Plan to be led by the CCG. Discussions with the JHOSC during the autumn of 2016 led the CCG to conclude that, in view of the wide scope of the transformation plans and the JHOSC's desire to see consultation on bed numbers begin in January 2017, the consultation should be split into two phases. This approach was agreed by the JHOSC when it considered the CCG's consultation plan at its meeting of 17 November 2016 and was formally approved by the CCG Board on 29 November 2016. Thames Valley Clinical Senate undertook a review to provide clinical assurance of the proposals, assessing their clinical quality, safety and accessibility. The 'Phase 1' proposals were formally considered by NHS England on 5 December 2016 and a letter confirming that the proposals had passed the NHS England assurance process was sent to OCCG on 10 January 2017.

The first phase of the public consultation, titled *The Big Health and Care Consultation Phase 1* was launched on 16 January 2017 to run to 9 April 2017. Phase 1 covered proposals for the following:

- Critical care at the Horton
- Acute stroke services across Oxfordshire
- Changes to bed numbers and increasing care closer to home in Oxfordshire
- Planned care services at the Horton including elective care, diagnostics and outpatients
- Maternity services – the consultation included a preferred option to create a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital in Oxford which would also be the base for the special care baby unit and emergency gynaecology services; a permanent midwife-led unit (MLU) would be provided at the Horton (as a consequence of this proposal consultant-led maternity services at the Horton would cease permanently)

The JHOSC scrutinised the consultation proposals at a special meeting of the Committee on 7 March 2017 taking into account submissions from interested parties including local MPs, Warwickshire County Council, Northamptonshire County Council, and Cherwell and South Northamptonshire District Councils. The JHOSC provided a formal response on 13 March 2017. Amongst a number of observations made, the response commented on *"an ambiguous picture for the future of maternity services, particularly in the north of the county"* as well as *"interdependencies between Phase 1 and Phase 2"*, notably the possible effect of removing consultant-led services on the sustainability of other related services at the Horton.

On 30 March 2017, permission for a judicial review of the consultation process for Phase 1 of the CCG's Transformation Programme was sought by Cherwell District Council, South Northamptonshire Council, Stratford-upon-Avon District Council and Banbury Town Council. Permission, considered on papers, was not granted.

On 25 April 2017, Stratford-upon-Avon District Council wrote to the Secretary of State to make a referral under Regulation 23(9)(a) of the health scrutiny regulations on the basis that *"…in the District Council's opinion, the consultation process by Oxfordshire CCG was seriously flawed and that the consultation be withdrawn".*

An independent analysis of the consultation responses, commissioned by the CCG, was completed in June 2017 and was considered by the CCG Board on 20 June 2017. The Board requested additional information with further testing of the obstetric options, including those identified during the consultation, to provide assurance that all variant options had been considered. This work informed the production of a decision making business case (DMBC) containing recommendations relating to each of the proposals consulted on.

On 1 August 2017, the Chair of the Warwickshire County Council Adult Social Care and Health Overview and Scrutiny Committee (ASCHOSC) wrote to the Secretary of State to offer support for the representations made by Stratford-upon-Avon District Council in that council's letter of 25 April 2017.

The DMBC was shared with the JHOSC at its meeting on 7 August 2017. The JHOSC supported proposals for critical care subject to assurances that there would be no 'knock-on' effects for the Horton. Proposals for stroke services were supported subject to clarification on ambulance response times and availability of rehabilitation beds in addition to those at the John Radcliffe Hospital in Oxford. The Committee supported plans to close 110 beds but did not support further changes without seeing improvement on delayed transfers for care and plans for community hospitals. The principle of planned care changes was supported and further discussion was invited when a fully developed plan was available. The JHOSC opposed the recommendation to close permanently consultant-led maternity services at the Horton and resolved, that should the CCG approve that recommendation, it would refer the matter to the Secretary of State.

The DMBC was considered by the governing body of the CCG on 10 August 2017. All recommendations were approved including the creation of a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital in Oxford and to introduce a permanent MLU at the Horton (and permanently close consultant-led maternity services at the Horton).

The JHOSC wrote to the Secretary of State on 30 August 2017 referring the decision to close permanently consultant-led maternity services at the Horton.

The claimants seeking a judicial review of the consultation process applied for an oral permission hearing which was held on 6 September 2017. The judge granted a full review to be heard on 6 and 7 December 2017. The claimant's case asserted that the consultation was unfair and defective. It cited six main grounds in support of that position and sought a ruling that the consultation be declared unlawful and re-run with *Phases 1 and 2* merged. The approved judgment of the Court was published on 21 December 2017 in which the judge dismissed grounds for the claim.

The Secretary of State wrote to the IRP Chairman, Lord Ribeiro, on 10 January 2018 to commission advice on the referral from the JHOSC. The commissioning letter specifically asked the IRP to consider:

- The scope of enquiries in relation to neighbouring local authorities
- Correspondence relating to Cherwell District Council and from Stratford-upon-Avon District Council and Warwickshire County Council

- The issue of which local authorities have oversight and scrutiny responsibilities and how CCGs can address challenges arising
- Whether the proposals for consultant-led maternity services at the Horton need to be looked in the wider context of changes across the STP generally and, if so, how that could be done

**Basis for referral**
The Oxfordshire JHOSC Chairman's letter of 30 August 2017 states that:

> *"…it is with the deepest regret that I am writing to you again following a special meeting of the OJHOSC held on Monday 7 August 2017. At that meeting, the OJHOSC unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) proposal to permanently close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton') to you, as the Secretary of State for Health, should the OCCG Board agree the proposal at its meeting on Thursday 10 August. The proposal was subsequently agreed by the Board, therefore the OJHOSC makes this referral pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013."*

**IRP view**
With regard to the referral by the Oxfordshire JHOSC, the Panel notes that:

*Regulatory issues*
- The 2013 Regulations and associated guidance set out how the NHS must consult local authorities with powers of health scrutiny including where proposals affect more than one such local authority
- A joint health scrutiny committee of all the affected local authorities was not formed – scrutiny was instead delivered through the Oxfordshire JHOSC

*Consultation issues*
- The JHOSC agreed a two stage consultation with the CCG
- The two stage process for consultation, focussing on five separate proposals in Phase 1, has been challenged by various parties and through a judicial review
- The JHOSC opted not to refer the decisions about four of those proposals and resolved only to refer the proposal concerning the future of obstetrics at the Horton

*Issues relating to obstetrics at the Horton*
- Since 2008, training accreditation for junior doctors has been removed from the Horton and other staffing models attempted – the failure of these models to provide a sustainable service led to the temporary closure of obstetrics at the Horton from October 2016
- The JHOSC believes that alternative models suggested through consultation have not been properly considered

*Issues relating to the future of the Horton's services and more widely*
- The implications of the changes proposed at the Horton for other services are strong features of the consultation response – the future of the Horton in general is a significant local concern
- In the light of its experience with the Phase 1 consultation, the CCG is considering how better to progress the work of the Oxfordshire Transformation Programme

**Advice**

The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel considers that further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.**

*Regulatory issues*

The Secretary of State asked the IRP to consider the issue of which local authorities have oversight and scrutiny responsibilities. Given the Panel's remit, we have only considered powers of *health* scrutiny. In doing so, we do not offer a legal opinion and rely on our understanding of the relevant regulations and Department of Health guidance on the subject.

The Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and associated Department of Health guidance, *Local Authority Health Scrutiny* (June 2014) describes those local authorities that have powers of scrutiny, essentially those councils with social services responsibilities[2]. These are "upper tier" authorities and include *"county councils, district councils (other than lower-tier district councils) and London Borough councils"*. The Panel understands that lower tier authorities including, for example, Stratford-upon-Avon District Council, do not have powers of health scrutiny vested in them by the 2013 Regulations unless a local authority that does hold health scrutiny powers has arranged for those powers to be discharged to another local authority. In this case, Warwickshire County Council (which holds health scrutiny powers) has confirmed that it did not make such an arrangement with Stratford-upon-Avon District Council. It is, therefore, unclear to the IRP how Stratford-upon-Avon District Council came to the conclusion that it had powers of referral as stated in its letter to the Secretary of State of 25 April 2017. The letter of 1 August 2017 from Warwickshire County Council ASCHOSC does not appear to be a referral in its own right since it professes only to offer *"support for the representations made to yourself by Stratford-upon-Avon District Council".* However, the Panel, in offering its advice on the referral by Oxfordshire JHOSC, has taken note of the contents of both letters.

Regulation 23(1) of the 2013 Regulations requires that where the NHS has under consideration "*any proposal for a substantial development of the health service in the area of the authority or a substantial variation in the provision of such a service"*, it must consult the authority. Regulation 30(5) requires that *"Where a responsible person* (normally the NHS body) *consults more than one local authority pursuant to regulation 23, those local authorities must appoint a joint overview and scrutiny committee for the purposes of the consultation…".*

In this case, the proposals consulted on by the CCG in Phase 1 impacted not only on the services and residents of Oxfordshire but also those of Warwickshire and Northamptonshire and possibly elsewhere. In the Panel's view, while the Oxfordshire JHOSC was the primary body to consult, the other affected authorities with powers of health scrutiny should have

[2] Regulation 20(1)(b) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
Local Authority Health Scrutiny: Guidance to support local authorities and their partners to deliver effective health scrutiny (June 204), paragraphs 1.2.1 and 2.1.1.

been engaged with the requirement to form a joint scrutiny committee. It is unclear to the Panel where responsibility lies for appointing an appropriately constituted joint health scrutiny committee but the wording of the Regulations suggests that it lies with the local authorities themselves.

The CCG's consultation plan states that it had shared information with Warwickshire and Northamptonshire County Councils. However, there is insufficient evidence for the IRP to assess whether the CCG contacted all potentially affected local authorities with health scrutiny powers or whether those authorities considered the requirement to form a joint committee. In the event, scrutiny was delivered through the Oxfordshire JHOSC which sought and received submissions from, among others, the Warwickshire County Council ASCHOSC, of which Stratford-upon-Avon District Council is a member. As a constituent member of the JHOSC, Cherwell District Council was part of the body consulted under the 2013 Regulations and, in conjunction with South Northamptonshire Council, made its own submission to the JHOSC.

The paragraphs above suggest misunderstanding about the process for consulting with affected local authority scrutiny bodies on the Oxfordshire Health and Care Transformation Plan. That plan is, of course, only one part of the wider Sustainability and Transformation Partnership (STP) covering Oxfordshire, Bedfordshire and Buckinghamshire. The complexity of consulting on issues on this scale is not to be underestimated and requires a level of preparation, co-operation and exchange of information that many NHS bodies and their local authority counterparts may not previously have faced. As has always been the case, it is important that consultation about the future of services, on whatever scale, takes account of patient flows and is not constrained by administrative boundaries.

In the Panel's view, the health scrutiny regulations provide the means to engage with health scrutiny effectively when properly understood and followed. Nevertheless, lack of knowledge or inexperience seems to be preventing this in some places. It is essential moving forward that all parties are aware of their responsibilities and follow the relevant regulations and associated guidance. The Department of Health and NHS England should consider whether the regulations and guidance are sufficiently understood and used effectively by all parties, particularly in the current context of STPs and "systems of care" rather than "organisations".

*Consultation issues*

Oxfordshire JHOSC has referred this matter to the Secretary of State on two grounds – that the consultation undertaken was inadequate and that the proposal would not be in the interests of the health service in its area. In considering issues of inadequate consultation, the 2013 Regulations relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders. The concerns expressed by the JHOSC and others about the lack of consultation with interested parties are addressed in this advice on the basis of their not being in the interests of the health service generally. The Panel's comments in this section are offered in the knowledge that the judge presiding over the judicial review dismissed grounds for the claim of an inadequate *public* consultation.

The JHOSC contends that the CCG failed to engage with local partners, including with Cherwell District Council in which the Horton is situated. A failure to engage with partners is different to and separate from the requirement to consult the relevant local authorities holding scrutiny powers. Nevertheless, it is self-evidently in the interests of the health service locally that all stakeholders should feel they have been involved in the development of proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward.

The JHOSC further contends that the two phase consultation process was inadequate. Yet documentation confirms that the Committee agreed this approach at its meeting of 17 November 2016 prior to the consultation launch. The findings of the judicial review, published on 21 December 2017 and which considered the public consultation process as a whole rather than just the future of obstetrics at the Horton, rejected the assertion that the public consultation – including the two stage process and the consultation with south Warwickshire residents – was either unfair or defective. The Panel notes that four of the five proposals consulted on have not been disputed, albeit that further work is required. As previously commented, consulting on multiple issues across a wide geographical area is a complex undertaking. While holding one large consultation covering all issues may appear desirable, the rationale for splitting matters into discrete packages and consulting in two phases equally holds some logic.

In this case, with the benefit of hindsight it might have been better to have divided the issues up between phases in a different way, in particular, whether it would have been more sensible to consult on obstetrics services at the Horton as part of Phase 2. As it is, splitting the consultation in the way that was done has added more to the confusion and suspicion than helped move matters forward. In the Panel's view, decisions about the future of obstetrics at the Horton must inevitably influence proposals that remain to be consulted on, including around the future provision of MLUs in Oxfordshire. As the JHOSC commented, a clear picture is lacking for countywide maternity services as result of the two-phased consultation. The same is true with regard to the future provision of children's services at the Horton as indeed is an overall vision for the Horton moving forward.

*Issues relating to obstetrics at the Horton*

The IRP notes comments from various quarters that the needs of mothers (to be) in north Oxfordshire and the surrounding areas have not changed since the Panel's review of 2008. The Panel conducts its reviews on a case-by-case basis taking account of the circumstances present at the time. The needs of the population are one of several variables to be considered. That was true of our 2008 review and remains true in offering this advice.

The heart of the matter for the JHOSC regarding the future of obstetrics at the Horton is that not all options have been properly explored in the context of maternity services across the county. In considering this issue, the Panel's view is based on two observations about the current circumstances. First, that action to consider alternative options is needed because the problems with sustaining the obstetric service at the Horton that led to its temporary closure in 2016 are real and the prospects for returning to the earlier status quo are poor given a national shortage of obstetricians, exacerbated by the local workforce recruitment challenges. Secondly, that this consideration must be driven by what is desirable for the future of maternity and related services and all those who need them

across the wider area of Oxfordshire and beyond rather than a search for any possible way to retain an obstetric service at the Horton. This necessarily brings into play potential trade-offs between meeting the needs of higher risk mothers in specialised services, access to more local services, sustainability of staffing and the best use of finite NHS resources.

The consultation response provided a number of suggested options which can be characterised as arguing for a larger volume of births at the Horton (through population growth and an artificial shift of catchment south towards Oxford) to provide a platform from which to recruit and retain the medical staff required on a sustainable basis. The CCG decided to examine the options, using the same criteria as they had for the consultation options, before making its final decision. The results of this evaluation are recorded in the DMBC. The IRP recognises that a considerable amount of work has been done but whether the analysis underlying the conclusions reached has drawn on all the available evidence and been explained sufficiently is less clear. In this respect, the Panel agrees with the JHOSC's view that the consideration of options between consultation and decision fell short.

In the Panel's view, a further, more detailed appraisal of the options, including those put forward through consultation, is required and needs to be reviewed with stakeholders before a final decision is made. This appraisal should incorporate the findings of the latest Clinical Senate review, now underway, considering the temporary Horton MLU and dedicated ambulance service. Equally important, there is an opportunity to learn from the experiences of mothers, their families and staff who have been involved in the temporary arrangements for more than a year now. This work should also address all the recommendations of the original Clinical Senate Report from November 2016 and the implementation issues that have been left outstanding, in particular how antenatal care is organised and how recommendations to address travel and parking issues will be carried through in practice. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future.

The Panel appreciates the desire of many to reach a final decision on the future of obstetrics at the Horton following the extended period of uncertainty both for the CCG and OUHFT and for local users of maternity services. The obstetric unit has been closed since October 2016 and must remain closed unless sufficient doctors with the necessary skills and experience can be recruited. The Panel accepts that this will be difficult in the current climate but attempts to recruit should continue until a final decision is made.

*Issues relating to the future of the Horton more widely*

While this referral from Oxfordshire JHOSC has focussed on the future of obstetrics at the Horton, it appears to the Panel that the key question for the population of Banbury and the surrounding area is 'w*hat does the future hold for the Horton?'*

The proposals consulted on in Phase 1 are at the same time only one part of the Oxfordshire Transformation Programme and only one part of the future of the Horton Hospital. The Panel's view is that both these need to be pursued in tandem and, building on work done already, brought to a conclusion. The 2016 OUHFT Strategic Review provides a comprehensive view of the Horton's services and offers a coherent vision for the future of the hospital which needs to be debated and, if necessary, refined. Unsurprisingly, lifting the

obstetric element out of this approach has raised questions about the impact on other services.

The Panel has noted, both in documentation provided by the CCG and in the Court judgment, the view that a decision to close the obstetric service at the Horton does not undermine decisions yet to be made about other services provided at the Horton. Whilst this is one view of the issue, the Panel considered an alternative perspective. Following consultation, were the decision to be taken to retain an obstetric service at the Horton, this would influence decisions about other services since, for example, it would be necessary also to seek to sustain paediatric services on the same site. In the Panel's experience of examining these matters, obstetrics and paediatrics in district general hospital settings are services that 'travel together'. A decision about the future of one necessarily influences the future of the other. If the effect can be said to flow through also into A&E services, then the picture of what the Horton will look like in the future remains unclear, at least to the residents of Banbury and the surrounding area who continue to be concerned that issues of population growth and access to services have not been fully taken into account.

The decision by the CCG, with JHOSC support, to include obstetrics at the Horton in the first of a two stage consultation - thus separating it from the future of paediatrics and other related services at the Horton along with maternity services elsewhere in the county - has served to highlight the interdependencies that must be tackled together to move forward successfully. Under all scenarios, the further detailed work on obstetric options at the Horton, advised above, is required. In parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stakeholders.

The question that then remains for the CCG and its partners is how to link further work and a final decision about maternity services to the next steps for the future of the Horton's other services and the rest of the Oxfordshire Transformation Plan. The experience of the Phase 1 consultation provides cause for some reflection and the need to learn from the experience for the NHS, the JHOSC and other interested parties. It is the Panel's view that the challenges facing the health and care system in Oxfordshire, in terms of the sustainability and quality of services, must be confronted honestly by all parties. This requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services. It is in everyone's interest that the next phase is commenced as soon as is practicable.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Oxfordshire Joint Health Overview and Scrutiny Committee**

1 Letter to Secretary of State for Health from Cllr Arash Fatemian, JHOSC Chairman, 30 August 2017
Attachments:
2 The Oxfordshire Big Health Care Consultation Document Phase 1
3 OJHOSC minutes of meeting, 17 November 2016
4 OJHOSC minutes of meeting, 02 February 2017
5 OJHOSC minutes of meeting, 07 March 2017
6 OJHOSC chronology of Oxfordshire Transformation Plan scrutiny
7 OCCG - Phase 1 - Decision Making Business Case
8 Mott MacDonald Integrated Impact Assessment Report
9 Mott Macdonald - hospital car parking survey
10 Healthwatch Oxfordshire – people's experiences of travelling to hospitals in Oxford and Banbury (Travel Parking Survey Report)
11 OJHOSC letter to Oxfordshire CCG - Phase 1 consultation proposals, 13 March 2017
12 Oxfordshire CCG response to HOSC on consultation, 23 March 2017
13 Draft OJHOSC minutes of Oxfordshire Transformation Plan consultation discussion at meeting, 22 June 2017
14 Draft OJHOSC minutes of meeting, 07 August 2017
15 OJHOSC notification to Oxfordshire CCG of intention to refer Horton maternity decision, 10 August 2017

**NHS**

1 IRP template for providing initial assessment information
Attachments:
2 Clinical Senate report, 30 November 2016
3 Pre-consultation business case, 10 January 2017
4 The Big Health and Care Consultation
5 Paper outlining consultation methodology
6 The Big Health and Care Consultation report, May 2017
7 Decision making business case, 10 August 2017
8 Cover paper to Board with DMBC, 10 August 2017
9 NHS England Stage two Assurance Checkpoint Review letter, 10 January 2017
10 NHs England Patient care test letter, 31 July 2017
11 Minutes of Oxfordshire CCG Board meeting, 10 August 2017
12 Oxfordshire Maternity Strategy, 15 August 2016
13 report on the Contingency Plan for Maternity and Neonatal Services, OUHFT Board paper, 31 August 2016
14 OUHFT Horton Strategic Review, Additional Obstetric Options Table, May 2016
15 Equality Impact Assessment, Horton Hospital
16 Care Quality Commission report
17 Strategic Review of the Horton General Hospital, October 2016, OUHFT
18 PCBC Appendix 7.6. Clinical evidence base and best practice for maternity services, Oxfordshire CCG

19 Letter to Cherwell District Council and South Northants Council from Oxfordshire CCG, 1 September 2017
20 Maternity Group obstetric Phase 1 evaluation

**Other evidence submitted**

1 Letter to Secretary of State for Health from Cllr Tony Jefferson, Chairman Overview and Scrutiny Committee, Stratford-upon-Avon District Council, 25 April 2017
2 Letter to Secretary of State for Health from Cllr Wallace Redford, Chair Adult Social Care and Health Overview and Scrutiny Committee, 1 August 2017
3 Letter to Oxfordshire CCG from Legal Service Manager, Warwickshire County Council, 25 May 2017
4 Stratford-on-Avon District Council Response to the Oxfordshire Clinical Commissioning Group's Big Consultation Stage 1 Process, 06 April 2017
5 Letter to Secretary of State for Health from Victoria Prentis MP for Banbury, North Oxfordshire, 18 September 2017
6 Approved judgment in the High Court of Justice, Queen's Bench Division Administrative Court before Mr Justice Mostyn between Cherwell District Council & Others and Oxfordshire CCG, 21 December 2017
7 Copy of email exchange between officials from NHS England regarding status of Stratford-on-Avon District Council, 11 January 2018
8 Briefing note for Department of Health from Oxfordshire CCG re Transformation Plan Phase 1, 11 October 2017
9 Letter to IRP Chairman from Victoria Prentis MP for Banbury, North Oxfordshire, 26 January 2018

**APPENDIX 2**

*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

21 August 2017

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Referral of the temporary closure of consultant-led maternity services at the Horton General Hospital**
**Oxfordshire Joint Health Overview and Scrutiny Committee**

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Yvonne Constance OBE, Chairman Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). NHS England and Oxford University Hospitals NHS Foundation Trust provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review.**

**Background**
Horton General Hospital ('the Horton') in Banbury, Oxfordshire is part of the Oxford University Hospitals NHS Foundation Trust (OUHT) along with the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre in Oxford. The Horton provides a range of district general hospital services for approximately 170,000 people in north Oxfordshire, south Northamptonshire and south Warwickshire.

Maternity services for Oxfordshire are provided by OUHT on five sites. The John Radcliffe Hospital provides obstetric care and also has an alongside midwifery-led unit (MLU). Obstetric care was provided at the Horton until its temporary cessation on 3 October 2016. The hospital currently provides a midwifery-led service only. There are three other stand-alone MLUs in Oxfordshire, at Wallingford and Wantage to the south of the county and at Chipping Norton in the north. Beyond Oxfordshire, maternity services are available in neighbouring counties including in Cheltenham, Warwick, Northampton and Milton

Keynes. Prior to its temporary closure, the obstetric unit at the Horton was one of the smaller units in the country. In 2015/16, there were slightly over 1,400 deliveries at the hospital, of which approximately 400 required obstetric-led care.

Maternity and related services at the Horton have been the subject of a referral to the Secretary of State for Health previously. In 2006, the then Oxford Radcliffe Hospitals NHS Trust proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the special care baby unit from the Horton to the John Radcliffe Hospital. Oxfordshire JHOSC referred the proposals and the Secretary of State commissioned a review from the Independent Reconfiguration Panel. The IRP's report, submitted on 18 February 2008 recommended that the Trust's proposals be rejected because they failed to provide an accessible or improved service for local people. The Panel recommended that further work be carried out to identify the arrangements and investment necessary to retain and develop the services involved at the Horton. The Secretary of State accepted the Panel's recommendations in full.

Consequently, consultant-led maternity services were maintained at the Horton supported by a training programme for junior doctors working in obstetrics. However, in 2012, post-graduate obstetric training accreditation at the Horton was withdrawn predominantly because of the low numbers of births at the hospital which resulted in only limited exposure to complex cases for those on the programme. A Clinical Research Fellow programme, based on eight posts, was then developed by the Trust in conjunction with the University of Oxford to support consultant-led services but the programme closed in December 2015 due to difficulties in recruiting staff to fill the posts. In April 2016, a new nine person, middle grade obstetric rota was developed allowing participating doctors the opportunity to get experience at the John Radcliffe Hospital as well as at the Horton. Despite advertisements for obstetricians being placed both nationally and internationally at monthly intervals from April 2016 onwards, and offering an enhanced remuneration package, difficulties in recruiting staff continued. Alternative solutions, including rotating staff between the John Radcliffe Hospital and the Horton and the employment of locum staff, were attempted but maintaining the rota of nine doctors required to staff the Horton unit safely on a consistent basis remained problematic.

In July 2016, in light of continuing recruitment difficulties and the resignation of existing staff, OUHT prepared contingency plans for the continued provision of maternity services at the Horton. Staff working in the maternity unit were briefed on 18 July 2016. On the same day, the JHOSC Chairman held an informal meeting with the Trust Director of Clinical Services to be advised of the immediate pressures affecting obstetrics services at the hospital and the contingency plans to be put in place. The Chairman was advised that of the eight resident doctors at the Horton specialising in obstetrics only three would still be in place by October 2016 following a number of resignations. Adverts for agency staff were being placed to recruit to vacant posts and midwives at the Horton would be trained in a midwifery-led approach to providing care should the consultant-led service have to cease. It was agreed that an update on the situation should be provided to the next JHOSC meeting in September 2016.

Workshops attended by representatives of the district and county council, local MPs and GPs, the Oxfordshire Clinical Commissioning Group (CCG) and local public and patient

groups were held on 20 July and 24 August 2016 to discuss the issue. During August 2016, further meetings took place with local MPs and GPs and representatives of the public including members of the Keep the Horton General Campaign. The Trust attended a public meeting in Banbury on 25 August 2016 and also responded to direct communications from the public.

An Extraordinary Meeting of the OUHT Board was held on 31 August 2016 to consider the single issue of maternity and related services at the Horton and to discuss the contingency plans. The plans included:

- The temporary establishment of a midwife-led birth unit (MLU) at the Horton
- The temporary cessation of obstetric care at the Horton and its transfer to the John Radcliffe Hospital
- The temporary cessation of the special care baby unit at the Horton and its transfer to the John Radcliffe Hospital
- The temporary cessation of the inpatient emergency gynaecology service and the establishment of a seven day ambulatory emergency gynaecology unit at the Horton
- The temporary withdrawal of the dedicated obstetric anaesthetic rota from the Horton General Hospital

The Trust Board was advised that the CCG, the Care Quality Commission and NHS Improvement had been advised of the risks posed by impending shortages of medical staff. The Board heard from clinicians that impending staffing shortages in the obstetric services at the Horton represented a risk to patient safety. It was reported that the Trust already had experience of running MLUs with protocols in place for safe operation of the service and that the temporary establishment of a MLU at the Horton would offer choice for local pregnant women whose deliveries had been assessed as low risk. Evidence of the efforts to recruit both permanent and locum staff was presented and further urgent work would be undertaken to review the enhanced remuneration package already available to aid recruitment. As part of the contingency plan, an ambulance would be available 24 hours a day at the Horton to ensure quick and safe transport of any woman requiring transfer to the John Radcliffe obstetric unit. Arrangements would be put in place for the John Radcliffe Hospital to accommodate up to an additional 1,000 births.

The Trust Board voted unanimously:

- *"that the continuation of the services of the Obstetric Unit at the Horton General Hospital was unsafe beyond 3 October 2016"*
- in favour of *"the temporary establishment of an MLU at Horton General Hospital from 2 October 2016"*
- to approve *"the Report on the Contingency Plan for Maternity and Neonatal Services"*

At a meeting of the Oxfordshire JHOSC on 15 September 2016, OUHT representatives presented the contingency plan and informed the Committee of the intention to temporarily close consultant-led maternity services at the Horton with effect from 3 October 2016. The Committee requested that OUHT representatives attend a special meeting of the JHOSC on 30 September 2016 to discuss specific issues including travel times, recruitment options and reasons for the observed decrease in birth numbers at the hospital.

The JHOSC Chairman met informally with the Trust Director of Clinical Services on 27 September 2016 to discuss the items for presentation at the forthcoming meeting.

The JHOSC meeting on 30 September 2016 further scrutinised OUHT's contingency plan. This included evidence of the Trust's efforts to maintain consultant-led maternity services at the Horton and discussion of the impact of the temporary closure and associated risks. The Committee accepted that the Trust had provided satisfactory reasons for invoking the temporary closure of consultant-led maternity services at the Horton without prior consultation. On the basis of the evidence provided, assurances given by the Trust that the closure would be temporary and the plan to increase staffing levels by March 2017, it was agreed that the matter should not be referred to the Secretary of State at that stage. The Committee requested that regular updates be provided to monitor service provision and recruitment progress.

Updates on maternity services at the Horton were provided by OUHT on 10 November, 5 December and 23 December 2016. The update of 23 December 2016 stated that, with three obstetricians in post at that time and the maximum number of doctors likely to be in post by March at five, there would not be enough experienced and skilled medical staff in post to reopen the Horton obstetric unit in March 2017 as planned.

At a meeting of the JHOSC on 2 February 2017, members considered the continued temporary closure of the Horton obstetrics unit and the proposals contained within Phase 1 of the Oxfordshire Transformation Plan (see below). A motion was unanimously agreed to refer the temporary closure of the consultant-led obstetrics unit at the Horton to the Secretary of State for Health. OUHT was notified by email of the JHOSC's decision on 3 February 2017. A letter of referral was sent to the Secretary of State on 14 February 2017 stating that the JHOSC believed the material grounds for not referring the matter had changed, that is, that the Trust's recruitment plan had failed and the closure would be longer than envisaged. Clarification of the procedural steps taken by the Committee to comply with the requirements of the 2013 Regulations was sought by the Department of Health by letter of 10 April 2017. The JHOSC Chairman responded providing additional information in a letter of 26 April 2017.

In parallel with the actions and events described above, the first phase of a public consultation on the Oxfordshire Health and Care Transformation Plan, led by Oxfordshire CCG, was launched on 16 January 2017. A two-phase approach to consultation had previously been agreed with the JHOSC in autumn 2016. The consultation included a preferred option to create a single specialist obstetric unit for Oxfordshire and neighbouring areas at the John Radcliffe Hospital which would also be the base for the special care baby unit and emergency gynaecology services. A permanent midwife-led unit would be provided at the Horton. The JHOSC scrutinised the consultation proposals at a special meeting of the Committee on 7 March 2017. The Chairman of the Council responded to the consultation on 3 April 2017 expressing its opposition to the proposals and rejecting the consultation. A decision-making business case, including a recommendation to remove obstetric care from the Horton and provide a permanent midwife-led unit, was presented to the governing body of the Oxfordshire CCG on 10 August 2017. All recommendations were approved including the one relating to maternity care at the Horton. Were such a

decision to be made, the JHOSC had already declared at its meeting on 7 August 2017, to refer the matter to the Secretary of State and this is now awaited.

**Basis for referral**
The JHOSC Chairman's letter of 14 February 2017 states:

*"... at its meeting on 2 February, the Committee resolved to refer the matter to the Secretary of State under Regulation 23(9)(b) of the 2013 Regulations and to ask that you refer the issue of provision of maternity services at the Horton General Hospital to the Independent Reconfiguration Panel."*

The JHOSC Chairman's letter to the Department of Health dated 26 April 2017 cites the grounds for referral as:

*"(1) the Committee believed that the material grounds for not referring the matter had changed, ie the Trust's recruitment plan had failed and the closure would now be longer than envisaged; and*
*(2) it considered that nothing could be gained by further discussion at a local level with the Trust."*

**IRP view**
With regard to the referral by the Oxfordshire JHOSC, the Panel notes that:

- Referral is made under Regulation 23(9)(b) of the 2013 Regulations relating to not being satisfied with the reasons given for not consulting with the JHOSC
- The JHOSC had previously accepted the reasons put forward by OUHT but asserts that the material grounds for not referring have changed – due to the failure of the recruitment plan and extended closure of the obstetric unit
- The obstetric unit at the Horton was closed on 3 October 2016 on grounds of safety due to the inability to recruit and retain sufficient doctors with the necessary skills and experience
- Failure to recruit additional staff meant that the obstetric unit could not be reopened in March 2017
- Safety of services must always be the primary consideration for any healthcare provider
- Events have now been overtaken by the decision of the CCG governing body to permanently locate obstetrics at the John Radcliffe Hospital and replace consultant-led maternity care at the Horton with a midwife-led service
- The JHOSC has declared its intention to refer this decision to the Secretary of State

**Advice**
The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review in relation to this referral would add any value.**

The Oxfordshire JHOSC has chosen to refer this matter under the somewhat obtuse Regulation 23(9)(b) of the 2013 Regulations. Regulation 23(1) requires NHS bodies to consult relevant scrutinising authorities on any proposal for a substantial development of the health service or a substantial variation in the provision of the service. Regulation 23(2)

provides for circumstances in which an NHS body makes a decision without prior consultation with the scrutinising authority because of a risk to safety or welfare of patients or staff. Regulation 23(9)(b) states that *"in a case where paragraph (2) applies, the authority* [may make a report to the Secretary of State where it] *is not satisfied that the reasons given by R* (a responsible person, that is, the NHS body) *are adequate"*. This regulation was relevant in autumn 2016 when the decision was taken by OUHT, without prior consultation with the JHOSC, to introduce a temporary cessation of consultant-led maternity services at the Horton on grounds of patient safety. The Committee scrutinised that decision in September 2016 and accepted that the reasons for doing so were valid. Whether the same regulation continued to be relevant in February 2017, when this referral was made, is for legal minds to ponder rather than the IRP. However, the Panel recognises that, faced with the prospect of the Horton obstetric unit remaining closed for more than six months, local concern about if and when the unit would reopen inevitably grew. That concern developed not least because a consultation was launched during the same period by the CCG that contained a preferred option to close the unit permanently.

In the circumstances, it is not surprising that scepticism exists in some quarters about the extent of the Trust's efforts to attract the skilled and experienced staff required to reopen the unit. As recorded in the background section to this advice, several creative staffing models have been used since the IRP's report in 2008. Whether more could have been done is, for now, a matter of speculation.

The obstetric unit at the Horton has, at the time of writing, been closed for some 10 months. The July report to the OUHT Board indicated that seven posts had been filled. This represents progress but still falls short of the nine required to fill the rota and safely staff the unit. Safety must always be the primary consideration in the provision of healthcare. The Panel accepts, as did the JHOSC in September 2016, that the Trust was correct to close the unit in the absence of enough doctors to staff the unit safely and that the unit could not be reopened until sufficient staff had been recruited. Nevertheless, the Panel concurs with the JHOSC's inference that a closure for this length of time exceeds what can reasonably be considered to constitute a temporary measure.

Subsequent events have now overtaken the substance of this referral. The governing body of the CCG decided on 10 August 2017 to remove obstetric care from the Horton and replace it with a permanent midwife-led unit. The Panel understands from press reports that the Oxfordshire JHOSC has declared its intention to refer that decision to the Secretary of State. When that referral materialises, the IRP stands ready to offer advice if requested.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Oxfordshire Joint Health Overview and Scrutiny Committee**

2 Letter to Secretary of State for Health from Cllr Yvonne Constance OBE, JHOSC Chairman, 14 February 2017
Attachments:
2 Oxford University Hospitals NHS Foundation Trust (OUHT) report to JHOSC Contingency plan for maternity and neonatal services, September 2016
3 Oxford University Hospitals NHS Trust updates on maternity at the Horton General Hospital, 10 November 2016, 5 December 2016 and 23 December 2016
4 Oxfordshire JHOSC minutes of meetings, 15 and 30 September 2016
5 Oxfordshire Health and Care Transformation Phase 1 consultation document
6 Letter to Department of Health Cllr Yvonne Constance OBE, JHOSC Chairman, 26 April 2017
Attachments:
7 Note of meeting between JHOSC chair and NHS official, 18 July 2016
8 Note of meeting between JHOSC chair and NHS official, 27 September 2016
9 Oxfordshire JHOSC minutes of meeting, 2 February 2017
10 Email to NHS representatives notifying of intention to refer matter, 3 February 2017

**NHS**

1 IRP template for providing initial assessment information
Attachments:
2 Contingency plan for maternity and neonatal services
3 OUHT equality analysis for maternity services
4 Geography of Oxfordshire and Oxfordshire CCG
5 OUHT minutes of Extraordinary Trust Board meeting, 31 August 2016

**Other evidence considered**

1 OUHT briefing on obstetrics at the Horton General Hospital in Banbury, Oxfordshire, 7 February 2017
2 OUHT Trust Board update paper, 12 July 2017
3 Decision-making business case, CCG governing body meeting, 10 August 2017